The Why and How of Psychiatric Consultation

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3.1 Vignette

The reason for the psychiatric consultation simply stated, "Behavioral problem. Please evaluate."

When the consultant called the requesting physician, she said, "I don't really know what the problem is, but the nurses seem to be upset about the patient. The patient just had an MI but is doing OK. I think he may be a little depressed though because he is so quiet." When the consultant spoke with the nursing staff, the night nurse had written that the patient was observed crying in the middle of the night. Upon interview, the consultant was able to diagnose a recurrent major depression.

3.2 The Nature of a Psychiatric Consultation

Why is a psychiatric consultation generated? Specialty consultations are requested to obtain expert opinion in diagnosing and treating conditions that fall in the specialty area. As psychiatry deals with a vast area of human experience including cognition, emotion, and behavior, it is often difficult to know the exact reason for referral as the Vignette illustrates. Psychiatric consultation, like any other consultation, is not the primary reason for the patient's hospitalization or contact with the health care system, and not a few patients may be surprised that a psychiatric consultation has been requested. Primary physicians may also be reluctant to request a

H. Leigh and J. Streltzer (eds.), *Handbook of Consultation-Liaison Psychiatry*,
DOI 10.1007/978-3-319-11005-9_3, © Hoyle Leigh & Jon Streltzer 2015

psychiatric consultation because of the perceived stigma. Therefore, requesting a psychiatric consultation on a patient requires a certain amount of motivation on the part of the referring physician. This motivation is often generated by a strain in the health care unit consisting of the doctors, the nursing staff, and allied professionals around the patient. Common causes of such strain are anxiety, communication difficulties, behavioral problems, and administrative/legal requirements.

While some consultations are generated at the patient's request, most psychiatric consultations arise out of discomfort on the part of one or more health care personnel, and recognizing this discomfort or strain is an essential part of a successful consultation. It is the consultant's job to ameliorate the strain so that the health care personnel can proceed to provide medical care without impediment.

As discussed in Chap. 2, the consultant serves two masters—the requesting physician/health care system (consultee) and the patient. The primary role of the consultant is to provide expert advice to the consultee so that medical/surgical treatment can be successfully rendered. A secondary role may be to provide direct psychiatric care for the patient with the consultee's agreement. In a collaborative care model, such as in medical homes, the consultant may supervise the ongoing mental health care provided by either the mental health care manager or the primary care physician (Croft and Parish 2013; Huang et al. 2013)

The psychiatric consultant is often the face of psychiatry in the health care facility. It is through her/him that the nonpsychiatric physicians form an impression about psychiatry, and, hopefully, learn psychiatric approaches and techniques. The educational function of the consultant psychiatrist, as discussed in the previous chapter, is an integral part of the practice of CL psychiatry.

3.3 How to Do a Consultation

3.3.1 Receive a Consultation Request

Most health care institutions have formal mechanisms for requesting a consultation—computerized request, written request, fax, e-mail, telephone, etc. Informal requests may also be made either by phone or by button-holing. While informal consultations, especially when urgent, are often attended to, it is a good idea to insist on a formal consultation request as well.

3.3.2 Talk to the Referring Physician and Clarify the Consultation Request

Consultation requests are often vague and sometimes misleading (as in the Vignette), usually because the consultee lacks the vocabulary of psychiatry. The consultee is aware of the discomfort of the strain mentioned above, but has difficulty putting it into words. Thus, it is critical that the consultant seeks out the consultee, usually by phone, and asks him/her to provide additional information about the consultation, particularly what the consultee would like from the consultant. It is a good idea to ask the referring physician to be sure to let the patient know to expect a psychiatric consultant, and, if possible, to introduce the consultant to the patient.

3.3.3 Determine the Scope of Consultation

The consultant should be able to determine the probable scope of the consultation after speaking with the referring physician, i.e., whether it is an emergency management of an agitated or acutely suicidal patient, a focused consultation about a specific question, i.e., the patient's ability to sign out against medical advice, to consent to a surgical procedure, a comprehensive evaluation of the patient in assisting with diagnosis, etc.

Even though the question asked by the consultee may sound focused and simple, at times the consultant can facilitate the medical treatment through a comprehensive understanding of the patient and facilitation of communication, e.g., a patient may decide to stay rather than sign out against medical advice after a question and answer period between the patient and her responsible physician, which was arranged by the consultant.

