A COMPARISON OF PSYCHIATRIC NURSING CONSULTATIONS WITH PYSCHIATRIC MEDICINE CONSULTATIONS

by

Linda Newton

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BY

LINDA NEWTON

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

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ABSTRACT

This retrospective, descriptive, and comparative study examined the contribution of psychiatric consultation liaison (PCL) nurses in the care of patients experiencing a physical illness. The purpose of the study was to document the unique practice domain of PCL nurses as contrasted to psychiatric consultation liaison physicians.

The conceptual framework for this study was a practice framework specifically developed for PCL nurses by Lewis and Levy (1982). The framework consists of five principles of equal significance to the model. These five principles are the consultation liaison model, the patient, the medical illness, the nurse and the system, and preventative management. The findings are discussed in relation to all five components of the model.

Selected information on all patients seen by the PCL nurses and physicians between January 1, 1989 to December 31, 1990 was used as the data base for the study (N=1396). Both parametric and non-parametric statistical tests were utilized to examine the variables of interest from these patients. These variables included age and gender, type of unit initiating the referral, reason for the consultation, medical and psychiatric diagnosis of the patient, and consultation suggestions. A subsample of patients seen by both PCL nurses and physicians was subjected to further analysis using the same statistical tests.

The analysis of the data revealed a different pattern of the clinical activities of the two groups of consultants, with the exception of patient age or gender and type of unit originating the referral. The PCL nurses were asked more often than the psychiatrists to see patients for nursing or behavioural management issues, including anxiety. This pattern was also seen in the subsample of patients seen by both PCL nurses and physicians. Only the PCL nurses were asked to see the patient's significant others as a reason for consultation. PCL nurses were significantly more often asked to see patients with a primary medical diagnosis of neoplasm, trauma, cardiovascular, renal, or COPD.

PCL nurses tended to assess their patients as experiencing psychiatric diagnoses which included phase of life problems, adjustment disorders, or bereavement more often than the psychiatrists. The psychiatrists saw more patients who were assessed as experiencing classical psychiatric illness such as delirium, dementia, or depression. The patients seen by the PCL nurses came to the illness experience with a higher level of psychosocial functioning and were assessed as experiencing a higher level of psychosocial stressors. This difference was not seen in the subsample.

The PCL nurses more often suggested behavioural management strategies or follow-up with other consultants such as social work, chaplaincy, or Child Life staff. The psychiatrists more often suggested an intervention which involved a psychotropic medication or follow-up in an outpatient psychiatry setting.

The findings of this study have resulted in implications for nursing practice, education, and research. The study confirmed the unique practice domain of a mental health practitioner, the psychiatric consultation liaison nurse, substantially different than that of consultant physicians from psychiatry.

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TABLE OF CONTENTS

		Page
ABSTRACT		iv
ACKNOWLEDGEMENTS		vi
CHAPTER ONE	**Introduction**	1
	Psychological Problems of the Medically Ill	2
	Depressive Response	2
	Myocardial Infarction	3
	Delirium	4
	Renal Disease	5
	Psychiatric Consultation Liaison Nurse	7
	Purpose of the Study	11
	Problem Statement	12
	Definitions of the Terms	13
	Summary	16
	Conceptual Framework	17
	Lewis and Levy Framework	19
	Components of the Framework	20
	Consultation liaison model	21
	The patient	22
	The medical illness	24
	The nurse and the system	25
	Preventative management	26
	Comparison of the two Frameworks	27
	Case example	28
	Organization of the Thesis	32
CHAPTER TWO	**Review of the Literature**	34
	Psychiatric Medicine Consultation	35
	Methodological Variation	35
	Sample Size	39
	Findings	41
	Limitations	42
	Strengths of the Studies	44
	Psychiatric Nursing Consultations	45
	Anecdotal Reports	46
	Research Studies	48
	Summary	53

CHAPTER THREE Methodology 55

Design 55
Sample 58
Setting 59
Instrument 60
Variables 61
Data Collection Procedures 62
Protection of the Rights of Human Subjects 63
Limitations 63
Summary of Methodology 64

CHAPTER FOUR Findings 66

Distinguishing characteristics of Psychiatric Nursing Consultations .. 67
Demographic Characteristics of the Patients 67
Type of Unit Initiating the Consultation 67
Reason for Consultation 71
Primary Medical Diagnosis of the Patient 73
DSM-III-R Diagnosis 74
Consultation Suggestions 76

CHAPTER FIVE Discussion 78

Relationship of the Findings to the Research Questions 78
Relationship of the Findings to the Conceptual Framework ... 87
Consultation Liaison Model 88
The Patient 92
Medical Illness 95
Nurse and the System 98
Preventative Management 99

Unique Practice of the PCL Nurse 102
Implications and Recommendations 106
Nursing Education 106
Nursing Practice 110
Nursing Research 114

CHAPTER SIX Summary and Conclusion 123

REFERENCES 127

APPENDICES

APPENDIX A Consultation Services - Adult Psychiatry Data Base 144

APPENDIX B Letters of Permission 146

APPENDIX C Letter of Approval - Ethical Review Committee . 149

TABLES

Table 1 PCL Nursing Consultations 48

Table 2 Findings of Stickney and Gardner 52

Table 3 Psychiatric Consultations by Unit of Referral 68

Table 4 Top Four Areas of Consultation .. 69

Table 5 Reasons for Consultation 72

Table 6 Comparison of Psychiatric Diagnoses 75

CHAPTER ONE

Introduction

The occurrence of psychosocial problems in patients admitted to general hospitals for medical-surgical conditions is well documented. A hospitalized patient must struggle to cope with the medical illness itself, as well as the psychosocial implications of the illness. Studies have demonstrated that many illnesses and disease states carry with them an increased risk for the development of psychosocial and psychiatric problems. Medical-surgical nurses, because of their educational preparation and their twenty-four hour a day presence on the ward, are the members of the health care team who frequently identify and intervene with the psychosocial problems of patients. Barry (1989), Bulechek and McClosky (1987), and Wesorick (1990) have suggested the most appropriate role for nurses to focus on in their practice is intervention in the realm of human response to illness. Several common health problems have been well documented as having a high psychosocial component in which the nurse's role may be central. These responses may include depressive and anxiety responses to myocardial infarction and renal disease.

Psychological Problems of the Medically Ill

Depressive Response

The development of a depressive response has been documented as a common occurrence in the medically ill. Up to 25 percent of medically ill patients experience a significant depression during the course of their illness (Grassi, Albieri & Marangolo, 1989; Kathol and Petty, 1981; Katon, 1987; Mai, 1989; Rodin and Voshart, 1987). The importance of the identification of a depression is clinically significant as depressed patients may experience difficulty in actively participating in their care, adhering to their treatment regime, and returning to their previous level of social functioning. They may even commit suicide. Patients may also misinterpret their symptoms as being a result of their physical illness when, in fact, the symptoms may be a result of the depression (Lustman, Clouse & Carney, 1988). This information reinforces the importance of medical-surgical nurses' ability to assess and intervene with depressed medically ill patients.

Myocardial Infarction

In 1971, Cassem and Hackett were among the first to document the psychological responses of a person experiencing a myocardial infarction (MI), a common reason for admission to medical-surgical wards. These responses included anxiety, depression, and denial. Further research by a number of authors has corroborated the significance of these early findings to clinical practice in medical-surgical settings. Bryne (1981) examined the social context of 120 survivors of an MI and found anxiety was highest in blue collar workers when compared to white collar workers. This anxiety was deemed by the researcher to be related to the type of work awaiting them on discharge from hospital. In a study conducted to identify potential determinants of poor outcome post-M.I., the authors (Ell & Haywood, 1985-86) found social support had a strong influence on psychological and functional outcomes in those persons with deficits in their support systems. Sterns (1987) emphasized that the failure of a clinician to assess and intervene with the psychiatric complications of an MI may aggravate the underlying cardiac condition. In a review of the literature pertaining to the

psychosocial determinants of recovery from an MI, Owen (1987) stressed the cardiovascular nurse's role in executing appropriate psychosocial interventions in order to help patients begin recovery.

Delirium

One of the organic mental disorders, delirium, is another common psychosocial problem experienced by patients admitted to many areas of the hospital. Trepacz, Teague, and Lipowski (1985) found 58 percent of the patients they assessed for psychiatric consultation experienced a delirium. An added concern was that delirious patients had a significantly higher six month mortality rate when compared to other diagnostic groups such as those with a dementia. This increased risk for death for delirious patients has also been found in a study by Cameron, Thomas, Mulvihill, and Bronheim (1987). Other patients are at increased risk for developing a delirium: up to 38 percent of conscious ICU patients (Easton & MacKenzie, 1988) and 60 percent of liver transplantation patients who were given a psychiatric diagnosis experienced a delirium (Trzepacz, Maue, Coffman, & Van Thiel, 1986-87).

Nurses working in medical-surgical settings must be able to accurately identify patients who experience a delirium as a concomittant of their medical illness. Unfortunately, studies have shown that nurses may miss detecting cognitive disorders at rates from 55 percent to 72 percent (Palmateer and McCartney, 1985; Knights and Folstein, 1977). Hall (1988) also writes of the problem of misdiagnosis of alteration in thought processes by geriatric nurses. The early identification of a delirium enhances the determination of the underlying physical cause of the delirium. Once the cause has been identified, it potentially can be treated.

Renal Disease

Another group of patients who have been identified as experiencing psychosocial problems as part of their physical illness are those persons with renal disease. For example, up to 48 percent of both transplant and dialysis patients in two studies were identified as having a psychiatric impairment (Kalman, Wilson, & Kalman, 1983; Petrie, 1989). Dialysis patients experience depression at rates up to 17.7 percent for minor

depression and 6.5 percent for major depression (Hinrichsen, Lieberman, Pollack, & Steinberg, 1989). Suicidal ideation and completed suicides are also psychosocial problems experienced by patients with renal disease (Livesley, 1981; Stewart, 1983). In a review article, Jack, Rabin, and McKinney (1983-84) point out long-term dialysis patients are also at higher risk to develop an encephalopathy as a sequelae of their treatment. Renal nurses, by virtue of their long-term and close involvement with their patients, are often in the best position of the health care team to identify the patient's psychosocial problems.

The previous review accentuates the importance of the identification and treatment of concomitant psychosocial problems in patients admitted with medical-surgical problems. Nursing staff on non-psychiatric units may feel they lack the requisite knowledge to deal with these non-physical problems. A study by Lucas and Folstein (1980) demonstrated that nursing assessments fail to identify psychiatric disorders in their patients. The researchers, using either the Mini Mental Status Examination or the General Health Questionnaire (GHQ), assessed 100 newly admitted

patients. The nursing staff failed to recognize 43% of patient's cognitive deficits and 41% of patients with emotional distress as identified by the GHQ. When faced with the complexities of psychiatric/psychosocial problems in medical settings, nurses may enhance care by having access to consultation with a specialist in the area of psychosocial nursing care, the psychiatric consultation liaison (PCL) nurse, in order to identify psychosocial problems in their patients.

Psychiatric Consultation Liaison Nurse

A PCL nurse is a nurse with expertise in psychosocial care of medically ill patients and their families. The PCL nurse assesses the patient situation, discusses the case with the ward nurses, documents a recommended treatment plan which is implemented and evaluated by both the PCL nurse and the ward nurses. Nelson and Schilke (1976), Robinson (1982), and Lewis and Levy (1982) in reviews of the development of this role suggest this is the most common implementation style. In the United States there are specialized graduate nursing programs to prepare PCL nurses (Nelson & Davies, 1979; Robinson, 1972). Due their great numbers PCL

nurses are a special interest group of the American Nurses' Association and have developed their own standards of practice (American Nurses Association, 1990). In Canada, there are no specialized graduate programs to prepare PCL nurses. At a national psychiatry nursing conference, held in 1986, approximately ten PCL nurses were identified as practicing in various cities such as Vancouver, Calgary, Toronto, Winnipeg, and Sherbrooke.

At the Health Sciences Centre in Winnipeg, Manitoba, a consultation liaison service was established in 1974 with a psychiatrist Director, part-time attending psychiatrist, psychiatric residents, medical students, and a half-time PCL nurse. The nurse initially worked closely with the rest of the psychiatric team, attending team rounds, completing psychiatric assessments that had been referred to the team, and working occasionally with the medical-surgical nursing staff. Over time, the role evolved, and the PCL nurse began spending more time consulting directly with nurses on the non-psychiatric units. These nursing referrals were mainly nursing management issues and requests for help in assisting the patient and family to cope with

response to their illness or hospitalization. Due to increasing demand for the nurse's service from her nursing colleagues, the position was expanded to one full-time PCL position and a part-time position in 1983. The two PCL nurses currently operate a parallel service to the medical psychiatric service and respond to consultations from nurses on non-psychiatric units. Occasionally, both nursing and psychiatric medicine services will be involved with the same patient.

Although there are abundant anecdotal reports of the clinical activities of PCL nurses in the literature (Adamson, 1970; Badger, 1988; Baldwin 1978; Baker and Lynn, 1979; Clemence, 1981; David, 1969; Fife, 1983; Gorton, 1958; Hart, 1982; Hendler, Wise & Lucas, 1983; Howard, 1978; Jackson, 1969; Minarik, 1984; Peterson, 1969; Przepiorka and Bender, 1977; Robinson, 1968; Skepple, 1984; Yoest, 1989), it is not possible to ascertain any pattern of referral to these nurses or to clearly articulate their unique contribution to the psychosocial care of the medically ill.

Leading nurses in the field of psychiatric consultation nursing have called for

PCL nurses to move beyond mere role description. Identification of the reason for consultation, the type of patients seen by the consultant, the problems presented, the management strategies suggested, and the development and testing of specific nursing theory are suggested in order to develop theory-based practice (Nelson & Schilke, 1976; Robinson, 1982). Robinson (1982) further suggests that by standardizing and classifying problems seen by PCL nurses and psychiatric consultation liaison teams, the extent of these problems may be measured and the evaluation of specific intervention strategies may begin.

Osborne (1984), in a review of the intellectual traditions of psychiatric mental health nursing textbooks, suggests powerful theory is required to assure the eventual maturity of the speciality. Hoeffer and Murphy (1982) stress the need for psychiatric mental health nurses to articulate what distinguishes their practice from other mental health disciplines. This is necessary in order to complete the task of developing and testing nursing theory relevant for the psychiatric mental health nurse. Goldberg and colleagues (1984) emphasize the necessity of clear role definition for a program such as an oncology

psychiatry consultation service to be successful. Clemence (1981) and Anderson (1983) echo these concerns for a clearer definition of the PCL nursing role. A more systematic role analysis will lead to theory development in the area of psychiatric mental health nursing, a much needed aspect of professional nursing.

