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European guidelines for training in consultation–liaison psychiatry and psychosomatics: Report of the EACLPP Workgroup on Training in Consultation–Liaison Psychiatry and Psychosomatics

Wolfgang Söllner[a,*], Francis Creed[b],
European Association of Consultation–Liaison Psychiatry and Psychosomatics Workgroup on Training in Consultation–Liaison[1]

[a]*General Hospital Nuremberg, Nuremberg, Germany*
[b]*University of Manchester, Manchester, United Kingdom*

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Abstract

Objective: The European Association of Consultation–Liaison Psychiatry and Psychosomatics (EACLPP) has organized a workgroup to establish consensus on the contents and organization of training in consultation–liaison (C–L) for psychiatric and psychosomatic residents. **Methods:** Initially, a survey among experts has been conducted to assess the status quo of training in C–L in different European countries. In several consensus meetings, the workgroup discussed aims, core contents, and organizational issues of standards of training in C–L. Twenty C–L specialists in 14 European countries participated in a Delphi procedure answering a detailed consensus checklist, which included different topics under discussion. **Results:** Consensus on the following issues has been obtained: (1) all residents in psychiatry or psychosomatics should be exposed to C–L work as part of their clinical experience; (2) a minimum of 6 months of full-time (or equivalent part-time) rotation to a C–L department should take place on the second part of residency; (3) advanced training should last for at least 12 months; (4) supervision of trainees should be clearly defined and organized; and (5) trainees should acquire knowledge and skills on the following: (a) assessment and management of psychiatric and psychosomatic disorders or situations (e.g., suicide/self-harm, somatization, chronic pain and psychiatric disorders, and abnormal illness behavior in somatically ill patients); (b) crisis intervention and psychotherapy methods appropriate for medically ill patients; (c) psychopharmacology in physically ill patients; (d) communication with severely ill patients and dying patients, as well as with medical staff; (e) promotion of coordination of care for complex patients across several disciplines; and (f) organization of C–L service in relation to general hospital and/or primary care. In addition, the workgroup elaborated recommendations on the form of training and on assessment of competency. **Conclusion:** This document is a first step towards establishing recognized training in C–L psychiatry and psychosomatics across the European Union.
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Keywords: Consultation–liaison psychiatry; Education; Guidelines; Psychosomatics; Residency; Training

* Corresponding author. Department of Psychosomatic Medicine and Psychotherapy, General Hospital Nuremberg, D-90419 Nuremberg, Germany. Tel.: +49 911 398 2839; fax: +49 911 398 3675.

E-mail address: wolfgang.soellner@klinikum-nuernberg.de (W. Söllner).

[1] Members: Annette Boenink (Amsterdam, The Netherlands), Graca Cardoso (Amadora, Portugal), Silla Consoli (Paris, France), Francis Creed (Manchester, United Kingdom), Roland Burian (Berlin, Germany), Aasta Heldal (Oslo, Norway), Antonio Lobo (Zaragoza, Spain), Maximino Lozano (Madrid, Spain), Teresa Maia (Amadora, Portugal), Susanne Maislinger (Innsbruck, Austria), Philippe Renard (Liège, Belgium), Marco Rigatelli (Modena, Italy), Angelika Riessland-Seifert (Vienna, Austria), Wolfgang Söllner and Barbara Stein (Nuremberg, Germany), Frederic Stiefel (Lausanne, Switzerland), Peter Stix (Graz, Austria).

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Introduction

In the last two decades, the number of psychiatric consultation–liaison (C–L) services increased in most European countries [1,2]. Multicenter trials on care delivery and quality management in C–L were conducted by The European Consultation–Liaison Workgroup [3]. Besides C–L services run by departments of psychiatry, stand-alone C–L services of departments of psychosomatic medicine and psychotherapy were developed in Austria, Germany, and Switzerland [4,5].

In spite of quantitative growth and the growing expertise of C–L psychiatry and psychosomatics, there are large differences in the consultation–liaison experience of residents at different sites and from different residency programs. There are serious shortcomings and unacceptable variations of the standard of training in this specialty of psychiatry across European Union (EU) countries [6–9]. This contrasts markedly with several other parts of the world, notably Australia and New Zealand [10], Canada [11], and the USA [12,13], where guidelines for residency training and advanced training have been established. In the USA, training in C–L psychiatry was supported by the National Institute of Mental Health in order to develop psychiatric and psychosocial care in general hospitals. Psychosomatic medicine has recently been recognized as an official subspecialty of psychiatry, with its own board examination and certification.

