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Letter to the Editor

BRIEF HISTORY OF CONSULTATION-LIAISON PSYCHIATRY, ITS CURRENT STATUS AND TRAINING IN MODERN PSYCHIATRY: A PERSPECTIVE FROM THE UNITED STATES

Dear Editor,

It was stated that the history of the psychosomatic medicine dates back to B.C. 3rd century. Johann Heinroth (1773 – 1843) coined the term of "psychosomatic" in 1818 (Steinberg 2007) and Felix Deutsch first described the concept of the "psychosomatic medicine" in 1922 (Lipsitt 2001). It can be argued that the clinical field and scope of the term evolved to secure its place in modern medicine within the first half of 20th century. Intersection of psychiatry and general medicine was generally ignored as a concept in the early psychiatry textbooks, which was contributed to the isolated state of psychiatry in the asylum model (Wise 2011). It was documented that James Jackson Putnam was the first consultation psychiatrist to work as a neurologist in Massachusetts General Hospital (MGH) in 1872. His colleagues reportedly called him the "Chief Electrician" and two beds were allocated to his neuropsychiatry service in MGH in 1903 (Friedman and Molay 1994).

The first psychiatry unit established within a general hospital was the 12-bed F pavillion at the New York Albany General Hospital in 1902 by James Mosher (Lipsitt 2003). Albert Moore Barrett established the "University Psychopathic Unit" at the University of Michigan (Hinsdale and Demmon 1906). Henry Phipps Psychiatry Clinic was opened in Baltimore Johns Hopkins Hospital in 1913. During the opening ceremony, Adolf Meyer and William Osler both made historical remarks advocating that the psychiatry services had to be available in the general hospitals (Osler 1913). Meyer who was the first director of the Phipps Clinic described the `psychiatric patient` as a somatic and psychological unity that contracted a disease as a result of the internal pathology and environmental adaptation difficulty. By describing the terms of "psychobiology" and "common-sense psychiatry," Meyer left a permanent mark in the understanding of biopsychosocial basis for the psychosomatic medicine (Lipsitt 2003). After approximately ten years, another psychiatry unit was opened in Detroit Henry Ford Hospital in 1923 under the management of Heldt who shared his experiences in the article entitled "Function of a psychiatry unit located in a hospital" (Heldt 1927). He reported the prevalence of the psychiatric disorders in the general hospital as 30%. In addition, Moersch reported the same prevalence at the Mayo Clinic Rochester as 35-40% for the same time period (Lipowski 1986, Moersch 1932). The concept of `hospital psychiatry` did not become popular until the beginnings of First World War. The ending of this period of stagnation coincided with the publication of the first consultation psychiatry article in the American Journal of Psychiatry in 1929 by George Henry—a pupil of Adolf Meyer. The article written by Henry entitled "Modern Approaches to the psychiatry in the General Hospital Practices," has played an important role in the history of C-L Psychiatry. Henry, for the first time, described the indications of a psychiatric

consultation for medical-surgical patients and emphasized the role of the hospital psychiatrist. A leading figure, Helen Flanders Dunbar, and her team at The Columbia University of New York published an article on psychiatric disorders with medical comorbidities including diabetes, heart diseases, and bone fractures (Dunbar and et al. 1936). Dunbar rejected the divided concepts of "organic" and "functional" and she theoritized her ideas in her book entitled "Emotions, Body and Mind" in 1935 (Dunbar 1935).

Internist Alain Greg was the chairman of the Medical Sciences Division of the Rockfeller Foundation in 1934. Greg controlled the research budget at the time, and allocated a significant amount of research budget to the psychiatric departments in the country. This helped establisments of new psychiatry services and also made contributions to improve the already available psychiatry services within others. C-L psychiatry research and education across the Unites States were supported as a result. The first formal C-L Psychiatry Division in the history was established in Colorado General Hospital in 1934 with the name of "Psychiatric Liaison Department" by Dr. Edward Billings who was also the first to describe the concept of "liaison" (Billings 1966). Soon after, C-L psychiatry services were established in Massachusetts General Hospital, Johns Hopkins Hospital, University of Rochester Hospital, and Mount Sinai Hospital in New York. In the 1970s, Dr. James Eaton, Director of National Institute of Mental Health, ensured that significant support was provided for the consultation liaison psychiatry programs. Although this support incurred a significant decrease in 1980s as a result of the budget cuts of the American Government, C-L psychiatry continued to develop until 1990s. In 1992, Academy of Psychosomatic Medicine applied to the American Board of Medical Specialties (ABMS) formally recommending that C-L psychiatry be an accredited subspecialty. However, the Academy's request was denied at that time. In 2001, an alternative academic name, Psychosomatic Medicine, for the subspecialty field was agreed upon by the Academy. In addition, the specialty description made for the basic patient population was modified as 'medically complicated' in the new proposal and the newly proposed application was accepted in 2003. Psychosomatic Medicine was approved as a recognized subspecialty of the Psychiatry by the Accreditation Council of Graduate Medical Education (ACGME), which has been since then the agency responsible for setting and enforcing the formal education standards. Academy of Psychosomatic Medicine, American Psychiatric Association, and American Board of Psychiatry and Neurology (Wise and et al. 2005) are collectively responsible authorities to set the practice guidelines of the specialty. C-L psychiatry is currently represented in USA by three professional organizations and the 'field' has three peer-reviewed and indexed journals (Philbrick and et al. 2012).

