Psychiatry and the general hospital in an age of uncertainty

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General hospitals have had an illustrious role in the evolution of psychiatry. They have provided a rich soil for the growth of inpatient psychiatric units, consultation-liaison psychiatry, psychosomatic medicine, med-psych units, outpatient psychiatric clinics, emergency services and a whole spectrum of resources for the communities in which they dwell. In some respects, whether attached to universities or not, they have functioned as small colleges for the education and training of scores of health professionals. In the setting of the general hospital, psychiatry has had opportunities to become remedicalized and integrated into the mainstream of medicine. However, recent trends in health care run the risk of jeopardizing these accomplishments. Managed care has had a profound impact on the way psychiatry is practiced, taught, and reimbursed. Concerns about cost-containment have raised questions about whether the general hospital will remain the best and most economical setting for psychiatric services. If the primacy of the patient is lost, psychiatry's role in the general hospital will be uncertain. The need to safeguard psychiatry's achievements must be a worldwide endeavor.

Key words: General hospital psychiatry, psychiatric units, consultation-liaison psychiatry, integration, managed care

The general hospital has played a pivotal role in the history of psychiatry, but current economic, political and ideological changes make predictions about its future role uncertain. In this paper, I will: a) review the history of psychiatry's entry into the general hospital setting, and describe the changes that have occurred in its role over the past century; b) examine the current status of general hospital psychiatry compared to the recent past decades; and c) assess problems, promises and perspectives for the 21st century.

HISTORICAL REVIEW

The first general hospital in Great Britain to announce provision for 'lunatics' is said to be Guy's Hospital of London in 1728 (1). In the United States, a Quaker almshouse, later to become the Philadelphia General Hospital, cared for the 'insane' in the early 1700s, followed soon in 1755 by the Pennsylvania Hospital, whose charter designated a number of beds 'for the cure and treatment of lunatics' (2). Other general hospitals in all likelihood offered safe haven for some mentally ill patients, but probably more by default than by design. Most hospitals did not proclaim a clear psychiatric presence until well into the 20th century.

In the meantime, during the 19th century, large asylums for the 'care' (or, more shamefully correct, 'warehousing') of the insane were being built (3). Psychiatrists, or 'alienists', lived on the grounds and practiced in these asylums, far removed from large cities and most of the population. Therapy was mostly primitive or nonexistent. This was the status of American psychiatric treatment in the beginning of the 20th century.

It was not until 1902 that psychiatry declared its first entry into an American general hospital, with a 12-bed 'pavilion' established by James Mosher at Albany General Hospital (New York) (4), specifically designed for acute psychiatric patients requiring triage, treatment of drug addiction, emergency care of delirium and 'sudden and often dangerous forms of mental disorder which occur in the course of general diseases or after the shock of surgical operations and anesthesia'; this latter function may have antedated the formal beginnings of consultation-liaison (C-L) psychiatry. He saw general hospitals supplementing rather than replacing treatment at home, in private institutions, or in custodial facilities like psychiatric hospitals.

With this formal entry of psychiatry into a general hospital began a period characterized by Lipowski (5) as 'one of the most far-reaching developments in psychiatry's history'. Gradually, more psychiatric units were established in general hospitals. Attracted back to the 'mainstream of medicine' (6), many psychiatrists left asylums for the general hospital, and began to think differently about their work. There, psychiatrists would work alongside other doctors and nurses and, even though stigma remained a major barrier to collaboration, they began to feel more comfortable with each other.