In general, the narrower the scope of consultation, the quicker should the consultant respond to the referring physician.

3.3.4 Review the Chart

The chart of the patient should be reviewed prior to seeing the patient. Most recent progress notes and nurses' notes should provide information about the patient's recent and current status. Medication orders, and more specifically, medications actually administered, should be reviewed, especially for any recent additions or changes that might contribute to the patient's changed mood or mental status. Laboratory and imaging findings should be reviewed for possible metabolic/structural causes of the psychiatric syndrome, as well as to determine which additional lab tests may be indicated. Reviewing chart notes from prior admissions, if available, may provide a perspective by which to put the patient's current medical and mental status in perspective. Old records may even have previous psychiatric consultation notes that can be very informative.

Talking with the nurse who is directly taking care of the patient can yield important information not only about the patient but also about visitors and patient's interactions with the staff. Furthermore, talking with the nursing staff allows them to discuss their impressions of the patient, and any difficulties they may be having in management. Nurses appreciate a doctor who is interested in their input. Their tolerance for deviant behavior will increase when the consulting psychiatrist shows interest. This alone may improve patient–nurse interactions.

3.3.5 Interview the Patient

The consultant should have a reasonable idea about the strain that resulted in the consultation, and the areas to focus in evaluating patient by the time she/he interviews the patient. Before interviewing the patient, privacy should be sought as much as possible—in many cases this may be drawing the curtains around the patient, or, in a private room, closing the door. If there are visitors with the patient, it is in general a good idea to ask them who they are, and then ask them to wait outside for a few minutes while the consultant talks with the patient. The consultant should not identify herself/himself as a psychiatrist until the visitors have left. An exception to this is when the patient's cognitive function is known to be impaired. Under those conditions, the visitors may remain with the patient's permission, and can provide valuable history and additional information.

Once some semblance of privacy has been obtained, the consultant should introduce self as a psychiatrist, and ask the patient whether he/she was expecting one. If not, the consultant should explain that the patient's primary doctor asked a psychiatrist to consult for a comprehensive evaluation—which may be for anxiety, depression, mood changes, memory problems, hallucinations, etc. The consultant should reassure the patient that many medical conditions and medications, as well as the stress of being in the hospital, can cause such problems and they can be managed effectively.

The initial interview should ordinarily take not more than 30 min, and should identify the patient's current concerns, the presence of major or minor psychiatric syndrome and its history, past history of psychiatric problems, family history, the family and occupational situation of the patient, and current mental status. In general, if the patient is obviously confused or delirious, a mental status exam (cognitive exam) may be performed in lieu of history, which may have to rely on collateral sources. When a patient is not obviously confused, the mental status exam may be performed for 5 min or less at the end of the interview, which can be prefaced by first asking the question, "How is your memory lately?", followed by, " I'd now like to ask you some questions to assess your current memory and concentration."

3.3.5.1 The Mental Status Examination

The mental status consists of the following components: (1) appearance, (2) levels of consciousness and orientation, (3) status of the communicative

facilities (speech and movement), (4) content of thought, (5) affect and mood, (6) cognitive processes (attention, concentration, comprehension, memory, perception, thinking logical thoughts, abstraction, judgment). Mental status examination usually refers to cognitive examination, and should be distinguished from mental status, of which cognitive status is a subset. For patients with cognitive deficits, cognitive tests such as the Mini-Mental Status Examination (MMSE) is useful in quantitatively determining the extent of cognitive deficit, and when used serially, in documenting changes in cognitive function (see Chap. 4 for MMSE).

Appearance. Appearance is an excellent indicator of the sum total of a patient's mental status at a given point. Body build should be first noted, i.e., medium, slender, emaciated, moderately obese, morbidly obese, etc. Sloppy, disheveled appearance often signifies self-neglect or preoccupation and distraction. Flushed appearance and the smell of alcohol on the breath, combined with characteristic drunken behavior, point to the diagnosis of alcoholic intoxication. Pale, emaciated appearance accompanied by malodorous and sloppy dress may indicate the presence of depression or cachexia. Some patients with a lesion in the nondominant hemisphere of the brain may dress only one side of the body, completely oblivious to the presence of the other side (hemineglect, hemiagnosia). Such patients may pay attention only to one half of the visual field. Notations on appearance should include observations on the general impression made by the patient (e.g., sloppy, neat), including any unusual features (e.g., completely shaved scalp, unusual bodily habitus, dress).

