Teaching and experience of liaison psychiatry in psychiatric postgraduates

DEAR SIRS

I would like to report a questionnaire survey of teaching and opportunities for clinical experience in the field of consultation-liaison psychiatry in senior house officers and registrars in psychiatry in England and Wales.

A list of the 164 psychiatric postgraduate training schemes in 1982 was obtained from the College. Half of them were selected for inclusion in the study by taking every alternate scheme from the list and a questionnaire sent to the clinical tutor of the selected training schemes. The questionnaire covered teaching and clinical aspects of liaison psychiatry, whether the psychiatric service was expected to cover general hospitals (and if so, were there any consultants who specialized in general hospital psychiatry), the experience trainees obtained in referral work and the opportunity they had to practise consultation-liaison psychiatry. The teaching of consultation and liaison psychiatry provided either within the trainee's own hospital or on a recognized training course that they might attend elsewhere was also enquired about.

Eighty-two training schemes were contacted and the tutors from 52 (63 per cent) returned questionnaires with adequate information. All 52 schemes were expected to provide psychiatric cover for at least one general hospital.

In 4 schemes (8 per cent) there was a psychiatrist with a contractual responsibility to either full-time or part-time liaison psychiatry. A further 28 schemes (54 per cent) had at least one general adult psychiatrist who considered liaison work a special interest and who in more than half these cases did an out-patient session in the general hospital and saw referrals from physicians during this session. In 20 schemes (38 per cent) there was neither a specific liaison psychiatrist nor a general psychiatrist with an interest.

Some schemes had a post in which SHOs/registrars spent a substantial amount of time doing consultation-liaison work. In 4 schemes (8 per cent), all trainees had part of their rotation in such a post, and in a further 11 (21 per cent) some trainees had such opportunities. In the remaining 37 schemes (71 per cent) no such posts were available so trainees obtained their experience via duty rotas or direct referrals to their consultants.

The tutors were asked about the opportunities which arose for juniors to be involved in self-poisoning, casualty and general hospital ward referrals (Table I). It can be seen that referrals from the general wards other than for self-poisoning is not a common experience.

The opportunity to have a particular liaison link via out-patient or ward round attendance with other departments in the general hospital was available for: all trainees in 4 schemes (8 per cent); some trainees in 9 schemes (17 per cent); and none of the trainees in 39 schemes (75 per cent). Most of these links had been organized to provide the psychiatric trainee with opportunity for medical teaching rather than offer the general department a psychiatric service. The most frequent of these 13 'links' was with a geriatrician (10–76 per cent), a neurologist (2–15 per cent), or a general physician (1–7 per cent).

TABLE I
Consultant-liaison experience

Referrals	Often seen	Occasionally seen	Rarely seen	Never seen
Self-poisoning	23 (44%)	25 (48%)	3 (6%)	1 (2%)
Casualty	7 (13%)	28 (54%)	10 (19%)	7 (13%)
General ward referrals	2 (4%)	26 (50%)	20 (38%)	4 (8%)

In 44 training schemes (85 per cent) the trainees received formal lectures or seminars on consultation-liaison psychiatry in their own hospitals or through a recognized MRCPsych course at another hospital. Eight schemes (15 per cent) felt there was no such teaching and one (2 per cent) was unsure.

Only 22 tutors (42 per cent) felt that trainees received adequate clinical experience in consultant-liaison work and 26 of the tutors (50 per cent) felt that formal teaching was adequate. Common problems noted were: the geographical separation of the psychiatric hospital from the general hospital it had to provide a service for; lack of consultants with the experience or the interest to train junior staff in liaison psychiatry; lack of interest in the trainees to become involved in this work; and too much time involved with self-poisoning cases leaving too little to see the other referrals.

Suggestions made to improve clinical experience and teaching were: more appointments of consultants with a designated responsibility in liaison work; more specific training posts in this area; development of specific liaison links with general hospital departments where trainees could attend regularly and provide a service with adequate consultant back-up; joint teaching via seminars and case conferences with general hospitals consultants.

As only 63 per cent of the tutors completed the questionnaire and only half the training schemes were contacted, any conclusions will be based on a survey of just less than a third of all schemes. Hopefully, however, the results will be representative of England and Wales as a whole as the tutors who did reply were distributed amongst University departments, general hospital psychiatry departments and postgraduate schemes in mental hospitals.