The 1930s saw a major advance of psychiatry in the general hospital, largely attributed to the commitment of Alan Gregg (7), an internist appointed as Director of the Medical Sciences Division of the Rockefeller Foundation. With his interest in integrated medicine he was able to direct developmental grants to several US general hospitals, establishing a platform for the rapid development of general hospital psychiatry in the US. The number of psychiatric units in general hospitals swelled from about 10 in the late 1920s to 153 in the mid- and later 1930s, reaching its peak in 1998 with about 1700 units (8). Gregg's philanthropic initiative also laid the foundation for the early expansion of C-L programs. Prompted by these new developments, leaders in American psychiatry predicted a tendency toward decentralization from psychiatric hospital care to local general hospitals (9). The advantages

were many: patients could be treated in more humane settings, there would be less stigma involved in being in a general hospital, and they would remain close to their families and communities so that they could have their support and be more quickly rehabilitated.

Such predictions would take at least 30 more years to begin to be a reality. Rising objections to the quality of asylum care, the rapid emergence of psychopharmacologic treatments, deinstitutionalization and the community mental health movement contributed to a migration of patients from psychiatric hospitals to general hospitals and community centers through the 1950s and 1960s (10).

It has been a prevailing notion amongst some that the term 'general hospital psychiatry' is equivalent to inpatient psychiatric beds only, but the growth of psychiatry in the general hospital setting was not by beds alone (11). The ensuing years have seen a robust development of other psychiatric services located in the general hospital setting: outpatient clinics, C-L services, emergency psychiatric services, partial day and night programs, children's psychiatric services, psychopharmacology clinics, walk-in clinics, behavioral medicine programs, substance abuse programs, geropsychiatric care and other specialized programs (12).

It was observed by some (13) that the location of inpatient units in the general hospital enabled the expansion of C-L programs to proceed more rapidly (14). However, excellent C-L programs have certainly flourished in settings where no inpatient unit existed. In fact, Bibring (15), one of the early pioneers of psychiatry's role in the general hospital, opposed inpatient psychiatric beds in the belief that their presence would have encouraged physicians to transfer responsibility for their patients, thus undermining the teaching leverage psychiatrists had by the absence of beds. Debate over the appropriateness of inpatient units in the general hospital has persisted (16).

The growth of C-L services in general medical hospitals has been well documented since its formal beginnings in 1929, attributed to Henry (17). Psychiatry's long tradition of trying to reintegrate itself with medicine seemed enhanced by the development of both inpatient units and C-L services throughout the 20th century (18). Indeed, almost 30 years ago, Lipowski optimistically wrote: "The entry of psychiatry into the mainstream of medicine has fostered changes in medical education and in the management of the physically ill in the direction of comprehensive medicine" (19). The optimism of this statement was tempered by the curtailment of major funding by federal agencies as they threw C-L and other psychiatric programs on the mercy of administrative or third-party support. Nonetheless, in spite of major barriers, C-L psychiatry has persevered and grown during the ensuing years and has come to represent a major component of general hospital psychiatry. Reflecting this breadth of interest, the journal General Hospital Psychiatry, in its premier 1979 issue, defined its scope as "building upon … liaison-consultation and psychiatric services which have burgeoned in the general hospital … to encourage new contributions to the understanding and treatment of illness in inpatient, ambulatory and community settings" (20).

A number of other developments in the 20th century contributed to the rise of general hospital psychiatry, perhaps less visibly than the evolution of inpatient units and C-L psychiatry. They included the following.

'Common sense psychiatry' of Adolf Meyer. Meyer recognized that his nonpsychiatrist colleagues could not readily apply psychoanalytic concepts of the day to patients in medical-surgical practice. He proposed a psychobiological 'common sense' psychiatry to counteract what he regarded as the 'useless contrast of mental and physical' in hospital treatment and medical education (21). Thus did Meyer provide a setting in which a more integrated psychiatry might find a home in the general hospital.

Psychoanalysis. Psychoanalysis was not considered a part of medicine, but Freud's theories about the unconscious in symptom formation, and psychodynamic interplay of physical and emotional disorders were relevant to an understanding of illness and its treatment. The nature of the patient-doctor interaction was much better understood in the context of theories of transference, countertransference and negative therapeutic reaction. Psychoanalysis contributed in another serendipitous way: when war broke out in Europe, many psychoanalysts emigrated to the US and became attached to major medical schools and hospitals, where they embarked on psychosomatic research. Their rich contributions helped create the foundations of psychosomatic medicine in the US and established the general hospital as a proper setting for the research and practice of psychoanalytically-informed medicine.

