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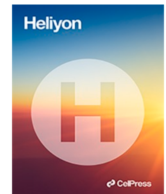

Research article

A supervised consultation–Liaison psychiatry training model in a general hospital in China

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A B S T R A C T

Consultation–liaison (CL) psychiatry is becoming a recognized subspecialty in medical settings; it is a branch of psychiatry that addresses the treatment of the medically ill. Training for CL psychiatry is still insufficient in China. We introduce our training model, supervised CL based on the Union Psychosomatic Clinical Approach with Learning Exchange (UPSCALE) model, to improve consultation–liaison skills among psychiatrists. We describe the supervision process via a clinical case. The supervisee expresses learning needs, and the supervisor selects a consultation case and performs interviews via the UPSCALE model. After the interview, the doctors provide feedback to the patients and discuss the case. The experience includes reporting summaries and experience narratives from supervisees, as well as comments and guidance from supervisors. Through the supervised consultation–liaison training model, young psychiatrists have multiple opportunities to improve learning by observing, practising, and exchanging experiences in CL psychiatry.

1. Introduction

Consultation–liaison psychiatry (CLP) is defined as psychiatry that includes the diagnostic, therapeutic, teaching, and research activities of psychiatrists in medical settings [1]. Consultation refers to providing assessment and management of a specific patient, whereas liaison refers to the education of medical providers regarding the general care of psychiatric patients in medical settings [2]. CLP was first established in 1929 [3] and has developed rapidly since the 1970s, especially in Europe and America [4]. With the increasing number of medical patients with mental disorder diagnoses [5], CLP has become a recognized subspecialty and is expected to provide services to patients with psychiatric comorbidities, services to patients with psychiatric symptoms due to their physical condition, help with clinical communication between patients and their doctors, and more. Consultation–liaison (CL) physicians are expected to have the following multidisciplinary knowledge and skills: (1) the ability to address the psychiatric problems of patients with physical illnesses; (2) the ability to assess and manage the risks of suicide, assault and agitation; and (3) the ability to communicate and interact with non-psychiatrists and patients' family members [6].

In China, mental and psychological health institutions can be classified into two categories: psychiatric hospitals and general hospitals with psychiatry or psychology departments. Mental health resources are scarce, and systematic training and research remain rare [7].

Approximately 173 million people in China have a mental disorder in need of treatment, while 158 million (92 %) of these patients

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have never been treated [8]. The interaction between physical diseases and mental disorders has thus far received little attention in our country [9]. Moreover, almost all the psychiatry or psychology departments in general hospitals are new and do not have wards or training bases for resident physicians. Psychiatry resident training is mainly completed in psychiatric hospitals: residents spend two years on rotation in psychiatric hospitals and one year on rotation in neurology, cardiology, and emergency departments in general hospitals.

Their clinical knowledge and skills are acquired through ward rounds, case discussions, and professional lectures [10]. This training is relatively basic, and CLP is not included in resident training. They have almost no opportunity to observe consultations or participate in multidisciplinary discussions. When psychiatrists start working in general hospitals as CL physicians, it is challenging for them to work effectively. Therefore, CLP training is necessary for psychiatry residents. A study by Charles Jin suggested that CLP training reduces the use of constant patient observation in general hospitals and may therefore increase physicians' clinical confidence in handling high-risk patients [11]. The World Psychiatric Association has developed a core curriculum for CLP training, and there is considerable variation in CLP training across European countries. This training typically includes rotations in CL services, general medicine and neurology; supervised consultation; training in special skills, such as relaxation techniques; and individual and group psychotherapy [12].

Combining international experience and our current situation, we sought to improve residents' CL skills through a new training method: supervised practice consultation based on the Union PsychoSomatic Clinical Approach with Learning Exchange (UPSCALE) model. We aim to provide a learning opportunity in CLP for residents and hope to increase attention to CLP training.

2. Materials and methods

2.1. Ethics approval statement

The study has received exemption from ethical review from the Institutional Review Board (IRB) of Peking Union Medical College Hospital (PUMCH).

2.2. Introduction of UPSCALE

UPSCALE is a multidisciplinary, biological–psychological–social, interview-based model established and optimized for the psychology division of a general hospital. The model aims to assist patients with physical diseases associated with mental disorders in general hospitals. The process involves case submission, interviews by psychiatrists, feedback to patients and their relatives, and doctor discussion.