Purpose of the Study

The purpose of this study was to compare psychiatric nursing consultations to psychiatric medicine consultations in order to begin to define the unique contribution of the PCL nurses to patient care and to identify patterns of psychosocial problems encountered by patients and families on non-psychiatric units. Previously only one study with a sample of 100 has examined the unique practice activities of PCL nurses (Stickney, Moir, & Gardner, 1981). Peterson (1988), in a study that examined the norms and values of three groups of nurses concerning psychosocial nursing practice on non-psychiatric units, states "there is a great need for the development of a body of supportive practical nursing skills which can be utilized with patients

in distress" (p. 101). Further theory development in this aspect of the nursing will improve the practitioners' ability to care holistically for their general hospital patients. This knowledge may help administrators and educators to encourage the incorporation of these psychosocial concepts into general patient care.

Problem Statement

In an effort to answer some of the deficiencies in the current knowledge base regarding the unique domain of psychosocial nursing practice on non-psychiatric units, this study sought answers to the following questions:

What were the distinguishing characteristics of psychiatric nursing consultations versus psychiatric medicine consultations in relation to:

1) demographic variables of the patients;
2) type of unit initiating the referral;
3) reason for consultation;
4) primary medical diagnosis of the patient;

5) DSM-III-R (psychiatric diagnosis)

6) consultation suggestions.

Definitions of the Terms

For the purposes of the study the following terms were utilized as defined:

Completed Psychiatric Consultation - is the submission of a psychiatric data base sheet to the Research and Evaluation Team of the Department of Psychiatry by the PCL nurse or a member of the Psychiatric Consultation Liaison team. The data base has been in use since 1979. An example is seen in Appendix A.

Consultation Suggestions - any suggestions from a choice of 16 are coded by the psychiatric consultant on the data base sheet in order of priority. Choices include medications, staff interactions changes, follow-up, no further involvement, etc. (See Appendix).

Consultee - is a nurse or physician on a non-psychiatric unit who consults the PCL nurse or a member of the Psychiatric Consultation Liaison team.

Diagnostic and Statistical Manual of Mental Disorders Third Edition Revised (DSM-III-R) - the manual of psychiatric diagnosis currently in use in the Department of Psychiatry at the Health Sciences Centre. Each patient is assessed in each of five areas Axis 1-Mental Disorders, Axis 2-Personality Disorders, Axis 3-Physical Health, Axis 4-Severity of Psychosocial Stressors; Axis 5-Global Assessment of Functioning Axis.

Non-Psychiatric Unit - is any unit in the Health Sciences Centre, excluding the inpatient psychiatry units, which use the services of the PCL nurse or the Psychiatric Consultation Liaison team.

Primary Medical Diagnosis - the psychiatric consultant chooses one of 19 categories on the data base sheet. Choices include neoplasm, trauma, renal, cardiovascular, etc. (See Appendix A).

Psychiatric Diagnosis - each of the five axis of the DSM-III-R is filled out on the data base sheet for each consultation seen by the psychiatric consultant.

Psychiatric Medicine Consultation - is a consultation directed to a member of the Psychiatric Consultation team by a physician on a non-psychiatric unit. The consultation may be assessed by any member of the Psychiatric Consultation Liaison team which consists of two staff psychiatrists, psychiatric residents, internes and medical students. The assessment is always discussed with a staff psychiatrist.

Psychiatric Nursing Consultation - is a consultation directed to a PCL nurse by a staff member on a non-psychiatric unit. The consultation may be answered by either the full-time or part-time PCL nurse.

Reason for Consultation - the psychiatric consultant (either PCL nurse or Psychiatric Consultation Liaison team member) chooses one of 19 categories and lists it in the order of importance on the data base sheet. Choices include evaluation, management, patient request, patient-staff conflicts, etc. (See Appendix A).

Type of Unit - the units are grouped in this study into five categories - medical, surgical, rehabilitation-respiratory, units in the women's

hospital and special care units which include the intensive care areas, outpatient clinics and the burn units.

Summary

In summary, medically ill patients may experience a wide variety of psychosocial problems such as depression, delirium, and anxiety. Nurses on non-psychiatric units are often the health professionals who interact most consistently with patients on a day-to-day basis and therefore, are in the best position to be able to identify these psychosocial problems. However, medical-surgical nurses though expert in physical aspects, may not have the requisite skill or knowledge to conduct a complete psychosocial assessment. The PCL nurse, an expert in psychosocial nursing care, may be called upon to assist the nurses. This study sought to more clearly define the unique contributions of the PCL nurse in the psychosocial care of the medically ill and their families. The conceptual framework for this study will discussed in the next section of this chapter.

Conceptual Framework

Physicians and nurses employ somewhat different conceptual frameworks as their guide to practice when asked to assess a patient on a medical-surgical unit. The work of Gerald Caplun (1970) provides the conceptual framework from which the psychiatry consultation service functions. Caplun saw consultation as the provision of clinical expertise to a consultee who maintains responsibility for the implementation of the treatment plan. He described four types of consultation: 1) client-centred; 2) consultee-centred; 3) program-centred administration; and 4) consultee-centred administration. The first two are the commonest types in clinical practice. They are also the two main functions undertaken by the psychiatry consultation service at the Health Sciences Centre (Mowchun, personal communication, 1992). In a client-centred consultation, the consultee seeks assistance in the management of a particular patient or group of patients. The consultant conducts a diagnostic interview including gathering data about the patient's personality, response to illness and additional psychosocial data (Lipowski, 1986). The consultee-centred consultation is one in which the

consultant assists the consultee to resolve personal and ward difficulties that interfere with the delivery of care to the patient (Caplun, 1970).

Caplun's framework is derived from the traditional medical model of the physician, similar to that of the psychiatry consultation service. Lipowski (1986), however, suggests that the psychiatric consultant works beyond the process of a traditional medical consultation which focuses exclusively on assessment and treatment suggestions. Several authors (Gabinet & Friedson, 1981; Hengeveld, Rooymans, & Hermans, 1987; Hengeveld & Rooijmans; 1987; Kucharski & Groves, 1976 - 77) have documented the impact of personal and ward dynamics on the process of psychiatric consultation. Psychiatrists must be cognizant of the impact of the consultee's personal feelings and conflicts on the genesis of consultations and the willingness/ability of consultees to implement psychiatric suggestions.

In spite of these publications Caplun's theory has not been formally revised and, as a result, consultation psychiatrists are left to incorporate additional theoretical knowledge such

as the inclusion of systems theory or cultural information derived from personal experience or expertise. Due to its early development and lack of subsequent revision, the Caplun framework does not demonstrate the articulation of many of the concepts in the nursing framework.

Lewis and Levy Framework

Lewis and Levy (1982) extended the Caplun framework by developing a conceptual framework specifically for PCL nurses. It is their framework which was used in this study. The Lewis and Levy framework integrated several theoretical models of nursing and psychiatry. These included Caplun's model, the nursing process, psychodynamic formulation, and developmental theory. Systems theory, crisis intervention, adult learning theory, and grief theory were also integrated into their framework. This framework is applicable to all areas of clinical practice and could be utilized by any PCL in any area of practice-acute care, long-term care, or the community. The framework's purpose is to guide practice and may be used with a variety of consultation modalities.

The framework is consistent with the goals of psychiatric liaison nursing set out by Lewis and Levy and is the basis of practice for the PCL nurses at the Health Sciences Centre. These goals are 1) to teach and to demonstrate the incorporation of mental health principles into clinical nursing practice on non-psychiatric units; 2) to effect appropriate psychiatric and nursing interventions; 3) to support nurses in the provision of quality nursing care; 4) to promote and develop professional and personal self-esteem of the nurse; and 5) to encourage tolerance by nursing staff in situations where an immediate or effective intervention is not possible (Lewis & Levy, 1982). The conceptual framework is comprehensive in scope, incorporating several of the multitude of perspectives required by the PCL nurse in clinical work.

Components of the Framework

Lewis and Levy's (1982) five part framework proposes five principles of equal significance to the model. The word principle is used to demonstrate the breadth of information required in each of the five areas identified, and to remind the consultant of the absolute

importance of attending to each of these areas if the total picture of the consultation is to be seen (Lewis & Levy, 1982). This process is called "diagnosing the whole consultation." Each principle blends with the others. The five principles are the consultation liaison model, the patient, the medical illness, the nurse and the system, and preventative management. The framework is illustrated in Figure 1.

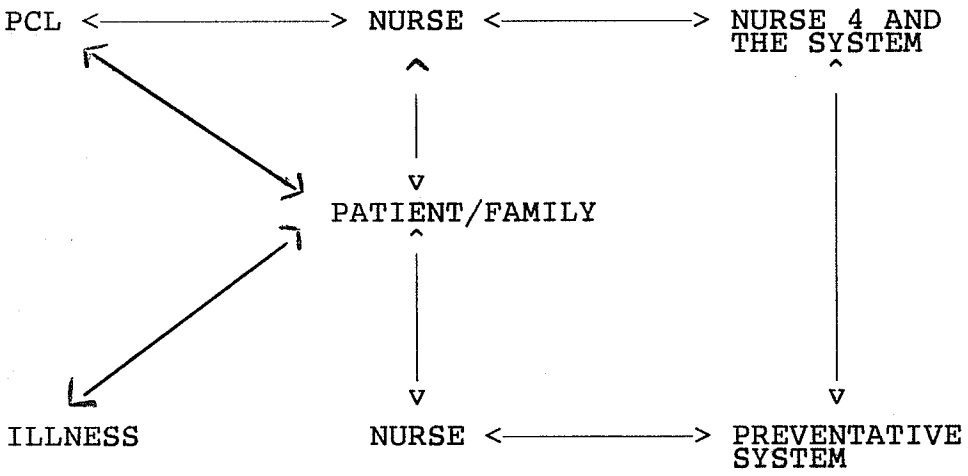

Figure 1 Lewis and Levy Framework

Consultation liaison model.

The consultation liaison model states that the consultant has an educative, collaborative relationship with staff on non-psychiatric units. The consultant attempts to

raise the consciousness of the staff about the psychosocial needs of patients and families and offers management/intervention strategies. The consultee may choose to implement these strategies. The establishment of this climate of mutual respect between consultant and consultee is seen as fundamental to the successful implementation of the consultant role (Cherniss, 1978; Simmons, 1985 in Critchley & Maurin, 1985). An example of this principle would be the conducting of weekly psychosocial nursing rounds in the Medical Intensive Care Unit (MICU). The purpose of the rounds is to develop a close working relationship with the staff, to promote the inclusion of psychosocial nursing concepts into daily practice, and to increase the knowledge base and expertise of the ICU nurses.

The patient.

The patient is the fundamental focus of patient-centred consultation. Patient-centred consultation is the most common activity of the PCL nurses at the Health Sciences Centre and comprises 75 percent of their time (Health Sciences Centre, PCL yearly reports, 1990-1991). The consultant must complete a thorough

psychiatric assessment of the patient. The nurse consultant must assess the needs of the patient and the needs of the consultee in order to determine who should be the focus of the consultation. The nurse consultant may decide the patient or family is the focus. She/he may decide to work directly with the staff to meet their needs and as a means of indirectly meeting the needs of the patient. An example of this principle would be the provision of expertise and support to the staff on a medical unit to assist them in the care of a diabetic woman with a severe personality disorder. It would have been detrimental for the nurse consultant to work directly with this woman as she had another mental health consultant working with her. The nurses required 1) knowledge about this particular mental health problem, 2) concrete suggestions to help them intervene when her behaviour became problematic, and 3) support when the interventions were not always successful. Though the consultation concerned a specific patient, indirect intervention with the nursing staff was the most appropriate action in this situation.

An element not identified in the Lewis and Levy framework is the impact of the illness on

the patient's family. The patient's family is also affected by the illness, the course of the illness, and the treatment. The family in fact may have a more difficult time dealing with the illness than the patient and, as a result, may be the focus of the consultation. Lenehan (1986) and Minarik (1984) have written of the importance of the care of families of the medically ill patient. This study provided evidence for the specific inclusion of this element into the framework, expanding its comprehensiveness and helpfulness.

The medical illness.

The medical illness principle reminds the nurse consultant to be cognizant of all aspects of the illness in completing the consultation. This includes an awareness of the etiology of the disease, the course of the illness, the impact of specific treatments, and the potential impact of the illness on the patient. Some of the psychosocial problems outlined in Chapter 1 would be examples of this principle. A pattern of specific types of psychological problems encountered by patients with specific medical illnesses may be revealed by future research. For example, the nurse

consultant must be aware of the high incidence and the normal course of delirium in medically ill patients in order to assist nurses in appropriate management.

The nurse and the system.

Principle four, the nurse and the system, outlines the influence of the ward atmosphere and the subsystems in operation in regard to the consultee's motivation in requesting a consultation. A number of consultations from one unit in rapid succession may reveal the impact of the system on the pattern of consultation. For example, the admission of a large number of severe spinal cord injuries to one unit resulted in an increased number of consultations as compared to previous months. The nursing staff were experiencing difficulties in coping with their own feelings in this situation and in providing the necessary psychosocial nursing care to this group of patients. The nurse consultant provided direct interventions with some of these patients as well as providing support to the nursing staff.

Preventative management.

Preventative management addresses the ability of the hospital system, including community resources, to meet the needs of the patient by means of a flexible and adaptive approach. Through the integration of the information gained by following the first four principles of the model, the consultation nurse works with the staff to improve the quality of care for the patient currently being seen as well as for others admitted to the unit in the future. An example of this principle would be the provision of educational sessions on mental status examinations for the geriatric nursing staff. These geriatric nurses also received one to one supervision by the PCL nurse in order to assure competency in future clinical encounters. Following the completion of these two activities, the geriatric nurses conduct and document a mental status examination on all new admissions to their unit. This information is used to identify actual and potential problems due to alteration in a patient's mental status.

Comparison of the Two Frameworks in the Study.

A comparison of the conceptual frameworks used by the two consultant groups revealed sources of some potential differences in the actual practices of the consultants. The psychiatric medicine consultants receive a referral, they conduct a complete psychiatric evaluation, and recommend specific interventions which are the responsibility of their medical colleagues to implement.

