

CONSULTATION-LIAISON PSYCHIATRY AT THE PRINCE OF WALES HOSPITAL-A NEW LOOK

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SUMMARY

Consultation-liaison (C-L) psychiatry has aroused world-wide interest as well as controversies in recent years. The preliminary experience of setting up a full-time C-L team at the Prince of Wales Hospital is reported. It is suggested that despite definite theoretical and practical limitations, this has the tripartite potential of improving clinical service, undergraduate and postgraduate education, as well as facilitating collaborative research in psychosomatic medicine.

INTRODUCTION

While the need for psychiatric care to patients in a general hospital is no longer disputed (Maguire et al, 1974), the necessity of creating a subspecialty for the specific purpose of psychiatric consultation remains debatable. In fact, consultation work has never been treated as a possible subspecialty in any branch of medicine apart from psychiatry. However, in the past ten years, substantial clinical and research work has accumulated in this domain of psychosomatic medicine. In the United States, for example, consultation-liaison (C-L) psychiatrists have succeeded in defining their expertise, theoretical framework and hence subspecialty status (Lipowski 1981 & 1986; Pasnau, 1988). In particular, their work has opened up new frontiers for psychiatric investigations, including psychiatric diagnosis in the medically ill, study of disease mechanisms, systematic evaluation of biological and psychosocial treatments, and health service research (Cohen et al, 1986). Standardization and computerization of C-L data, which serve the multiple purposes of auditing, training and service development, have also been actively under way (Hammer et al, 1985; Hengeveld, 1988).

In the United Kingdom, due to financial constraints and a different organisation of health service, C-L psychiatry has not been formally recognised as a subspecialty, but is treated as a 'special interest' instead. Nevertheless, since 1982, the Royal College of Psychiatrists has formed its own Liaison Group that continually examines various issues in the field. Despite a persistent degree of skepticism, the recommendation by the College that 'liaison psychiatry

should be an integral part of all approved training programmes' (Royal College of Psychiatrists, 1988) to a certain extent reflected the increased recognition of the need for more organised C-L training for future psychiatrists. Since then, various groups have held regular meetings (Anderson, 1989; White, 1989; Jenkins, 1990; Mayou, 1990; Guthrie, 1991), and the teaching of liaison psychiatry to undergraduate students has received increasing attention (Lloyd, 1980; Priest, 1983). Part of this growing interest is likely to result from the realization of the limitations of the medical disease model, the appeal of holistic management, and the expectation of a higher standard of medical care from the public (Engel, 1977; Lipowski, 1989).

The organisation of C-L service in a general teaching hospital is usually targeted at three main levels, namely clinical service, training potential and research prospect (Lipowski, 1990). These three targets are interrelated, and the relative amount of time spent on each depends on the resources and the particular orientation of the psychiatrist-in-charge. Though in conflict at times, they can potentially be streamlined, provided there is right planning.

Although full-time consultation service is available in a few general hospitals in Hong Kong, no full-time C-L psychiatrists, to our knowledge, have ever existed in Hong Kong. This paper gives an account of the first six months' activities of our consultation team at the Prince of Wales Hospital.

THE TEAM MEMBERS

Our C-L team at the Prince of Wales Hospital was established in July 1990, and belongs to the adult unit of the

Department of Psychiatry, Chinese University of Hong Kong. It deals with adult patients aged 16-65, as patients outside this age range are dealt with by the child and psychogeriatric psychiatrists respectively. The team consists of a consultant who overlooks the service, a qualified psychiatrist who assumes the immediate supervisory role and establishes liaison with various subspecialties, a full-time registrar with at least one year's previous experience in adult psychiatry, and an intern rotated to psychiatry. There is also a part-time clinical psychologist providing mainly inpatient psychiatric service.

THE CLINICAL SERVICE

The registrar and the staff psychiatrist are responsible for seeing consultations (which average about three daily) from various clinical departments except the Accident & Emergency Department (A & E) (Consultations from the A & E department are dealt with by the registrar on call, and supervised by the corresponding team leader). There are a total of three clinical rounds a week, and one of them is dedicated to monitoring the progress of patients in their wards. The nature of the consultations varies and their distribution over a given period can easily be generated from our C-L database system. They range from assessment of suicidal risk, confusional states and psychological component of somatic complaints, to advice on psychotropic medication, fitness for baby care in the postpartum period and terminal care. Liaison service with the renal unit, our only formal liaison with another department at the moment, includes predialysis and pre-transplant assessment.

