JISC update Aug – Sept 2017

Factitious disorder

A colleague asks: 'I would be very grateful for your expertise on devising a management plan around a patient with factitious disorder who is presenting hundreds of times each year to a range of EDs in our area.

We are pulling together a MDT management plan, with our aim being to change the systemic response to this patient with a low expectation of internal change/insight

My main question relates to how services have approached the medicolegal aspects of limiting investigations in these situations?'

Salisbury responds: A difficult case. 'I wonder whether it'd be useful to speak to the Medical Director (or other board level person), maybe also the safeguarding lead and then involve the Trust solicitors to contribute to the care plan or letter.'

Another colleague tells us that a patient in the north of England spent over 300 days a year in hospital beds across the region. Apart from the MDT one of the strategies which worked was getting an experienced therapist from the Liaison team see the patient weekly. This really helped – so much so that the client found a job and the drop in presentations was significant. This clinician thought that introducing the idea of limiting investigations should happen when there is a reasonable therapeutic alliance.

Southampton has 'front door ED care plans which are multi-specialty and have a high intensity user group monthly led by an ED consultant'. The care plan is quite thorough and becomes available to see when the patient attends ED. It gives advice about potential medical investigations. It also says what grade of clinician to see and whether any senior specialists should be involved in ED and follow up plan in place. This is done for patients with psychiatric presentations including somatoform problems and substance misuse (any specialty can bring a patient with core members being ED, psychiatry and chronic pain).

North London thinks 'the challenge is to formulate a very boundaried management plan and help other staff to adhere to it in the face of threats and new symptoms. I would suggest that you and the ED team, medics etc weigh up the relative risks of investigations and intervention versus doing nothing. If presentations are frequent and varied then the iatrogenic risk will be higher than the natural risk of doing nothing. As previously suggested it would be helpful to share this risk across organisations - unmanaged risk forum in the mental health trust and medical director & clinical lead for ED in acute trust. To further reduce intervention, you could put in the care plan that tests etc could only be done with the joint agreement of the ED Consultant and the Consultant Psychiatrist on call. This might limit the number of investigations and admissions.

Sydney adds: Regarding specifically the medicolegal aspects, there is nothing more to be done than to ensure that on each occasion the patient is seen that clinicians have considered all the various risks involved (both associated with possible actual pathology and associated with investigations themselves), have taken steps that a reasonable clinician would take in response to those risks, and have delivered care that reaches the standard of a responsible body of medical opinion. And then that they document all of this. Of course this is what you should always do. This care will be greatly assisted by good communication between centres and professionals. Probably the main thing on the medicolegal side is not to worry about the medicolegal side, assuming everyone is working and documenting as above.

Another clinician is surprised at how Liaison Psychiatrists 'favour managerial solutions to clinical problems.' In this clinician's experience people with extreme MUPS may have Delusional Disorder if they are given time to give a full account of their issues. He goes on to say that 'psychosis seems a bit of a blind spot for Psychiatrists who don't see Psychotic people regularly'. This clinician reports that such patients when prescribed antipsychotics. (1) Improved (2) hospital visits and scope for iatrogenic harm reduced (3) hospital staff and family were appreciative of a diagnosis and an explanation.

Leeds (as ever exuding experience and wisdom): 'Certainly some of these presentations challenge the way we define delusion (at least in the textbooks). I always look for some other feature e.g. atypical behaviour, unusually severe agitation associated with physical presentations.' Perhaps the issue is not that liaison psychiatrists haven't seen enough psychosis but that they are over-influenced by traditional teaching – like don't diagnose psychosis on a single symptom. 'Antipsychotic medication is always worth a thought because some people do respond; but I'd have to say pretty rarely' and it's difficult when a partner doesn't agree it's a mental health problem.

Bariatric surgery group discussion forum

A clinician in South London is trying to set up a special interest group for bariatric psychiatry. 'As our numbers grow and the pressures we are likely to face intensify, I think such a group could allow sharing of experience and expertise, give us the strength in numbers and patient data for contract negotiations and hopefully could also pave the way toward informing national guidelines.'

Dr Jackie Gordon, Worthing