ACLP How To Guide: Doing a Consult

How to Do a Consult

Learning Objectives:

1) Clarify the consult question, including both explicit and implicit requests
2) List the necessary steps to carry out a psychiatric consultation in the medical-surgical setting
3) Build skills for conducting a psychiatric interview in the medical-surgical setting

Step 1: Clarify the question

Direct conversation with the primary team is needed to clarify the consult question, which may or may not be clear initially. Sometimes the question initially stated by the primary team is too broad, too specific, not something psychiatry can do, etc. Remember that the primary team is calling psychiatry because *they want help*, and through discussion you can usually arrive at a mutually agreeable consult question. This will help you perform an appropriately focused evaluation.

Examples of clear and specific consult questions:

- Assess for depression/anxiety
- Evaluate change in mental status
- Treatment recommendations for anxiety and insomnia
- Psychotherapy to assist with coping with illness
- Psychopharmacology recommendations in the medically ill
- Assess safety (SI/HI)
- Assess decision making capacity
- Substance detoxification and rehabilitation
- Manage agitation
- Assess reasons for treatment non-adherence
- Treatment referrals

Examples of vague consult questions:

- HELP! This patient is difficult.
- Please transfer the patient off our service
- Help referee conflict between team members and patient
- Make the patient more adherent
- Community-based program requires a consult prior to acceptance
- Attending insists on the consult
- Can we discharge this challenging patient?

Step 2: Review the chart

- Much of the important and necessary information for a consultant will come from thorough chart review.
- Patients often experience frustration with providers who have not reviewed the chart prior

Carrie L. Ernst, MD, Vers. 10/09/2020
Laura Brogoch, MD and Joseph Dragonetti, MD, Vers. 10/24/2024
Residency Education Subcommittee

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to an evaluation and may be easier to engage if confident that the provider is familiar with their history.
- May begin to write the note while reviewing the chart.
- Especially helpful elements of the chart include:
    - Previous psychiatry or neurology notes
    - Current inpatient and outpatient medications: focusing on psychotropics, medications with neuropsychiatric side effects (opioids, steroids, anticholinergics), medications that may be involved in drug-drug interactions or prolong the QT interval
    - Controlled substance database (Prescription Drug Monitoring Program)
    - Brain imaging
    - Labs
    - EKG (QTc interval)
    - EEG (if done)
    - Vitals: any suggestion of sedative-hypnotic withdrawal, infection, hypoxia

Step 3: Establish rapport with the patient
- This may be challenging in the general hospital due to lack of privacy, external distractors, physical discomfort, concerns about confidentiality, lack of familiarity with a new psychiatrist, team-based care, and the unexpected nature of a consult.
- Introductions
    - Clarify your role and service
    - Determine whether patient was told about the consult
    - Tell the patient why you were asked to consult
    - Describe what you already know about their situation
- Acknowledge and address (if possible) privacy/confidentiality issues.
    - Get introduced to any family/friends in the room (unless a patient objects, for adults the general guideline is to conduct the first part of the interview alone with the patient)
- Demonstrate sensitivity, empathy, compassion, warmth. Acknowledge, normalize, and validate difficult human plight.
- Ensure a comfortable environment (sit, provide hearing/visual aids, interpreter) and address physical discomfort prior to evaluation (e.g., pain, hunger, thirst, position, privacy, bathroom)
- Identify patient's most pressing concerns
- Ask about:
    - Beliefs regarding the nature, cause and prognosis of illness/injury
    - Impact of illness on relationship and social roles
    - Specific activities and accomplishments in which patient takes pride
    - Explain purpose of cognitive exam
- Leave patient with something concrete - your formulation, a sense of what you will do with the information obtained in the interview, and your plan for return
- Ask for feedback and questions

Step 4: Take a history
- There are some nuances to a consult interview that can be different than a typical patient assessment.

- One task is to determine the extent to which psychiatric symptoms are caused or exacerbated by a physical condition or medication; reading more about the patient's illness or treatments and getting collateral will help make this determination.
- Assess adequacy of pain/somatic symptom management.
- Does the patient's behavior represent a normal response to stress of illness or is there a psychiatric disorder present? Normalizing behavior or emotional response can be validating for the patient. Educating the primary team about the differences between normal responses to stress vs psychiatric disorders is also an important task.
- Evaluation of patient's character style: it is important to understand *what kind* of patient has the illness, *who* is this person, *what* is this person like under normal circumstances, *how* does this person usually cope with adversity, and *what* strategies has this person utilized to manage adversity historically (and can those strategies be employed this time).
- Thoughts of dying: Conversations about mortality are an important part of the work of healthcare providers. Some patients may spontaneously start these conversations, while others may be more resistant. For more information, see *ACLP How To Guide "How to Talk about Death and Dying"*
- Spiritual assessment: addressing spirituality may greatly help the patient during the crisis of an illness. Making referrals to hospital chaplains or community resources may be useful for the patient.

