COMMUNICATIONS

The Liaison Psychiatrist as Busybody*

EDITOR'S NOTE: *We are aware of the controversial nature of this communication and invite responses from psychiatrists in practice as well in academic settings.*

I would like to mention some presuppositions and then make three points. There is no time to justify the presuppositions:

1. Psychiatrists are, first and foremost, physicians.
2. The cerebral hemispheres are man's psychosocial organ.
3. The limbic system is, however, as (or more) important for psychiatric behavior.

This communication is direct, with little embroidery, and much of it will probably be inflammatory. I would like to speak almost as a decorticate preparation, save for Broca's area, that is, mainly from limbic structures. I am, therefore, decreasing cortical inhibition on limbic thrust. That is, I will not use limbic bypass and I have turned off the cortical squelcher. In effect, I would hope to whistle up some limbic tunes that everyone feels are there but prefer to ignore in formal papers and presentations because of either the aforesaid limbic bypass or cortical squelch.

There are three things I would like to state:

1. What all nonpsychiatrist physicians appreciate, and what, in fact, works, is the medical model of consultation psychiatry.
2. Liaison psychiatry is more myth than reality.
3. The liaison psychiatrist is to a great extent a relatively high-status busybody.

Derek Freeman has shown us recently how well cortical squelch worked for Margaret Mead in damping out her limbic music when studying the Samoans [1]. It should not be surprising for us to see how liaison psychiatry as a myth has come to the fore. A myth is not primarily the work of one thinker. It is not an intellectualistic construction. Myth is not a lie either. It is an organized, holistic vision that sums up a set of aspirations and does not necessarily correspond one-to-one to realism. What I take to be the myth of liaison psychiatry is the following: that other physicians see the need for, and appreciate, the content and form of liaison psychiatry with its deemphasis on consultation and its emphasis on teaching the importance of psychosocial milieu. Liaisonists, in the myth, would have us believe that doing liaison psychiatry fulfills an aching need for the rest of the medical profession. Obviously, I think that liaison psychiatry has little to do with patient care or with being clinically helpful to fellow physicians.

This is not the place to attempt a review of the extant literature on liaison psychiatry. Most of it, however, has little to do with patient care or being clinically helpful to fellow physicians. Let me take one article by way of example. Tarnow and Gutstein say, "After reviewing the history of consultation psychiatry, the authors conclude that a logical development would be a systemic model in which the entire hospital system is seen as the focus of consultation and in which the goal of the consultant's work is seen as creating a more open and flexible hospital system" [2]. What does this have realistically to do with patient care? It is quite unrealistic, it is abstractionist, it tends to put things into nonrealistic "systems," and it cloaks in reality a drive for power.

A familiar dictum in the groves of academe and academic medicine is "those who can, do; those who can't, teach." One wonders if this has been one of the factors influencing the relatively recent separation of liaison psychiatry, with a primary function of teaching, from consultation psychiatry, with a primary function of care to the patient and help to the requesting physician.

One of the underpinning limbic "raw feels" that is found in liaison psychiatry parlors is the heralding of Engel's biopsychosocial model in medicine [3] and conversely the denigration of so-called Cartesian dualism. There has long existed a current of the idealistic mind in psychiatry to unify the various words like "psychosomatic," or Adolph Meyers' "psychobiology," and now we have a new one, the "biopsychosocial." All of these are attempts to put the biologic and the psychical together. This is in contrast to the medical model, which is said to be

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strongly influenced by Cartesian dualism and which, by its very nature, cannot be interested in the whole person.

This should not be a surprise to us since we have always had people back to Heraclitus, Plato, and Plotinus trying to make what is pluralistic or dualistic into a monistic system. There are those who need to see multiplicity completed in a unity. In science their basic limbic melody is to yearn for a *Naturphilosophie* view of the world. This monistic drive is seen in the contemporary Holistic medicine movement. It always tickles me to hear people speak about Cartesian dualism, especially since the majority of people from whom I have heard this have never read Rene Descartes. I agree with George Berrios when he says, "After all, it is high time the secular abuse that Descartes (as the assumed perpetrator of the dualistic fallacy) has been made the victim of, should stop, and the question put whether words alone can be asked to set together what words alone set asunder" [4]. I am spending some time on monism and dualism because the distinction between them lies at the basis of the biopsychosocial model in medicine.

