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Part I

Basic skills

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1

The development of general hospital psychiatry

Richard Mayou

General hospital psychiatry is the practice of psychiatry in a particular type of medical setting, whilst liaison psychiatry (the principal focus of this chapter) refers to the clinical expertise and practice relating to psychological and psychiatric problems and treatments in patients presenting to general medical care. Whilst this subject matter has been a part of medicine from the earliest time, its history as a recognized specialist interest is inextricably part of the complicated evolution of psychiatry as a speciality and its at times troubled relationship with the rest of medicine (Shorter 1997). Although now firmly established and expanding, its precise role is uncertain, insecure and misunderstood at least as much within psychiatry as within general medicine. This history cannot be understood as a separate identifiable theme and must be seen as part of the whole social history of medical practice and the rather recent evolution of current patterns of health (Mayou 1989).

This chapter focuses on liaison (or consultation liaison) psychiatry. Although mainly based on historical evidence from the United Kingdom, the central ideas are applicable to the histories of liaison psychiatry in other developed countries. Most other histories of liaison psychiatry have concentrated on North American developments in the last 70 years (Lipowski & Wise 2002; Schwab 1989). Although these have been influential, there is a need for a much more long-term view of the wider relationships between psychiatry and general medicine. The main themes of the chapter can be summarized:

1. Psychological care has always been implicit in the practice of good medicine.
2. In the nineteenth century separate special interests in mental illness (the alienists) and in nervous disorders emerged and gradually became more established. The former was based in large new asylums; the latter

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was initially provided by physicians interested in treating 'nervous' problems within the general hospital and later by specialists in psychological medicine.

3. During the twentieth century these two approaches became a single new speciality of psychiatry which was increasingly seen as a part of medicine. During the second half of the century a very few psychiatrists (now calling themselves liaison psychiatrists) concentrated on the general hospital consultations, predominantly with inpatients, and on the teaching of colleagues and students.
4. Liaison psychiatry has become a substantial body of expertise largely practised in the general hospital by a small minority of psychiatrists but which relates to a very substantial proportion of medical problems.
5. Since liaison relates to an interface of physical and mental care across the whole range of medical problems, it cannot be precisely defined in terms of particular clinical disorders, settings, or types of care. It is a speciality positioned uncomfortably between psychiatry and medicine and unfortunately not fully accepted by either.
6. Despite an increasingly robust evidence-base on epidemiology, the nature and course of clinical problems and the effectiveness of treatments, psychiatric, psychological and behavioural methods are underused in general medical care by both specialists and non-specialists.

Early history

For most of history both body and mind have been cared for together, apart from a small minority of the most disturbed. The first hospital as we know it in England was St Bartholomew's, established in 1123. In the medieval period mentally ill people were commonly treated in hospitals and religious institutions (Porter 1987; Shorter 1997). Few of these institutions survived the Reformation. In the eighteenth century most of the voluntary hospitals established in many British towns specifically excluded lunatics. Inevitably some patients with physical problems developed certifiable mental illness during their admissions; most were rapidly discharged, although some were transferred to private institutions for the insane and later to asylums. The first general hospital in Britain to admit lunatics to a special ward was Guy's in 1728. There were a small number of others, but none survived beyond the mid nineteenth century. There were similar experiments in other countries.

Some forms of what we would now see as psychiatric disorder have always been accepted in the general hospital, for example functional nervous symptoms, odd behaviour, delirium and complications of physical illness and

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childbirth. There are many records of admissions for hysteria, hypochondriasis and apparently functional somatic symptoms in surviving eighteenth- and nineteenth-century admission and discharge books. It was also recognized that there were small numbers of disturbed patients who could not be managed in normal settings. Some hospitals had private rooms or special areas for disturbed patients with delirium or puerperal fever. Doctors accepted these problems as part of their responsibility. Alcohol was often mentioned as a cause of physical problems and delirium tremens one of the most frequent explanations for disturbed behaviour. A very small number of general hospitals established special wards for such patients. Records show an even wider range of psychological disorder amongst those attending outpatient clinics (Mayou 1989).

The beginnings of specialization

Asylum psychiatrists (alienists)

The segregation of the mentally ill into large new asylums in the nineteenth century was associated with the development of two groups of specialists – alienists (Porter 1987) and those interested in nervous disorders. This resulted in the development of procedures within the new general hospitals to identify and to transfer disturbed patients to asylums. In a rather small number of general hospitals there were pioneering attempts at the end of the nineteenth century to establish specialist psychiatric care. A few asylum doctors also began to offer early and voluntary treatment of psychiatric illness and less serious disorders. This was very often within outpatient clinics established within general hospitals.

