INPATIENT PRACTICE

A Case for Medical-Psychiatric Units

Editors' Note: *Intense and demanding work takes place on inpatient psychiatric units. Because of the heavy demands that are placed on inpatient psychiatrists and the broad knowledge base needed to do this work effectively,* CLINICAL PSYCHIATRY NEWS *is launching "Inpatient Practice."*

In this column, CLINICAL PSYCHIATRY NEWS *will seek out a different psychiatrist or other mental health expert each month with expertise in a key issue of interest to inpatient psychiatrists. The goal is to educate readers about some of the many challenges involved in the practice of this increasingly complicated area.*

BY MICHAEL J. SERBY, M.D.

Some experts see the establishment of medical-psychiatric units as an important part of providing quality care for the mentally ill, particularly in light of the large percentage of medical comorbidities among psychiatric patients (Psychiatr. Serv. 2002;53:1623-5). This issue is even more critical among geriatric psychiatric inpatients (Gen. Hosp. Psychiatry 1990;12:396-400).

In this first column, Dr. Michael J. Serby examines some of the issues that would be involved in setting up a medical-psychiatric unit.

CLINICAL PSYCHIATRY NEWS: How would you go about converting a psychiatric inpatient unit to a medical-psychiatric unit from a staffing perspective?

Dr. Serby: There are two key elements to staffing such a unit—the physicians and the nursing personnel. Various potential models exist. Doctors would need to diagnose, evaluate, track, and treat both medical and psychiatric problems. Generally, it would not be feasible to use both internists and psychiatrists full time. A better model would be to employ psychiatrists who have some additional medical training (for example, a combined residency) and an interest in and a commitment to dealing with basic medical issues. Under a more complex model, a medical-psychiatric unit would come under the bailiwick of a part-time internist who would round daily on all patients. Similarly, psychiatric nurses would be preferred. They should be trained to handle basic, uncomplicated medical problems, and equipment.

CPN: Which U.S. hospitals have what you would consider to be model medical-psychiatric units, and what makes them so effective?

Dr. Serby: These units are scarce. There is a well-established one at Bellevue Hospital in New York that has the benefit of experience. Probably the key to its success is that they have well-delineated guidelines regarding their limits of medical care. Specifically, any patient requiring telemetry and those with unstable vital signs are unacceptable. I am not aware of other hospitals in the United States that have specifically designated medical-psychiatric units. However, there are probably several geropsychiatry inpatient units that in essence function the same way, making them de facto medical-psychiatric units.

CPN: Besides cost issues, what arguments would you make against medical-psychiatric units?

Dr. Serby: It often is difficult to maintain a manageable level of medical comorbidities. In all hospitals, internal medicine services are looking very closely at their lengths of stay and their threshold for medical hospitalization may be quite different from what a psychiatrist might think appropriate. So patients with difficult medical illnesses could linger inappropriately on a medical-psychiatric unit.

CPN: What would be the best way to handle equipment that traditionally has been kept out of psychiatric units for safety reasons, such as oxygen and BP machines?

Dr. Serby: This is a key issue. The use of oxygen and the presences of needles and tubing pose risks that are unacceptable on standard psychiatric wards. To accommodate the use of such equipment, medical-psychiatric units must set limits on the degree and nature of psychopathology they can accept. Patients who may require seclusion or restraints, are highly agitated, or who pose a substantial suicide risk are especially dangerous in this kind of milieu.

CPN: Should medical care of these patients remain in the hands of psychiatrists under such a model?

Dr. Serby: Again, psychiatrists with some degree of medical knowledge and interest should share the medical care with a part-time internist. It would be important for these units to be considered part of both the psychiatric and the medical services in a given institution. That way, weekend and evening coverage would be the responsibility of both departments. ■

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Head Off Conflicts Over Conscience-Based Refusals of Care

BY JOHN R. BELL
Associate Editor

BALTIMORE — There are many situations in which a physician may find that a treatment requested by an employing institution or a patient is contrary to the physician's religious or moral beliefs—but the best practice is to prevent these conflicts in the first place, Helen Norton, former Deputy Assistant Attorney General for Civil Rights, said at a conference on conscience-based refusals in health care sponsored by the University of Maryland School of Law.

