28 Systems Understanding and Intervention, and Ethical Issues

Hoyle Leigh

CONTENTS
28.1 Vignettes ................................................................. 394
28.2 Overview ................................................................. 395
28.3 The Hospital as a Social System ................................. 396
28.4 The Sick Role and the Doctor Role ............................. 397
28.5 Psychiatric Consultation and Social Systems ............... 398
28.5.1 Theoretical Considerations ..................................... 398
28.5.2 Practical Considerations ......................................... 399
28.6 Ethical and Legal Issues in Consultation Psychiatry ........ 399
28.6.1 Competence/Capacity to Consent to or Refuse Treatment, or Placement, or to Sign Out Against Medical Advice .......... 400
28.6.2 Capacity to Live Independently ................................ 400
28.6.3 Testamentary Capacity ........................................... 401
28.6.4 Involuntary Hold and Hospitalization ..................... 401

28.1 Vignettes

1. A 67-year-old woman with a hip fracture was referred to the psychiatrist, as she wished to leave the hospital against medical advice prior to surgery. The patient was described as being hostile, agitated, and irrational by the nursing staff. On interview, the patient insisted that she had to go home, but upon further questioning, it was found that the patient lived alone with three cats, and she was concerned about not being able to care for the cats. When the consultant called the social worker, she was unaware of the patient’s concern about the cats, as she had only asked whether the patient had a home and family (human family!). The consultant explained to the nursing staff why the patient was so agitated: she was worried about her cats. They empathized with her concern. The social worker was able to contact a sister who lived in another city, who was willing to care for the cats while the patient was in the hospital. The patient was now willing to stay and have the necessary surgery.

2. An urgent psychiatric consultation was requested for a 47-year-old man with suspected coccidioidomycotic meningitis to evaluate his capacity to refuse a lumbar puncture. On examination, the patient was found to be mildly delirious,
but he understood that the doctors wanted to put a needle into his spine to get fluid to help treat him. However, he was sure that he would be OK without the test as he had trust in God. The consultant contacted his wife, who turned out to be quite supportive, and was willing to try to persuade him to undergo the procedure as well as to sign the consent form as next of kin.

3. A 54-year-old woman was referred to the psychiatrist for “declaration of incompetence and institutionalization.” She was admitted to the hospital with chest pains, and a myocardial infarction was ruled out. The referring physician stated that she had received a call from a psychiatrist working for the patient’s managed care company, who stated that the patient should be certified by the hospital to be placed in a nursing home facility. On examination, the patient had no evidence of delirium, dementia, or any other psychiatric condition. The patient stated, however, that she had been previously “harassed” by a psychiatrist hired by the managed care company. The consultant called the managed care psychiatrist, who insisted that the patient was “subtly delusional and paranoid,” which becomes manifest only when she is repeatedly confronted. On further discussion, the managed care psychiatrist confided that the patient was a drain in resources for the company as she had frequent presentations to the emergency department with chest pains, and that she would be better cared for in a nursing home under psychiatric certification for inability to function independently. Having no basis for such certification at present, and unwilling to “confront the patient repeatedly,” the consultant refused any further intervention.

4. A 34-year-old man was admitted for pneumocystis pneumonia associated with AIDS. A psychiatric consultation was requested because the patient appeared depressed and expressed suicidal ideation. The nursing staff also stated that the patient’s partner, who was always at the bedside, made disparaging remarks about the care the patient was receiving. Through an interview with the patient and his partner, the consultant found out that they had recently moved from another city because the partner’s job was transferred, and that the patient and his partner had had a long-standing relationship with the health care system of their former city. As the patient fell ill, they did not have an opportunity to build a social support system in the new city. The consultant provided the patient’s partner with contact information for gay and HIV support groups in the community, and restarted the fluoxetine that the patient was receiving previously but that had run out. The patient recovered uneventfully, was discharged, and has outpatient appointments with a psychiatrist who is associated with an HIV clinic.

28.2 Overview

The consultation process occurs in a social system. As we discussed in Chapter 3, the request for consultation usually arises as a result of a strain in the system around the patient, consisting of the doctors, nurses, allied health professionals, health care organizations, as well as the patient’s family, friends, and, at times, social agencies.

To relieve the strain that led to the consultation, then, it is necessary to recognize the state of the social system around the patient. While treatment of the