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A proposal of basic guidelines for training in psychosomatic and liaison psychiatry in Spanish psychiatry training programs

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ABSTRACT – Background and Objectives: The Psychosomatic and Liaison Psychiatry is an emerging psychiatric subspecialty. This article is intended to summarize the philosophy supporting training programmes in Spain, and the recommended training guidelines.

Methods: Review of the literature and teaching experience.

Results: The increasing complexity of diagnosis and treatment, and the demand by patients and providers of resources for higher and more efficient quality of care, make skills training a key tool for achieving these goals. The human being is biology, feelings, thoughts, experiences and thus individuality when sick. Understanding all this is the core on which to base our competencies in this exciting crossroads between psychiatry and other medical specialties. We propose a set of competencies to achieve, and point learning spaces and evaluation mechanisms.

Conclusions: Based on accumulated experiences in Spain, and the review of European and international literature, it is possible to summarize a realistic set of norms and directions for training in Psychosomatic and Liaison Psychiatry in residency programmes.

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The best Psychiatrists are those whose humility allows them to recognize what they do not know but whose humanism drives them to learn what they need to know¹.

Introduction

In the past century hospitals were acquiring its modern appearance conforming in general hospitals, whose purpose was to admit all kinds of surgical patients and focus attention on the acute illness. It soon became apparent that consultations regarding psychiatry not only included patients with “classic” mental disorders but also situations encountered during admission, care and treatment in non-psychiatric wards². Nowadays the increasing complexity of medicine and the need for patient-centered management make the Psychosomatic and Liaison Psychiatry a key subspecialty in organizing many healthcare processes with a role at several levels: mental health support of patients, provision of quality healthcare and development tasks to ease interaction between different professionals.

Rising costs in treatment and the need to increase interventions efficiency make necessary for residents, family and hospital physicians to know the basics of patients’ diagnosis and treatment in comorbid psychiatric and medical conditions, as well as active participation of a consultant psychiatrist for the most difficult patients.

Screening patients, early treatment or psychotherapeutic support that can perform non-psychiatric physicians or other health professions (nursing, psychology, social work) requires that the psychiatrist should be formed as a diagnostician and psychopharmacologist expert, systems coordinator and consultant / supervisor of complex patients³.

The psychosomatic and liaison psychiatry began to be integrated into the training of res-

idents in the late 60s. In the 80s all psychiatry residency programs were required by RRC (Resident Review Committee) to introduce training for the diagnosis and treatment of psychopathological alterations in medical-surgical patients⁴. During the early years of this century the ACGME (Accreditation Council for Graduate Medical Education) has redefined the standards for training programs of various specialties, establishing six core competency areas (Table 1)^{5,6}.

In our country, the national training program in Psychiatry, (BOE N° 224, 16th September 2008, ORDER SCO/2616/2008, pp 37916-21)⁷ clearly defines sixteen competencies grouped into five competency domains: clinical, knowledge and research, communication, health promotion, clinical and ethical management. These skills are perfectly grouped into the ACGME competency domains or similar⁸.

With the growth of the different subspecialties in psychiatry, it is necessary to continue developing these skills, specifically applying them to each subspecialty, which will result in higher quality training and a minimal standardization among the various teaching units. The guidelines should specify special training, knowledge and abilities necessary to provide psychiatric consultation for patients and doctors of other specialties, and define appropriate areas of the clinical experience for psychiatrists.

The differences between residents training in our country are very significant, the attached importance for the rotation is variable and there are not enough official guidelines which can provide guidance. In other parts of the world like New Zealand, Australia⁹, Canada¹⁰ and USA^{6,11} were established basic and advanced educational guides. In USA psychosomatic medicine has been recognized as a Psychiatry subspecialty⁴, with its own “board examination” and certification. In

Table 1
Basic competences in the training of residents ACGME.

Patient care:

The psychiatrist must have diagnostic skills such as exploring and describing clinical and psychopathologic elements. He/she must also provide the adequate care to the patient, including biological, psychotherapeutic and psychosocial treatment. He/she must have the necessary skills to use and apply the right knowledge and the right therapeutic processes as well as recognize his own professional limits.

