

What Referring Physicians Can Expect From the Psychiatrist

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Introduction

I reread the title many times as I began work on this talk, all too promptly and uncritically agreed to many months previously. Since that occurred shortly after a *tricky* paraphrase of a well-known quote from a famous inaugural address, I could not help the thought, "Ask not what referring physicians can expect from the psychiatrist; ask what the psychiatrist can expect from referring physicians." That seemed facetious at first, but I realized that Dr. Lebensohn would be addressing himself, among other things, to the latter question. He has been discussing the task of the consultee half of the consultation team, and my assignment is to discuss the consultant's role.

As I looked again at my idle paraphrase, I realized that both parts could be answered partially by, "colleagueship, communication and counsel." To be effective the consultation must evolve out of a sense of mutual respect and mutual goals. Proper communication, which must be a two-way operation, as I will detail later, is the key to a successful consultation. Counsel or, perhaps more appropriately put, teaching is a major contribution the psychiatrist can make to his colleague at this point in time, though he, too, can learn much from the referring physician and the patient. In fact, not nearly enough is known about the psychological problems of illness and medical management so that non-psychiatrist and psychiatrists work-

ing closely together have the potential for acquiring new knowledge and teaching the medical community.

I asked a wise, sensitive, experienced internist what he thought the referring physician can expect of the psychiatrist. He thought carefully for a moment and then said, "You ought to emphasize what the referring physician *cannot* expect of the psychiatrist." The point was, he then went on to elaborate, that the referring physician should not expect the psychiatrist to take every problem patient with emotional difficulties off the physician's hands. He said, "The referring physicians need to know that they will have to care for the bulk of patients with psychological problems themselves and expect the psychiatrists to take care of the complicated or the severe psychiatric problems. I hope you emphasize this very strongly."

He then said, "Now, let me ask you a question. Is it right to expect the psychiatrist to spend some time clarifying for the referring physician how he should understand what is happening to the patient and provide ongoing advice as to how to deal with him? Can the referring physician keep asking the psychiatrist more questions about what is not clear to him?"

At this comment, I was excited and elated and responded, "That's exactly what I think referring physicians should expect and request from the psychiatrist!"

I was much reassured by this exchange with my internist friend, for in my initial thinking about this

paper I had been inadvertently interpreting the title as "What Referring Physicians *Expect* of the Psychiatrist." That paper would have been better presented by a non-psychiatrist. However, my friend's question had emphasized "What Referring Physicians *Can* Expect of the Psychiatrist." I now knew that the answer to that should come from a psychiatrist who had experience in consultative work with medical colleagues.

Now, it would be easy for me to fall into the trap of discussing what the referring physician *should* expect from the psychiatrist, that is, what the ideal psychiatrist consultant should do for his consultee. I will certainly emphasize that in this paper, but a word of caution is in order. Psychiatrists are human and fallible.

Difference Between Psychiatrist and Referring Physician

An important point that must be emphasized is that the referring physician may have expectations about the psychiatrist that are not exactly appropriate. In many ways, the psychiatrist is similar to his non-psychiatric colleagues. He has shared a common professional education to the point of specialization. This is an enormous advantage for colleagueship and communication and may lead the referring physician to expect the psychiatrist to think and function in the same manner as he does. However, this is usually not accurate.

I am reminded of the year I worked in England as a research fellow. As an English-speaking

person, I had expected that I would have no trouble in communication. I soon learned, however, the meaning of the expression "the common language that divides." One often has fewer misunderstandings in communicating with someone whom he anticipates to be different than in communicating with someone who superficially seems just the same but has subtle differences.

The average psychiatrist has been shown to be somewhat different not only in his beliefs and interests, but especially in his attitude toward patients. How much he was a somewhat different person to begin with, for which there is some evidence (Funkenstein, 1968), and how much his specialty training is responsible for, no one knows. However, there are differences, and these seem to make for mutual lack of understanding at times, as I have discussed at more length in a paper called "The Gap Between the Psychiatrist and Other Physicians" (1962).

Briefly, the physician traditionally has been oriented to taking over responsibility from the patient and being authoritarian and decisive. The psychiatrist tends to play a much less active directing role and, after clarifying a situation, leaves the decision up to the patient.

