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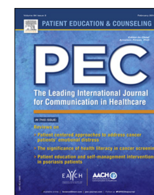

Mental health

The primary care physician/psychiatrist joint consultation: A paradigm shift in caring for patients with mental health problems?

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ABSTRACT

Objective: Thirty to forty percent of patients seen in primary care medicine suffer from mental health problems, but primary care physicians (PCPs) often feel unprepared to deal with their patients' mental health problems. Joint consultations conducted with a liaison psychiatrist can help. The purpose of this study was to evaluate the experience of joint consultations in a primary care service in Geneva, Switzerland.
Methods: We retrospectively analyzed reports of psychiatric evaluations conducted between October 2010 and August 2012 ($n = 182$), in the Primary Care Service of the Geneva University Hospitals. We also carried out 4 focus groups with 23 physicians-in-training to explore their experiences and perceptions of the joint consultations.
Results: Seventy two percent of the evaluations resulted in a psychiatric diagnosis. Psychiatric follow-up was not considered necessary in 61% of cases. Focus groups revealed that prior to experiencing joint consultations, PCPs considered mental health problems to be the domain of psychiatrists and outside their own area of competence. Joint consultations helped to demystify the role of psychiatrists, reduce their anxiety and increase PCPs' confidence in dealing with patients' mental health problems.
Conclusion: Joint consultations enabled PCPs to shift away from a dichotomous view of somatic versus mental health problems and their management, and towards a more integrated view.
Implications for practice: Joint consultations provide a useful strategy for training primary care physicians in the management of mental health problems. Integrated management of somatic and mental health problems can lead to a better understanding of the patient and improve the therapeutic relationship.
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1. Introduction

Primary care physicians (PCPs) are often the first contact for patients with mental health problems [1,2]. About 30–40% of primary care patients suffer from mental health problems, and many problems – for example depressive disorders, dysthymia, generalized anxiety disorders, panic disorders and substance abuse – are primarily taken care of by the PCP [3,4]. About 90–95% of patients with psychological problems are seen only by their PCP [5]. However, less than 30% of general medicine patients with mental health problems are treated adequately [6]. The need to enhance the training and skills of PCPs in the field of mental health is now recognized and has been addressed in some training courses. In the context of liaison psychiatry, the joint consultation between a PCP and a psychiatrist represents an opportunity to promote a close link between the psychiatrist and the PCP and to learn through modeling. However, we found scarce medical literature on the benefits of joint PCP-psychiatrist consultations, except in the field of ENT patients with tinnitus [7]. Joint consultations between PCPs and specialists have been described in different fields of medicine (cardiology, rheumatology, orthopedics) [8–10]. They seem to improve PCP skills in the specific field and reduce the rate of referrals when both physicians agree on the need to communicate and improve skills linked to the discipline.

The objectives of our study were to describe the characteristics of joint consultation reports in a university hospital primary care service, and explore PCPs' expectations and experiences of the joint consultation model.

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2. Methods

2.1. Setting

The joint consultation is offered within the primary care division (locally referred to as the SMPR) at the Geneva University Hospitals. The SMPR is an outpatient clinic that provides care for acute and chronic problems to a socially, culturally and linguistically diverse patient population. About 30–40 physicians-in-training work part-time at the SMPR and 28 at the general consultation. In general, they have 2–4 years of post-graduate medical training and spend 1–2 years at the SMPR before going into private practice as primary care physicians or moving to another hospital department. In order to work as primary care doctors, Swiss physicians must obtain the title of general internist. For this title, the Swiss licensing board requires 2 years of hospital internal medicine and 6 months of ambulatory medicine. The remaining 2.5 years of training can be spent in different subspecialties of internal medicine (e.g. cardiology) or other specialities (e.g. surgery, gynaecology, paediatrics, psychiatry) for a maximal length of a year [11]. A psychiatry rotation is not compulsory.