Medical knowledge.

Communicative and interpersonal skills:

It refers to the ability to establish a therapeutic relationship, both with the patients and their relatives; and with other staff members who could be involved in their care. The psychiatrist's job is developed as part of a multidisciplinary team. This is the reason why cooperation with other professionals is crucial, both during the exchange of information and when making decisions.

Professionalism:

The psychiatrist, as a health professional, has the right knowledge, skills and attitudes to treat and improve the mental health of the patients. He/she offers a high quality attention, in a professional and ethical way, respecting his/her medical, legal and professional obligations.

Organizational and management skills (practice based on the context of the Health System):

This ability has to do with making decisions about time, resources and task management, both with an individual patient and with the organization of the Health System.

Skills to improve his/her learning and clinical practice:

This is the ability to apply in the clinical practice what we learn.

2007 Creed and Sollner¹² published the excellent European guidelines for training in consultation-Liaison Psychiatry and Psychosomatic, that have helped us to elaborate this proposal, with whom we would like to open discussions over the education in this subspecialty in our country.

The official program of the Psychiatric Specialties Committee in Spain, include Psychosomatic and Liaison Psychiatry rotation as compulsory in general education programs, but it has poor specification of objectives or specific activities to cover, despite some improvement over the 1996 program (Table 2 and 3)⁷. Note that the program makes a distinction between basic and advanced skills and makes reference to the need of developments in their measurement. In relation to this, we also wanted to propose ideas

about learning areas and assessment criteria of the rotation. Moreover, the group continues to work on a proposal of advanced skills, their learning spaces and their measurement.

Acquiring **knowledge, craft and art** is the ultimate teaching objective for residents in psychosomatic and liaison training. Knowledge is the learning that must be held to apply to their practice, craft is the coping experience in psychopathological patients' problems, and art is the position adopted by the physician in the patient's transference accompanying him throughout his/her suffering¹³. This proposal is based on a review of various literature sources and personal experience of those who are part of this working group, and was based on a paper presented at the conference held by the Spanish Society of Psychiatry in Bilbao in 2012.

Table 2

Knowledge, attitudes and skills in Psychosomatic and Liaison. Psychiatry. Programme for the specialization in Psychiatry 2008. Basic.

-
- A) Interview with the medical patient. Knowledge of the basic psychosomatics theory. Communication with the patients who are severely ill or terminal. Communication with the patient's relatives. Liaison with other professionals and health teams.
-
- B) Assessment and dealing with psychiatric and psychological disorders in medical patients. Psychopharmacology and interventions in crisis, and psychotherapeutic interventions in medical patients (including their relatives). Coordination of care in a complex medical patient.
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Table 3

Knowledge, attitudes and skills in Psychosomatic and Liaison. Psychiatry. Programme for the specialization in Psychiatry 2008. Advanced.

-
- A) Specific attitude and identity of the liaison psychiatrist, with knowledge and skills in issues regarding special psychosomatic issues and specialized psychotherapy adapted to medical patients and the intervention during crisis.
-
- B) To be able to achieve the adequate advanced technical level of liaison with health teams and to be able to advise in situations of ethical dilemmas.
-
- C) Specific training through interdisciplinary clinical sessions, with participating medical staff and both internal and external supervision by staff with experience in liaison psychiatry. Bibliographic sessions and study of the bibliography. Competence measurements must be developed.
-

Recommendations for basic training in psychosomatic and liaison psychiatry

1. General goal

To establish an evaluable rotation schedule in Psychosomatic and Liaison Psychiatry in psychiatric residents.

2. Organization and requirements of the units

1. **Duration:** 4 months full time.
2. **Location:** A Service or Psychosomatic and Liaison Psychiatry Unit in a General Hospital.
3. **Minimum number of referrals:** Trainees must perform between 30 and 40

first evaluations, supervised by the responsible psychiatrist.