The European Association of Consultation–Liaison Psychiatry and Psychosomatics (EACLPP) was formed in 1997 to improve the management of patients with psychiatric disorders and psychological problems in medical settings by promoting the advancement of scientific knowledge and clinical practice in the field of C–L psychiatry and psychosomatics [14]. It aims to: (a) improve information exchange among members of the association and to educate the general public regarding C–L psychiatry and psychosomatics; (b) develop and promote standards for the training and practice of C–L psychiatry and professional conduct within the field; and (c) provide a forum for the presentation, dissemination, and discussion of scientific problems in C–L psychiatry and psychosomatics through the organization of meetings, conferences, workshops, and publications.

These guidelines for approved training in C–L psychiatry and psychosomatics have been prepared in relation to Item (b) above. It reflects a consensus drawn from representatives of EU countries prior to the enlargement of the EU in 2004.

Methods of the consensus procedure

An EU-wide workgroup (members are listed above) that derived these training guidelines was established in 2001. The following actions were undertaken to achieve a consensus on standards of training and to establish national and European guidelines:

-*First expert meeting in Leiden in 2001* This meeting commenced the process of defining the form and content of specialist training in C–L psychiatry and psychosomatics. It demonstrated wide diversity between training programs throughout Europe.

Consequently, we undertook a survey on training in C–L using a semistructured questionnaire with 13 items on the existence, organization, contents, didactics, implementation, and accreditation of training. One leading C–L psychiatrist in each European country[2] (among them the national representatives of the EACLPP) was asked to fill out the questionnaire (Appendix A). Sixteen representatives from the following countries answered the questionnaire: Austria (one psychiatrist and one psychotherapist), Belgium, Denmark, France, Finland, Germany (one psychiatrist and one psychosomaticist), Italy, The Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom.

-*Second expert meeting in Lisbon in 2002* Consensus was derived on the basic training for residents, and the first steps towards European guidelines were taken.

-*Third expert meeting in Zaragoza in 2003* European guidelines on training for residents in C–L psychiatry and psychosomatics and on advanced training (fellowship) were proposed and discussed in small groups and plenary sessions.

The results of the expert meetings were documented in detailed protocols.

A formal *Delphi procedure* [15] was then conducted. Delphi begins with an open-ended questionnaire or with preselected items (drawn from reviews of the literature or interviews with selected content experts) that are given to a panel of experts to solicit specific information about a subject or content area. In subsequent rounds of the procedure, participants rate the importance of individual items and also make changes to the phrasing or substance of the items. Through a series of rounds, the process is designed to yield a consensus. In our case, a panel of 20 experts in the area of C–L psychiatric and psychosomatics from 14 European countries took part in this procedure. They agreed or disagreed on a detailed preliminary consensus protocol, which was elaborated based on the protocols of the Lisbon and Zaragoza expert meetings. The protocol included 37 items concerning the objectives, contents, and organization of: (a) training in C–L for psychiatric residents, and (b) advanced training in C–L

[2] The questionnaire was sent out in 2002 before the enlargement of the EU to Eastern European countries.

(fellowship training). Panel members were also asked to make comments and to suggest rephrasings of the items.[3] The answers were collected by the first author and documented in a consensus report. There was high overall agreement already in the first round of the procedure (between 75% and 100%). During the two subsequent rounds, the results of previous rounds were fed back to panel members, and they were asked to re-rate the newly formulated items based on the results of the previous rounds. Finally, a ≥90% agreement was reached in all items.

Results

Results of the survey on training across EU

On general residency in some countries, C–L psychiatry or psychosomatics[4] forms part of the rotational training program. Rotation to a C–L service is *mandatory* in Spain (full time for 4 months) and Portugal (full time for 3 months on the third or fourth year of psychiatry training). It is *recommended* in Norway (full time for 6 months), the United Kingdom (full time for 6 months), and Germany (psychosomatics: half time for 3–6 months; psychiatry: no time frame). Mandatory training in C–L will be included in the residency in The Netherlands (in 2006) and Austria (in 2007). A mandatory 1-year rotation to internal medicine is required for psychosomatic specialty in Austria, Norway, and Germany. A 1-year rotation to neurology is required for psychiatric specialty in Austria and Germany.

