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Trainees' forum

Psychiatric patients and their medical care

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Informal discussions between psychiatric trainees reveal frequent difficulties and frustrations in providing adequate medical care to psychiatric patients. Our writing this article was prompted by the death of a patient who had been referred to casualty with behavioural and physical problems, and who, once labelled as a 'psychiatric patient, did not receive the medical attention he required. Other trainees will have their own similar examples, at best resulting in only inconvenience to the junior doctor. This may seem surprising given the knowledge that people with psychiatric problems suffer increased physical morbidity. We were all taught as medical students that a physical presentation may mask a psychological problem and vice versa, and that both problems may co-exist. However, this knowledge does not always impinge on hospital clinical practice. From the viewpoint of junior psychiatrists, cross-specialty referral and consultation, and the provision of adequate medical care to our patients can be difficult. In this discussion, we will deal briefly with the contribution of 'physical' medicine to this state of affairs and then turn in more detail to the influence of psychiatry. Recommendations for improvement are made.

From the medical side

There might be the fear that a psychiatric patient will cause havoc on a medical ward, or an assumption that he or she will not cooperate. It is sometimes difficult for an actively ill psychiatric patient to comply with even minor procedures. Problems are increased if the clinician has little experience of disturbed people, who often need repeated explanation and reassurance and a firm manner, which other specialists may not be accustomed to providing. In addition, our colleagues may be under pressure from their own nursing teams not to accept patients perceived to be 'difficult'.

From the psychiatric side

There are several aspects to be considered.

The psychiatric trainee

A reality of any specialist practice is that unused skills atrophy. Most trainees are not as experienced in detecting and managing physical problems as, say, a medical SHO. This may lead to a lack of confidence in the referrer, which in turn will affect the attitude of colleagues to a referral.

Nursing colleagues

The training of psychiatric nurses may include only eight weeks in a general ward. This is scarcely sufficient to familiarise nurses with basic techniques e.g. suture removal, changing dressings, insertion of urinary catheters and management of IV lines. Without adequate nursing care of physical problems, good medical management is impossible. This can be difficult to convey to medical colleagues who wonder why we cannot manage simple medical or surgical problems, with their advice and supervision, in our own wards.

The institution

In a recent statement, the College (1990) recommended that, "Patients must have access to good medical and surgical facilities and trainees must have the opportunity to liaise with appropriate specialists." Both depend on the nature of the institution. In large psychiatric hospitals, where many of our patients still remain, investigations are at best limited and often non-existent, with significant delay in obtaining even routine investigations and results. Psychogeriatric patients are especially vulnerable. In one health district, 40% of patients admitted to psychogeriatric wards from home had medical problems, many of which could not be dealt with in the psychiatric setting (Kafetz, 1988). Of equal concern, it is our impression that in large psychiatric institutions the educative value of liaison between psychiatry and other specialities is often minimal.

Community care

A significant number of the chronically mentally ill now live in the community. Services and facilities

available to them are frequently less than adequate. It has been shown that the most deprived mentally ill often have poor access to medical care (Weller *et al*,1989). With changes in mental health care policy, increasing numbers of patients are likely to have difficulty obtaining the medical care they may need.

Strategies for improvement

Increased awareness

Because referrals between specialities are usually dealt with by junior doctors, consultants may be unaware that any problems exist. If juniors experience problems liaising with other clinicians, it is crucial that these are brought to the attention of more senior medical, surgical and psychiatric staff. This can be achieved both by informal communication with our seniors as well as by direct enquiry as part of the audit process.

Undergraduate training

Attention must be focused on the relationship between physical and psychiatric illness and the frequency with which they coexist. The kinds of psychiatric problems likely to be met in future practice in specialities, including general practice, should be emphasised. Problem based learning is a strategy used in some medical schools, and can be recommended as an approach which fosters the notion of the patient as a whole person whose problems might inter-relate.

Postgraduate learning

More contact between specialists is the key to increased interdisciplinary awareness. How can this be achieved? Joint management of patients, where appropriate, is a good start. There are, unfortunately, few beds for those who are both psychiatrically and medically unwell (Mayou *et al*, 1990), but joint clinics go some way in this direction, for example, in paediatrics, geriatrics and pain management. Junior doctors in the specialities involved should take part. With many psychiatric units located in District General Hospitals, there are greater opportunities for contact between specialities. However, gains in terms of training and improved service will only be made if junior doctors are not so overburdened by service provision that they are unable to avail themselves of such opportunities.