4. **Tutors' training:** There must be at least one psychiatrist dedicated to this area for continued periods of time over a minimum of two years.
5. **Previous Resident Training:** Prior to the rotation, the resident must have gone through Neurology, Acute psychiatric hospitalization and Addictions, and must have experience in emergencies.
6. **Number of residents per staff:** 1-2.
7. **Activities and outpatient follow-up:** The resident must follow-up an estimated number of about 100 patients previously assessed. The resident will have a progressive level of responsibility with either hospitalized or ambulatory patients.
8. **Liaison Activities:** The unit must be running at least one active liaison program.

- 9. Supervision:** During the initial stage of the rotation, residents should accompany the staff while performing evaluations (recommended the first month at least). The frequency and duration of ruled standardized supervisions should be recorded.

3. Knowledge / skills / attitudes

3.1. Knowledge^{6,12,13,20}

- a) *Learning of the theoretical models:* Knowledge of the theoretical bases of the main models used as bases of the subject: the biopsychosocial, psychophysiological, psychoneuroimmunological and the systemic models^{22,23}.
- b) *The consultation process*²⁴.
- c) *Changes in the clinical relation:* One of the most important changes that has taken place in the practice of medicine in the last decades has been the change in the clinical relationship doctor-patient, which currently requires doctors to respect the autonomy of patients when making decisions about their health and the protection of those with impaired mental capacity.
- d) *Deliberation in clinical practice:* Deliberation as a method that helps health professionals to make prudent and responsible clinical decisions²⁵.
- e) *Knowledge of group dynamics:* An introduction to group dynamics. The psychiatrist may become involved in disputes between staff and patients and between staff members, so it is necessary to have a significant knowledge of group dynamics and to be a skillful negotiator.
- f) *Ethical and medico-legal aspects :* Assessing the mental capacity of patients to decide about treatment or participation in research studies is included within the general theory of informed consent and requires both from the ethical and legal perspectives that the physicians obtain the patient informed consent^{26,27}. This includes:
- Assessment of Mental Capacity to make health decisions.
 - Ethics in clinical psychosomatic and liaison psychiatry²⁸.
 - Evaluation to indicate the transfer to Acute Psychiatric wards.
- g) *Impact of the disease and coping in the individual and the family*^{29,30}.
- Coping with illness and hospitalization.
 - Communication with terminal or seriously ill patients and relatives.
- h) *Understanding the pathophysiology, epidemiology, and diagnostic criteria of a number of clinical disorders* (List topics Theoretical seminar).
- Delirium.
 - Cognitive Impairment and Dementia in the general hospital.
 - Affective disorders and anxiety in the medical patient.
 - The attempted suicide in patients in medical wards.
 - Treatment of patients with major psychiatric disorders (psychosis and bipolar) undergoing medical and surgical treatments.
 - Addiction problems in the medical environment.
 - Psychopharmacology in medical and surgical patients. (Including drug interactions).
 - Patients with medically unexplained symptoms.

3.2. *Skills*^{6,12,13,20}a) *Basic communication skills*¹².

- Ability to obtain the necessary information before the patient's visit. This includes the necessary information provided by doctors, nurses and other staff.
- Ability to interview the patient and his relatives. This includes an interview with a person who may not have been ready for it, and also using interview techniques for medically ill patients or somatizing patients.
- Ability to explain to patients the cause of their disorders and its treatment when there are physical and psychological factors that contribute to the clinical presentation.
- Ability to advise doctors or surgeons about managing patients refusing voluntary treatment.
- The resident should be able to write a piece of useful answer in a clear and easily accessible language that can be understood by doctors and nurses, and must also maintain confidentiality³¹.
- The resident must demonstrate ability to work as a member of a multidisciplinary team.

b) *Diagnostic formulation of objectives and skills*.

- Ability to perform the evaluation of patients with psychiatric and physical disorders, establishing a hierarchy of syndromes: Delirium, psychotic, depressive, anxious³².
- Ability to determine the main reason for referral, and to decide about the urgency, to respond accordingly.
- Ability to review the medical history and available information, collecting the necessary data.

