Psychological Medicine, 1980, **10**, 11–14
Printed in Great Britain

EDITORIAL

Whence and whither 'liaison' psychiatry?[1]

For much of its history psychiatry has been conspicuously absent from the general hospital, a setting which should be one of its more natural habitats. Cartesian dualism and alienist attitudes have cast a lingering shadow.

Attention to the emotional factors associated with physical illness has always been an essential part of good medical practice but it is only relatively recently that organized psychiatric services have been provided to the medical and surgical departments of general hospitals. This interface of psychiatry with other medical specialties has come to be known as 'liaison' psychiatry. Sometimes the term 'consultation-liaison' is used, thereby emphasizing two distinct but related processes. In this sense, consultation refers to the assessment and advice on treatment of a particular patient in response to a request from another specialist. Liaison, on the other hand, has much broader aims whereby psychiatry is seen as having a preventive, as well as a therapeutic, role (Strain & Grossman, 1975). The psychiatrist becomes an integrated member of a clinical team, attends ward rounds and conferences, and holds teaching sessions for the other staff. Lipowski (1974) has described the psychiatrist here as mediating between patients and staff to maintain communication, allay conflicts and prevent the deterioration of clinical care.

It is doubtful whether liaison psychiatry can be considered a discrete subspeciality. The term refers rather to a style and locus of practice; it is best regarded as an ill-defined area of interest in which the psychiatrist has particular skills to contribute to the care of the physically ill and to those in whom psychiatric disorder presents in somatic terms. This involves close collaboration with other doctors whom the patient initially consults. Usually this collaboration occurs within a hospital setting, but it could also take place at the level of primary care.

Liaison psychiatry, as we now recognize it, is largely an American phenomenon. Its development can be traced back at least fifty years (Henry, 1929), although the term 'psychiatric liaison' first appears to have been used in the 1930s to describe the department at Colorado General Hospital, Denver (Billings, 1936, 1937). Similar units were gradually established elsewhere (Greenhill, 1977) and particularly close links with other disciplines were forged by Romano, Engel and their colleagues at Rochester, New York (Kehoe, 1961; Engel, 1967). At about this time psychosomatic medicine, of which liaison psychiatry is probably an offspring, was attracting increasing interest and support. However, some of the claims of the psychosomatic movement concerning mental and physical interaction in disease did much to discredit psychiatry; in this case the parent was more wayward than the child. Fortunately, psychiatry's contribution to medicine survived the eclipse of the various psychosomatic hypotheses and a resurgence of interest in liaison psychiatry has been one of the characteristic features of the American scene in recent years. The remarkable extent of its growth has been described by Lipowski (1978). Between 1974 and 1978 the Psychiatry Education Branch of the National Institute of Mental Health in Washington increased the funding for training psychiatrists in liaison work by 270%; liaison programmes thus consumed one-fifth of the Branch's disposable funds. As a result, there have been increases in the numbers of residency programmes providing liaison training and of post-residency fellowships. Other prominent writers have attested their belief in the importance of this area of psychiatry (West, 1973; Hackett, 1977; Moore, 1978; Eisenberg, 1979) as American psychiatry at large seeks to re-integrate itself within the medical family.

There has been much less recognition of liaison psychiatry in Britain, despite reports a decade ago of fruitful collaboration between physicians and psychiatrists (Crisp, 1968; Macleod & Walton,

[1] Address for correspondence: Dr Geoffrey G. Lloyd, Department of Psychological Medicine, Royal Infirmary, Edinburgh EH3 9YW.

0033-2917/80/2828-4800 $01.00

1969). British psychiatry has probably not felt the need to emphasize its medical identity but, more importantly, its organization and manpower deficiencies have prevented as extensive an involvement with other specialties as exists in the United States.