Although a full-time psychiatric consultation service has existed at the Prince of Wales Hospital since its opening in 1984, in those days requests for consultation were distributed on a rota basis to various psychiatrists (Lai & Tsoi, 1985), who tended to be preoccupied with other duties and often lacked a sense of full commitment to C-L work. Partly because of the constraints caused by such an arrangement, it proved difficult for qualified C-L psychiatrists or major research work to emerge in the subsequent years. With the new system, the C-L psychiatrists are totally involved in consultation work, while other psychiatrists in the unit can be relieved to have more time to work with other general psychiatric patients. Since the establishment of the team, the response time in seeing consultations has been shortened. Most of the patients are attended to on the same day as the requests are received. Less commonly, they are seen on the following day. Urgent phone consultations are handled more efficiently as the C-L registrar can be identified easily. From this point of view, C-L psychiatry may not really be as 'expensive' as it sounds. Moreover, such increased efficiency allows us to establish better communication with the consultees, cuts the waiting time by patients, and helps easing the strain on the shortage of beds. More importantly, deepened contact with other branches of medicine may help to clarify the long misunderstood role of psychiatrists, and decrease stigma-

tization of the mentally ill by nonpsychiatric staff. Our initial impression indicates that the current arrangement is welcome by various specialties.

Apart from offering various recommendations and psychotherapeutic measures, a great deal of emphasis is put on the respect for privacy during psychiatric assessment, establishment of rapport, and the social needs of patients. Follow-up sessions in the ward are provided as required, while an outpatient C-L clinic has also been set up to monitor progress after discharge. Patients requiring inpatient treatment, such as those who are persistently suicidal or floridly psychotic, are taken over to our psychiatric wards for further management.

THE EDUCATIONAL AND TRAINING PERSPECTIVE

The consultation service in its current structure furnishes not only a more organised training program for psychiatric trainees, interns and medical students, but its full-time nature also enables the staff psychiatrist to acquire more intensive clinical experience and commitment to his work.

After seeing consultations, the registrar is supervised in the clinical rounds, during which cases are presented and discussed. Patients with diagnostic or management problems are seen by the whole team in the wards concerned. The number of cases and their clinical data are monitored with the help of a computer programme which makes the supervisory work more efficient. Besides, the programme makes it possible to print a case summary that helps the trainee to formulate the diagnosis and management plan. Finally, written replies to consultations are scrutinised before the trainee writes up his final formulation.

The intern is attached part-time to the consultation team. Exposure to a variety of consultations and active participation in clinical rounds are encouraged. As many interns will not necessarily end up pursuing psychiatry in the future, we believe this will encourage him to develop a more holistic view of patient care.

Medical students are rotated in small groups to the team on a 2-weekly basis, and they are taught both at the bedside and in clinical rounds. Each group takes turn to present a consultation case at the weekly teaching round, in which the registrar and intern also participate. The use of audiovisual facilities including portable videotaping (e.g. an alcoholic exhibiting florid visual hallucinations during delirium tremens) is maximized. In the teaching round, dichotomous biological or psychosocial views are discouraged, while a holistic approach is emphasized. Indeed, C-L teaching symbolizes one major philosophy of our undergraduate medical teaching. Thus, instead of an exclusive emphasis on conventional psychiatric disorders such as schizophrenia and affective psychosis, we aim to make our students good physicians, surgeons or pediatricians, by paying due attention to the psychosocial dimensions of illnesses (Lee, 1990). Recently, we are delighted to find that some students, historically, have applied for attach-

ment to the C-L team during their elective clerkship. This may indicate that students find C-L teaching relevant to their medical training, and welcome more exposure in this area. Though difficult to assess now, this may mean considerable long-term gains to psychiatry as a whole.

The team members, because of their experience in psychosomatic medicine, are also involved in the teaching of advanced courses in nursing such as renal and intensive care, which are generally well received.

RESEARCH PROSPECTS

The improved communication with various clinical departments, better follow-up service and an efficient data storage system promise potential for research. Joint venture with other specialties, which facilitates the sharing of viewpoints and mutual learning, is one of the goals of psychosomatic research. At present, research projects on cognitive impairment among patients undergoing hip surgery, and psychosocial predictors for success of peritoneal dialysis, are being planned and carried out. Finally, a comprehensive database auditing system, apart from allowing easy retrieval of clinical data, permits useful statistical manipulation, which may guide future planning of our C-L service.

