Teamwork Touted for Transplant Psychiatrists

BY DAMIAN McNAMARA
Miami Bureau

FORT MYERS, Fla. — Psychiatrists should not cast the sole vote on whether someone is a suitable candidate for organ transplantation, panel members agreed during a presentation at the annual meeting of the Academy of Psychosomatic Medicine.

“There is no other area of psychiatry where you might be involved in a decision as to whether a patient gets a lifesaving procedure or not. How comfortable do you feel with this?” asked Catherine C. Crone, M.D., of Georgetown University, Washington.

Psychiatrists contribute to transplantation teams in many different ways. Most often, psychiatrists assist in the total evaluation and treatment of a given patient, including direct psychotherapy. Some psychiatrists consult, and others are full team members. Some psychiatrists vote on potential candidates, while others do not.

“Transplant psychiatrists multitask,” Dr. Crone said. Other duties include development of psychosocial selection criteria for the program, assessment of living donors, and treatment of waiting-list patients, transplant recipients, and family members.

Psychiatrists should consider themselves integral team members who maintain their own identity. “It is important not to be viewed by the team as an outsider. Although we work with surgeons and internists, we are not competing with them,” she said.

“It is unfortunate if you work in a system where you are asked to be the sole gatekeeper,” said Owen S. Surman, M.D., of Harvard Medical School, Boston. For example, a surgeon might approach the transplant psychiatrist and simply ask “Yay or nay?” about a candidate. Dr. Crone suggested providing additional information about the patient. “Try to pull [surgeons] in some by giving them context. Humanize that patient by giving the considerations on either side of the decision.”

“One of the things I find extremely helpful is to tell stories about patients. Sometimes there are fascinating family stories, occupational stories, or things that they have done that make them people and not just cases,” Dr. Surman said.

If a candidate has behavioral or psychiatric issues, the psychiatrist effectively becomes the gatekeeper in many instances. “If you think in good conscience you cannot recommend someone, state that,” said Steven A. Epstein, M.D., professor and chair of psychiatry at Georgetown.

Use the term “risk assessment” when discussing a patient with other doctors. “Other physicians are familiar with looking at medical issues using that term,” said Curley L. Bonds, M.D., director of the consultation-evaluation psychiatry service at the University of California, Los Angeles.

A meeting attendee asked if psychiatric consultation with transplant patients improves postoperative recovery or long-term outcome. “There are no good data. But we have fairly compelling anecdotal data,” Donald L. Rosenstein, M.D., replied.

Cite whatever data you can to back your decision, Dr. Bonds suggested. “In California there have been lawsuits because we denied someone, and they go to another center and get listed.”

Despite a transplant team’s best efforts at candidate screening, results are not guaranteed. “On retrospect, transplanting some people turns out to be a bad idea, and we should have listened to our gut,” said Dr. Rosenstein, deputy clinical director of the National Institute of Mental Health, Bethesda, Md.

On the other hand, “we see people who benefit from transplant whom we never would have expected to benefit,” Dr. Surman said.

One audience member asked about absolute psychiatric contraindications to transplantation. “The only absolute contraindications are circumstances—such as active psychosis, delusional depression, or active substance abuse—that impact an ability to give informed consent,” Dr. Rosenstein said. “Obviously, certain behaviors get you a lot closer to an absolute contraindication.”