There is certainly abundant evidence that physical and psychiatric morbidity frequently co-exist (Maguire & Granville-Grossman, 1968; Maguire *et al.* 1974; Eastwood, 1975), and several mechanisms can explain this increased association (Lloyd, 1977). The presence of psychological problems has been shown in several studies to have an adverse effect on the outcome of illness (Querido, 1959; Cay, 1968; Morris *et al.* 1977). In addition to those with established somatic disease, a hospital population will contain many with somatic symptoms who show no evidence of any form of physical illness. Shepherd *et al.* (1960) found that 38 % of a consecutive series of patients attending a medical out-patient clinic had psychiatric disability but no physical illness. These and other studies indicate that the need for an effective psychiatric liaison service within the general hospital is indisputable.

Referral rates to the psychiatric department vary considerably between hospitals and all are much lower than the reported prevalence of psychiatric morbidity. As an isolated observation this discrepancy is not necessarily a cause for concern because not all psychiatrically ill patients require specialist treatment. Physicians and surgeons treat many patients themselves and are ideally placed to do so, while other patients improve spontaneously with resolution of their physical illness. The appropriate rate of psychiatric referral will depend on a number of factors, many of them local, and it is not possible to generalize about this. However, there is evidence that much psychiatric morbidity is unrecognized, particularly if the emotional symptoms are unobtrusive and do not create problems for the medical staff (Maguire *et al.* 1974). Moffic & Paykel (1975) diagnosed depression in 43 out of 150 medical in-patients; only two of these had been referred to a psychiatrist and in only six did the notes refer to depression. Similar observations have been reported by Knights & Folstein (1977).

Psychiatrists rightly complain of the under-diagnosis of psychiatric symptoms in the physically ill but there are also complaints by non-psychiatrists about the quality of psychiatric service provided. Mason (1975) has expressed a physician's view which highlights many deficiencies and which regrettably is all too common. In particular, Mason criticizes psychiatry for being not readily available, remote in thought and inclined to express opinions in a style which alienates physicians. His comments echo the findings of Mezey & Kellett (1971) who, in a survey of hospital specialists, found that dissatisfaction with the psychiatric services and lack of rapport with the psychiatrists were important factors militating against psychiatric referral.

There are major conceptual differences between psychiatry and general medicine but these should not disguise the poignancy of many of the criticisms directed at the psychiatric services within general hospitals. They lend weight to those who advocate a closer liaison between the various specialists, a liaison which, to be effective, will have to involve greater integration in thinking as well as location. This is unlikely to come about unless staffing provisions are altered so that more psychiatrists are able to be based entirely within the general hospital and to devote adequate time to liaison activities. In his description of the typical consultant psychiatrist's working week, Russell (1973) was unable to allocate any time for general ward consultation, although he acknowledged that the establishment of general hospital psychiatric units would increase demands for this activity. Much of the available time has been taken up with the assessment of patients admitted after suicide attempts. When Anstee (1972) reviewed psychiatric referrals at Guy's Hospital and compared them with the findings at the same hospital ten years earlier (Fleminger & Mallett, 1962), he found that the rate had doubled. This was almost entirely explained by the increased number of admissions for attempted suicide; when these patients were excluded there had been very little change in the rate or pattern of referrals. Higher rates of referral are reported from units and hospitals where close liaison has been established (Crisp, 1968; Hackett, 1978). Indeed, Crisp has claimed that the psychiatrist is able to influence the amount of consultation he is called to do according to his availability and inclination. If closer inter-disciplinary collaboration means that more psychiatrically ill patients are diagnosed and treated, then this is obviously to be encouraged.

While advancing psychiatry's aspirations, one must avoid a repetition of the exaggerated claims which characterized the psychosomatic enthusiasts of the 1940s. A leading article in 1937 warned

against excessive psychiatric pretensions, fearing that non-psychiatric colleagues who took the ardent claims of psychotherapists too seriously might become disillusioned and derisive (*Lancet*, 1937). This advice was not followed; it would be wise to heed it now.