Levels of Consciousness and Orientation. Awareness of self and environment constitutes consciousness in the mental-status examination. Consciousness may be subdivided into content of consciousness and arousal. The sum total of mental functions, including the ability to remember and to think, comprises the content of the consciousness, while the appearance of wakefulness and response to stimuli form the bases of inference concerning arousal. The content of consciousness is largely a function of the cerebral hemispheres, while the state of arousal is largely a function of the reticular activating system in the brain stem (Boly et al. 2008; Boveroux et al. 2008; Lapitskaya et al. 2013)

Arousal: Levels of consciousness may be classified as follows:

Hyperalert state: Increased state of arousal in which the patient is acutely aware of all sensory input. Anxiety and certain central nervous system stimulants can cause this state.
Normal degree of alertness.

Dullness and sleepiness: May be due to fatigue and insomnia, as well as to sedating medications (as either primary effect or side effect). Metabolic derangements due to disease can also result in dullness and sleepiness, such as in uremia and hypercalcemia.

Clouding of consciousness: A state of reduced wakefulness in which periods of excitability and irritability often alternate with periods of drowsiness. Illusions, especially visual, may occur, and the patient is often startled. Mild to moderate toxic states, withdrawal states, and metabolic derangements can cause this.

Confusional states: In addition to clouding of consciousness, there is consistent misinterpretation of stimuli and shortened attention span. There is disorientation at least to time and often to place. Memory is often poor, and the patient appears perplexed. This is a more severe degree of clouding of consciousness.

Delirium: When used to denote a particular and often fluctuating level of consciousness, delirium may include a florid state of agitation, disorientation, fear, misperception of sensory stimuli, and, often, visual hallucinations. The patients are often loud, talkative, and suspicious and are sometimes completely out of contact with the environment. The degree of contact may vary. Delirium usually occurs in moderately severe toxic states and metabolic derangements of the

central nervous system, including withdrawal from central nervous system depressants such as alcohol and barbiturates.

The term delirium is often used to denote all reversible organic brain syndromes due to metabolic encephalopathy (see Chap. 12). When used in this sense, delirium is in contrast to dementia, which implies chronic and irreversible changes in the brain. Agitation and florid psychotic picture may be lacking in patients with delirium in this broader sense; that is, the patient with reversible confusion and disorientation may be placid and drowsy rather than agitated. In delirium, there is evidence of abnormal neural connectivity and a hyperdopaminergic state (Caplan 2012; Choi et al. 2012)

Stupor: In this state, the patient is unresponsive to stimuli unless their application is very strong and repeated. Usually caused by diffuse cerebral dysfunction.

Coma: Complete unresponsiveness to stimuli. Even strong and repeated stimuli cannot arouse the patient. This occurs in severe dysfunction of the brain, such as serious intoxication or severe head trauma.

Content of consciousness: *Orientation* refers to the person's consciousness of the orienting markers, such as correct awareness of time, place, person and situation. Impairment of orientation results in confusion. The orientation of a patient is determined by asking questions such as: "What day of the week is it today?" "Where are you right now?" "What is your name?" "Why are you in the hospital?" In case of insufficiency in the cerebral cortical functions for any reason (most often due to metabolic derangement of the brain or neuronal destruction), orientation may be impaired to varying degrees. Impairment of orientation usually occurs in the order of time, place, situation, and person. In hospitalized patients, disorientation as to date is not uncommon, perhaps due to the change in daily schedule following hospitalization, distractions by the medical procedures, and other disruptions in the patient's usual routine. In the absence of delirium, however, most patients are oriented to the month and year if not to the exact date. Orientation as to person, especially to the patient's self, usually is not impaired until the very latest stage of cognitive impairment, although the patient may often forget the names of others, especially those persons encountered recently. Disorientation to the self despite relatively normal mental-status examination in other areas strongly suggests a dissociative syndrome rather than an organic brain syndrome such as delirium or dementia.

Status of Communication Facilities (*Speech and Movement*).

In assessing the communicative facilities of a patient, one should consider the integrity of the apparatuses, the effect of learning and psychological state, and the content of the communication.

