Process of Psychiatric Consultation in the Medical Setting

Elena Friedman, M.D.
Philip R. Muskin, M.D.

Abstract: Psychiatric consultation in the general hospital differs greatly from consultation in psychiatric clinics or private offices due to the nature of the patients' medical illnesses and the physical setting of the hospital. This review highlights these differences and describes the process of the in-hospital psychiatric consultation. We examine specialized patient populations and important consultation scenarios, as well as ways in which patients and physicians cope with medical illness. We address bedside recommendations for clinicians and examine some of the controversies in consultation-liaison psychiatry.

Clinical context

History

The connection between the mind and physical symptoms appears with Thomas Sydenham's 1682 description of hysteria where he brought forth the notion that this condition of the mind could mimic any organic disease. Johann Christian Reil, a German physician who coined the term "psychiatry," urged clinicians to use medical psychotherapy to cure both physical and mental illness. A monumental step in the reconceptualization of psychiatry as a medical discipline occurred when Benjamin Rush published the first textbook of mental diseases. In the late 19th century, Breuer and Freud cemented the understanding of psychological phenomena manifesting as physical symptoms in *Studies of Hysteria* (1).

In 1818, Johann Christian Heinroth used the word "psychosomatic" to describe insomnia, declaring that the soul (psyche) and the body were one and the same. In 1922, Felix Deutsch coined the term "psychosomatic medicine" in describing conversion (1). Franz Alexander, a physician and psychoanalyst, is commonly referred to as the father of psychosomatic medicine. In *Psychosomatic Medicine: Its Principles and Applications* (1950), he linked specific unconscious conflicts and organic disorders known as the "holy seven," such as peptic ulcer, asthma, and hypertension (1). While his exact theories did not endure, he was instrumental in bridging the gap between psychoanalysis, psychiatry, and medicine.

Adolf Meyer, the director of the first university-based psychiatric clinic and the father of psychobiology, lay the groundwork for consultation-liaison psychiatry by integrating psychiatry into the main hospital. He promoted the idea that psychiatrists should be involved in medical care on the wards (2).

By the middle of the 20th century, many researchers and clinicians started to wonder about the influence of stress on medical illness. Respect for psychiatry grew as soldiers returned home from war with psychiatric illnesses, and psychiatrists began to work with internists and surgeons. Consultation Psychiatry was considered to be the clinical aspect of the field, while the term "psychosomatic medicine" was used to describe ongoing research.

As psychiatric units started to open in general hospitals, psychiatrists began to work side-by-side with other physicians and to round on the medical floors. Albert Barrett was likely the first to refer to psychiatry as *liaison* to medicine in 1922 (1). A formal consultation-liaison service was created at Massachusetts General Hospital in 1956, and by

Author Information and CME Disclosure
Elena Friedman, M.D., Assistant Professor of Psychiatry, Weill Cornell Medical College/New York Presbyterian Hospital

Philip R. Muskin, M.D., Professor of Clinical Psychiatry, Columbia University; Chief: Consultation-Liaison Psychiatry at Columbia University Medical Center/New York Presbyterian Hospital

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Address correspondence to: Philip R. Muskin, M.D., Chief, Consultation-Liaison Psychiatry, Columbia University Medical Center/New York Presbyterian Hospital, 622 West 168th St., Mailbox #427, New York, NY 10032; e-mail: prm1@columbia.edu

the 1970s there was a psychiatrist on every MGH ward. C-L psychiatry became a residency requirement in 1987. Levitan and Kornfeld showed that C-L could be cost effective to the hospital (3). In 2001, "Consultation-Liaison Psychiatry" changed to "Psychosomatic Medicine," becoming the seventh accredited psychiatric subspecialty in psychiatry in 2003. It was defined by a population and not by an illness. The population served was described as complex medically ill, which includes patients with somatoform disorders, patients who have mental disorders secondary to primary medical conditions, and patients whose psychiatric disorders affect their medical care.

