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Liaison Psychiatry and Psychosomatic Medicine, New Perspectives in Chile

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ABSTRACT

The urge of psychiatrists to acquire a specific set of knowledge to assess and treat the medically ill has opened the need for developing a subspecialty that systematizes years of this theoretical and practical area within mental health. Liaison Psychiatry and Psychosomatic Medicine becomes a relevant part of current medical practice and a key feature of a resolute health system. Several experiences from psychiatrists in general hospitals, in addition to the contribution from biomedical and social sciences, have brought international recognition to this specialized field of mental health. The history of liaison psychiatry in Chile shares a similar background with other experiences around the world and can be traced back to 1953. Even though the progress in this field is dissimilar across the region, we emphasize the fact that the local efforts are reflected in two major milestones: the publishing of the first Latin American textbook of Liaison Psychiatry and Psychosomatic Medicine and the development of a subspecialist two year training program in Liaison Psychiatry and Psychosomatic Medicine; the first in Chile and Latin America, which started teaching its first resident in 2016 and it will have its third titled subspecialist by the end of this year.

Keywords: Liaison psychiatry, Consultation-liaison, Psychosomatic medicine

INTRODUCTION

Current medicine moves towards an approach that considers human being in its integrity, evolving from an overpassed model of biomedical causality to one that takes account of psychological and social variables as fundamental in the health-disease process.

Even though the biopsychosocial framework has shown an exponential growth in the past few decades, with its general acceptance in the contemporary medical practice, it is remarkable how the fluid relationship between mental and body phenomena, psique and soma, can be traced back to the history of medicine in its entirety, from ancient Egypt, early medical references in China and the systematization of diseases as propose by Hippocrates, just to name a few examples.

In our recent history, this just passed century [1], the evolution of psychiatric and psychological care of the medically ill has grown exponentially. The magnitude of scientific advances in medicine, in addition to the ethical considerations brought by the end of the Second World War, became a fertile field to start taking account of the mental health requirements in the general hospital. This brings the development of initiatives that incorporate the psychiatrist in the day-to-day work of the classically somatic medicine.

Even though there is a long tradition of psychiatrists teaming with colleagues from other medical specialties, there is no unanimous agreement on how to call this specific field of work. It's believed that Johan Heinroth coined the expression psychosomatic in 1818 and that Felix Deutsch was the first to use the concept psychosomatic medicine in the 1920s [2]. Liaison psychiatry was used in the Psychiatry Service of Colorado General Hospital in the US [3]. Since then, there have been many names and different traditions on why use one specific designation over the other, revised elsewhere by the authors [4]. As a product of the local experience, the authors rather name this subspecialty as

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Liaison Psychiatry and Psychosomatic Medicine (LPPM), which reflects both the technical skills and knowledge required to treat mental symptomatology in the clinical setting and the theoretical studies of the mind-body relationship.

The urge of psychiatrists to acquire a specific set of knowledge to assess and treat the medically ill has opened the need for developing a subspecialty that systematizes years of this theoretical and practical area within mental health. Liaison Psychiatry and Psychosomatic Medicine gets relevant in current medical practice and becomes imperative in how a resolute health system should be conceived. The creation of the Group of Interest in Liaison Psychiatry of the Royal College of Psychiatrists in the 80s [5] and the recognition of Psychosomatic Medicine as a medical subspecialty by the American board of Medical Specialties in the US in 2003 [6], are pristine reflections on how the work of psychiatrist with medically complex patients in fields such as oncology, HIV, neurology and transplant medicine gets its proper recognition [7,8].

Several experiences from psychiatrists in general hospitals, in addition to the contribution from biomedical and social sciences, support the specific work ethos of the LPPM specialist [9]. There is a demanding atmosphere surrounding the somatic patient, so the proceeding of the psychiatrist can no longer be limited to answer medical and surgical consults; the LPPM specialist is an active part of the team and not a visitor from a distant psychiatric ward.