Psychophysiology. Psychosomatic medicine research was accelerated in 1915 by the seminal work of Cannon on 'flight or fight' responses of the body to threatening stimuli. In the same year, Pavlov's experiments on conditioning offered the scientific tools required to examine mind-body connections. Relevance of both lines of research to mind-body dilemmas in the practice of general hospital psychiatry is apparent.

World War II. Many psychiatrists learned to work closely with surgeons, internists and others on the battlefield and, because of their effectiveness there, won many friends in medicine and government. The American Psychiatric Association grew rapidly from just a few thousand doctors to about 20-25,000. Many physicians returned with a strong social conscience growing out of the horrors of war. The general hospital became the locus for psychiatrists wanting to help patients returning with traumatic neuroses and other medical-psychiatric conditions and for internists with psychiatric interest wishing to

enter educational programs in general hospitals.

National Institute of Mental Health (NIMH). After the war, the federal government put a great deal of money into mental health. NIMH was the first Institute founded and psychiatric training programs were supported in practically every university medical school in the country. Perceiving the application of 'battlefield psychiatry' to emergency, preventive and community health care, the federal government provided generous funding for training in psychiatry, residency programs, and C-L services in general hospitals. Programs were site-visited regularly to assure high quality educational content; training in psychotherapy and long-term treatment was encouraged. This developmental phase of general hospital psychiatry may well be regarded as its heyday.

Psychopharmacology and deinstitutionalization. In the mid-1950s, moral opposition to the 'warehousing' of patients gave rise to a movement in the US to try to close, or at least to make smaller, the large state psychiatric hospitals. The state hospitals had already begun to look toward the general hospital as a preferred treatment facility when psychopharmacologic drugs began appearing in the 1950s, making it possible for many of the most chronic patients to be discharged home or into residential settings in the community. Unfortunately, this began happening before the start of the community mental health movement, with many patients remaining sick and homeless, and being returned to state hospitals or incarcerated in jails.

Community mental health movement. When President John Kennedy signed the Community Mental Health Centers Construction Act in 1963, the general hospital, as the hub of community programs, became the major resource for episodic treatment, maintenance and monitoring of patients discharged from psychiatric hospitals. Additional financial support became available for the construction of psychiatric beds in general hospitals. Government insurance programs, Medicare and Medicaid, provided expanded health insurance coverage for mental illness. Although administrative, political, and organizational problems left many gaps, patients were generally offered greater continuity of service, support systems to help them remain in their communities, and the back-up of general hospital care closer to home. This movement also made use of many nonmedical professionals like social workers, psychologists and psychiatric nurses, so that the authority of the psychiatrist in this new system was diminished. There was concern that psychiatrists and psychiatry were being devalued, reflected in decreased numbers of medical students choosing psychiatry for specialty training.

Med-psych units. With increasing psychiatric experience and research in the general hospital setting, it was evident that medical and psychiatric illnesses were more often comorbid than they were independent. Consequently, in the 1980s and 1990s, med-psych units began to supplement or to replace more traditional psychiatric units (22). Revised target populations, treatment goals and staffing influenced philosophy of care, structural requirements, and funding of such units.

'Remedicalizing' psychiatry. Psychiatry has long sought reintegration with medicine (23). The general hospital setting would appear to be the most logical place for this to occur, although many obstacles have stood in the way. New opportunities have appeared on the horizon in the latter decades of the 20th century. The new discoveries in brain sciences, immunology, imaging, genetics, molecular biology and psychopharmacology have enhanced psychiatry's acceptability to 'mainstream' medicine. Inpatient units have shifted away from the 'therapeutic community' and 'milieu' models and adopted more 'medical' or 'somatic' models of treatment. The evolution of standardized psychiatric diagnostic systems has contributed in some measure to the medicalization process.