Psychosomatic Medicine and Consultation-Liaison Psychiatry

By their historical development, Psychosomatic Medicine and C-L Psychiatry are intertwined concepts; however, certain differences have been emphasized in the literature. C-L Psychiatry has been described as the practical field requiring all the clinical skills and knowledge collectively used to diagnose and manage emotional and behavioral conditions of the patients (patients having medical comorbidities) referred from medical-surgical units. In addition, the description of Psychosomatic Medicine emphasizes a nonclinical theoretical field that traditionally examines biological and psychosocial factors contributing to the development of disease. To simplify two concepts using their historical references (Lipowski 1967), it would probably be appropriate to define Psychosomatic Medicine as the academic field examining the mind and body relationship within Medicine and to define C-L Psychiatry as the clinical practice implementing the academic field of Psychosomatic Medicine within a structured psychiatric subspecialty. Psychosomatic Medicine and C-L Psychiatry were used interchangeably in the common consensus published by the European C-L Psychiatry Association and Academy of Psychosomatic Medicine in 2011. Both concepts are used in the same meaning in today's academic psychiatry.

C-L Psychiatry Training in the United States

C-L Psychiatry training required for general psychiatry residents, set by ACGME, includes a period of at least 2 months, which is to be spent within inpatient and outpatient psychiatric consultation services for the surgical and medical units of a general hospital. Although ACGME stipulates a minimum of two-month rotation in residency, most of the resident education programs require a minimum of three-months. Some training programs require this period to be at least 6 months (ACGME 2014, "Cleveland Clinic Adult Psychiatry Residency Program" 2015, "Georgetown University Psychiatry Residency Program" 2015). American Psychosomatic Medicine Society (APM) tried to increase the percentage of C-L Psychiatry curriculum in general psychiatry residency from the beginning of 1990's. Current accepted C-L Psychiatry curriculum was developed by the task force led by the head of APM, Davit Gitlin in 1996. Basic subject titles that were proposed to be included in C-L Psychiatry rotation can be summarized as follows: acute stress disorders, aggression/impulsivity, AIDS/HIV, alcohol and substance-use disorders in the general hospital environment, depression, anxiety and personality disorders, decision-making capacity evaluations, coping with disease, death and mourning states, delirium/agitation, dementia, factitious disorders and malingering, pain, psychiatric syndromes caused by the medical and neurologic diseases, psychological factors effecting

medical states, psycho-oncology, psychopharmacology for medical and surgical patients, psychotherapy, somatoform disorders and suicide (APM-Task-Force 1996).

Fewer than half of the general psychiatry residents in the US chose to pursue subspecialty training in the year of 2011 according to American Board of the Psychiatry and Neurology (ABPN) (Faulkner and et al. 2011). In order to become a psychiatrist in the US, one must complete a four-year medical school education to obtain an M.D degree. This also requires a four-year premedicine degree, and attendance of a four-year post-graduate psychiatry residency training in a program recognized by ACGME. Upon completion of residency training, psychiatrist may attend one of the subspecialty training programs accredited by ACGME. However, graduates of a general psychiatry residency program are not allowed to sit for subspecialty board examinations unless they are board certified in psychiatry ("American Board of Psychiatry and Neurology" 2013). C-L Psychiatry has been an accredited psychiatric subspecialty in the US since 2003 and subspecialty board certification examination has been administered biannually since 2005. Accreditation process for C-L Psychiatry training programs by ACGME has been ongoing since 2003. The University of Maryland, Boston University, Georgetown University, University of Washington, and Virginia Commonwealth University were the first training programs to receive accreditation. These were followed by Mayo Clinic, Cleveland Clinic, and Massachusetts General Hospital. This number has gradually increased in the following years. According to American Medical Association FREIDA database and ACGME data (ACGME 2015, American Medical Association 2015), there are currently 59 ACGME-accredited C-L Psychiatry subspecialty-training programs throughout the US (including the University of Ohio State that received accreditation in the year of 2015). Eighty nine psychiatrists of the 6,531 psychiatrists (1.36%) who graduated from general psychiatry programs in the US choose to subspecialize in C-L psychiatry (Psychosomatic Medicine) according to the 2014 data of the American Psychiatric Association. C-L psychiatry became the mostly preferred psychiatry subspecialty following Child and Adolescent Psychiatry (American Psychiatric Association 2014).

