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Careers in psychiatric specialities

6. Liaison psychiatry

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Definition

This speciality is predominantly concerned with the psychiatry of patients in the general hospital setting. It involves the psychiatric management of patients who present with physical symptoms, and the treatment of psychiatric illness in physically ill patients. In addition, it also includes the management of patients who deliberately self-harm.

Career prospects

Liaison psychiatry is only beginning to emerge as a speciality. The future pattern of development of services is therefore unclear, although there are an increasing number of special responsibility/interest posts being advertised.

Training requirements

There is, as yet, no specific, formal training programme for liaison psychiatry as with other subspecialities. In addition, however, to general psychiatry training, the psychiatrist should have had at least one year's experience of psychiatry in the general hospital setting, preferably as part of his/her higher psychiatric training. Additional post-registration training in general medicine is useful, and attainment of the MRCP qualification would undoubtedly be an asset.

Job structure

There are very few full-time liaison psychiatry posts; the majority of posts that are advertised are special responsibility or special interest posts. The style of service varies greatly, largely depending on the time available. The liaison consultant is likely to be responsible for the deliberate self-harm service, although this may be a co-ordinating role only. The role of the consultant can range from being an integral member of a medical/surgical team, to a less frequent consultative relationship with a medical/surgical firm. The former model of service delivery is more unusual and most liaison psychiatrists operate a consultation service only, seeing patients on the medical/surgical wards, and discussing their management with the appropriate medical and nursing staff. Further links can be fruitfully developed by participation in case presentations at medical meetings, and taking an active part in helping general medical staff to understand the relationship between psychological factors and physical illness.

Satisfaction and frustrations

The work of liaison psychiatry is interesting and challenging, as the psychiatrist is involved with the subtlety of the interplay between physical disease and psychological factors. Confidence is essential when dealing with patients with physical disorders, and great skill is required to engage and treat patients with somatisation disorders, who are often initially reluctant to be interviewed by a psychiatrist. It may be difficult to supervise psychiatric treatment programmes on busy medical and surgical wards, although the successful accomplishment of this can be rewarding.

When poor liaison exists, or if the liaison service is just developing, referrals tend to be the most intractable and difficult patients about whom the physicians/surgeons feel frustrated. The psychiatrist may be tested to see if he/she can miraculously cure them! As improved liaison develops, greater understanding of psychological factors in physical illness can lead to attitudinal changes in staff, with more realistic expectations of psychiatry, and more appropriate referrals. This can be very rewarding, although it may require patience, persistence and tact.

There have been complaints in the literature (see suggested reading) of poor referrals, reflecting poor liaison between psychiatrist and physician. Having to deal with liaison referrals late in the evening, when physicians are unavailable for discussion, is unrewarding work. Although psychiatric colleagues

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may favour a sectorised service, physicians find the allocation of patients by address irksome and incomprehensible. Very few liaison services have specialised in-patient facilities, so if the patient has to be admitted to a psychiatric unit, the psychiatrist loses the satisfaction of continuity of patient care. A common aggravation of liaison work is the lack of privacy when interviewing patients on medical wards. There are usually no interview rooms, and this means that some interviews are conducted in side rooms, broom cupboards or even toilets! It is essential for the new liaison psychiatrist to be assertive and see cases only if there has been adequate preparation of the patient by the physician and there is a quiet, private, facility in which to interview the patient. Without such a stand the psychiatrist's opinion may be disregarded. Another problem can be the initial wariness of nursing staff towards the psychiatrist, although it can be particularly gratifying to witness this change as the psychiatrist comes to be perceived as a valuable resource.

Research

Research in this relatively new field of psychiatry is burgeoning. It covers a wide spectrum including both biological and social aspects of psychiatry. There are numerous opportunities for collaborative projects with medical and surgical colleagues (many of whom are anxious for such a collaborator but have not found a suitable psychiatrist), to establish the role of psychological factors both in the aetiology and management of physical illness. Useful projects can still be done without sophisticated resources and prevalence surveys are still of value, if sensible comparison groups are chosen. In addition, there is increasing research interest in somatisation patients who present to the physician or surgeon with non-organic physical symptoms. Audit of liaison psychiatry services is clearly necessary, and some American work has already demonstrated that psychiatric intervention with certain group of patients reduces the overall cost of treatment and leads to improved patient care.

Conclusion

Most general consultant posts involve a degree of liaison psychiatry, and it is possible for any interested psychiatrist to develop this further. Unfortunately, too many consultants have not been exposed to proper liaison psychiatry as senior registrars and do not know how to go about developing a liaison service. It is well worth gaining first-hand experience in a specialised centre, as a senior registrar. Patchy development of more specifically liaison posts will continue, but such posts may be sparse and consequently difficult to obtain. Liaison psychiatry is a stimulating career choice, and may particularly suit a confident, clinically-orientated, psychiatrist who is able to communicate clearly and simply, and forge effective links with medical colleagues.

Further reading

Anderson, H. M. (1989) Liaison psychiatry in Scotland: the present service. *Psychiatric Bulletin*, **13**, 606–608.

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Sensky, T., Greer, S., Cundy, T. & Pettingale, K. (1985) Referrals to psychiatrists in a general hospital – comparison of two methods of liaison psychiatry: preliminary communication. *Journal of the Royal Society of Medicine*, **78**, 463–468.

Career information pack and poster

The Public Education Committee has recently produced a career information pack and two posters which are available for Careers Fairs free of charge, and are aimed particularly at medical students thinking of specialising in psychiatry.

The committee also hopes to produce a short video which should be available later on in the year, on 'The day in the life of a psychiatrist'.

Copies of the posters and the careers packs are available from Deborah Hart at the College upon request.

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