Nervous disorder

Separately, physicians based in general hospitals began to identify and to treat nervous patients and this became a particular interest of some physicians and of the developing speciality of neurology. The role of neurologists is well illustrated in the accounts, especially from North America, of neurasthenia and of the rest cure (Wessely *et al.* 1998). However, the neurologists' initial enthusiasm was not maintained as they became more and more interested in neurological disorders defined by pathology. There was a similar decline in interest amongst general physicians. This left a small number of general hospital physicians who practised what, in Britain, became known as psychological medicine; a new form of psychiatry associated especially with the teaching hospitals in Britain, Europe, North America and elsewhere. Some of these psychiatric specialists in nervous

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disorder travelled widely in the United States and Europe and became interested in new psychodynamic methods of treatment.

Psychological medicine specialists generally saw themselves as very much apart from alienists working in large and remote asylums. There were, however, signs that there could be a coming together. Some specialist outpatient clinics were established in general hospitals and a few medical schools eventually began to see psychiatry as a subject that might develop on a new and more academic basis, alongside other specialities. Even so, it was many years before nervous patients found it in any way acceptable to be referred to psychiatrists.

These developments occurred against a background of wider change in ideas about mental disorder and its management. A high and conspicuous prevalence of psychological problems during the 1914–18 war had a large influence on care and attitudes. It became obvious that in wartime there were many disabling problems which did not have physical causes but whose psychological understanding was quite different to the narrow concepts and practice of asylum-based psychiatry. From the beginning of the war, many soldiers began to report symptoms of what came to be known as ‘shell shock’. There was considerable clinical innovation, although psychiatrists contributed much less to routine military medicine than did other doctors and psychologists (Shephard 2000). More generally, research by the first cardiologists on another very common syndrome, ‘soldier’s heart’, also contributed to developing understanding of anxiety disorder and neurosis, as recently identified and described by Freud. These new ideas and interests in psychological treatments were especially influential on the wider intellectual culture, as is evident from novels, memoirs and literary criticism of the period. The new ideas about mental disorder were soon also reflected in post-war textbooks and journals and in clinical practice so that in the 1920s and 1930s many physicians emphasized psychological care.

Psychiatry in the general hospital

General hospital specialist psychiatry

In the first half of the twentieth century psychiatric care expanded very slowly within the general hospitals. In Britain, this meant outpatient psychological medicine in the teaching hospitals using methods promoted by the new specialist and academic Maudsley Hospital (founded 1923), and by a small number of pioneering asylums. Influential specialists in psychological medicine, such as Sir Aubrey Lewis, saw psychiatry as a medical speciality which should

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have a substantial presence in teaching hospitals and in other large general hospitals. These views were not always accepted by mental hospital doctors who saw reformed asylums as a more appropriate therapeutic setting. However, in the 1930s there were some experimental developments in psychiatric inpatient care in general hospitals, usually for the care of the severely mentally ill, but sometimes also offering opportunities to treat less severe nervous disorder and psychological complications of physical illness. In the teaching hospitals such wards or the availability of small numbers of psychiatric beds within medical wards offered the opportunity for limited amounts of teaching.

There were several other major influences on continuing change – psychosomatic medicine, the extensive consequences of the Second World War for medical practice, and North American psychiatric consultation units.

Psychosomatic medicine

Psychosomatic medicine – the idea that psychological factors are important in the aetiology and course of many physical disorders – arose from psychodynamic theory and practice in the early twentieth century. It became influential in the 1930s, especially in the United States and in German-speaking countries. In the latter it has continued to flourish as a distinct medical speciality, separate to both psychiatry and internal medicine. Elsewhere it failed to survive the 1940s and 1950s and the beginnings of a more scientifically and evidence-based approach to medical practice.

Outside German-speaking countries few psychiatrists now see psychosomatic theory as useful. The emphasis on the interaction of physical and psychological processes is beneficial, but simplistic assumptions about possible psychological causes of physical disorder (such as stress and overwork) still hinder professional and public understanding. Psychosomatic medicine has had a lasting legacy within medicine in promoting greater understanding of the psychological aspects of physical symptoms and disorders and, more generally, cultural attitudes as shown in literature and art throughout the twentieth century. Even more important have been wider developments in psychodynamic, cognitive and behavioural understanding and treatment of 'neurotic' disorders.

