Dr. Feelgood, a clinical psychologist who had previously worked in specialty MH care, was hired to develop a new PCBH service. Despite a reasonably strong health psychology background, Dr. Feelgood had never worked in a PC clinic. Similarly, despite some experience with consultation-based work, this had never been the focus of Dr. Feelgood’s work, and only rarely had he needed to make rapid decisions as a consultant. Most of his consultation experience involved administering traditional, lengthy psychological evaluations of medical patients and providing detailed reports to medical providers. Curbside consultations, a common PC occurrence in which he was asked for advice on patients he had never met or only barely knows, had not previously been a part of Dr. Feelgood’s clinical repertoire. Most of Dr. Feelgood’s experiences in MH clinics had involved the usual combination of diagnostic assessments, hour-long therapy visits on a weekly or every-other-week basis, and psychoeducational groups. Before leaving his previous job, Dr. Feelgood had attended a workshop on the PCBH model and had read a few journal articles about it, but this was the extent of his exposure to the field prior to beginning in PC. Thus, Dr. Feelgood’s specialty MH experiences hadn’t prepared him well for what he faced in his new job.

The characteristics of Dr. Feelgood’s new patients were also quite different from those he had encountered in specialty MH care. Previously, in his private practice, Dr. Feelgood’s clients were usually middle-class, English-speaking, and basically healthy. However, with the move to his new community health center job, Dr. Feelgood discovered an entirely different patient population. Suddenly he was presented with patients addicted to heroin and methamphetamine, psychotic patients unwilling or unable to get specialty care, and patients with multiple chronic and complex medical problems. He was often asked to help with problems with which he had little familiarity, such as diabetes and autism. The majority of patients in his clinic spoke primarily Spanish, necessitating the use of interpreters and challenging his understanding of different cultures. Initially, PCPs weren’t sure how to utilize Dr. Feelgood, and they peppered him with questions about medications. Questions such as, “What’s the maximum dosage for this medication?” and “What medication should we use for this patient?” were common. Patients also didn’t understand Dr. Feelgood’s background and, owing to his title of “Doctor”, assumed he could answer questions such as, “How will my diabetes medication interact with my antidepressant?” and “Is my blood pressure ok now?”

In short, Dr. Feelgood was surprised by how different the challenges of his PC job were from those of his private practice job. He faced a new and diverse patient population with a range of ages and clinical problems he had not encountered before, and his new position required that he respond to situations where his knowledge and training was lacking. Dr. Feelgood was surprised to find that the transition to PC was more challenging than he had imagined it would be.
Informed Consent: The Case of Ms. B. Healthy, M.S.W.

Amy L. was a 52-year-old woman visiting her doctor for a diabetes check. She had not been into the clinic for almost a year, and labs run by her PCP showed her diabetes was poorly controlled. When notified of her lab results, Amy confessed that she had a lot of difficulty adhering to dietary recommendations and rarely exercised. Amy’s PCP knew that she had a history of depression and thus screened for depression. Her screen was positive, and her PCP felt certain that depression was interfering with Amy’s diabetes self-care. However, in the past when the PCP suggested a referral to a MH clinic, Amy had refused to go. She had always insisted that she didn’t believe in telling her problems to others and always promised her PCP that she would improve her self-management efforts on her own, though she clearly had not done so.

This time, the PCP was determined to get better MH care for Amy, and fortunately the clinic had recently begun a BHC service. Thus, before concluding her visit with Amy, the PCP sought out the BHC and brought her into the exam room. Amy was a bit perplexed when the PCP returned with Ms. B. Healthy, but the PCP quickly explained, “This is Ms. B. Healthy, our BHC. Before you go, I’d like you to have a visit with her. She helps me figure out how to help my patients make healthy lifestyle changes, and she just happens to be available for an appointment right now. So see her right now, then see me again in two weeks, ok?” Amy looked quizzically at Ms. B. Healthy, clearly skeptical of this arrangement, but before she had a chance to reply the PCP was out the door and Amy was being whisked away by Ms. B. Healthy.
Confidentiality: The Case of Mr. Sufferless, M.F.T.

Mr. Sufferless, a marriage and family therapist, was excited to be in his initial weeks of work in a BHC service. Mr. Sufferless had previously worked in specialty MH, but had an interest in health psychology so had jumped at the chance to work in PC. The service he joined had been in place for a few years and thus had protocols and procedures already documented in a manual, and Mr. Sufferless started the process of reading about them. When he began to see patients, Mr. Sufferless experienced concerns about some of the practices that were expected of him. For starters, Mr. Sufferless was told to write his notes in the patient’s medical chart, where anyone with access to the chart could also access his notes. Mr. Sufferless was accustomed to a very different recordkeeping process in MH, one in which his notes were never available for others to read without first obtaining the written consent of the patient. He wondered to himself, “What if a patient divulges something extremely personal to me, like a history of sexual abuse or a recent commission of a crime? Will I need to write that in the medical record, for any staff person to see?”

A second area of concern for Mr. Sufferless involved the frequent interruptions by staff during his patient visits. He was already uncomfortable with PCPs knocking on his door to consult with him, but during his second week, a NA knocked on his door to see if Mr. Sufferless was meeting with a patient who had met earlier with a PCP. Apparently the patient had left his PCP visit without taking his prescription, so the NA was searching for him to return it. The most disconcerting part of these interruptions for Mr. Sufferless was that the patient in his office was visible to the person at the door. In his previous practice, interruptions during a therapy visit were almost unheard of, partly to avoid disturbing the therapy process but also partly to protect the privacy of the patient. In the PC clinic, interruptions seemed to be common. He had a difficult enough time adjusting his treatment style to the intrusions, without also having to worry about patient confidentiality. Shouldn’t he be taking steps to better protect the privacy of his patients?

To add to these concerns, Mr. Sufferless felt very uncomfortable talking with PCPs after visiting with a patient. Quite often PCPs would approach him after a visit and ask, “How did it go with the patient I sent you?” He sometimes came across sensitive information during his patient visits and felt especially awkward spilling that information right out to the PCP. In the specialty system to which he was accustomed, Mr. Sufferless would never talk with others about information divulged by a patient during a visit, unless that patient had given him written permission to do so. He even insisted on written permission before talking with another professional that provided care to the patient, such as a PCP. “How”, he mused, “can I be expected to develop a trust-based relationship with my patients if I have to almost immediately divulge to another person (the PCP) the information given to me?”