In some countries, residents in the general program need a specified number of supervised consultations in C–L psychiatry or psychosomatics. In Germany, this equals 20 consultations [16]; in Italy, it equals 25 [17]. The number of seminars/case conferences required for approved training varies between 10 and 128 h in different countries. Some centers with extensive experience with C–L work offer short-term full-time C–L courses [18], which are attended by C–L psychiatrists and psychosomaticists from the respective countries but also from other European countries.

There are formal and published national guidelines for training in C–L psychiatry in the United Kingdom [19] and Spain [20], and in C–L psychosomatics in Germany [21]. In The Netherlands, guidelines were developed by The Netherlands Consortium of Consultation Psychiatry, which were later acknowledged by the Section of General Hospital Psychiatry of the Dutch Psychiatric Association [22].

Official recognition of *advanced training* in C–L psychiatry or psychosomatics exists in the following countries. In Finland, a 2-year approved training leads to the recognition of "special competence" in general hospital psychiatry [23]; in the United Kingdom, a special endorsement in C–L psychiatry as part of specialist training requires at least 1 of 3 years of full-time training in a C–L unit.

The following problems were observed in the current training on C–L psychiatry and psychosomatics:

1. Lack of clear objectives and lack of guidelines;
2. Very heterogeneous quality of teaching programs;
3. Lack of well-structured C–L units that can provide training;
4. Lack of full-time senior C–L psychiatrists who can teach/supervise trainees;
5. Lack of clear requirements for teachers;
6. Lack of training posts for rotation to C–L units;
7. Problematic rotation inside the C–L unit (continuity of care);
8. Lack of clarity regarding the role of experienced C–L nurses and psychologists in training programs;
9. Lack of evaluative research;
10. Concern on how the cost of this part of training will be covered.

Recommended training for residents in C–L psychiatry and psychosomatics

Goals and objectives of training

The training of residents during their rotation to a C–L clinical experience should take place on the second half of the residency and is based on the attitudes, knowledge, and skills acquired during their residency program in general psychiatry or psychosomatics. Rotation to a C–L unit should add specific attitudes, knowledge, and skills to the residency program. Graduates of residency training in C–L should be able to:

1. Develop basic competence based on a holistic biopsychosocial approach to treating patients with somatic and psychiatric comorbidity in inpatient and outpatient medical settings;
2. Understand the influence of psychological and social variables on somatic illness;
3. Perform comprehensive psychiatric evaluations of medically ill patients with psychiatric comorbidity;
4. Apply a range of psychiatric interventions for these patients, including crisis intervention, brief psychotherapy, and psychopharmacology;

[3] The consensus protocol may be obtained from the EACLPP Web site (www.eaclpp.org).

[4] In Germany, psychosomatic medicine is a specialty on its own, apart from general psychiatry and child psychiatry. In Germany and other German-speaking countries, both psychiatric and psychosomatic C–L services exist in tertiary-care general hospitals. Services differ in relation to the patients referred and the methods applied: patients with delirium and dementia are predominantly referred to psychiatric C–L services, and patients with anxiety or adjustment disorders are referred to psychosomatic C–L services. While general psychiatry runs consultation services and applies pharmacological treatment in most cases, psychosomatic medicine mainly runs liaison services and uses psychotherapeutic methods [4].

5. Effectively and quickly form a therapeutic alliance under a variety of clinical settings;
6. Appropriately communicate diagnostic and therapeutic information to medical colleges and other hospital staff members;
7. Critically evaluate and understand research in C–L psychiatry and psychosomatics.

