Lab to Smartphone

Retiring the Med Check

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Several years back, I was attending a small conference on pediatric bipolar disorder. The speaker was pitching the creation of a database from actual practicing physicians that might be used to gather more information about what interventions were and were not working out there in the real world of clinical medicine. The presenter was interested in knowing not only which medications were actually being prescribed to patients with bipolar disorder, but also about other aspects of our patients' lives that might be having an impact on their mental health.

"Of course," the speaker continued, "We would have to contact the patient's therapist for that information."

I was taken back. You would? Really? The comment struck me as odd, and I glanced around the room to see if any of the other participants where revealing puzzled looks before mustering up the courage the raise my hand and express the idea that, actually, most of us might know what is going on in our patients' world without having to bring in collateral informants.

That brief interaction has stayed with me for years. With some reflection, what was surprising to me wasn't the concept of split treatment, in which a patient gets their care from both a psychiatrist and a therapist, but how narrowly focused the expectations were surrounding the purview of the psychiatrist as the prescribers of medications.[1]

Now don't get me wrong, it is not my intention to downplay the skill and judgement involved in being an excellent psychopharmacologist. What was peculiar, in my view, was the presumption that even someone who sees themselves tasked with "just doing meds" could accomplish this responsibility without a good understanding of what was going on in a patient's life. Before upping the sleep meds on the request of a parent, isn't it important to know if your adolescent patient is up all night playing Call of Duty? Before pulling out an antipsychotic to curb a patient's aggressive behavior, isn't it worthwhile to make sure that a drunk Dad isn't yelling at him every night? There also needs to be at least some knowledge of what is happening in psychotherapy, as many best practice recommendations explicitly state that some medications should only be considered after therapy has been insufficient.

These things may sound obvious, but the reality is that such information is easily missed when both doctor and patient are rushing through a quick inventory of symptoms and then simply matching them up with best medication.[2] For most mortals, it is simply unrealistic to expect that all the relevant information from a patient and their family can be ascertained, processed, and converted to good treatment decisions in 15 minutes. With some extra time, not only does a clinician usually get *more* information but also *better* information because there is a stronger relationship between the doctor, the patient, and the family.

The progression of psychiatric appointments from being about 50 minutes long and focusing on the entirety of the patient's mental health to 15-20 minute visits concentrating on psychiatric medications has occurred over many decades. It has been attributed to a number of forces, most notably those related to economics and workforce shortages. In theory, the med checks exist as just one part of a coordinated mental health care approach. In reality, the psychiatrist often works with a lot more isolation and fragmented knowledge of what treatment, if any at all, is taking place outside of the psychiatrist's own session. It's little wonder then, that the med check has become a target of complaints and

scorn from both patient and psychiatry advocates alike who express concern that the model is driving the use of excessive and unnecessary medication use.[3] These critiques are generally leveled at the proverbial "system" that has created this structure but can go after individual providers of psychopharmacological care as well. And while many of the concerns are well founded, it's worth acknowledging that criticizing the split treatment model in favor of the psychiatrist being both psychopharmacologist and therapist (and everything else), is a lot easier when you don't accept Medicaid and can get good compensation for that full hour you are spending with each patient.

Fortunately, you don't have to "just do meds," even under conditions when you are taking insurance and feeling pressure to see as many patients as possible. Some psychiatrists do indeed also function as a patient's primary therapist, but those who don't can still operate in that beloved hybrid role of doctor, counselor, wellness coach, social worker, advocate, and motivational speaker by taking a little extra time than what would be provided in a standard med check. This time can be used to broaden the focus of the appointment beyond the realm of symptoms and side effects. Exactly *how much* extra time a psychiatrist must spend to meet this threshold depends on characteristics of the family, the patient, and, of course, the psychiatrist. Especially under conditions when families are being seen closely by other mental health professions, and when information is well communicated throughout the treatment team, the psychiatrist doesn't need to spend a whole lot of time asking redundant questions.[4] In my own clinic, where med checks have been *banned* both in name and in spirit, some of our psychiatrists find it optimal to schedule hour long appointments somewhat infrequently (like every 3-4 months), as long as there are other clinicians working more regularly with the family. My default follow-up appointment tends to be 30 minutes long every 1-2 months, which very often is modified to fit the needs of the family. At some appointments, the clinical situation demands that medications move front and center. Frequently, however, they are of secondary concern. After some active listening followed by some combination of parental advice, psychoeducation, clumsy mini-speeches designed to boost motivation, advocacy, and designing a plan going forward, I'm well known for asking with about 5 minutes left in the session, "Is there anything about the medications we need to talk about?"

The 15-minute med check is indeed due for retirement. It limits our capacity to connect with patients, stunts our ability to empower positive change in families, and creates a self-fulfilling "if you're a hammer than everything looks like a nail" approach to psychopharmacology. Expert knowledge of psychiatric medications is necessary but hardly sufficient in getting our patients to the place they want to be. While at times it may seem as though the med check is the de-facto mode of interaction between patient and psychiatrist these days, this can change whenever enough of us have decided that it should.

References

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About the Author

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Disclosure: Dr. Rettew has received royalties for his blog for *Psychology Today* and from Guilford Press.

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