PROCESS OF PSYCHIATRIC CONSULTATION

Psychiatric consultation in the general hospital differs from an outpatient consultation. Due to the pressure to reduce the length of stay, consultants must perform the assessment and provide recommendations in a swift manner. There are many barriers to a speedy assessment. Patients are often debilitated and/or in pain and are unable to participate in lengthy interviews. There are numerous interruptions to the consultation: patients must be seen by the primary team or other consultants, their vital signs must be taken, and they might be taken away for procedures. The ability to reproduce the comfortable and private atmosphere of the office is all but an illusion in the hospital setting (4).

While patients come to the psychiatrist's office often, if not always, of their own accord, patients in the hospital might not know about the psychiatric consult. Thus they might perceive it as an intrusion or as a sign that their doctor thinks they are "crazy." The physical structure of the hospital does not help matters; its size, odor, and the confusing labyrinth of rooms and hallways may be anxiety provoking for both the patient and the consultant. Upon entering the hospital, patients relinquish their armamentarium of comforting measures, including constant access to family, clothing, and other personal items. Patients give up their privacy, control over their surroundings, and even control over bodily functions (4).

In their offices psychiatrists are the primary decision makers. Psychiatric consultants must learn to relinquish control to the medical or surgical team. In the hospital we can recommend and give advice, but that does not always determine what actually happens. At times we serve at least three masters: the patient, the medical team, and the hospital system. Consultants must become experts in managing responsibilities to all three.

Meyer and Mendelson note that uncertainty and responsibility in the clinician drive the request for a psychiatric consultation (5). Problems that commonly lead to requests for psychiatric consultations include acute stress reactions, aggression, agitation, substance abuse/intoxication/withdrawal, anxiety, depression, presence of psychiatric history, delirium, dementia, need for capacity determination, somatoform disorders, pain, malingering, personality disorders, psychosis, and suicidality (6). Lipowski proposes a classification of five diagnostic problems: psychological presentation of organic disease, psychological complications of organic disease, psychological reactions to organic disease, somatic presentation of psychiatric disorders, and "psychosomatic" disorders (7).

The tasks of consulting psychiatrists are diverse. We may need to diagnose and treat a medically ill patient with a psychiatric disorder and then transfer the patient to a psychiatric unit. We may be called to help manage behavioral disturbances that are part and parcel of certain medical illnesses, such as dementia, delirium, and traumatic brain injury. These tasks require a good understanding of the behavioral manifestations of a variety of medical disorders (6). Many patients require our assistance to cope with the hospital environment or with the experience of a debilitating illness. Some patients require brief psychotherapy, and consultants must possess the skills to provide such treatment. At the same time a consultant must be well versed in psychopharmacology. We assist the team in dealing with difficult or uncooperative patients, helping to manage countertransference and resolve conflicts. We must always be sensitive to the effects of the patient on the staff (6). We are often asked to assess a patient's capacity to make decisions, and as many as 10% of consultations are for this request (8, 9). We are involved in ethically and legally complicated cases dealing with end of life issues, surrogacy, and guardianship. Psychiatric consultation provides an educational opportunity to teach in real time regarding real patients, and the consultant should be skilled in bedside teaching.

According to the Academy of Psychosomatic Medicine Practice Guidelines, the aims of the psychiatric consultation include ensuring patient's safety within the medical setting, collecting history and medical data, performing a mental status exam and neurological/physical exam when necessary, establishing a differential diagnosis, and initiating treatment (6). The consultant should remember that the ultimate goal of each consultation is "the promotion of improved patient care" (10). Consultants are not responsible for providing psychotherapy to the consultee; however, we may help the

consultee in gaining self-insight in so far as it aids in providing better patient care.

