Psychiatrists and Primary Caring: What Are Our Boundaries of Responsibility?

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This column provides a framework for considering the extent of psychiatrists' responsibility for patients' medical conditions. Psychiatrists have the greatest responsibility for medical conditions that occur as a result of their own actions. Next on the continuum of responsibility is psychiatrists' obligation to remain alert for medical conditions that can cause, trigger, or exacerbate psychiatric conditions or interfere with treatment. Another potential responsibility is for preventive monitoring, screening, and education for medical conditions that disproportionately affect psychiatric patients. Characteristics of the setting, practitioner, and patient that affect how such responsibilities are fulfilled are also discussed. (*Psychiatric Services* 58:600–602, 2007)

Mr. J is referred for an evaluation of his depression. He also has obesity and hypertension, and he smokes.

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Mr. P's schizophrenia is well controlled on a second-generation antipsychotic medication, but he has gained 20 pounds in six months and his hemoglobin A1c is 7.2.

Ms. R mentions in her weekly psychotherapy session that over the past few weeks she has experienced the onset of repeated episodes of shortness of breath and chest discomfort.

Medical problems are common among patients seen in psychiatric practice. Less common is a consistent understanding of best practices for psychiatrists when they address these medical issues or assume primary care roles.

As psychiatrists, we have been proud advocates of the biopsychosocial model. We teach the psychological underpinnings of human behavior and have become acclimated to addressing social and economic factors, such as stressful family and employment situations and homelessness, that affect our patients and their psychiatric conditions. Many social and life factors lie beyond the scope of our formal training, and it may be extremely difficult to have a positive impact on them.

Ironically, many psychiatrists have been only peripherally involved with patients' medical problems despite their medical training and licensure, their increasing understanding of the neuroscience that underlies many psychiatric diseases and treatments, their insistence that psychiatry is a medical specialty, and the availability of many useful medical interventions that would benefit their patients. Psychiatrists are aware of the complex nature of medical issues. They know that their expertise regarding nonpsychiatric medical disorders is often not as extensive as that of primary care physicians and medical specialists. For these reasons many psychiatrists may believe that patients with medical problems could experience inferior care at their hands when superior alternatives exist.

There are likely a number of acceptable responses to questions about the limits of our medical practice within existing care structures. Both action and inaction can confer medical, social, human, and legal risks and liability. Part of our dilemma in determining what to do or not to do may be attributable to the lack of an appropriate framework for considering our levels of responsibility and potential actions based on these responsibilities. In this column, we offer a structure of such a framework. This framework has two interrelated components: determining the responsibility of the psychiatrist and determining how that responsibility can be properly discharged.

The column grew out of a discussion among members of the Commit-

tee on Psychopathology of the Group for the Advancement of Psychiatry (GAP) (www.groupadpsych.org). GAP, an organization of psychiatrists dedicated to shaping psychiatric thinking, public programs, and clinical practice in mental health, meets twice a year to explore issues and ideas on the frontiers of psychiatry. A primary objective is to develop and disseminate papers based on these explorations and discussions.

What is the responsibility of the psychiatrist?

The question about psychiatrists' responsibility for medical conditions arose several decades ago in the context of community psychiatry and may be best addressed by considering the characteristics and severity of the medical problem that needs to be managed or prevented (1,2). We posit a continuum of responsibility and obligation based on these considerations.

Psychiatrists have the greatest level of responsibility for medical conditions that occur as a result of an action taken by the psychiatrist. For example, in the vignette about Mr. P above, the weight gain and diabetes is at least partially attributable to the psychiatrist's medication treatment. There is an emerging set of guidelines to monitor metabolic abnormalities among patients receiving antipsychotic medications (3). The psychiatrist is responsible for being aware of potential medically adverse reactions to psychiatric treatments and for facilitating appropriate monitoring and, if necessary, corrective interventions. For example, well-accepted treatment guidelines exist for the monitoring of parameters such as renal function and thyroid-stimulating hormone among patients treated with lithium (4).

Next on the continuum of responsibility is psychiatrists' obligation to remain alert for co-occurring medical conditions that can cause, trigger, or exacerbate the psychiatric conditions that they are treating or that can interfere with psychiatric treatment. Psychiatrists need to identify such medical conditions and ensure that they are properly addressed. For example, the psychiatrist should consider whether Mr. J, in the vignettes above, has obstructive sleep apnea or hypothyroidism.

A potential responsibility that may be more vigorously debated is whether psychiatrists have a responsibility for providing preventive monitoring, screening, and education for medical conditions that disproportionately affect psychiatric patients. Poor health literacy is associated with poor health outcomes (5), and there is an association between poor health literacy and depression among elderly patients (6). Many would argue that psychiatrists should be able to provide baseline preventive care and screening (7) as well as health education. For example, some would contend that psychiatrists are responsible for providing education and screening for hepatitis C infections for patients such as Mr. P because studies have indicated that people with serious mental illness are at increased risk for this condition (8). Such testing could slow the spread of hepatitis C and reduce our patients' morbidity and mortality.