The PCL nurses receive a referral, conduct a complete psychosocial assessment, devise a care plan in consultation with the unit nurses, and return to evaluate the plan's effectiveness. As many of a PCL nurse's suggestions may entail changes in staff- patient interactions, it is necessary to maintain a close, ongoing relationship with the unit staff. This ongoing relationship may permit the PCL nurse to become aware of issues which evolve during the patient's stay in hospital. In contrast, the psychiatric medicine consultant relies on the medical staff to notify them of the need to become involved for another issue. Also, the psychiatric medicine consultants more often suggest some type of

pharmacotherapy than the PCL nurses. The effects of such an intervention may not manifest themselves immediately.

Case example.

The Lewis and Levy model is currently the basis of practice for the psychiatric consultation liaison nurses at the Health Sciences Centre it provides a natural conceptual framework for this study. A case example where both the medical and nursing consultants were involved provides elucidation of the impact of these two frameworks on clinical practice of psychiatric nursing and medical consultants.

> *An eighteen year old unmarried young man, F., from a rural area was admitted to the Surgical Intensive Care Unit for treatment of a self-inflicted gunshot wound to his face. The nurse consultant was called the day of admission in order to provide support and information to his concerned parents and adult siblings. The psychiatric consultants were not consulted to see this man until he was transferred to the plastic surgery unit, four days later. F. had a tracheostomy and his speech was difficult to comprehend due to his injuries and facial edema.*
>
> *The family quickly resolved their own personal crisis state and became quite supportive to their son and brother. Most of them returned to their home in the rural*

area with the proviso they could call the nurse consultant with any concerns. The nurse did not become involved directly with the patient as the psychiatric consultation team had been asked to assess him and make any required follow-up plans.

Approximately one week later the plastic surgery nurses contacted the nurse consultant regarding concerns about the young man's mental state. Their specific concerns included his increasing social withdrawal, his ability to cope with a radically different body image on discharge, and his consumption of alcohol prior to admission. The psychiatric consultation had consisted of a one-time initial assessment visit without follow-up.

The nurse consultant contacted the psychiatry consultation team about these concerns. They had seen and assessed this young man, decided he was not experiencing any major mental illness at that time (i.e. depression), and decided alcohol consumption had played a role in his suicide attempt. They were not planning on following him. Issues not included in their contact were concerns about body image changes, how he might stop drinking, or any follow-up in his home community. The team did not see any reason to follow him as he did not have "a major mental illness".

The nurse consultant then went to meet this young man for the first time in order to assess his current mental state and to discuss with him the plastic surgery nursing staff's concerns. He confirmed that he was withdrawing from people as he was experiencing difficulty accepting how he looked. He was concerned about how people in his home town would respond to his changed appearance. He was also

concerned about how people would respond to him knowing he had survived a suicide attempt. He showed the nurse consultant a picture of himself prior to the shooting and commented about how different he looked. He had moderate concerns about his drinking and was not sure whether he would need help to stop it.

The nurse consultant met with him three times per week for a period of three weeks. The identified concerns were addressed in brief therapy and provision was made, through a letter of referral to the community mental health clinic in his home town, for supportive follow-up. The issue of his drinking was discussed and options for possible sources of assistance were also provided.

During the three weeks of therapy the young man had an opportunity to discuss openly his concerns related to his changed body image, his re-integration into his social world, and what he might expect from further surgical intervention. His mood brightened and he indicated he felt more prepared to return home.

This case example clearly elucidates the impact of the two frameworks on the practice of the nurse and the psychiatric medical consultants. The psychiatry team had carefully assessed this young man including gathering collateral history from his family and had determined he was not experiencing a major mental illness. They had concerns about his alcohol consumption but did not pursue this with him. The conceptual

framework, from which the psychiatry team operates, does not mandate them to intervene beyond the questions asked of them on the consultation. The nurse consultant, originally only involved with his family, took over the therapy issues which evolved over the course of his hospital stay. The nurse consultant, working from the Lewis and Levy framework, was mandated to look at the many issues surrounding the psychosocial care of F. The relationship of the PCL nurse with the plastic surgery nursing staff was the beginning of the request for a psychiatric consultant, the PCL nurse, to intervene in issues related more closely with psychosocial than psychiatric care. The resolution of some of these concerns was of major importance to this young man's recovery.

Psychiatric nurse consultants and psychiatric medical consultants often employ different conceptual frameworks as their guide to practice. Generally, in the study hospital, the early work of Gerald Caplun serves as a guide for the psychiatric consultants while the nurse consultants use the framework developed by Lewis and Levy. A case example was used to illustrate the impact of these differences on clinical

practice. The differing frameworks may account for some of the variations identified in this study. Selected literature, as it pertains to psychiatric medicine and to PCL nursing, will be reviewed in the next chapter.

Organization of the Thesis

This initial chapter has provided an introduction to the study, outlining the need for more research in this area and the purpose of this study. The theoretical framework for the study was presented. Chapter Two provides a summary of the research findings pertinent to both psychiatric consultation doctoring and psychiatric consultation nursing. The contrast in the depth of research completed by the two groups is highlighted. Chapter Three describes the research design, including the setting and the sample, the research methods which were utilized, and the ethical considerations of the study. The limitations of the study are also discussed.

Chapter Four presents the research findings which are used to elucidate the distinguishing characteristics of the consultations seen by the PCL nurses. Chapter

Five is the discussion of the results as they relate to the research questions, the literature, and the conceptual framework. The contribution of the findings to the clarification of the unique practice domain of the PCL nurse are also reviewed. Implications of the findings for nursing education, practice, and research are outlined. The final chapter is a summary of the findings of the study.

CHAPTER TWO

Review of the Literature

The review of the literature in this study is a selective examination of the patterns of psychiatric medicine and psychiatric nursing consultations. There are a large number of studies documenting the activities of psychiatric medicine consultants. Studies chosen for the review included some of the earliest work in this area from the 1960 to 1980 period. Other studies were chosen for their large sample sizes (over two thousand) or for the varying sites of the studies. Studies employing both retrospective and prospective designs were also included in the review. The studies are discussed in terms of design, sample, findings and limitations.

In contrast, the psychiatric nursing literature is not as rich as the psychiatric medicine literature in terms of research describing the activities of PCL nurses. Only four nursing research studies were located (Davis & Schilke, 1980; Joynes, 1974; Stickney, Moir, & Gardner, 1981; Wolff, 1978) and were included in the review. The different questions addressed and the varying methodologies used in these studies

did not allow comparisons to be made in the research findings. Due to the paucity of nursing research literature, anecdotal or case reports from the psychiatric nursing literature are included and summarized.

Psychiatric Medicine Consultation

In spite of variations in the methodology used by the researchers, the numerous studies of psychiatric consultation services report consistent patterns of reasons for referral, origin of consultation, and psychiatric diagnoses of patients seen. Most consultations originated from medical wards. They originated because of the need for evaluation or differential diagnosis, and because of ward management issues. Most patients seen were assessed as experiencing an organic brain syndrome, a depression, or had a personality disorder.

Methodological Variation

The study of consultation medicine roles has utilized a variety of designs with certain strengths and weaknesses. Many are retrospective designs which rest upon the accuracy,

appropriateness, and completeness of previously recorded data. A few are prospective designs which permit greater completeness, accuracy, and attention to variables of interest to the researchers. The differences in methodology in these studies are summarized first. Some of the authors used a retrospective design (Bustamente & Ford, 1981; Chandarana, Conlon, & Steinberg, 1988; Colon, Popkin, & Callies, 1988; Paddison, Strain, Strain, & Strain, 1989; Shevitz, Silberfarb, & Lipowski, 1976; Taylor & Doody, 1979); others used a prospective design (Craig, 1982; Karasu, 1978; Karasu, Plutchik, Steinmuller, Conte, & Siegel, 1977; Perez & Silverman, 1983).

Retrospective studies examine some phenomenon in the present which is linked to some phenomenon in the past (Polit & Hungler, 1987) and have several strengths. The retrospective studies whose pooled total sample exceeds 3000 patients add to the total data base from which to draw information about psychiatric consultation activities. Information from this large number of subjects in these retrospective studies adds to the understanding of the role of the psychiatric consultant. However, drawbacks of retrospective studies were that they are limited to the

information actually recorded. Also, clarification of missing data may not be available as psychiatric residents and medical students rotate off these services on a regular basis.

Prospective studies began with a defined phenomenon of interest and proceeded to examine this phenomenon forward in time (Polit & Hungler, 1987). Prospective studies have the advantage of being able to decide what data would be required prior to the implementation of the study. If this information was missing for a particular patient, the researchers would be able to identify this deficiency and seek clarification from the appropriate consultant. A more complete data set would then be available for analysis, and increase the confidence of the findings. Information on over 3000 patients is available from the prospective studies cited.

Study designs are strengthened further with the use of a comparison group to provide a basis to compare those patients who receive a psychiatric consultation with those who did not, in order to determine if true differences exist between the two groups. Two studies (Bustamente & Ford, 1981; Colon, Popkin, & Callies, 1988)

employed a comparison group of patients. Bustamente and Ford (1981) report more of their consultations originated from medical than surgical units. Depression and organic brain syndromes were the most frequent psychiatric diagnoses. The researchers did not report on the medical diagnoses of the patients they had seen. There was an underrepresentation of minority races and the aged in those receiving psychiatric consultation (Shevitz, Silberfarb, & Lipowski, 1976; Small & Fawzy, 1988).

Colon and his colleagues (1988) found emergency consultations were most often initiated for patients with suicidal ideation and psychotic thinking. This resulted in the consultant recommending psychotropic medications more often than they suggested that further diagnostic work-up be completed. Older patients were less likely to be included in the emergency consultation group. The authors did not report on the type of units originating the consultations, the medical diagnoses of the patient or the psychiatric diagnoses. This was a beginning effort to identify the unique characteristics of patients who do receive psychiatric consultations. This information would be useful in the early

identification of patients at high risk for the development of psychosocial problems in the context of their physical illness.

Two studies examined a special population, the elderly, who received psychiatric consultation (Mainprize & Rodin, 1987; Small & Fawzy, 1988). Both were retrospective in design. This special group of patients were most often diagnosed with organic mental disorders (delirium and dementia), followed by depression. Most referrals originated from medical units. Small and Fawzy (1988) reported medical diagnoses for their patients with most experiencing cardiovascular or neuromuscular illness. The study results remain consistent with findings based on a broader population. This suggests that these broader studies were likely representative of the total population.

Sample Size

Many of the studies reported small sample sizes which may not be representative of the population and therefore provide a weak basis for generalization to larger groups. One study did not report a sample size (Karasu, 1978).

Another reported a sample of ten (Meyer & Mendelson, 1961). Another cited a sample of 2,251 (Kligerman & McKegney, 1971). This diversity produces some difficulty in comparing the research findings. However, regardless of sample size, the findings demonstrate a consistent pattern of referral. Most referrals originate from medical wards; were initiated for evaluation, differential diagnosis, or management issues; and most patients were diagnosed as having depression, organic brain syndrome, or having a personality disorder. The larger studies may be considered as more representative of the variation if the total population had been studied.

The overall similarities in the findings of both the large and small studies provides support that the smaller studies did capture a representative population. Psychiatric consultation medicine, is fortunate to have such a large data base from which to draw conclusions about clinical activities, unlike psychiatric consultation nursing which draws information from approximately 158 cases.

Some studies used only specific patient populations such as individuals in a chronic care

hospital or on an orthopaedic unit, or emergency consultations (Colon, Popkin, & Callies, 1988; Kuhn, Bell, Seligson, Laufer, & Lindner, 1988; Wasylenki & Harrison, 1981). Therefore, comparison of various study findings and generalization to different populations is problematic.

Findings

Comparison of findings is also difficult because the categorization of the reason for referral varies from no reasons given to a range of three to thirteen (Bustamente & Ford, 1981; Craig, 1982; Karasu, Plutchik, Steinmuller, Conte, & Seigel, 1977; Karasu, 1978; Kligerman & McKegney, 1971; Lipowski & Wolston, 1981; Perez & Silverman, 1983; Shevitz, Silberfarb, & Lipowski, 1976; Taylor & Doody, 1979). Some of the reasons for referral include assistance with diagnosis, advice on management, and disposition (Lipowski & Wolston, 1981). Other authors add history of psychiatric disorder, suicide attempt, assessment of competency, preoperative evaluation, and psychosis (Brown & Cooper, 1987; Craig, 1982; Taylor & Doody, 1979) as reasons for referral.

The reader is left to wonder how the categories were determined.

The pattern of referral to psychiatric medicine consultation services and the pattern of psychiatric findings remains relatively constant as reported in the existing studies. Most referrals originate from the medical services. They are initiated for evaluation of patients (mainly for depression), differential diagnosis, ward management issues, or disposition to psychiatry (Brown & Cooper, 1987; Bustamente & Ford, 1981; Craig, 1982; Karasu, Plutchik, Steinmuller, Conte, & Seigel, 1977; Kligerman & McKegney, 1971; Lipowski & Wolston, 1981; Meyer & Mendelson, 1961; Perez & Silverman, 1983; Taylor & Doody, 1979; Wasylenki & Harrison, 1981). The predominant psychiatric findings in the previous studies are organic brain syndrome, depression, and personality disorders.

Limitations

Some authors reported the medical diagnosis for the patients seen (Karasu, 1979; Karasu, Plutchik, Steinmuller, Conte, & Seigel, 1977; Perez & Silverman, 1983; Shevitz,

Silberfarb, & Lipowski, 1976) while others did not (Bustamente & Ford, 1981; Craig, 1983; Lipowski & Wolston, 1981; Taylor and Doody, 1979). For those studies reporting a medical diagnosis, the patients experienced neurological, cardiovascular, and gastrointestinal diseases, and traumatic injuries most often. The deficiency in the other studies makes the identification of specific psychiatric problems associated with specific medical diagnosis troublesome.

The changing diagnostic schema (ICD-9, DSM-II, DSM-III-R) used in psychiatry over the past 25 years have resulted in differing diagnosis being reported (Kuhn, Bell, Seligson, Laufer, & Lindner, 1988; Meyer & Mendelson, 1961; Pablo & Lamarre, 1988; Perez & Silverman, 1983) causing difficulties in the comparison of patient problems. It is possible, however, to determine what diagnostic criteria were used by reviewing the historical diagnostic literature in order to make comparisons of category definitions used in a particular era in which the study was reported.