TREATMENT STRATEGIES AND EVIDENCE

A consultation usually starts with a message or a page, which might include the patient's name, location, and the reason for the request. The "reason" might be terse, vague, and sometimes confusing. The first step of the consultation is to speak directly with the referring clinician to decipher the reason for and the urgency of the consult. It is crucial to learn the facts of the patient's medical and psychiatric history (if known), the reason for admission, and the reason the physician is requesting the consultation. We must discern the "secondary process" or the explicit message of the request and the "primary process" or the implicit message. Is the patient requesting a psychiatrist due to suffering or is the physician unable to cope with the patient's suffering but requesting a consultation for the patient? Is the medical team angry at the patient due to lack of progress or cooperation? Does the physician feel frustrated and hopeless and want to transfer responsibility for the patient to the inpatient psychiatric team? Is the main issue the patient or the team's response to the patient? The consultant must keep in mind exactly who requested the consult, "why now, why this way, what led to it, what can be done to influence it?" (4).

To elucidate the answers the consultant may ask what the referring clinician thinks the answer to the consult question is and what s/he envisions would be a helpful intervention. One way to achieve this is to ask, "How can I help you?" The consultant must also ensure the patient's awareness of and agreement with the request for psychiatric consultation, absent an emergency. We must keep in mind the urgency of the consultation. Emergent consultations include suicidality, use of physical restraints, treatment over objection, behavioral disturbances, attempts to leave against medical advice, and capacity evaluations in urgent medical conditions.

After speaking with the primary team, the consultant should review the available current and prior medical records. Sometimes records are in storage and cannot be obtained for days but hopefully electronic health records will change this. Particular attention should be paid to disorders that may present with psychiatric symptoms (e.g., SLE, MS, seizures, TBI, anti-NMDA antibody disorders, etc.). Consultants need to review and compare patients' home medications with medications received in the hospital, keeping in mind medications that cause psychiatric disturbances (e.g., steroids, interferon, beta blockers) and withdrawal symptoms (benzodiazepines, barbiturates, antidepressants) (11). Approximately 5% of the population abuses alcohol, and a consideration should always be given to behavioral symptoms related to alcohol withdrawal, even when patient and/or family deny alcohol use. All pertinent test results merit review, including blood work, ECG, and imaging studies, to assess if any metabolic or neurological abnormalities may account for the behavioral symptoms. Nursing notes often yield clues to the patient's mental states, behavior, and personality traits. Social work notes provide information about the patient's social and psychiatric history. A consultant might need to gather collateral information from family, friends, and outside providers, especially in cases of emergencies and for patients with impaired mental status.

After reviewing the information, the consultant interviews the patient. In the medical setting the psychodynamic principles of neutrality, abstinence, and anonymity may not readily apply (12). Consultants should attempt to be engaging and helpful and aid the patient in improving any physical discomfort or pain. It is important to address the patient's views about the medical illness, the psychiatric consultation, and the interactions with the medical team and the hospital setting (12). The interview should begin with open-ended questions and move between biologically and psychodynamically informed models, depending on the patient's presentation and needs. Special attention needs to be paid to the patient's mental status. Assessment of the patient's level of consciousness, orientation, attention, memory, language, executive function, mood, affect, perception, insight, and judgment all must occur during the interview (11). While some of these are assessed while conversing with the patient, others may need to be determined formally by cognitive testing such as the MMSE, MOCA, or clock-drawing test. The consultant should also be comfortable performing at least a limited physical exam when necessary (e.g., testing for tremor and tongue fasciculations in alcohol withdrawal, testing for rigidity in a patient on an antipsychotic, looking for signs of self-injury) (11). While the interview and the exam should be focused on trying to address the concerns of the primary team, the consultant must keep an open mind and consider other explanations. The request might be to assess depression but we might find a delirious patient. The "anxious" patient might be in active withdrawal.

After the interview, the consultant should put together a diagnostic formulation and treatment recommendations, deciding whether further diagnostic workup is necessary. The most common tests requested by psychiatrists include CBC, CMP,

TSH, folate and cyanocobalamin levels, ßhCG, urine and serum toxicology, RPR, HIV, urinalysis, and electrocardiogram (11). Thyroid function tests should be examined with caution, since they are abnormal in up to one-third of psychiatric patients, without evidence of true thyroid disease (13). Neuroimaging may be considered in the case of delirium of unclear etiology, dementia, new-onset psychosis, and mental status change with history of head trauma (14).

