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Trainees' forum

Working in consultation-liaison psychiatry in the USA

An educational experience

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Consultation-liaison psychiatry had its inception in North America, the term making its first appearance in the 1930s to describe the department at Colorado General Hospital in Denver. As Mayou (1987) points out, when comparing British and American liaison services, the role, boundaries, and organisation of this subspecialty are very different in the two countries. Money and resources do not exist in Britain within the National Health Service to provide the extent of involvement liaison psychiatry now enjoys with the general wards of many American hospitals. Thomas (1985) refers to basic differences between the countries. He points out that few British district general hospitals have consultation psychiatric units now in place and that the theoretical background of psychiatrists in the two countries are different. In addition, he suggests that there may well be differences in the referral patterns and expectations with regard to psychiatric consultation requirements of general hospital doctors in the two health care systems.

I am presently working as a clinical fellow for a one-year period in the consultation-liaison service of the Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire. This centre is a 400 bed general teaching hospital that serves as one of the principal tertiary care referral sources for patients in the states of New Hampshire and Vermont. The local area is semi-rural, with a major college, many farms and small industries. The hospital is one of the major specialty care facilities in New England. There are general medical and surgical beds, together with all the subspecialties that would be found in a British district general hospital.

The consultation service staff

The consultation liaison service at Dartmouth-Hitchcock has been in existence since 1970. We work as a multidisciplinary team representing medicine, nursing, substance abuse and psychology. The physician members of the team include a psychiatric resident in either the second or fourth year of training, two attending staff, one to two medical students and myself, a clinical fellow.

The residents are equivalent in experience to psychiatric registrars in the UK at the same stage in their training. The attending staff are consultant equivalents and certified by the American Boards of Psychiatry and Neurology.

In addition to the physician component, the team includes a clinical nurse specialist with training in psychosomatic nursing who functions as a liaison for the general nursing staff, and works on the model of mental health consultation described by Caplan (1970). This model is drawn from social work theory, is broad in applicability, and provides a useful way of looking at the nature of consultation. It is divided into four choices of approach: [1] client centred, [2] consultee centred, [3] programme centred, and [4] administrative centred. Client centred consultation is self-explanatory and is the traditional method by which, for example, a general practitioner asks for an opinion on diagnosis and treatment from a consultant specialist. Consultee centred focuses on the referring agent who is having difficulty in managing the client's difficulty, either because of lack of consultee knowledge or skills, lack of self confidence, or lack of professional objectivity due to countertransference issues. A programme centred approach is where the consultant suggests general administrative and planning changes to improve the environment of the client based on the consultant's specialist knowledge of social systems and mental health theory. In consultee centred administrative consultation the focus is on the group of consultees as a whole who are experiencing difficulties as a result of poor leadership, authority issues or communication blocks within their

working group. The clinical nurse specialist does see some individual patients as clients as in model [1], but primarily those with mild degrees of distress which result from their admission to the general hospital rather than those with ongoing psychiatric disorders. Most of her work, however, is concerned with supporting the nursing staff to help them deal more effectively with patient and physician psychosocial problems (models [2 and 4]). If there have been a number of such problem areas or patients she will arrange a group meeting for the staff concerned to help them explore these areas. Some of these situations involve working with issues of transference or countertransference in individual nurses.

The social worker member has had specialist training in drug and alcohol counselling. There is good evidence that a significant and often overlooked percentage of patients admitted to general hospital have problems with their alcohol use. Cohen *et al* (1986) indicate that their alcohol related problems are often noted in the emergency department or at the time of admission, but are frequently not pursued. The specialist counsellor provides addiction specific treatment for in-patients and can coordinate appropriate aftercare services. She relates partly to our team and partly to the alcohol service and works both as a patient therapist and as a liaison educator for general hospital staff at all levels.

There is also liaison with the department of psychiatry's division of behavioural medicine. There has been interest in the USA recently to integrate more closely the activities of behavioural medicine with those of consultation-liaison. McKegney (1986) suggests that they could most usefully be joined organisationally into a single department of "consultation-liaison and behavioural medicine." In our service a doctoral level psychologist from this department attends our daily meetings and helps us assess patients appropriate for training in areas like self-relaxation, stress reduction, and the management of chronic pain.

Referrals

In the first two months of working here our service has had some 30 new referrals. They are phoned in to our secretary by the staff on the general wards. The standard and detail of the information provided is variable. Some referrals seem straightforward and occasionally urgent, while the purpose for others is at first unclear.