CURRENT STATUS OF GENERAL HOSPITAL PSYCHIATRY

Today the general hospital provides a relatively secure home to the large spectrum of educational, therapeutic and research programs in psychiatry. Traditional inpatient, outpatient, emergency, and C-L services have been supplemented with specialized programs in geropsychiatry, substance abuse, eating disorders, med-psych units, psychopharmacologic clinics and so on.

The general hospital in the past has served as a small university (24) to educate physicians, medical students, nurses, social workers, other health professionals and volunteers, but recent changes in the health care landscape have posed a threat to some of the general hospital's essential functions.

Perhaps managed care, introduced about two decades ago to try to control rising costs in health care delivery, has had the greatest impact on general hospital psychiatry, resulting in a number of changes and potential threats (25). It has imposed rigorous guidelines, restrictions, regulations, and reimbursement schedules on health care professionals ('providers'), patients ('consumers'), and hospitals. In its wake, hospital stays have been reduced from an average of 30 days two decades ago to a current average of 5-7 days. Reimbursement to hospitals and practitioners has been markedly 'discounted', and physicians' authority and control of their patients' care have been severely compromised. Physicians have decried the moral and ethical implications of a trend they describe as substituting stockholder profits for patient care. While lip-service is paid to the importance of integration of care, continuity of service and cost-effective treatment, insurance companies until recently had shown a preference for 'carved out' mental health services; in such arrangements, treatment previously

covered as part of medical insurance is contracted out to separate facilities, and managers try to reduce costs while still maintaining quality of care. What may be lost in the process is the highly sought after desire to integrate a patient's medical and psychiatric treatment in the same facility.

Because managed care companies require pre-admission approval, patients may be denied access to inpatient care. Only those patients considered by an external reviewer to be too sick or too dangerous to be treated in outpatient settings are allowed by insurance companies to be admitted to the hospital (26). While previously locked doors in state hospitals were subsequently opened, now inpatient units in general hospitals that had previously been 'open' units must be locked to accommodate 'involuntary' patients.

Short stays have resulted in what has been referred to as the 'revolving door' phenomenon. Patients previously hospitalized in a single admission until sufficiently improved for discharge are now transferred to less restrictive settings as quickly as possible and readmitted when necessary. The milieu model of older inpatient units, with a psychodynamic focus on therapy, has been replaced with a medical model where decisions are made by staff. The goal is stabilization more than remission or resolution of problems, with extensive use of day programs and partial hospitalization rather than residential therapeutic communities. The impact on training and education has been significant. With much briefer hospitalizations, there is less opportunity for extended contact with patients, hastier treatment, and minimal observation of the course of illness.

Managed care has introduced many new problems: legal, ethical, clinical, financial and administrative. Nonetheless, our system of general hospital psychiatric care has come close to what Mosher had proposed at the beginning of the 20th century: it is quite comprehensive, less restrictive for most patients, and more humane than that experienced by patients in the large custodial institutions of the 19th century. In 1998, there were more than 261,000 psychiatric inpatient beds in the US, 54,200 of these in general hospitals. Although general hospitals account for only 20% of total beds, they provide care for more than twice as many episodes of care than psychiatric hospitals (8). In addition, the general hospital offers biopsychosocial evaluation, brief medical-psychiatric intervention and psychopharmacological management to many thousands of non-psychiatric patients in the general medical setting, both inpatient and outpatient.

Case-finding of comorbid conditions like substance abuse and combined medical/psychiatric illness is an important function of the C-L psychiatrist. Emergency psychiatric consultation, ambulatory services, substance abuse programs, services for the elderly, neuropsychological assessment, and child psychiatric services round out the spectrum of general hospital psychiatric services (28).