OUR LIMITATIONS

Mayou(1987) once remarked that 'Liaison psychiatry is very much a North American creation.' Outside North America, indeed, development of the subspecialty is still in its infancy, while the validity of its expertise and its cost-effectiveness have been seriously challenged. Furthermore, the conflict between 'liaison' and 'consultation' in C-L work has not been clearly settled (Hackett, 1981). The U.K. system has tried to limit itself mainly to the consultation model, i.e. 'Liaison psychoatry is concerned with the psychiatric accompaniments of physical illness, the somatic presentation of psychiatric illness and the assessment of patients following deliberate self-harm' (Royal College of Psychiatrists, 1988). Up to 1987, in fact, there were less than ten full-time liaison psychiatrists in U.K. and Ireland (Mayou, 1987).

Locally, we anticipate difficulties in asking for additional manpower for various reasons: namely, shortage of psychiatrists in the mental health service as a whole, 'vagueness' of the subspecialty concept, and finally its still unconfirmed training status. Given such restriction on resources, our C-L team has focused mainly on the consultation model, with a view for further expansion in the future. However, even at the consultation level, we have, for obvious manpower problem, failed to include A&E patients for regular assessment. Furthermore, the issue of whether we should provide consultation service for referrals from other specialist outpatient clinics at the Prince of Wales Hospital remains to be solved. Currently, these referrals are treated as similar to new referrals from sources outside the hospital, with a potentially long waiting time. As for treatment, we still fall short of a true multidisciplinary team

approach. For example, the consultation-liaison service provided by clinical psychologists is largely independent of the activity of our team, and we have a part-time clinical psychologist only as a back-up service for inpatients. Due to the lack of manpower, psychiatric nurses and social workers are not directly involved in our work.

Other loopholes exist concerning training at the registrar level. Although his full-time exposure to consultation work for six months is wide, formal postgraduate teaching in C-L psychiatry, say in the form of lectures and seminars, has remained meagre. Up till now, for examples, standard guidelines for dealing with common problems such as assessment of suicidal risk and child-caring ability in the puerperal period, have not been clearly laid down yet. It is hoped that with gradual buildup of experience and a better collection of literature on C-L psychiatry, a more structured training program will be available in the future.

Overall speaking, true liaison with other specialties has remained limited while research activity is scanty. Contributing factors include both heavy clinical workload and general skepticism towards the role of psychiatrists. This is partly reflected by the observation that a significant proportion of the consultations are merely directed at 'disposal.' Such an atmosphere tends to deter cooperation and joint venture. Not uncommonly, liaison with other specialties is first established on a personal basis rather than by formal meetings. Understandably, the best result would occur if the C-L psychiatrist had classmates in every other specialty! Nonetheless, it is hoped that with more time and contact, the biopsychosocial model will gain wider acceptance among medical staff, doctors and nurses alike.

CONCLUSION

The role of a C-L psychiatrist is special in that his expertise centres on the borderland between psychiatry and other branches of medicine. He needs to be truly 'psychosomatic,' and can neither be a mindless physician nor a brainless psychiatrist, so to speak. It has even been predicted that the subspecialty will ultimately develop into a real 'psychiatric medicine' (Haupt, 1989). However, one must not be over-optimistic. Critics, for example, have emphasized that C-L psychiatry has generated neither new ideas nor therapies, and its research has not led to major findings (Lipowski, 1986). Furthermore, training may be demanding as it encompasses experience in medicine as well as a sound base in psychiatry. This tends to turn away bright 'general psychiatrists' who may not be keen to establish intimate links with their medical colleagues. Besides, psychotherapeutic skills that can potentially expedite recovery, such as hypnosis, require drill and even a degree of talent. Finally, a full liaison service appears costly in the current climate of a serious shortage of qualified psychiatrists in Hong Kong. We believe, however, that when realistically tailored to local needs and resources, an organized C-L psychiatric service is a potentially promising endeavour. Apart from offering a much needed link with our

other fellow medics, it has, from our still limited experience, the potential of providing a better standard of patient care, a more systematic educational programme, and possibilities for joint research. Even if its subspecialty status remains controversial in Hong Kong, more unbiased attention, especially from skeptics, is suggested.

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