We meet on a daily basis early in the morning as a multidisciplinary team to present any new patients we saw the day before and to discuss follow-up cases. Arrangements for the day ahead are then made in terms of who will see the next referral; we have anything from none up to four new consultation requests each day, averaging one a day. Most referrals come from general medicine and surgery with a significant proportion from subspecialties, especially neurology, dermatology and neurosurgery.

The most common diagnoses of patients referred to the consult service are adjustment disorder, depressive illness, organic brain syndromes and alcoholism. Although we have to submit a DSM-III-R diagnosis for the purpose of billing, there is a recognition that diagnosis in this area of psychiatry is difficult. There is a complex mixture of somatic, psychological and social symptoms in medical-surgical patients in hospital; cause and effect relationships are difficult to demonstrate. A survey of the psychiatric consultations in this centre by Shevitz *et al* (1976) from 1971 to 1974 recorded a concurrent physical and psychiatric disorder in 68% of cases of the general hospital patients referred to the service. Depression was the most common disorder, accounting for more than one half of the cases. Lipowski & Wolston (1981) analysed the referral patterns again for the period 1975 to 1979, finding that the frequency of diagnosed depressive disorders was significantly less. However there were significantly more patients classified as "other" or "no psychiatric diagnosis". Many such patients would now be diagnosed as suffering with adjustment reactions.

Clinical assessments of patients

We have a policy of discussing each consultation request with the responsible general ward doctor prior to our interview. This is partly to understand the problem more clearly and reformulate it when necessary and partly to ensure that the patient has given consent to be seen by a psychiatrist. We only consult on patients who have consented to be seen by us, unless they are combative or appear to be seriously disturbed. Patients are usually charged for the first consultation visit only; follow-up visits are not charged unless the attending psychiatrist sees the patient again.

All the new referrals are seen within 24 hours by the medical student, an attending psychiatrist, and either myself or the resident. This allows for a variety of psychiatric views as well as properly supervised training in interviewing and differential diagnosis. The interviews are usually conducted by the medical student with one of us supervising. Whenever possible we speak to the relatives or an informant either in person or on the telephone. The medical student and resident make their entries in the ongoing progress notes. The attending psychiatrist makes his note on a special referral sheet within the case notes. These sheets are designed for medical consultant specialists of all kinds to record their clinical opinions when requested by the ward doctor.

Wherever possible we interview the patient in a single room but there are many occasions when this is not possible and privacy may be limited to drawing the curtains around the patient and pulling a chair up close to the bedside. Even then there is intermittent noise disturbance either from conversations between nearby patients, visitors and nursing staff or, if the patient is in the Intensive care unit, from the sound of life support technology. The most frequent interruption is from the sound of a neighbour's television. Most psychiatrists wear a white coat in the general hospital which differentiates them from visitors; I have found it has helped me to form a more rapid liaison with ward staff and has not, I believe, detracted from therapeutic interviews with patients.

Treatment approaches

Many of our referrals seem in part to be the result of patients complaining that they have not been told enough about their medical diagnosis and management. Simple explanations and supportive counselling during their brief stay in the hospital is usually sufficient treatment. It could certainly be argued that we are not the ideal ones to be doing this, and that it should rest with their physicians or surgeons to provide such explanations. However, the general residents are overworked and usually inexperienced in the variety of psychological impact of medical illness on their patients. Although it is not uncommon in this country for primary physicians (GP equivalents) to visit their patients in the hospital when they are nearby, this general hospital is a referral centre for a large surrounding area, and patients' primary care physicians are often far away. As a multidisciplinary team we employ an eclectic therapeutic approach which encompasses supportive psychotherapy, behavioural therapy and psychopharmacology. We are also interested in the social network of the patient and will try to meet family members whenever possible. When we recommend psychotropic medication it is usually either a course of antidepressants for a patient with a significant depressive illness, an anti-psychotic to control untoward behaviour or a benzodiazepine for anxiety symptoms. For example, we were recently referred a young logger who had sustained multiple injuries, burns and a fracture of a number of cervical vertebrae following a road accident. This necessitated him being totally immobilised in a Striker frame and a halo. Anger and frustration about his enforced immobilisation caused him to try to dislodge his halo and pick at the dressings on his skin grafts. We have been visiting him daily to offer supportive therapy and to make recommendations to the medical staff about pharmacotherapy and how it may interact with the opiate analgesics he is also receiving. His history of a road accident following alcohol ingestion is a very common here and there is a high prevalence of alcohol related disorders in this rural community. He is getting follow up care for his drinking problem from our drug and alcohol counsellor.

