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Consultation-liaison psychiatry: the past and the present

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Summary
Consultation-liaison (C-L) psychiatry a subspecialty in psychiatry is referred to as the guardian of the psychological and holistic approach to patient. It has been undergoing rapid changes especially in the developed countries but its practice is strongly affected by stigma and negative attitude by professional colleagues. In this review, it is recommended that C-L psychiatry must not be restricted to conspicuous acute psychiatric disorders alone but must have impact across the whole of medical care. C-L psychiatrists ever than before must not only concentrate on managing psychotic patients but must strive to maintain intellectual and clinical leadership for the psychological system in its entirety. There is yet more to be done in the area of research and campaign against stigmatization.

Keywords: *Psychiatry, consultation-liaison, co-morbidity, referral services, physical disorder.*

Résumé
La spécialité de liaison de consultation (LC) en psychiatrie est référée comme le gardien de l'approche psychologique et appliqué aux patients,suivit des changements rapides spécialement dans les pays développés mais grandement influencée en pratique par le stigma et l'attitude des collègues professionnels. Dans cette revue,il est recommandé que la liaison de consultation psychiatrique doit avoir un impact à travers la médecine des soins de santé en entier et chercher à maintenir le front intellectuel et clinique dans le système psychologique en entier. Beaucoup de recherche reste à faire et des campagnes contre la stigmatisation

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Introduction

Consultation-liaison (C-L) psychiatry is defined as the study, practice and teaching of the relation between medical and psychiatry disorders. In C-L psychiatry, psychiatrists serve as consultants to medical colleagues (either another psychiatrist or more commonly, a non psychiatric physician) or to other mental health professionals (psychologist, social worker, or psychiatric nurse). In addition, C-L psychiatrists consult regarding patients in medical or surgical settings and provide follow-up psychiatric treatment as needed [1]. Though early C-L psychiatrists were better known as clinicians and teachers than as scientists this seems to have changed as C-L psychiatrists are now involved in carrying out various types of research peculiar to the sub-Specialty [2].

A broad consultation-liaison model which is a combination of an active "traditional" in -patient C-L service, active outreach to offer psychiatric referral service in various primary care clinical settings and significant involvement in didactic instruction of primary care physicians is now being proposed and practiced in some places [3,4].

Historical review of consultation-liaison psychiatry

In 1929, George W. Henry published a paper on some modern aspects of psychiatry in general hospital practice and thus became the founder of what later came to be known as liaison psychiatry [5]. The work of Henry and a few other pioneers bore fruit. Psychiatry was at last brought into general hospital and the mainstream of twentieth century medicine It was a development of far reaching consequence for both clinical disciplines, and a major landmark in the history of modern psychiatry [5].

The term, C-L psychiatry was coined out for the field in the 1960s because it was felt that other terms, such as psychosomatic medicine, physical/psychiatric co-morbidity and somatisation, psychological medicine: and medical/surgical psychiatry were unsuitable. Thus, the term C-L psychiatry remains: the psychiatry of those with physical/psychiatric co-morbidity and somatisation and liaison with those professionals who care for them [6].

C-L psychiatry grew in the 1970s out of a tradition of psychosomatic medicine and in response to the problems engendered by the increasingly technological nature of medical practice, an explosion in medical specialisation, and the dilution of the traditional patient-physician relationship in large tertiary care hospital [7].

In an early paper on C-L psychiatry, Krakowski described the C-L psychiatrist as the "guardian of the psychosocial and holistic approach to patients" [8] C-L psychiatry has had its roots in Meyerian psychobiology, which attempted to reintegrate the sciences of body and mind: it asserted the wholeness of human organism, an idea now contained in the wider concept of "biopsychosocial" [9]. This influence has provided, on the one hand, the framework for introducing psychological and social perspectives into the understanding of physical disease, and on the other, the impetus to "mainstream" psychiatric service within general health care delivery [10]. The activities of the C-L psychiatrists have traditionally involved clinical care, teaching and research. Pioneers at the University of Rochester medical school saw the educational aspect as paramount [11]. At Mount Sinai Hospital in New York, an extensive "liaison" organisation was developed [12], while at the Massachusetts General Hospital; the "consultation" element of C-L psychiatry has been emphasized [13]. In each case, the interaction of psychiatrists and non-psychiatrists has provided fertile ground for creative endeavour and research [14].