All the schemes that replied were expected to cover at least one general hospital and in some cases as many as four or five. It is likely therefore that all psychiatric services may be called on to provide liaison work and junior staff deserve to have training in this area. Nearly two-thirds of those hospitals contacted had a consultant with a contractual responsibility or an interest in liaison psychiatry who would therefore be expected to help in the training of junior staff. Over one third of the schemes had

no such 'specialist' and in these hospitals it might be difficult to arrange proper teaching experience. For the majority of trainees the opportunity for clinical experience in liaison work is likely to be rather haphazard and competing with other clinical duties. Further, in 92 per cent of schemes self-poisoning referrals were seen either occasionally or often and so it is possible that junior staff are expected to cover this aspect of general hospital psychiatry (perhaps because senior staff are less willing to do it) and have less opportunity for other referral work. Specific links with medical teams, which would provide such opportunity for this form of referral was only available to a minority.

To improve the clinical experience and teaching of liaison psychiatry means identifying at least one consultant prepared to see part of his responsibility in this area and therefore able to properly supervise the junior staff on such referrals. It may not be possible to designate specific training posts in liaison psychiatry in most rotational training programmes, but some posts should be able to accommodate one or two days each week to liaison work. Such sessions should not get swallowed up as a convenient way of dealing with the self-poisoning cases.

There are many potential advantages to having effective liaison psychiatry services in the general hospital for patients, psychiatrists and general medical staff. To make these services effective postgraduates must be given the correct teaching, experience and support to develop the proper skills.

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A suggested forum for newly-appointed consultants in child psychiatry

DEAR SIRS

There are five components to the job of consultant: clinical, teaching, research, administrative and political. The first three are usually better taught and assimilated during our senior registrar training than are the last two, which really only begin to make sense when we take up our first post as consultant. Yet particularly in child psychiatry there are many hazards and difficulties. It seems to me that there might be some sense in newly-appointed consultant child psychiatrists meeting together regularly in their first year with senior colleagues to discuss these problems.

Child psychiatrists have more difficulties because they are very often the only member of their discipline in a District or Hospital and because they work more intimately with non-medical disciplines. I am willing to convene a monthly forum if there is enough interest. Perhaps newly-appointed consultants in child psychiatry could write to me if they are interested.

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Linked or joint consultant posts in the psychiatry of mental handicap

DEAR SIRS

In a letter to the *Bulletin* last year (May 1984, **8**, 96), I asked readers for information about possible changing trends in appointing psychiatrists to joint/linked appointments in two different branches of psychiatry.

Nine consultants replied with information about eight specific posts. One of these was a special interest post with two sessions in mental handicap and nine in general psychiatry; three were formal joint appointments, one with seven sessions in mental handicap and four in mental illness and the other two equally divided. Four were informal joint appointments in which the majority of the work load was in the psychiatry of mental handicap and a significant minority in child psychiatry.

In addition, five senior registrars wrote or telephoned to express an interest in joint appointments or special interest posts after reading my letter.

I asked readers about the success or otherwise of such an appointment and the response was largely favourable. The only criticisms were expressed in terms of recommendations to prospective applicants; that job descriptions should be studied with care to see if the stated allocation of duties is realistically divided and will not be weighted retrospectively in one direction. The comment was made that advertisements do not always reveal that a special interest in mental handicap is required.

A view repeated by several of the correspondents was that joint appointments are a success where they are welcomed by the local general psychiatric fraternity. It was commented that joint posts are likely to be more interesting and stimulating and should attract more able applicants, with the added bonus of the support of colleagues from general psychiatry. It was also suggested that joint appointments would enable better treatment facilities for those people with mental handicap and mental illness. In addition a consultant in a linked post is in an advantageous position to have an overview of all community facilities. This overview would be made easier where linked posts enabled the catchment area of any one consultant to be reduced. The same respondent suggested that a good balance in any one district could be achieved by appointing one consultant with a mental illness background and one with a child psychiatry background, both with linked posts in the psychiatry of mental handicap. Another obvious advantage of linked posts is the increase in the number of consultants available for on-call rotas and for cover of both sick leave and holidays.

The fact that joint posts were initiated in Scotland by the 1971 Batchelor Report was referred to frequently. Such posts are commonplace in Scotland, and in the Republic of Ireland there is current interest in establishing formal joint appointments.

Another respondent argued in favour of a restructuring of specialties in psychiatry into three broad areas: general (functional) psychiatry; organic psychiatry (including