Chapter 1

The consultation process

Jeanne M. Lackamp

Introduction

Consultation psychiatrists are skilled clinicians and expert liaisons in the general hospital setting. In their roles as "med-psych detectives," consultation psychiatrists are called upon to assist in complex cases and to interact with primary teams, nursing teams, ancillary services, and patients and family members. They investigate medical/psychiatric interactions, assess psychiatric symptoms, and offer treatment recommendations. *Communication is the most crucial element of the consultation process*. Clear communication improves the process of your consultation as well as the result, by ensuring accurate, timely, and helpful interventions. This chapter strives to give residents the tools necessary to enter the world of consultation-liaison psychiatry.

First steps

Institutional and personal organization

As a member of the psychiatric consultation team, you must *know your role and maintain your identity* in your institution (1, 2). Who are the members of your team? Who carries the consult pager? What consults are appropriate for you to see (adult, pediatric, emergency room, other)? With whom do you staff new evaluations?

Being organized and having the requisite tools will prepare you to perform the duties expected of you (Table 1.1). Carry necessary items with you, and know where to access other information when needed. Finally, as noted by Wise and Rundell, "Wear a white coat – on your shoulders and in your brain" (3). Your role as a medical practitioner should be clearly and visibly evident to those who consult you, as well as to the patients you see.

Who is calling?

When a consult is called, you need to record the *name, pager number, and team affiliation of the consulting individual* (Table 1.2). This helps you in filling out your paperwork thoroughly, and ensures that you will give final recommendations to the appropriate team. If the person calling is not one of the patient's clinicians (unit clerk, nurse, social worker), ask for the appropriate contact information.

Psychosomatic Medicine: An Introduction to Consultation-Liaison Psychiatry, eds. James J. Amos and Robert G. Robinson. Published by Cambridge University Press.

Table 1.1 Things to carry with you

Interview/assessment forms • Departmental or personal interview guides • MMSE, SLUMS, MoCA, etc
Psychiatric admission forms • Voluntary • Involuntary
Medication reference guides Penlight Reflex hammer Stethoscope
Key: MMSE = Mini-Mental State Examination (29) SLUMS = St Louis Mental Status Examination (30) MoCA = Montreal Cognitive Assessment (31)

Table 1.2 Important initial information

Who is calling? • Physician name • Physician pager number • Physician team affiliation (e.g., internal medicine, ICU, surgery) • Contact name/pager number for team member who should get final recommendations
What is the patient's information? • Full name • Age • Gender • Hospital number • Specific location
What is the question? • Formal consult question
Urgency (routine, urgent, emergent)

Who is the patient? Where is the patient?

It is important to get the *patient's full name, age, gender, hospital number,* and *hospital location* from the person who is calling the consult (Table 1.2). You want to be sure that it is appropriate for you to see the patient, and you want to find the patient quickly. It is important to note that you do not want to see the wrong patient!

Patients may change locations temporarily for testing or procedures, and at times they are transferred to other parts of the hospital for medical reasons, such as moving from the ICU to the general medical floor. When speaking to a consultee, ask how long the patient will be available in his or her current location. This will maximize your consultation time and effort.

Patients sometimes attempt to elope from hospital grounds. If you know where the patient started, you may be able to determine likely routes of egress and you can inform security personnel.

What is the consult question?

You need to know *what is prompting the consultation at this time* (Table 1.2). A statement such as, "The patient has a history of schizophrenia," is insufficient. Common consultation topics are mental health/behavioral problems and capacity evaluations; we will address these briefly. Later chapters in this handbook will address these and other frequently asked questions, elements of evaluation, and treatment recommendations (Table 1.2).

Do not limit the scope of your consultation to the initial question. Consultations for mental status changes, anxiety, depression, psychosis, and behavioral problems may evolve into consultations for delirium or other conditions. Mental flexibility is key.

Consulting teams may have identified new psychiatric symptoms or behaviors (the post-stroke patient who is voicing suicidal ideation; the post-surgical patient who is confused and pulling out intravenous lines). Consulting teams may know or suspect that the patient has a psychiatric history (the patient with schizophrenia who has been admitted for surgery and is currently NPO; the frequently admitted patient who is demanding large doses of pain medication). Consulting teams may feel that the patient would be better served on a psychiatric unit (this is particularly common in patients with suicidal ideation and mental status changes). Although consults for psychiatric transfer are common, you must *verify medical stability and appropriateness* for admission to the inpatient unit before facilitating the transfer.