Consultants should write a succinct note that is free of technical jargon. While psychodynamic understanding of the patient may inform the assessment and recommendations, it may not need to be part of the note (11). The note should include a clear differential diagnosis and unambiguous diagnostic and treatment recommendations, addressing the initial consult question.

Research indicates that primary medical diagnosis, psychiatric diagnosis, psychotropic drug class, the title of the consultant, and the service requesting the consultation have no bearing on the concordance rate with consultants' recommendations (15). Concordance rates increase when the exact drug and the exact dose are specified, and when multiple drug recommendations are made. Concordance rates are lower with recommendations to start and discontinue medications (versus adjust or continue). Therefore, to increase concordance rates, the consultant must be as specific as possible and provide alternatives for the proposed treatment, where appropriate.

Along with writing a note, the consultant should discuss all recommendations directly with the referring physician and with the patient. Follow-up visits are often required. Daily follow up is appropriate for patients who are suicidal, agitated, violent, delirious, on constant observation, or psychiatrically unstable in other ways (6).

SPECIALIZED POPULATIONS

The consulting psychiatrist may work with many specialized populations, such as obstetrics, transplantation, HIV, and oncology patients. Details of every subspecialty are beyond the scope of this paper, but we will mention some areas of interest.

In obstetrics, we may be asked to aid in infertility assessment and to ascertain potential psychiatric causes and sequelae of infertility. We may assess a woman's feelings and understanding of hysterectomy and its aftermath, counsel patients after spontaneous and elective abortions, assess psychosexual factors in vulvodynia, and work with pregnant women on the psychological and physical stresses of pregnancy. We assess antepartum and postpartum psychiatric illnesses, such as depression, mania, psychosis, and substance abuse; providing recommendations regarding psychopharmacology in pregnancy and lactation (16). A psychiatrist may be asked to evaluate maternal competency or the capacity to care adequately for a newborn (17).

Psychiatrists who work with HIV patients help treat and diagnose neuropsychiatric complications and symptoms, such as cytomegalovirus, toxoplasmosis, neoplasms, and fatigue. Depression, delirium, dementia, and substance abuse occur at high rates in patients with HIV, and consultants should have expertise in psychopharmacology to understand interactions between psychotropic medications and HAART (18, 19).

The psychiatric consultant to oncology evaluates patients' adjustment to the diagnosis and treatment. We evaluate and diagnose depression and anxiety, which may interfere with treatment adherence. Management of illness and treatment complications, such as mania and delirium, is often necessary. End-of-life issues are an area of importance and goals of care should be part of every consultation (20).

A psychiatric consultant is an integral part of the transplant team. Psychiatrists aid in evaluation of the patient's eligibility for transplant, identify needs that must be addressed prior to transplant, and assess risk factors that foreshadow poor outcomes (21).

SUICIDAL PATIENT

An important scenario that warrants consideration is the assessment and treatment of suicidal patients. Consultants are asked to evaluate patients after a suicidal attempt or gesture or patients who have expressed suicidal thoughts. The first task is to assess the risk and to ensure the patient's safety. Medical/surgical units are full of items that can be used for self-harm, such as cords, needles, medications, windows that open, and patients' own belongings. Medical/surgical units are unlocked, and the medical personnel may not be trained in suicide safety measures (22). The consultant must educate staff, ensure a secure environment, and when appropriate, place the patient on constant observation. The second task is to identify causes of suicidality and impulsivity, and to determine which of the causes are reversible and can be treated. A patient may be intoxicated, withdrawing, delirious, psychotic, and/or depressed. While some medical illnesses, such as cancer, HIV, and Huntington's disease, have been associated with increased risk of suicide (22), it is psychiatric illness that portends the highest risk. Treating the psychiatric illness, as well as symptoms of medical conditions, such as pain, insomnia, and disinhibition, may significantly lower the suicide risk.