Strengths of the Studies

A methodological strength in the previously cited studies is a clear description of all of the settings and the personnel composition of the psychiatry consultation teams. However, the authors do not mention the threat of inter-rater reliability resulting from different personnel's variations in the use of diagnostic criteria. Another strength is the description of the type of unit from which the consultations originate. This type of description allows comparison between studies, permits generalization where appropriate, and provides adequate information for replication by other researchers.

Studies of psychiatric medicine consultations show considerable consistency of patterns in psychiatric diagnosis, wards of origin, and the use of large sample sizes. The available literature provides a clear picture of the activities of psychiatrists on non-psychiatric units. As will be seen, the nursing literature does not provide such a clear picture of the unique activities of PCL nurses.

Psychiatric Nursing Consultations

The number of studies examining the pattern of psychiatric nursing referrals is limited, as is the total sample size from which to draw conclusions abut the actual clinical work of psychiatric nurse consultants. Robinson (1987), in reviewing the differences between psychiatric consultation nursing and psychiatric consultation doctoring, summarized them as follows:

1) Psychiatrists are frequently asked to aid in differential diagnosis while nurses are frequently asked about behavioural problems.

2) Psychiatrists utilized direct care modalities such as brief therapy, behavioural strategies or insight-oriented therapy, while nurses tend more often to work with the nursing staff to alter patient behaviour.

3) Psychiatrists are more often asked to diagnose organicity, prescribe medications; or to provide psychotherapy, while nurses focus more on the patient's adaptation to illness and how nurses can assist in this process. (e.g. assisting patients in learning how to adjust their lives to an ongoing chemotherapy regime.)

Robinson concludes "it is hoped the disciplines can sustain those aspects of their similarity that have been beneficial and

strengthen their differences to the same end, improved patient care" (Robinson, 1987, p. 79).

Anecdotal Reports

In comparison to the nineteen medical studies cited, the information regarding the activities of PCL nurses is limited. As mentioned, many anecdotal or case reports have been used as illustration by PCL nurses in describing their role (Armascott, Turner, Martin, & Hott, 1974; Baldwin, 1978; Barron in Hamric, 1983; Berarducci, Blandford, & Garant, 1979; Campinha-Bacote, 1988; Cressy, 1972; Davidson & Noyes, 1979; Freeman, 1979; Goldstein, 1979; Grace, 1974; Hart, 1982; Hitchens, 1973; Horsley, 1988; Issacharoff, Gooduhn, Schneider, Maysonett, & Smith, 1970; Jackson, 1969; Jansson, 1979; Johnson, 1963; Kelso & Barton, 1972; Langman-Dorwant, 1979; Lehmann in Stuart and Sundeen, 1991, Minarik, 1984; O'Brien, 1985; Palermo, 1978; Palmateer, 1982; Peterson, 1969; Przepiorka & Bender, 1977; Richardson, 1982; Robinson, 1968; Robinson in Lego, 1984; Shulman, Corrigan, Hudnut, & Pfouts, 1966; Smith, 1981; Smith, Buckwalter, & Albanese, 1990; Stokoloff, 1983; Tunmore, 1990; Weinstein, Chapman, & Stallings, 1979; Wise, 1974;

Yoest, 1989; Zahourek & Morrison, 1974; Zangari in Wilson and Kneisl, 1983). When these PCL case examples from general hospitals were totalled there were 158 patients. PCL nurses from specialty areas provided 11 cases. Two PCL nurses who consulted to a nursing home saw 87 residents in a 9 month period.

The major reasons for referral in these 158 cases were nursing management, family issues, depression, and grief. Less frequent reasons included nurse-doctor conflict, supportive psychotherapy, assessment, suicide (ideation or attempt), and staff concerns. Robinson (1969) mentions anxiety as the major reason for referral in her group of patients. The patients experienced a wide variety of medical/surgical problems including metabolic disturbances, MI, cancer, trauma, infection, or liver disease. The patient's medical diagnosis was not always given so it was not possible to identify the most common problems. Also, the wards of origin of the consultation were not usually identified.

There were five papers (Berarducci, Blandford, & Garant, 1979; Goldstein, 1979; Hart, 1982; Robinson, 1968; Zahourek & Morrison, 1974)

where total numbers of consultations (898) seen were documented. These are presented in Table 1.

Table 1

PCL Nursing Consultations

Authors	Number of Consultations	Time Period
Berarducci, Blandford, & Garant	99	1 year
Goldstein	271	1 year
Hart	44	1.5 years
Robinson	395	2 years
Zahourek & Morrison	89	1 year

The authors did not provide any further descriptions of their sample and, as a result no patterns of PCL nurses clinical activities can be determined. These deficiencies make it difficult to clearly describe the unique contributions of PCL nurses.

Research Studies

Four studies of psychiatric nursing consultation were located. A British study examined 21 patients referred to a psychiatric-

trained sister (Joynes, 1974). Fourteen of these patients were referred from surgery, with five originating from medical wards; one each from obstetrics and casualty. Reasons for referral were confusion, aggressive behaviour (both physical and verbal), restlessness, suicide attempts, and miscellaneous behavioural problems. There was no discussion of the consultant's recommendations to the staff, an important component of the consultation process.

Wolff (1978) investigated the actual referral process itself in order to determine staff reasoning in making the decision to refer. In the hypothetical referral of patients, the author found nurses had more negative than positive feelings to referred patients. However, nursing observations, rather than negative feelings, were the most important factor in their decision to refer. Depression and patient worrying were identified as the most common reasons for referral. The twenty-seven nurses who participated all came from the surgical area which limits the generalizability of the findings to other types of nursing areas which might seek consultation. However, the study illustrates an attempt to understand the reasoning behind a

nurse's independent decision to refer a patient to a psychiatric nurse consultant.

Davis and Schilke (1980) investigated changes in the characteristics of referrals to PCL nurses over a period of a year and a half. The study was designed to examine the impact of the consultant/consultee relationship on the nature of psychiatric referrals. The authors hypothesized that a positive relationship would increase the consultee's concern for psychosocial patient care issues. Their findings demonstrated an increase over time of referrals being stated in psychological terms, rather than in behavioural terms alone. For example, a referral would read "Please intervene with this patient who is having trouble coping with their recent diagnosis of cancer" versus "See this patient who is angry with the staff". Referrals became more patient-specific and more comprehensive in describing the patient's problem. There was no indication of the type of units from which the referrals originated or the reasons for referral. The authors felt the changes over the period of having access to a PCL nurse may have indicated an increase in the consultee's ability to assess and identify a need for help with psychosocial intervention or an

increase in the nurses becoming more comfortable integrating psychological care into their day-to-day practice. This change was felt to have resulted from the close relationship which developed between the consultant and the nursing staff on the units studied. The development of such a relationship between consultant and staff is an important component of the consultation process (Howard, 1978; Lewis & Levy, 1982; Termini & Ciechoski, 1981).

Stickney and her colleagues (1981) examined the subject of psychiatric nursing referrals as compared to psychiatric medicine referrals. This is the only nursing study located which compared psychiatric consultants and the only one with a large sample size. "Large" is defined as a sample of over 50.

The following referral pattern emerged from the sample of 100 for each service (nursing and medicine):

1) 89 percent of the psychiatric nursing consultations originated from the medical wards or specialty units while 73 percent of the psychiatric medicine consultations came from these two areas;

2) critical care consultations accounted for 6 percent of nursing consultations and 22 percent of the psychiatric consultations; and

3) reasons for referral are depicted in Table 2:

Table 2

Findings of Stickney and Gardner

	Nursing	Medicine
Psychological Manifestations	31%	62%
Behavioural Manifestations	31%	17%
Death and Dying	17%	9%
Suicide Assessment	1%	12%
Evaluation of High Risk Patients	11%	1%
Other (Known Psychiatric Disease)	2%	8%

(Stickney, Moir & Gardner, 1981; Stickney & Gardner, 1981)

This table suggests that the PCL nurse saw many high risk patients or those individuals who required active intervention to help them with behavioural disturbances. There was no discussion of the findings or recommendations made by the psychiatric or nurse consultant.

Summary

In summary, the nursing studies which included information on reasons for referral or sources of referral indicate nurses are asked to see patients most often for behavioural or psychological problems, or for issues related to death and dying. One study found more consultations originated from the surgical areas while in the other, most consultations originated from the medical/special care areas. The majority of the research conducted in the field of psychiatric consultations does not refer specifically to nursing consultation. It suffers from the limitations of small sample sizes, a lack of descriptive detail, and limited generalizability. The nursing studies and anecdotal reports demonstrate the lack of consistent findings documenting the work of the PCL nurses, the areas from which the consultations originate, the problems for which nurses are consulted, and the approaches suggested by the PCL nurses. This study adds additional information to this scant knowledge base.

In the next chapter, the methodology used obtain the necessary information about the unique practice of PCL nurses is presented.

CHAPTER THREE

Methodology

Design

This study employed a retrospective, descriptive, and comparative design. This design allowed the comparison of the pattern of psychiatric nursing consultations with psychiatric medicine consultations. Due to the paucity of previous research studies in this area, a descriptive design was appropriate in order to add to the existing knowledge base. A descriptive study is desirable when the researcher wishes to summarize the current state of some phenomenon of interest and wishes to establish the frequency with which the phenomenon occurs (Polit & Hungler, 1987). The use of the identical data base form by the PCL's and the psychiatric medicine service ensured comparability on the data that was gathered.

The data base sheet, which was in use commencing in 1979, is felt to have content validity as it was developed from an extensive review of the psychiatric consultation liaison literature. The data base sheet contained the variables of interest reported in previous

studies, especially the Stickney and Gardner (1981) study, the only similar nursing study reported. Connelly (1986), Kruger (1981), Polit and Hungler (1987), and Noble (1979) emphasize the importance of replication studies if nursing is to develop its own substantial body of unique knowledge.

The study replicated sections of the Stickney and Gardner study, in addition to examining more variables of interest. There was a comparison of the clinical activities of the two groups of psychiatric consultants (nursing and medicine). This task was completed by comparing the demographic characteristics of the patients seen, the areas from which the consultations originated, the patient's medical diagnosis, and the reasons for referral. The study also examined DSM-III-R diagnosis for the patients and consultation suggestions. These latter two components were not investigated in the Stickney and Gardner study.

The time period chosen for this study was from January 1, 1989 to December 31, 1990. This period of time was chosen as the data base sheet (see Appendix A), which has undergone

several revisions since its inception, was not changed during this time. The consistency of the data base sheet during this time period allowed statistical comparison of the two groups.

Statistical comparison was conducted on the data which was available and which was checked for accuracy by the researcher. The researcher confirmed data from the original data base sheets with the data generated by the computer. The number of cases for each analysis varied as all information was not available on all cases. Only information which was confirmed by comparison with the original data sheet was used in the study. Additional missing information was obtained through a review of the patient's chart. The SPSS-X program was used to complete the statistical comparisons. There was sufficient data to allow comparison between the two groups.

The t-test and chi-square were the two statistical analyses used, depending on the nature of the variable being examined. The number of cases for each analysis varied as all information was not available on all cases. Only information which was confirmed by comparison with the original data base sheet was used in the study.

Additional missing information was obtained through a review of the patient's chart.

According to Fox (1982), this research design met the criteria for a comparative study as it enabled the researcher to decide whether two or more entities (the two consultation services) were similar on two or more variables of interest.

Sample

This study was a purposive sampling of all consultations seen by the psychiatric nursing and medicine services from January 1, 1989 to December 31, 1990. Wilson (1985) states this type of sampling is appropriate if the researcher wishes to examine a specific circumstance; i.e. a specific patient population. Letters of permission from the Director of the Psychiatry Consultation Liaison Service and the two PCL nurses (other than the researcher) were obtained (see Appendix B). A letter of permission from the Director of Research and Evaluation, Department of Psychiatry, was also obtained (see Appendix B).

A subsample of 82 patients from the entire sample was selected for additional comparison. This group of patients is referred to as the "subsample" throughout the rest of this document. These 82 patients were seen by both the PCL nurses and the psychiatry consultation service. The same statistical tests were completed on this subsample. This subsample was chosen as it was felt that it provided further evidence of the unique practice domain of the PCL nurses.

Setting

This study was conducted in an 1100 bed tertiary care, university-affiliated hospital. This setting was used as there were naturally occurring, parallel psychiatric nursing and psychiatric medicine services which provided logical comparison groups. The PCL nurses may receive consultations from any area of the Health Sciences Centre which is comprised of several physically adjacent hospitals covering 32 acres (e.g. General, Children's, Women's, and Rehabilitation-Respiratory). The nurses also see referrals from ambulatory care settings such as clinics and the dialysis units. The psychiatry

medicine service only receive referrals from the adult inpatient services. They are also responsible for the provision of psychiatric consultation to the Chemical Withdrawal Unit, an inpatient psychiatric unit.

Both services operate from 0800 to 1700 hours on a Monday to Friday basis. Emergency coverage for the medical-surgical units was provided by the "on-call" psychiatric service. There was no comparable coverage for the PCL nursing service.

Instrument

The instrument used was the data base sheet developed in consultation with the Director of the Psychiatry Consultation Service and the Director of the Research and Evaluation Team by the researcher for the Psychiatry Consultation Services at the Health Sciences Centre (see Appendix A). The data base sheet contained information on the demographics of the patients (age and gender); the ward of origin (the type of unit-medicine, surgery); the professional classification of the consultee; the consultant who completed the consultation; the reason(s) for

consultation; the patient's primary medical and DSM-III-R diagnosis; consultant's suggestions; and the number of follow-up visits provided by the consultant. All psychiatric consultants completed a data base sheet on every consultation seen. This information, which was stored in the Department of Psychiatry's computerized data base, formed the raw data which was analyzed for this study.

Variables

The variables which were compared for this study were age and gender of the patients; the wards from which the consultations originated; the reason for referral; medical and DSM-III-R diagnosis of the patient; and consultation suggestions. These variables were chosen as it was felt they would best assist the researcher in defining the unique practice domain of the PCL nurses. The two comparison groups were the PCL nurses and the psychiatry consultation medicine service.

Data Collection Procedures

The completed data base sheets were submitted to the Service Evaluation Team, Department of Psychiatry. The information from all sheets was coded and stored in the Department's computer. This information formed the computerized data base on all consultation liaison activities in patient care. Patients entered into this data base were referred to in this study by their hospital chart number rather than by name. The original data base sheets were stored in the Department. These sheets were available for clarification of missing or unclear data. When available, missing data was obtained from the patient's hospital chart and entered into the computer. All information on the computer print out was confirmed by the researcher by comparison to the original data base sheets. In some cases the information was not available and analysis was conducted only on the confirmed data. Therefore, the total number of cases for specific comparisons varied.

