State of Consultation-Liaison Psychiatry in India: Current status and vision for future

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ABSTRACT

Over the years Consultation-Liaison (C-L) psychiatry has contributed significantly to the growth of the psychiatry and has brought psychiatry very close to the advances in the medicine. It has also led to changes in the medical education and in the providing comprehensive management to the physically ill. In India, although the General Hospital Psychiatric units were established in 1930s, C-L Psychiatry has never been the main focus of training and research. Hence there is an urgent need to improve C-L Psychiatry services and training to provide best and optimal care to the patients and provide best education to the trainees.

Key words: Consultation, liaison, psychosomatic, India

"Consultation-Liaison Psychiatry provides a fit vantage point for watching the changes that permit prediction of future directions in psychiatry as a medical discipline. The kind of psychiatry that the consultants practice and the type of training, skills, and professional attitudes that their work requires represent a model that is likely to prevail in psychiatry in the coming years".[1]

INTRODUCTION

Consultation-liaison (C-L) psychiatry as a subspecialty has been defined as the area of clinical psychiatry that encompasses clinical, teaching and research activities of psychiatrists and allied mental health professionals in the non-psychiatric divisions of a general hospital.[1] C-L Psychiatry is derived conceptually from the old tradition, which advocates a ceaseless dynamic interaction between mind and body. It has brought psychiatry out of the mental asylums to the general hospitals and has also contributed significantly to the reduction of stigma that follows mental illness not only among members of the public but within the medical professionals and establishments also. Over the years C-L Psychiatry has contributed significantly to the growth of the psychiatry and has brought psychiatry very close to the advances in the medicine. It has also led to changes in the medical education and in the providing comprehensive management to the physically ill.

UNDERSTANDING THE TERM CONSULTATION-LIAISON

According to Lipowski, the designation “Consultation-Liaison” reflects two interrelated roles of the consultants. “Consultation” refers to the provision of expert opinion about the diagnosis and advice on management regarding a patient’s mental state and behavior at the request of another health professional. The term “Liaison” refers to linking up of groups for the purpose of effective collaboration. In the context of current C-L Psychiatry, liaison involves interpretation and mediation i.e., the consultant psychiatrist mediates between patients and members of the clinical team and between mental health and other health professionals, respectively.[1-4] Further the consultation and liaison are mutually complementary. A consultation encompass
three interlocked foci i.e., the patient, the consultee, and the therapeutic team. Hence for consultation to be most effective the consultant psychiatrist need to have personal contact with both the patient (including his family) and those taking care of him.[1]

However it, is important to understand the differences between the terms C-L Psychiatry and “Psychosomatic Medicine”. Psychosomatic medicine is conceptualized as a non-clinical discipline that is concerned with ideas such as “the interplay of biological and psychosocial factors in the development, course and outcome of all diseases.” In fact, the idea of psychological factors play an important role in the etiology of various physical disorders emerged from practice and theory of psychodynamic principles.[9] Hence, some authors consider C-L Psychiatry as the practical/clinical arm or an applied form of psychosomatic medicine.[6,7] The basic assumption of C-L Psychiatry is to integrate the information so as to provide optimal health care, which is sensitive to people’s needs, mindful of prevention, and economically sound.[1]

**HISTORY OF GENERAL HOSPITAL PSYCHIATRIC UNITS, POSTGRADUATE TRAINING AND C-L PSYCHIATRY IN INDIA**

Prior to 1930, mental health services in this country were confined to the mental hospitals. The C-L Psychiatry as a subspecialty started in 1930s with the establishment of general hospital psychiatric units (GHPUs). Dr Girindra Shekhar at R. G. Kar Medical College and Hospital, Calcutta started the first GHPU in 1933.[8] When one looks at this beginning, it can be said that we were not far behind United States, were the first viable general hospital psychiatric unit was opened in the Albany Hospital in 1902 by JM Mosher to bring psychiatrists into proximity with non-psychiatrists for training purposes and to provide psychiatric treatment that would favorably compare with neurotic and psychosomatic disorders. When one compares this growth of C-L Psychiatry in India with worldwide development [Table 1], the rapid growth of C-L Psychiatry in India coincided with that of development of the subspecialty in other parts of the world. When one compares this growth of C-L Psychiatry in India with worldwide development [Table 1], the rapid growth of C-L Psychiatry services in India coincided with that of development of the subspecialty in other parts of the world. In a survey of postgraduate training centres in India done in mid eighties, it was reported that 75% of the postgraduate training centres were in the general hospital setting. Although this survey did not assess the functioning of C-L Psychiatry services but pointed out that there was indifference to the psychosomatic rounds.[10] A National workshop on general hospital psychiatry was held in 1984 in Chandigarh and a series of articles were published in Indian Journal of Psychiatry in 1984 after the national workshop and with respect to post graduate training it was pointed out that “A workable