LIAISON PSYCHIATRY IN CHILE: HISTORY AND PERSPECTIVES

The history of liaison psychiatry in Chile shares a similar background with other experiences around the world; psychiatry units in general hospitals starts answering to colleagues from the rest of the hospital until the help from a mental health professional becomes part of the regular interactions in surgical or medical wards. Such is the case of Hospital José Joaquín Aguirre, in Santiago, Chile; the first general hospital in Chile with a Psychiatry Service, with its respective liaison unit or the Psychiatry Service of Hospital de Temuco, led by Dr. Martín Cordero from 1969 to 1973; a service with an active participation of patients and community members [10]. The pioneering public health system model designed in the 60s encouraged many psychiatrists and mental health professionals to integrate their work to the general health care until 1973, when Augusto Pinochet dictatorship disarticulated the organization of Chilean health care and progressively replaced it with one centered in health as a consumer good.

Since the return of democracy, several factors have come together to help the evolution of LPPM in Chile, like the recommendation from the Health Ministry in 2003 for including a Liaison Psychiatry module in the general psychiatry residence [11]. Unfortunately, this is just a recommendation, and the teaching in this subject is still very divergent and varies widely from one university to the other. Despite what can be considered as lack of uniformity, the local effort of psychiatrists working in LPPM is reflected in the conformation of a Group of Interest in Liaison Psychiatry, part of the Chilean Society of Neurology, Psychiatry and Neurosurgery (SONEPSYN), with monthly reunions that gather liaison teams from different regions of Chile. From an academic point of view, we have to emphasize the importance of publishing the first Latin American textbook of Liaison Psychiatry and Psychosomatic Medicine in 2016, a book that summarizes years of clinical experience and updated evidence based practice in this field. The conjunction of this fertile clinical environment and psychiatrists with widely diverse academic backgrounds and training experiences in different parts of the world, like England, Spain and Germany, just to name a few, sets the ground for one of our local most proud achievement: the development of a subspecialist two year training program in Liaison Psychiatry and Psychosomatic Medicine [12], the first in Chile and Latin America, which started teaching its first resident in 2016 and it will have its third titled subspecialist by the end of this year.

The relevant work of this subspecialty is manifested by such reasons as the high psychiatric morbidity rate in general hospital admissions, which goes from 27.7% to 38.7% [13]. A major concern and one of the main reasons on why a LPPM assessment is needed is in the case of what we call a “complex patient”, not only from a medical-somatic point of view but also from the behavior that he or she may present and the effect or response from the medical team. In this group of patients, the psychiatric comorbidity is overrepresented, with an estimation of 2-5 times more prolonged stays in the general hospital [14]. It is well documented that neuropsychiatric diagnoses such as delirium, raise the morbidity and mortality and that the cost for the general hospital administration can double when compared with patients that are not delirious during their in-patient stay [15,16]. A hospital management that considers an adequate implementation of a liaison psychiatry program has proven to be cost-effective and impacts in lowering the length of stay; a fundamental justification for investing in LPPM as a resource [17,18].

In our country, we can consider two main frames that highlight the effort of validating the work of conjoining mental health with the general health system. The first one is the incorporation of psychiatric diagnoses in a law that guaranties access and treatment of highly prevalent disorders (Law of Explicit Health Guarantees) where primary care and general practitioners have a main role in diagnosing and treating major depression, bipolar affective disorder and schizophrenia, and at the same time incorporates psychiatric care in other diseases such as HIV, transplant medicine, metabolic surgery, among others. The second one is the recently published Mental Health Management Model

(Management Model: The Mental Health Thematic Network in the General Health Network, 2018) were is explicitly stated that mental health care is a part of the general health network and even stipulates that highly complex hospitals should have a Liaison Psychiatry, Health Psychology and Psychosomatic Medicine Unit. Despite all of this, the implementation of such recommendations lacks of equity, mainly because of the disparity of incomes through different regions of Chile and one of the main liabilities towards mental health patients in our country; the lack of a Mental Health Law.

In conclusion, the history of Liaison Psychiatry and Psychosomatic Medicine advances at a staggering speed from the last century to the first decades of the new millennia. The robust core knowledge in this field is wide and its teaching results beneficial to health teams, and to our main goal: the wellbeing of our patients. This is why it is imperative to develop and standardize programs in training new clinicians and future leaders in this fascinating subspecialty.

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