It is my contention that most of the so-called liaison work is part-time, missionary in tone, evasive of hard work, mainly verbal, and more slightly antiphysician. It depends for success on applications to patients' problems that are only mildly psychiatric, and tends to be self-righteous activity with a "pop" moral tone justified by the so-called biopsychosocial model. Thus, the biopsychosocial model is assumed as justificatory needing no more explanation. Obviously, I find the biopsychosocial model to be idealistic and not realistic and will comment on this below.

William James, M.D., physiologist, psychologist, and philosopher of pragmatism, spoke of various "temperaments" in philosophical discussion. Recall his famous "two temperaments," the tender-minded and the tough-minded:

Tender-minded	*Tough-minded*
rationalistic	empiricist
(going by "principles")	(going by "facts")
intellectualistic	sensationalistic
idealistic	materialistic
optimistic	pessimistic
religious	irreligious
free willist	fatalistic
monistic	*pluralistic*
dogmatical	skeptical

As James says, "The tough think of the tender as sentimentalists and soft-heads. The tender feel the tough to be unrefined, callous or brutal" [5, pp. 21–23]. Obviously, it is my contention that liaison psychiatry is tender-minded and consultation psychiatry is tough-minded.

The major difficulty with the biopsychosocial model of medicine is that it presumes the intelligible object of medicine to be the totality of the person. This is an error. The *material* object of medicine *is* the person and all its commonly known attributes. However, the *formal* object, that is, the formality precisely under which medicine views the person, is the person with pathology. If medicine does not have the selective abstraction of a formal object, then it is no different than the ordinary person looking at the human race as a whole. All intellectual disciplines and arts that have "the whole of humanity" as a material object also have a specific formality under which humans are being understood, e.g., theology, philosophy, physics, painting, tailoring, or barbering.

Medicine does not consider a person according to the whole reality—it never did. The Holistic chanters to the contrary notwithstanding, medicine considers people under a certain formality, that is, as sick and/or diseased, no matter how much culture plays a role in "illness theory."

Medical specialties and subspecialties consider people at an even higher level of selective abstraction, that is, they have a more narrow formal object than general medicine. It is precisely this selective abstraction and more formal narrowing down to a specific area within a person (and at this point those who are antidualist get nervous) that precisely gives contemporary medicine its tremendous efficacy and power and hence its value to the patient. For example, cardiac surgery looks at a person from the selective point of view of what physically can be done to repair a malfunctioning heart. The cardiac surgeon, being a person, may in general be interested in the patient's psychosocial attributes, but *qua* cardiac surgeon, that's not what the patient is asking for. As a cardiac surgeon there are priorities, the psychosocial aspects of the patient being low down on the list. Moreover, the patient expects a cardiac repair job, not a psychosocial evaluation.

Another difficulty with Engel's biopsychosocial model for physicians is that it is unrealistic. For the bulk of specialists today, it is an idealistic notion when set, side by side, to the intrinsic power and

proven validity of their own specialties. And, of course, to achieve such a specialty status, the physician has to spend time at a higher level of selective abstraction. That means, in reality, excluding much of the psychosocial component of the patient's life.

The psychiatrist geared primarily for the psychosocial may well feel the same priority as Holism advocate, Helen Flanders Dunbar, did, i.e., "Whether the psychic or the somatic problem be considered primary, the real problem is to treat the patient, second the disease process and only third the symptom" [6]. The power of specialty medicine today has those priorities exactly reversed.

Again, the biopsychosocial model partakes of a recurring theme in the history of ideas, i.e., the drive to monism. More recently, Engel has been clothing his biopsychosocial model in the contemporary costume of general systems theory, moving from subatomic particles to the so-called biosphere. This is not much different in limbic thrust than what people meant by "psychosomatic" and "psychobiology." We hear from William James again [5, p. 171]:

> The world we live in exists diffused and distributed, in the form of an indefinitely numerous lot of *eaches*, coherent in all sorts of ways and degrees; and the tough-minded are perfectly willing to keep them at that valuation. They can *stand* that kind of world, their temper being well adapted to its insecurity. Not so the tender-minded party. They must back the world we find ourselves born into by "another and a better" world in which the eaches form an All and the All a One that logically presupposes, co-implicates, and secures each *each* without exception.

