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

- It is important to clarify by direct conversation with the primary team what the explicit (stated) question is, as well as to consider the implicit (unstated) question or request.

Table 1 lists common implicit and explicit questions.

Explicit consult questions	Implicit consult questions
• Diagnostic: Assess for depression/anxiety; evaluate for change in mental status	• HELP! This patient is difficult.
• General treatment: provide treatment recommendations for anxiety and insomnia; provide psychotherapy to assist with coping with illness	• Support/provide a forum for expression of primary team members' frustration
• Psychopharmacology recommendations in the medically ill	• Resolve a difficult situation
• Safety: Assess SI/HI	• Transfer the patient off our service
• Legal: assess decision-making capacity	• Help referee conflict between team members and patient
• Psychiatric clearance for discharge	• Primary team is busy and needs help getting collateral, old records, taking full history, and determining outpatient medications
• Patient requesting psychiatric consultation	• Make the patient more adherent
• Substance use: assist with detoxification and rehabilitation	• Attending insists on the consult
• Behavior: manage agitation, assess reasons for treatment non-adherence	• Nursing facility or community based program requires a consult prior to acceptance
• Treatment referrals	• Give us permission to discharge a challenging patient

Step 2: Review the chart

- Much of the important and necessary information for a consultant will come from a thorough chart review.
- Patients often experience frustration with providers who have not reviewed the chart prior to an evaluation and may be easier to engage if confident that the provider is familiar with their history.
- One can begin to write the note while reviewing the chart.
- Especially helpful elements of the chart include the following:
    - Previous psychiatry and/or neurology notes
    - Brain imaging
    - Labs: particularly TSH, B12, folate, RPR, HIV testing, blood alcohol level, urine toxicology screen, CSF studies if applicable

- EKG: QTc interval
- EEG (if done)
- Current medications: focusing on psychotropics, medications with neuropsychiatric side effects (opioids, steroids, anti-cholinergics), medications that may be involved in drug-drug interactions or prolong the QT interval
- Vitals: any suggestion of sedative-hypnotic withdrawal, infection, hypoxia
- Controlled substance database (if exists in your state)
- External records
- Shared database of mental health encounters (if exists in your state)

Step 3: Find the patient

- Delays in finding a patient often lead to frustration and inefficiency.
- Try to locate a patient and, if possible, bring the patient back to the room or conduct some of the psychiatric assessment in the other location. Long waits for tests or procedures (e.g., dialysis, radiology) provide an opportunity for the psychiatrist to perform the most important aspects of the initial interview.

Step 4: Establish rapport with the patient

- This task is 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. Consideration of the below issues may help to establish rapport in this setting.
- Introductions: clarify your role and service, determine whether patient was told about the consult, tell patient why you were asked to consult
- Acknowledge and address (if possible) privacy/confidentiality issues.
- Demonstrate sensitivity, empathy, compassion, warmth
  - Address physical discomfort prior to evaluation (e.g., pain, position, bathroom)
  - Address patient embarrassment or lack of knowledge about consult
- Ensure a comfortable environment (sit, provide hearing/visual aids, interpreter)
- Do something tangible for patient (get water, improve patient's position, etc.)
- Start by telling the patient what you know and ask to correct misinformation
- Identify patient's most pressing concerns
- Ask about beliefs regarding the nature, cause and prognosis of illness/injury
- Ask about the impact of illness on relationship and social roles
- Ask about specific activities and accomplishments in which patient takes pride
- Acknowledge, normalize and validate difficult human plight
- 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 5: Take a history

- You are familiar with the basic psychiatry history and mental status exam, but there are some unique aspects of the history and exam that should not be missed.

- 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. The surgeon and writer Atul Gawande suggests 5 questions which can be helpful in starting such a conversation (1):
  1. What is your understanding of where you are and of your illness?
  2. What are your fears or worries for the future?
  3. What are your goals and priorities?
  4. What outcomes are unacceptable to you? What are you willing to sacrifice and not?
  5. What would a good day look like?

- Spiritual Assessment: While it is important to respect a patient's privacy regarding spiritual beliefs, 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. An acronym (2) can be used to remember what to ask in a spiritual history.

Step 6: Examine the patient

- A thorough cognitive exam is an important aspect of most consultations. A standardized assessment tool such as the MOCA or Folstein MMSE can provide an important baseline.
- A complete psychiatric MSE is also important and helps to remind consultees that psychiatrists base conclusions on orderly series of evaluations
- 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 7: Obtain collateral

- Information from family members, partners, friends, and other providers can be helpful in assessing accuracy of 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.

Step 8: 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 9: Generate a differential diagnosis and develop a formulation and management plan

- Much of this discussion is beyond the scope of this guide
- It is important to consider the biological, psychological and social aspects of each case
- It is acceptable to pend a diagnosis or plan until more information is obtained

Step 10: Communicate recommendations to team

- Since note completion or review may be delayed, it is important to contact the primary team in a timely manner and verbally communicate the recommendations.
- Doing so ensures that the recommendations are known and allows the primary team to ask questions or clarifications.
- Document the person to whom you gave the recommendations.

Step 11: Write the consultation note

- The consult note must serve the function of answering the consult question.
- In contrast to most psychiatric notes, this note must be designed to be viewed and used by the entire treatment team and it is more easily available to the patient to review.
- The consult psychiatrist must decide which details are essential information for the entire team to know to successfully care for the patient.
- It is important to avoid psychiatric jargon and keep the note well organized and succinct.
- The assessment should answer the consult question, contain a balance between oversimplification and overly technical language and should be clear, direct, concise, scientific, professional, informative and practical.
- Would maintain the broadest possible understanding of the patient by describing the problem/symptoms and limiting diagnostic labeling beyond what is absolutely necessary.
- In some cases it may be appropriate to mention psychodynamic factors as a means of explaining patient's behavior, but do so in a succinct manner with limited jargon.
- Assessments should be void of any reference to diagnosing the consultee's behavior or undermining the current treatment. "Chart wars" should be avoided.
- The recommendation section may be the only section read by 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.
- Clearly state what your follow-up plan is for the patient.
- END with appreciation for referral and your contact information/availability.

Step 12: Follow up

- Ensure that you follow-up on the aspects of the plan that you had 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 a psychiatric history but in remission.

References/Further Reading

1) Gawande, Atul. Being Mortal: Medicine and What Matters in the End. New York : Metropolitan Books, Henry Holt and Company, 2014.
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