Protection of the Rights of Human Subjects

Ethical approval for this study was granted by the Ethical Review Committee, Faculty of Nursing, University of Manitoba on May 10,1990 (see Appendix C). As mentioned, permission to access the records was obtained from all psychiatric consultants and from the Director of Research and evaluation, Department of Psychiatry. Patient names were not identified. Anonymity of individual patients was further protected by collapsing information into categories and, therefore, preventing identification of any single patient during the discussion.

Limitations

A potential limitation to the reliability of the data base was the number of consultants who completed the form, and the different, individual interpretations they made regarding assessment and diagnosis. There were more psychiatric medicine personnel completing the data base sheets than PCL nurses. Therefore, there was a possibility of increased variability in the medical group's application of the assessment criteria. At any given time there were

up to five medical personnel completing the data base sheets. All cases, however, were reviewed with one of three staff psychiatrists who were responsible for final diagnosis and recommendations. There were three nurse consultants who completed the data base sheets. All consultants used the DSM-III-R as the criteria for psychiatric diagnosis.

Another limitation was the retrospective design of the study. The researcher was limited to information which was already recorded on the data base sheets. Some missing information was obtained from a review of the patient's chart. However, the missing information was not always recorded. Therefore, the information could not be analyzed for this study.

Summary of Methodology

A retrospective, descriptive, and comparative design was chosen to compare the consultations seen by the psychiatric nurse consultants versus the psychiatric medicine consultants. Information on all patients seen for period of two years was compared using parametric and non-parametric statistical techniques. The

methods used to protect the ethical rights of the patients were presented. The limitations of the study were identified.

The findings of the study are presented in the next chapter. A description of the sample is presented, followed by the statistical analysis of the variables of interest to the study.

CHAPTER FOUR

Findings

The purpose of this study was to compare psychiatric nursing consultations to psychiatric medicine consultations in order to begin to define the unique contribution of PCL nurses in the care of medically ill patients and their families. The findings are reported in relation to the research questions which were addressed in this study.

All information used for this study was confirmed by comparing the actual information on the data base sheet with the information generated through the computer. Some information was obtained by reviewing the patient's medical record and missing information was then entered on the data base sheet. In cases where the information could not be confirmed or obtained, the case was not used for statistical comparison. As a result of analysis being completed only on verified information, the total N varied, with the largest N being 1434. The total number of unusable cases was 57.

Distinguishing Characteristics of Psychiatric Nursing Consultations

Demographic Characteristics of the Patients

Of 1401 cases examined, there was no significant difference in age between the two groups of consultations seen by medicine and nursing ($\bar{x}$ males = 49.42, $\bar{x}$ females = 49.95, t(-.45), df=1399, p>.65. Of 1434 cases examined, there was no significant differences in gender between the two groups (x^2=.129,NS).

Type of Unit Initiating the Consultation

The areas generating the referrals can be seen in Table 3:

Table 3

Psychiatric Consultations by Unit of Referral

Type of Unit	Psychiatric Nursing	Medicine
Medicine	220	284
Surgery	257	241
Rehabilitation/ Respiratory Hospital	79	33
Critical Care	108	61
Women's Hospital	5	24
Chemical Withdrawal	0	18
Clinics	40	0
Children's Hospital	25	0
Physiotherapy	1	0
Psychiatry	1	0
Manitoba Cancer Foundation	1	0
Total	737	661

There was no significant difference between the two groups when the four highest sources of referral were compared ($p>0.05$). These results are shown in Table 4.

Table 4

Top Four Areas of Consultation Analyzed for Differences in Referrals to Nursing and Psychiatric Medicine

Type of Unit	Psychiatric Nursing	Psychiatric Medicine	x^2	Significance
Medicine	220	284	2.31	NS
Surgery	257	241	0.01	NS
Rehabilitation/ Respiratory	79	33	2.25	NS
Critical Care	108	61	1.50	NS

The single referral from the physiotherapy department was for an outpatient who had had a neurosurgical procedure at the Health Sciences Centre. Both the patient and his family were struggling to cope with his diagnosis and his worsening physical state. The PCL nurse provided direct intervention for both him and his family when he attended the physiotherapy department.

The lone referral from psychiatry was for a known psychiatric patient with schizophrenia requiring an admission to a surgical unit. The PCL nurse was felt to be the appropriate person to provide a consistent psychiatric care giver

throughout this patient's stay on the surgical unit. The PCL nurse also assisted the surgical nurses to develop and implement an appropriate nursing care plan for this patient.

The PCL nurses, as employees of the Health Sciences Centre, are not expected to provide consultation to the Manitoba Cancer Foundation, a source of only one referral. Consultations are completed if the resources, normally available to the staff, are not sufficient to meet the patient's needs. This patient was in a state of crisis, perceived to be taxing the resources and the expertise of the Foundation's nurses. An appropriate plan of care was devised with the staff. The patient was eventually admitted to the Health Sciences Centre and was followed by the PCL nurse.

The low number of nursing referrals (five) from the obstetrical/gynaecological areas is due to a number of factors. The public health nurse at Women's Hospital who is responsible for discharge planning has a strong psychiatric mental health background. As the first nurse to be employed in an expanded nursing role as a nurse therapist in the psychiatry outpatient department,

she is able to assist the nursing staff with psychosocial problems. Due to actual physical presence at Women's Hospital, she is also readily available to consult with the social workers. The social workers at Women's Hospital often meet their patients while they are receiving outpatient ante-partum care. Because of this, there is a strong therapeutic relationship with the women prior to admission. Any major mental health or psychosocial problems likely would have been identified and appropriate care, like referral to outpatient psychiatry, initiated. Although small in number, referral of specific patients that are beyond the expertise of the nursing staff indicates nurses are aware of the available resource of the PCL nurse.

Another interesting pattern was seen in the greater number of referrals from the Rehabilitation/Respiratory Hospital, Children's Hospital, and various clinic settings. The PCL nurses cross over many clinical settings.

Reason for Consultation

The five most common reasons for referral to the PCL nurses were evaluation,

nursing and behavioural management issues, anxious patients, and to see a significant other. The psychiatric consultation team never identified nursing management or seeing a significant other as a reason for consultation. The remaining three reasons for referral (evaluation, behavioural management, or anxiety) were grouped and were submitted to the chi square test (see Table 5). The bonferonni technique was used to control the overall error rate (x^2=172.601, p<0.00001).

Table 5

Reasons for Consultation

Reason	Psychiatric Nursing	Psychiatric Medicine
Behavioural Management	263	93
Evaluation	205	383
Anxious Affect	122	40

(x^2=172.601, p<0.00001)

On the subsample of the same patients this pattern was again observed. The nurses were asked significantly more often than physicians to assist with nursing or behavioural management

issues or with anxious patients ($x^2=26.33$, $p<0.0001$). Therefore, the medical-surgical nurses and physicians were able to differentiate between nursing and medical management. There were no referrals to the PCL nurses for medical management or the reverse.

The PCL nurses were asked one hundred and thirty four times to see a patient's significant other. The psychiatrists did not receive any referrals to see patients' families. In the subsample PCL nurses were asked to see 9 family members; the psychiatrists were not asked to see any significant others.

Primary Medical Diagnosis of the Patient

Of the nineteen possible choices on the data base sheets the five most common reasons for referral to the PCL nurses were neoplasm, trauma, cardiovascular, renal, and COPD. The five most common reasons for referral to the psychiatrists were other, trauma, neoplasm, neurological, and alcoholism. Other included such reasons as suicide attempt, social admission, etc. A significant difference was seen when the five top reasons for nursing referral were compared to the

reasons for referral to the psychiatrists ($x^2=9.81$, $p<0.05$).

DSM-III-R Diagnosis

The PCL nurses and psychiatrists significantly differed on the psychiatric diagnoses of the patients they saw ($x^2=181.6$, $p<0.0001$). For the purposes of comparison, the "classical" psychiatric diagnoses (affective, schizophrenic, organic, paranoid, and anxiety disorders) were grouped and the "adjustment" type disorders (adjustment disorder, phase of life problems, and V. codes) became a second group. V. codes include diagnoses such as "phase of life" problem, "other specified family circumstances", or uncomplicated bereavement. The results of this comparison can be seen in Table 6.

Table 6

Comparison of Psychiatric Diagnoses

	Psychiatric Nursing	Psychiatric Medicine
Classical Psychiatric Diagnoses	128	276
Adjustment Type Disorders	530	218

(x^2=181.6, p<0.0001)

On the subsample the PCL nurses assessed their patients as experiencing significantly more phase of life problems than the psychiatrists (x^2=14.22, p< 0.0005).

On Axis IV, the severity of the psychosocial stressor experienced by the patient, there was a significant difference between the PCL nurses and the psychiatrists (t,9.03, df=1394, p<0.00001). The PCL nurses assessed their patients as experiencing a higher degree of psychosocial stressors. On the subsample there was no significant difference.

On Axis V, the global assessment of functioning scale, there was a significant difference between PCL nurses and the psychiatrists (t,10.61, df=1388, $p< 0.0001$). The PCL nurses assessed their patients as having functioned at a higher level of global functioning over the year prior to admission. On the subsample there was no significant difference.

Consultation Suggestions

The suggestions offered by the two groups of consultants differed significantly. For the purpose of statistical comparisons several groupings of suggestions were made. The groups included 1) medication suggestions (antipsychotics, antidepressants, anxiolytics, discontinue medication, or alter medication regime); 2) interpersonal issues (behaviour modification, staff-patient interaction changes, or doctor-patient interaction changes); 3) follow-up by a private psychiatrist or a community mental health worker; or 4) follow-up by another consultant such as social work or chaplaincy. The PCL nurses more often suggested interpersonal changes (x^2=118.76, $p<0.0001$) or referrals to other consultants (x^2=5.72, $p<0.05$). The

psychiatrists more often suggested medications (x^2=96.80, p<0.0001) or follow-up through a psychiatric service (x^2=24.14,p< 0.0001). When working with the same patients i.e. the subsample, the PCL nurses suggested interpersonal changes more often than the psychiatrists (x^2=6.73, p<0.01).

The discussion of these results as they pertain to the conceptual framework, the literature, and the research questions will be done in the next chapter.

CHAPTER FIVE

Discussion

In this chapter, the findings will be discussed in relation to the research questions, conceptual framework, and the literature. There will be a discussion of the findings as they relate to the overall purpose of the study; that is, to begin to define the unique contributions of the PCL nurses to patient care on non-psychiatric units. Finally, the limitations of the study will be identified.

Relationship of the Findings to the Research Questions

Question 1. The first question asked in this study was: what are the distinguishing demographic variables of the patients seen by psychiatric nurses versus psychiatric medicine consultants?

The lack of significant differences in either age or gender of the patients suggests that, although the consultants did see many different patients the groups seen by medicine and nursing were relatively similar on these factors,

and that the statistical differences cannot be accounted for on the basis of either of these variables. This, in turn, adds credibility to the other findings.

The Stickney and Gardner (1981) study, which found a younger mean for both their male and female patients than the current study, did not provide a description of the population served. The Health Sciences Centre provides care for patients from any age group. This may, in part, account for the older mean age of the patients seen in this study.

Stickney, Moir, and Gardner (1981) found that the psychiatrists saw twice as many females, while the nurses saw an almost equal distribution. In studies of psychiatric medicine consultation this pattern of more referrals of women was also documented (Bustamente & Ford, 1981; Chandarana, Conlon, & Steinberg, 1988; Craig, 1982; Kligerman & McKegney, 1971; Lipowski & Wolston, 1981; Perez & Silverman, 1983; Shevitz, Silberfarb, & Lipowski, 1976; Taylor & Doody, 1979). Both Health Sciences Centre consultant groups saw a relatively equal distribution of males and females. A possible explanation of the equal

number of consultations from both genders for the nurses may lie in the nature of the patients which were referred. The PCL nurses saw essentially normal people struggling with abnormal situations; these type of events could happen to both genders on a relatively equal basis. The psychiatric medicine consultation literature cited is, for the most part, older than ten years. The equal gender distribution in the psychiatric service may have been due to changing societal attitudes about men seeking psychological support.

Question 2. The second research question asked in the study was: what are the distinguishing characteristics of the units initiating the referrals to the PCL nurses versus the psychiatric medicine consultants?

The finding of a lack of difference in units initiating referrals was in marked contrast to the literature from both medicine and nursing which found the majority of psychiatric referrals originated from medicine or speciality services (Chandarana, Conlon, & Steinberg, 1988; Lipowski & Wolston, 1981; Shevitz, Siberfarb, & Lipowski, 1976; Stickney, Moir, & Gardner, 1981). This unexpected lack of difference was possibly due, in

large part, to the format of the data base sheet. The ward of origin is coded on the sheet, but not the type of service, i.e. medicine, surgery. A number of medical patients were "off-service" on surgical units but on the data base sheets were identified as surgical patients. In subsequent revisions of the data base sheet this deficiency will be corrected.

Question 3. The third research question asked in this study was: what are the distinguishing characteristics of the reason for consultation between the PCL nurses and the psychiatric medicine consultants?

This study revealed that many of their referrals to PCL nurses were for assistance with behavioural and nursing management issues or with anxious patients. The pattern of referral was consistent with the literature which has documented the activities of other PCL nurses. Stickney was asked most often to see patients for behavioural manifestations, issues surrounding death and dying, and family/staff support. Of the 158 cases gleaned from the anecdotal reports of nurse consultant activities, the most common reasons for referral were nursing management,

family issues, depression, and grief. In Joynes' study (1974), the major reasons for referral were assistance with nursing management of difficult behaviours such as aggression, restlessness, and confusion.

Question 4.. The fourth research question that was asked in this study was: what are the distinguishing characteristics of the primary medical diagnoses of the patients referred to PCL nurses versus the psychiatric medicine consultants?

PCL nurses were asked significantly more often than the psychiatric consultants to see those patients with a primary medical diagnosis of neoplasm, trauma, cardiovascular, renal, or chronic obstructive pulmonary disease. These illnesses often require long-term adjustment and changes in life-style for which nurses are viewed as ongoing resources.

The psychiatric nursing literature is not extensive enough to reveal any particular pattern of medical illness in the patients seen by PCL nurses. In the Stickney study the most common medical diagnoses were gastrointestinal, cancer,

neurological, burns, and musculoskeletal. In the anecdotal reports no clear pattern could be identified as the patient's medical diagnosis was not always reported.