- Ability to build a diagnostic formulation, developing clear goals for intervention, even when there are complex combinations of psychological, social and environmental factors that contribute to the clinical problem.
- Ability to develop an appropriate differential diagnosis when physical and psychiatric disorders are present.
- Coding following ICD- 10 criteria.
- Recognition of psychopathologic disturbances secondary to physical illness.
- Basic knowledge of the cognitive tests in patients with organ deterioration. Clock drawing, Mini-Mental Spanish version, Neuropsychological assessment of bedbound patients.
- Assess and interpret laboratory and physician's data, related to psychiatric illnesses.
- Ability to apply diagnostic assessment tools regularly. They must use at least the following (HADS, PHQ -9, CAGE, GDS, HAM D6 and HAM A6)³³.
- Fill-up the basic documentation in the PLP Unit (Preparation of report with diagnostic and therapeutic approaches, Record data sheets, mechanical restraint etc.).
- Assessment of mental capacity for making health decisions.
- Development of a monitoring plan during the patient's admission, setting the frequency of the next intervention, and maintaining at the same time an expectant attitude for future problems.

c) *Therapeutic Skills*^{12,20}.

- Ability to perform a therapeutic plan from a biopsychosocial point of view.
- Make appropriate indications from a variety of somatic treatments in medical-surgical patients.

- Understand the use of psychotropic medication, electroconvulsive therapy, contraindications, interactions and dosage of treatments.
- Understand the use of psychotherapeutic treatments, including at least brief psychotherapy, behavior and cognitive modification techniques and psychoeducation.
- Working in a multidisciplinary team, performing coordination tasks to maximize the care of medically complex patients.

d) *Skills to improve their learning and clinical practice*^{12,20}.

The residents...

- Will seek feedback from their supervisors and other health professionals on their performance, using these observations to improve them.
- Should be able to apply their knowledge of the study design, statistical methods, and evidence-based medicine to evaluate clinical studies.
- Should present at clinical sessions and seminars on topics of psychosomatic and liaison psychiatry.
- Should use information technology to access on-line information and support their own education.
- Should facilitate learning for medical students and other students of the health sciences to the best of their abilities, without violating current legislation which is coordinated with the rest of rotations of the various Units of Psychiatry.
- Should acquire knowledge and skills to write at the end of the course a personal research project.
- Should develop the ability to solve problems in hospital clinical envi-

ronments, to integrate knowledge and research hypotheses from a critical review of the information, to study independently and to learn to communicate their findings publicly.

e) *Organization and management skills.*

Trainees ...

- Should understand that psychosomatic and liaison practice helps organizing the growing complexity of the psychiatrically ill, and this should be an opportunity to provide quality care processes.
- Must take into account the needs of people with a mental disorder, their families, therapists and simultaneously be guided by principles of equity and greater efficiency and effectiveness in the use of resources.

3.3. *Attitude*^{6,20}

The Resident in Psychosomatic and Liaison psychiatry is expected to develop the correct attitude to work in an environment where the multidisciplinary team, unlike in the mental health units, has no specific training in this area. He will also be expected to be a professional with humanistic and scientific rigor in the area of mental health. Therefore, he may need:

1. To show respect, compassion and integrity in all dealings with patients, families and other health professionals.
2. To insist on the psychological aspects of care, when in danger of being ignored.
3. To ensure that a correct use of legislation on mental health is performed.
4. To help teams when differences of opinion in the management of a patient occur and when the team faces an ethical dilemma.

5. To demonstrate a commitment to excellence and professional development, as a means of preparation for practice as an staff member. To maintain scientific and technical knowledge, as well as ethical knowledge and attitudes, since new ethical issues arise with changes in medical practice and its social environment.
6. To demonstrate consideration and responsiveness to the individual characteristics of each patient, including age, gender, culture, ethnicity, religion or disability. To be an advocate for the patient.
7. To maintain confidentiality, even when under pressure to reveal confidential details.
8. To get used to the method of deliberation in clinical practice.

Learning spaces^{6,12,19,34}

Malcolm Knowles introduced the term “andragogy” defining it as “the art and science of helping adults learn”. Andragogy is based on five assumptions about how adults learn and their attitude and motivation for learning (Table 4)³⁵.

