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Review

DIFFICULTIES IN COMBINING SOMATIC AND PSYCHIATRIC CARE IN PSYCHOGERIATRY

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SUMMARY

Background: *This article attempts to understand the difficulties encountered in the articulation of health care, particularly between the organic and psychiatric aspects. It also aims to provide solutions to these collaboration issues.*

Methods: *We realized a literature review based on articles dated from 2002 to 2021 and selected from following databases: Pubmed, Cochrane, Scopus, Cairn, Psychinfo and Google. Used key words are "aging, multidisciplinarity, psychiatric stigma, impotence, efficiency".*

Results: *Medical staff may encounter different problems in terms of care, faced to psychogeriatricpatients.These are both related to the medical aspect, including the difficulty of establishing a clear diagnosis in the face of a complex medical situation,clinical unknownledge, multiplication of intervenants with loss of centralisation in terms of care, etc. Added to this, is the organization of health care, which is increasingly specialized and restrictive in terms of hospitalization criteria. Finally to this, is the relational experience of the caregiver, both in relation to the patient and his disorders, and to their colleagues.*

Conclusion: *In the era of the advent of medicinal progress and the advance of diagnostic and therapeutic techniques, it seems mandatory to place the human being at the center of our care. Interhuman interactions constituting the basis of medical care especially in terms of transdisciplinary collaboration. This last point could lead to cost reduction, a more efficient diagnostic and therapeutic management. It seems to be mandatory to reinforce our health care politics in order to time and importance to these various essential and fundamental relational issues.*

Key words: *aging – multidisciplinarity - psychiatric stigma – impotence - efficiency*

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INTRODUCTION

In the era of multidisciplinarity, we rather prefer taking care of the patient in a global approach. Despite the over-specialization of health care professionals in their competency domain, the caregiver has to welcome the patient and his complaints, analyze them taking into account his comorbidities and the differential diagnosis related to his symptom. These items frequently include somatic but also psychosocial or psychiatrical aspects. Geriatrical patients often represent a category of patients who really need a psycho-socio-medical collaboration, mandatory for them because of close relation between their health status and their economic, social, family and cultural life course. Face to these complex medical situations, we often need input of our colleagues. This pluridisciplinarity could lead to a complete quality care. However, we are still too often confronted in our daily practice with the difficulty of collaboration between health care teams, particularly in somatic and psychiatric care. Why ? Is it only due to lack of communication or due to other factors of this apparent segregation between somatic and psychiatry ? How can we improve this collaboration and thus also the management of patients?

METHODS

A literature review has been conducted to identify the key difficulties in the articulation of medical care in psychogeriatry to enable searching appropriate solutions. The articles are from 2002 to 2021 and have been selected from data of Pubmed, Cochrane, Scopus, Cairn and Psychinfo. Used key words are "aging, multidisciplinarity, psychiatric stigma, impotence, efficiency".

RESULTS

We identified several problems related to the articulation of psychogeriatric care. First of all, the elderly people are representing a single category of persons, but most of the therapists are approaching them as "adult" subjects, without bearing in mind their specificities due to their age (Cohen et al. 2014, Clement 2019). As per definition, elderly people represent a dynamic process caracterized by multiple morphological, functional, cognitive and psychological changes. Those changes are inevitable and irreversible. Humans are passing through the state of "old age", frequently experienced as a rupture with real and symbolic losses. This stage goes through various bereavements and he sees his narcissism weakened, making him more vulnerable to everyday "stressors". This transition period exposes principes of vulnerability but also finitude, remembering our immortality illusion (Clement 2019). This confrontation, quite often brutal, gives a feeling of loss of control and powerlessness for the subject but also, frequently, for his entourage and caregivers. The last ones, are confronted to suffering but also to potential end of live, which is often regrets and sorrows. The caregiver is indirectly confronted to the vision of the

