

Sigmundoscopy

Medical-Psychiatric Consultation-Liaison The Bases

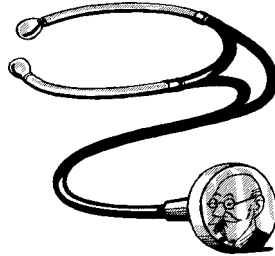


*"In order to cure the human body, it is necessary
to have knowledge of the whole of things."*

Hippocrates

Sigmundoscopy — The Bases





1/ History & Organization of C-L Psychiatry

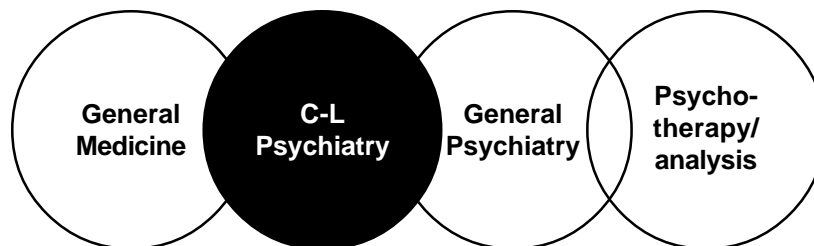
Introduction

Consultation-liaison (C-L) refers to the branch or subspecialty of psychiatry that focuses on the interface between psychological (mental) and somatic (medical) illnesses. C-L psychiatry is an integral part of **psychosomatic medicine**, which involves:

- the study of the effects of psychological and social factors on physiological functions in the development, course and outcome of illness
- using a **biopsychosocial** approach to understanding and treating the predisposing, precipitating, perpetuating and preventative (or protective) aspects of illnesses

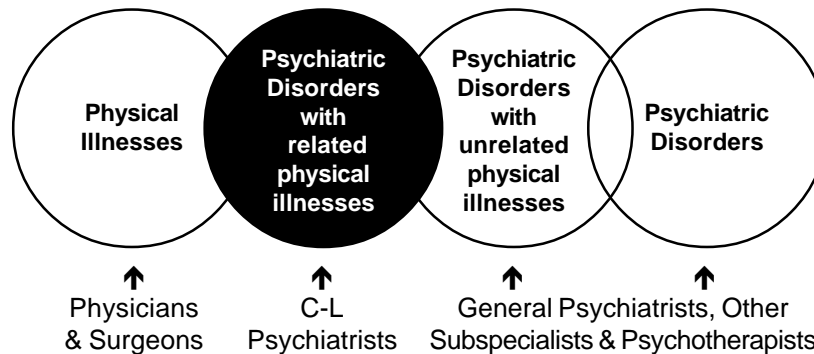
Adapted from Lipowski (1984) & Engel (1977)

The main function of C-L psychiatry is to provide clinical services linking mental health professionals to those in other medical specialties (as illustrated below), on both an inpatient and outpatient basis. As a field of scientific endeavor, C-L psychiatry also has educational and research components.



Sigmundscopy — The Bases

C-L psychiatry can be conceptualized as bridging the gap between illnesses which are considered to be entirely physical in nature and those considered to have entirely psychological causes.



Depending on the availability of clinical resources, some hospitals have psychiatrists who further subspecialize and offer their services exclusively to areas where the psychosocial aspects of illness are particularly pronounced. The most common services requiring this degree of psychiatric involvement are: Transplantation, Cardiology, Gastroenterology, Oncology and HIV Clinic. The **American Hospital Association (AHA)** estimated in 1984 that almost nine-hundred hospitals offered C-L services.

Noyes (1992) reported on the **Academy of Psychosomatic Medicine (APM)** survey of the 6000 members of the **American Psychiatric Association (APA)** (membership at that time — 36,740) who indicated an interest in C-L psychiatry. It was estimated that about 2,700 psychiatrists (7.5% of the membership) spent at least one-quarter of their time engaged in C-L work, and nearly 1,200 psychiatrists (3.2% of the membership) spent at least half their time involved in C-L activities. The majority of psychiatrists conducted less than one-hundred and fifty inpatient consults per year, though some were referred up to six-hundred per year.

Further, about 3,800 psychiatrists (10.5% of the APA membership) had some affiliation with a C-L service (involved in conducting consults, educational activities or research).

C-L is the Complete Subspecialty

Psychiatry is a diverse field. Psychiatrists are commonly and unfortunately polarized into being either principally psychopharmacologists (biologically-oriented) or psychotherapists (dynamically-oriented). Both sides have their strengths and weaknesses, proponents and opponents. There are subspecialties within psychiatry (listed later in this chapter) that further narrow the range of patients that some psychiatrists treat.

