
Commentary

Meeting The Medical Needs Of Adults Public Psychiatric Facilities

by James C. Hurowitz

Public psychiatric “hospitals” are in an identity crisis as they search for the best means of providing high-quality medical care to their adult inpatients. Should these facilities base their delivery of medical care on an acute care hospital model, an ambulatory care model, or a chronic care or nursing home model?

That such confusion exists is not surprising. The number of beds in state and county mental hospitals has declined from its peak of more than 500,000 in the 1950s to 130,000 in 1984.¹ With this trend away from institutionalization has been a parallel shift of focus away from the services provided within the institution. Furthermore, public psychiatric facilities often have psychiatrists as their chief physicians, who focus more attention on psychiatric care than on medical care.

I contend that the medical care of mentally ill patients is as important as their psychiatric care. In my experience as Chief of Medicine at a state psychiatric hospital for adults, I have found that the illness and death of these patients is usually the result of medical problems.

Although professionals in these facilities may discuss the issue of providing high-quality medical care and some of what I propose may already be taking place, what I believe we lack is a mechanism by which these models can be objectively evaluated, discussed, compared, and finally implemented. The purpose of my comments, therefore, is to generate discussion of these issues. While my focus is specifically the medical care of adult inpatients, some of the concepts may apply to their psychiatric care as well. By intention, do not discuss possible models for providing medical care for mentally ill people outside of institutions. However, the benefit of providing good medical care while such patients are in the hospital can extend to those who have been released. For some patients, an occasional psychiatric hospitalization may be their only

James Hurowitz is an attending physician in the Department of Medicine, Division of General Medicine and Primary Care, at the University of Massachusetts Medical Center in Worcester. In addition to his medical degree, he holds a master of science degree in health services administration.

opportunity to see a primary care physician and subsequently be followed appropriately as an outpatient.

Because so little literature exists on this subject, my comments primarily reflect my experiences, which in some circumstances may contradict the experiences of others. As others are urged to respond, a body of literature will develop, and the process will move forward.

The Adult Psychiatric Inpatient From A Medical Perspective

Before we can design a model for the delivery of medical services, it is necessary to define the patients for whom the services are intended. First, it should be noted that mentally ill people are at higher risk for medical diseases than the general population.² In addition, psychiatric symptoms may be caused by a number of primarily medical problems such as hypothyroidism, electrolyte imbalances, or congestive heart failure. Psychiatric inpatients are four to eight times more likely than psychiatric outpatients to have coexisting medical illness. These patients are often from lower socioeconomic strata with poor access to health care. They may be uncooperative or threatening to health care providers and unable to provide an adequate history or allow a physical examination, leading to inadequate evaluation and care.

Typical patients in a public psychiatric facility are admitted because of a psychiatric illness, not because of an acute medical illness. There is usually a screening process, diverting patients with acute medical illnesses to a general medical hospital. Thus, the typical psychiatric inpatient is ambulatory, is admitted in street clothes, and continues to wear street clothes while in the hospital.

Most patients admitted to public psychiatric facilities are readmissions; hospital staff often are familiar with the patients and with their coincident medical diseases.³ For those patients admitted for the first time, the characterization is only slightly different. These patients are unknown to the extent that their medical histories are unknown. However, they also are not acutely medically ill because of the screening process.

The median length-of-stay in state and county mental hospitals is twenty-three days.⁴ Many medical events can and do occur to these inpatients during their hospital stay. Development of a fever, for example, can be due to a viral or bacterial infection that can rapidly spread among patients in closed quarters. Cigarette smoking is common, and respiratory infections are a frequent result.⁵ The incidence and etiologies of these problems, however, are unknown in psychiatric hospitals.