patients' own death (Charazac 2020) and all his representations he made on it. Those representations are depending of multiple elements out of which the image we have of our advanced age and those of our loved ones. Another important aspect in this interhuman changing is the patients' personality (Cohen et al. 2014, Vannotti 2002). One has to go to explore the History of patients' live. This aspect is rather difficult for the caregivers, because this is a human-to human relation instead of caregiver-patient. It cannot be learned and requires a consequent investment of time and personnel. This emotional sphere, less present in part of somatic care, is now taking major dimension. Moreover, social-political-economical aspects related to overall aging process of the population have to be taken into account. Currently ageing is rather described as « healthy » or « dependant and bedridden » and as a matter of fact being costly and time-consuming. It seems that there is no transition between those 2 states. We therefore start by this way considering advancing age as inseparable from a state of functional decline and dependence. This false belief is still more present amongst the medical staff, who only observe in daily consultancy, « missing » ageing. However, there is a intermediate level between physiological ageing and loss of autonomy, called « weakness ». This last one is being progressively installed as a result of the appearance and combination of several factors such as physiological changes, sedentary lifestyle, malnutrition or undernutrition, or low socio-economic resources (Cohen et al. 2014, Clement 2019, Lemogne et al. 2018) (Figure 1).

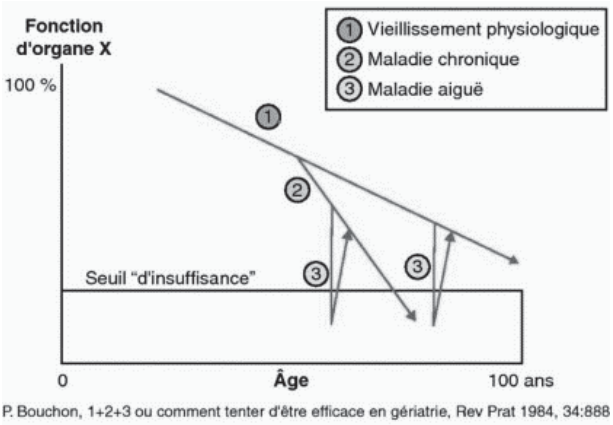
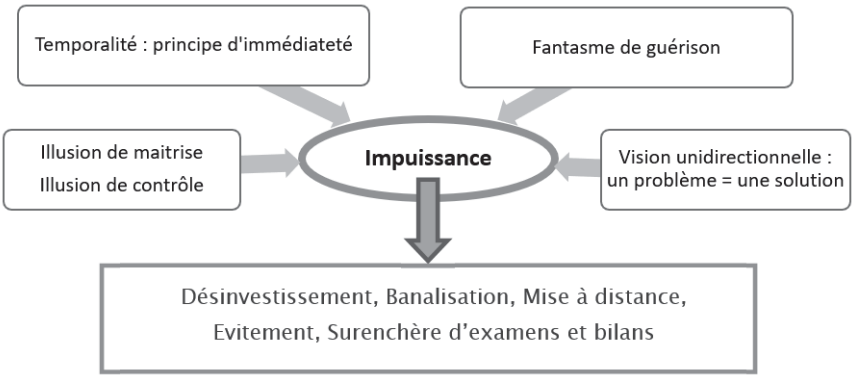


Figure 1. Concept of geriatric fragility (Clément & Calvet 2018)

Detecting reversible frailty is part of every caregiver's mission, and is vital for significantly improving patient quality of life and life expectancy (Blouses 2013). That is why taking care of elderly people needs specific back-ground to avoid to falling into certain tricks such as confusing ageing and sickness; physiological and pathological ageing, etc. Finally ageism, defined as being discriminating attitudes towards seniors, also exists in health care, often related to prejudices leading to negative anticipation of the relation. Management may also be guided by the patient's age, rather than by factors such as life expectancy, quality of life and patient preferences (Cohen et al. 2014, Clement 2019).

Secondly, the access to somatic care for psychiatric patients are complex for several reasons. The first concerns the patient's psychiatric impairment as such, which can alter the patient's experience of relationships with the outside world. Sometimes this is altered by distorted thinking, irrational or delusional thoughts, perceptual disorders or the frequent absence of morbid awareness. Thus psychiatric patient does not really want somatic care. In addition to thie, there are also representations of psychiatric patients as being a « fool ». Over the centuries, psychiatric patient's relationship with others has changed. During the middle ages, perceived as « a sinner », he becomes progressively a heretic, inactive person in the world of work, disruptive and therefore placed in public institutions (hospices). In the 18th century, Pinel and Esquirol revised their condition and developed the « asile » concept, excluvely reserved for mental patients. They introduced the idea that the insane can be "cured" of their insanity. Political views are changing: all citizens are equal, whether healthy or sick. Unfortunately, the disease is still considered as a form of deviance with potential danger for the society. In the 20th century, Freud's work on the unconscious would change the way people think: the segregation between « madness » and « reason » fades, giving way to a new divide, present in every mind: every individual may present signs of unreason. It is rather shocking because it can introduce the possibility of our own alienation (Hochmann 2011). Despite those destigmatisation centuries, our collective unconscience is still conditionned by the psychiatric's history and its socio-policics representations (Hochmann 2011). It is the same in health care where many caregivers percieved those patients like being unpredictable and impulsive, approching them with suspicion. Patient is often juged as unreliable and poorly compliant. Some symptoms, out of which the delirium are often too quickly attributed to psychiatric or « psychosomatic » (Lemogne et al. 2018, Anastasi 2021).