| Phases                          | Years                        | Major events                                                      |
|---------------------------------|------------------------------|------------------------------------------------------------------|
| Preliminary phase               | Pre-1900 to 1930             | Medical revolution, new role for hospital and medical school      |
|                                 |                              | First true general-hospital psychiatry unit was established at Albany Hospital in 1902 |
|                                 |                              | First clinical consultation psychiatry paper was published in 1929 by Henry |
| Organization/pioneering phase   | 1930s to late 1950s          | The term “liaison psychiatry” was used for the first time by Billings |
|                                 |                              | Academy of Psychosomatic Medicine founded in 1953                |
|                                 |                              | CL services established in many hospitals, using many different models |
| Developmental phase: Conceptual- | 1960–1975                    | Many publications devoted to CL psychiatry                       |
| development phase               |                              | Research in CL Psychiatry started accumulating                    |
|                                 | 1975–1980s                   | Rapid growth in number of CL services                             |
|                                 |                              | Formal organizational models and training programs established    |
| Developmental phase: Rapid-growth | 1980 onwards                 | Lipowski published 3-part review detailing scope and function of a CL service |
| phase                           |                              | NIMH training grants for CL programs began                        |
| Consolidation/retrenchment      | 1980 onwards                 | Consultation vs liaison debates                                  |
|                                 |                              | Rethinking objectives: No more proselytizing                     |
|                                 |                              | NIMH training grants reduced, reimbursement limited               |
|                                 |                              | Liaison nurses and behavioral medicine                           |

Unfortunately, initially establishment of GHPU in India was faced with strong resistance from the medical personnel and health administrators, who did not think beyond asylum concept of mental illness management. Due to this, till 1960 there were few GHPUs that were initially established in collaboration with Department of Neurology and were often called as neuropsychiatric clinics. However, 1960s saw a major rise in number of GHPUs and by late 60s-early 70s there were 90 GHPUs.[11] Some of these units also started running the residency training programs. All India Institute of Medical Sciences was the first GHPU unit to start postgraduate psychiatric training in 1962 and the first batch of post-graduate students passed out in 1964.[12]

Over the years GHPUs became popular and were found to be more accessible than the custodial care. With a firm footing in the general hospital these GHPUs also started providing C-L Psychiatry services in which psychiatrists showed their knowledge and skills in the management of neurotic and psychosomatic disorders. When one compares the quality of care offered to medical patients. This effort is considered to be a forerunner of the later med-psych unit.[9] In the context of history of C-L Psychiatry [Table 1],[10] C-L Psychiatry made a beginning in India when it was in the Organization/Pioneering phase in other parts of the world.
knowledge of psychiatry subspecialties like Child psychiatry, mental retardation, psychotherapy, alcoholism, drug dependence and psychogeriatric is advisable. Familiarity with psychosomatic medicine and liaison psychiatry is advisable. However, it was pointed out that GHPUs should make efforts to organize suitable training programmes to provide training in liaison psychiatry, psychosomatic medicine and organic brain disorders.

Over the years general hospital psychiatry became more popular and with the exception of few centres postgraduate psychiatry training in India is now more or less confined to the general hospitals. As per recent data of Medical Council of India, 112 Centres are providing postgraduate training in psychiatry and 246 MDs are awarded every year. Of these 112 centres, 109 are in the medical colleges or postgraduate institutes in a general hospital setting. Every year 124 candidates are awarded the degree of Diploma in Psychological Medicine by 55 centres; again 52 of these centres are in general hospital setting.

Although most of the psychiatry training in last 50 years has been provided in the general hospital psychiatric units in India, the C-L Psychiatry has never been the focus. Although Indian Psychiatric Society has made long strides in improving the psychiatry training in India and providing clinical care to general public, somehow, C-L Psychiatry has never been the focus. Over the years Indian Psychiatric Society has constituted specialty sections and task forces for various sub specialties; somehow C-L Psychiatry has never received a sub-specialty status. It is quite possible that C-L Psychiatry has always being considered as part of general adult psychiatry and it is presumed that all the training centres are providing adequate training.