The non-psychiatrist tends to think in precise physical and chemical terms in his approach to human biology. The psychiatrist is generally concerned at present with somewhat imprecise psychological and social issues.

I emphasize some of these differences to forewarn the non-psychiatrist not to be upset or annoyed if his psychiatric colleague doesn't function exactly the way he does.

The Consultation

Now, let us turn to the consultation proper. First, the referring physician can expect a quick response to his request. However, even more

than many physicians, the psychiatrist is apt to be overbooked and, because of the nature of his practice, has a less flexible schedule than many physicians. Hence, he can give more satisfactory willing consultation if he is given advance warning. When the situation is a real emergency, of course, it is appropriate for the individual to expect immediate help.

One of the major problems for the consulting psychiatrist is to ascertain exactly why a consultation is being requested. Therefore, the more precisely the referring physician poses the problem with which he wants help, the more likely it is that the consulting psychiatrist can be useful.

The referring physician should expect a prompt, clear, relevant communication from the psychiatrist after the consultation. He should expect it to be reasonably free of jargon.

For most consulting psychiatrists, putting the report into plain clear language is the most difficult task. Psychiatrists often surpass other physicians in the tendency to use overcomplicated pseudoscientific jargon. However, there are some technical terms in our field which, on occasion, need to be used, and the referring physician should be willing to learn some new terms if he has not had previous adequate training in the psychological and behavioral areas. In most instances, as well as in diagnosis, formulation and definition of the overall problem, there should be some precise suggestions as to the course to be followed. Here, again, the consulting psychiatrist is apt to find himself in trouble. It is infrequent that step-by-step instructions, including drugs and certain prescribed activity, will be sufficient. Instead, subtle attitudes or modes of psychological support often may be in order. These are extremely difficult to detail in a short, simple statement, particularly if the consulting psychiatrist does not know the referring physician well

and is unfamiliar with the degree of his psychiatric understanding.

For the above reasons it will usually be a more useful consultation if the psychiatrist, in addition to preparing a written report, has direct verbal contact with the referring physician either by phone or in person. This creates the optimum opportunity for all concerned to be sure they are communicating appropriately.

I indicated above that few psychiatrists can live up to the ideal, and many of the reports the referring physician receives will neither entirely satisfy his need nor be completely understandable. In this situation, I most strongly urge the referring physician to call the consultant for clarification instead of griping to himself or other colleagues about these "fuzzy-thinking, obscure psychiatrists." He should get back to the psychiatrist, make clear his questions and confusions and see whether he then receives help. Only if that fails should he write him off and find another psychiatric colleague to consult in the future.

Who is Responsible for Continuing Care of Patient

Sometimes the referring physician will expect the psychiatrist to take the patient off his hands and then be disappointed if this doesn't work out. On occasion, the psychiatrist may hold on to a patient the referring physician wished returned.

Proper communication will go a long way to clearing up these difficulties. First, the referring physician should make clear his expectations. Difficulty frequently arises not only because psychiatrists are scarce, but also because their treatment time is usually entirely committed. There are not now enough psychiatrists, nor are there going to be any time in the foreseeable future, to provide continuing care for all the patients with emo-

tional difficulties. Indeed, there is no more reason to think that all emotionally disturbed patients should be treated by a psychiatrist than that all patients with congestive failure should be treated by a cardiologist or all diabetics managed by an endocrinologist.

In my opinion, the average practicing psychiatrist should keep a major portion of his time available for consultations, management of emergencies and severely psychiatrically ill patients; the remainder should be reserved for ongoing patient care. Since the amount of time available for ongoing care is never going to match the need, it is appropriate that the psychiatrist be selective in those patients that he works with regularly and extensively. Ongoing psychotherapy by a skilled psychiatrist has much to offer certain patients. The time involved cannot be significantly compromised, or the process may not be worth carrying out. Moreover, there is major educational gain for the psychiatrist in intensive work with some patients. Through keeping in close touch with the subtleties of human behavior, he will become more skilled in the evaluative process and, hence, a more useful consultant.

Therefore, I am asking the referring physician to be understanding and refrain from pressuring his psychiatrist colleague to keep under his management all or even most of the patients who have psychological difficulties.

