Consultation-Liaison Psychiatry and Personal Views

Prepared for Advanced Trainees Dinner

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Thank you for asking me to share my view on CL tonight. I will briefly describe my history in CL in the hope that an old person's completed journey may resonate with those who set out on similar roads. I know that a personal journey leaves out other personal stories. I apologise for that.

History in Div A

My CL story started in 1975, 36 years ago, when I was 38, and a psychiatrist for 9 years. Dr Orchard at Prince Henry's Hospital introduced me to Dr Ian Jones, head of general medicine Division A. I had no idea what my role was to be. I thought I would monitor antidepressants to secondarily depressed patients.

I was given a couple of weeks' grace, in which I was grateful that I did not have to deal with life and death issues like my medical colleagues. Then I was thrust into life and death issues, and did not leave them till the end of my working life, if even then.

I was asked to help the group on how much morphine dying patients in pain should receive. I could have given a glib answer, but I had the idea to talk to dying patients in pain. Again I had no idea how to approach them. I couldn't ask "How is your dying going?" Necessity made me devise a question that I found to be useful subsequently for all patients. The question was, "Of all the things that worry you, what worries you the most?"

Emergency departments

The emergency department wanted a liaison psychiatrist but nobody wanted to fill that post. Psychiatrists were reluctant to work in a chaotic unfriendly environment, to just rid the department of unwanted overdoses so doctors could get on with real medicine. I agreed to give it a 3-month trial. I stayed for a quarter of a century.

I soon realised that overdoses were the tip of an iceberg of fear that pervaded the department: fear of the unknown that signified death. The unknown was mental- why did people find life so meaningless that they wanted to end it? And another fear: why were people aggressive and violent, threatening the security of staff? If I could get rid of the depressed and the violent, they could just get on with rationally saving people's lives.

I had previous experience of locked up patients becoming violent due to terror and indignity resulting from their treatment. This translated to the emergency department. We taught staff that aggressive patients were four times as frightened as the staff themselves, and if asked, aggressive patients would communicate their fears. Civilised treatment pacified patients.

In fact we had built a homely yet professional talking room in the emergency department where agitated patients calmed down. The room was lockable but it was never locked.

The journey to understand despair and "The mental" was longer but of course neither understanding violence against self, nor against others, solved

life and death issues for emergency department staff. But understanding did help patients.

Let me just interpose that at our peak, we had developed a nice little team in the emergency department: we had a psych registrar, 2 psychologists, a social worker, and emergency department residents and registrars. We had regular clinical meetings and students could observe interviews in the talking room through a one-way mirror.

I want to mention briefly two life and death areas of experience that greatly influenced my journey. The first area was stress and trauma.

Stress and Trauma

When I started my emergency department CL work, Dr Allen Yuen, head of the department and a friend of mine to this day, was developing Victoria's medical Disaster Plan. He organised a major disaster exercise in which for the first time mental health staff took a significant part.

Not long after this the 1983 Ash Wednesday bushfires erupted in Victoria. Through the auspices of the new Disaster Plan, Prince Henry's psych department sent a mental health team to the Mt Macedon area.

Observations of raw trauma threw up many interesting observations. I want to mention just one. In the initial days people were very clear that their various aches and pains and palpitations were part and parcel of their fire experiences. However, within 2 weeks these very same manifestations became disconnected from traumatic experiences and became symptoms that caused people to flood their doctors. These symptoms resembled many similar symptoms that we saw in the emergency department, and on enquiry they were also results of disconnected personal disasters.

Whether in the bushfire or in the emergency department, these psychophysiological symptoms were not random. They belonged to one or other survival strategy that we realised were used ubiquitously in disasters: - fight, flight, rescue, attachment, goal achievement, goal surrender, competition and cooperation. Symptom relief was achieved by tracing symptoms back to the original traumatic situation, contrasting that situation

with current security, and resolving moral dilemmas and meanings embedded in the traumatic situations.

