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Consultation/liaison psychiatry practice: Combined medical and psychiatric consultations

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When patients present with physical symptoms but their physician believes that those symptoms are psychological in origin, we usually find that the patients are not prepared to understand or accept that their illness may be psychological [1]. Typically, we encounter two situations: Some patients may feel abandoned, or even unwanted, because they feel as if they are just pretending to be ill [2]. Other patients do not feel understood by their doctor when they try to express the suffering that they feel from their illness or may even feel rejected by their physician when talking about their beliefs. Those situations are not rare: Nimnuan et al. [3] found that 52% of new outpatients at a general hospital had at least one medically unexplained symptom (significantly higher in females; more likely to be younger, currently employed, and with higher educational attainment).

We decided to create for outpatients combined medical and psychiatric consultations with the internal medicine staff in the University Hospital of Lille because, during our work in consultation/liaison psychiatry, we saw a lot of those situations in which patients felt misunderstood and rejected by their doctor.

Our objectives in these consultations included optimizing the treatment of patients with somatic disorders and comorbid psychiatric disorders, helping patients presenting with a somatic expression of a psychiatric disorder, making it easier for reticent patients to make contact with the psychiatric staff, developing research into the overlap between somatic and psychiatric diseases, developing collaboration between the internal medicine staff and the psychiatric medical staff, and evaluating the effectiveness of integrated treatments.

We included three steps in these consultations: The first step consists of an ordinary internal medicine consultation in which physicians explain the problem to the patients which symptoms they do not understand from a biological point of view and why they require psychiatric help to find the best solution for the patients. Each physician would then ask a patient to come in for a combined consultation with a psychiatrist so that they could help the patient together.

The second step is the combined consultation itself, lasting for 1 h. First, the physician and psychiatrist discuss the case together for a few minutes before meeting a patient. They then let the patient come in, and the physician would explain the problem to the patient. The patient is given a chance to express himself or herself and to ask questions. The psychiatrist simply acts as a mediator. At this point, a change is made from a medical language to a psychopathological language. The psychiatrist then leads the consulta-

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tion (transition and redefinition of the symptoms). At the end of the combined consultation, the physician and psychiatrist write a joint letter to the general practitioner in front of the patient.

The third step follows the combined consultation itself: the physician and the psychiatrist discuss together and analyze the consultation, deciding on which management they would like to offer to a specific patient and to future patients (psychopathological explanations, medical explanations, and pragmatic management plans). They also discuss how they felt about the consultation from objective (e.g., looking for signs of depression) and subjective (e.g., the doctor–patient relationship) points of view.

Three kinds of situations characterized our practice over 1 year of combined medical and psychiatric consultations, during which we saw 100 patients:

1. A comorbid psychiatric disorder (57% of the consultations): For this, the doctors offered explanations and treatment and gave an appointment for a psychiatric consultation.
2. A somatic expression of a psychiatric disorder (mood disorder, anxiety disorder, and somatoform disorder; 41% of the consultations): The doctors helped patients put their symptoms into words (from soma to psyche) and a psychiatric appointment was given, but the physicians continued to see the patients during the psychiatric follow-up.
3. A psychiatric expression of a somatic disorder (2% of the consultations): Combined medical and psychiatric care was organized.

This type of practice has certain advantages. First, communication with patients is made easier because physicians start the consultation and then introduce the psychiatrists, with whom they work and whose opinion they have requested [4]. This is a three-way consultation, with a physician handing the torch onto a psychiatrist [2]. This avoids letting patients feel excluded or rejected and makes the first contact with a psychiatrist easier. The medical staff have the opportunity to find out what patients think, and they take countertransference into account in the doctor–patient relationship. It also helps in making a clear diagnosis, giving patients the feeling that they are justified in consulting. Combined consultations (1) improve the prognosis by treating comorbid psychiatric disorders and (2) encourage compliance by involving patients in working out a treatment plan together [5]. Physicians find this pragmatic psychiatric or psychotherapeutic intervention interesting, and it helps them look out for the psychological origins of disease in the future. Finally, because the psychiatrist simply acts as a mediator at the start of the consultation, this allows the physician and the patient to explore together other possible explanations for the patient's symptoms, other than a biological one, and to consider the subjective part of the symptoms.

There are limitations in these combined consultations, however, as there is the risk of paradoxically putting too much emphasis on the dichotomy between somatic and psychological symptoms because the physician and psychiatrist work in different fields. There is also the question of whether it is better to have sequential or combined consultations because the physician needs to have good knowledge of medical psychology for sequential consultations [6]. The medicoeconomic impact is difficult to estimate because it has to be viewed in the longer term. In France, there are additional administrative difficulties with combined consultations because it is not possible for patients to pay for two consultations at once, and this type of consultation is not recognized by the French Social Security because it lasts too long.

Combined medical and psychiatric consultations offer another vision of medicine—*subjectivity-based medicine*. This provides us with a new way of looking at psychosomatic medicine by examining the subjectivity of organic symptoms in the light of biological and objective definitions of diseases. This approach is a very useful tool in consultation/liaison psychiatry because it improves the doctor–patient relationship. We also chose this combined consultation method from a systemic point of view of liaison psychiatry [4] because patients in these situations do not ask for psychiatric help—because their psychological suffering is only expressed in their body. This systemic approach gives physicians the chance to request psychiatric care for their patients, without feeling that they have failed. It also helps the patients accept their need for psychological help better because their somatic symptoms make them think that they have a purely somatic problem. A three-way consultation is a good way of making the transition from somatic to psychological suffering.

Our future objective is to measure the medicoeconomic impact of this practice by looking for evidence of its cost-effectiveness because it is currently generally considered as being too expensive and is insufficiently recognized in public health policy.

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