The Role of Liaison Psychiatry

Outside the Traditional Paradigm in the Teaching of Medicine

Liaison psychiatry is the area of mental health sciences that addresses the psychiatric approach to the patient with a medical-surgical pathology, whether in- or outpatient. Already in the seventies, Zbigniew Lipowski, one of the founding fathers of this discipline, described the three fields supporting it: the clinical work, the education role and the development of different lines of research (1).

The second one of these, teaching, is based on a non-traditional paradigm in teaching medicine, addressed to medical students, residents in psychiatry and other areas, medical assistants in different specialties and health professionals in other disciplines, such as nursing, psychology and social work (2).

Without discrediting the classical formal education based on personally attended classes or structured clinical sessions, the liaison psychiatry favors a system of practical teaching, focused on the importance of psychiatric aspects and their interaction with somatic elements in each one of the treated cases, at the patient's bedside, during the clinical intervention and, above all, while the team that requested the interconsultation is being feedbacked. (2-4).

Different authorities in this subject agree that this process must be carried out based on this medical paradigm (2-4) That is, special emphasis is made on a horizontal relationship, where the leaguage used, the type of relationhip, and the intervention strategies are based on a practical, schematic and, above all, a clinical lecture, that furthermore combines the other two work spheres of the liaison psychiatry.

Psychiatry, however, has historically shown humanistic lines that are not lost when this subject is addressed (5). The traditional respect towards the patient and human suffering, above all at emotional level, must be an element conveyed to the rest of the hospital staff as part of a sensibilization

process towards mental pathology and the different available strategies, which sometimes are unknown to the rest of the health team, such a psychotherapy in its diverse tendencies and even pharmacotherapy.

When these elements are evaluated together, it is evident that this teaching process refers to a bi-directional interaction (2-6), in which the specialist in liaison psychiatry is receiving information and education from different fields, and this, at the same time, allows strengthening and complementing the integral vision one has towards the physical pathology and its relationship with emotional and psychiatric components.

A particular situation arises with the medical students: by the time they are in their third or forth year of their undergraduate studies, they have generally been exposed to a series of prejudices, myths and preconceived ideas on mental pathology. In this sense, the education by means of the classical asylum psychiatry does not contribute to eliminate these precepts; on the contrary, in many cases they are increased by it. The main risk is then that the apprentice ends up considering mental disease as something apart from the field of action of medicine and most of its specialties.

Consequently, liaison psychiatry finds itself in a unique position to show the variety of vicious circles that are established between the physical and mental pathology and the importance of their detection (6), whichever the field where the future physician is going to work later on. In other words, it has the capacity to show the psychiatric aspect of any medical condition and, as such, the student will have a better diagnostic ability and a practical therapeutic vision. The above is complemented by the incorporation of the medicine paradigm based on evidence, applied world-wide in many training programs of different specialties (7).

According to the World Health Organization (8), the neuropsychiatric disorders are four of the ten main causes for discapacity all over the world. Depression ranks fourth, but it is estimated that by 2020 it will rank first or second, as a consequence of the increase in armed conflicts, migrations, poverty and natural disasters. During 2002 it was estimated that 154 million people were suffering from depression.

Furthermore, it is known that there exist a very high prevalence of physical and mental comorbidity, that this relationship generally goes unnoticed and that when both states coincide and are not treated, the long-term functional prognosis and mortality are drastically increased (2-6).

In this sense, the IMPACT collaboration studies (9-11) have scientifically demonstrated that the psychiatric intervention on community patients, who previously had not been diagnosed with some mental disorder, not only allows reducing medical care costs (12), but also improves survival and multiple medical parameters in diabetic patients (13), elderly (14) or patients with pain and arthritis (15). All this is carried out in collaboration with primary care physicians who, accordingly, should be sensibilized as to this issue since they were students.

The above generates different questionings with respect to the teaching planning in medical schools: Is the time dedicated to psychiatry teaching during undergraduate studies proportional to the possible exposure to mental diseases during the future practice of the profession? Should psychiatric teaching be focused on pure mental pathology or, on the contrary, should it put special emphasis on its link with physical entities to which statistically the general practitioner or specialist will be most exposed? Need the general health professionals be part of this continuing education process? Is there any academia dedicated to the prevention of mental entities as a way to avoid future development of medical-surgical diseases?

The aim is then to contribute in this way to one of Lipowski's initial aims when he founded the still valid theoretical bases of the liaison psychiatry: to equate medicine in general with mental health, in such a way that the historical gap as regards resources and care is reduced, favoring truly integral health models, based on the actual needs of the world's population.

Ricardo Millán-González
MD psychiatrist, specialist in Liaison Psychiatry
Teacher of Psychiatry, Universidad de Costa Rica
Unidad de Neurociencias, Hospital Dr. Rafael Ángel Calderón Guardia
and Centro Costarricense de Investigaciones Médicas

References

1. Lipowski ZJ. Consultation-liaison psychiatry: an overview. Am J Psychiatry 1974;131(6):623-30.
2. Stern T, Fricchione G, Cassem N, Jellinek M, Rosenbaum J. Massachusetts General Hospital: Handbook of general hospital psychiatry. Mosby: New York; 2004.
3. Gitlin DF, Levenson JL, Lyketsos C. Psychosomatic medicine: a new psychiatric subspecialty. Acad Psychiatry 2004;28(1):4-11.

4. Kornfeld DS. Consultation-liaison psychiatry: contributions to medical care. Am J Psychiatry 2002; 159(12):1964-72.
5. Smith FA, Querques J, Levenson JL, Stern TA. Psychiatric Assessment and Consultation. FOCUS 2005; 3(2):241-51.
6. Millán-González R. Psiquiatría de enlace: hacia una verdadera integración de la medicina. Medicina, Vida y Salud 2009;2:36-37.
7. Guyatt G, Rennie D, Meade MO, Cook DJ. JAMA evidence: Users' guidelines to the medical literature. New York: McGraw-Hill Medical; 2008.
8. World Health Organization. Ministerial Round Tables 2001. 54th World Health Assembly. Geneve: World Health Organization; 2002.
9. Unützer J, Katon WJ, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, et al. Depression treatment in a sample of 1,801 depressed older adults in primary care. J Am Geriatr Soc 2003;51(4):505-14.
10. Unützer J, Katon WJ, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, et al. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. JAMA 2002; 288(22):2836-45.
11. Oishi SM, Shoai R, Katon W, Callahan C, Unützer J, Arean P, et al. Impacting late life depression: integrating a depression intervention into primary care. Psychiatr Q 2003;74(1):75-89.
12. Katon WJ, Schoenbaum M, Fan MY, Callahan CM, Williams J Jr, Hunkeler E, et al. Cost-effectiveness of improving primary care treatment of late-life depression. Arch Gen Psychiatry 2005;62(12):1313-20.
13. Williams JW Jr, Katon W, Lin EH, Nöel PH, Worchel J, Cornell J, et al. The effectiveness of depression care management on diabetes-related outcomes in older patients. Ann Intern Med 2004;140(12):1015-24.
14. Noël PH, Williams JW Jr, Unützer J, Worchel J, Lee S, Cornell J, et al. Depression and comorbid illness in elderly primary care patients: impact on multiple domains of health status and well-being. Ann Fam Med 2004;2(6):555-62.
15. Lin EHB, Katon WJ, Von Korff M, Tang L, Williams JW, Kroenke K, et al. Effect of improving depression care on pain and function among older adults with arthritis. Journal of the American Medical Association 2003;290(18):2428-29.