In this context, Indian psychiatry has lagged behind many of the Western countries. In 2003, C-L Psychiatry was given the accredited subspecialty status in the field of psychiatry under the name “Psychosomatic Medicine” in United States. With well-established C-L Psychiatry subspecialty there are training guidelines with respect to C-L Psychiatry in United States and Europe. In United States American Psychiatric Association Council on Psychosomatic Medicine, the Psychosomatic Committee of American Board of Psychiatry and Neurology, and the Academy of Psychosomatic Medicine have defined the core competencies for Fellowship Training in Psychosomatic Medicine. The European Association of Consultation–Liaison Psychiatry and Psychosomatics (EACLPP) have given recommendations for the European countries which covers various aspects as to when during the training C-L rotation should be done, what should be the goals and objectives of the training and also lays down guidelines about the basic acquisition of knowledge, skills and attitudes for practice of C-L Psychiatry. Also provides guidelines for fellowship programme.

### CONSULTATION LIAISON MODELS WORLD WIDE VIS-A-VIS INDIA

Various models of psychiatric consultation are described in literature depending on the focus of consultation, function and focus of work. These models based on the focus of consultation include patient oriented approach, crisis oriented approach, consultee-oriented approach, situation oriented approach and expanded psychiatric consultation. In the patient oriented approach, patient is the primary focus of the consultant’s interest. It not only includes diagnostic interview and assessment of the patient but also includes a psychodynamic evaluation of the patient’s personality and reaction to illness. The crisis-oriented approach involves a rapid assessment of patient’s problem and coping styles and immediate therapeutic intervention to address the problem. In the consultee-oriented approach the motive of the consultee and his related difficulties and expectations are the major focus. The situation oriented approach focuses on the interpersonal interactions of all the members of the clinical team involved in the care of the patient for whom consultation had been sought are taken into consideration to understand the patient’s behavior and the consultee’s concern about it. The expanded psychiatric consultation model includes an operational group that involves the patient, the clinical staff, other patients, and the patient’s family, however the central focus is the patient for whom consultation has been sought.

Depending on the function the models of consultation-liaison include consultation model, liaison model, bridge model, hybrid model and autonomous psychiatric model. The traditional consultation model has patient as the focus. The liaison model has the consulting physician as the center of focus and in addition to providing consultation for the patient also involves teaching psychiatric and psychological aspects of patient’s problem to the physician and the clinical team. The bridge model basically involves the teaching role of a C-L psychiatrist for the primary care physicians. The hybrid model has psychiatrist as part of multidisciplinary team. In the autonomous psychiatric model the C-L psychiatrist is not affiliated to any department but is hired by primary care services. Depending on the focus of work the different models include critical care model, biological model, Milieu model and integral model. In the critical care model the C-L psychiatrists is attached to a critical care unit, like intensive care unit, cardiac care unit who is involved in patient care and redressal of issues of staff. The biological model lays emphasis on neuroscience, psychopharmacology and psychological management. The milieu model is based on interpersonal theory and involves group aspects of patient care, reaction and interaction of staff and understanding of ward environment. The integral model is usually agency based and involves providing psychological care as an integral factor of clinical and administrative need.
Depending on the model and available resources the composition of C-L team has been discussed in the Western literature. Accordingly the composition of C-L services has varied from single remote consultant to multidisciplinary teams. In general a multidisciplinary team is recommended. In recent times collaboration at the outpatient level with physicians and surgeons or primary care has also started and there are no fixed recommendations for the composition of the team. In general the composition of team is determined by local and feasibility factors.\(^5\)

As with other subspecialties of psychiatry, broadly the functions of a C-L psychiatrist can be divided into clinical work, teaching, administration and clinical research. The clinical work involves facilitation of the medical treatment of the patient. The liaison of C-L Psychiatry in general denotes the educational function of the same and the C-L Psychiatrists is expected to cater the patients, requesting physicians, nursing staff, patients' families and friends, and the health care system.\(^2\) In addition to this C-L Psychiatrist may be required to teach the trainees. The administrative functions of the C-L Psychiatrist depends on the setting in which they work and may involve measures like holding the patient in the emergency, involuntary hospitalization of patients and assessment of suicidal and homicidal patients. The C-L Psychiatry setting provides unique opportunity for research in the areas that are at the interface of psychiatry and medicine. Depending on the medical set-up over the years based on these functions of C-L psychiatrists many further sub-specialties like psycho-oncology and psycho-obstetrics have emerged.