We want these proposals to ease the learning process and encourage personal responsibility, autonomy and free will as the basis for the acquisition of skills. This involves enhancing self-direction, in other words, asking, evaluating critically new information, identifying gaps in our knowledge / skills and reflecting critically on our learning process. Our motivation is immediate; we learn to do the things we need to improve our daily work, making our daily experience an endless

Table 4
Principles of learning in adults.

| |
|---|
| – Learning must be self – directed. We are independent beings and we are responsible of our own learning. |
| – A considerable amount of experience is gathered, which is an amazing source for our learning. |
| – We value learning something as long as it could be used for the demands of our daily life. |
| – Learning is based on specific problems, rather than on general subjects. |
| – We are more motivated by internal drives than by external ones. |

source of learning. There is no better teacher than experience itself, so the reflection on the problems or doubts appearing anytime should be our guide as apprentices³⁴.

Learning spaces that we think can be used in this training are the following:

- a) *Clinical sessions.* At least to present or work in a clinic session on a list of basic skills issues.
- b) *Teaching at the bedside*
 - For example, the components of neuropsychiatric test (release front sig-

nals, facial praxis, the clock drawing test, Luria maneuvers, alternating sequences etc.).

- Interactions with patients (e.g., use of body language, posture and tone).

c) *Learning notebook or more extensively supervised learning cases:*

- Two cases involving some of these symptoms: confusional, depressed, chronically ill with more than three admissions per year, consumption of drugs or alcohol, or somatization disorder admitted in the medical-surgical wards.

- It is writing down and recording structured situations that allow the learning and, once recorded, force to think about the things to be learned, how and what mechanisms can be used to solve the problem and how to increase the learning experience.
- d) *Daily supervision*: In the morning rounds.
- e) *Theoretical seminars and journal clubs*: 10 hours.
- Three or more sessions about specific Psychosomatics and Liaison Psychiatry journals on topics related to basic skills issues.
 - Students should be encouraged to combine these seminars with reading research from primary sources (journal articles) that are relevant to their cases, not only from secondary synopsis (textbooks, or medical web sites).
 - A list of journals of Psychosomatic interest is provided (Table 5).

Table 5
Main Journals in Psychosomatic and Liaison Psychiatry.

| | Impact Factor |
|---|---------------|
| Psychosomatics | 1.732 |
| Psychosomatic Medicine | 4.077 |
| General Hospital Psychiatry | 2.744 |
| Journal of Psychosomatic Research | 3.608 |
| Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace | 0.200 |

- a) *Presentation of clinical cases*: Assessing clinical sessions presented.
- b) *Monitoring of patients* (Either bed-bound patients or overall summary reports)
- c) *The two cases more thoroughly supervised*. At least one of them should be

Assessment of competences

Evaluation is an essential pillar of the educational process. The evaluation problem may be related to the precision of the instruments or the methods used, which depends on the forms used, including the training or explanations given to the evaluators. In view of the available literature, it appears that ‘360-degree instruments’ are promising for summative assessment techniques, lending themselves especially well to the assessment of interpersonal and communication skills, professionalism, and patient care. Patient care and medical knowledge appear to be best evaluated by standardized clinical exams and standardized written exams, respectively. Direct observation or videotaped treatments could be an important complement to the traditional methods of psychotherapy supervision accessories³⁶.

Items that we propose as the basis of the basic evaluation are:

prepared with the critical incident technique, understanding critical incidents as “those facts of practice that have disrupted, created doubts, caused surprise, annoyed or disturbed by their lack of consistency, or by presenting unexpected results”. This relates to episodes with a particularly positive or negative

development, which provide the opportunity to reflect on our own practice and therefore improve it.

d) *The report of the rotation*

This report should be mandatory for the resident, and include...

- The teaching activities; and the research activities, if any.
- Number of patients and diagnoses.
- Comments on strengths and improvements needed in the rotation.
- Self-assessment and evaluation of tutors.

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