If there is one quality that does apply to psychiatry as a whole, it is the avoidance of physical examinations and the lack of familiarity with diagnostic tests. Kick (1997), reporting on this observation, states that *“As a result, the discipline’s claim that it alone is capable of including medical causes of psychiatric syndromes produces a hollow tone to nonpsychiatric physicians who observe their practice.”*

All psychiatrists have completed medical school, yet the knowledge so acquired tends to play a minimal role in their day-to-day practices. C-L is the subspecialty that ties together all the “factions” of psychiatry as well as keeping its practitioners in touch with medical and surgical practices. C-L psychiatrists require at least a working knowledge of the following areas:

- Psychotherapy
- Forensics
- Addictions
- Neuropsychiatry
- Psychopharmacology
- Geriatric & Adolescent psychiatry
- Emergency Psychiatry
- Crisis Intervention

In this way, C-L psychiatry is the complete subspecialty. The diagnostic diversity is at least as varied as that encountered on general psychiatry units, with additional skills being required to adapt management plans to patients’ physical illnesses. Since the majority of psychiatrists engaged in C-L work do not make this their only avenue of practice, they have the opportunity to enhance their skills in other areas. It is not unusual to have researchers, psychoanalysts or even administrative psychiatrists involved in C-L activities for a portion of their practice.

Sigmundscopy — The Bases

Langlsey (1988) conducted a survey among psychiatric practitioners and educators regarding their opinion on what skills and knowledge define a specialist in psychiatry. Forty-eight items regarding skills and fifty-one items regarding knowledge were ranked. Those particularly relevant to C-L psychiatry with an agreement of at least 90% are listed below with their rank:

Rank Skill

- 1 • conduct a comprehensive diagnostic interview
- 10 • maintain records including history, mental status exam, physical examination, diagnostic tests and progress notes
- 11 • conduct crisis intervention
- 12 • use appropriate laboratory tests, psychological testing and other diagnostic procedures
- 14 • conduct a comprehensive assessment and develop a management plan for physically or psychosomatically ill patients
- 15 • conduct brief psychotherapy
- 16 • develop liaison relationships with other professionals

Rank Knowledge

- 2 • differentiate between physical and psychiatric disorders
- 5 • evaluation and management of psychiatric emergencies
- 11 • psychiatrically relevant aspects of neurology
- 12 • psychological aspects of stress, coping, loss, bereavement, etc.
- 13 • syndromes of importance in C-L psychiatry
- 14 • indications/contraindications for various forms of psychotherapy
- 15 • indications/limitations of psychological testing

C-L work requires the greatest breadth of skills and knowledge of all the areas in psychiatry. As an example, consider the range of skills required to manage the following case:

A sixty-seven year old male with a history of bipolar mood disorder is admitted after a lithium overdose. Because of his high lithium level, he is too obtunded to consent to dialysis, which is deemed necessary by the medical consultant. Substitute consent is obtained for this procedure. After recovering from the overdose, he goes into alcohol withdrawal delirium two days later and attempts to leave hospital. After crisis intervention takes place to prevent him from leaving, his status is changed to that of an involuntary patient (due to safety concerns and so he can receive further treatment). He is medicated to treat his withdrawal. Once he's recovered from the withdrawal delirium, he requests psychotherapy to help him deal with his "anniversary reaction" to his wife's death.

A Rose By Any Other Name. . .

Schwab is credited with first using the term “consultation-liaison” in the late 1960’s (Mendel & Solomon, 1968). Since this introduction, use of the term has been met with considerable controversy, aptly summed up by Bronheim, quoted in Thompson (1993):

All physicians reserve for themselves the right, honor, and privilege to consult with patients for colleagues. Using the word consultation in our title, irrespective of what specialized knowledge we may have about a particular patient population, even one that no other psychiatrist would want to treat, is exclusionary and fundamentally an insult to our psychiatric colleagues. (p. 259)

Thompson (1993) contacted two-hundred and ten psychiatrists, selected by him, half of whom were prominent educators and/or clinicians who did not primarily practice C-L psychiatry, with the other half from the APM. Recipients were asked to define the role, patient population and expertise possessed by C-L psychiatrists. Their consensus is as follows:

C-L psychiatrists evaluate and treat inpatients and outpatients with significant medical and surgical illness who are also experiencing significant psychiatric symptoms. These patients’ symptoms may be due to their medical-surgical conditions, medical-surgical medications, and other treatments (and may be worsened by these factors), and their psychiatric symptoms may be interfering with optimal medical management. (p. 260)

Alternative names for the subspecialty were also solicited. The alternatives most commonly suggested were:

- Psychosomatic Psychiatry
- Medical Psychiatry
- General Hospital Psychiatry
- Psychiatry of the Medically-Surgically Ill
- Psychiatric Medicine
- Medical-Psychiatric Practice
- Medical-Surgical Psychiatry

The clear favorite was **Medical-Surgical Psychiatry**. This term was considered to be both concise and reflective of the patient population treated, though it was criticized for leaving out other specialties (e.g. obstetrics-gynecology, etc.).