Primary teams may request consultation to assess a patient's capacity – that is, to determine if the patient is able to make a particular decision (4). (Recall that "capacity" is a clinical opinion, whereas "competence" is a legal judgment.) You must know *what specific issue* the patient is being asked to consider (5). To facilitate communication, it may be helpful to ask what "ability" the team wants you to evaluate – for instance, the *ability* to understand pros/cons of treatment or treatment refusal. It is not enough to posit that patients lack capacity to make decisions simply because they disagree with their doctors (see Chapter 5).

If your role limitations preclude you from seeing a patient, or if the consult question seems better suited to another service, redirect callers appropriately. Merely refusing the consultation does not help the caller, and it can negatively impact your relationship with the consulting team. Most important, *such behavior does not help the patient*.

Although some consults may seem "inappropriate," for purposes of this chapter we will refrain from using this descriptor (6). Consult questions may be difficult to discern, or they may have "hidden agendas" (7) or "covert" motivations (8). The challenge is to *determine what you can do to help the patient and primary team*.

How acute is the consult?

Though institutional conventions vary, consults are typically described as *routine, urgent,* or *emergent*. *Routine* consults should be completed within 24 hours of when they are called (8). *Urgent* and *emergent* consults may require quicker action (within four hours and "as soon as possible," respectively). Asking to see a routine consult "later" is not inappropriate per se, but you must *know your department's policy* before deferring any consult. It is typically advisable to do today's work today (3).

It is considered *unprofessional* to defer consults until the next shift simply because you are tired or do not want to be bothered! This reflects poorly on you as an individual and as a team player.

Table 1.3 Information gathering

Documentation: Notes • Current admission • Past admissions
Recent orders • Activity • Diet • Medication (administration, discontinuation)

Vital signs and trends
Results of testing
• Laboratory results (see Table 1.4)
• Imaging results
  ◦ Head imaging
  ◦ Other imaging
• Electrocardiogram
• Electroencephalogram

Additional results • Other consultations • PT/OT evaluations • Speech/swallowing evaluations
Patient information: Interview and examine the patient Obtain collateral information
Key: OT = occupational therapy PT = physical therapy

Next steps

You have been called to see a new patient. Your expectations are clear, and your preparation is complete. You are ready for the next steps of information gathering; these are summarized in Table 1.3.

Review documentation and results

Depending on the institution, patients may have written medical records, electronic medical records, or both. Knowing what records are available, and where different information is located, will facilitate your job as "med-psych detective."

Notes

Multidisciplinary healthcare teams include physicians, medical students, nurses, social workers, and other personnel. Review notes quickly but thoroughly to see if problems or symptoms are being documented (8). Watch for trends (confusion which worsens every evening; agitation which occurs with each dressing change). Some consultations can be averted, or significantly truncated, if you review notes carefully for details that may have been overlooked.

Records for the current admission are only part of the story – if you have access to old records, look for prior psychiatric consultations or inpatient psychiatric notes (7). Past records are especially important if the patient is unwilling or unable to participate in the interview, and/or if collateral informants are unavailable.

Table 1.4 Laboratory tests to review

Common Laboratory Tests:
- Complete blood count with differential
- Comprehensive metabolic panel including calcium, magnesium, phosphorus
- Therapeutic drug levels
- Thyroid and liver function tests
- Toxicology screens
- Urinalysis with culture/sensitivity

Additional Laboratory Tests:
- Arterial blood gas
- Blood cultures
- Cerebrospinal fluid studies
- Heavy metal screens
- Hepatitis panel
- Human immunodeficiency virus test
- Rapid plasma reagin (RPR) or Venereal Disease Research Laboratory (VDRL)
- Vitamin B12 and folate

Recent orders

Review recent orders with careful attention to *changes in activity level, diet, and medications* which correspond temporally to psychiatric symptoms. Dietary or activity restrictions can contribute to irritability; medication administration (or discontinuation) can cause behavioral and/or cognitive problems. Critically review medication lists, with awareness that non-psychiatric medications can cause psychiatric symptoms. Utilize on-line or electronic media to verify medication effects and interactions if you are unsure.

Vital signs

Vital signs out of the normal range, and vital sign trends, are important to identify because they can help you detect underlying issues. For instance, vital sign instability in a confused patient who has been hospitalized for two days might lead you to diagnose alcohol or benzodiazepine withdrawal – conditions with potentially life-threatening complications if not identified and treated promptly (9) (see Chapter 19).