Psychiatrists and doctors in related somatic disease departments can evaluate patients and their symptoms from a biological–psychological–social perspective, providing holistic and integrative care. Conversely, patients can receive comprehensive responses from both specialists in physical diseases and psychiatrists. Additionally, doctors can broaden their perspectives by learning from each other and sharing their ideas based on their skill sets. Therefore, UPSCALE aims to improve patients' psychosomatic health [10].

2.3. Supervised practice consultation based on UPSCALE

The supervised practice consultation is based on UPSCALE. First, the junior psychiatrist (supervisee) expresses their learning needs. The teaching senior psychiatrist (supervisor) then selects a suitable consultation case and submits it to UPSCALE. The interviews are conducted by the supervisee, while the senior psychiatrist inquires about key details if needed. The process includes feedback and discussion, summary reports, experience sharing from supervisees, and comments and guidance from supervisors.

2.4. Process

The process of supervision is illustrated through a clinical case. Neurologists present a case of "motor dysfunction of the right upper limb after transient ischaemic attack (TIA)": an elderly female with no neurological diagnosis to explain her symptoms, who feels disappointed by these negative interpretations and disregards her doctors' explanations, leading to confusion and frustration. Doctors in the neurology department refer this case to a psychiatrist. After evaluation by the chief resident and supervisor, the case is deemed to meet one supervisee's request to interact with patients who complain of physical symptoms without a medical explanation, and the case is submitted to UPSCALE for supervision.

2.5. Interview

The interviews included the following: the patient's physical symptoms and history; the impact of physical problems on the patient; the patient's understanding, attribution, feelings, and coping strategies; the patient's current living, family, and work conditions; the patient's personality and personal development; the family's attitudes towards the patient and her symptoms; and the patient's expectations and plans [13]. The information was collected using open-ended questions and verified with closed-ended questions. The interviewer communicates in a patient-centred manner, offering appropriate understanding, recognition, support, and empathy to patients [13]. After the interview, an effective and trusted doctor–patient relationship can be established, allowing patients to feel that

their problems have been clearly understood and appreciated by the doctors. Once patients understand their background, symptoms, burdens, and treatment needs, doctors can provide comprehensive treatment [13].

Brief introduction to the case interviews.

Doctor A (supervisee): After a brief greeting to the patient, the doctor introduces the onsite personnel and explains the purpose of the ward round, and then the patient's chief complaint is discussed.

Patient: The patient is confused by the psychiatrist's presence but accepts the interview. She experiences stiffness in the right upper limb, but multiple doctors from different hospitals told her that her examination revealed no neurological disorders. The patient strongly hopes that this doctor can explain the nature of her condition.

Doctor B (neurologist): The neurologist discusses her neurological symptoms and summarizes the tests and examinations performed.

Doctors may believe that psychological factors affect the patient's symptoms but should not suggest this to the patient at this time. Instead, they should acknowledge their patients' hard work and desire for an explanation.

Patient: She is concerned about her health after suffering a TIA one year prior. Gradually, her arm become unable to move freely. This inhibits her function and interferes with her pursuit of career and life goals. She is unable to concentrate on daily activities and is uncertain about the future.

Doctor A (supervisee) realized that the patient was overly concerned with her symptoms and had emotional issues, which led to poor compliance. Doctors should inquire about the impact of symptoms on her life and mood; clarify the nature and severity of her emotional issues; and understand the patient's usual life state, personality, and growth history.

Patient: She is diligent and responsible. As an economist, she has written a book to express her theories, but it has not sold well. Her family takes good care of her needs, but her husband cannot understand her career plans, and her son does not heed her advice on life plans. Currently, she has a strong desire for treatment to completely cure her arm.

Doctor A (supervisee) asks the patient's relatives about their attitudes towards the disease and the patient. In this way, the doctor seeks to gain a fuller understanding of the patient and her family, including the resources or difficulties within the family.

Patient's Husband: He thinks his wife is a workaholic, so it is not surprising that she has become ill. She should put aside her work and focus on her health. He is willing to support her. Her high expectations for those around her may strain her relationship with her son. The disease is also confusing due to its unclear diagnosis and ineffective treatment.

Doctor C (supervisor) asks for more details about the case and then introduces the feedback group.

2.6. Feedback group

The feedback group consisted of spectators who were doctors or nurses. Through positive and supportive discussions, they provide emotional support and validation to the patient and help her access available resources from her family, experiences, work systems, etc. [13].