Already there are signs that liaison psychiatry is expanding its boundaries (Faguet *et al.* 1978). It should be remembered that there are virtually no evaluation studies of the effectiveness of liaison services (Greenhill, 1977) and that expansion without foundation is a hazardous exercise. Psychiatry in a general medical setting will probably be most effective if it limits its role to detecting and treating patients with demonstrable psychiatric disorders and to increasing staff awareness of these problems. This will inevitably mean stronger links with certain units, especially those dealing with intensive care, oncology and rehabilitation.

Few hospitals will be able to match the extensive facilities which have been developed at leading American hospitals, notably those described by Hackett (1978) at Massachusetts General Hospital Boston. For the majority, the more ambitious prophylactic aims of liaison psychiatry should be set aside until adequate care can be provided for patients with co-existing physical and psychiatric problems. In any case, some liaison functions may be carried out effectively by other professions and the expanding role of the nurse-clinician (Bilodeau & O'Connor, 1978) is one which deserves careful assessment. Research is needed into means of identifying patients who are especially vulnerable to emotional complications during physical illness. Appropriate psychiatric intervention can then be evaluated with regard to its influence on outcome in social, psychological and physical terms.

Another development of liaison psychiatry which merits further scrutiny is its potential in medical student education. Established methods of teaching psychiatry do not appear very attractive to those on the receiving end (*Lancet*, 1979), and Mason (1975) has complained that psychiatry is presented as an esoteric subject whose relevance to everyday medicine is not made apparent. This criticism might be countered if more psychiatry were taught in medical wards and clinics. Besides demonstrating the relevance of psychiatry to medicine, such teaching would emphasize the essential part played by medicine in psychiatric practice, in contrast to other areas of psychiatry where a medical degree often seems redundant. A few medical schools have initiated teaching sessions on medical firms, and programmes already exist where the entire psychiatric clerkship is spent in this environment (McKegney & Weiner, 1976).

Liaison psychiatry needs no apologists. Its existence is justified by the poor mental health of the physically ill and by the fact that the needs of these patients are not being met at present. Psychiatry in the general hospital is here to stay.

GEOFFREY G. LLOYD

REFERENCES

Anstee, B. H. (1972). The pattern of psychiatric referrals in a general hospital. *British Journal of Psychiatry* **120**, 631–634.

Billings, E. G. (1936). Teaching psychiatry in the medical school general hospital. *Journal of the American Medical Association* **107**, 635–639.

Billings, E. G. (1937). The general hospital: its psychiatric needs and the opportunities it offers for psychiatric teaching. *American Journal of Medical Science* **194**, 234–243.

Bilodeau, C. B. & O'Connor, S. O. (1978). Role of nurse-clinicians in liaison psychiatry. In *Handbook of General Hospital Psychiatry* (ed. T. P. Hackett and N. H. Cassem), pp. 508–523. Mosby: St Louis.

Cay, E. L. (1968). The influence of psychological factors in the outcome of treatment of chronic peptic ulcer. M.D. Thesis: University of Edinburgh.

Crisp, A. H. (1968). The role of the psychiatrist in the general hospital. *Postgraduate Medical Journal* **44**, 267–276.

Eastwood, M. R. (1975). *The Relation Between Physical and Mental Illness*. Toronto University Press: Toronto.

Eisenberg, L. (1979). Interfaces between medicine and psychiatry. *Comprehensive Psychiatry* **20**, 1–14.

Engel, G. L. (1967). Medical education and the psychosomatic approach: a report on the Rochester experienc 1946–1966. *Journal of Psychosomatic Research* **11**, 77–85.

Faguet, R. A., Fawzy, F. I., Wellisch, D. K. & Pasnau, R. O. (1978). *Contemporary Models in Liaison Psychiatry*. SP Medical and Scientific Books: New York.

Fleminger, J. J. & Mallett, B. L. (1962). Psychiatric referrals from medical and surgical wards. *Journal of Mental Science* **108**, 183–190.