Finally, some would argue that psychiatrists are responsible for ensuring that their patients are receiving appropriate medical care for all existing medical problems and that they are also engaging in health-promoting behaviors (9). Research indicates that people with severe mental disorders experience significant barriers to the receipt of medical care (10–12). In a number of programs, psychiatric residents are trained to provide integrated psychiatric and primary care (13,14), and in some systems of care, psychiatrists are responsible for some primary medical care (15). Part of this responsibility might include counseling patients about exercise, food selection, nutrition, relaxation, and stress reduction.

Relevant to considerations of responsibility in all of the situations described above is the acuity and severity of the medical condition. In general, the greater the acuity and severity, the greater the responsibility of the psychiatrist to ensure that the condition is appropriately addressed. For example, in the vignette above, even though Ms. R's episodes of shortness of breath and chest discomfort are probably not a result of her psychiatric treatments and probably not a medical disorder that is exacerbating her psychiatric condition, most psychiatrists would assume an immediate responsibility to assist her in securing appropriate treatment.

How can the responsibilities be fulfilled?

Psychiatrists' practices vary, and clearly, in most settings the psychiatrist does not have to be the provider of all medical services. In general, however, psychiatrists must be satisfied that appropriate action has been taken to address the medical conditions for which they have responsibility. Exactly what is done and who does it is affected by three factors: the service or practice setting, characteristics of the practitioner, and characteristics of the patient.

The service or practice setting is crucial in determining the supports available to a psychiatrist to meet medical responsibilities. Solo practices differ dramatically from practices in large integrated health care systems. Other important factors include the amount of time allocated for patient sessions (and for paperwork and interaction with other providers or other potential caregivers), whether the setting is urban or rural, whether patients have access to high-quality primary care or specialty services, and whether effective technology is available for sharing medical information. In an integrated care system, psychiatrists might appropriately discharge their responsibilities for medical care by requesting that a member of the larger health care team, such as a primary care physician, evaluate and manage the patient's medical condition. In systems with electronic medical records, such as Veterans Affairs programs, the necessary communication might be as simple as making an electronic note that requires the signatures of all who are responsible for the patient's care, coupled with monitoring of the patient and system follow-through for the condition.

For psychiatrists in private practice, discharge of responsibilities may entail simply encouraging patients to take responsibility for ap-

propriate follow-up. However, discharge of responsibilities may be fairly complex, involving direct facilitation of follow-up through calling for the appointment, involving family members, communicating directly with a primary care clinician, and so forth. Finally, in areas with diminished access to other services, the psychiatrist may need to provide direct management of co-occurring medical disorders, such as managing Mr. J's hypertension.

Relevant practitioner characteristics include knowledge and expertise concerning medical matters, appropriate assessment of one's abilities and capacities, and medical networking options that are available as resources. Examination of provider characteristics in the light of service setting may help determine important areas for additional provider training.

Important patient characteristics include overall health literacy and the capacity to understand and be responsible to follow through with medical appointments, tests, and interventions. The patient's support systems, such as family, friends, and participating agencies, may also be crucial in this regard. Opportunities and limitations may also be created by characteristics of the patient's payer system and insurance coverage. It is important to note that psychiatrists' responsibilities may vary depending on differences in patients' strengths and deficits. Although the recovery movement emphasizes the importance of empowering patients to participate in their own care, this movement does not diminish providers' responsibility to advise and facilitate appropriate care.

Conclusions

The need for psychiatrists to be involved in the medical care of their patients reflects the principle that psychiatrists attend to the whole patient, both as advocates for biopsychosocial care and as members of a medical specialty. The clinical problems that psychiatrists face have both medical causes and medical repercussions. We can play an important part in delivering better care by attending to these issues. Clarifying, refining, articulating, and establishing clear expectations on the part of all involved—psychiatrists, other medical and mental health professionals, administrators, patients, and family members—is a task that remains to be done so that expectations will be realistic, feasible, and appropriate. Although some psychiatrists, on the basis of their training, experience, and interests, may choose to go further than others with these issues, professional and public discussion is warranted to set at least minimal performance standards. Available tools include requirements for additional medical training, continuing medical education, and certification as well as administrative and professional strategies for quality assurance and improvement.

The National Association of State Mental Health Program Directors recently issued a technical report underlining the excess morbidity and mortality of persons with serious mental illness (16). It calls for national and statewide efforts to implement established standards of care for prevention, screening, assessment, and treatment and improved access and integration with physical health care services. Psychiatrists and psychiatric organizations must assume leadership roles in these discussions. In addition, research should be conducted to identify and establish a greater scope and range of best practices.

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