The feedback group acknowledge the patient's ability and the support, from her family, understands her sense of responsibility toward her family and work, and identifies the discomfort the patient is experiencing and its negative influence on her life. These reassurances are persuasive and suggest that the patient view the symptoms as one of the difficulties she can overcome in her life.

The patient appears lost in thought. She says that this is the first time that someone has listened to her patiently and understood her feelings. The discussion with the feedback group has given her a new perception of her disease. She needs time to consider how to integrate this new understanding.

The doctor does not provide additional thoughts at this time but inform the patient that, once the process is complete, they will discuss the diagnosis and treatment of her condition. After scheduling a follow-up appointment, the patient and her husband leave with gratitude.

2.7. Supervised discussion

The supervisee summarizes the patient's medical history, psychiatric examination, and sociopsychological factors; explains the differential diagnosis, which includes depressive episodes, somatization disorders, and hypochondriac disorders; illustrates the possible roles of psychotherapy and medication; and reviews their own feelings, including confusion, during the interview. Expected support from supervisees.

The supervisor compliments the supervisee on their performance, raises questions about key points, and offers suggestions on skilful interview techniques.

The neurologist expresses an improved understanding of the patient after learning about her background through the interview, acknowledges that psychological problems can present as somatic symptoms, discusses the diagnosis and treatment of motor dysfunction, and seeks advice about communication skills.

3. Results

We followed up with the patient, the neurologist, and the supervisee, and their feedback is summarized below.

The patient's acceptance of her symptoms may be related to her emotional status. After psychotherapy and a prescription for psychological medication, her social function improved.

The neurologist felt that the doctor–patient relationship improved after the interview, was able to recognize similar patients with

emotional problems, and was willing to request C-L services for such patients.

The supervisee realized the importance of expressing concern for a patient's somatic symptoms and recognizing the patient's efforts to seek medical advice, providing a differential diagnosis for organic diseases, validating the confusion and frustration of consultation-requesting doctors, and being open in discussions with colleagues from other departments.

4. Discussion

In recent decades, CLP has become essential in general hospitals. More than one-third of patients admitted to medical or surgical services have psychiatric comorbidities, and proactive CLP can reduce the length of hospital stay and improve satisfaction among providers and nurses [14]. The growth of CLP is dependent on the education of residents, fellows, and even practicing doctors. In China, CLP is not a main focus of resident training. As more psychiatrists join multispecialty hospitals, training in CLP is becoming increasingly important. Comprehensive training that helps residents achieve mastery in CLP is therefore necessary. If this need for training is not properly addressed, it will negatively impact the quality of psychiatric services in China.

In contrast to other medical specialties, CLPs exist and are practiced at the intersection of psychiatry and somatic specialties; thus, multidisciplinary teaching methodologies are essential [15].

When reviewing the literature on CLP instruction, we found that relevant research was sparse [16,17]. A review of outpatient CLP rotations highlighted multiple benefits for trainees, including exposure to specific clinical scenarios and therapeutic interventions applicable in the outpatient setting, increased continuity of care, and the unique experience of providing liaison and education to non-mental health providers [18]. Fipps et al. [19] introduced an engaging competitive strategy for learning CL psychiatry through a card game: where participants learn how to select treatment options in the context of complicated medical comorbidities. The discussion of Meresh et al. [20] on CLP grand rounds —formal meetings at which physicians and trainees discuss optimal medical care — is inspiring. In this initial study, we introduced our novel training method—supervised practice consultation based on the UPSCALE model—to attract attention from psychiatrists and encourage further research.

CLP was introduced in China in the 1980s and has developed relatively slowly. In 2002, our hospital began performing CL work within its medical, gastroenterology, cardiology, neurology, neurosurgery, immunology, basic surgery, traditional Chinese medicine, and obstetrics and gynaecology departments. On July 1, 2020, our psychology medicine department began exploring and adopting the CL hospitalization model through ward rounds and regular follow-ups [21]. Like the "proactive integrated CLP" described by Michael Sharpe, the new service model for CLP requires clinicians to (a) initiate consults with patients (and families) who have not been referred and explain their role in the patient's overall care; (b) complete comprehensive yet rapid, biopsychosocial assessments that go beyond the simple identification of psychiatric disorders; (c) create considered and targeted action plans based on the broad biopsychosocial assessment rather than merely recommending treatment for a psychiatric illness; and (d) take an active role as a member of the ward team to ensure that their plan is actually accepted and implemented [22]. The new working model not only improves care accessibility for patients but also provides collaborative learning opportunities for trained doctors.