Although Title VII of the Civil Rights Act of 1964 requires employers to "reasonably accommodate" any sincerely held belief, the clause stating that the accommodation must not pose an undue hardship on an employer has led courts to consistently rule that almost any compromise offer extended by an employer will meet that standard. Ms. Norton, now of the law school, advised letting prospective employers know up front of any treatments or procedures you are unwilling to perform or participate in.

"In general, I think it's a very good idea to identify possible conflicts sooner rather than later," she said in an interview. "Advance notice gives the institution a chance to plan ahead, identify reasonable accommodations, and make arrangements that address the concerns of all involved. Plus institutions are likely to see such notice as a gesture of good faith—as are courts, if a matter ever ends up in litigation."

Treatments that more often result in conscience-based refusals include abortion, prescribing emergency contraceptives, care for the terminally ill, and sterilization procedures.

What a physician is legally obligated to do varies by state. Although in most states, while physicians are required to perform any emergency treatment, emergency contraceptives are often placed in a different category.

"Four states have passed conscience clause statutes that go beyond the usual focus on abortion, and sometimes sterilization, to allow pharmacists to refuse to dispense emergency contraception," Ms. Norton said. "It's true that some state conscience clauses make clear that health care providers' refusals are not protected when they identify the conflict during certain emergency situations—like public health emergencies or in the middle of patient care when no other provider is available. But as far as I know, the four don't-have-to-dispense-EC states do not define a patient's interest in emergency contraception as such an emergency."

Ms. Norton noted that Title VII protects only employees, not independent contractors.

"Most state conscience clause statutes, on the other hand, allow health care workers generally—regardless of their status as employee or independent contractors—to refuse to provide certain services," she said.

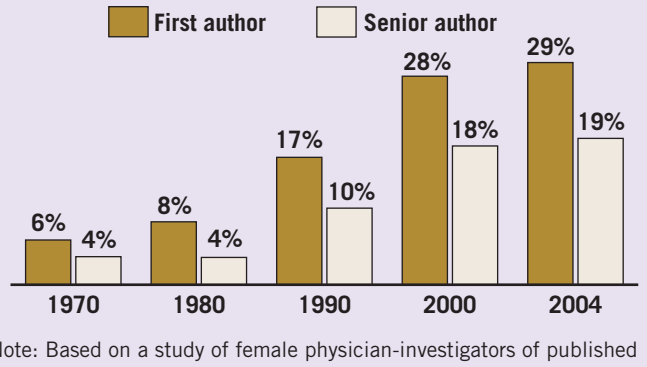
As to whether there is any limit to how burdensome a compromise offer extended by an employer to an employee can be while still protecting the employer legally, "there is not a very clear answer," Ms. Norton said. "What does 'reasonable accommodation' mean? Some courts define reasonable accommodation to mean any change offered by the employer that would eliminate the conflict between the employee's conscience and his or her job. This would include a transfer to a job that does not involve the challenged procedure, even if the new job offers less pay or a less attractive location.

As to the direction the law is likely to take, Ms. Norton expects the diversity of state statutes to continue. "In the short term, I think we'll continue to see a lot of action—and variation—on the state front. Some states clearly are focused primarily on protecting individual providers' claims of conscience and thus are enacting broader conscience clause statutes that, for example, protect a pharmacist's refusal to dispense EC. On the other hand, others are clearly focused primarily on patient access to health care services and thus are enacting laws that require institutional providers to expand access to that care."

Ultimately, the different legislative approaches taken by states are setting up the kind of situation that has historically tempted Congress to weigh in, she said. ■

DATA WATCH

Percentage of Female Lead Authors in U.S. Medical Journals Still Lags



Note: Based on a study of female physician-investigators of published original research in six U.S. journals.
Source: N. Engl. J. Med. 2006;355:281-7

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