The psychiatric medical studies infrequently reported medical diagnoses but for those who did the cited ones included neurological, cardiovascular, and gastrointestinal diseases, and traumatic injuries.

The pattern of medical diagnosis of patients seen by PCL nurses revealed by this study, coupled with the findings of a higher level of global social functioning and a higher degree of psychosocial stress, suggest that the PCL nurses see "normal people experiencing abnormal life situations" such as acute illness or unexpected trauma. The other group of patients with which the PCL nurses appeared to interact were those patients who were coping with a chronic illness such as renal or pulmonary disease.

Question 5. The fifth research question asked in this study was: what are the distinguishing characteristics of the primary psychiatric

diagnoses of the patients seen by the PCL nurses versus the psychiatric medicine consultants?

The findings in this section continue to provide evidence for a different role for the PCL nurses versus their psychiatrist colleagues. The psychiatrists assessed more of their consultations as experiencing the classical psychiatric disorders such as depression, dementia, and paranoia. This pattern is consistent with the previous reports of consultation psychiatry (Bustamente & Ford, 1981; Mainprize & Rodin, 1987; Kligerman & McKegney, 1971; Small & Fawzy, 1988). The PCL nurses assessed more of their patients and families as experiencing adjustment problems such as adjustment disorders or phase of life problems. This finding was also seen in the subsample of the same patients. No information was available in the literature on the psychiatric diagnosis of patients seen by other PCL nurses so comparison is not possible.

The question of whether assessment differences, perhaps engendered solely by their different disciplines, might account for some of findings was partially addressed in discussing the results in the subsample. The PCL nurses and

psychiatrists did not differ regarding their assessment of global assessment of functioning or on level of psychosocial stressor in this group. This suggests that, when seeing the same patients, the mental health consultants used the same criteria upon which to base their assessments.

Question 6 . The sixth research question asked in this study was: what are the distinguishing characteristics of the consultation suggestions offered by the PCL nurses versus the psychiatric medicine service?

A differing pattern for nurses and physicians also emerged when comparing the consultation suggestions of the two groups. The physician group more often made recommendations which entailed a psychotropic medication or psychiatric follow-up, either privately, in the outpatient department or in the community mental health system. These two groupings of suggestions suggest those individuals with a diagnosis of a major mental illness should have some ongoing follow-up. The Stickney study did not elucidate specific psychiatric recommendations.

The PCL nurses, being consistent with the reasons for referral and the psychiatric diagnoses of their patients, more often suggested behavioural management strategies or changes in staff-patient interactions. This pattern was consistent when the two consulting groups were involved with the same patient. A key feature of the relationship between PCL and medical-surgical nurses is one of collegiality, a function of the long-term contact with one another. The nursing management suggestions, in contrast to those of the psychiatrists, required some degree of ongoing contact in order to evaluate the effectiveness of a behavioural program and to make appropriate changes in the plan. In some extremely difficult situations it is not uncommon for the PCL nurse to spend long hours on one unit, to actually assist the nurses with interventions, or to return to evaluate the plan of care three or four times per day. The effects of such a program may not be as immediate as the prescription of an anti-psychotic medication to help with sleep. Lewis and Levy state "sometimes the continued willingness of liaison nurses to be involved is all that consultees need" (1982, p.103). The underlying theme of a nursing presence, which has emerged from this study, appears to have been a partial

explanation for the differing consultant recommendations.

The PCL nurses also significantly more often suggested referral to other consultants such as social service, chaplaincy, native services, occupational therapy, and Home Care. The holistic framework of the PCL nurses practice encourages and in fact, mandates them to be aware of more patient and family issues than just major mental illness.

Relationship of the Findings to the Conceptual Framework

The conceptual framework for this study was developed by Lewis and Levy (1982) as a practice guide for PCL nurses in all settings. The framework consists of five principles, all of equal significance to the model. The five principles are the consultation liaison model; the patient; the medical illness; the nurse and the system; and preventative management. The study provided evidence that this framework is indeed a useful practice guide for PCL nurses and was appropriate as a conceptual framework for a study such as this. The major need for expansion and

refinement of the conceptual framework would be a more complete description of the role of the PCL nurses with the family. These comments will be included in the discussion of the patient section of the framework.

Consultation Liaison Model

The PCL nurse is expected to have an educative, collaborative relationship with the staff on non-psychiatric units. The consultation component is the provision of advice, regarding a specific clinical situation, from a clinical expert to a colleague. Advice was sought for 752 physically ill patients from all non-psychiatric units. The majority of referrals originated from medicine, surgery, rehabilitation/respiratory, and critical care.

The pattern of referrals which emerged from this study required further analysis. The majority of referrals originated from four areas (medicine, surgery, rehabilitation/respiratory, and critical care); what about an area such as Women's Hospital? Why were there so few referrals from here? One possible explanation is the concept of "presence". The four areas mentioned

are all in fairly close geographic proximity to one another. The PCL nurses are a visible presence on these units as they complete their regular work. The PCL nurses must walk through many of these units in order to access the others. This visible presence may encourage medical-surgical nurses to refer certain patients for further assessment and intervention by the PCL nurse. Even in the relatively protected environment of critical care the PCL nurses were present through the provision of weekly psychosocial rounds and informal walk rounds with the charge nurse. Women's Hospital, however, is in a completely separate building, approximately a block away from the rest of the Centre. The PCL nurse is not routinely in the building and therefore, is not a day-to-day presence.

Presence in nursing has recently been written about as an important component of the relationship between staff and their patients and families (Marsden, 1990). Presence is seen as a "demonstration of our commitment to that individual as someone valuable, unique, and worthy of respect" (Marsden, 1990, p. 540). Gilje (1992) completed an analysis of the concept of presence which sheds further light on the relationship of

presence to the work of PCL nurses. Although Gilje's analysis was completed to add to our understanding of presence in the nurse-patient relationship, some of the points that she made are applicable to the relationship between the PCL nurse and medical-surgical nurses. Presence is being, being here as opposed to being elsewhere. Presence is a closeness, an ability to influence in the present. Finally, presence is also associated with caring.

The establishment of the credibility of the PCL nurse is seen as critical to successful role implementation (Lewis & Levy, 1982). They and other PCL nurses (Luna-Raines, 1989) emphasize the crucial importance of spending time on the medical-surgical units in order to establish one's credibility with the staff. Although not named as such, this spending time on units is the establishment of the PCL nurse's presence.

After initiating a referral, medical-surgical nurses must trust the PCL nurse enough to implement some of the suggested strategies. The ability to exert some influence in the present, another component of presence, was particularly critical as the PCL nurse strove to meet the fifth

goal of PCL nursing. This goal is to encourage tolerance in nursing staff in situations where effective or immediate resolution of a practice problem is not possible.

The last component of presence, the aspect of caring, is especially crucial in these type of situations. The PCL nurse does not abandon her colleagues and demonstrates this caring by her ongoing presence on the unit. Marsden's definition of presence certainly applies to the relationship between PCL nurses and their medical-surgical colleagues. Through presence and caring for nurse colleagues the PCL nurses endeavour to meet the second goal of PCL nursing, the supporting of nurses in the provision of quality nursing care. The differing patterns of referral from the diverse areas of the Health Sciences Centre suggest that there may be a relationship between the presence of the PCL nurse and the initiation of referrals by medical-surgical nurses.

The absence of referrals from the Chemical Withdrawal Unit (CWU) to the PCL nurses is most likely due to the unit being part of the Psychiatry Nursing Department. CWU is staffed by

nurses with a background in psychiatric mental health nursing. As such, it is likely that they possess the requisite skills and knowledge necessary to meet the psychosocial needs of their patients. Conversely, the psychiatric physicians were likely consulted because the doctors in CWU are internal medicine specialists and do not have a psychiatry background, therefore may not possess the requisite skills and knowledge for meeting special psychosocial needs.

A key feature of the maintenance of the relationship between the PCL nurse and the staff on non-psychiatric units is the flexibility to do "what needs to be done". The pattern of referrals from all areas with the illustration of three unique cases (physiotherapy, psychiatry, and the Manitoba Cancer Foundation) suggests that this relationship does exist. The staff in non-psychiatric units utilize the clinical expertise of the PCL nurse to assist in the management of a wide variety of patients' problems.

The Patient

The PCL nurses, in a period of two years, assessed 752 patients. The psychiatric

consultants assessed 672 patients during the same time period. The 205 general requests for evaluation indicates the need for access to a nurse with greater expertise in assessing patients with psychosocial problems. The highly significant grouping of issues related to management, nursing and behavioural, and anxiety issues suggest a need for access to a clinical expert to aid in the development of an appropriate care plan or to provide expert intervention.

The study identified an area of the conceptual framework which requires revision and expansion. Although the involvement of the family and the impact on them of the patient's illness is mentioned occasionally throughout Lewis' and Levy's discussion of their framework, the nature of this work is not fully elucidated. The patient may not be the focus of the request for consultation. During the period of the study, the PCL nurses were asked one hundred and thirty four times or 18.23% to see the significant other of the patient. The psychiatric medicine service received no requests to see the patient's family or significant other. This pattern was also observed in the subsample; the psychiatric service were not asked to see any family members.

The nurse's role in family care has been clearly formulated in textbooks by Gilliss and her colleagues (1989), Leahey and Wright (1987a, 1987b, 1987c, 1989), and Friedman (1991). Other authors outline the role of the nurse with the families of the head injured (Bailey, 1989; Gordon, 1989; Stansfield, 1990), of the terminally ill (Logan, 1988), of the critically ill (Hodovanic, Reardon, Reese, & Hedges, 1984; Sabo et al, 1989), of the oncology patient (Lewis, 1986; Jassak, 1992), of the diabetic (Evans, 1988), and the trauma victim (Solursh, 1990).

This present study demonstrated the need for medical-surgical nurses to be able to consult a nurse with expertise in family-centred care. The PCL nurse with her background in individual and family development, crisis intervention, and knowledge of the illness process and hospital system is the ideal person to assist nurses in family care. The PCL nurse is able to intervene directly with the family, if this is required. The PCL nurse's intimate knowledge of the hospital system allows her to "guide" the patient's family through what they often perceive to be an incomprehensible maze. She is also able to assist

the nurses to develop a plan of care for the entire family, not just the patient. Sometimes, it is the care of the family that is most difficult for the nurses, not the care of the patient. At times, the nurses trust the PCL nurse to be a mediator of difficulties between themselves and the patient's family. Further support for this revision to the conceptual framework is seen in the Standards of Psychiatric Consultation-Liaison Nursing Practice published by the American Nurses Association. Throughout the document, client/families is used as the standard for intervention by the PCL nurse.

Another possible explanation for the number of referrals of families to the PCL nurse is the strong nursing identification of the PCL nurses. The medical-surgical nurses, because of the visible referral patterns and the ongoing presence of the PCL nurse, may choose to refer what they perceive to be a nursing management issue to another nurse for assistance.

Medical Illness

PCL nurses received referrals concerning patients experiencing a wide variety of medical

illnesses. This suggests medical-surgical nurses, requiring expert assistance with patients experiencing any type of medical illness, feel confident in obtaining ready access to the expertise of the PCL nurses when necessary. The medical-surgical nurses ready use of the PCL referrals however may indicate a lack confidence in themselves to accurately assess and implement an appropriate intervention strategy for patients or families experiencing exceptional life stressors.

In order to serve medical-surgical referrals in a practical way, the PCL nurses are called upon to integrate the knowledge of psychiatry/mental health with appropriate medical knowledge in order to be of assistance to the nurses, their patients, and the families. The credibility previously mentioned rests upon a relatively sound knowledge of the process of a particular medical illness (Lewis & Levy, 1982).

Lowery (1992), in her discussion of psychiatric nursing in the 1990's and beyond, states psychiatric nurses are well-educated to ensure that the non-biological side of illness is not ignored. The PCL nurses saw those patients

who, for the most part, were not experiencing a classical mental illness. Rather, the patients and families who were seen were experiencing difficulties adjusting to their illness and hospital experience. The patients seen by the PCL nurses were mainly struggling to cope with chronic illness such as renal, cardiovascular, or respiratory illness, or with the acute impact of trauma, or a newly diagnosed neoplasm. The nurses' requests for help with ward management strategies suggest that they may view patients and families as sometimes requiring some help "negotiating the system", a role which the PCL nurse is well able to fill.

The language of the PCL nurses should be congruent with her medical-surgical colleagues; the use of psychiatric jargon must be kept at a minimum. Newton and Wilson (1990) found that practicality of recommendations was a component in the overall satisfaction of a PCL nursing service. Pasnau (1985) emphasizes this as an important component of etiquette for consultation psychiatrists as well.

Nurse and the System

This principle focuses on the ward milieu; the relationships and the subsystems which may impact on the initiation of a referral. The referral of a different group of patients, other than the eighty-two in the subsample, suggest that medical-surgical nurses are identifying different psychosocial problems than their physician colleagues. A possible explanation for this phenomenon is the concept of caring as it relates to nursing practice. Caring, which has been discussed at length by many authors (Benner & Wrubel, 1989; Leininger, 1984; Morse, Solberg, Neander, Bottoroff, & Johnson, 1990), reminds nurses to incorporate the human response to illness as an important component of their practice. Wesorick (1990) suggests that the human response to illness be the major focus of the practice of professional nursing.

The referral of those patients and families who were experiencing a higher degree of psychosocial stressors and who functioned at a higher level prior to hospitalization suggests an attendance to this human response. The need to seek assistance from a clinical expert suggests

medical-surgical nurses do not always feel confident in their intervention skills in this domain. The care focus of nursing's practice likely resulted in the referral of patients or families that the physicians, with a greater focus on the cure model, may not have felt required intervention from a mental health professional.

Another possible explanation for the different referral pattern from medical-surgical nurses is their twenty-four hour a day presence on the nursing units. This amount of time spent with both patients and families may have enabled the nurses to identify less apparent psychosocial problems. Problems such as family fatigue or stress or a patient's inability to sleep due to anxiety about impending test results may only become evident to a nurse who is present for long hours, such as on the twelve hour shift. The nurses may have felt a referral for these "softer" issues more appropriately could be managed by a fellow nurse.

Preventative Management

The purpose of the preventative management principle is to remind the PCL nurse to

promote flexibility and adaptation of the hospital system to meet the needs of the patient and the family. In a large bureaucratic institution like the Health Sciences Centre it is important to have staff who are aware of the various resources which are available to help meet a wide diversity of patient and family needs.

