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The Role of the Psychiatrist in the General Hospital — I — Investigation and Analysis Pertaining the Status of the Psychiatrist in the General Hospital

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Data for this study consisted of answers to a series of questions on the image of clinical psychiatry adressed to all the non-psychiatric clinicians in the Tokai University Hospital, and all the referral sheets for psychiatric consultation from non-psychiatric departments of the hospital for about 2 years since the beginning of the hospital's operation.

The reaction was analysed as follows: (1) psychiatric services were requested for the reasons of "no organic abnormality" or for "differential diagnosis" in 59.4% of total referrals, (2) as many as 37.9% of non-psychiatric clinicians made no attempt to refer the patient to psychiatrists in spite of their recognition that these patients apparently needed psychiatric treatment, (3) trouble in doctor-patient relationship, if it was the real reason for asking for sychiatric services, was frequently not mentioned in the referral sheet, and (4) the reason for psychiatric consultation was rarely told clearly to the patient.

On the basis of the above-mentioned findings, the role of the psychiatrist in the general hospital setting was reexamined.

(Key Words: Consultation-Liaison Psychiatry, The Reason for Consultation, No Organic Abnormality, Doctor-Patient Relationship)

INTRODUCTION

The role of the psychiatrist in the general hospital has been becoming broader in recent years. This has been the subject of our study since the establishment of the Tokai University Hospital in 1975. We approached the problem from the following three viewpoints:

Evaluation of —

(1) the role of psychiatrists proper,

(2) the role of psychiatrists in the complex of inerrelationships between psychiatry and other branches of medicine, and between the psychiatrist and non-psychiatric clinicians, nurses or any other medical workers,

(3) the role of the psychiatrists in general management of the hospital.

We first examined role (2). Around the time of the start of this study (1975), "Consultation—Liaison Psychiatry" edited by Pasnau (8) was published in the U.S., and was soon introduced to Japan.

Liaison psychiatry was defined by Lipowski (5) as follows:

"That area of clinical psychiatry which includes all diagnostic, therapeutic, teaching and research activities of psychiatrists in the non-

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psychiatric parts of a general hospital."

Liaison psychiatry is said to have a long history in the U.S. (1, 6) In the 1920's formal psychiatric consultation services were established in teaching hospitals because of the emergence of interest in psychosomatic medicine, but initially, the psychiatric consultant interviewed a patient, made diagnostic or treatment recommendations, and communicated them to the attending internist or surgeon, mainly in writing. In the 1930's and 1940's the role of the psychiatrist in the general hospital became broader. He no longer made his contribution as a visitor, helping the non-psychiatric staff in making psychiatric diagnoses or evaluating patients with suicidal possibilities, but he also started to give advice concerning problems in patient management, understanding the patient's responses to illness, and helping patients to cope with illness, in addition to the more traditional consultative functions. The post-World War II period saw the establishment of model psychiatric services dedicated to the teaching and practice of liaison psychiatry and psychosomatic medicine. In 1966, Mendel (7) in the United States surveyed training programs of the resident to find out to what extent they were exposed to training experience in consultation psychiatry. His survey showed that 76 per cent of all psychiatric training centers offered instruction in consultation psychiatry.

In Japan too, the interest in liaison psychiatry has been rapidly increasing since it was taken up at the 4th International Congress of Psychosomatic Medicine held in Kyoto in 1977. Liaison psychiatry, a practical area of psychiatry, has an aspect concerned with the progress-oriented reassessment of psychosomatic medicine, which aims at understanding the patient as a whole human being, by psychiatrists. The approach to liaison psychiatry through the afore-mentioned aspect establishes a new direction in the psychiatrist's activities away from the conventional role assigned to him in Japanese general hospitals, which consists of providing psychiatric services "on request from non-psychiatric clinicians".

Actually, only a few hospitals in Japan offer services in psychosomatic medicine and general hospitals equipped with a staff devoted to liaison — consultation medicine are almost non-existent (2). It is impossible and improper to introduce liaison-consultation psychiatry developed in the U.S. directly into Japanese general hospital settings without any modification under such circumstances.

To study the interrelationship between psychiatrists and non-psychiatric clinicians or other staff members, therefore, we first investigated "what is expected of a psychiatrist in general hospitals?", i.e. the status of clinical psychiatry in general hospitals. The results of the investigation and discussion follow.

MATERIALS AND METHODS

The following two methods were applied in elucidating the role of psychiatrists expected by non-psychiatric clinicians:

(1)Investigation of referral sheets for psychiatric services from non-psychiatric departments in the 2 year period from Feb., 1975 to Jan., 1977.