In some psychiatric training schemes trainees can have six months experience in general practice. Such placements are likely to be helpful in maintaining our skills, and enabling us to liaise more effectively with general practitioners, who, after all, practise a good deal of psychiatry.

The role of liaison psychiatry

Although it has been slow to develop in the United Kingdom, liaison psychiatry is a well established subspecialty in the United States and Australasia, where it deals with clinical work, teaching and research at the interface of psychiatry and medicine. Such services vary greatly throughout this country and are frequently provided by junior psychiatrists with inadequate supervision (Mayou *et al*, 1990). Consultation-liaison psychiatry is more than simply dealing with the behavioural problems of patients on medical wards. One of the authors (SC) has worked in a health care setting with a well developed liaison psychiatry service. There, psychiatry had a higher profile and interchange between specialties was facilitated, to the benefit of patient care and junior doctors' education.

Nurse training

There is a strong case for requiring general nursing training before specialisation into psychiatry. Project 2000 is an initiative which proposes a core training of 18 months for both general and psychiatric nurses (UK Central Council for Nursing, Midwifery and Health Visiting, 1987). This will improve the quality of physical care offered to patients in a psychiatric setting. Likewise, nurses in the field of physical care will be more confident in dealing with patients with disturbed thinking or behaviour.

Community care

We suggest that the community psychiatric nurse is the person whose role is best adapted to the new 'case manager' position in respect of psychiatric patients. A professional with some medical knowledge is less likely to overlook physical problems which can make such a significant contribution to a chronic lack of well-being.

Audit

Audit should be used to enquire specifically into the quality of medical service provided for psychiatric patients. Trainees could use this development to help themselves if they are prepared to become involved, looking, for example, at availability of equipment, length of time for take up of referrals, and their own levels of skill.

Psychiatry is a vital part of the wider discipline of medicine. For the benefit of our patients, we hope that future psychiatric and medical practice will reflect this more clearly than is the case now. Today's trainees will help shape tomorrow's services. It is crucial that we increase discussion of issues such as those addressed above and act on them to improve patient care.

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Foreign report

Towards an implementation of the Italian model of community psychiatry

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The Italian Reform Act (Law 180) has been considered one of the most revolutionary Mental Health Acts in Western countries and has been the subject of considerable attention since its promulgation in May 1978. Interest in the Italian model of community psychiatry has been reflected in the number of articles, special supplements and letters, published in noteworthy European and American journals. However, for a better understanding of the meaning of Law 180 (now part of Law 833 concerning general health measures) the political and sociocultural climate surrounding the enactment of the Italian Mental Health Act should be considered.

From the early 1970s, Professor Franco Basaglia, medical director at Gorizia and Trieste mental hospitals in the north-eastern part of Italy, developed an innovative model of community psychiatry which was supported by left-wing political parties, student organisations and the general public in the context of the battle for civil rights. In 1977, a petition called by the Radical Party to repeal articles of the 1904 Mental Health Act, gained 700,000 signatures and on 13 May 1978 the Italian Parliament quickly passed Law 180 to avoid the likely political vacuum that a public consultation would have created. Finally, Law 180 became part of a national Health Care Reform (Law 833) which set up a National Health Service and established catchment areas (Local Health Units) with a population of 50,000 to 200,000 inhabitants.

Briefly, Law 180 ('Act on voluntary and compulsory examinations and treatments') stated:

(a) the prohibition of new first admissions to mental hospitals after May 1978 and no admission at all after December 1981 (the 'closing down' of the mental hospitals)
(b) the focus of psychiatric intervention on community based services such as day hospitals, crisis intervention centres, sheltered accommodation and family homes
(c) the 'continuity' of care with the integration of intramural and extramural services coordinated by members of the same psychiatric team
(d) the authorisation of compulsory admission within the general hospital in psychiatric wards of up to 15 beds on the basis of two medical proposals and with the prescription of the mayor
(e) the above statement to be national guidelines but with practical implementation given to regional and local authorities.