Psychiatry during and after the Second World War (1939–1945)

The Second World War had at least as great an impact on psychiatry as the First World War. Wartime experience in emergency hospitals of the treatment of neurotic conditions changed the views on the scope and methods of psychiatry. Psychological treatment became generally more acceptable and new physical treatments offered answers to illnesses previously dealt with only by chronic

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institutional care. Anxiety, depression and other common disorders were more widely recognized and seen as deserving of treatment both by doctors in general and by psychiatrists who, with a wider view of their role, no longer wished to limit themselves to the care of patients admitted compulsorily to asylums.

The changes in patterns of healthcare after the end of the Second World War accompanied rapid scientific advancement and increasing specialization. The asylums began to close. Psychiatry returned to some extent to the general hospital and it became more unified, reconciling the alienists and the specialists in psychological medicine. It seemed for a while that psychiatry was rejoining the rest of medicine. In Britain, there was a coming together of academically minded psychiatrists at both the Maudsley Hospital and also in the undergraduate teaching hospitals with asylum psychiatry, which was developing social and physical methods of treatment and moving increasingly into community outpatient care (Mayou 1989). General hospital psychiatry largely came to mean the provision of specialist psychiatry within the general hospital, remaining clinically and very often managerially separate. Psychological medicine was ready to be renamed liaison psychiatry.

Consultation liaison

The practice of liaison psychiatry evolved in the first half of the twentieth century well before it was given the name. Hindsight allows us to see general hospital and liaison psychiatry services being established around the world, developing in response to local demands and in ways that reflected individual enthusiasms. Most aimed to help with the most conspicuous problems of disturbed and difficult patients. Only tiny proportions of the overall morbidity were recognized (let alone referred and treated) at a time when psychiatric epidemiology was increasingly showing the scale and range of psychiatric issues in all medical settings.

American histories of liaison psychiatry have focused on the influence of a small number of large innovative services in the 1930s, and more recent literature has continued to be dominated by a small number of people working in particularly well-resourced departments. This emphasis is misleading since it ignores the contributions made by many other psychiatrists providing simpler forms of consultation in the United States and around the world. Thus in the 1980s, whilst those working in large centres continued to suggest that 5% of general hospital admissions would benefit from assessment by the consultation liaison psychiatrist, it was apparent that real rates of referral were far lower, well below 1% in the United States (Wallen *et al.* 1987) and lower in other countries.

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Consultation and liaison as a specialist interest

The practice of consultation liaison has developed alongside changing methods in psychiatric and psychological treatment as a part of the whole range of psychiatric care.

The United States

In the United States what we now know as consultation-liaison psychiatry is usually dated to pioneering services in the 1930s and particularly to five units established with grants from the Rockefeller Foundation which were intended to stimulate collaboration between psychiatrists and other physicians. They provided consultation and teaching to medical students and staff. The term liaison psychiatry was also introduced for a variety of models involving both psychiatrists and physicians and, in a few instances, based in departments of medicine. Between 1935 and 1960 services were established in many teaching hospitals with a variety of models depending on local enthusiasms and opportunities. However, these developments remained isolated (Wallen *et al*. 1987) and there was no book published or comprehensive review of the subject made until the mid 1960s.

In 1974 the psychiatry education branch of the National Institute of Mental Health (NIMH) decided to support the development and expansion of consultation liaison services throughout the United States (Lipowski & Wise 2002; Schwab 1989). This decision was based on the view that in the future healthcare delivery should be mainly in primary care and that doctors needed appropriate training in psychosocial and psychiatric problems. Many of those involved were influenced by the writings and teaching of George Engel and his colleagues at Rochester in New York State on what they called the biopsychosocial approach (see White 2005). As liaison psychiatry prospered in the 1970s and 1980s, there were widening differences of opinion about methods (Lipowski 1967). The consultation model focused on assessment and treatment of individual patients, whereas the liaison model had a more ambitious role of working with and through medical teams. There was however no agreed conceptual basis and the advocates of consultation and of liaison engaged in bitter controversy, a controversy that reflected extremes of practice rather than the everyday practice of a few specialists in small units. In the end, the increasing financial difficulties resulting from the end of Federal funding favoured consultation programmes, which were easier to fund. Eventually, consultation and liaison combined as a new entity – consultation-liaison psychiatry (CL).