Further, C-L psychiatrists are viewed as the most suitable persons to prepare primary care clinicians to manage these psychiatric patients. Further, due to biomedical sophistication in medical care, busy physician specialists have started expecting the hospital-based psychiatrists to assume some of the traditional roles of the primary clinical caretaker for their patients. Due to all this, consultation-oriented model has begun to prevail.\(^10\)

Unfortunately the practice of C-L Psychiatry is not well described in India. In a recent review of studies on C-L Psychiatry, Parkar and Sawant\(^23\) commented, “there is no specific philosophy or particular clinical context being identified in liaison psychiatry in India”.

Based on the studies available from India, broadly the C-L Psychiatry services at various centres focus on inpatient and outpatients. Studies which have been published in relation to the inpatient Consultation-Liaison Psychiatry services, most of these have been silent on the functional aspect of the services. What is evident is that, the C-L services are mostly in the line with the consultation model, in which on receiving a referral from the physician/surgeon, a psychiatrist evaluates the patient and psychiatric inputs are provided.

Department of Psychiatry at Post Graduate Institute of Medical Education and Research, Chandigarh has been one of the premier training center in general hospital setting, which provides training opportunity in C-L Psychiatry. The model followed at this center is described here and it is presumed that many other centres in India also follow similar model. Department runs C-L Psychiatry services round the clock to provide psychiatry inputs to all the inpatients and patients attending the emergency outpatients. The patients who are referred from other outpatients are usually seen in the psychiatry outpatient Walk-in-clinic. The C-L Psychiatry services have a faculty member who is incharge of the administrative part of the services and carries out regular audits on weekly basis with respect to the functioning of the services. All the faculty members provide supervision to the junior resident and the senior resident on daily rotation basis. With respect to the functioning part the services are organized as a three-tier system, in which all the cases are first evaluated by a trainee psychiatrist under the supervision of a senior resident psychiatrist and finally reviewed by a consultant psychiatrist. The trainee junior resident is usually posted for 3 months in the C-L Psychiatry services, besides having exposure of the same during the two-and-half year of his training in the form of evening on call duty on rotation for providing emergency on call C-L Psychiatry services. The junior resident is supervised by a senior resident who is posted in C-L Psychiatry services for a period of 6 months. The clinical evaluation focuses on psychiatric morbidity and its attribution to physical illness. The diagnoses are made according to the ICD system, and appropriate treatment plan is formulated, implemented and periodically reviewed. The teaching of clinical skills focuses on the elicitation of psychiatric signs and symptoms, establishing the relationship of psychological morbidity and physical illness, documentation of history from the medico-legal point of view, confidentiality issues, providing psychotherapeutic interventions and psychopharmacological intervention wherever required. All the patients are followed up on regular basis by the C-L Psychiatry team till discharge or death. Besides documenting the history in the primary treating team case records, the C-L Psychiatry team maintains its own records in which patient’s history (physical and psychological), treatment, investigation findings and follow-up etc are documented. The information from the C-L Psychiatry case records is summarized in a referral register under the following headings: age, sex, source of referral, physical diagnosis, reason for psychiatric referral, psychiatric diagnosis, management done and outcome. These case records and the register are monitored weekly for completeness by the consultant in charge of C-L Psychiatry services. Once the patient is discharged from the hospital, the case records are transferred to psychiatric outpatient service where the same psychiatric team provides the continuity of psychiatric care. In all cases, an effort is made to communicate with the primary physician about the psychological morbidity,
its relationship with physical illness and treatment of the same. In all cases the C-L Psychiatry team regularly also communicates with the other staff of the hospital involved in the patient care (e.g. nursing staff). The family members are also informed about the psychological morbidity and in cases, which require intensive psychiatric management; patient and family are advised to follow-up in the psychiatry outpatient. Patients who come for follow-up in the psychiatric outpatients are seen by the same C-L team (the junior resident, senior resident or the faculty members) to maintain the continuity of care.

Besides providing clinical services, the C-L Psychiatry services has two other basic components, i.e., teaching the trainee junior residents in psychiatry and other specialties, and having joint academic rounds. While the senior resident and the faculty members evaluate the case in the medical-surgical wards, it also provides good opportunity to teach basic clinical skills to the junior resident. The academic activities involve monthly psychosomatic rounds with Internal Medicine, General surgery, Pediatrics and Neurology. The psychosomatic rounds is attended by faculty members from psychiatry and the other concerned specialty in which a case of common interest is presented by a trainee junior resident of psychiatry and a trainee junior resident of the other specialty.