Organization of recommended training

All trainees should be exposed to C–L work as part of their clinical experience in general psychiatry and psychosomatics. This, in itself, is inadequate, however, because (a) residents often have a heavy workload in general psychiatry and C–L component may be minimal; and (b) supervision of the C–L component is often inadequate because a consultant trainer has had no specific training/experience in C–L psychiatry/psychosomatics and/or because the supervision only covers the general psychiatry part of the resident's clinical work. For these reasons, we recommend training in C–L psychiatry and psychosomatics if it fulfils the following criteria:

1. *Full-time training* is strongly recommended. Part-time training must be a minimum of half of the equivalent full-time post. In this case, the kind and amount of other tasks of the trainee should be clearly defined, and there must be adequate protected time for C–L psychiatry and psychosomatics.
2. A minimum of *6 months* full-time or equivalent part-time rotation to a C–L department should take place on the *second part of residency* when trainees have already acquired basic knowledge and skills in general psychiatry and psychosomatics and can learn the more advanced skills of C–L work. This allows for the continuity of care of patients and communication with consultees. Ideally, they should perform *100 referrals* during this rotation.
3. The *principal training site* should be a general hospital in order to provide exposure to a broad range of patients. The trainee should gain experience with the most prevalent disorders and problems of patients with psychiatric and medical comorbidities. Ideally, during the rotation, the trainee should be assigned to units with liaison service.
4. Supervision of trainees should be organized with (a) a clearly designated and named supervisor; (b) clearly defined frequency and duration of supervision sessions; and (c) clearly defined individual and/or group supervision.
5. The *ratio between regular C–L team members and trainees* should be fixed so that a single trainer is not responsible for an excessive number of trainees.
6. Residents should either have *basic expertise in general medicine* prior to commencing their training in C–L psychiatry or obtain this as part of the training in C–L psychiatry. This is necessary in order to gain a clinical and theoretical understanding of the relationships between physical and psychological disorders. Higher levels of knowledge are expected in those areas of general medicine that particularly relate to psychiatric/psychosomatic practice.

Content of training in C–L psychiatry and psychosomatics

The trainee in C–L psychiatry and psychosomatics should acquire knowledge, skills, and attitudes.

Knowledge

1. Awareness of the different theoretical models used as bases of the subject (e.g., biopsychosocial, psychophysiological, and psychoneuroimmunological models);
2. Ethical and medicolegal issues (general ethical topics such as limitation of treatment and genetic testing, as well as special issues relevant to a particular country);
3. Assessment and management of the following clinical disorders or situations:
   (a) Delirium/dementia and other psychiatric disorders with organic cause;
   (b) Somatization;
   (c) Depression and anxiety in medically ill patients;
   (d) Suicide/self-harm (with special emphasis on the management of a medical unit and transference/countertransference issues);
   (e) Addiction problems in medical settings;
   (f) Abnormal illness behavior in somatically ill patients;
   (g) Coping with chronic disease and terminal illness;
   (h) Chronic pain;
   (i) Gender-specific disorders, sexual dysfunction in medically ill patients, and sexual abuse in specific patient populations (e.g., somatoform disorder and chronic pain);
   (j) Psychiatric comorbidity and psychological problems in child and adolescent disorders;
   (k) Management of patients with psychiatric disorders (e.g., psychotic and bipolar) in need of medical/surgical treatment.

Skills

Communication skills

1. Ability to manage the referral process and to obtain necessary information prior to seeing a patient. This involves communication with senior and/or junior medical staff, nurses, and other staff, as relevant;
2. Ability to interview medically ill patients and their relatives. This includes the introduction and commencement of a psychiatric interview with a person

who may not have been prepared fully for this, and the use of particular techniques relevant to medically ill patients or somatizing patients;
3. Understanding the systemic and scenic aspects of referrals and issues of transference/countertransference in the relationship between physicians, staff, and patients;
4. Explaining to patients the causation of their disorder and its treatment when there are physical and psychological contributory factors present;
5. Communication with severely ill patients and dying patients and their loved ones;
6. Ability to advise consultees on the management of noncompliant patients;
7. Ability to record appropriate details in general medical notes in a language easily understood by all medical and nursing attendants while preserving confidentiality;
8. Communication with other specialties' colleges and nurses;
9. Communication with mental health providers outside the hospital.