Stigmas and consultation-liaison psychiatry

Arboleda-Florez [15] defined stigma as a social construction whereby a distinguishing mark of social disgrace is attached to others in order to identify and to devalue them. Stigma can be divided into self-stigma and public stigma. Self –stigma is the prejudice which people with mental illness turn against themselves, while public stigma is the reaction of the general population to people with mental illness [16]. For some psychiatric patients, the illness itself or its treatment (i.e. neuroleptics) may signal their outward difference, but even to be seen attending a psychiatric service marks the individual as different [17]. These negative attitudes may be expressed by family members, friends, the general public, employers and even doctors [18]. Conferring a psychiatric diagnosis on an individual or admission to a psychiatric facility has multiple personal, social, vocational and financial consequences [16].

In Africa, the stigma and prejudices attached to mental illness partly stem from the belief that the mentally ill is cursed and deserved to be ill. It is also believed that the mentally ill is of no use to the society, as he has nothing to offer [19].

A psychiatric patient most often contend with stresses and pressures different from those suffered by the patient who does not have a psychiatric disorder. Those stresses include the stigma attached to being a psychiatric patient. It is more acceptable to have a medical or surgical problem than to have mental problem. Many patients are reluctant to accept that their somatic symptoms may have psychological causes and that referral to a psychiatrist may be appropriate [20]. Thus, this negative attitudes and stigma have direct effects on the clinical practice of every psychiatrist [17]. Dislike of psychiatric patients by doctors is not a new finding: Sivakumar *et al* [21] reported that 28% of medical students believed psychiatric patients were "not easy to like" but as doctors two years later, this rose to 56%. From the other perspective, in a study of 57 patients referred to a psychiatrist, 82% refused referral, citing the stigma of psychiatric assessment and treatment [22]. Stigma has been implicated for psychiatric outpatient drop-out rate of 50% in developed and developing countries [23,24,25]. Adeyemi *et al* [26] also reported in a study of primary care physicians that about 84% of doctors agreed that stigma is an issue that militates against psychiatric referral. All stages of mental illness: - recognition of symptoms, presentation, treatment adherence and rehabilitation – are influenced by the stigma of that illness [27]. Also stereotypical and stigmatising attitudes towards the mentally ill can be major obstacles to patients' ability to reintegrate socially [28].

Part of the reasons advanced for low referral rate from the non-psychiatric wards of the general hospitals, is the tendency by the physician to want to avoid stigmatising their patients [28,29]. In a study done in a West African general hospital, the attitude of the medical and nursing staff towards the mentally ill was described to be that of rejection. They always requested for immediate transfer of the patients to the psychiatric ward [28].

The stigma is even extended to those working in the field of psychiatry. There is the erroneous belief held by even colleagues that those who work in field of psychiatry are unbalanced. These ideas about workers in the field of mental health affected recruitment of staff due to perceived fear of the speciality [19].

Against this background, it is easy to appreciate the fact that there are profound and enduring benefits in putting up measures that will reduce psychiatric stigma. Some authors have suggested some measures which include the use of shifted outpatient clinic, where mental health professionals, counsellors or psychologists do outpatient clinic in primary care setting [30].

The effort being made by the Royal Colleges of Psychiatrists by mounting up a campaign to change peoples' mind and their behaviour [17] is a step in the right direction to reduce psychiatric stigma.