Psychiatrist's Role as Educator

A corollary of the above is that the referring physician can expect education and ongoing support from the psychiatrist. Unless he has graduated relatively recently from one of a select number of medical schools, the referring physician will not have a background of sufficient training in psychological medicine to care for a number of his patients. He should expect to be able to learn, by working

side by side with the psychiatrist, to be more effective with psychologically disturbed patients. While this can be accomplished through informal contact about continuing care of patients, there are two models for doing this even more effectively.

Grotjahn and Treusch (1957) have developed a technique whereby the psychiatrist goes to the referring physician's office as a guest and consultant and both he and the referring physician interview the patient. The psychiatrist then discusses the case with the referring physician or occasionally may make his recommendations in the presence of the patient. In every instance, the primary physician concludes the interview with the patient. In recent years Treusch and Grotjahn (1967) have extended the technique to include, in many instances, close family members of the patient. This technique, while seemingly expensive of professional time, affords better patient care and can be professionally instructive to the referring physician. It might even be a more profitable use of time for the referring physician than listening to a talk like this.

Balint (1957) in London has for many years met regularly with small groups of general physicians to participate in ongoing discussions of their own problems in dealing with the psychological difficulties of their patients. The success of such a program is highly dependent on the motivation of the physicians and the skill of the leader. During the year I spent in London, I became convinced of the success of this program as I witnessed the interest and sophistication in psychological medicine manifested by many general practitioners in a variety of different settings.

What the Physician Can Expect from the Consultation

Let us consider the substantive things the physician can expect from the psychiatrist.

1. Confirmation or precise diagnosis of major psychiatric disorder, such as schizophrenia, depression, mania and severe neuroses. In these instances, the referring physician can ordinarily expect the psychiatrist to take over care of the patient or help and advise with regard to appropriate hospitalization.

2. Help in diagnosis and formulation of the problem in complicated cases presenting with obscure somatic symptoms. In this situation joint discussion of the case may be extremely important. The referring physician, who has concluded the obscure symptoms must be neurotically based because all of the usual and unusual laboratory tests are negative, should be prepared on occasion to have the good consulting psychiatrist inform him that no positive evidence of neurotic or psychologically determined illness can be found and that ongoing observation of the patient will have to continue until the underlying etiology becomes manifest. The diagnosis of psychological illness should no more be made by negative findings than any other.

3. Help in the clarification and diagnosis of patients with organic brain disease and advice in the management of such patients.

4. Counsel in the management of previously psychotic patients usually being maintained on drugs. The number of these cases which must be treated by the non-psychiatrist is increasing greatly.

5. Help in the management of seriously somatically ill patients the stress of whose illness has decompensated them psychologically or whose response to the stress has led to behavior which may compromise the proper care of the basic condition. A prime example of this sort of problem is the care of the patient immediately following a coronary infarction. Grete Bibring (1956), in an elegantly lucid paper replete with examples, has shown how an understanding of the personality structure of the

medically ill patient can permit the physician to much more successfully manage the patient during a period of critical illness. In a subsequent paper she and her colleague, (Kahana and Bibring, 1964) outline seven types of behavior patterns that may be recognized and give general guidelines for the appropriate strategy in management of each type of patient.

6. Help in the care of patients with chronic illnesses in which psychological factors may play an etiologic or exacerbating role. The so-called psychosomatic disease would fall in this category.

7. Improvement in communication and the disjunctive social situation whenever there is major difficulty in management of or communication with a hospitalized patient—particularly the patient displaying aberrant behavior. This category includes the situation in which a physician finds himself unduly uncomfortable or puzzled in his relationship with a specific patient. Problems in this category have been particularly well clarified by some of the psychiatric liaison services in university general hospitals. Meyer (1962) and Meyer and Mendelson (1961) write clearly about these problems.

8. Support in his attempts to handle difficulties both in and out of marriage as well as other difficulties of a psychological or behavioral nature within families. Antisocial behavior and drug problems in adolescents are increasing in frequency. Grief in the family members who have lost a close relative needs attention.

9. Help in more fully understanding the patient with pain and support the physician in the arduous task of long-term care of such a patient. Pain is too complex an issue to discuss here, but it is important to remember that pain is an intensely subjective experience and that the general set of the individual determines how pain is experienced and dealt with.

