



The Art of the Psychiatric Consult

In the medical and surgical setting

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DISCLOSURES

I have no disclosures.

I have no financial relationships or conflicts of interest to disclose relevant to this presentation.

The diagnosis is the science. Making your recommendations useful is the art.

Anyone can write a formulation. What changes outcomes is making useful recommendations—and getting them enacted in service of the patient and team.



What we'll cover

- | | | |
|-----|----------------------------------|---|
| I | Foundation | Prevalence, referral rates, and why C-L Psychiatry? |
| II | Before you enter the room | Decoding the referral; preparing the encounter |
| III | The encounter | Interviewing without privacy; using collateral |
| IV | The communication | The note and the conversation |
| V | The team | Systems and countertransference |
| VI | Making the service useful | What the hospital values; pitfalls to avoid |

I

Foundation

Psychiatric illness is common in hospitalized patients. Psychiatric consultation is not.

Common illness, uncommon consultation

30–40%

of general hospital inpatients

carry a diagnosable psychiatric
disorder

10–30%

**of medical inpatients develop
delirium**

highest in older surgical and critical
care patients

1–3%

are referred to psychiatry

far below measured prevalence

Commonly cited ranges; varies by setting. The gap is the point — most psychiatric morbidity here is managed without us.

How American medicine is subdivided

24

ABMS member boards

the certifying bodies of American medicine, including the American Board of Psychiatry and Neurology

40

primary specialties

the broad disciplines a physician trains and certifies in

89

subspecialties

including consultation-liaison psychiatry, recognized since 2003

CONSULTATION-LIAISON PSYCHIATRY IS THE ONLY SUBSPECIALTY CENTERED ON CONSULTATION.

Three barriers to addressing psychiatric issues

01

Knowledge gap

Minimal psychiatry training in medical school and other specialties.



02

Discomfort with psychiatric symptoms

Agitation, suicidality, refusal, and unexplained behavior can generate anxiety and avoidance.



03

Psychiatry often outside the house of medicine

Psychiatry is often practiced in non-medical settings.



Despite subspecialty status, far fewer than half of hospitals have a dedicated psychiatry consultation service.

Two jobs

Consultation

- Patient-centered and episodic
- Triggered by a specific request
- Answers a question about one patient
- Succeeds with an actionable recommendation

Liaison

- Team-centered and continuous
- Often preventive
- Focused on how care is delivered
- Succeeds when the team improves

Most services are asked for consultation and judged on liaison. Reputation is built on the latter.

II

Before you enter the room

The question you receive is rarely the question you must answer.

The stated question and the real one

WHAT IS WRITTEN

WHAT IS OFTEN MEANT

“Please assess capacity.”

The patient is refusing, and the decision distresses us.

“Patient is agitated — needs medication.”

Staff are frightened and unsupported.

“Rule out depression.”

The patient is failing to progress and so discharge is stalled.

“Psych clearance before discharge.”

We want the risk documented and shared.

Call the referrer. One minute on the phone turns a vague request into an answerable question.

Before you knock on the door

- | | | |
|----|----------------------------------|---|
| 01 | Clarify the question | Call the referrer. Establish urgency and the decision at stake. |
| 02 | Read the chart properly | Medications, labs, operative course — and the nursing notes. |
| 03 | Talk to the nurse first | The highest-yield five minutes of the whole consult. |
| 04 | Form a working hypothesis | Enter with a differential. Think broadly while honing your questions. |
| 05 | Plan the practicalities | Awake? In pain? Awaiting a procedure? Timing decides the exam. |

III

The encounter

A psychiatric interview without privacy, time, or a door.

THE ENCOUNTER

Interviewing in a room without walls

- **Sit down**, at eye level, every time.
- Introduce yourself as the psychiatry team.
- Ask the patient if they knew you were coming (less than 50% do).
- Address the elephant: pain, prognosis, fear of dying. Be mindful of trauma.
- Do something for the patient.
- Examine cognition and perform a targeted neurologic exam.