As regular and relatively long-term members of the nursing staff, the PCL nurses are keepers of much knowledge and information about the entire hospital system. The psychiatric residents and students, by nature of their rather brief exposure to the system, could not be realistically expected to be aware of the availability of these resources. The referral, significantly more often, to other consultants such as child life therapists, the staff of the Home Care or Native Services departments, and chaplains suggests that the PCL nurses may keep an awareness about a wide variety resources in the forefront of their intervention strategies. This practice is consistent with the tenth standard, multidisciplinary collaboration, of the American Nurses Association PCL nursing practice standards.

A related explanation for the suggestion of referral to other consultants may arise from the nature of the patients and families seen by the PCL nurses. These patients and families were higher functioning prior to their hospital encounter and, as a result of this level of functioning, may have been able to utilize the resources of other consultants more effectively than those patients who had severely impaired functioning. The higher level of psychosocial stressors may have also prompted the PCL nurses to involve more consultants in order to mitigate against some of the debilitating effects of a crisis period.

The differing conceptual frameworks of the two disciplines may also partially explain the variation seen in the consultant suggestions. The complex nature of the nursing framework mandates the PCL nurses to look at all issues which may be impacting on the patients and families. Lowery (1992) writes that part of the centrality of nursing is to concern ourselves with the "science and skills that might mitigate against illness and the severity of its symptoms" (p.11).

Unique Practice of the PCL Nurse

The next section will discuss the findings as they relate to the overall purpose of the study, beginning to define the unique practice of the PCL nurse.

As mentioned, the PCL nursing position at the Health Sciences Centre began as a part-time position in 1974. This study has provided an opportunity to determine what, during this period of evolution and role development, defines the unique practice domain of this mental health professional. The need to define a unique domain of nursing practice has clearly been documented in the literature. Carol Lindeman (1989) states "doctors and nurses provide different services - they are not substitutes for each other but offer services which are complimentary. There is some overlap but there are significant differences" (p.71). Weiss (1983) writes that the ambiguity regarding unique nursing functions is one of the major barriers to the full implementation of nursing expertise. Many authors echo this crucial need to clarify the nursing role and to define the unique practice domain of professional nurses (Anthony, Williams, Hoagland, & Cunningham, 1988;

Batey & Lewis, 1982; Hinshaw, 1989; Jones, 1988; Lewis & Batey, 1982; Meleis, 1975; Orlando, 1987; Orlando & Dugen, 1989; Porter, Porter, & Lower, 1989; Ritchie, 1990; Schlofeldt, 1987; Simpson, 1989; Singleton & Nail, 1984). Fitzpatrick comments that the weakest claim to professionalism is nursing's limited lack of a unique body of knowledge. A unique body of knowledge is the foundation upon which a unique nursing practice can be built. This study demonstrated that the PCL nurses at the Health Sciences Centre do indeed have a unique domain of practice, even when they are involved with the same patients as the psychiatric consultants.

The PCL nurses in this study appear to receive consultations to work with individuals and families experiencing life crises and periods of adjustment when faced with an acute illness, acute episodes of chronic illness, or coping with chronic illness. In the majority of situations, these individuals come to the illness experience with a higher level of psychosocial functioning and experience a higher degree of psychosocial stress as a result of their illness than the patients seen by the psychiatry consultation service.

The PCL nurses utilize different strategies of intervention than the psychiatrists. These strategies include behavioral management programs, changes in nurse-patient interactions, and referral to a broader range of in-hospital and community resources.

The findings of this study are a contribution to the challenge to psychiatric mental health nurses raised by Pothier and her colleagues (1990) in an article entitled *Dilemmas and Directions for Psychiatric Nursing in the 1990's*. These authors emphasize the need to define the continuum of mental health (psychosocial) problems and mental illness (psychiatric) problems and to differentiate between the role expectations when working with any of these problems. The Health Sciences Centre PCL nurses work predominantly, although not exclusively, with persons experiencing psychosocial problems.

A division between the work of PCL nurses and psychiatrists appears to have emerged from this study. In these times of economic restraint and justification of health care services it is helpful to clearly delineate

psychiatric/mental health services which do not duplicate one another. It appears that the two psychiatric services do indeed complement the practice of one another and are able to offer different services even when they were involved with the same patient.

The need to define the unique practice domain of nurses is especially critical in a field like psychiatry where the phenomena of concern are sometimes viewed as nebulous (Stuart & Sundeen, 1989). It is more difficult to "see" the manifestations of a life crisis than it is to identify a pneumonia on a chest x-ray. Hazy role definition within the many mental health disciplines further adds to this nebulous picture.

PCL nurses, for both professional and economic reasons, must evolve from the early type of practice where they functioned as a member of a psychiatric consultation team (Barton & Kelso, 1971; Lipowski, 1981; Moreau, Kahn, & Lai, 1974) to an independent practitioner who works with a specific patient when her expertise and skill are required. The PCL nurse is still available for those patients seen by psychiatrists who require psychiatric nursing expertise. This study has

demonstrated that not all patients requiring psychiatric assessment and intervention need the involvement of the entire team.

Smoyak (1987) and Kaltreider and her colleagues (1974) suggest that successful interdisciplinary work will occur when professionals work together as equals, each recognizing the unique contributions of the other. This study has demonstrated the evolution of an independent nursing role which, along with the psychiatric consultation team, helps meet the variety of psychosocial needs of the medically ill.

Implications and Recommendations

In this final section recommendations, which arose from the findings of this study, for nursing education, practice, and research will be identified.

Nursing Education

The findings of this study that medical-surgical nurses chose in high numbers to access specialized advice from the PCL nurses suggested

that medical-surgical nurses may not be confident in their own ability to assess or to intervene unaided in the realm of psychosocial problems. Nursing education programs might consider making modifications to prepare nurses who are more confident in the psychosocial realm. The first change which could be incorporated is a switch from a focus on major mental health problems to teaching and opportunities to learn about psychosocial problems encountered by the medically ill. This approach has been suggested by Pothier, Stuart, Puskar, and Babich (1990).

For example, the researcher conducted a class with second year diploma nursing students and their teacher on "How to talk to someone who is dying." The class was a discussion of practical approaches to help students talk to their patients when one says, "I'm going to die, aren't I?" and had been prompted by an anxious student who had encountered this situation in his clinical practice. The class also discussed ways to answer questions such as, "What is it like to die, what will it feel like?".

Educators need to examine ways to incorporate these concepts into programs as they are likely to be of benefit to more future graduates than a broad overview of mental illness. PCL nurses are an ideal resource to assist nurse educators in increasing their own comfort level regarding topics such as death and dying.

Education programs, as part of the above process, should include a component of values clarification which examines the values and attitudes students hold regarding psychosocial nursing care. Unfortunately, many nurses regard psychosocial care as an extra. In Work Situation Reports filed with the Manitoba Nurses' Union, psychosocial care and patient education are the needs most often reported as not being completed by nurses when their units are busy (Brooks, personal communication, 1992). Attention may not be paid to this need until a problem, such as severe anxiety or agitation, arises. This may viewpoint stem from several reasons.

Many educators feel most comfortable in focusing on the structured, physical side of nursing practice (Botkin, 1992). Students are not always given an opportunity to see the value of a

thorough psychosocial assessment and the information, both regarding the psychological and physical realms, which may arise from the completion of this assessment. Students must also be exposed to a systematic method of psychosocial assessment in order that they do not view assessment in this realm as a "magical" experience, only to be carried out by the magicians in the field.

Another component of the nursing education program which appears to need to be amended or expanded is knowledge about work with families. As many of the nursing referrals in this study were to see a patient's significant other it appears to be important to include more theory and practice for students in this area. This is not to suggest that all nurses must become experts in family intervention; they should have a basic understanding of family growth and development, not just that of the individual patient. If nursing continues to purport itself as a family centred discipline, our practitioners must have a basic understanding of family process.

Nursing Practice

This study resulted in a number of areas for suggested change in the realm of nursing practice. PCL nurses need to continue documenting their domain of unique practice. As practitioners who work away from the mainstream of psychiatric mental health nursing it is imperative that the practice domain of the PCL nurses remains true to its roots in psychiatric nursing and that nurse colleagues still view PCL nurses as practitioners of the speciality, psychiatric/mental health nursing. It is important that PCL nurses continue to publish articles in the mainstream psychiatric journals to keep alive the profile of PCL nurses in the minds of their colleagues.

PCL nurses must continue to institute quality assurance activities which evaluate the quality of services provided. The project by Newton and Wilson (1990) is one of the few published articles on quality assurance in PCL nursing. Another quality assurance approach is a peer review board as outlined by Titlebaum, Hart, and Romano-Egan (1992). Standard eight of the *Standards of PCL Nursing Practice* mandates PCL nurses to engage in such activities.

A natural extension of the evaluation of satisfaction by nursing consumers of such a service, as in the Newton and Wilson project, is the satisfaction of patients and families seen by PCL nurses. This type of project would be quite difficult to complete due to the nature of the service provided, i.e. very physically ill patients, and the use of short contacts sometimes comprised of one-time only consultations. However, it would be important to know from patients and families whether the service provided by the PCL nurses meets their needs. Wilson (1987) believes that, in spite of challenges inherent in assessing quality in the "soft" services such as PCL nursing, quality assurance activities can effectively be conducted.

PCL nurses continue to need to sensitize their medical-surgical nursing colleagues to the psychosocial needs of their patients and their families. As opportunities arise PCL nurses could discuss the findings of the assessment and to plan appropriate intervention strategies with, not for, the nurses. PCL nurses could work to identify effective and efficient methods for nursing staff to use in the assessment of psychosocial problems. What may be appropriate on a psychiatric unit may

not be useful or practical on a busy medical or surgical unit.

PCL nurses can work to maintain a relationship with their medical-surgical colleagues which encourages the referral of patient or family concerns. This relationship can be based on the criteria of presence by Marsden (1990). The PCL nurses should see their medical-surgical nurse colleagues as valuable, unique, and worthy of respect. Such a relationship, rather than one of a "drop-in" expert, is likely to give PCL nurses more opportunity to actively pursue Lewis and Levy's first and second goals of increasing the skill and knowledge of these nurses in the realm of psychosocial nursing.

PCL nurses may offer continuing education sessions for staff on the medical-surgical units. The provision of unit based education sessions on topics such as mental status assessment or the care of the delirious or suicidal patient will enhance practicing nurses abilities to function competently in the psychosocial realm.

It is recommended that PCL nurses also provide opportunities for nurses to enhance their hands-on skills by providing direct clinical supervision. This approach could entail a staff nurse conducting a mental status examination of a patient with the PCL nurse present; the PCL nurse could then provide immediate feedback on the nurse's performance and offer suggestions for improvement.

In crisis situations, it is useful for the PCL nurse to provide on-site intervention as a visible role model conducting a psychosocial intervention. Following stabilization of the crisis, the PCL nurse again may find it enhances practice skills to take the opportunity to discuss the situation and evaluate the process. It is recommended that these sessions be conducted from a viewpoint of enhancing practice skills, not from one of questioning the competence of the nurse(s). This is the approach taken by Doleysh (1986) in describing effective strategies for consultants to use in their practice.

As demonstrated in this study, nurses who function in a consultation liaison role are required by the nature of the referrals to be

proficient in the practice of family centred care. They need to be extremely comfortable with family intervention strategies. The ongoing education of medical-surgical nurses in the area of family assessment and intervention would also be important in order to enhance their practice skills.

Nursing Research

As this was a descriptive study which explored an area not previously thoroughly researched, many research questions arose. These projects could include the variation in referral rates of both genders and the different type of units, such as obstetrical or medical-surgical units, originating the consultations. Subsequent to the necessary revisions being made to the data base collection tool itself it would be useful to replicate the study, for a shorter time frame, to see if the results are still found. If they were found, future research could be conducted which might answer the "why" of these discrepancies.

A group of related questions arose around the concept of presence and its impact on

referrals to PCL nurses. As few referrals were received from Women's Hospital it would be useful to propose a project which would include the presence of a PCL nurse on one or two units in Women's Hospital.

Information could be gathered from the nursing staff in order to tap into the impact of the PCL's presence on the medical-surgical nurse's motivation to refer a particular patient. Similar information could be gathered from other areas which routinely consult the PCL nurses to ascertain if there are any differences in those areas which do not routinely consult the PCL nurses. Information such as this would be useful for beginning and the current PCL nurses as it would provide feedback about the relationship between presence and the occurrence of nursing referrals.

Another question which could be researched is the impact of ward dynamics on the motivation to refer a patient or family. Knowledge about this particular part of the consultation process would aid PCL nurses in identifying what might be the source of the problem requiring intervention. That is, perhaps

the patient or family are not the ones in real distress or in need of support. Sometimes the nursing staff require support and encouragement in order to continue the delivery of quality patient care.

Information about the impact of ward dynamics on the referral process has been written about from a psychiatric medicine perspective (Gabinet & Friedson, 1981; Kucharski & Groves, 1976-77). Other authors (Hengeveld, Rooymans, & Hermans, 1987) have suggested that the presence of such criteria as an emotionally worded consultation, unclear or unusually timed referral, or an unjustified urgent request may indicate the occurrence of staff problems. This research could also add to the questions about different referral patterns from different units.

Following upon the motivation for referral are many questions related to the patients and families with which the PCL nurse works. A study could examine how the medical-surgical nurses identify those patients or families which they refer. What is it about certain patients which alerts the nurses that they might need expert assessment or intervention? Is

it possible to develop profiles of high-risk individuals or families? Nurses in the Intensive Care units for example, often refer family members on the day of the patient's admission. What is different about this family member versus the one that is not referred until a month later? A related question is one which would identify the optimal time of referral to a PCL nurse.

Another patient/family centred question relates to the possible pattern of specific problems encountered by patients with specific physical illnesses. This study revealed that PCL nurses work with individuals with acute problems, acute exacerbations of chronic problems, or with chronic illnesses. An in depth study could focus on a particular physical health problem such as multiple trauma and follow the patient and the family through that experience, documenting evolving nursing diagnoses.

Some studies have already been completed on the effectiveness of psychiatric medicine intervention with specific patient groups such as newly diagnosed cancer patients (Worden & Weisman, 1984). PCL nurses need to examine what impact their interventions have with specific patients

and families. Work has begun in this area with articles published on the role of PCL nurses in patients with sitters (Talley, Davis, Goicoechea, Brown, & Barber, 1990) and in the decision to remove life-sustaining treatment (Hart, 1990). Again, in order to build a substantial theory base it would be important to replicate these studies in other centres and settings.