Consultation-liaison psychiatry and management of physical disorders

Physical symptoms and psychiatric disorders commonly occur together in the general population, in patients who consult primary care practitioners, surgeons and other specialists. When treatment is needed for the psychiatric disorder, it can often be provided by the practitioner who is treating the physical illness. However, the more severe disorders are likely to require treatment by psychiatrists who should have good knowledge of the problems. Psychological symptoms of insufficient severity to satisfy diagnostic criteria for a psychiatric disorder may cause considerable morbidity and lead to an increased use of medical services [31]. Numerous studies have found associations between physical and psychiatric disorders among general hospital inpatients and outpatients. For example, Mayou *et al* [32] reported that around one-quarter of those with major physical disorders suffer psychiatric disorder or other psychologically determined but medically unnecessary complications, which may cause adverse effect on quality of life, poor compliance with effective medical treatments and possibly some effects on long term physical morbidity and mortality. The authors also noted that "medically unexplained" symptoms are extremely common in both primary care and hospital care settings. Many of these problems result in persistent distress and disability, which are often difficult to treat and associated with a huge use of medical resources [33]. Research by Well *et al* [34] has documented at length the increased costs associated with co-morbid medical-psychiatric illness, the negative impact of psychiatric illness on the functioning of medical patients, and the generally poor quality of psychiatric care in the primary care setting. They also reported that the combination of depressive symptoms and advanced coronary artery disease was associated with a two-fold greater decline in functioning compared to either condition alone.

Elderly patients with hip fracture who were screened and assessed for psychiatric morbidity have a shortened length of stay and have increased rates of home versus institutional placement than hip-fracture patients who do not receive psychiatric intervention [35]. Thus, both clinical qualities as well as economic value are improved by psychiatric interventions in many medical-surgical disorders with co-morbid psychiatric disorders [36].

Furthermore, recent findings suggest that psychiatric disorder may interfere with recovery from physical illness. More recent evidence indicates that mood may affect physical outcome. For example, patients with acute coronary syndrome (ACS), (a collective term for myocardial infarction (MI) and unstable angina pectoris), that are also depressed have much higher morbidity and mortality [37]. Ten percent of patients with ACS, at discharge have been reported to fulfil ICD-10 criteria for depression using a self-completed questionnaire and three of four of these have a moderate or severe depression, equivalent to DSM-IV diagnosis of major depression [38]. Other studies where depression has been assessed through a non-diagnostic questionnaire measuring different psychological or somatic symptoms have even reported a higher rate of 15-40% [39,40,41]. Luutonen *et al* [39] also affirmed that having depressive symptoms after myocardial infarction was not a transient phenomenon and that less than one quarter of patients with depressive symptoms at the beginning were free of them at 18 months. Coronary patients with moderate or severe depression are as affected as their psychiatry counterparts and should therefore be treated in the same way [38]. Management plan for cardiac patients should therefore include assessment and treatment of depression, since treatment of depression leads to improvement in health status and is associated with better outcome [42]. This situation causes increased financial costs and emotional pain, which can be decreased by behavioural intervention. Data leaves no one in doubt that psychological factors affect the development and outcome of co-morbid disease state and calls for active involvement of C-L psychiatrist in the management of patients in the somatic wards. Varoy [43] asked this question: "If obvious psychopathology is neglected or missed when the clinical picture strongly features somatic findings, who is better than the psychiatrist to provide guidance for our colleagues?" It is the psychiatrist who possesses

the complete set of skill for assessing and managing the complex biopsychosocial issues involved [6].

Future projection

For the practice of C-L psychiatry, the development in the developed countries sounds a success story, but the success is modest and the future is uncertain if C-L psychiatry continues to restrict itself to conspicuous acute psychiatric disorder and does not strive to have an impact across the whole of medical care [33]. C-L psychiatry must focus on the sub-threshold disorders and the somatizing presentations of emotional distress that lead to over utilization of health services while continuing to treat the psychotic patients [6].

Furthermore, psychiatry must be guided by the axiom that it is our duty to maintain intellectual and clinical leadership for the psychological system in its entirety, not just that bit of it that can become psychotic [6,43]. C-L psychiatrists should be involved in carrying out more research, more so when there are still many areas yet untouched [2].

Our universities and medical schools need to take fresh and thorough look at our educational programmes [43]. Psychiatry as a major clinical neuroscience should be integrated at all levels of the teaching of medicine [43]. There is also the need for improved training in neurology and organic psychiatry for all departments at undergraduate and postgraduate levels [25].

Lastly psychiatry liaison services should be expanded in general hospitals and to general practitioners and this may be one of the ways to solve the problem of stigmatization.

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