(2) A questionnaire response on the image of clinical psychiatry requested from all non-psychiatric clinicians in the Tokai University Hospital im March, 1977.

RESULTS

(1) The total number of new patients in the Department of Psychiatry in 2 years was 1,711, of whom 336 patients (19.6%) were referrals from non-psychiatric departments. Table 1 shows the reasons for requesting psychiatric services on behalf of such patients, which were classified under eight headings. The most noticeable comment was "in spite of somatic complaints, no organic abnormality or abnormalities corresponding to the complaints were found." which accounted for 162 cases (48.1%), and the referral "differential diagnosis wanted" was found for 38 cases (11.3%). Either of the above reasons was given for a total of 200 cases (59.7%). Patients who were considered to "need psychiatric services for clear psychiatric symptoms" totalled 54 (16.1%), and were far outnumbered by the afore-mentioned patients.

Table 1 reasons for requesting psychiatric services in referrals

1. Absence of organic abnormality	162 (48.1%)
2. Psychological symptoms manifested in the course of treatment	54 (16.1%)
3. Differential diagnosis wanted	38 (11.3%)
4. Request for psychological tests	34 (10.1%)
5. History of psychiatric intervention	19 (5.7%)
6. P.S.D. in the narrow sense	11 (3.3%)
7. Preoperative psychiatric check-up	9 (2.7%)
8. Miscellaneous (not classifiable)	9 (2.7%)
	336 (100.0%)

(2) In a questionnaire addressed to non-psychiatric clinicians, 68 out of a total of 119 clinicians sent back answers, which means that the response rate to the questionnaire was 55.5%.

One of the questions was "In what situation do you feel the need for consultation with a psychiatrist? Have you ever felt such a need?" Answers to this question are shown in Table 2. It is remarkable that only a small percentage of non-psychiatric clinicians feel the need for consultation with a psychiatrist in clinical situations 5 to 8. However, to another question pertinent to patients who developed mental symptoms, all the doctors answered that they felt the need for consultation with a psychiatrist. Answers to the afore-mentioned question, moreover, show that as many as 92.4% of the doctors feel the need for consultation in severely suicidal situations.

(3) To the question "Are you in charge of any patient whom you feel needs psychiatric treatment but for whom you have not requested psychiatric services?", 25 doctors (37.9%) answered "yes". Of those who answered "yes", 17 gave as the reason for not requesting psychiatric services "patient's unwillingness", five gave "difficulty in persuading the patient to undergo consultation with the psychiatrist", and five gave "fear of losing the patient's confidence", i.e., the doctor-patient relationship. (Table 3)

Table 2 reasons for requesting psychiatric services

	A. Need for psychiatric services felt	B. Request made	B/A
1. Patient with mild anxiety	18 (27.3%)	5 (7.6%)	27.8%
2. Patient with a noncancerous physical illness and intense anxiety	40 (60.6%)	30 (45.5%)	75.0%
3. Dying patient	8 (12.1%)	2 (3.0%)	25.0%
4. Potentially suicidal patient	61 (92.4%)	29 (43.9%)	47.5%
5. Patient clinging beyond justifiable limits to doctor-patient relationship	18 (27.3%)	7 (10.6%)	38.9%
6. Doctor-patient conflict	8 (12.1%)	4 (6.0%)	50.0%
7. Demanding patient	18 (27.3%)	14 (21.2%)	77.8%
8. Patient who resists doctors' or and nurses' instructions	17 (25.8%)	9 (13.6%)	52.9%

Table 3 Are you in charge of any patient who you feel needs of psychiatric treatment but for whom you have not requested psychiatric services?

Yes 25 (37.9%)

Reasons for not requesting psychiatric services

1. Patient dislikes interviews with psychiatrists	17
2. Complicated and inconvenient procedures and formalities in making arrangements for psychiatric consultations	0
3. The case seems beyond the capacity of psychiatric services in the hospital	2
4. Psychiatrists are not reliable	1
5. Difficulties in explaining the situation to the patient	5
6. Pity for the patient	1
7. Apprehension of losing patients	5
8. Miscellaneous	4

DISCUSSION

We tried to clarify the non-psychiatric clinicians' image of the psychiatrist and what these clinicians expect of psychiatrists, while investigating the reasons for requesting psychiatric services for patients actually referred to the psychiatric department. From these findings, in addition to what we experienced in our daily clinical work, the current situation concerning the role of the psychiatrist in general hospital settings in Japan was examined and can be summarized as follows.

