guest editorial

This Issue:

Issues in Consult-Liaison Psychiatry

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Guest Editor

The consultant psychiatrist is often the discipline's most visible professional point of contact with practitioners of other specialties. Although we lack the sophisticated diagnostic tests and procedures used by other specialties, diagnosis of many psychiatric disorders is nonetheless quite reliable and clinically valid. Our practices, like that of our colleagues, can be firmly grounded in clinical research, treatments can be evaluated for efficacy, and prognoses can be rendered with a reasonable degree of confidence.

This approach to patient care, one that we share with other disciplines, is sometimes called "evidence-based medicine." Although the term probably has as many meanings as there are physicians, Sackett and colleagues describe it as follows:

> "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research ... By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens...External clinical evidence can inform, but can never replace, individual clinical expertise …".[1]

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In a general hospital environment, the patient's psychiatric diagnosis is frequently obscured by medical illness. Optimal treatment must often be extrapolated from other (typically less medically ill) populations, and in many cases clinically salient information is simply not obtainable. For many questions involving the treatment of the psychiatric patient on a general medical or surgical service, even "best evidence" may be substantially lacking or difficult to apply to the case at hand. Much of what we do seems reasonable based on clinical experience, but it should be remembered that our decision making is often based on reasoning by analogy from what we know in other populations: There are many fewer studies specific to the circumstances of those who are concurrently psychiatrically and physically ill. As a result, psychiatric consultation work is often less "evidence-based" than we would like.

The articles in this issue address this point from different vantages, looking at issues that frequently arise in consultations. **Marley Doyle, MD,** and **Lisa J. Rosenthal, MD, FAPM** (see page 58) review the evidence that antipsychotic medications can, under some circumstances, dangerously disrupt cardiac rhythm. That much is clear: But how significant is the risk in everyday practice? How can we best use this information we have to balance the risk of cardiac complications against the danger of undertreatment of severe agitation or psychotic illness?

In the case of evaluation for organ transplant or bariatric sur-

gery, there is even less evidence on-point, as **Michael J. Marcangelo, MD** (see page 66) discusses. Many questions remain, at best, incompletely answered: How can we assist the transplant patient to maintain long-term adherence with immunosuppressant drugs? How effective is treatment of psychiatric illnesses such as depressive or anxiety disorders in the posttransplant or post-surgical patient, and how can we improve outcomes? To what extent does pretransplant mental health predict long-term outcome?

In assessing decisional capacity, the consultant is asked to assess issues that have been defined by law and custom rather than identified by empirical research. Clinical decision making in such cases is a matter of applying expert judgment to address issues that are not fundamentally medical at all. Instead, the consultant is asked to render opinions as to the nature and quality of the patient's reasoning processes, and what degree of confidence can be had as to the patient's ability to make treatment decisions properly. As clinicians, we often take a global approach to the assessment of decisional capacity, but as pointed out by **Larry S. Goldman, MD** (see page 72) a more accurate and nuanced picture may emerge if the question is approached in a systematic manner.

Finally, questions of a different sort arise when thinking about somatization disorder in the context of consultation psychiatry. In this case, there is a wealth of empirical information from studies going back half a century; the difficulty is applying it to patients — since to make the diagnosis often requires more time and resources than is available. Of what use is a diagnosis that can be made either reliably or efficiently — but not both? It remains to be seen whether or not the newest conceptualization ("somatic symptom disorder") will prove more tractable.

Practicing "evidence-based medicine" in psychiatric consultation work requires (as does practice in any other area of psychiatry) familiarity with current research relevant to diagnosis and treatment. Unfortunately, in this area, all too often specific guidance from clinical research is lacking.

It behooves us all to be aware of what is — and what has not yet been — established by good studies. But applying the results of clinical research to individual cases is always an exercise of the art of medicine; and when dealing with complex clinical situations, there is often less scientific guidance than we would prefer.

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REFERENCE

1. Sackett DL, Rosenberg WMC, Muir Gray JA, Haynes RB, Richardson WS: Evidence based medicine: what it is and what it isn't. *BMJ* 1996; 312:71.

about the guest editor

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He completed his training with, and subsequently joined, the faculty of the Department of Psychiatry at Washington University in St. Louis, where he participated in research on the genetics of alcoholism and conduct disorder.

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