

# Why Guidelines for Consultation-Liaison Psychiatry?

ALAN STOUDEMIRE, M.D.  
HAROLD BRONHEIM, M.D.  
THOMAS N. WISE, M.D.

For hundreds of years, physicians have been aware that psychiatric factors increase the risk for the development and outcomes of physical disorders. Scientific confirmation of these clinical intuitions has been rapidly accumulating. At the basic science level, the field of psychoimmunology has documented that stress and depression can impair immunocompetency.<sup>1</sup> Psychocardiology research suggests that type A behavior, when associated with hostility, imparts higher risk for the development of cardiovascular disease<sup>2</sup>; that ventricular arrhythmias and myocardial ischemia can be induced by stress<sup>3</sup>; and that major depression is associated with exaggerated platelet reactivity, which can increase the chance of ischemic events in patients prone to cardiac and cerebrovascular disease.<sup>4</sup> Clinical research has not only revealed relatively high rates of psychiatric illness in most medical illnesses, but also that the presence of major depression negatively affects the outcome of some illnesses such as myocardial infarction.<sup>5</sup> Furthermore, patients with poststroke depression have a poorer prognosis and lower rates of functional recovery than patients who do are not depressed.<sup>6,7</sup>

Recent reviews have examined the literature on the epidemiology of psychiatric disorders in primary care, the impact of psychological factors on the onset and course of medical illness, intervention studies, and the impact of psychiatric education and training of primary care physicians.<sup>8-10</sup> Research by Wells et al. has documented at length the increased costs associated with comorbid 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.<sup>11</sup>

In well-conducted studies of patients in health care delivery systems, it has been documented that patients with depression incur twice the costs of nondepressed patients and that the costs associated with management of the depression are only a fraction of these increased expenditures.<sup>12</sup> Even when depression, anxiety, and somatization disorders are recognized by primary care physicians—which occurs in only about 50% of the cases—such recognition does not guarantee appropriate treatment.<sup>13</sup> Involvement of a consulting psychiatrist appears to be critical in improving depressed patient outcomes in the primary care setting. Katon et al. has developed models for co-management between family physicians and psychiatrists as well as educational and training models that have been proven to improve medication compliance and clinical outcomes, compared with “routine” or “usual” care by primary care physicians.<sup>12</sup> In similar efforts, Smith et al. developed models of psychiatric consultation in the identifi-

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From the Emory Central Clinic-Section of Psychiatry, Atlanta, Georgia; the Division of Consultation and Behavioral Medicine, Department of Psychiatry, Mt. Sinai Hospital, New York; and the Department of Psychiatry, Fairfax Hospital, Falls Church, Virginia. Address reprint requests to Dr. Bronheim, 1155 Park Avenue, New York, NY 10028.

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cation and management of patients with somatization disorders, with improved patient outcomes and dramatic reductions in medical utilization.<sup>14</sup>

Interventions in hospitalized patients are also effective. Both depression and delirium are associated with increased hospital lengths of stay. Elderly patients with hip fractures who are psychiatrically screened and assessed have a shortened length of stay and have increased rates of home vs. institutional placement than hip-fracture patients who do not receive psychiatric intervention.<sup>15</sup> Thus, both clinical quality as well as economic value are improved by psychiatric interventions in many medical–surgical disorders with comorbid psychiatric disorders.

The aforementioned data clearly document that psychological factors affect the development and outcome of comorbid disease states. Furthermore, the high rate of psychiatric illness that exists in both ambulatory, hospital, and long-term care settings is poorly recognized and managed.<sup>16</sup> This situation causes increased financial costs and emotional pain, which often can be decreased by behavioral interventions.

Given that health care delivery systems will continue to discourage specialty referrals such as psychiatry, we need to teach primary care residents and physicians the basic aspects of diagnosis and treatment exists, as well as, actively involve a consulting psychiatrist for more difficult patients. As psychologists, social workers, and nurses will be used for screening and psychotherapy because of lower costs, these individuals need and frequently request similar education in psychiatric diagnosis and psychopharmacology, as do non-psychiatric physicians.

Because of such cost factors, the psychiatrist has evolved as an expert diagnostician, psychopharmacologic expert, systems coordinator, and consultant/supervisor for complex patients. With a medical heritage and psychiatric expertise, the psychiatric physician is mandatory for any mental health team within a medical setting. It is essential that the psychiatrist be part of such teams.

The Academy of Psychosomatic Medicine, the society for psychiatrists working at the interface between medicine and psychiatry, has developed standards for the training of psychiatric residents in consultation-liaison psychiatry as well as established standards and an accreditation process for fellowship training in the subspecialty.<sup>17</sup> This organization formally examines and certifies fellowship programs in consultation-liaison psychiatry. In “The Academy of Psychosomatic Medicine Practice Guidelines: Psychiatric Consultation in the General Medical Setting,” Harold Bronheim, M.D., and associates

have comprehensively documented the integrated basis for psychiatric consultation and liaison in medical care.

Through these guidelines, the Academy documents the need for expert consultation in the general medical setting; outlines the knowledge base and clinical skills necessary to render quality care; and sets the basic standards for the diagnostic evaluation, psychotherapeutic, and pharmacologic treatment of this patient population.

Why are guidelines necessary?<sup>18</sup> The primary reason is to ensure that patients with psychiatric illness in medical-surgical settings receive the highest possible quality of care. Thus, the guidelines specify the special training, knowledge, and skills required to provide psychiatric consultation for medical patients and their physicians and delineate the appropriate areas of clinical expertise in this process for mental health professionals. Special emphasis is placed on fundamental components of psychiatric assessment (history taking; physical, neurological, and mental states examination; laboratory and neuroradiographic tests) as well as the process of consultation systems analysis. Treatment issues receive special attention as well and emphasize treatment intervention based on a biopsychosocial model. Hence, the intervention recommended should be based on a knowledgeable assessment of the biological/medical aspects of the patient, which may require additional medical testing, change, or adjustment of medications used to treat the patient's medical disorder, as well as specialized psychopharmacology for the medical patient. Special issues in psychotherapy for the medically ill are noted, taking into consideration the need for pragmatic, often shorter, forms of dynamic and cognitively based interventions to address the impact of acute and chronic illness on the patient's emotional equilibrium. The importance of family and social assessment and intervention in the treatment plan is also outlined. The third part of the guidelines discuss special issues such as supervision standards, ethical standards, research issues, and special considerations for medically ill children and adolescents.

These guidelines are not meant as a mandatory set of imposed standards that the psychiatrist must follow. Guidelines are meant to assist the physician in treating the patient; the uniqueness and necessities of each individual clinical situation is paramount. Ideally, guidelines should be based on well-developed scientific evidence such as controlled clinical studies. Because medicine is a continuously evolving field, guidelines by their nature are a hybrid construction from evidence based on scientific investigation and evidence based on consensus opinions from clinicians. The Institute of Medicine has outlined the process of developing guidelines that incor-

porates these principles.<sup>18</sup> The present guidelines represent such a hybrid, which is based on an extensive examination of the available scientific evidence as well as the consensus opinion not only of the task force but also of the members of the Executive Council of the Academy.

As the primary goals of medicine are the prevention of disease and the promotion of the health and well-being of the patient, we hope these guidelines will help achieve these ends by ensuring excellence in the clinical care of patients with combined medical and psychiatric illness.

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