With respect to outpatient C-L Psychiatry services in India, again a consultation model is mostly followed at various centers[26] or only some research activities with special focus have been carried out[27,29] and a true liaison model is not evident from the available studies.

RESEARCH IN C-L PSYCHIATRY SUBSPECIALTY AND CONTRIBUTION TO MEDICINE: WORLDWIDE VIS-À-VIS INDIAN SCENARIO

C-L Psychiatry research has made major contribution to the practice of medicine. Broadly speaking C-L Psychiatry has brought forward the concept of psychiatric sequelae of medical disorders, contribution of psychiatric manifestations to the etiology, course and outcome of various medical illnesses. There have been landmark studies in diabetes, HIV/AIDS, coronary artery disease, cancer, and stroke. C-L Psychiatry has also highlighted the issues of management of various psychiatric disorders in the presence of comorbid medical illnesses, drug interactions of psychotropics with other medications, and medication induced psychiatric symptoms. The importance of role of psychiatric disorders in medicine can be understood from the fact that over the years there has been evolution of terms like psycho-oncology, transplant psychiatry, psycho-nephrology, cardiac psychiatry etc. The role of C-L psychiatrist in identification and appropriate management of delirium has contributed significantly to reduce the hospital morbidity and health care costs.[10,31] In fact proper identification of causes of delirium has led to change in designs of intensive care unit (ICU) and procedural changes in ICU management in the form of providing more periods of uninterrupted sleep, providing orientation as to time and place, and transfer of patients out of ICU setting as soon as possible.[31] Proper understanding of panic attacks in 1970s and 1980s, led to application of this knowledge in the C-L Psychiatry and demonstration of panic disorder in significant number of patients with chest pain and normal coronary angiograms.[32,33] This led to consideration of panic disorder as an important differential diagnosis of cardiac symptoms. This has led to more accurate diagnosis and therefore fewer unnecessary angiograms and more appropriate treatment of a relatively common and often disabling disorder.[34] Depression as an important risk factor for myocardial infarction and unrecognized depression leading to poor outcome in coronary artery disease patients is now an established fact.[31] Many clinical trials have been done to evaluate the effect of antidepressant on the outcome in the post myocardial infarction phase.[34-39] Findings on similar lines have been reported about impact of depression on the outcome of post-stroke patients.[40]

The liaison with neurologist has led to identification of various psychiatric manifestations of Parkinsonism and psychiatric symptoms in epilepsy. C-L Psychiatry has also played an important role in managing the medically ill patient who come up with the request to leave the hospital against medical advise and it has been found that most of these patients are very angry, very anxious, psychotic or demented.[31] By showing that sleep deprivation leads to higher number of errors and dysphoric mood in interns who are on duty for 48-72 hours C-L Psychiatry has also contributed to changes in the hospital policies with respect to the training and posting of the interns.[41] Studies have also highlighted how various surgical procedures can lead to different psychological outcome and hence have influenced what kind of surgery is practiced for a particular ailment.[42-44] C-L Psychiatry has also contributed to discussion about diagnosis like cancer more openly and acceptance of the same. It has also influenced the policy of “truth telling” in medicine and individualization of information disclosure as to “What truth, for which patient, at what time?”.[21,45] With the advancement in the field of organ transplant, C-L psychiatrists are not only required for pre- and post-operative evaluation of the recipient and potential donors, but they are also required to deal with a situation in which a potential donor, related to the patient, is reluctant to give up an organ but is unable to tell their family.[31] The role of C-L psychiatrists in HIV/AIDS can’t be underestimated in the present era. Studies have also shown that teaching primary care physicians as to how to apply psychiatric principles to the treatment of outpatients with hypochondriasis has lead to reduction in the medical cost.
Other important contribution of C-L Psychiatry to practice of whole medicine despite proliferation of technologies has been an attempt to preserve humanism in medicine, direction provided to communication skills of physicians and preservation of medical ethics in difficult situations. Today clinical ethics goes beyond issues of legal competency and theoretical ethical principles such as “autonomy” and “beneficence” and it requires a knowledgeable clinician with an understanding of psychological factors that are inherent in making life-and-death decisions. The role of C-L psychiatrist in end of life issues has also received significant attention.[31]