Testing results (laboratory studies, imaging, electrocardiogram, electroencephalogram)

As with vital signs, abnormal laboratory studies (hyponatremia in a confused patient, hyperthyroidism in an anxious patient) may contribute to the patient's presentation. Common labs are listed in Table 1.4. If you do not see routine laboratory test results in the patient's record, or if tests have not been done in recent days, recommend them.

Imaging studies, such as head imaging revealing an acute bleed or expanding subdural hematoma, or chest imaging revealing pneumonia, may provide other medical reasons for the patient's apparent psychiatric problems. As with laboratory tests, if you feel that imaging studies may be helpful, recommend them.

Electrocardiograms (ECGs/EKGs), if available, should be reviewed and may have to be requested if not yet done during the patient's stay. Special attention should be paid to *prolongation of the corrected QT interval* (QTc), because some psychiatric medications

(antipsychotics including IV haloperidol; antidepressants including citalopram) can contribute to or worsen this condition and may cause serious adverse consequences including torsades de pointes (10, 11).

Electroencephalogram (EEG) results showing seizure activity can be helpful in patients with agitation or somnolence (post-ictal phenomena), and EEG results showing diffuse slowing might be relevant in patients with ill-defined confusion (consistent with delirium). EEGs certainly are not required for every psychiatric consult, and they are not specific enough to use as a psychiatric diagnostic tool. Nonetheless, they can be helpful in certain cases, such as in helping to differentiate *general delirium* (with diffuse slowing) from *benzodiazepine/alcohol withdrawal delirium* (with faster beta wave patterns) (12). As in the above studies, recommend an EEG if the patient's case so warrants.

It is not appropriate to order every test for every patient on every occasion, in a "shotgun approach" to consulting. Use common sense! Medical acumen is a necessary part of the consultation process.

Additional results (other consultations, PT/OT evaluations, swallow studies)

Patients may see multiple consultants during their hospital stay. Review consultation notes to see if mental health issues have been noted, and/or addressed, by other teams before the time of your involvement. Neurology, palliative care, hospice, and pain management consults can be particularly illuminating.

Physical therapy (PT) and occupational therapy (OT) evaluations often comment on the patient's ability to ambulate safely and live independently. Speech and swallowing evaluations also are helpful. Inability to eat or drink properly may impact a patient's mood and cooperation with care, and may also affect what medications and routes of administration you can recommend – for example, being unable to swallow pills may necessitate liquid, intramuscular, or intravenous medications.

Interview the patient!

Psychiatric interviews in the general hospital setting are significantly different from interviews in the outpatient clinic setting. Hospitals are noisy, scary places and privacy is not easy to ensure. Roommates, visitors, nursing staff, and even maintenance personnel can infringe upon your interview! Couple the busy environment with a patient who may be struggling emotionally or cognitively, and who may not want to talk to you, and the interview becomes very challenging (13).

Basics

Before entering the room, check with the patient's nurse – is the patient going to a test? Is another consultant with the patient? Is she or he having a bedside procedure, or washing up? Is he or she finally sleeping for the first time all day? Unless you must see the patient immediately, the consult may have to be deferred temporarily. Additionally, before entering the room, make sure that you have identified any isolation or contact precautions needed (i.e., mask, gloves, or gown).

If you attempt to see a patient but are unable to do so, leave a note in the chart or page the primary team. Indicate that you attempted to do the consultation, and state when you or

one of your colleagues will return. This is reassuring to the primary team, and appropriately reflects that you attempted to see the patient in a timely fashion. Notify your team that the patient wasn't seen, so another attempt can be made later.

Upon entering the patient's room, survey the scene and introduce yourself. If a 1:1 sitter is present, ask him or her to leave for the interview. If visitors are present, ask if the patient would like them to stay or leave. It is ideal to interview the patient alone, at least initially. However this is not always possible or comfortable for the patient.

Introduce yourself as a psychiatric consultant called by the primary team. Depending on the case, you may explain that it is routine for your team to be called when someone has made a suicide attempt. You may say that your team commonly visits patients who are experiencing symptoms such as low mood/confusion/insomnia. You may simply say that the team was worried and wondered if there was something you could do for the patient (14).

Ideally, the patient's team will tell him or her about the consultation before you arrive. If this doesn't happen, the patient may be surprised or upset about seeing a psychiatrist. The patient may feel ambushed (7)! Empathize with the patient, and voice a commitment to collaboration (15). Statements such as, "I wouldn't be happy about a surprise visitor either," and "Let's try to see how I can help," may set the patient at ease and facilitate the conversation.