Thirdly, the current general organization of health care plays a determining role in the articulation of care. With the advent of medical knowledge and care techniques, the over-specialization of professionals could lead to a form of compartmentalization of care, generating simplifying attitudes and care. Eacht specialist give his feedback and his opinion without attempting to assemble. So, in case of complex medical situation and in absence of cooperation, multiplication of opinions could lead to increased errors or unadequate treatments (Bordeleau & LeBlanc 2017). This reductive vision leads to a certain detachment or even a lack of accountability of the caregiver towards the patient (Boyd et al. 2005, De La Tribonnière & Gagnayre 2013). Finally the caregivers, in his personal experience, but also collective imagination, occupies a reassuring



Temporality: principe of immediatity / Healing fantasy / illusion of control / helplessness / unidirectional vision: a problem = a solution / desinvestment, banalisation, remote control, avoidance, outbidding examinations and balans

Figure 2. The feeling of powerlessness and induced unappropriate corrective reflexes

place of knowledge and having the capacity to act and to heal. These feelings of controll and expertise are maintained by the surspecialisation of the caregivers still looking for know-how. However, in case of complex medical situation, insidious psychiatric and/or organic decompensation or clinical misconceptions, the absence of clear diagnostic could compromise this illusion of know-how, providing a feeling of powerless. So that causes a feeling of incapacity to helplessness which lead to really loosing caregiver's sense. This could lead to unappropriate corrective reflexes versus the patient such as taking avoiding actions, detachment or even banalization (Figure 2).

The feeling of powerlessness appears also when medical temporality confronts the political-economic organization of health care. Currently, the time of care underpins the principle of immediacy, where clinical and complementary examinations are supposed to provide a clear and rapid response. The fantasm of « immediate respons » is often maintained by the patient itself, waiting for response, but also by the institutions' idea where it is mandatory to have a diagnostic for entering the hospital. But in complex situations, screening and therapeutical results need time. Unfortunately, it is now rather difficult to hospitalize a patient « without diagnostic ». This is reinforced by structural constraints (specific hospital services) and temporaly (lenghts of stay shorter and shorter). We are now assisting to a real organizational disorder where, in addition to responding to clinical efficiency, hospitals have to obtain several efficiency goals such as rentability, productivity or optimalization of ressources (Blouses 2013). In this entrepreneurial logic, limiting the relationship (non-measurable and therefore non-billable) makes it possible to be more profitable.

DISCUSSION

After having analysed the encountered difficulties, let's think about solutions. Evidence Based Medicine recommendations are preconising that every patient must receive qualified care, regardless of the nature of the disorder (Vannotti 2002, Van Orden et al. 2009, Scott et al. 2009). To do so, it seems to be evident that a transdisciplinary approach is mandatory in complex medical situation. Transdisciplinarity, different from pluri and interdisciplinarity are oriented to overall integration amongst disciplines. Fusion of know-how permits to create new knowledge. Thus, from an anthropological point of view, the analysis of the entanglement of biomedical, psychological, sociological, economic and family factors leads to a new understanding of the complexity of the human (Bordeleau & Leblanc 2017, Fernandes & Flak 2012, Scott et al. 2009). This vision thus sweeps away the idea of a dichotomy between psychiatric and somatic medicine. Many research attests of the existence of liaison between good professional collaboration and the obtention of positive health results: better collaboration will decrease number of additional tests, the lenght of hospital stay and morbidity level rates. It permits to professionals to create a climat of trust between them, to enable dialogue of think about complex situations (Lemogne et al. 2019, Anastasi 2021) (Figure 3).

