Liaison Psychiatry

A personal view

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There is currently considerable interest in liaison psychiatry and recently a Royal College Special Interest Group has been set up in this field. Although few psychiatrists are employed full-time in this sub-speciality, it appears that much time is spent by psychiatrists in doing liaison work[1] and this is likely to become more important with the increasing movement of psychiatrists into the District General Hospital (DGH). There is ample evidence to suggest that there is a high prevalence of psychiatric morbidity in a DGH population[2,3] which can be seen as representing potential for expansion. However, there is no consensus as to the scope of liaison psychiatry, whether expansion would indeed be desirable and whether psychiatrists possess suitable skills for the job[4].

I would like to present a personal view of liaison psychiatry based upon my experience as a registrar working exclusively in this field in a teaching hospital with DGH responsibilities. My referrals came from the casualty department, in-patient wards, and occasionally from the out-patient departments.

Each morning I assessed the overdose cases of the previous night in the accident and emergency department which included an overnight stay ward where patients could rest until an assessment could be made. This system was useful in avoiding medical admission, and for allowing time for the patients to sleep off any drug-induced sedation (benzodiazepines being the most usual drugs of overdose). Seeing a large number of cases enabled me to gain confidence in assessing suicidal risk; only 12% of patients seen were transferred for in-patient psychiatric management. In a further 28% community-based follow-up was made, either psychiatric out-patients or referral to the community psychiatric nurses. In the remaining 60%, the GP was informed and sent a short written assessment. In time my presence in casualty led to greater acceptance of what I had to offer and also to more informal and relaxed relationships with the staff, and although I was occasionally referred to as 'the shrink' this was usually in jest. I did ask that the casualty officers made an attempt at assessing the mental state before referring the patient and in general I was impressed at their competence in this. By giving tutorials to the casualty staff and details of the working of the psychiatry department, such as how to arrange an outpatient appointment, they were able to deal with many cases themselves.

Ward referrals posed greater problems than casualty referrals. It is impossible to know everybody in a large hospital; stepping on to a strange ward I would often feel, and be viewed as, an outsider. The means of referral itself varied widely and was often indicative of the attitude of the referrer. Some were impersonal written requests to 'see and advise', conveying their perfunctory nature, in much the same way as the surgeon may be asked to come and put a hand on an abdomen. Such requests recognise the specialist's area of expertise but also serve to diminish the medico-legal anxieties of the referrer. Happily, some referrals were detailed and showed insight and, particularly if contact was made by telephone, I was often able to discuss the case with the referrer before seeing the patient. As in casualty, communication became more effective once I was known to the referrer. It was clear that commonly the impetus for referral came from the nursing staff and I therefore discussed the patient with them on my visit to the ward. I was impressed by the ability of the junior medical staff to assess and discuss the psychiatric aspects of their patients, although they often displayed a lack of confidence in their views.

Referrals came from all departments with a preponderance from the medical specialities especially hepatology and neurology (multiple sclerosis was frequently associated with psychiatric problems). Referrals from surgical specialities were common too, especially for cancer patients and those with chronic orthopaedic problems, such as back pain. Drug and alcohol-related problems were also frequent, posing difficulties due to the absence of specialist units for their treatment. It was clear that although the staff recognised some degree of psychological upset in almost all patients and were prepared to tolerate and support most of them unaided, those referred to me showed a greater degree of disturbance. The diversity of medical and surgical conditions, treatments and procedures encountered was often bewildering, needing judicious enquiry and a visit to the library in order, at least, to appear well-informed. Some conditions encountered were obscure and presented diagnostic difficulty, such as psychiatric manifestations of drug toxicity or withdrawal. Examples include a vivid visual hallucinosis associated with an overdose of orphenadrine and a case of acoustic neuroma presenting in a woman with earache, deafness and a paranoid psychosis.

