A Model for Revitalizing Psychiatry's Role in Medicine

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By Sidney Weissman, MD [1]

Psychiatrists are being marginalized in this current era of managed care and treatment teams. What can be done to secure the psychiatrist's role in the diagnosis and treatment of patients?

Time: 3 a.m. Sunday morning, Anytown, U.S.A.
An 18-year-old boy is brought to the emergency department (ED) of a community hospital. He has been in a gang fight. His shirt and pants are bloody. After taking the patient's history, the triage nurse starts an IV and urgently pages the ED physician on the intercom. A quick examination by the physician reveals multiple stab wounds to the abdomen. Immediate calls are made to the general surgeon on call and to the surgical operating room to prepare for a potential emergency procedure. Appropriate lab work is performed, with steps taken to stabilize the patient's condition while awaiting the surgeon and the availability of an operating room.

Time: 4:30 a.m. later Sunday morning in the same ED.
The police bring a 16-year-old boy to the ED for assessment. He had attended a party where alcohol was served. After consuming an indeterminate amount of beer, he told his friends that he was quite upset because his girlfriend had just broken up with him. He said that his only out was to kill himself. He then ran out of the house in the direction of the commuter train tracks two blocks away. Unable to stop him and frightened for his safety, his friends called the police. The police apprehended him and brought him from the railroad tracks to the ED.

As the triage nurse obtained the history from the police, she drew blood for labs. At this point, the patient was unable to give a coherent history. Lab results indicated his blood-alcohol level was 2.5 times the state level for intoxication. The ED physician concluded that the patient was only intoxicated and not in other medical distress. He advised the triage nurse to place the patient in observation and repeat the blood alcohol level in two hours. If it approached a range below legal intoxication, the nurse was to ask the social worker on call to assess the patient for suicide potential and determine if he needed either a psychiatric evaluation or hospitalization. Analysis
These two cases involve two boys of similar age with potentially life-threatening conditions who were seen and treated in the same ED in two totally different ways by the same staff. The first boy's care was directed by the ED doctor to a surgeon. The second boy's care was directed by the same doctor to a non-M.D. Each boy had an equally life-threatening situation. For the boy with the stab wounds, a surgeon was critical for his ongoing care. For the intoxicated suicidal boy, a non-M.D. was seen as appropriate.

Are psychiatrists not seen as front-line physicians for acute, serious mental disorders? Why wasn't a psychiatrist called to assess the potentially suicidal boy? Was this hospital's response new in the treatment of a suicidal patient or was this the standard of care?

The answers to these questions will go a long way in explaining psychiatry's current status in society and medicine. Who are the actual front-line deliverers of care for the seriously or chronically mentally ill? A varied group of providers and organizations have been developed to provide services for these patients. Community mental health centers provide care to individuals with serious and chronic mental illness. These community-based agencies are staffed by a mix of community residents, social workers, psychologists, counselors and physicians who may or may not be a psychiatrist.

The initial interaction for a distressed individual seeking care in a community mental health center will either be with a nonprofessional community worker or possibly a social worker. If they determine that the mentally ill individual needs further assistance or assessment, they will make the essential arrangements. This could include enrollment into a day program, a detoxification program, hospitalization or referral for medication. The psychiatrist in these settings is usually not the patient's initial contact. The psychiatrist may be asked for assistance in diagnosis, but the usual psychiatric intervention is to provide medications for another mental health care worker's client.

Follow-up to the physician will usually be only to assess and provide medications. Responsibility for
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oversight of a patient's care is by a treatment team, which may or may not include a psychiatrist. Various arguments are used to support this system: because psychiatrists do not want to work with individuals with severe mental illness, other mental health care professionals have to assume responsibility for patient care; psychiatrists are expensive and not cost-effective; medical training interferes with a physician's ability to understand the special issues that seriously or chronically mentally ill individuals face. For whatever reason, psychiatrists are not the key players or the captains of the treatment team, and they may not even be on the treatment team in some treatment centers.