The consultant must also aid in the transfer of the patient to a psychiatric unit if necessary and evaluate whether the patient is truly "medically cleared" before transfer. Countertransference toward the suicidal patient on the part of the medical team can lead to clearing the patient prematurely without a proper medical workup (22). For any transfer to a psychiatric ward, the consultant should make sure that the ward is able to handle any required medical care (6).

AGITATED PATIENT

The assessment of agitated patients is another reason for urgent consultations. The first task is to assess risk and to ensure the safety of the patient and of the staff. If the patient does not respond to verbal redirection, it may be necessary to use calming medication and mechanical restraints, and security may need to be called. The second task is to identify the causes of agitation as early as possible, since this information will help elucidate the best management strategies. Common causes of agitation include delirium, dementia, psychosis, and drug intoxication/withdrawal. Agitation can represent a behavioral concomitant of a medical disorder. Patients with mood and personality disorders can also become extremely agitated. The consultant's task is to discern what is psychiatric in nature and what is not.

If agitation is due to delirium, the consultant may help manage the agitation as well as guide the team to determine the cause. The prevalence of delirium is 10%−30% in the general medical populations and up to 80% in the ICU population (23). Untreated delirium is associated with higher morbidity and mortality (24). Delirium can be hyperactive, hypoactive, or mixed. Hyperactive delirium can present as agitation, prompting a psychiatric consult. Hypoactive delirium, on the other hand, can be mistaken for depression. The main treatment of delirium is correction of the underlying cause(s) (infection, medication side effect, metabolic derangement, etc.). A careful chart review and work up may elucidate a potential cause, though the pathogenesis of delirium is often multifactorial. In addition to correcting the underlying cause, behavioral manifestations of delirium, such as agitation, paranoia, hallucinosis, and confusion can be treated behaviorally and pharmacologically. If behavioral interventions fail, antipsychotics are the mainstay of treatment. As always, risks and benefits of the medications should be assessed carefully. The FDA has issued warnings regarding first- and second-generation antipsychotics as treatment of behavioral disorders in elderly patients with dementia, stating that these medications are associated with increased mortality. Long-term antipsychotic use may put patients at an increased risk of extrapyramidal symptoms (EPS), cardiac events, hyperglycemia, hyperlipidemia, and metabolic syndrome. Short-term use may increase the risk of EPS, sedation, as well as prolonged QTc interval, which is associated with torsades de pointes and sudden death. In addition to antipsychotics, an alpha-2 agonist, dexmedetomidine, has been investigated recently as a treatment for delirium (25). Risks of medications should be weighed against risks of untreated symptoms, such as agitation and psychosis. Lowest effective doses should be used, medications should be discontinued when it is safe to do so, and drug-drug interactions should be considered carefully.

Agitation may be due to drug withdrawal. Alcohol, benzodiazepine, and barbiturate withdrawal may present with anxiety, agitation, tremor, hyperreflexia, vital sign instability, hallucinosis, confusion, and seizures. It is important to understand the cause of delirium or agitation, since treatment with benzodiazepines can improve alcohol or benzodiazepine withdrawal, while exacerbating delirium due to other conditions. If withdrawal is suspected, patients should be treated promptly, usually with benzodiazepines (26). Exact medication preferences for withdrawal treatment are institution-specific and are beyond the scope of this paper. In general, benzodiazepines with fast-onset of action should be used frequently initially, with the goal of minimizing withdrawal symptoms, erring on the side of mild sedation rather than agitation. Once the symptoms are controlled, the physician should calculate the average daily medication requirement and switch the patient to a standing medication regimen. If the patient has only mild signs of withdrawal and does not have a significant withdrawal history, benzodiazepines can be used on an as-needed basis. If the patient requires significant amounts of benzodiazepines and continues to have withdrawal symptoms and/or autonomic instability, transfer to an ICU should be considered. Overall, it is best to have a clear protocol for medications, including doses and frequencies, that are administered based on objective measures, such as CIWA (Clinical Institute Withdrawal Assessment) scores (27–29). Patients with alcohol abuse, as well as patients with other risk factors for nutritional deficiency, should be started on intravenous or intramuscular thiamine (30).