10. Collaboration in the care of

dying patients. The problem of the dying patient is one which the medical profession all too often fails to meet directly. The psychiatrist is generally not involved unless behavior becomes blatantly abnormal. Those psychiatrists who have dealt with significant numbers of dying patients—usually because of making a special study—have demonstrated that the suffering of many can be greatly alleviated by intelligent, individualized treatment. We need to learn much more about this area of the physician's responsibility.

Psychiatric Consultation-Liaison Programs

Before closing, I would like to make some comments about general hospital-based psychiatric consultation-liaison programs which have made major contributions to the psychological understanding of medical practice and to indicate some different points of view toward the consultation process, especially as it pertains to the hospitalized patient. These programs have been especially meaningful, since with rare exceptions other psychiatrists do not get significantly involved with the mainstream of medical practice. Generally consultations are requested for the very disturbed, those with obvious psychiatric problems, and those patients who create serious difficulties in communication for the physician.

The better psychiatric liaison programs have developed an approach which makes members of the psychiatric groups integral members of the medical team on other services in the hospital. This permits psychologically well-trained physicians to come into direct contact with the totality of medical problems, at least as they present themselves in the general hospital. I will not detail all the references in this area but suggest that those of you who are interested in pursuing this further read two articles by Z. J. Lipowski in *Psychosomatic Medicine* (1967a, b). His extensive

bibliography will permit you to read as widely as you wish in this area. A number of excellent books have been written on this subject. A useful one, particularly because it is the most recent, is that by John Schwab entitled *Handbook of Psychiatric Consultation*. It also has an extensive bibliography and, while it is addressed to psychiatrists primarily and is somewhat less profound and comprehensive than some others, it is quite readable and would provide a good source for the non-psychiatric physician.

Approaches to Consultative Process

Over the years, chiefly from work of psychiatric liaison psychiatrists, a number of approaches to the consultative process have evolved. The first approach has been called patient-oriented. This approach is that of the traditional medical consultation. Gradually, we have become aware that this approach in the psychological sphere can be somewhat limited. In this approach the psychiatrist focuses primarily on the patient and responds only to the explicit questions raised by the referring physician. This approach is primarily oriented to patients with obvious psychopathology. It doesn't fit the frequent circumstances where some other difficulty, such as the patient's behavior, difficulty in management, etc. becomes the reason for the consultation. Moreover, as psychiatric consultants worked closely with their colleagues in the general hospital, it gradually became apparent that the concerns of the referring physicians, both covertly and overtly, were often more complex than the usual explicit requests would indicate.

The next approach to be developed was the consultee-oriented approach. It follows from some of the things I have said earlier about the lack of training of the physician in psychological medicine in the past and the problems raised

in the physician by certain types of patients that the psychiatrist would become oriented in helping the referring physician to understand his part in the difficult situation. The notion of the consulting psychiatrist having a role which included teaching and an ongoing relationship with the referring physician was an integral part of the development of the consultee-oriented approach.

As an outgrowth of careful attention of the general hospital-based liaison-psychiatrist to all the problems concerned with patient management, the situation-oriented approach developed. Gradually it became apparent that, in many instances, in order to understand the difficulty in patient management it was necessary to know the total social or ecological circumstances of the hospital ward and medical care team where the patient was hospitalized. Some patients, for example, have the capacity to create difficulties between the attending physician and the nurse or between members of the house staff and the attending staff; on occasion, inherent difficulties in communication among the staff may light up certain problems in the susceptible personality characteristics of the patient. The point is that a hospital service is a complicated small social unit, and, to insure the best medical management for some patients, it is necessary to understand the total complex of all the forces in action, that is, the patient and his interaction with all those immediately concerned with his care. A collateral extension of this has already been referred to above, namely, that in some instances one cannot appropriately care for and treat some patients without an involvement of the total family of the patient. The need for the situation-oriented approach becomes increasingly great as we develop special care units, coronary care units, renal dialysis units, and others. In fact, some of the special medical situations now developing

lead to such significant stress for the emotional lives of the physicians, nurses and other staff that the psychiatric member of the team becomes essential.

Summary

I hope that I have persuaded you that the psychiatrist can be a very useful colleague to non-psychiatric physicians. He can be most useful if the referring physician works at developing a mutual learning relationship with him and keeping all lines of communication open.

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