Integrity of apparatuses. The organs related to speech and movement should be assessed. Weakness of the tongue or facial muscles may produce dysarthria (difficulty in articulating words). Hemiplegia may cause the patient to gesticulate with only one hand. A painful lesion in the mouth may force the patient to be verbally noncommunicative. Deafness may result in nonresponse to a question.

Disorders of language (*aphasia*) caused by brain lesions may be present. Aphasia should be distinguished from dysarthria; the former is due to problems with language itself at the brain level, while the latter refers to difficulty in articulation. In aphasia, written language as well as verbal speech is affected. Aphasias may be roughly classified into expressive (Broca's or motor) and receptive (Wernicke's or sensory) types. Expressive aphasia is related to lesions of the motor speech (Broca's) area in the dominant frontal lobe of the brain. The patient with expressive aphasia has major difficulties in translating thoughts to symbols; thus, what the patient wishes to express may come out in a distorted form or not at all. The patient is usually aware of this distortion or difficulty in his/her own speech and, for this reason, is usually reluctant to speak (or write). Receptive or sensory aphasia is due to lesions of the sensory speech (Wernicke's) area of the dominant temporal lobe. In this condition,

the patient has difficulties in comprehending language, including their own speech. Thus, the patient's speech may be garbled, but they may not be aware of the problems with speech. Unlike patients with expressive aphasia, those with the receptive form are usually fluent, although often incomprehensible to others. There are varying combinations and subtypes of aphasias. For example, in conduction aphasia, there is a disconnection between the Broca's and Wernicke's areas, and thus the patient is unable to repeat what the examiner says to the patient.

Effect of learning and psychological state. Given intact apparatuses for communication, the form of communication often depends on the patient's psychological state and the effect of learning. The effect of learning determines the language in which the patients will express their feelings and thoughts as well as the fluency and facility of the language. For example, middle-class patients are more likely to use grammatically correct syntax. Some patients may use dialects or culturally specific expressions. The current psychological state also determines speech and nonverbal communication. A euphoric patient is more likely to be effusive, verbose, and flamboyant; a depressed patient may be uncommunicative and withdrawn.

Content of communication. What the patient is communicating forms the content of communication. The content of communication often reveals the patient's psychological state, for example, themes of hopelessness and death in depressed states, and bizarre contents in psychotic states. Extreme suspiciousness and ideas of persecution may indicate paranoid psychosis.

Affect and Mood: In current usage, *mood* denotes the subjective feeling/emotion of the patient (euthymic, sad, happy, depressed, euphoric, etc.), while *affect* refers to the way the emotion is expressed (normal range, flat, obtunded, labile, appropriate, inappropriate, etc.). In another, common usage, *affect* refers to feeling and is synonymous with emotion, while *mood* refers to prevailing and relatively enduring emotional tone. Mood can be documented by observation and direct questioning. By observation, one can see whether the patient's affect is appropriate or inappropriate relative to the topic of conversation (does the patient smile while talking of sad events?) and whether it is stable or labile. Labile affect, as manifested, for example, by laughing one minute and crying the next, may be indicative of organic brain dysfunction, in which case there will be additional signs of cognitive difficulties. Flat affect means the absence of any display of affect and is often a negative symptom of schizophrenia or is associated with extreme use of isolation as a defense mechanism (Chap. 19). Direct questions about affect might be "How do you feel right now?" and "Do you feel anxious?" Physiological signs such as sweating, rapid heart rate, and facial expressions also reveal affective states. Family, friends, and relatives of the patient may also provide useful information concerning the patient's mood.

Cognitive Processes. These are the processes that determine the content of consciousness. The processes include attention, perception, memory, concentration, comprehension, abstraction, logical thinking, and judgment. Diminution in the function of any of these areas may indicate the presence of pathology in the cerebral cortex or limbic system. It should be noted, however, that what is important is a decrease in function from the premorbid state and not necessarily the absolute level of functioning, since the absolute levels of abstract thinking, comprehension, and other processes may be determined by background and by long-term variables such as constitutional endowment, educational level, and habitual functional level, as well as by illness. For example, cerebral pathology is more probably present in a college professor who cannot remember the names of the past five presidents than in a blue-collar worker with a tenth-grade education who evinces the same inability.