Before launching into the formal interview, *sit down* (14). This communicates willingness to stay and listen to the patient. Offer to help the patient get comfortable for the interview (14). Raise the bed, turn down the television, and speak loudly enough for the patient to hear you. As in any psychiatric patient interview, be mindful of safety issues including the patient's proximity to the door and potentially dangerous objects in the room (e.g., metal silverware, cigarette lighters).

When starting your interview, it is both informative and polite to ask how the patient is feeling physically. Pain or fatigue may necessitate a brief initial visit, with follow-ups scheduled as the patient can tolerate. Share what you know about patients' current circumstances, so they do not have to tell their entire story, and ask how they are handling the experience of the hospitalization (14).

After establishing your identity and the reason for the interview, and after discussing the patient's medical issues, it is time to address the basic portions of the psychiatry interview (Table 1.5). Be flexible, listen closely, and follow the patient's lead (16). Adhering rigidly to a list of questions may be off-putting. Speak to patients in a manner and style to which they can relate (17). Bedside cognitive testing may be important if you suspect that the patient is having cognitive processing problems. Inform the patient that you need to ask a few standard questions, before firing away (14).

In some cases, patients are too emotionally or cognitively impaired to participate in the interview. Although sometimes described as being a "poor historian," it is less judgmental to describe the patient as "unable to contribute to the interview at this time" by virtue of emotional/cognitive impairment.

In concluding your interview, *discuss intervention options* being sure to discuss them with your attending. You may offer return visits for bedside support; you may offer medications; you may offer ancillary services such as chaplains or other therapies; you could offer the patient a list of outpatient psychiatric resources for use after discharge; you may inform patients that you will be arranging inpatient psychiatric care when they are medically stable. Tell patients that you will be calling their primary team, and tell them if and when you will return for another visit. Before exiting the room, ask if the patient needs anything (nursing assistance, refill of water pitcher), and offer to tell visitors that they can return.

Table 1.5 Elements of the mental status examination (with sample responses)

Appearance: clean, disheveled, in hospital gown, in street clothes
Psychomotor activity: retarded, agitated, restless; tremors/tics/dyskinesia/seizure activity if evident
Eye contact: poor, fair, good
Behavior: uncooperative, minimally interactive, cooperative, appropriate, pleasant
Orientation: self, location, date, circumstances
Speech: rate, tone, and amount; fluent, spontaneous; slurred or aphasic if evident; naming, repetition, comprehension
Mood: quoted in the patient's own words whenever possible
Affect: quality (appropriate/inappropriate), quantity (full-range, restricted, blunted, flat, labile), description
Thought processing: linear, future-focused, goal-directed, confused, circumstantial, tangential, loose, concrete
Thought content: psychosis (hallucinations, delusions), lethality to self/others
Bedside cognitive testing • Memory: 3/3 registration and recall testing, remote personal history, general fund of knowledge • Attention/concentration: serial 7's, spelling backwards • Abstraction: idioms, similarities • Clock-drawing test, MMSE, SLUMS, MoCA
Insight: poor, fair, good
Judgment: poor, fair, good

Key:
MMSE = Mini-Mental State Examination (29)
SLUMS = St Louis Mental Status examination (30)
MoCA = Montreal Cognitive Assessment (31)

Special cases

In some cases, communication barriers require special services. Use of professional interpretive services (via translators or phone translation systems and sign language services) is superior to using friends/family members. Friends and family may "edit" interactions between you and the patient if sensitive material is being discussed (18).

If patients are intubated, have tracheostomies, or are aphasic, creative communication may be necessary. Techniques include writing on blank paper, using word boards or computerized keyboards, and nodding/shaking head or blinking eyes for "yes" or "no."

Examine the patient

Psychiatrists typically refrain from physically examining their patients because this intimate activity can blur therapeutic lines. However, physical examinations including neurologic examinations (noting cogwheeling, rigidity, tremors, asymmetric appearance or strength, hyperreflexia, and pupil size and reactivity) can be appropriate for psychiatric consultants to perform (8). Other elements of physical examination should be done on an as-needed basis. Your exam may confirm previous physical findings, or may identify pivotal changes.