Whilst there has been great innovation and enthusiasm in liaison psychiatry in the United States, as shown by the rest of this chapter and by references throughout this book, most services have remained small. However, there is now

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a large body of research and clinical evidence to guide practice (see Levenson 2005). Many services have suffered cuts in funding and lack of support from both psychiatry and medicine. The majority of services continue to focus on traditional inpatient consultation (Kornfeld 2002) and very few CL psychiatrists have time for research or teaching. Despite these setbacks there has been significant political progress in achieving recognition as a special interest and in 2003 sub-speciality status was eventually recognized by the American Board of Medical Specialists (ABMS) with support from both the American Psychiatric Association and the American Board of Psychiatry and Neurology. The name of this sub-speciality, debated fruitlessly for many years, is Psychosomatic Medicine. It seems unlikely that this reversion to a controversial historical term will prove satisfactory. Even if less obscure than consultation liaison, it will be no more meaningful or popular with medical colleagues or with patients.

Liaison psychiatry in the UK

After the Second World War consultation became more firmly established, either as informal referrals to individual psychiatrists or by emergency requests to duty doctors. It became essential to involve psychiatrists in any transfer to psychiatric hospital and, at the same time, psychiatrists were increasingly invited to give their opinions on less severe problems. A few hospitals began more organized consultation services, for example at Guy's Hospital. A more elaborate liaison service was established in 1961 at the Middlesex Hospital by Sir Denis Hill and colleagues, modelled on the biopsychosocial approach developed in Rochester by Romano and Engel, in which psychiatrists had liaison attachments to individual medical units (Mayou 1989; White 2005).

New generations of psychiatrists were heavily influenced by North American experience and, inevitably, they took on the terminology of consultation-liaison psychiatry, which in the UK was eventually abbreviated to the no more meaningful 'liaison psychiatry'. As soon as the new name was publicized it was recognized that it was unsatisfactory and that its only advantage was to get away from terms such as psychosomatic which were discredited or seen as having too many alternative meanings.

The literature from the late 1960s until recently assumed that liaison psychiatry should be concerned with acute problems amongst medical inpatients. It recognized that, even in the small number of large centres, referral rates were low, especially as compared with the increasing epidemiological evidence that psychiatric disorder is extremely common amongst hospital inpatients. However, psychological medicine outpatient clinics continued in some teaching centres. Additionally psychiatrists became involved in the assessment of patients who had attempted suicide and who were being seen in increasing numbers in

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emergency departments. The abolition of suicide as a criminal offence and government recommendations about psychiatric assessment resulted in changes in practice, especially in teaching hospitals.

Developments in the last 20 years have been substantially associated with the work of the Royal College of Psychiatrists' Liaison Group (now Faculty) (Lloyd 2001). Formed in 1983 by a small number of psychiatrists particularly interested in working in the general hospital, it rapidly gathered support and has been responsible for promoting clinical practice, training and research (Guthrie 1998; Mayou & Lloyd 1985). Progress has been steady but slow; there is continuing concern about the lack of acceptance, both within the rest of medicine and within psychiatry, but there have been solid achievements in terms of the number of services, acceptance as a central part of psychiatric training, in collaboration with medical and other groups, and a significant increase in research output. Progress has been aided by increasing contact and collaboration with colleagues in Europe and elsewhere.

Inevitably clinical developments have depended on individual initiatives and local planning and have been largely separate from increasing knowledge of epidemiology, aetiology and treatment effectiveness. Few services have been evaluated. Increasing national and local efforts to define patterns of service and

Table 1.1. Estimate of size of liaison service and workload for a multidisciplinary liaison team for a district general hospital with 600 beds serving a catchment area of 250 000.

Composition of liaison psychiatry service	Number
Consultant liaison psychiatrist	1
Senior house officer	1
Liaison nurses	5
Health psychologist/clinical psychologist	1–2
Secretary	1
Estimated workload of patients seen	**Annual rate**
Deliberate self-harm	500
A&E episodes	200
Ward referrals	200
Outpatient contacts of patients seen	**Annual rate**
New	100–150
Follow-up	500
Specialized liaison contracts with one or two specific units	100

Source: Royal College of Physicians and the Royal College of Psychiatrists (2003).

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