The joint consultation is a psychiatric evaluation offered to PCPs in training at SMPR who encounter diagnostic or management difficulties with patients suffering from mental health problems. PCP's are informed of this option at the beginning of each academic year. PCPs may request a joint consultation via a written form which is sent to liaison psychiatry. The joint consultation generally consists of a psychiatric assessment of the patient conducted by the liaison psychiatrist in the presence of the PCP, who may simply observe the psychiatrist or may actively participate in the evaluation. The evaluation is followed by a discussion between the two physicians. An evaluation report is drafted by the psychiatrist and included in the patient's electronic medical record. Generally, the PCP requests a joint consultation when he feels unsure about some aspect of care regarding the patient's mental health (for example, difficulty establishing a psychiatric diagnostic, personality difficulties in the relation with the patient, suicidal ideation, medically unexplained symptoms). When the clinical situation clearly points to the need for a psychiatric referral (indication for psychotherapy, history of severe psychiatric illness, etc.), the PCP directly sends the patient to a specialized psychiatric consultation.

2.2. Data collection and analysis

2.2.1. Review of psychiatric evaluation reports

We performed a retrospective descriptive analysis of psychiatric joint consultation evaluation reports ($n = 182$). All evaluation reports were written by the principal author, an experienced liaison psychiatrist, between October 2010 and August 2012. For each report, SS extracted and coded the following items: age and sex of the patient, place of residence, insurance status, languages spoken, presence of somatic co-morbidities, psychiatric history, presence of a previous psychiatric diagnosis, adequacy between the diagnostic impression of the requesting physician and diagnosis by the liaison psychiatrist, medications recommended, and advice given to the requesting physician. Reliability of the coding was checked by NJP on 10% of the written reports and was satisfactory (kappa = 0.87).

2.2.2. Focus groups with primary care physicians

In addition, we conducted 4 focus groups with SMPR physicians-in-training. Out of 28 physicians contacted, 23 participated in the study (participation's rate 82%; reasons for non participation were not collected). Three groups were conducted with physicians who had participated in joint consultations, and one group was conducted with physicians who had never participated in a joint consultation. This last group was included in order to explore any differences in their perceptions and attitudes regarding the care of patients with mental health problems. Physicians were contacted via email or telephone and invited to participate on a voluntary basis. Before the focus group, participants completed a brief sociodemographic questionnaire and a consent form (see Table 3).

The focus groups were conducted by 2 non-physicians with no direct hierarchical relationship to the participants. The discussions lasted 90 min, and were organized around 4 main topics: (1) When/for what kinds of situations joint consultations are requested (2) How joint consultations compare with standard referral of patients to a psychiatrist, in terms of acceptability and usefulness for both doctors and patients (3) Perceived benefits of joint consultations for doctors and patients (4) Additional mental health training that would be helpful to PCPs. Participants were not paid for their participation, but were offered lunch during the focus group discussion.

2.3. Analysis

We analyzed the focus group transcripts using a descriptive, thematic approach [12]. First, transcriptions were read by all four authors, who then met to discuss their observations and develop an initial list of codes. Codes were developed to reflect the discussion questions, and focused on participants' perceptions of and experiences with joint consultations, and their need for mental health training . Next, SS coded all transcripts using MAXQDA® software [13]. The adequacy of coding was then checked by the other authors, and any discrepancies were discussed and corrected. Coded texts were then read by code, to explore the range of variation in experiences and opinions of participants across the 4 focus groups.

The project was approved by the Geneva University Hospitals Research Ethics Committee.

Table 3
Focus group participants (n = 23).

Characteristic	Mean (SD)
What proportion of your primary care consultation patients suffers from mental health problems?	43.6 (24.6)
What is your level of interest to treat patients with mental health problems?	5.3 (1.1)
Scale from 1 to 7: 1 = no interest, 7 = very great interest	
Do you have difficulties in taking care of patients suffering from mental health problems?	4.5 (1.1)
Scale from 1 to 7: 1 = no difficulty, 7 = very difficult	
Have you been trained to treat patients with mental health problems?	3.1 (1.0)
Scale from 1 to 7: 1 = no training, 7 = lots of training	

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