Supervised practice consultation based on UPSCALE is a problem-based learning method. The topic is identified by supervisees from questions arising in their daily work. The method enhances efficiency through interviews and discussions, thereby enabling active problem-solving in inpatient CL services. The actions of a supervisee during interviews and discussions represent a normal part of a CL psychiatrist's job. This process challenges supervisees to consolidate their knowledge and improve their interview and intervention skills. Through communication with somatic disease departments, supervisees remain sensitive to the comorbidity of psychosomatic condition. Moreover, as questions or even conflicts between the consulting primary team and CLP consultants may arise, supervised practice provides a valuable opportunity for trainees to learn how to manage such issues [23]. This may help residents better understand the role of a CL psychiatrist and improve their future CL work in general hospitals.

This process allows consultation-requesting doctors to better recognize mental illness, change their perception of CLP, and potentially overcome the barriers leading to low CLP referral rates [24]. Through discussion and communication, consultation-requesting doctors may learn more about the importance of and need for, CL services. Thus, our training method also helps improve collaboration across different departments.

In addition, China also has the foundation for developing its own characteristic CLP, which includes traditional Chinese medicine. As is well known, Chinese traditional medicine (CTM) is deeply ingrained in Chinese culture, and numerous theories concerning body–mind interactions have been developed [25]. The fundamental theory is similar to that of western CL Psychiatry. Given this socio-cultural background, CTM could also be integrated in CLP in future.

There are currently no standardized training programs for CLP in China, even in tertiary comprehensive academic facilities, such as our hospital. Improving the training system and optimizing self-learning within it may present unique managerial and leadership challenges for C-L psychiatry directors [26]. The supervised practice consultation we have introduced is feasible and practical in general hospitals. Disseminating this teaching model on a national scale would be a step toward establishing a national CLP training curriculum. In our future work, we plan to evaluate supervision across multiple aspects of CLP, including resident self-experience, patient satisfaction, and medical quality. The program will be improved based on feedback. In addition to establishing psychiatry resident training centres in general hospitals and developing CL services, we aim to design clear outlines for core competencies specific to CL skills while addressing the limitations imposed by the heterogeneity of clinical experiences and hospital systems. Increasing psychiatrists' proficiency in CLP can lead to enhanced treatment for our patients.

4.1. Limitations

This article provides only a description and discussion of a training mode and lacks quantitative or qualitative data. CLP in China is still in its infancy, and relevant training is almost non-existent. Its development is an urgent issue, and we hope that this article will attract the attention of more industry insiders to this work. In future, we plan to collect more data and conduct systematic researches.

5. Conclusion

In summary, through supervision, residents come to understand the role of a CL psychiatrist and improve their CL skills. This process will aid them in their future CL work in general hospitals. Widely disseminating this feasible and practical training method would be a step toward establishing a standardized CLP training curriculum in China. We hope that this research will provide insights that contribute to improvements in the organization of psychiatry training for the general hospital.

Ethics approval statement

The Institutional Review Board (IRB) of Peking Union Medical College Hospital (PUMCH) Issued an exemption from ethical review certification》stating: According to Article 32 of the《Measures for Ethical Review of Life Sciences and Medical Research Involving Human Beings》, this study meets the conditions for exemption from ethical review and is allowed to be exempt from ethical review.

Human experiments

Written informed consent for publication of their clinical details was obtained from the patient. A copy of the consent form is available for review by the Editor of this journal.

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Data availability statement

The datasets used and/or analysed during the current study are available from the corresponding author upon reasonable request.

CRediT authorship contribution statement

Ruixue Sun: Writing – original draft. **Jinya Cao:** Writing – review & editing. **Yinan Jiang:** Supervision. **Yanping Duan:** Supervision. **Wenqi Geng:** Resources. **Jing Wei:** Supervision, Funding acquisition.

Declaration of competing interest

I have nothing to declare.

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Not applicable.

List of abbreviations

CL	consultation-liaison
CLP	consultation-liaison psychiatry
TIA	transient ischemic attack
UPSCALE	Union Psycho-Somatic Clinical Approach with Learning Exchange

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