Many requests were for me to talk with the patient, thus

carrying the subtle inference that nobody else had time to do just that. Indeed, many staff made apologetic comment about how little time they had for such things and I heard of more than one student nurse being reprimanded for talking to patients, as if this was somehow divorced from a nurse's role. Certainly, talking to patients was the mainstay of my intervention. A supportive counselling style was modified in some cases to include an attempt to achieve insight into the meaning of psychosomatic symptoms. On a number of occasions a cognitive therapy approach was used[5]. Medication was used surprisingly infrequently. There was often the expectation I should want to prescribe and, indeed, the act of writing on the prescription chart seemed to have a profound effect on ward staff by lowering anxiety levels, presumably relating to their familiarity with the medical model. In some cases staff viewed the patient as a threat to the running of the ward and me as a means by which the disruptive patient could be removed.

On other occasions the fact that not all members of the referring team were aware of, or agreed with, the referral seemed to sabotage the intervention. For example, I was referred a woman in her 50s who was incapacitated by back pain and yet had only minor physical and X-ray changes. The thoughtful referral had come from a member of the junior medical staff at the instigation of the nurses, who had noticed her pain to be most severe when her daughters visited. Over several sessions I helped her to voice her need for more family support rather than demand sympathy for her pain. However, when I met the consultant, who had been unaware of the referral, and explained what I had been doing, he reiterated to the patient the X-ray changes found and what he viewed as the (albeit untreatable) physical basis for her pain, so undermining the work I had done. In some cases I was able to contribute not only to the patient's psychological management but also to the medical decision-making. For example, my views were sought by a cardiology team regarding whether cardiac surgery should be delayed in a man who had made a serious suicide attempt.

My reception from the patients was mixed. Many were not prepared for my arrival and were confused as to what exactly a psychiatrist was. Curiously, some staff insisted on introducing me as a psychologist as they felt that this had more acceptable connotations. Some patients expressed disquiet over the large number of different staff they had seen; others found my presence intrusive, unwanted and stigmatising. Yet others were pleased by the time I spent with them and were grateful for the attention. In some instances, I felt that psychological stress was not a consequence of physical illness, but frankly iatrogenic. The repeated surgical procedures for cancer, serial amputation for peripheral artery disease in diabetes, prolongation of life by supportive measures after severe strokes, etc. produced a profound state of depression and loss of the will to live in some patients. To attempt to treat such depression, although an undoubtedly humane aim, felt an uneasy and illogical splitting of the patient's problem into physical and psychological components. Those responsible for the physical care were thus absolved of responsibility for the patient's psychological well-being and freed to do what they saw as the correct thing surgically or medically, often to the patient's further psychological detriment.

In conclusion, my personal experience of liaison psychiatry is that it is demanding but potentially rewarding. I was constantly aware of having an ill-defined role. There was often a high level of anxiety, sometimes amounting to frank hostility, in the referrers. This may be seen as a projection of the anger and frustration that they often feel about the patient. Another demanding aspect of liaison psychiatry is the need to be conversant with current medical practice in several areas. It has been suggested that liaison psychiatrists should seek greater training in general medicine[6] but psychological problems are still likely to occur in obstetric and surgical patients, requiring a broader knowledge of medicine than that covered by the MRCPsych. Perhaps a psychiatrist who has completed a GP training may be better equipped for liaison work? Indeed, perhaps personality factors, the ability to pour oil on troubled water, are more important than the seal of approval from any number of Royal Colleges.

One danger of liaison psychiatry is the 'psychiatrisation' of unhappiness. All physical illnesses have emotional concomitants and medical and nursing staff must learn to handle their patients with their psychological well-being in mind. By calling a psychiatrist to handle the emotional needs of a patient undergoing a physical treatment, there may be a danger of diluting the physician's responsibility for all aspects of his patient's care. The referral may represent a conscience, an attempt to help, but one which enables abdication from the complex emotional management of that patient. The physician or surgeon may then be free to contemplate the medical or surgical problems posed by that patient, but will not take emotional factors into account. Thus, by perpetuating Descartian dualism—the mind body split, liaison psychiatry may promote a more mechanistic approach to medical care. Perhaps liaison psychiatrists should concentrate on educating hospital staff regarding their patients' psychological needs so that a 'whole' person approach to medicine is engendered and practised by all.

References

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