

Collaboration

Clinical Jazz

January 10, 2002

The case

“During psychiatry rotation at Consolidated Care I observed the psychiatrist seeing patients. The first patient was a woman in her late 40’s, overweight, with irregular “buzz” type hair cut. She wore sweatpants, a T-shirt with imprinted scary looking faces and a coat on top of that. Her speech was at times difficult to understand and she had some odd facial asymmetry and had no good eye contact with people. She has a history of being followed by MRDD, has caseworkers, a recent change from one family physician to another and had several suicide attempts and bursts of impulsive angry behavior and had been on multiple antidepressants/sedatives.

She is here today for follow-up of her situation, especially to address her depression and impulsivity (on the psychiatrist’s agenda). In the room also present was a social worker who did not have much input in what happened during the session.

The patient had quit all antidepressants because she felt so disappointed with her contact persons so she would just like to “give it all up”. She has had a recent hospitalization in inpatient psychiatry where she seemed to have been established on a fairly good regimen of a mood stabilizer and antidepressant. The patient however, said that the medications “knock me out” and “do nothing for that terrible pain when it hits”. Later in the interview as the patient again talks about “the pain” it becomes clear that it is a deep sense of disappointment, betrayal and “pain” when she yet again loses one of the providers that she gets familiar with. At this point she gets really emotional, tearful, choked up.

The reaction of the psychiatrist was empathy with the feeling of the patient but immediately [indicated] that they cannot do anything about it and suggested an antidepressant that “gives her back a sense of control” so that she would not get so angry all the time. Hesitantly, after a while, the patient agrees and will be seen in three weeks for follow-up, with no intentions to contact the caseworker at MRDD or the family physician.

I cannot help but think that not much was done to address the “pain” that the patient experienced and that the psychiatrist operated in isolation from the other people in the support network.”

The Question

“What are the factors in a complex multi-disciplinary situation of patient care that influence outcome and what is the right balance of involvement and communication for me as a family physician?”

Discussion

The jotter indicated that of the two questions, it was really the latter upon which he wished to focus. The group then distilled that question into, “How can I be a good collaborator (in similar situations)?” The psychologist in the group identified with this concern, stating, “My goal as a teacher is to influence residents to become the kind of physician I miss in the community,” indicating that, in practice, few physicians are very good at collaborating around the care of such patients.

In this case, the patient had very few if any connection with or support from family or friends, and is dependent upon a mercenary network of health care and social service providers for emotional and social support. Given the turnover of personnel in many social service agencies, she is extremely vulnerable to loss. Not having a collaborative physician can only make matters worse. In addition, provider systems are often not set up for collaboration. Time pressures, self-referrals, managed care and other contracts that leave physicians out of the loop, and logistical factors around place of service all work against collaboration. To make matters worse, many of the patients who would most benefit from collaboration are good at triangulation and splitting providers involved in their care.

Collaboration means:

- Working together for the good of the patient
- Working toward similar goals (or at least not working against each other!)
- Open communication and information sharing, e.g. sending copies of progress notes, summary letters
- Mutual respect, even when lacking in knowledge of the other
- Acknowledging the importance of the other(s), or even the role of the other(s)
- Engaged in relationship
- Placing yourself in the other person’s place, attempting to understand their perspective
- Both (all) parties taking responsibility for nurturing the relationship

The group agreed that any effort to collaborate (“anything you do”) is better than nothing. Practitioners who model this behavior often are able to do so in relatively brief encounters, in their attitude and willingness to listen, and as a matter of habit. Communication among collaborating providers need not be lengthy or include more detail than necessary, but should be specific in the sense of

“focused” – “the abstract, not the study!” It helps, when attempting to collaborate with a colleague or consultant, to “go with a question” - a specific question - in mind.

The group came up with the following practical ways for fostering collaborative relationships:

- Construct a “Release of Information” form that explicitly gives permission to talk to the therapist, implying to the consulting therapist that it is your expectation
- Become familiar with a limited number of therapists you can learn to know well, and cultivate relationships
- Set aside time for communication and engaging interaction (e.g. a specific time each week)
- Practice collaborative relationships in residency training

Visiting mental health providers, social workers, agencies in the community, as in the residents’ longitudinal Community Medicine rotation, is one way to learn more about the perspectives of others, about our respective roles in patient care, and about potential ways of collaborating. A physician new to a community could do the same, particularly early in practice before “things get busy,” and use his/her newness as an opening. It requires a willingness to go beyond the routine, break out of your professional niche, and make a special effort to build a relationship.

Clinical Pearl:

“Get out of your niche – Go (and visit) with a question”

Will this change the way you practice? If so, in what one specific way?

- I think the session has opened up my eyes to better communication with therapists who work with my patients
- Will be more aware of what it’s like to be on the other side, whether it be as a consultant or the one requesting it and respecting each other & communicating
- Yes, I need to work on how I do this with behavioral people
- Hopefully, I will have the time, will make time
- More visits (to volunteer faculty, to residents, to consultants)