ASSESSMENT OF CAPACITY

Psychiatric consultants are frequently asked to assess capacity in spite of the fact that any physician can assess capacity. Psychosomatic medicine practitioners do not rate their capacity assessment training highly, they find capacity consultations to be more challenging and time-consuming than other

consultations, and feel they have less of an evidence-base to rely upon (31). Psychiatrists are asked to assess capacity if the primary physicians are not aware that they are permitted to make the assessment, are unsure of whether the patient has capacity, or have an answer in mind but want legal protection in the form of a psychiatric evaluation. Nearly 40% of capacity requests are actually not about capacity and many such requests entail underlying ethical dilemmas (9, 32). If there is a need to determine capacity, the consultant must clarify that capacity is specific to a particular decision, since the same patient may have capacity to make one decision, such as appointing a health care proxy, but not another, such as consenting to a complicated surgical procedure (6). The consultant must also clarify the urgency of the consultation, the extent of the information provided to the patient, and the significance of the decision. The determination of capacity is relative; the threshold for capacity varies based on the urgency of the situation and the risks of the treatment and the alternatives (33). Appelbaum suggested four criteria for determining capacity: communicating a choice, understanding the relevant information, appreciating the situation and its consequences, and reasoning about treatment options (8). Research shows that most common diagnoses in patients lacking capacity are dementia and delirium, followed by psychoses (31). The consultant can recommend treatment for potentially reversible causes when the patient is found to lack capacity. Although psychiatric symptoms may at times contribute to lack of capacity, a psychiatric diagnosis in itself does not automatically preclude a patient's ability to make decisions.

DEPRESSED PATIENT

A common reason for consultation involves assessment of depressed mood. A patient who appears depressed may have hypoactive delirium, adjustment disorder or major depressive disorder. Mood disorders are prevalent in patients with chronic medical illnesses. The presence of depression can worsen medical prognosis, worsen adherence to medical treatment, increase morbidity, and decrease survival (34, 35). Depression increases the risk of coronary and cerebrovascular disease and worsens prognosis in patients with existing cardiac disease or history of strokes. Depression can affect the course of neurological disorders, diabetes, cancer, and HIV, complicating treatment, worsening prognosis, and increasing health care costs (34).

COPING WITH MEDICAL ILLNESS

Hospitalization is potentially stressful for even the most well-adjusted patient. Numerous authors have addressed the issues that patients must handle when hospitalized (36, 37). Consultations are often generated in response to patients' maladaptive coping with medical illness and hospitalization, particularly regression. Emotional responses to medical illness include anxiety, anger, shame, sadness, guilt, and relief. Such emotional and/or behavioral responses may interfere with diagnostic workup and treatment. Patients' subjective experience and behavior may be influenced by personality type, coping style, and defense mechanisms (38). Countertransference can be a powerful guide in helping the physician understand the patient's internal state and personality type (39).

The seven personality types (oral, compulsive, hysterical, masochistic, narcissistic, schizoid, and paranoid) first described by Kahana and Bibring (40) that determine subjective experience and behavior are still useful. These habitual ways of dealing with the world may work well when the person is not medically ill but may interfere with treatment and provoke countertransference reactions in treaters.

Understanding the coping styles of each personality type can help the consultant to understand the patient's experience and tailor management appropriately. A more modern approach to the personality types, based upon DSM terminology, is useful in understanding such patients (41).