The cognitive processes can be tested both indirectly and directly. Indirectly, inferences can be made concerning the patient's memory, judgment, concentration, comprehension, and other abilities by asking the patient to describe the present illness and his personal history. Does the

patient remember the dates (or years) of graduation from schools, marriage, and other significant events? Does the patient comprehend the nature of her/his illness and the proposed procedures? Does he/she remember what has been told him by the physicians? Does she/he seem to be aware of the possible risks and complications?

Direct tests of cognitive processes. In introducing direct tests of cognitive processes, it may be helpful to explain that they evaluate memory, concentration, and so forth and so are useful in evaluating possible mental effects of medications, procedures, and the illness itself. For example, sedating medications may need to be reduced if the patient is found to be too drowsy or if concentration is diminished. This type of reassurance may put the patient at ease about possible errors they may make and gives the testing a medical context.

A. Orientation. When doing a direct cognitive testing, it is useful to ask questions concerning orientation first. The questions may be "What day is today? What is the date (or day of the week)?" If the patient does not know, then "What month is it now?" "What year?" may follow. Mild disorientation as to time (e.g., not knowing the date) is common even among normal persons, but severe disorientation (e.g., not knowing the month and year) is indicative of a cognitive disorder. "Where are you right now? The name of this place?" These test orientation as to place. If the patient does not know, then he may be asked "Are you in a hospital, a hotel, or a supermarket?" The patient may know that he/she is in the hospital (or a doctor's office), but may not know the name of the hospital or clinic, which indicates a milder degree of dysfunction than not knowing the nature of the place or confusing it with somewhere else, such as a hotel room. The situation may be inquired simply, "What brings you here?" The next question (orientation as to self) might be "What is your name?" As discussed previously, dysfunction in orientation proceeds in an orderly manner from time to place to situation to person. In fact, except in cases of very severe brain disease, orientation as to self is usually well preserved. Of course, a delusional patient may have a distorted orientation as to self, for example, "I am Napoleon Bonaparte."

B. Memory, attention, concentration, comprehension. Presidents: "Who is the President of the United States now?" If the patient answers correctly, continue asking "Yes, and before him?" until four or five names have been given correctly. This tests recent memory and information of the patient. Most patients with average high-school education can remember four or five recent presidents.

Calculations: Asking the patient to do simple calculations can test the patient's ability to attend to and comprehend the physician's instructions and to concentrate and utilize immediate memory. "How much is 15 plus 17?" "25 minus 7?" If the patient has difficulty, an easier calculation involving single digits should be tried. Unlike additions and subtractions, simple multiplications, such as 4 times 6, are easier tasks, since they involve primarily long-term memory (which is resistant to decay) and comprehension of the instructions. Thus, if the patient can do 4 times 6 but not 15 plus 17, then one might wonder whether the patient has difficulties with concentration and immediate or recent memory but not with remote memory and comprehension (indicating possible brain dysfunction). On the other hand, if the patient has difficulties with both, low educational level or mental retardation might be suspected.

If there is reason to suspect difficulties on the basis of simple calculations, serial 7 s and digit span might be done. Serial 7 s are done by asking the patient to subtract 7 from 100 and to keep subtracting 7 s from the results. This tests sustained attention and concentration as well as short-term memory. If serial 7 s are too difficult for the patient, serial 3 s may be tried. For example, "Could you count backwards from 20 by 3 s?" Digit span is tested by asking the patient to repeat a number of random digits, not including zero, such as 5-7-2-8-6. Digit span backward is tested by asking the patient to repeat in reverse order the numbers that you gave the patient. For example, "If I say 1-2, please say 2-1" This tests

primarily short-term memory and concentration. Most patients without brain dysfunction can do at least six digits forward and four digits backward. Failure to repeat 6 digits forward strongly suggests cognitive impairment. In contrast, the ability to repeat 5 numbers backward is very unlikely in the presence of brain dysfunction.

