From Consultant to Consultee: Lessons from a Medical Psychiatry Unit

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BACKGROUND

- Most patients on psychiatric units have at least one medical comorbidity and transfers to medical-surgical services are common.[1,2]
- Medical psychiatry units (MPUs), present in < 3% of hospitals, care for psychiatrically and medically ill patients.[3]
- **Research on the psychiatrist as a consultee is limited.**[4]
- By speaking with MPU staff, a set of psychiatric providers who frequently interface with medical-surgical providers, we can better understand how to **improve interdisciplinary collaboration and care for medically and psychiatrically complex patients.**

OBJECTIVE

- To understand perspectives of MPU staff on working with medical-surgical providers in the setting of consults and transfers.

METHODS

Four semi-structured focus groups were conducted and evaluated using a thematic analysis lens.

We recruited participants from a single NYC hospital MPU (psychiatric unit with 2 embedded medical nurse practitioners):
- 4 Psychiatry Attendings
- 5 Psychiatry Residents
- 2 Medical Nurse Practitioners

REFERENCES

Best practices for interdisciplinary collaboration between psychiatric units and consultants:

- Shared understanding of unit's medical capabilities
- Discussion of the interplay between psychiatric and medical issues
- Fostering interdisciplinary relationships and effective communication

LESSONS

Table 1: Experiences working with medical-surgical providers and factors that impacted collaboration

Understanding the Unit	"There's been a lot of **education** that I've had to do... like a patient can't really be in continuous restraints for days and be expected to transfer [to the MPU]..."	Limited understanding of the unit rules, medical capabilities, and patient population is a barrier to care. Participants discussed educating consultants.
Responding to Psychiatric Staff Concerns	"I felt completely dismissed. The [medicine] attending who came and saw [the patient] barely just looked at him from a couple of feet away, pushed on his belly, but really **didn't take anything that we had to say about what we had observed seriously**."	Participants knew when patients' medical needs exceeded unit capabilities and were frustrated when consultants did not take their concerns seriously.
Territoriality and Stigma	"Patients with psychiatric illness **are not the most loved** in the general hospital and that becomes a reason for quick transfers to [the MPU]..."	Tensions between specialties and resistance to transfers/consults exist, stigma against patients with psychiatric illness may contribute.
Benefits of Close Collaboration and Interservice Relationships	"I do think that does go a long way when you actually get to know the person aside from their Epic picture. You can get a feel for them, **you get to feel like they actually really care**..."	When psychiatric staff and consultants worked closely together and formed relationships, patients and providers benefitted.

Table 2: Outcomes: Impact on patient care

Delayed Transfers	"Something is acutely wrong with this patient and we could not get anyone to accept him from [medicine]. It progressed over a day or 2 days before he got transferred to medicine. And, what was the [diagnosis], **gangrenous cholecystitis**?"	Perceived delays in transfers from the MPU to medical-surgical services were often due to disagreements on which service was taking a patient and if transfer was warranted.
Consults Not Feasible	"So even if you as a nephrologist are saying that someone must be on dialysis. What if they are completely refusing? May not have capacity. **But what does that mean in terms of how you proceed?**"	Lack of consideration of unit capabilities and patients' psychiatric issues impacted feasibility of recommendations.
Consults Feasible	"The infectious disease fellow is amazing. She's like, we have an LAI [long acting injectable] version of an antibiotic, so **really thinking outside of the box**."	When consultants and MPU staff worked closely to create an individualized care plan, recommendations could be carried out despite unit constraints.

RECOMMENDATIONS

- **Improved Awareness of Unit Capabilities and Policies**
- **Increased Goodwill among Specialties**
- **Individualized Approach for Psychiatric Patient Population**
- **Liaison between Specialties**

DISCUSSION

- MPU staff care for medically complex patients and desire assistance from their medical/surgical colleagues in doing so. Feeling their medical concerns are heard and that consultants are willing to work closely with them is key.
- Education for medical-surgical providers on the medical limitations of an MPU and improved collaboration across specialities could help ensure realistic consult recommendations and appropriate transfers

"Even though [a patient's] psychiatric diagnosis is what is at the forefront at that moment, their [medical] comorbidities are severe and often completely untreated... so when we reach out with an issue that's currently happening or with a concern it behooves [consultants] to pause and consider that patient as an individual, what we are presenting to them in this vignette at that moment and also what the necessary treatment plan would be for that person optimally and what we are actually able to provide on our unit. So it's a multi-step process. **And it's not just a simple this is the patient, this is what you need to do, we signed off. We really need a more in-depth dedicated consultation on the patient wherein we're really collaborating."**

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