Groves in 1978 described four types of challenging patients: dependent clingers, entitled demanders, manipulative help-rejecters, and self-destructive deniers (42). Dependent clingers can be compared with Kahana and Bibring's oral personality type. They are needy and evoke aversion and anger in their treaters. Management of such a patient includes firm limit setting in addition to empathy. Entitled demanders, like patients with narcissistic personality type, use intimidation and devaluation to control the physician and provoke a fear and a wish to counterattack. Their entitlement should be acknowledged and used as a tool to involve them in partnering with a physician to get the best care possible. Manipulative help-rejecters, like the masochistic patients, appear hopeless and do not improve despite extensive workup and treatment. They do not seek symptom relief but rather an ongoing relationship with a caregiver. They evoke feelings of inadequacy in the physician. The treater needs to convey that losing the symptom does not mean losing the doctor. This can be done by scheduling frequent follow-up visits that are independent of symptom severity. Self-destructive deniers appear to work hard to not stay well, likely because they have given up hope of ever getting better. They evoke rescue fantasies as well as wishes for the patient's death. The physician should

recognize limitations of caring for such patients and not expect to be able to provide perfect care. The physician should rule out depression in this kind of patient.

In addition to personality types, a patient's coping style determines the way he or she deals with medical illness (38). To elucidate one's coping style, a consultant can ask patients how they have dealt with stressful situations in the past. Folkman et al. (43) divide coping strategies into problem-focused and emotion-focused. They note that when people see the situation as within their control, they use problem-focused coping strategies. When people see the situation as out of their control, they use emotion-focused coping. The consultant can change the patient's appraisal of the situation and help the patient feel in control and, thus, use the problem-focused coping strategy (38).

Patients' experience of illness and response to illness can also be influenced by defense mechanisms (38). A psychiatric consultation may be initiated if the patient uses denial that the primary team cannot comprehend. Denial can be adaptive and can help the patient to not become overwhelmed. It can also be maladaptive if it delays diagnosis and treatment or causes nonadherence. Denial becomes maladaptive when it causes a distortion of reality (42). The best way to deal with denial is to work on the emotions underlying denial, instead of confronting the patient. Improving anxiety, fear, and sadness may decrease the patient's need for denial (42).

One behavioral response that may precipitate a psychiatric consultation is signing out against medical advice. Albert and Kornfeld (44) identified overwhelming fear, anger, and psychosis or confusion as the most common reasons for signing out against medical advice. By empathic listening a psychiatrist can help decrease the patient's frustration, make the patient feel understood, and allow the primary team to re-engage with the patient (38).

In general, ways to improve treatment adherence include informing the patient of the illness and treatments, ruling out cognitive deficits, addressing psychological motivating factors, minimizing side effects and complexity of the treatment, involving the family, using positive reinforcement, and building alliance with the patient (38).

The psychodynamic life narrative is a brief intervention that helps some patients deal with illness and hospitalization and is based on the premise that all patients have a life narrative underlying their response to illness (45). The psychiatrist "comes to understand the underlying dynamics that have formed the trajectory of the patient's life, his personality type, his ego strengths and weaknesses, and his core conflicts." (46). The psychiatrist then forms a psychodynamic narrative of the patient's life, which is presented to the patient. This narrative focuses on how the medical illness has compromised the patient's sense of identity and connects the illness and the patient's response to the illness to the narrative of the patient's life. When successfully employed, the patient feels understood and develops better coping mechanisms (45).

We have described the ways in which patients cope with illness. Equally important is how physicians deal with performing psychiatric consultations. There are three maladaptive approaches to working with medically ill patients: pseudoanalytic, rigidly biological, and overly sympathetic (10). A pseudoanalytic physician is "excessively stilted and constrained" and fearful of being spontaneous. A rigidly biological physician treats a patient as a constellation of symptoms and does not pay attention to dynamics of the interactions, using emotional detachment and intellectualization. An overly sympathetic physician fails to establish sufficient distance from a patient and loses perspective. A "therapeutic stance" approach works best, deviating as necessary from the standard anonymity, abstinence, and neutrality (12). There are three maladaptive responses in working with medical teams, which include being overly competitive, solicitous, or detached. In such situations the physician might assume a "liaison stance," which involves establishment of an alliance and use of therapeutic maneuvers to alter staff behavior (47). This approach encourages consultants to use psychodynamic knowledge not only to understand the patient's feelings and behavior, but those of the staff as well.

