Integrated Medical Care for Patients With Bipolar Disorder: Who Will Be the Principal Physician?

To the Editor: Leboyer and Kupfer[1] clearly presented the chronic and systemic consequences of severe and persistent mental illness. Furthermore, by describing bipolar disorder as a chronic disease requiring comprehensive and multidisciplinary care, they suggested that patients with bipolar disorder could be cared for in an "integrated medical care system." This call for integrated health care services (delivery of primary and psychiatric care in the same setting) is commendable and, based on much of the evidence they presented, important. However, the authors left one point unaddressed: if two physicians (a primary care physician and a psychiatrist) and numerous allied health staff members (eg, dieticians, social workers) care for the same patients in one clinic, who will primarily direct (or be in charge of) the patients' care?

Current reorganization[2] of primary care and chronic disease care is based on developing the patient-centered medical home (PCMH). The PCMH is designed to provide patients with a primary (first-contact) physician and patient-centered, comprehensive, and coordinated care in a setting with ongoing reassessment of the quality of care delivered.[3] Generally, the first-contact physician is trained in the delivery of wide-ranging care of common acute and chronic problems—the family physician, internist, or pediatrician. Some specialist physicians, however, have reported that for certain patient populations, and with the appropriate clinic infrastructure meeting all PCMH requirements, specialists can serve as first-contact physicians in a PCMH.[4]

Patients with schizophrenia and bipolar disorder generally receive care in a psychiatry clinic from a young age through late adulthood and usually attend a psychiatry clinic more often than a

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primary care clinic.[5] These patients may consider the psychiatrist as the first-contact (or principal-care) physician even if the psychiatry clinic is not designated a PCMH. Additionally, psychiatrists often coordinate care from numerous mental health and social services. Because it seems unlikely that all mental health clinical services provided to patients with chronic mental illness could be centered or coordinated from a primary care setting, for these patients the psychiatrist might effectively serve as the principal physician, with a primary care physician serving as a consultant. Integrated care could be delivered by bringing primary care services into a psychiatry clinic.[5,6]

If the future of primary care throughout the country involves the PCMH, and if psychiatrists are interested in integrating their services with primary care services, we must address which physician (psychiatrist or primary care physician) should be identified as the principal physician in a PCMH serving patients with chronic mental illness. Future studies should describe the psychiatrist's ability to serve as a principal-care physician, the primary care physician's ability to serve as a "primary care consultant" to a population of patients with chronic psychiatric disorders, how different models of integrated care influence patient outcomes, and whether psychiatric training should be adjusted to meet the new models of health care delivery.

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Dr Leboyer was shown this letter and declined to comment.

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