Collateral is key

The bedside nurse

Fluctuation, nighttime behavior, intake, visitors.

Family and carers

Baseline cognition — without it, delirium looks like dementia.

The medication record

Anticholinergics, steroids, opioids, abrupt discontinuation.

Prior records

Past episodes and what has already worked or failed.

The referring clinician

The unstated worry behind the request.

Allied health

PT/OT/SLP see effort and capacity in action.

The patient is one source. The interview alone is generally not sufficient.

IV

The communication

An unread recommendation is not useful.

Habits of an effective consultant

- 1 Determine the question** Answer what was asked before you answer what you noticed.
- 2 Establish urgency** Emergency, urgent, or routine — agree to it explicitly.
- 3 Look for yourself** See the patient. Don't consult on EMR
- 4 Be brief** Focused recommendations beat a long formulation.
- 5 Be specific and practical** Drug, dose, route, frequency, review point.

After Goldberg and Stoudemire's commandments of medical consultation.

Habits of an effective consultant

- 6 Provide contingency plans** Say what to do if the first plan fails.
- 7 Honor your role** Advise on management; don't take it over.
- 8 Teach with tact** Educate without indicting. Leave the team more capable.
- 9 Talk directly** Phone or speak in person for anything sensitive.
- 10 Follow up** Return and close the loop. This is very valued.

Following up is what turns a one-off consult into a respected service.



DOCUMENTATION

Be concise and practical

Keep your note concise.

Avoid extraneous or overly sensitive information

Focus on actionable recommendations

This is the most important section and what everyone reads.

Justify briefly

Concise prose as explanation/justification is useful. Too much is overwhelming.

Avoid jargon and hedging

“Consider possible affective component” commits no one.

State your follow-up

Say when you will return and how to reach you.

Specificity is key

VAGUE

“Consider antipsychotic if agitated.”

“Optimize the environment.”

“Patient may lack capacity.”

ACTIONABLE

“Haloperidol 1 mg IV up to twice daily, for agitation threatening safety. Re-assess after each dose; call if QTc over 500 ms.”

“Glasses and hearing aids on by 08:00. Curtains open during the day. No overnight vitals.”

“Patient is able to state a preference but cannot weigh the risk of refusing surgery. He does not currently have capacity due to delirium; reassess after delirium resolves.”

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V

How to serve the team

Many consults are about a team that doesn't have a clear concept of how to help the patient.

SYSTEMS

When the question is really about the team

- Consults cluster around patients who make teams feel helpless.
- Repeat referrals often signal ongoing conflict, not new illness.
- No stupid consults—reframe the question in service of team needs.
- Sometimes the intervention is a team meeting, not a drug.



Disagreements and the fragmented team

What you'll see

- Incompatible descriptions of the same patient
- Polarized opinions held with unusual certainty
- Plans that change frequently, not the illness
- Informal rules made for one patient alone

What to do

- Get everyone in one room; let the versions coexist
- Reframe the split as distress, not blame
- Agree one written plan with explicit limits
- Name the difficulty out loud

Splitting happens when team members see the patient differently.

Your reaction is data

Dread before the visit

Signals a patient the whole system is avoiding.

Unusual rescue urgency

You may be recruited to fix what the team gave up on.

Irritation with the referrer

Often the team's frustration, transmitted to you.

Overidentification

Important to discern root of this as individual.

Relief at a quick discharge

Speed sometimes serves the consultant, not the patient.

Supervision and peers help calibrate.

What the hospital actually values

Speed

Same-day response on urgent referrals, above all else.

Availability

A named, reachable clinician who answers.

Decisiveness

A clear position on capacity, risk, and discharge.

Flow

Unstick patients. Length of stay is top of mind.

Teaching

Staff who learn to manage delirium refer better.

Presence

Regular presence on the floors means earlier referrals and fewer emergencies.