As well, PCL nurses could examine their work with families, with the chronically ill, the respiratory patient, or with renal dialysis patients. Studies could examine different aspects of the PCL nurse's role such as impact on the development of psychosocial or biological complications, length of hospital stay, or the use of medications.

Again, psychiatric medicine services are fortunate to have a research base which suggests that their interventions exert a positive influence on the patient's hospital experience (Mannino & Shore, 1975; Medway & Updyke, 1985; Moses & Barzilay, 1967). PCL nurses need to research their unique, specific contributions to patient care through the use of outcome studies

and in-depth qualitative designs which access the human dimensions of the care they offer.

Another study which could be completed is a more thorough examination of what the suggestion of follow-up by a PCL nurse entails. PCL nurses write eloquently of their interventions as including support (Horsley, 1988; Smith, 1981) and the provision of hope (Larkin & Crowdes, 1976). A study could elaborate on the application of the concept of the provision of support and supportive psychotherapy as described by Gardner (1979), Schoenhofer (1984), and Winston, Pinsker, and McCullough (1986). A related study could look at the provision of hope by PCL nurses as a distinctive nursing activity. The framework for the clinical assessment of hope developed by Farran, Wilken, and Popovich (1992) could be used as the conceptual framework.

Another study could look at the PCL's application of interventions, based on Norris' work (1992), to improve a patient's self-esteem. All of these studies could continue to elucidate the unique clinical activities of the PCL nurse.

PCL nurses are in an ideal position to utilize the single case design as used by Baradell (1990) in order to examine and evaluate the effectiveness of specific nursing care plans. This design could evaluate the effectiveness of specific interventions in a single case. This would be an extremely useful methodology for those patients and families who could be described as emotionally complex and who require intensive psychosocial intervention to help them recover from their physical health problems.

A closely related project is an evaluation of whether consultees do follow the PCL nurse's recommendations. Much work in this area has already been done by psychiatric consultants (Billowitz & Friedson, 1978-79; Popkin, Mackenzie, & Callies, 1980; Popkin, Mackenzie, & Callies, 1981). A blend of quantitative measures which actually looked at the numbers of interventions implemented plus a qualitative examination of why some measures were used and why others were not could be used as the methodology for such a study.

More research is also needed in documenting the PCL nurse's interventions with families. This study clearly pointed out that

intervention with families is an important part of the PCL role. In a recent work by Craft and Willadsen (1992), it is concerning to note that of the one hundred thirty nurse experts on the family not one of them was identified as a PCL nurse. The authors of this study are members of a group actively working to develop nursing theory of the family. PCL nurses must provide research which adds to the development of theory which would be applicable in a broad range of practice settings, including medical-surgical units.

A component of the PCL nursing role is to facilitate the improvement of practice skills in our medical-surgical colleagues. Further research is needed in order to identify and evaluate the most effective methods of assisting nurses to improve these practice skills. The extensive nursing education literature could provide the background upon which to develop such a study. Given the limited amount of continuing education time available to both the PCL nurse and her colleagues it would be beneficial to identify the most effective means of improving psychosocial nursing practice skills. Is didactic teaching or clinical supervision the most effective teaching strategy? Should there be blend of both methods?

A companion study could compare the comfort level of those nurses with a specific program with those nurses who have not received it and their intervention in psychosocial areas.

CHAPTER SIX

Summary and Conclusion

The purpose of this study was to document the unique contribution of a PCL nurse in the care of patients experiencing a physical illness. In order to accomplish this goal, the work of the PCL nurses at the Health Sciences Centre was compared to the work of the psychiatric medicine consultation service. The study was guided by the following research questions: what were the distinguishing characteristics of psychiatric nursing consultations versus psychiatric medicine consultations in relation to: 1) demographic characteristics of the patients; 2) type of unit initiating the referral; 3) reason for consultation; 4) primary medical diagnosis of the patient; 5) DSM-III-R diagnosis of the patient; 6) consultation suggestions.

The conceptual framework for the study was a framework developed by Lewis and Levy (1982) as a practice guide for PCL nurses. This framework proved to be an appropriate and useful choice for the study. The study revealed that the five principles of the framework, consultation liaison model, the patient, the medical illness,

the nurse and the system, and preventative management are indeed components of the work of PCL nurses. A weakness which was identified was the need for incorporation of a more comprehensive discussion of the work of the PCL nurse with the families of the medically ill. The PCL nurses in this study received a great number of referrals to see the significant other of the patient. This revision would expand the framework's comprehensiveness and its usefulness.

The literature review revealed a lack of research studies which documented the contributions of PCL nurses to the care of medically ill patients. Many of the articles were anecdotal reports with case examples of clinical activities as illustration. Only one research study was identified which documented the practice of a PCL nurse in contrast to that of a psychiatric medicine consultation service (Stickney, Moir, & Gardner, 1981). The present study replicated certain components of the Stickney study with the addition of added variables of interest.

Records of the consultations completed by the PCL nurses and the psychiatric medicine

consultation service for the period of January 1, 1989 to December 31, 1990 served as the data for this study. The data was analyzed using both parametric and non-parametric statistical tests.

The analysis of the data revealed a different pattern of the clinical activities for the two groups of consultants, with the exception of patient age or gender differences. The PCL nurses were asked more often than the psychiatrists to see patients for nursing and behavioural management issues, including anxiety. This pattern was also seen in the subsample of patients seen by both the nurses and the psychiatrists. A major difference in the reason for referral was that the PCL nurses were asked to see the patient's significant other one hundred and thirty-four times. The psychiatrists were never asked to see the family. PCL nurses were significantly more often asked to see patients with a primary medical diagnosis of neoplasm, trauma, cardiovascular, renal, or COPD.

PCL nurses tended to assess their patients as experiencing psychiatric diagnoses which included phase of life problems, adjustment disorders, or bereavement more often than the

psychiatrists. The psychiatrists saw more patients experiencing classical psychiatric illnesses such as depression, delirium, dementia, schizophrenia, and paranoia. The patients seen by the PCL nurses came to the illness experience with a higher level of psychosocial functioning and were assessed as experiencing a higher level of psychosocial stressors. This difference was not seen in the subsample.

The PCL nurses more often suggested behavioral management strategies or follow-up with other consultants such as social work, chaplaincy, or Child Life staff. The psychiatrists more often suggested an intervention which involved a psychotropic medication or follow-up in an outpatient psychiatry setting.

The findings of this study have resulted in implications for nursing practice, education, and research. The study confirmed the unique practice domain of a mental health practitioner, the psychiatric consultation liaison nurse.

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APPENDIX A
Consultation Services - Adult Psychiatry Data Base

Revised 12/87

CONSULTATION SERVICES - ADULT PSYCHIATRY DATA BASE

FOR OFFICE USE ONLY [0][1] 2
[ ][ ][ ][ ][ ][ ][ ][ ] - [ ] 11

(This section for both first and follow-up visits)

1. Name: _____
   Last First

2. Sex: 1=male, 2=female [ ] 12

3. Chart Number: [ ][ ][ ][ ][ ][ ][ ][ ] - [ ] 21

Has the patient been carried over from the previous quarter? 1=yes, 2=no [ ] 22

Data Base Number; this quarter: (i.e. 1st form=1, 2nd form=2, etc.) [ ][ ] 24

MHSC or other number (if other, specify Province _____) [ ][ ][ ][ ][ ][ ][ ][ ] 32

4. Ward/Clinic: [ ][ ][ ][ ] 36

Centre: 1=General, 2=Respiratory, 3=Rehab, 4=Children's
5=Cancer Foundation, 6=Women's [ ] 37

5. Date of Birth: [ ][ ][ ][ ][ ][ ] 43

6. Date of Consultation: [ ][ ][ ][ ][ ][ ] 49
   Day Month Year

7. Consultant: 1=Linda Newton, 2=Teunisie DeVisser, 3=Medical [ ] 50

House Staff Name _____ Attending Staff Name _____

8. Consultee classification: 1=M.D., 2=Nurse, 3=S.W.,
   4=Physiotherapist, 5=Other [ ] 51

Consultee's Name _____

(FIRST VISITS ONLY)

9. Reason for Consult: (left to right in decreasing order of importance: [ ][ ][ ][ ] 55
1=Evaluation, 2=Management-behavioural, 3=Management-medical,
4=Management-nursing, 5=Affect anxious, 6=Assess competency,
7=Suicide attempt (_____, specify method), 8=Disposition,
9=Transfer to Psychiatry, 10=Pain evaluation, 11=Patient request,
12=Substance Abuse, 13=Follow-up, 14=Compliance, 15=Doctor-patient
conflict, 16=Other staff-patient conflict, 17=Evaluate psychosis,
18=See significant other, 19=Other

10. Primary Medical Diagnosis: [ ][ ] 57
1=Neoplasm (specify _____), 2=Immunologic,
3=Trauma, 4=Infection, 5=Chronic Obstructive Pulmonary
Disease, 6=Musculoskeletal disorder (specify _____),
7=Neurologic disorder (specify _____), 8=G.I. disorder
(specify _____), 9=Renal, 10=Urologic, 11=Endocrine
(specify _____), 12=Nutritional, 13=Obstetric,
14=Gynecologic, 15=C.V. (specify _____), 16=Hematologic,
17=Alcoholism, 18=Diagnostic work-up, 19=Other,

(over)

11. DSM-III-R Diagnosis:

Axis I (primary) [ ][ ][ ][ ][ ] 62

Axis I (secondary) [ ][ ][ ][ ][ ] 67

Axis II [ ][ ][ ][ ][ ] 72

Axis IV [ ] 7

Axis V [ ][ ] 75

FOR OFFICE USE ONLY [0][2] [ ][ ][ ][ ][ ][ ][ ][ ] - [ ] 1

12. Dispositions/Suggestions (in order of priority): [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] 2
1=Meds: antipsychotic, 2=Meds: antidepressants, 3=Meds: anxiolytics, 4=Discontinue medication, 5=Behaviour modification, 6=Staff interaction changes, 7=Doctor interaction changes, 8=Other illness intervention changes/work-up, 9=Follow-up: psychiatric, 10=Follow-up: other consultant, 11=Follow-up: OPD Psychiatry or CMHW, 12=Follow-up: private, 13=Follow-up: Social Service, 14=Transfer to Psychiatry, 15=No further psychiatric consult service involvement, 16=Alter medication regimen, 17=Other

(FOR FOLLOW-UP VISITS ONLY)

13. Date: [ ][ ][ ][ ][ ][ ] 27
Day Month Year

14. Time Spent: 1=0-30 min., 2=30-45 min., 3=45-60 min., 4=60-75 min., 5=over 75 min. [ ] 28

15. DSM-III Axis I Diagnosis (only if changed): [ ][ ][ ][ ][ ] 33

16. Date: [ ][ ][ ][ ][ ][ ] 3
Day Month Year

17. Time Spent: 1=0-30 min., 2=30-45 min., 3=45-60 min., 4=60-75 min., 5=over 75 min. [ ] 4

18. DSM-III Axis I Diagnosis (only (if changed): [ ][ ][ ][ ][ ] 4

19. Date: [ ][ ][ ][ ][ ][ ] 51
Day Month Year

20. Time Spent (see above codes): [ ] 52

21. Date: [ ][ ][ ][ ][ ][ ] 5
Day Month Year

22. Time Spent (see above codes): [ ] 5

23. Date: [ ][ ][ ][ ][ ][ ] 65
Day Month Year

24. Time Spent (see above codes): [ ] 66

25. Date: [ ][ ][ ][ ][ ][ ] 7
Day Month Year

26. Time Spent (see above codes): [ ] 7

APPENDIX B
Letters of Permission

Health Sciences Centre

820 Sherbrook Street
Winnipeg, Manitoba R3A 1R9
Dial Direct (204)-

DEPARTMENT OF PSYCHIATRY

THE UNIVERSITY OF MANITOBA
Faculty of Medicine
770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3

February 23, 1990

Ms. Linda Newton

Winnipeg, MB
R

RE: Access to Dept. of Psychiatry Databases

Dear Linda,

As we discussed, I would be happy to provide you with access to the computerized records of the Department of Psychiatry Consultation Service and Psychiatry Nursing Service. I am really only the "caretaker" of these databases, however; the real "owners" are the service chiefs. So, while you certainly have my approval, you will also require theirs as well.

I don't think you should have any trouble in that regard. All the best with your thesis.

Sincerely,

Keith Wilson, Ph.D.

Health Sciences Centre

820 Sherbrook Street
Winnipeg, Manitoba R3A 1R9
Dial Direct (204) -

24 01 90

Ms. Linda Newton

Winnipeg, Manitoba
R

Dear Linda:

We are writing in response to your correspondence of January 10, 1990 requesting access to the data pool of psychiatric nursing consultations. We have no objection to your use of this information towards your thesis. Will forward a copy of this letter to C. Walker for her approval.

Good luck with your project - will look forward with interest for the results.

Sincerely

T. Devisser
Consult Liaison Nurse

S. Sadler
Consult Liaison Nurse

/ATD2

Health Sciences Centre

820 Sherbrook Street
Winnipeg, Manitoba R3A 1R9
Dial Direct (204)-

DEPARTMENT OF PSYCHIATRY

THE UNIVERSITY OF MANITOBA
Faculty of Medicine
770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3

January 25, 1990

Ms Linda Newton

Winnipeg, Manitoba
R

Dear Linda,

In response to your letter of January 11, 1990, I herewith grant permission for you to access the psychiatric medicine data bases for the period of December 1, 1987 to December 21, 1989. Good luck with your project.

Sincerely,

Dr. Neil Mowchun

NM/db

APPENDIX C
Letter of Approval - Ethical Review Committee

The University of Manitoba

SCHOOL OF NURSING

ETHICAL REVIEW COMMITTEE

Proposal Number N#90/10

Proposal Title: "A Comparison of Psychiatric Nursing Consultations with Psychiatric Medicine Consultations"

Name and Title of Researcher(s): Linda Newton
Master of Nursing Student
University of Manitoba

Date of Review: May 07, 1990

Decision of Committee: Approved: June19/90 Not Approved: _____

Approved upon receipt of the following changes:

APPROVED with the submitted access clarifications of June 13, 1990.

Date: June 19th 1990

Theresa George, RN, PhD. Chairperson
Associate Professor
University of Manitoba
Position

NOTE:

Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.