Diagnostic and formulation skills

1. Taking and reporting the history of patients with physical and psychiatric disorders;
2. Ability to formulate a diagnostic summary and to develop clear goals of intervention even when there is a complex combination of physical, psychological, and social factors contributing to the problem;
3. Ability to draw up an appropriate differential diagnosis, including International Classification of Diseases diagnosis, when physical and psychiatric disorders are present;
4. Ability to construct a diagnostic formulation, including psychodynamic and other psychological, social, and environmental aspects, when physical disease is also present;
5. Assessment of various issues on competency;
6. Basic documentation of C–L episodes.

Specific areas of clinical interventions

1. Ability to draw up a treatment plan using the biopsychosocial approach;
2. Psychopharmacology, including drug–drug interactions, in medically ill patients;
3. Crisis intervention and short-term psychotherapy suited for the treatment of medically ill patients;
4. Assessment and coordination of the care of complex patients.

General aspects of working in C–L psychiatry and psychosomatics

1. Adequacy of written records, confidentiality, and appropriate storage of records;
2. Presentation of psychiatric cases and discussion of liaison issues in general medical/surgical case conferences, ward rounds, and so on;
3. Learning how to access and utilize C–L literature on specific clinical and research topics. (They should be able to critically appraise published research on C–L psychiatry and psychosomatics.)

Attitudes

The trainee in C–L psychiatry or psychosomatics is expected to develop appropriate attitudes as a psychiatrist or psychosomaticist working as a member of a multidisciplinary team, whose other members do not have psychiatric training or background. This is different from the multidisciplinary team in mental health services. For example, in the general hospital or primary care setting, the psychiatrist or psychosomaticist may have to: (a) be an advocate for the patient; (b) preserve confidentiality even when under pressure to disclose confidential details; (c) insist on psychological aspects of care when these are in danger of being disregarded; (d) ensure that mental health legislation is used appropriately; (e) help teams when differences of opinion regarding the management of a patient occur and when the team is faced with an ethical dilemma.

Recommendations for advanced training in C–L psychiatry and psychosomatics (fellowship)

Goals and objectives of advanced training

In addition to the goals and objectives of C–L training for residents, graduates of advanced training should become specialists in C–L psychiatry and psychosomatics who are able to deal with complex and difficult problems in the interface between psychiatry and medicine. In particular, they should be able to:

1. Identify and assess complex patients with increased care needs, and formulate an appropriate treatment plan and care coordination for these patients;
2. Formulate an appropriate treatment plan and a care coordination for these patients;
3. Provide comprehensive psychological and pharmacological treatment for medically ill patients with psychiatric comorbidity;
4. Work effectively in a liaison role;
5. Sensitize physicians and nurses to the psychosocial aspects of patient care, to the prevention of psychosocial problems in physically ill patients, and to the early detection and treatment of psychiatric comorbidity;
6. Provide support to medical staff and mediate conflicts between patients and medical staff;
7. Educate other specialties' physicians and staff;

8. Participate in the training of residents in C–L psychiatry and psychosomatics;
9. Plan and/or conduct research in C–L psychiatry and psychosomatics;
10. Conduct quality management in C–L services;
11. Organize and implement new C–L services in a particular medical department.

Organization of recommended training

1. Advanced training in C–L should be a *full-time* postgraduate training with a *minimum of 12-month* full-time rotation to a C–L department and/or a PsychMed unit or a psychosomatic unit (2-year training is preferable).
2. During advanced training, the trainee should be assigned to C–L services with *different medical specialty areas* (including intensive care, palliative care, and issues related to pregnancy) where they have clinical responsibility throughout their training under the direct supervision of an experienced C–L psychiatrist or pychosomaticist. On the second part of the advanced training, the trainee should be assigned to a *liaison service* with at least one specific medical unit (e.g., oncology, cardiology, dialysis, transplant, and pain) to gain experience with a more integrated model of care and cooperation.
3. *Supervision of trainees* should be clearly defined and organized, with: (a) a named supervisor; (b) clearly defined frequency and duration of supervision sessions; and (c) clearly defined individual and/or group supervision.

Content of advanced training in C–L psychiatry and psychosomatics

A trainee in fellowship programs of C–L psychiatry or psychosomatics should *intensify knowledge, skills, and attitudes* that are described in the resident's training in C–L (see Content of Training in C–L Psychiatry and Psychosomatics). Additionally, advanced training should include knowledge and skills in several areas.