In contrast to West, research in C-L Psychiatry in India has been meager and has been recently reviewed by many authors.[25,46-49] Earlier studies [Table 2] have focused on the routine referral rates from the medical-surgical inpatients and in general concluded that the referrals rates in India are much lower (0.15-3.6%).[50-57] However, studies, which have screened all the patients for psychiatric morbidity, have reported higher morbidity rates (31%-34.5%)[58,59] and a study, which specifically evaluated the psychiatric morbidity in geriatric inpatients, reported morbidity rate of 49%.[60] Besides evaluation of psychiatric referrals rates, some of the studies have also presented the rate of psychiatric morbidity and usually these have been reported to be high (74.7%-83%).[54,55] Few studies have also evaluated the referral rates from emergency outpatients [Table 2].[61-63] Studies have also screened patients presenting to various outpatient departments (General Medicine, Cardiology, Gynecology)[27,28,30,64,65] for psychiatric morbidity and have reported a prevalence rate of 18.42% to 53.7%.

Studies have also evaluated the prevalence of various psychiatric disorders, personality features and influence of various interventions in patients with various physical illnesses. However, the studies have been few in number. A review of studies published in Indian Journal of Psychiatry from 1950-2010 shows that there are only 117 studies on psychiatric aspects of various physical illnesses [Figure 1].[70-186] Among the various group of patients studied issues of women mental health has received considerable attention. In general most of the studies which have been done have included smaller samples and have methodological limitations. There is lack of data originating in the form of a multicentric study. Besides the studies published in Indian Journal of Psychiatry, many studies have been published in

| Author          | Setting                                      | Sample Size | Prevalence of psychiatric disorders (%) | Referral rates (%) | Most common diagnosis (%)       |
|-----------------|----------------------------------------------|-------------|----------------------------------------|-------------------|---------------------------------|
| Prabhakaran[51] | Psychiatric referrals                         | 108         | –                                      | 1.4               | Abnormal behaviour (60.2)       |
| Parekh, 1968[52]| Psychiatric referrals of inpatients           | 60          | –                                      | 0.66              | Organic psychosis (41.6)        |
| Wig and Shah[56]| Inpatient referrals                           | 638         | 34.5                                   | –                 | Depression (47.9)               |
| Mathur[59]      | Screening of patients admitted with physical illness in a military hospital | 22          | 0.15                                   | –                 | Hysteria (19.2)                |
| Jindal and Hemrajans[60] | Inpatient referrals | 22 | 0.06 | – | Epilepsy and associated disorders (37.3) |
| Kelkar et al.[61]| Emergency outpatient referrals                | 100         | 87                                     | 5.4               | Neurosis (51)                   |
| Trivedi and Gupta[66] | Screening of causality register of the hospital | 204         | –                                      | 2.93              | Epilepsy and associated disorders (37.3) |
| Malhotra[54]    | Inpatient referrals                           | 336         | 74.7                                   | 1.48              | Organic brain syndrome (20.53)  |
| Sachdeva et al.[53] | Screening of medical inpatients              | 100         | 31                                     | –                 | Affective disorders (51.6)      |
| Bagadia et al.[64] | Screening of medical OPD patients            | 258         | 36                                     | –                 | Anxiety neurosis (18.60)        |
| Sriram et al.[50] | Screening of medical OPD patients            | 300         | 53.7                                   | –                 | Details not provided           |
| Bhatia et al.[65] | Screening of medical OPD patients            | 5000 females | 18.42                                 | 3.6               | Neurotic disorder (44.6)        |
| Srinivasan et al.[77] | Inpatient referrals                          | 672         | –                                      | 1.5               | Neurosis (31.1)                 |
| Bhattia et al.[81] | Emergency outpatient                         | 126         | 0.74                                   | –                 | Depression and organic mental disorders |
| Doongaji[88]    | Inpatient referrals                           | 110         | 49                                     | –                 | Neurotic depression (57.4)      |
| De and Ka[99]   | Screening of patients attending Gynec OPD     | 40          | 52.5                                   | –                 | Depression (95.23)             |
| Avasthi et al.[95] | Inpatient referrals to C-L Psychiatry team | 1245        | 83                                     | 0.65              | Organic psychosis which included delirium (25.5) |
| Bhogale et al. 2000[96] | Patients referred to psychiatry OPD from other specialities | 153 | – | 0.24%               | Neurotic, stress related, somatoform disorders (52.29) |
| Bhogale et al.[26] | Patients referred to psychiatry C-L services from other specialties | 185 | – | 1.94    | Neurotic, stress related, somatoform disorders (36.76) |
| Goyal et al.[27] | Cardiology OPD                                | 1000        | 75                                     | –                 | Panic disorder (36)             |
| Sood et al[99]  | Screening of all geriatric inpatients         | 528         | 49                                     | –                 | Depressive disorders (26.13)    |
| Grover et al[77] | Inpatient referrals                           | 3092        | 0.92                                   | –                 | Delirium (33.95)                |
| Sidana et al[95] | Emergency outpatient referrals                | 268         | 94.4                                   | 1.42              | Substance use disorders (15.67) |

