A New Subspecialty for Psychiatry?

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Editor

Medicine has advanced very rapidly over the past 100 years. This is nowhere more evident than in the field of Psychiatry. During this time, we have passed from regarding psychiatric illness as a form of demonic possession, through measures used to segregate those afflicted, to the primitive treatment methods used in phrenology and mesmerism, and later to the psychoanalytic methods propounded by Sigmund Freud. Up to the 1950s, Psychiatry has moved very much away from mainstream medicine.

However, the pendulum has swung very much in the opposite direction in modern days. Psychiatric Units are now important parts of general hospital complexes. Patients are managed in the community rather than sent away to mental hospitals.

This has all been made possible by renewed understanding that psychiatric illness is a disease of the brain, and by the gradual unfolding of the pathological mechanisms that underlie such illnesses, and the consequent development of effective medications targeted at specific mechanisms. Today we are making advances in psychiatric illness in terms of the interplay of neurotransmitters and receptors, neurochemistry, genes, cell and molecular biology, and imaging techniques. We have also seen great advance in the efficacy and diversity of drugs available for use in psychiatry. Treatment of psychiatric patients nowadays has returned to a very similar model and approach as treatment of patients in other specialties in Medicine.

This convergence of psychiatry and medicine has taken a further twist. Nowadays we discover that there are a large number of patients with comorbidities of both medical and psychiatric illnesses. The patient with schizophrenia is more prone to diabetes and the metabolic syndrome, and certain antipsychotic drugs promote hyperglycaemia and hyperlipidaemia. Patients with physical illnesses, e.g. ischaemic heart disease, may require treatment with psychotropic drugs which may induce cardiac arrhythmia or influence warfarin levels. Patients under treatment for viral eradication of hepatitis B and C often suffer from severe depressive symptoms that require psychiatric intervention. Similarly patients on chemotherapy for cancer may need psychotropic drug treatment. How do these different drugs interact in the body? And how does one disease process affect another? (Among middle-aged women, the presence of depression increases the adjusted wish of dying from heart disease by 50%). Does the doctor prescribing cardiac drugs have any shortage of clinical material for research and management, and in fact this proposed new subspecialty will be in great demand in the days to come.

I therefore propose that there should perhaps be a new subspeciality of psychiatry, in addition to psychogeriatrics, child and adolescent psychiatry, forensic psychiatry, addiction etc, that specifically deals with this group of patients. For want of a better name, this subspecialty may be tentatively called “Somatic Psychiatry” or “Co-morbid Psychiatry”. Physicians who work in this field should be trained in both psychiatry and general internal medicine, ideally with formal postgraduate qualifications in both specialties. This field is different from liaison psychiatry, in which the psychiatrist attends to patients, for example, in the surgical ward in close co-operation with the surgical team. In “Somatic Psychiatry”, the doctor is expected to deal relatively independently with patients with co-morbid ischaemic heart disease and depression, or a diabetic patient with schizophrenia. I am sure there will not be any shortage of clinical material for research and management, and in fact this proposed new subspecialty will be in great demand in the days to come.