First, it was noteworthy that the reasons for requesting psychiatric services were "no organic abnormality" or "differential diagnosis wanted" which accounted for 60% of the entire referrals who were psychologically disturbed patients with physical complaints. In our experience, the true reason for the majority of patients referred to the psychiatrist were derived from poor management of patients such as troubles between the patient and doctor and/or other medical staff, or a negative doctor-patient relationship. As Table 2 shows, however, doctors in general feel no need

to consult psychiatrists concerning interpersonal conflicts in clinical situations, at least on the conscious level. The above-mentioned gap between reality and the clinicians' consciousness is the greatest barrier in practicing liaison psychiatry.

Second, if the doctor-patient relationship is positive, in which case the relationship is most likely to become dependent, the clinician does not send the patient to the psychiatrist even when he recognizes the necessity of psychiatric services. The present survey showed that 37.9% of the doctors have such a relation with patients. It may not be going too far to assume that there are potentially more doctors than the above results indicate who enjoy such relationships. Krakowski (6) stated that there undoubtedly were more patients who needed consultation with psychiatrists in the U.S. than those actually referred. He attributed the above situation to the resistance of patients who wanted to deny their own mental troubles or who were afraid of stigmas attached to psychiatric intervention. Above all, he pointed out that non-psychiatric clinicians themselves consciously or unconsciously barbor prejudices toward mental illness. These tendencies were also clearly revealed by our investigation. Sociocultural prejudice toward mental illness still remains in Japan, more strongly than in the U.S., which accounts for the greater resistance of both patients and doctors to consultations with psychiatrists in Japan. As shown in Table 2, therefore, consultation with psychiatrist is not feasible for a great many patients in spite of the "absence of any organic abnormality".

Third, experience tells us that the majority of patients referred to psychiatrists have not been provided with the proper motivation for visiting the psychiatrist by non-psychiatric clinicians. These patients, moreover, are frequently kept uninformed of the reason for consultation with the psychiatrist or even of the fact that consultation is needed. This seems to due to the negative counter-transference on the part of clinicians, poor doctor-patient relationships and the fear of mental illness by both the doctor and the patients.

Fourth, conventional psychiatric education in Japan has emphasized descriptive psychiatry and tended to neglect dynamic orientation including understanding of clinical interpersonal relationships. As Iwasaki (2) and Kimball (3) stated, it is absolutely necessary for the practice of liaison psychiatry that medical students should be trained in psychosomatic medicine and liaison psychiatry based be dynamic psychiatry.

Finally, some appropriate and practical measures have to be worked out for the management and treatment of patients with physical complaints, who accounted for 60% of the patients referred to psychiatrists by non-psychiatric clinicians. There must be some efficient way by which psychiatrists can function at their best to pursue the role assigned to them in general hospital settings in Japan at present.

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REFERENCES

1) Enelow AJ: Consultation-liaison psychiatry. In Kaplan HI, Freedman A, Sadock BJ (eds): Comprehensive Textbook of Psychiatry/III. Baltimore, Williams & Wilkins, 1980, 1980—1985pp.
2) Iwasaki T: Teaching liaison psychiatry and clinical practice of psychosomatic medicine in the general hospital. In Kimball CP, Krakowski AJ (eds.): The Teaching of Psychosomatic Medicine and Consultation — Liaison Psychiatry. Basel, S. Karger, 1979, 32—38 pp.
3) Kimball CP: Teaching medical students psychosomatic medicine: of substances and approaches. In Kimball CP, Krakowski AJ (eds.): The Teaching of Psychosomatic Medicine and Consultation-Liaison Psychiatry, Basel, S. Karger, 1979, 23—31pp.
4) Krakowski AJ: Liaison psychiatry in North America in the 1970s. In Kimball CP, Krakowski AJ (eds.): The Teaching of Psychosomatic Medicine and Consultation — Liaison Psychiatry. Basel, S. Karger, 1979, 4—14pp.
5) Lipowski ZJ: Review of consultation — liaison psychiatry and psychosomatic medicine, J Psychosom Med 29: 153—171, 1967.
6) Lipowski ZJ: Consultation-liaison psychiatry: past, present, and future. In Pasnau RO (ed.): Consultation — Liaison Psychiatry. New York, Grune & Stratton, 1975. 1—28 pp.
7) Mendel WM: Psychiatric consultation and education. Am J Psychiatry 123: 150—155, 1966.
8) Pasnau RO (ed.): Consultation—Liaison Psychiatry. New York, Grune & Stratton, 1975.