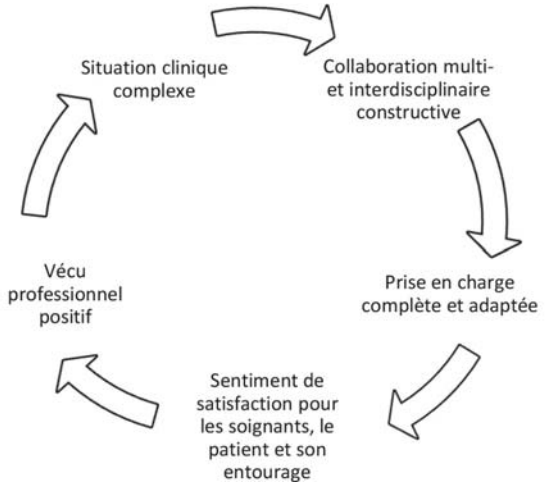


Figure 3. Constructive collaboration enabling a positive feedback loop

Constructive collaboration needs to respond to several criteria. First point is to avoid multiplication of caregivers in the same discipline. It is mandatory that the specialist who makes the overall health balance remains constant amongst all evaluations in order to maintain a critical vision on the symptomatological evolution and global status of the patient (De La Tribonnière & Gagnayre 2013). The centralization of patient data with a defined colleague will allow less confusiogenic management and therefore more fluid and adapted. A second element is the articulation of the collaboration around common defined objectives during patients' treatment. This implies, beforehand a dialog focused on the patient and his problem. The definition of these intervention objectives is based on multiple factors out of which patients' needs but also caregivers' obligations, rules and institutional guidelines. Depending on the degree of importance accorded to each of those factors, caregivers will have different sensibilities. It will therefore be important to establish a common intentionality towards a defined objective. This implies an organization of roles and a distribution of work, with mutual respect for each other's skills (Laude 2013). Capacity to develop interhuman interactions of quality is another essential item. To do so, caregivers should have trainings on relationship, above medical theories, in order to obtain relational competencies such as conflict managment, differencies on opinions, mitigating professional hierarchies etc. All exchanges implicates perceptual, affective and cognitive phenomena: emotion is unevitable in each relation. It is mandatory a acquire relational competencies while caregiver have to maintain the necessary distanciation, in order to avoid the introjection of patients' suffering in our experience and to avoid possible errors of treatment. Besides good collaboration, one have also to know available ressources to enable optimilazation of treatments with adapted partners. One the one hand with collaboration of extrahospital network, one the other hand intra-hospital ressources often unknown of forgotten. It is fundamental in our health politics to establish visibility and communication of those ressources to optimize treatment. Finally, health care system needs to be revised, to enable industrilisation procedures, in a blind desire to imitate the entrepreneurial sector, gives way to a multicentric approach, placing the patient in a central position.

CONCLUSION

Caregivers may encounter in psychogeriatry, several problems in terms of treatment. These are related to medical point of view, such as the difficulty to make a clear diagnostic versus complex medical situation, clinical unkowledge, multiplication of intervenants with loss of centralization of patients' treatment, etc. In addition, the organization of medical care becomes more and more specialized and restrictive concerning hospitalization. Finally one have to add caregivers' relational experience versus patient and those around him and his confrators as well. Health care professional can be confronted to helplessness, leading to avoiding attitudes or even minimization. Moreover health care organization seems to be more and more specialised and restrictive concerning hospitalisation criteria. Thus, in the era of the advent of medicinal progress and the advancement of diagnostic and therapeutic techniques, it is fundamental to replace human being central in overall treatment because the patient represents a complex but singular bio-psycho-social model. Interhuman interactions are constituting fundaments of care, caregiver has to follow training on relationship above his scientific knowledge. Transdisciplinary collaboration seems to be essential to maintain qualified health care management to enable cost reduction, a better diagnostical and therapeutical approach but also to sharing knowledge and data amongst caregivers. It is mandatory to reform our health care managment to reaccord the importance of relational essential goals.

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Contribution of individual authors:

Aurore Sourdeau: research and analysis of littérature, data interpretation and writing of manuscrit.

Denis Jacques & Nicolas Zdanowicz: supervision of article and proofreading.

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