Table 2: Studies showing psychiatric referral rates, prevalence of psychiatric morbidity in psychiatric referrals and the most common psychiatric diagnosis
other national and international journals. But in general the studies are few in number and limited group of researchers have worked consistently in these areas. The major areas of research by psychiatrists have been cancer (for details see review), pain, gynecological issues, HIV, dermatological disorders, diabetes mellitus and chest pain. Occasional studies have evaluated psychiatric morbidity and other aspects in diseases like Cushing disease, Acromegaly and Delirium. Some studies have also evaluated the usefulness of screening instruments in diagnosing common mental disorders in medically ill. Another major area of focus has been patients with deliberate self harm.

SOME OF THE IMPORTANT RECENT TRENDS

An important change in recent times has been the focus on the physical health of mentally ill subjects. Studies have shown that about 50% of mentally ill subjects have some or other form of physical illness. Further with the increase in life span, there is rise in geriatric population in India. These important trends again alarm us that a psychiatrist with good knowledge of C-L Psychiatry may be able to manage his patients in a better way in general.

OTHER SIDE OF THE COIN: PSYCHIATRIC KNOWLEDGE AND AWARENESS ABOUT PSYCHOLOGICAL ISSUES IN MEDICALLY ILL SUBJECTS IN PHYSICIANS AND SURGEONS

There has been a great debate about the dismal psychiatric training in the under-graduate level and most of the graduates who pass out from the medical colleges are unaware about the psychiatric disorders and the role of psychological factors in the manifestation, course and prognosis of various medical and surgical illnesses. Indian Psychiatric Society has made many attempts to improve the training in psychiatry at the undergraduate level and recently also submitted its recommendations to the Medical Council of India for the undergraduate training in psychiatry. The lack of knowledge about psychiatric disorders at the undergraduate level is never rectified if a trainee opts for any other branch and hence remains deficient in these skills. However, some of the physicians and surgeons because of their own interest make efforts to gain this knowledge and apply the same in their clinical practice. The fact that many physicians and surgeons are deficient in their psychiatry knowledge was exemplified in a survey in which 87% of the physicians and surgeons opined that they would have been helped if there undergraduate training in psychiatry had been better. Ninety-one percent of the physicians and surgeons also opined that development of C-L psychiatric units would definitely help in improving the care of the patients with psychiatric problems in non-psychiatric units in general hospitals. It was also seen that many of the clinicians underestimated the psychiatric morbidity in their patients. Some of the clinicians also pointed out that there was a need for public awareness and education about the psychiatric disorders. Another survey of general practitioners and specialist also showed that they felt deficient in their psychiatric skills provided to them during their training and were eager to learn more about management of their psychiatric cases. However, if we want to sensitize the undergraduate students about psychiatry, besides providing knowledge about primary psychiatric disorders, there is equal need to educate them about the role of psychological factors in causation, precipitation and management of various physical illnesses.

Figure 1: Number of Studies published in Indian Journal of Psychiatry from 1949 to 2010 on psychiatric aspects of various physical disorders
WHERE DO WE GO FROM HERE: VISION FOR FUTURE

The role of psychological factors in the etiology of various physical disorders emerged from practice and theory of psychodynamic principles. However, over the years, focus of mind and body has not received much attention. This is understandable, because over the years the main focus has been on improving the reliability of psychiatric diagnosis. With the improvement in reliability of psychiatric diagnosis and understanding of neurobiology, there is evidence to suggest that psychiatric disorders have underlying biological underpinnings. The neurobiological research in primary psychiatric disorders, suggests that there are neurochemical, neuroanatomical, functional changes in the brain and dysfunction in the endocrine system in various psychiatric disorders. However, in the process of improving the reliability of psychiatric disorders and understanding their biological correlates, the mind-body interaction has somehow not received its due attention.

Physical comorbidity in mentally ill subjects has generated significant interest in the recent times and importance of the same in holistic management of psychiatrically ill patients cannot be over-emphasized. Further now there is emphasis on providing psychiatric care at the primary care level, where patients frequently have physical comorbidity and psychosomatic symptoms. Hence, whatever way it is looked at now, it is increasingly been accepted that mind and body cannot be seen separately and both the aspects need to be addressed together for better patient outcome.