The community hospital emergency department follows this model. Even though initial patient interactions are with medical staff, the ED has demedicalized mental health care at the point of the patient's critical psychiatric assessment. Although a psychiatrist supervises the on-call mental health care worker who actually sees the patient, the psychiatrist will seldom see or know the patient and will usually defer decisions to the non-M.D. mental health care worker.

It might be argued that this is only a model of care provided by community mental health centers, community hospitals or community hospital EDs at night. Yet variations of this model exist in various teaching hospitals and HMOs. New outpatients are seen by nurses, social workers, psychologists, and psychiatrists or other physicians. A nurse or social worker, in combination with a psychiatrist, may also see a patient where they take the psychosocial history. The patient is assessed by the physician, who confirms the diagnosis and prescribes medications, if necessary, while the other members of the team provide psychosocial treatments.

In situations where a joint assessment is not built into the evaluation, follow-up care may be provided by an array of practitioners that might not include a psychiatrist. Furthermore, there might not be any input from the psychiatrist in the disposition.

For individuals who are not members of an organized health care system, the choice of which mental health care provider to select is not clear. They may not know the differences in training between psychiatrists, psychologists, counselors and social workers. Individuals who speak to their primary care doctors first are as likely to be referred to a social worker as a psychiatrist. If the social worker feels that the individual might benefit from medication in addition to psychotherapy, the internist might be asked to provide it. Frequently, HMOs steer patients to nonpsychiatrists and use psychiatrists only to provide medication. The individual seeking care is not likely to obtain an explanation for why they were seen by a particular mental health care provider. In some group practices headed by psychiatrists, most of the professionals are non-psychiatrists, and the psychiatrists essentially function to provide medication treatment and assist in diagnosis if asked by other professionals.

One might argue that this process of non-M.D.s providing key services in psychiatry is not significantly different from what physician extenders or nurse practitioners do in other areas of medicine. Yet I believe it is. Laws regulate the relationship of other providers to physicians, and usually an oversight relationship exists with the physicians. In psychiatry, it would seem that the non-M.D. frequently determines treatment. In some community settings, bachelor's degree-level or community workers can override the judgment of psychiatrists or other mental health care professionals with advanced training. In addressing psychiatric disorders, we have large numbers of individuals with varied educational and training experiences making critical health care decisions. Psychiatry has not made it clear to patient groups, potential patients or various medical professionals (including other mental health care professions) what the essential criteria are for seeing one mental health care professional rather than another. Furthering this confusion are the diverse names given to psychiatric clinics; psychiatric clinics, mental health clinics, behavioral health clinics or neurobehavioral health clinics may all see the same patients and be staffed by individuals with similar training. In some universities, even the name of the department of psychiatry has been altered, which reduces the focus on psychiatry. I might note that I have not heard of surgical clinics changing their names to "Invasive Health Care Centers" because they feel some individuals are afraid of surgery. Yet all of these actions occur in psychiatry.

Do psychiatrists feel stigmatized by working in psychiatric clinics? Is there something wrong with being called a psychiatrist? **Call to Action**

In light of this confusion as to what psychiatry is and what psychiatrists do, we must take an immediate set of actions:

1. Define psychiatry's core knowledge base.
2. Define the core skills essential to practicing psychiatry, such as performing in-depth assessments; using psychopharmacologic agents; practicing psychotherapy; and evaluating psychiatric research, particularly as it relates to clinical practice.
3. Assure that all psychiatric practitioners possess the essential knowledge and skills to treat patients.
4. Develop practice parameters in conjunction with other mental health care providers that outline psychiatrists' roles.
5. In conjunction with other mental health care providers, develop practice parameters that outline who is the appropriate mental health care worker to address varied clinical situations.

Once we have acted on these five points, we will have to battle to implement them. Psychiatry's failure to define itself will only mean that we will have a declining role in the practice of mental health care. However, by addressing each of these points, psychiatry can have a robust future.

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