I came to realise that my psychotherapy patients had suffered similar traumatic situations and had developed similar symptoms. The difference was that their symptoms were more entrenched and their traumatic situations had often occurred in childhood.

The other area that greatly influenced my thinking were the biopsychosocial expressions of stress and trauma.

Biopsychosocial Medicine

The bushfires made it crystal clear that survivors' survival strategies led to concurrent biological, psychological, and social symptoms. It also became clear that survivors communicated symptoms according to helpers' cultures. Physical symptoms were culturally most acceptable, and were the ones survivors communicated to doctors. However, psychological symptoms were communicated to psychiatrists and psychologists, and social symptoms to social workers.

The harm done by restricting communication to a particular mode was clinched for me when I observed a registrar making physical observations on a raped woman. His purely physical approach contrasted with the patient's face- it expressed horror. She was being re-raped, re-traumatised.

It was as if medicine was a three-sided pyramid of biological, psychological, and social surfaces that were invisible to each other, each striving for a simple diagnosis at the top. Our CL team tipped the pyramid upside down. The question "Of all the things that worry you, what worries you the most?" allowed the heaviest contents of the pyramid to emerge first, in a conglomerate of biopsychosocial problems. For instance, instead of climbing up the pyramid gathering symptoms of depression and finishing with depressive or bipolar disorder, grief would pour out from the inverted pyramid and depression would dissolve in the shed tears.

We took "The mental" to all emergency department patients. We picked patients randomly from a white board. To our surprise we found that even typical physical illnesses had significant psychosocial contributions.

Eventually we postulated 6 overlapping categories of illnesses: classically physical; classically psychiatric; psychophysiological stress responses, like after the bushfires; reliving of traumas; symptoms cherished for purposes such as keeping a spouse from leaving; and lastly, symptoms that replicated those of deceased love persons; such as a widow who suffered chest symptoms that she imagined her husband had suffered prior to his death.

Finally, I want to say a few words about why CL has been treated as the Cinderella of medicine.

Rejection of CL Psychiatry

Medicine has become ever more technical, fragmented, reductionist, and infiltrated by managers who use statistics for their own and their masters' purposes. The movement was abetted by Big Pharma who benefited from ever more DSM diagnoses that its drugs supposedly cured.

CL psychiatry, on the other hand, is less technical, more mental, human, and integrative. Its psychodynamic revelations are not naturally amenable to statistics, and they often render drugs to be superfluous. So we swim against a cultural tide.

Yet I believe that there is more to CL psychiatry being a poor cousin than the rise of technology, specialisation, and computer-like thinking. It goes deep into the way we are made up; divided into logical, rational, verbal, thinking, time-aware, self-aware selves, and emotional, non-verbal, unthinking, time insensitive, integrative, creative, self-unaware selves.

You realise that I am referring to the split between the right and left hemispheres of our brains. Historically one or other hemisphere has dominated cultures at different times. Currently the left hemisphere is dominant and it has taken over medicine and psychiatry, which hangs on to medicine's coat-tails for survival.

Left-brain dominance allows only a mechanistic view of life and death issues. Traumatic ripples of survival and moral predicaments, existential dilemmas, even regulation of psychophysiological responses, all of which are right-brain functions, are outside left-brain consciousness. Those threatened by the secrets of the unconscious deride any attempts to expose this can of worms. And yet, at the least, we did introduce compulsory departmental debriefs whenever a death occurred in the department, and the

doctors were grateful to be able to resolve their hidden guilts, angers, and existential meanings. After all, life and death issues, beyond suicide and violence, were ever-present in the emergency department.

In conclusion, I want to say that we are the only ferrymen who can navigate the right- and left-brain biopsychosocial streams; who recognise mind and body and their evolutions into science and spirituality. I mean it is we who appreciate the value of this special jewel in the crown of medicine, one which is constantly re-buried in dust rather than is polished and allowed to glitter.

You are the special jewellers in whose care we entrust this treasure in the hope that it will survive and impart its light.