How to make your service valuable

JOIN COMMITTEES

01 Workplace Violence

02 Quality and Safety

03 Patient Safety

04 Ethics

How to make your service valuable

DESIGN PROTOCOLS

- 01 Suicide Precautions
- 02 Delirium
- 03 Care of the Patient with Eating Disorders
- 04 Alcohol Withdrawal
- 05 Opioid Withdrawal

Specialty consult services and liaison roles

EMBED A NAMED LIAISON

01 Burns / Trauma

04 Transplant

02 ICU

05 Psycho-Oncology

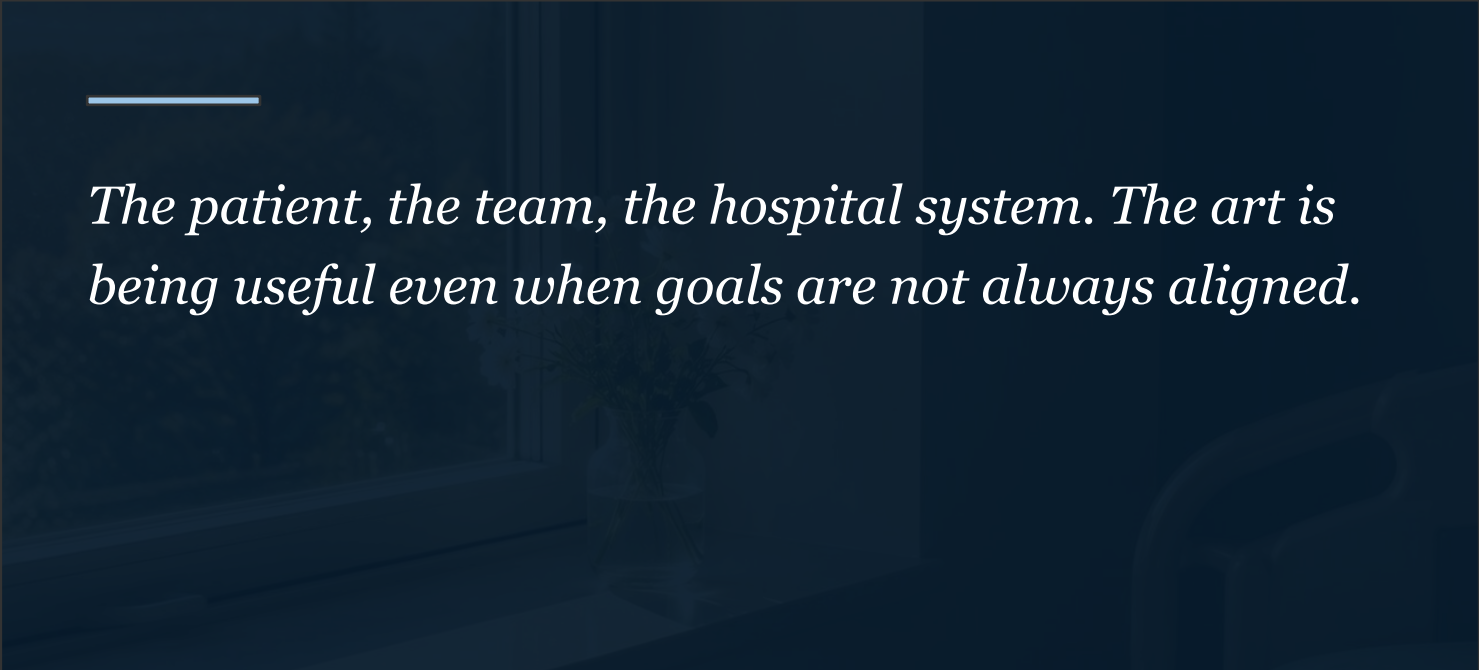
03 Women's Mental Health

06 Addiction

IN CLOSING

Take homes

- 01 Find the real question without pushing back.
- 02 The nurse and family are key for collateral.
- 03 Be brief, be specific, plan contingencies.
- 04 Understand the dynamics of the team and be useful to them.
- 05 Follow up. Reliability builds the service.
- 06 Take a leadership role on hospital committees and protocols.



*The patient, the team, the hospital system. The art is
being useful even when goals are not always aligned.*