Memory, especially recent memory, is very sensitive to dysfunction of the brain. The hippocampus is involved in the coding of recent memory into the long-term memory mechanisms. Any metabolic derangement of the hippocampus and the cerebral hemispheres can result in problems with memory. When memory dysfunction is suspected, the registration, retention, and recall of memory can be tested by the following steps: First, ask the patient if he/she remembers your name. If the patient does not remember it, repeat your name and ask the patient to repeat it (immediate memory: registration and immediate recall). Then, tell the patient that you will mention three objects that you are asking them to remember, as you will ask again in a few minutes. The objects may be items such as "apple, penny, and table". Tell the patient to repeat the names of the three objects immediately. In about 5 min or so, ask the patient if he/she remembers your name; also, the names of the three objects (recent memory: retention and recall). The patient may be able to remember only one or two objects (diminished recent memory). If the patient cannot recall the names at all, ask the patient "Please say 'yes' if any of the objects I name now is one of the objects I named before. If the patient can identify the articles but could not remember them, it may indicate the presence of retention but difficulty with recall.

C. Abstraction. Similarities: This tests the ability of the patient to categorize objects on the basis of the similarities. For example, "What is the similarity between a cat and a dog?" The patient may answer "They are both animals" (a good abstraction) or "They both have legs" (a concrete response). In case of the latter, you might ask "Then how about a dog, a cat, and a snake?" At this point, the patient may be able to abstract and say "They are all animals." Proverbs: If I told someone, "Don't judge a book by its cover", what am I trying to say? "Don't cry over spilt milk," etc. Proverb interpretations are most subject to influences of educational level, cultural background, and language. For example, those from non-English-speaking cultures may have great difficulty in abstracting English-language proverbs. A concrete response in tests for abstraction may indicate possible brain dysfunction, low educational level, low intelligence, or formal thought disorder, as in schizophrenia. An idiosyncratic or bizarre response may indicate an unusual way of thinking, as in psychosis. For example, "What is the similarity between a cat and a dog?" "They are both my enemies." "What does the proverb, 'People who live in glass houses shouldn't throw stones' mean?" "That means that even if you have enough money to buy a glass house, you should not throw away money. Stones are gems, you know, which cost a lot of money."

D. Logical thinking and judgment. Patients with brain dysfunction may show varying degrees of difficulty with judgment. Judgment means the ability to act appropriately in social and emergency situations. Many questions concerning judgment also involve the ability to think logically. For example, "If you were in a crowded theater and happened to discover fire and smoke coming from the ceiling, what should you do?" A good answer would be "I would tell the usher or manager." If the patient replies "I would yell 'Fire'," the physician might ask "If you yelled 'Fire,' what would happen?" The patient with intact logical thinking may then say "I guess that would cause panic … perhaps I should not yell 'Fire'." Other judgment questions include "What should you do if you found an envelope with an address and a stamp on it on the street?" Patients with personality disorders without organic brain dysfunction may give idiosyncratic or inappropriate responses to judgment questions. For example, an impulsive patient may say "I would try to put out the fire by throwing my can of soda on it."

E. Perception. The patient's perception can be tested by first observing whether the patient seems to be aware of the tester's presence and whether the patient seems to be responding to visual or auditory hallucinations (e.g., carrying

on a conversation). Then, the patient can be asked questions such as: "Have you ever had any experiences of hearing things or seeing things that others couldn't see or hear?" "Any experiences of things changing shape or becoming distorted?"

F. Delusions and paranoid thinking. A delusion is an idea firmly held by a patient that is not corroborated by reality. Delusions may be grandiose ("I am God"), persecutory ("Everybody is out to get me"), or depressive ("Worms are eating my brain out"). Some delusions involve diseases, such as: "I know I have cancer, no matter what the tests show." The term "paranoid" is often used to describe patients who have persecutory ideas or delusions.

The presence of delusions is usually manifested by the content of the patient's communications. Delusion formation is a process by which perceptions are put into some kind of perspective. Thus, strange bodily sensations, due to whatever cause, may be attributed to "poisoning" and continuing presence of anxiety to "people spying on me." Obviously, when cognitive processes are not functioning optimally, and when the anxiety level is high (such as in a hospitalized patient with preexisting cognitive difficulties due to poor blood supply to the brain), the risk of delusion formation is greater; it is easier to misperceive stimuli or attribute confusing stimuli to a cause unrelated to reality (e.g., "The doctors are trying to kill me so that they can give my kidneys to someone else").

In addition to indicating the possible presence of cognitive difficulties, delusions give clues concerning the emotional state of the patient. For example, persecutory delusions are associated with anxiety, grandiose delusions with euphoria, and depressive delusions with a depressive syndrome.