Questions and controversy

Controversy about the relative importance of consultation and liaison models has existed for years. In the 1980s, Thomas Hackett, the MGH department chair, downplayed the importance of liaison. He referred to the service as *consultation* only, arguing that, "liaison service requires manpower, money, and motivation" (1). In contrast, Ralph Kaufman at Mount Sinai Hospital felt that liaison was the most important role of a hospital psychiatrist. More recently, the controversy has been between liaison and embedded psychiatrists, with a growing shift toward collaborative care.

To improve depression and medical illnesses, some researchers have advocated a collaborative primary care team model. In patients with depression and diabetes or coronary heart disease, a collaborative care intervention aimed at improving depression and diabetes improved quality-adjusted-life-years, added depression-free days, and decreased health costs (48).

A collaborative approach to depression in patients with HIV/AIDS was effective in improving depression, as well as immunologic and virologic outcomes (49). Questions remain whether psychiatrists will become embedded in primary care settings, and if they do, what their role will be on the team. Will they have a liaison role while primary care physicians treat mentally ill patients, will they see all patients with mental illness, or will they do something in-between?

Many psychiatric consultations are performed in community-based settings and involve primary care physician (PCP) referrals to outpatient psychiatrists. This creates potential issues in access to care for patients with comorbid disorders. A collaborative care approach may help address some of the obstacles inherent in this process. Current barriers to outpatient consultations include provider characteristics (shortage of providers, time limitations in high-volume practices), patient characteristics (lack of insurance, stigma of mental illness, lack of awareness of treatment possibilities), and system factors (managed care, limited coverage of psychiatric services). Two-thirds of surveyed PCPs report that they are unable to get outpatient mental health services for their patients. They cite lack of insurance coverage, lack of providers, and health plan barriers/managed care restrictions as the main reasons for lack of access to mental health care (50). While a collaborative care model may bring more mental health providers into community clinics, its impact might be limited by managed care restrictions. How the model currently in use will translate into the world of fee-for-service medicine is unknown. How health homes will modify the care of the complex medically ill also remains to be seen.

Controversy aside, collaborative care may be where the future of primary care and perhaps some portion of psychiatric outpatient services are heading. Inpatient psychiatric consultation will always be a necessity as there will always be patients admitted with psychiatric and other complex medical problems. There are now hospitalist psychiatrists embedded in medical teams, who round with the teams and attempt to preempt psychiatric issues, rather than waiting to be consulted. This approach may lead to early detection of patients at risk for psychiatric comorbidities. Whether a consultation-liaison psychiatrist or a dedicated hospitalist psychiatrist is more effective remains to be seen.

Another controversy involves pharmacological prophylaxis of delirium. Given the high morbidity and mortality of delirium, researchers have investigated the use of antipsychotics, alpha-2 agonists, and ketamine for delirium prevention (21); results have been mixed. A recent meta-analysis found that antipsychotic prophylaxis reduces the risk of postoperative delirium in the elderly (51). It remains unclear whether prophylaxis leads to reduction in morbidity and mortality and which medications are most efficacious. More research is needed to understand the potential risks and benefits of delirium prophylaxis.

RECOMMENDATIONS FROM THE AUTHORS

We have included our recommendations throughout this manuscript. We will conclude with bedside manner suggestions outlined decades ago, but still valid today (52, 53). When seeing a patient, the consultant should sit down. This conveys to the patient that the physician intends to spend some time with the patient. The consultant should do something tangible to make the patient more comfortable (bring water, adjust bed/pillow). The consultant should ask the patient about his/her most pressing concerns as well as any concerns about pain, disability, and death, if applicable. The physician should try to understand the patient's beliefs about the illness as well and the impact the illness has had on the patient's life roles and relationships. The consultant should validate the patient's current experience, discuss the patient's accomplishments and compliment the patient in order to improve self-esteem and combat demoralization, which is common in the hospital setting. Lastly, the consultant should discuss with the patient his/her formulation and recommendations. Above all, the consultant should attempt to make the patient's likely difficult experience more comfortable and humane.

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