Communication skills

1. Understanding the referral process, including wishes and needs that are not overtly expressed by the consultee;
2. Comprehensively understanding the systemic and scenic aspects of referral and issues of transference/countertransference in the relationship between physicians, staff, and patients, and integrating this knowledge in formulating a working hypothesis and a treatment plan;
3. Understanding the consultant's role in advising general medical doctors and nurses, and their different roles and responsibilities in such working;
4. Effectively communicating with a multidisciplinary team;
5. Advising the medical team on the psychosocial aspects of physical illnesses and treatments, and performing continuing medical education of medical staff on the psychological consequences of illness and the indications of psychiatric/psychosomatic consultation.

Diagnostic and formulation skills

1. Methods of screening for psychiatric disorders in medically ill patients;
2. Advanced methods on the assessment and care coordination of complex patients (case management and planning);
3. Knowledge of cognitive testing for patients with organic impairment.

Specific areas of clinical interventions

1. Advanced training of psychopharmacology, including drug–drug interactions, in medically ill patients;
2. Psychotherapy methods appropriate for medically ill patients and disorder-specific therapy (cognitive–behavioral therapy, expressive–supportive therapy, and group approach);
3. Coordination of care for complex patients across several disciplines in secondary care and primary care;
4. Special interventions for patients treated in the units of cardiology, oncology, chronic pain, gynecology, geriatrics, pediatrics, AIDS, intensive care, and so on;
5. Liaison with particular units such as those listed in the previous paragraph;
6. Skills necessary for effective team performance, including (a) skills to clarify and resolve conflicts between patients, their relatives, and staff; and (b) debriefing to relieve staff after severely distressing situations (e.g., after suicide attempts of patients).

General aspects of working in C–L psychiatry and psychosomatics

1. Management/organizational skills: how to run a C–L service in relation to (a) general hospital and/or primary care, and (b) general psychiatric or psychosomatic service;
2. Audit of C–L service, initiation and maintenance of quality management in C–L, and production of annual report;
3. Psychiatric input into general hospitals' major incident planning;
4. Presentation of psychiatric cases and discussion of liaison issues in general medical/surgical case conferences and ward rounds;
5. Knowledge on the funding mechanisms of C–L services and the implication of these for service delivery;
6. Research in C–L (particular methodologies);

7. Teaching C–L at undergraduate and postgraduate levels and to nursing and similar groups.

Form of training

Training in C–L psychiatry and psychosomatics takes place in several forms.

Tutorial and supervision

All trainees should be supervised by a named attending physician with experience in C–L psychiatry/psychosomatics (tutor). During the early part of the rotation, trainees should accompany the attending C–L psychiatrist while performing clinical consultations. Trainees should be able to observe all elements of a consultation process and discuss it in supervisory sessions. Trainees should be given the opportunity to experience permanent C–L staff informal meetings and communication, and direct and indirect supervision of other doctors and other staff members involved in the care of patients seen by C–L psychiatrists in general hospitals. The supervisor should have the opportunity to observe the trainees perform an entire consultation, providing the trainees with appropriate feedback.

Case conferences

Attendance at case conferences should be weekly. Case conferences should usually be interdisciplinary (primary care physician, general hospital ward staff, social worker, etc.), conducted by a full-time C–L psychiatrist or psychosomaticist, and open to physicians from other wards, nurses, medical students, and psychiatric rehabilitation students (compare to the Modena model [17]). The trainee should present cases, and medical staff members who are responsible for a patient should be invited to contribute to a case presentation. The trainee should present at least one written comprehensive case history. Actively participating in case conferences reifies and builds professional identity.

Seminars

Trainees should attend seminars on theoretical topics and skills training.

Journal clubs

Trainees should be given access to journals dedicated to C–L work, as well as to general medical and general psychiatric journals. Textbooks in C–L psychiatry and psychosomatic medicine are now readily available [24–27].

Courses and conferences

Short-term full-time C–L courses at "centers of excellence" should be promoted. Attendance at annual national C–L meetings or EACLPP conferences should be encouraged for trainees to enhance their skills (follow-up/refreshment courses) and also meet C–L trainees from other centers.

Assessment of competency and efficacy

Assessment of competency and efficacy includes the following:

1. Feedback from tutors (checklist based on the above curriculum);
2. Number of supervised consultations attended;
3. Assessment based on trainees' performance under clinical supervision;
4. Examination (for advanced training).