Once initial interview is concluded, the consultant proceeds to the next steps:

3.3.6 Obtain Collateral Information

After interviewing the patient, obtaining collateral information from the spouse, significant others, families and friends can provide valuable information. The consultant should obtain permission from the patient to speak with available collaterals whenever feasible. If the patient is severely cognitively impaired, or the patient refuses to give permission, still the consultant may speak with collaterals as long as they are aware that the patient is in the health care facility, and as long as the consultant only obtains information and does not divulge information about the patient.

3.3.7 Diagnose the Consultation: The Syndrome, The Patient, The Environment

After reviewing the reason for consultation, patient's history, family history, information from collaterals, lab, vital signs and physical exam data, the consultant is in a position to make a comprehensive diagnosis of the consultation itself. Such a diagnosis may include primarily *a systems strain*, e.g., a personality or opinion conflict between the health care professional(s) and the patient (see Chap. 10). When the patient shows evidence of a psychiatric condition, the consultant develops a differential diagnosis leading to a working diagnosis of the psychiatric syndrome, its interaction with the medical condition, and an understanding of the patient as a person dealing with the medical and psychiatric condition. Such an understanding will include an understanding of the patient's developmental history, childhood, recent, and current stresses, as well as the patient's coping ability and psychosocial assets. Differential diagnosis of the psychiatric syndrome should be from general to specific, e.g., psychotic syndrome secondary to drug use, psychotic syndrome secondary to delirium secondary to multiple metabolic causes—electrolyte imbalance, increased serum ammonia. Very often, the psychiatric syndrome may represent multiple possible contributing etiologies, e.g., major depression which may be a recurrence of existing unipolar depression, plus the effects of chronic alcohol abuse, plus secondary to hepatic failure, plus cocaine withdrawal. (See Chap. 7 for further discussion of psychiatric diagnosis).

3.3.8 Provide Diagnosis and Recommendations

The proof of the pudding of a psychiatric consultation is how informative it is and how implementable the recommendations are. The most effective way of conveying the recommendations is to speak with the referring physician directly, either face to face or on the phone, so that the referring physician may be able to ask questions and interact with the consultant. The consultant should communicate to the consultee the findings and diagnosis clearly and concisely, without using unnecessary psychiatric jargon, and discuss alternative treatments and recommendations. The recommendations should be presented very concretely, and specify who is to do what. For example, "I recommend olanzapine 10 mg po hs on a regular basis for the patient's psychosis, plus lorazepam 1–2 mg IV q 4 h prn for agitation. Please tell the nursing staff to orient the patient each time they do any procedure with the patient such as taking the vital signs—they should say, I am nurse so and so and I am going to take your blood pressure."

The written consultation note should be concise and, above all, comprehensible, without obscure abbreviations or jargon. The note should contain, as a minimum, the reason for referral, brief history and mental status, relevant labs, working diagnosis, and specific concrete recommendations.

3.3.9 Consultation Interventions

In the course of psychiatric consultation, the consultant, ipso facto, provides intervention through an empathic interview process, and through supportive psychotherapeutic elements inherent in a psychiatric interview. In addition, the consultant may provide immediate relief of agitation through listening and reassurance, and when indicated, with stat medications. There may be need for an involuntary hold if the patient is considered to be dangerous to self or others and is in need of psychiatric hospitalization.

The consultant may find it advisable, at times, to arrange an ad hoc nurses meeting, meeting with the patient's family, or a meeting of the patient, referring physician, the consultant, and others to facilitate communication and/or plan a course of action.

The consultant may also perform specialized procedures such as lorazepam interview when indicated (see Chap. 34).

3.3.10 Follow-Ups

At least one follow-up visit is recommended for all initial consultations whenever feasible. A follow-up visit is valuable to determine any changes either as a result of the treatment recommendation or of the disease process. In delirious patients, the fluctuation in mental status during follow-up visits may be diagnostic. When a patient no longer requires follow-up, but is still in the health care system, the consultant should sign off and communicate it to the referring physician.

Note: A Computerized Psychiatric Consultation Database with Forms, Reports, and Queries, which is a Microsoft Access Database application, is available free of charge for download from Springer. This database was developed by Hoyle Leigh, MD and is used at the Community Regional Medical Center, Fresno, CA. It is made available "as is" with the explicit understanding that it will be used for clinical and academic purposes only, and it is without any warranty. It is usable only as an application of existing Microsoft Access database.

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