Current C-L Psychiatry Practice in the US

C-L psychiatry is a recognized clinical subspecialty, and it renders services as a seperate clinical unit within psychiatry departments of all major general hospitals. Most C-L psychiatrists in academic centers completed one-year formal subspecialty training in C-L subspecialty, and are board certified in the field of psychosomatic medicine. In the recent years, some major academic medical centers in the US moved psychiatry services out of their main campus. C-L Psychiatrists, however, consistenty remained in main campuses regardless of the site of other psychiatric services provided. C-L Psychiatry is divided into further subspecialty fields in the academic practice. Such fields include, but are not limited to, HIV Psychiatry, Psycho-oncology, Transplantation Psychiatry, and Perinatal Psychiatry. In US general hospitals, C-L psychiatrists perform evaluations of decision-making capacity, In some hospitals, C-L Psychiatrists are part of crisis intervention teams rendering a 24-hour consultation service ("Cleveland Clinic Adult Psychiatry Residency Program"2015). C-L psychiatrists are important members of the tranplantation committees in US academic centers and they are involved in the decision making process of candidate selection. C-L psychiatrists participate in the management of delirium and somatoform spectrum disorders and they are essential members of the hospital bioethics committees.

Medicine, Psychiatry and C-L Psychiatry

On a mission to solve the most convoluted problems of medicine, psychiatry's journey in the history of medicine has been eccentric. Going through the asylum era, psychiatry accomplished to become a part of the general hospital practice utilizing consultation-liaison practice in the beginning of 1900's. It can be argued that psychiatry has faced more challenges than any other field of medicine throughout its history. For example, it went through periods inwhich psychiatric patients were discriminated. Having experienced an identity crisis lasting almost a century, psychiatry has obtained its today's esteemed place in medicine and in the general hospital practice as a result of the academic, clinical, and political struggles (Pasnau 1987). Today, a strong psychiatric consultation-liason service is indispensable for any major general hospital in the US. Psychiatry has come a long way from not being included as a medical specialty within a general hospital to an absolutely required service. C-L psychiatry certainly has played the most important role in this process as detailed above (Ali et al. 2006, Pasnau 1982).

Some important reasons of the critical role played by C-L psychiatry on the unification (remedicalization) of psychiatry and medicine will be argued below:

Scientific contributions by C-L psychiatry

There are important scientific contributions made by CL psychiatry to the other medical fields. For example, drawing attention to the psychiatric sequelae of the medical problems, diagnosing, treatment, and psychopharmacological management of the psychiatric diseases associated with medical comorbities and determination of psychiatric effects of the non-psychiatric drugs. C-L psychiatry made some important academic contributions, which arguably modified the clinical management in diseases such as diabetes, HIV/AIDS, coronary artery disease, cancer, stroke, Parkinson's disease,

dementia, and delirium (Ali et al. 2006, Levenson 2011, Philbrick et al. 2012).

Hermeneutic Role of C-L Psychiatry

Hermeneutics is described as the science and art of interpretation. As Leder emphasized in 1988, C-L psychiatry has acted as a "moderator" between medicine and psychiatry by reinterpreting the accumulated knowledge from a patient centered perspective (Leder 1988). The scope of this mediation mission has included the addition of the psychiatric aspect (psyche) to the "biophysical" aspect, which reflects the anatomical and physiological aspects of the diseases. This effort has certainly helped the historical separation of physical and psychological points of view (*Cartesianist dualism* - one of the vectors that excluded the psychiatry from the medicine throughout its history) to be melted in the same pot for the patient benefit. In addition, it can be argued that the compatibility issues of Freudian concepts and terminology with general medicine have been largely resolved with the help of C-L Psychiatry. In time, C-L psychiatrists have played a role to unite the mind-brain dilemma (psycho-soma) in the medical frame by reinterpreting the psychiatric knowledge base. This role of C-L psychiatry certainly has increased the prestige of the field in the modern hospital and reinforced its place (Brown 1989, Leder 1984).

C-L Psychiatrist as a role model

C-L psychiatrists represent the clinical and theoretical academic field where medicine and psychiatry have gotten closest in their history. This is evident by the unique clinical and academic relationship of C-L psychiatrists with other specialists (especially neurologists and behavioral neurologists). C-L psychiatrists: 1) rely on laboratory work-up and brain imaging; 2) concentrate on explaining psychiatric problems with physiopathology; 3) use common medical terminology; 4) are familiar to general medicine and psychiatric disorders associated with medical comorbidities; and 5) demonstrate knowledge base and experience by which they can communicate to non-psychiatric physicians effectively (Ali et al. 2006). In this context, C-L psychiatry is a psychiatric subspecialty, which most firmly represents the academic existence of the `field` within medicine and its "organic" connections with medicine.

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