PROMISES, PROBLEMS AND PERSPECTIVES FOR THE 21ST CENTURY

While the above characterizes general hospital psychiatry over the past 100 years as it has evolved in the United States, the future of mental health care around the world faces similar problems and many uncertainties. There is much interest in other countries in the role of general hospitals in their mental health networks, but the timing and extent of developments have varied widely, depending on different interests, attitudes, professional availability, needs, economies, health care systems, cultures and so on (28-40). Perhaps Great Britain's experience most closely resembles that of the US (41). Italy in 1978 responded to a new law requiring the closing of all large psychiatric hospitals in favor of the general hospital as a source of mental health resources (42). Japan was still building large state institutions when the US was beginning to close theirs (43). Germany, with its unique psychosomatic hospitals, has had no special need for med-psych units (44). But in spite of such differences, there appears to be a universal quest for greater integration of mental and physical health care and a high degree of consensus that this is most likely to be achieved in the setting of the general hospital (18).

There continues to be a great need for research into models of care, best practices, professional roles, and treatment outcomes. Innovations are needed to account for ethnocultural diversity and to provide refugee mental health programs. Treatment facilities for children and adolescents are woefully inadequate, as are programs for treatment of substance abuse and the psychosocial sequelae of AIDS. Inadequate funding is a constant problem and requires persistent lobbying, public education, and creativity. In times when government budgets are continually stretched, the fate of general hospital psychiatric services often hangs in the balance. Psychiatric services are always being expected to 'prove' themselves by justifying their costs. Some psychiatry departments, caught in the web of serious hospital financial difficulties, have been downsized or totally cut.

Although C-L psychiatry has demonstrated its value to effective whole-person care, it is constantly under threat because of poor reimbursement and funding (45). Even inpatient units in some hospitals have not been spared. Many general hospitals have been under siege in recent years; many have merged, some have collapsed; in several instances, patients have been deprived of essential services. Questions are repeatedly raised about the most suitable location of mental health services: in the community, the smaller general hospital, or the larger state institution? (16,46,47). One author (48), 40 years ago, assessing the rapid rise of general hospitals between 1920 and 1960, questioned the 'absolute certainty' with which psychiatry was relocated to general hospitals at that time; simi-

lar questions are posed today as the most suitable model for mental health services is constantly reassessed (49).

Attempts to marry 'psyche' and 'soma' over the years have been arduous (50); if integration is to be successful, it is most likely to happen in the general medical setting, where opportunities for a biopsychosocial approach to medicine are most prevalent (51). It is here that future explorations of collaborative care between psychiatry and primary medicine are most likely to take place; C-L psychiatry will play a major part as it finds new ways to collaborate with primary care colleagues in innovative health care delivery systems. With the prospect of C-L psychiatry (psychosomatic medicine) becoming an approved specialty, its cachet in the general hospital will be enhanced. But it will still need to 'market' itself in this competitive climate, so that administrators, politicians, and health policy experts will appreciate and support its essential role in biopsychosocial medicine. And I believe that whatever form mental health services ultimately take, the general hospital will be pivotal in its development (52); some aspects of general hospital psychiatry will endure while others perpetually change. In the future, with better economic analysis, we may see a realignment of the spectrum of facilities that accommodate both acute and chronic psychiatric patients, since no one 'unit' can comfortably attend to very heterogeneous populations. As long as inpatient services continue to 'follow the money' and are subject to 'bottom line' planning, decisions about what services stay and which must go will depend more on which service has the greatest revenue-producing ability at any particular time than on patients' health needs. Psychiatrists will need to be aware not only of the latest developments in psychiatry, medicine, and neuroscience but will also need to attend more to the 'business' aspects of their profession (indeed, it is becoming more common for physicians to obtain advanced degrees in business administration). It might be said that the role of the general hospital in delivery of mental health care is a work in progress (53).

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