Concerning examinations, competency measures should be developed and experiences from other countries should be analyzed [28–31]. Residents should also evaluate supervisors.

Conclusions

The current state of training in C–L psychiatry and psychosomatics shows serious shortcomings and unacceptable variations across EU countries. This document is a first step towards establishing recognized training in C–L psychiatry and psychosomatics across the EU. At present, the EACLPP is seeking approval for the following:

1. Recognized training of residents in C–L psychiatry and psychosomatics, with a minimum requirement that trainees work full time in a suitable training post for at least 6 months; and
2. Advanced training (fellowship) in C–L psychiatry and psychosomatics, with a minimum requirement that trainees work full time in a suitable training post for at least 12 months.

This will enable trainees to develop specialist skills required for this work, which are likely to grow as the importance of psychiatric disorders in general medical settings is increasingly recognized.

We have to address a limitation of these guidelines. The consensus report was derived almost exclusively from EACLPP members and acknowledged experts in the field of C–L psychiatry and psychosomatics. A consensus report including a broader range of psychiatry program directors might have led to somewhat different results (such as, maybe, a shorter rotation to C–L training during residency). However, we think that a consensus report derived from leading European C–L experts is an important first step to developing European quality standards in training residents and fellows in C–L psychiatry and psychosomatics.

Following these guidelines, C–L training has to be developed and implemented on a national level. C–L units that provide such training must meet quality standards for the organization of training. A psychiatric or psychosomatic

institution or service that offers training in C–L should be certified by national boards/societies of psychiatry or psychosomatics. Psychiatrists or psychosomaticists responsible for the training of residents and fellows should have extensive expertise in C–L work. They should be also certified by national boards and societies of psychiatry or psychosomatics. On a European level, C–L units with a high level of experience in clinical practice, in research and training, and in meeting specific requirements ("centers of excellence") should provide intensive courses in C–L psychiatry and psychosomatics. These centers and intensive courses in C–L should be approved by the EACLPP. The EACLPP workgroup on training is currently establishing guidelines for the accreditation of such courses.

Finally, we are convinced that training in C–L plays an important role in forming the professional identity of psychiatric residents, as Kornfeld [32] pointed out in his overview on the impact of C–L psychiatry on medical practice: "I believe that there is nothing more powerful than a good consultation–liaison experience to reinforce young psychiatrists' perception of themselves as members of the medical profession."

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Appendix A. Questions on training in C–L psychiatry and psychosomatics

1. Do guidelines for training in C–L psychiatry and/or psychosomatics exist in your country? Are they published? (If available, please add a reference or a copy.)

2. Is training in C–L psychiatry and psychosomatics part of the training program for psychiatric residents? If yes, is it
( ) Mandatory
( ) Recommended
( ) Optional

3. Is training organized nationally or locally?

4. How is the organization and what is the time frame of the training?

5. Does theoretical training include the following:

	Yes/no	If yes, how many hours?	Comments (e.g., kind of "other" courses)
Theoretical training			
1. Delirium and dementia			
2. Somatization			
3. Treatment of suicide attempts			
4. Interaction of psychotropic drugs			
5. Other courses			
6. Total theoretical courses			

6. Does skills and practical training include the following:

	Yes/no	If yes, how many hours?	Comments (e.g., kind of "other" courses)
Training of special skills			
1. Focused psychotherapy			
2. Relaxation techniques			
3. Group psychotherapy			
4. Systemic approaches			
5. Team counseling			
6. Other skills training			
7. Total skills training			
Clinical experience			
1. Supervised clinical practice			
2. Supervision/case conferences			
3. Quality management meetings			
4. Rotation to C–L units			
5. Rotation to medical/surgical units			
6. Other			
7. Total clinical experience			
Skills and practical training total			

7. Please add some more information on the main topics of the training, if necessary.

8. Is there a formal procedure for finishing the training (certificate)?

9. Are follow-up sessions or meetings for further education organized?

10. Do requirements concerning teachers of such training exist?

11. What are the costs of such training? Who pays the fees?

12. Which next steps would you consider necessary, or do you plan for the future?

13. Add personal comments.