Liaison psychiatry, buttressed by the biopsychosocial model, I submit, is the result of a certain temperament yearning for monistic music in an intellectualized, cortical way, and squelching the limbic "raw feels" that characterizes the more tough-minded medically modeled consultation.

Now, of course, this is not all bad. We all have some "yearns" for idealism, and Platonic purity. However, when the biopsychosocial model is used as the so-called solution to Cartesian dualism, it speaks more of the inner wants of the propounder than it does to the pragmatic realities around him. Concretely, the physician in the medical model who concentrates solely on brain malfunction, and does not consider the whole patient, has committed the sin of Cartesian dualism. So Dr. James sings again [5, p. 104]:

> We all have some ear for this monistic music: it elevates and reassures. We all have at least the germ of mysticism in us. And when our idealists recite their arguments for the Absolute, saying that the slightest union admitted anywhere carries logically absolute Oneness with it, and that the slightest separation admitted anywhere logically carries disunion remediless and complete, I cannot help suspecting that the palpable weak places in the intellectual reasons they use are protected from their own criticism by a mystical feeling that, logic or no logic, absolute Oneness must somehow at any cost be true.

To summarize briefly, then, the biopsychosocial model in medicine stresses a *person* with an illness, whereas the medical model, which has been clearly powerful in the past, stresses a *disease* in a patient. It should be clear by now, I think, that a physician should be interested in the disease of a patient; any man or woman should be interested in a person with illness.

Most "liaison talk," when analyzed, leads to the conclusion that the hard work of seeing patients and accepting the accountability and responsibility for them is being avoided. Instead, there is the tendency to talk around the patient, teach, and interact with support personnel. In effect, without clout of direct patient care and attendant responsibilities, one is not much more than a high-status busybody, ofttimes compared to the Utilization Review officer who "pokes around" but has little to add in patient care.

There is a certain Olympian quality surrounding liaison psychiatrists. It is as if they will teach others the wonders of the labyrinthine biopsychosocial factors involved in patient care. The other Olympian feature centers on the so-called consultee-oriented consultation. In hearing discussions and reading the literature one can get a downwind whiff of anti-physician feeling. There are remarks made, for example, of the insensitivity of surgeons, of patient "harassment" and how little the attending physi-

cian understands this hysteric's or sociopath's inner dynamics. This attitude is snobbish, unhelpful, and, in semistreet parlance, "chickendip." It does not seem to bother liaison psychiatrists that there are no liaison cardiologists, liaison endocrinologists, and so forth—another clue to the vacuity of liaison psychiatry.

What is helpful is consultation in the medical model. As Walsh McDermott has said, to be a consultation *specialist* one must be able to do something useful for other doctors [7]. Getting to nurse countertransference issues is not necessarily useful. What works and is appreciated by hard-working physicians and surgeons is consultation with daily follow-up until the psychiatric illness is cured, the patient is discharged, or he or she dies. Most psychiatrists look on consultation as a more or less one-shot deal, they have little eagerness to charge out there and see patients, they do relatively minimal follow-up on the patient, and do not wear beepers for fear it will interrupt their psychotherapy.

Physicians and surgeons will call psychiatrists when they need them. If they do not help, they are not needed. To be successful consultation psychiatrists, that is, to be helpful to the rest of the medical profession and to give good responsible care to patients entrusted to them, they have to "make it on the street," not be a "houseboy/housegirl," not be a "kept man/woman," not be a snooper, a busybody, the resident ethicist, the nursing staff daddy or mommy, the patient ombudsman, the burnout troubleshooter, or the unit holistic humanist.

The nonstated fact is consultation psychiatry means hard work to those who love it, taking all-hour telephone calls, going back in to see a patient for whom they have psychiatric responsibility. It takes the Jamesian tough-minded medical model approach. Liaison psychiatry implies a softer, tender-minded approach, much "sharing" of ideas, endless, idealistic psychosocial jaw-music, and more narcissistic strokes from nonphysician nonpeers.

Well, the decorticate preparation has spoken. I hope I have whistled up some limbic tunes for consideration. If I have been offensive please remember what William James might say of me, "He is unrefined, callous, *and* brutal."

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