Geriatric psychiatry inpatients (age sixty-five or older), like the general population, tend to have more chronic medical illnesses than younger

people. George Molnar found that, in a psychiatric inpatient population in a general hospital, ranging in age from twenty-one to forty-five, only 18.5 percent had a medical diagnosis.⁶ In contrast, Charles Weingarten found that 75 percent of patients admitted to a geropsychiatry unit had at least one medical problem.⁷ Many had multiple medical illnesses. In addition, the length-of-stay is markedly longer than that of younger inpatients. The median length-of-stay for inpatients age sixty-five and older is sixty-one days. For patients older than age eighty-five, the median length of stay is ninety-two days.⁸

Here I have described two patient populations in public psychiatric facilities. The first population consists of adult inpatients who are ambulatory, with no acute medical diseases. These people would not be in institutions if not for their psychiatric illnesses. They may however, have chronic medical diseases or require preventive care. The second population consists of inpatients who develop acute medical problems requiring a secondary level of medical care- such as intravenous medications or fluids.

Designing The Structures For Medical Care Delivery

In medical care delivery systems, the microstructure is the organization of a department of medicine within each facility. The macrostructure is the organization of a larger department of medicine-for example, a statewide department of medicine-of which each facility's medical department is a component. Given the above descriptions of adult inpatients in public psychiatric facilities, the question remains: What model fits best to deliver medical services within each facility?

I introduced this dilemma as an "identity crisis." In my experience, public psychiatric facilities provide random services, peripatetically selected from the various models. One reason is that there are no standards or policy guidelines that define expectations in the provision of medical services. Ultimately, this is a failure of leadership on a macrostructural level. The result is that the physicians and administrators in each facility are placed in untenable positions. They, independently, are expected to design and implement services based on their own priorities, operating budgets, and the quality of their leadership.

Adding to this identity crisis is the term "hospital." I believe this word evokes an inaccurate perception of the services that public psychiatric facilities provide. This, in turn, contributes to an expectation from the general population, and from family members of the mentally ill, that cannot be met. Most people think of a hospital as a structure with an emergency room, laboratories, modern x-ray facilities, operating rooms,

intensive care units, high technology, and health care personnel in white lab coats or uniforms. On a more subtle level, defining a public psychiatric facility as a hospital has implications in terms of accreditation that I think are inappropriate.

I believe that each public psychiatric facility should provide medical care for its inpatients on the basis of an outpatient, ambulatory care clinic model. All patients, within a few days of admission, should be referred to the primary care clinic for an evaluation. The evaluation should be no different from that of a mentally well patient at a primary care physician's office. Consistent with this model, the primary care provider, whether a physician, a nurse practitioner, or a physician assistant, functions as a consultant to the psychiatrist. The psychiatrist should be the primary physician on the psychiatric ward.

Options for design. There are essentially two options in designing a macrostructure. One is centralized, in which the delivery of medical services is standardized and coordinated. The other is decentralized, in which each psychiatric facility is autonomous. In my experience, the latter is more common. As I already intimated, I believe the decentralized structure leads to the delivery of a quality of medical care that varies too much from one facility to the next. One facility may employ poorly trained primary care physicians, while the next may employ board-certified physicians. One facility may have an affiliation contract with an academic medical center to provide primary care physicians, specialists, or laboratory services, while the next may not. One hospital may provide one physician for every sixty patients, while the next may provide one for every 100 patients. Finally, there may be an unnecessary duplication of services between two facilities.

In addition to quality of care problems, patients do not have the freedom to choose the particular facility to which they prefer to be admitted in a decentralized system. Patients are admitted to the facility that serves their catchment areas. If this were a competitive market, a patient or family would choose the facility based, in part, on perceived quality of care.

I favor a centralized structure in which there exists a state-, city-, or regionwide department of medicine. This department's leadership should be provided by a physician/administrator. Medical care would more likely be standardized and coordinated. Furthermore, if the economies of scale were larger, it seems reasonable that the unit cost of supplies, equipment, and labor would decrease.