One interesting difference from a British general hospital is the relative frequency with which we are asked to see patients in a confusional state because of a metabolic imbalance, quite commonly acute alcohol withdrawal. In Britain a consultant physician, in my experience, is more likely to manage the patient without consulting a psychiatrist, at least in the initial stages. The diagnosis in the wards here is more often made by our service after we have completed a full assessment and mental state examination.

Advantages and limitations of service

A criticism that might be made of the consultation-liaison service in this hospital is that we seem to have too much emphasis on consultation and not enough on liaison. While we do keep in close ongoing contact with the patient's referral doctor, and visit all our patients daily on the ward, our forays into education of the general hospital staff are limited. On the theory that it is better to "teach someone to fish than to fish for them", I think we could be doing more general education at ward level with the aim of becoming a more effective empowering force for specialty internists. On the other hand, staff time constraints are a factor limiting our involvement in this kind of liaison. Lloyd (1980) suggested that since there are very few evaluation studies on the benefits of liaison it would be better to limit psychiatry in a general ward setting to the detection and treatment of patients with demonstrable psychiatric disorders and to increasing staff awareness of these problems. It is important not to make unrealistic claims of what liaison interventions might provide.

On the other hand, I am impressed with the excellent learning experience this specialty provides, both in general and specifically for medical students. Medical students in this country are given more responsibilty than they would be in the UK, and do much of the work that a British house officer might do. Our students visit and follow up patients on a daily basis. They are allowed and encouraged to write in the patients' notes, to develop the attitudes of critical scientific thinking and to read thoroughly, especially on topics related to patients they are seeing. They are also main contributors to our weekly clinical consultation conference. We are joined for this meeting by the consult psychiatrists from the nearby Veterans Administration hospital. Once a month the conference takes place there. Psychiatric residents on our training scheme rotate through both hospitals. At this conference a written summary history of one of the patients we are following is circulated and read. The patient is then interviewed

by another member of the psychiatric staff, usually from the other hospital, and we then discuss the case. The summary and a number of relevant articles are prepared and selected by our student. I am expected, among others, to provide informal and didactic teaching for the student who is with us for ten weeks, and we fill in regular assessment forms on each others' performance.

Lloyd (1980) has commented on the potential educational value for students of a period of attachment to a general hospital psychiatry service. This might be especially appropriate for those who are destined to be general hospital consultants in the UK. There is some evidence that students attached to a clerkship in liaison psychiatry perform at least as well as students doing other psychiatric attachments when they are measured on "strictly psychiatric parameters" McKegney (1976). They do equally as well as general in-patient psychiatry students with written standardised evaluation and scores on an end of rotation psychopharmacology exam. Their own subjective experiences of this learning arena tend to be positive and indicate their interest in viewing physical illness in a bio-psycho-social context. Arguing from a theory of state-dependent learning, McKegney (1976) postulated there may be compromise of recall of information gained in a traditional psychiatric setting when medical students go on to practice in different settings. These considerations will become increasingly important points of debate in Britain where liaison psychiatry is in its infancy and where, as Priest (1983) has pointed out, medical student teaching is piecemeal and in need of a more coordinated approach.

Other activities

While I have been here I have been encouraged to become actively engaged in a research project connected with the work of the consultation service, and I am at present reviewing the notes of our referrals over a one year period who have been assigned the diagnosis of adjustment disorder to explore the validity of this DSM-III category in our general hospital population.

I also provide a once weekly liaison service to a nearby nursing home and receive referrals from the nurses there and the specialist physicians who tend also to work at the general hospital. About once a month I facilitate a group for the nursing staff in which issues related to the emotional impact of caring for their clients are shared.

In conclusion, I am finding my present experience both personally and professionally satisfying and would recommend it to any psychiatrist in the UK interested in the interface between hospital medicine, general practice and psychiatry. Since many of our patients are over 65, this work would also appeal to those interested in psychogeriatrics within a general hospital. It is also good experience in the art of teaching medical students, for which one receives little preparation while a registrar in the UK.

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