General hospital psychiatry: uncertainty starting from its name

Luis G. Ruiz-Flores
Department of Psychiatry, National Medical Center, Mexico City, Mexico

There is uncertainty even in the name of our sub-specialty: we practiced psychosomatic medicine, then consultation/liaison (C/L) psychiatry, general hospital psychiatry, medical psychiatry, etc., and finally, according to the WPA, we are psychiatrists in medicine and primary care. Do we all agree?

Don Lipsitt's reflection about uncertainty in general hospital psychiatry allows me to compare his vast experience with our Latin American reality, i.e., the practice of C/L psychiatry in developing countries like Mexico.

We were late bloomers, but we are coming. It was the mid 1950s when Alfonso Millán Maldonado, a pioneer of Mexican psychiatry, created the first department of psychiatry in a general hospital affiliated with the Ministry of Health. Years later, in the early 1970s, Mexico, with a population of more than 70 millions at that time, had only five general hospitals that formally included consulting psychiatrists, not all of them with beds available for psychiatric purposes.

For many years, most of our psychiatrists have been trained in an asylum setting, practicing mostly with chronic severe patients. Psychiatrists were considered people using an obscure and incomprehensible terminology

and easily misjudged as 'not really physicians', but mere charlatans excluded from 'real medicine'. Mental health for general hospital patients was not an option to be considered; very few psychiatrists had the opportunity to be trained in a systemic environment. Systemic therapy, mostly with a family therapy approach, started in Mexico in 1972 with Raymundo Macias and did not generalize to other psychiatrists in medical settings. That delay collected its toll and it was not until the early 1980s that people like Javier Sepulveda and Juan Ramón de la Fuente, both trained abroad, came back emphasizing the importance of C/L psychiatry, which is now included in the formal training of all Mexican psychiatrists.

Today Mexico, with a population of 100 million, has only 2200 psychiatrists. This is about two psychiatrists per 100,000 people, much fewer than its North American neighbors. Of those psychiatrists, less than 300 practice in institutional C/L settings, which puts a large demand on these doctors, approximately 168,000 people for each psychiatrist, with an average of 1500 consultations per psychiatrist every year.

It is obvious that Latin America needs more psychiatrists in general hospitals and primary care settings but, because of the low salaries, most of our psychiatrists, after finishing their residency, start a private practice and seclude in their offices, far from helping with the public health needs.

Moreover, liaison activities in our country have diminished because my colleagues find difficulties in the payment of consultation services, and also because psychosocial issues have been washed away by an avalanche of neuropsychiatric and pharmacologic data.

To deal with the uncertainty, as a sub-specialty of psychiatry, we have to start agreeing on a name that better describes our daily duties and interests, if we want to overcome the mind-body dilemma, or the general hospital vs. psychiatric setting dilemma, etc. It makes sense to me what P.R. Mc Hugh wrote recently about the crisis of psychiatry, insisting that beside the fight for domination between psychoanalysis and biological psychiatry, the influence of the drug industry and the managed care, the reason we are in trouble is that "we labor under a strange classificatory system (compared to medicine in general), one that insists to define mental disorders by their symptomatic appearance and not by their essential nature". He proposed four perspectives for psychiatry: the perspective of disease (what the patient has), the perspective of dimensions (what the patient is), the perspective of behaviors (what the patient does), the perspective of life story (what the patient encounters) (1).

I think that our task is to develop a language in common with the rest of the medical specialties without losing our own bio-psycho-social identity.

References

1. McHugh PR. Beyond DSM-IV: from appearances to essences. Psychiatric Research Report, Summer 2001:2-15.