Step 5: Examine the patient

- A complete psychiatric MSE is important and helps to remind consultees that psychiatrists base conclusions on orderly series of evaluations
- A thorough cognitive exam is an important aspect of most consultations. Explain the purpose of the cognitive exam (without downplaying its importance).
- A standardized assessment tool such as the MOCA or SLUMS can provide an important baseline, or more targeted tests can be used. Keep in mind that a MOCA score in the setting of delirium is not likely indicative of the patient's baseline mental functioning
- Selected aspects of the physical exam, including the neurological exam, will be helpful in identifying potential side effects/toxicity of medication, clarifying neurological/metabolic vs psychiatric etiology of a symptom, and diagnosing a syndrome such as catatonia.

Step 6: Obtain collateral

- Information from family members, partners, friends, and other providers can be helpful in assessing the accuracy of the patient's history, establishing risk, and clarifying symptom course.
- The patient's nurse will likely be able to provide helpful information regarding symptoms and behavior in the hospital. It can be useful to check in with the nurse prior to seeing a patient.

Step 7: Seek Attending supervision

- Clarify with your attending in advance how the attending would like to supervise the case. Some attendings prefer to see the patient from start to finish with the trainee, while others request that the trainee see the patient alone and present the case for discussion.

- Your learning experience will be enhanced by observing the attending interview the patient as well as by having the attending observe you do the interview.

Step 8: Generate a differential diagnosis, formulation, and management plan

- It is important to consider the biological, psychological, and social aspects of each case
- It is acceptable to provide provisional diagnoses or plans until more information is obtained
- This will provide good information to discuss with the attending psychiatrist

Step 9: Communicate recommendations to team

- It is important to contact the primary team in a timely manner and verbally communicate the recommendations, as note completion may be delayed. Verbal discussion is strongly preferred over texting.
- Doing so ensures that the recommendations are known and allows the primary team to ask questions or clarifications and initiate interventions
- Document the person to whom you gave the recommendations.

Step 10: Write the consultation note

- The consult note must serve the function of answering the consult question.
- The consult psychiatrist must decide which details are essential information for the entire team to know to successfully care for the patient.
- The recommendation section may be the only section read by the consultee, so should be informative and practical, including further work-up to clarify diagnosis and which aspects of care will be managed by the primary team vs the psychiatric consultant.
- Avoid psychiatric jargon and keep the note well organized and succinct.
- The assessment should answer the consult question and be clear, direct, concise, scientific, professional, informative, and practical.
- In some cases, it may be appropriate to mention psychological factors as a means of explaining the patient's behavior, but do so in a respectful manner with limited jargon.
- Assessments should be void of any reference to criticizing the consultee's behavior or undermining the current treatment. "Chart wars" should be avoided.
- Include a safety assessment and, if known, whether you anticipate the patient may need to be transferred to psychiatry.
- Clearly state your follow-up plan.
- End with contact information/availability for further questions (keeping in mind that patients will have access to this).

Step 11: Follow up

- Ensure that you follow-up on the aspects of the plan that you promised to do.
- Daily follow up is generally needed for patients in restraints, on 1:1, with severe agitation/violence, suicidality, psychotic/psychiatrically unstable, and medically compromised patients recently started on new psychotropics.
- One-time consultations may suffice for a capacity assessment, transplant clearance, same-day psych transfer, and a patient with low symptom burden.

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References:

1. Gawande, Atul. Being Mortal: Medicine and What Matters in the End. New York : Metropolitan Books, Henry Holt and Company, 2014.
2. Puchalski, C. Romer A. Taking Spiritual History Allows Clinicians to Understand Patients More Fully. Journal of Palliative Medicine; 2000. 3: 129 – 137.
3. Garrick TR, Stotland NL. How to write a psychiatric consultation. Am J Psychiatry. 1982;139(7):849-55.
4. Mermelstein HT, Wallack JJ. Confidentiality in the age of HIPAA: a challenge for psychosomatic medicine. Psychosomatics. 2008;49(2):97-103.
5. Schiff SK, Pilot ML. An approach to psychiatric consultation in the general hospital. Arch Gen Psychiatry. 1959;1:349-57.
6. Yager J. Specific components of bedside manner in the general hospital psychiatric consultation: 12 concrete suggestions. Psychosomatics. 1989; 30(2):209-12.

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