Although most of the psychiatric care in India is provided through the Government funded GHPUs, GHPUs in private medical colleges, multispecialty private hospitals, the focus of training has never been on C-L Psychiatry. One argument can be that there is mismatch between the available trained manpower and the requirement of the community; hence the focus of services and training has been on treating the patients with primary psychiatric illnesses. However, it is now important to remember that we can not see patients of psychiatric disorders and those with physical illnesses in isolation and there is a need to focus on both the aspects while catering to these patients and training the residents. Hence, integrated approach, which focuses on both the aspects, i.e., psychological aspects of physical illnesses and physical comorbidity and its impact on psychiatric disorders, is important. Besides training the resident in diagnosing and managing primary psychiatric disorders, the training should also focus on C-L Psychiatry. Further, C-L Psychiatry as a subspecialty should be looked as an important component of child psychiatry, geriatric psychiatry and community psychiatry training. Efforts to enhance C-L Psychiatry services so as to improve clinical services, training and research at the GHPUs can enhance the quality of care to large extent. Taking the availability of the human resources into consideration, consultation model at the start can be useful. The centers which have well established consultation model should go beyond it and establishment of true consultation-liaison model with certain medico-surgical specialties; in which psychosocial issues are very important in overall management can be very useful.

With regard to training of residents, making a proper diagnosis, communicating with the primary treating physician and other treating team members, documentation of psychiatric history from medico-legal point of view, reviewing the cases from time to time, learning to provide non-pharmacological treatment in a non-psychiatric set up and use of psychotropic medications in medically ill subjects must be emphasized. Psychiatry resident should at least have 3-4 months of training exclusively focusing on the C-L Psychiatry. Besides the resident undergoing training in psychiatry, trainee doctors undergoing residency in other medical and surgical specialties can also be targeted, so that they are sensitive to the psychological aspects of medical illnesses. Having common clinical case conferences or psychosomatic rounds can do this to some extent. In addition didactic lectures covering various topics can be helpful. Centers with well-established C-L services can start fellowships programmes of 6 months to 1 year to provide training to interested candidates. Starting of this kind of programme will have 2 fold advantages. One, it would help in enhancing the available human resource in providing services and second it would also enhance the skills and training of the candidate. Besides focusing on the psychiatrist there is need to enhance the training of other mental health professionals like nurses, clinical psychologists and social workers so that they can provide some of the basic inputs to improve the mental health and care of medically ill subjects.

Beyond the efforts of establishing services and training at the specific institute levels, having a task force of Indian Psychiatric society on psychosomatic medicine/C-L Psychiatry may be useful, which can focus on holding regular continuing medical education (CMEs) programmes on various aspects of C-L Psychiatry. Further, coordinating with other scientific societies of various disciplines in holding joint conferences to enhance skills of specialist from other discipline can be considered.

In future elderly with medical illnesses, those with metabolic syndrome and diabetes, patients with heart disease with depression and anxiety, the HIV-infected population living under conditions of stress and depression, and those patients in need of physical rehabilitation will require lot of psychiatric inputs. Many of these patients will require use of behavioral measures like relaxation exercises and cognitive behaviour therapy. The training and research should focus on some of these areas with priority to meet the need of the needy population.
There is an urgent need to carry out research in this area with the aim of developing indigenous instruments, models of practice and intervention to improve overall outcome of patients. Many of the patients seen in C-L Psychiatry services also don’t fit into clear diagnostic categories as described by the current nosological systems. Hence there is need to develop diagnostic models which can fit the symptomatology of various disorders in the C-L Psychiatry set up. Further it is important to carry out multicentric studies to have a better countrywide data that can ultimately be translated in providing mental health care at the primary care level.

CONCLUSIONS

C-L Psychiatry has a rich tradition knowledge base. The relationship of psychiatry with other medical illnesses has progressed from the phases of psychodynamic understanding of medical symptoms, subsyndromal symptoms of various primary psychiatric disorders to diagnosing syndromal psychiatric disorders. In future, with emerging research and role of epigenetic in various psychiatric and physical illnesses, new clinical challenges are going to emerge which will further enhance the role of a psychiatrist who is well equipped to deal with psychological issues in medically ill subjects and has better understanding of the comorbidity. Hence there is a need to improve CL psychiatry to provide best and optimal care to the patients and provide best education to the trainees.

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