As a case in point, suppose an inpatient develops an acute medical illness that requires a secondary level of medical care. This level of care requires more skilled nursing, the ability to provide intravenous antibiot-

ics or fluids, or perhaps oxygen. Historically, such a patient has been transferred to a general hospital. However, this may not be best from both a medical care and a cost perspective. Psychiatric patients in a general hospital frequently require one-on-one staffing and are frightened by an unfamiliar, threatening environment. One-on-one staffing places a tremendous burden on staffs of general hospitals that are already chronically understaffed. Staffs in psychiatric facilities, which are also chronically understaffed, care for these patients every day. Finally, costs undoubtedly would be less for treatment at the psychiatric hospital than at the secondary or tertiary medical hospital. While I would expect that, on a regional or statewide basis, the prevalence of psychiatric inpatients who are being treated in general hospitals is sufficiently high to justify an acute care medical ward in one of the public psychiatric facilities, there are no data to this effect. As a matter of policy, central offices in departments of mental health should be carrying out this research.

Providers of care. The final component in the design of a macrostructure for delivering medical care is the quantity and quality of health care providers. Public psychiatric facilities are constantly in search of well-qualified physicians. The reasons why physicians do not choose to work in these facilities are complex. The practice of primary care medicine is out of context in a psychiatric institution, at least as it exists today. One does not typically see an internist or surgeon in the hallway. The physical structure of the facilities discourages physicians from working in them. Lighting is poor, buildings are old and poorly maintained, examination rooms are either in short supply or poorly equipped, private office space is scarce, and laboratory facilities are inadequate. The environment is very isolating. Support services—such as secretarial assistance, modern paging systems, or transcription services—are often grossly inferior to those in general hospitals. Finally, an extraordinary amount of time is spent on issues tangential to the practice of medicine, such as the need for or the process of obtaining guardianships for incompetent patients. This aspect is so unfamiliar and frustrating to primary care physicians that it frequently interferes with their timely delivery of good medical care and compromises their personal ethics so that they prefer not to work in such an environment.

It is beyond the scope of this Commentary to address, in detail, the role of foreign medical graduates (FMGs) in public psychiatric facilities. At the risk of simplifying this topic, I think it is fair to say that the relationship is symbiotic; public psychiatric facilities have difficulty finding physicians to staff them, and FMGs who are not board-eligible or board-certified have difficulty finding positions in mainstream medicine. What is disturbing, however, is that our society allows physicians deemed

unqualified to be on the staff of a community hospital or medical school faculty to practice medicine in public psychiatric facilities merely to satisfy staffing shortages.

Possible solutions to attract qualified physicians to public psychiatric facilities may be as straightforward as providing modern ambulatory care clinic work areas. Other incentives may be financial, in the form of increased salary, reduction of medical school loans, or tax incentives.⁹ Public psychiatric facilities might be designated as underserved sites for federal Public Health Service placement of physicians. Alternative incentives such as opportunities to become part of an academic medical center and participate in teaching, clinical research, or the development of a clinical practice may be effective. The opportunity to work fewer hours for a full-time-equivalent salary could provide adequate incentive and is probably justified to avoid physician “burnout” in this emotionally taxing environment. Allowing FMGs into U.S. residency programs and thereby providing them with the same training as U.S. graduates would be beneficial. Finally, mandated service in programs such as the National Health Service Corps for all graduates of U.S. residencies may be necessary. These issues should be addressed on a statewide or national level, not in each individual facility.

Conclusion

The medical care of adult inpatients in public psychiatric facilities is inadequate for complex reasons. On a basic level, these people have been ignored by our society. We have not provided the resources to deliver medical care to them that is equal in quality to the care provided to other segments of society. We can no longer accept this level of substandard care.

I have sought to call attention to this need and to stimulate the development of research to begin to address it. I also have proposed three specific recommendations: (1) a two-tiered organizational structure that, on a macrostructural level, sets standards and coordinates the delivery of medical care for all of the facilities within that structure (the availability of one referral, secondary care ward for a region of facilities is one example of the benefits of centralization); (2) a model of medical care, on a microstructural level, in which each inpatient is evaluated and treated in an ambulatory care clinic setting; and (3) potential solutions to the issues of quality and quantity of primary care physicians in public psychiatric facilities.

The “cycles of history” suggest that our country is beginning to take an interest in the mentally ill again.¹⁰ It is my hope that governments,

policymakers, and health care providers will seize this opportunity to develop and test various models that ultimately will improve the medical care of this special population.

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NOTES

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