Greenhill, M. H. (1977). The development of liaison programs. In *Psychiatric Medicine* (ed. G. Usdin), pp. 115–191. Brunner/Mazel: New York.

Hackett, T. P. (1977). The psychiatrist: in the mainstream or on the banks of medicine? *American Journal of Psychiatry* **134**, 432–434.

Hackett, T. P. (1978). Beginnings: liaison psychiatry in a general hospital. In *Handbook of General Hospital Psychiatry* (ed. T. P. Hackett and N. H. Cassem), pp. 1–14. Mosby: St Louis.

Henry, G. W. (1929). Some modern aspects of psychiatry in general hospital practice. *American Journal of Psychiatry* **86**, 481–499.

Kehoe, M. (1961). The Rochester scheme: a medical-psychiatric liaison service. *Lancet* ii, 145–148.

Knights, E. B. & Folstein, M. F. (1977). Unsuspected emotional and cognitive disturbance in medical patients. *Annals of Internal Medicine* **87**, 723–724.

Lancet (1937). Referred to the psychiatrist, ii, 1496–1497.
Lancet (1979). Who puts students off psychiatry?, i, 481.
Lipowski, Z. J. (1974). Consultation-liaison psychiatry: an overview. *American Journal of Psychiatry* **131**, 623–630.
Lipowski, Z. J. (1978). Consultation-liaison psychiatry to-day. Paper read at Biennial Meeting of the New York State Psychiatric Association.
Lloyd, G. G. (1977). Psychological reactions to physical illness. *British Journal of Hospital Medicine* **18**, 352–358.
McKegney, F. P. & Weiner, S. (1976). A consultation-liaison clinical clerkship. *Psychosomatic Medicine* **38**, 45–54.
Macleod, J. G. & Walton, H. J. (1969). Liaison between physicians and psychiatrists in a teaching hospital. *Lancet* ii, 789–792.
Maguire, G. P. & Granville-Grossman, K. L. (1968). Physical illness in psychiatric patients. *British Journal of Psychiatry* **115**, 1365–1369.
Maguire, G. P., Julier, D. L., Hawton, K. E. & Bancroft, J. H. J. (1974). Psychiatric morbidity and referral on two general medical wards. *British Medical Journal* i, 268–270.
Mason, A. S. (1975). Critical review of the psychiatric services: a physician's view. *Medicine* (Second series) **11**, 510–512.
Mezey, A. G. & Kellett, J. M. (1971). Reasons against referral to the psychiatrist. *Postgraduate Medical Journal* **47**, 315–319.
Moffic, H. S. & Paykel, E. S. (1975). Depression in medical inpatients. *British Journal of Psychiatry* **126**, 346–353.
Moore, G. L. (1978). The adult psychiatrist in the medical environment. *American Journal of Psychiatry* **135**, 413–419.
Morris, T., Greer, H. S. & White, P. (1977). Psychological and social adjustment to mastectomy: a two-year follow-up study. *Cancer* **40**, 2381–2387.
Querido, A. (1959). Forecast and follow-up: an investigation into the clinical, social and mental factors determining the results of hospital treatment. *British Journal of Preventive and Social Medicine* **13**, 33–49.
Russell, G. F. M. (1973). Will there be enough psychiatrists to run the psychiatric service based on the district general hospital? In *Policy for Action* (ed. R. Cawley and G. McLachlan), pp. 111–116. Oxford University Press: London.
Shepherd, M., Davies, B. & Culpan, R. H. (1960). Psychiatric illness in the general hospital. *Acta Psychiatrica et Neurologica Scandinavica* **35**, 518–525.
Strain, J. J. & Grossman, S. (1975). *Psychological Care of the Medically Ill: A Primer in Liaison Psychiatry*. Appleton-Century-Crofts: New York.
West, L. J. (1973). The future of psychiatric education. *American Journal of Psychiatry* **130**, 521–528.