Gather collateral information

Collateral information is helpful in cases where patients are unable to communicate effectively. It is also crucial in cases where patients can communicate, but there may be concerns

about truth-telling or ability to maintain safety. This includes post–suicide attempt patients now denying suicidal intention, and patients with apparent substance disorders who are minimizing their usage. Family, friends, and outpatient clinicians are common sources of collateral information. Members of the multidisciplinary team also provide key collateral information regarding the patient's status while hospitalized. Gathering data through this "expanded psychiatric interview" (19) gives a comprehensive picture of the patient.

Remember that you are allowed to obtain information from clinical care providers that the patient has seen previously, as part of care coordination. *This is allowable under HIPAA regulations* (20). Also, you can *obtain* vital information from family/friends/others, but you cannot *release* patient information unless permitted by the patient. Of course, you must not discuss any patient issues with persons to whom the information is neither relevant nor pertinent.

Interventions

Write a note

Once you have reviewed the records and interviewed the patient, you can make treatment recommendations for the patient ("consult"), and you can review basic educational concepts with the primary team ("liaison") (21). Your note is a crucial element of this process (22).

Consultation notes should be simple, devoid of "psycho-speak" terminology, modest in length, legible if handwritten, and pertinent to the consult question (7, 8). Adhere to your institution's conventions for consultation documentation. This helps primary teams identify the note visually and on the basis of location (in the "consultation" portion of the record). Document the source of your information – from the patient, from past records, from current records, or from family/others. This prevents people from assuming that your note is a record of what the patient told you himself/herself, and explains discrepancies if any.

Table 1.6 summarizes elements of your interview and consultation note. Although mental status elements of psychiatric consultation notes are much the same as other psychiatric notes, additional emphasis is placed on medical issues, medications, results of testing and other consultations, and information synthesis.

Offer treatment recommendations

It is important that recommendations are clearly detailed in the "Assessment and Recommendations" portion of your note, so primary teams understand exactly what you think needs to be done (8).

Safety first

First, you should comment upon safety issues. Primary teams may have to make adjustments in personnel or patient location if the patient needs a 1:1 sitter, so you should tell them as soon as possible about any need for sitters. If the patient is not acutely dangerous (and therefore does *not* need a 1:1 sitter), this is another helpful message for the primary team.

When patients are acutely dangerous on the open medical unit, comment on whether they might warrant an inpatient psychiatric admission. If so, this is an opportune time to comment on what issues (vital sign instability, need for intravenous medications) should be resolved before the time of psychiatry transfer. This reassures the primary team that you are

Table 1.6 Elements of the consultation interview and note

(Patient identifier: medical record sticker or electronic note tag, with name and hospital number)
Date and time of consultation
Name of consulting team attending
Names of psychiatric consultants
Patient's identifying information (first/last name, marital status, race, gender, employment status; reason for hospitalization; current hospital location)
Reason for consultation
Chief complaint (quoted in the patient's own words whenever possible)
History of present illness • Elements of the patient's medical course (medical issues, surgical procedures, current status, progress and disposition planning) • Symptoms that prompted the consultation
Psychiatric review of systems (including mood disorders, anxiety disorders, psychotic disorders, substance use disorders, eating disorders, somatoform disorders, cognitive disorders, lethality)
Past psychiatric history • Age of first treatment • Diagnosis/diagnoses • Past medications (including efficacy, side effects, reason for discontinuation) • Current home medications • Current outpatient provider • History of, and most recent, inpatient hospitalizations and suicide attempts
Past medical history, including allergies
Family medical history
Family psychiatric history
Social history • Brief childhood/developmental information/educational level • Employment or disability status • Current living situation • Marital status and social supports • Abuse (physical, sexual, emotional), legal, and military histories
Substance use history (including caffeine, alcohol, tobacco, illicit substances, and routes of use) • Most recent usage • Past history of detoxification or rehabilitation • Past history of withdrawal syndromes • Longest sobriety • Psychosocial problems resulting from usage
Current inpatient medications (including medications, dosages, frequency, scheduling, and any correlation between medications and psychiatric symptoms or problems)
Pertinent laboratory test results, imaging results, EKG, EEG, etc
Mental status examination (see Table 1.5)
Assessment (including brief summary/formulation of the patient's case)
Axis I-V
Recommendations • Safety issues • Pharmacologic and non-pharmacologic recommendations • Laboratory studies or other studies as indicated • Follow-up plans
Psychiatry contact information, including 24/7 pager number for emergencies

Key:
EEG = electroencephalogram
EKG = electrocardiogram