The hospital-based psychologist: Paradise or purgatory?

By Paula Hartman-Stein, Ph.D.

Dr. Hartman-Stein

Working as a clinical psychologist in a general hospital setting can be a challenging and energizing experience that provides numerous opportunities for using one's clinical, teaching, and research skills. Clinical work in this setting is rarely boring and there are never-ending occasions to use creative problem-solving skills.

Examples of typical work activities in the average week may include: providing supportive psychotherapy with an inpatient recovering from a mastectomy; presenting a lecture to medical residents about differentiating depression from dementia; doing outpatient therapy with a man who is depressed following open heart surgery; conducting group therapy for test anxiety with nurses preparing for boards; or participating on a committee to design a suicide risk protocol for medical inpatients. The diversity of medically based referrals expose the psychologists to problems and personalities not commonly encountered in traditional outpatient practices. The debatable issue is which type of department or division in the hospital provides the best professional fit for the psychologist, thus enabling the appropriate use of his/her knowledge and expertise.

Best case scenario

Traditionally, psychologists are grouped under a Behavioral Science division of the Department of Psychiatry. Although this arrangement typically places the psychologist in a hierarchical order beneath the psychiatrist, it can be workable and satisfactory. But the success of such an organizational approach depends largely on the personality and philosophy of the department head. In the best case scenario, the Chief of Psychiatry understands and acknowledges the value of psychology as a profession — treating the psychology staff in a collegial and supportive manner. Decisions regarding program planning in the department may be shared demonstrating both respect and credibility for the psychologist's input. In such an ideal department, the psychologist is encouraged to develop creative ways of reaching the needs of both the patient and the medical staff. Usually such a department includes psychiatric residents, nurses, and social workers, creating a sense of camaraderie, and allowing for opportunities to both teach and learn from related disciplines. Finally in this model department, hospital-based psychologists have parity with hospital-based psychiatrists regarding financial arrangements and benefits, either through private practice opportunities, profit sharing, or fees for consulting and teaching if an independent contractor model is in place.

And the worst

In the worst case scenario, the Chief of Psychiatry treats the psychologist as a paraprofessional whose clinical duties are restricted. The psychologist may be permitted to treat only certain types of clinical cases (usually those that the psychiatrist does not want to see, such as personality disorders), and autonomy in program planning and teaching are nonexistent. The duties of the psychologist may be limited to diagnostic procedures only since providing psychotherapy of any kind to psychiatric or medical inpatients may threaten the pocketbooks of attending psychiatric staff. Even if the Department Chief appreciates what psychologists are trained to do, the Chief's allegiance is greater to the attending physicians. Therefore, political pressures and turf issues will interfere with the duties and responsibilities available in the medical setting, which, after all, is not the psychologist's "own house" — to clone George Albee's phrase. In essence, the professional autonomy of the psychologist is controlled and obstructed in this arrangement. Additionally, the psychologist will have limited income-producing power with a "no compete" clause in effect regarding private practice while psychiatric staff have no analogous restrictions.

An alternative situation would be an appointment in departments such as Medicine, Family Practice, Rehabilitation, Geriatrics, or Pediatrics. In such settings, the psychologist usually reports to a nonpsychiatric physician who is the Department Chair. This arrangement usually offers more freedom, enabling the psychologist to use all of his/her armamentarium of clinical and teaching skills. The Chief of the Department may not have a clue as to what psychotherapy means or how psychodiagnostic procedures are done. One surgeon who was particularly supportive of having a psychologist in his de-

Continued on next page

Paula Hartman-Stein, Ph.D., worked as an employee for four years in the Department of Psychiatry in a general hospital. Eight years ago, she transferred to the Department of Medicine. Currently she has a private practice and works on a part-time contractual basis as the Director of Clinical Psychology in the Department of Medicine at Akron General Medical Center. Dr. Hartman-Stein is Chair of the Geropsychology Committee of OPA.

Nat Psych Vol 1, 7. (1991)

Continued from previous page

partment quipped "if you were in your office roasting chestnuts with a patient, I wouldn't know whether this was the thing to do or not." The nonpsychiatric department chief may function as a conduit to the hospital administration who gives support and sanctions rather than direction and supervision to the psychologist. There is minimal competition, and virtually no turf battles for psychologists in such departments. This fact allows not only for greater control over professional duties, but also it may enable the psychologist to negotiate a fair financial arrangement.

Initially, the psychologist plays a unique and perhaps unknown role in a medical department. Thus, there is the need to prove his/her professional worth. After the psychologist helps the physician manage a particularly difficult case or provides a diagnosis which explains a patient's chronic physical complaint, or helps identify a medical resident whose personal problems are interfering with his/her performance, the psychologist gradually becomes a valued and respected member of the department.

The negative side of working in a medical department can be that the psychologist is often isolated from peers, especially if he/she is working in a small to medium-size general hosptial. There are not many opportunities to confer about cases or to discuss new modalities of therapy or research findings. Therefore, the psychologist needs to be self-directed and able to thrive in a nonstructured work environment, obtaining peer support by becoming involved in professional organizations, and case consultation with colleagues outside the department. Interpersonal qualities of tenacity, perseverence, polished social skills, and a healthy sense of self-esteem bode well for being successful as a psychologist in a medical setting because inclusion in staff meetings, in hospital-related social events, and in policy committees that would advance professional development, are not necessarily automatic. The psychologist must be judicious about assertively pushing for involvement in such activities, while at the same time overcoming feelings of personal rejection when the actual reason for not being invited may be due to the psychologist's assigned hospital privilege list (i.e., active or admitting staff versus advisory or consulting staff). Also, medical residents, in particular, may not value learning about psychological aspects of patient care. However, more seasoned physicians often appreciate the psychologist's input, although compliments and overt recognition for a job well done may be infrequent.

Indeed, working in a medical setting under any arrangement is no paradise for psychologists. Increasingly nonpsychiatric divisions or departments tend to provide greater opportunities for the use of a psychologist's training and expertise and a greater likelihood of professional parity with physicians. A sense of increased control and freedom in a psychologist's work life may improve both personal productivity as well as his/her own mental health.