Identification of psychological demands in patients seen by inter-consultation: differences in physicians' and psychologists' perceptions

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ABSTRACT

Falling ill and the need for hospitalization may imply psychological damage to the patient. In this sense, the work in multi-professional teams is configured as an important tool to offer integrated health care. The psychological inter-consultation is characterized by a brief and focused service requested by the team responsible for the patients' care, in which the psychologist proposes practices together with the health team. This study aimed to compare the psychological demands identified by the physician in the inter-consultation request, with the demands evaluated by the psychologist in the first assistance to patients hospitalized in a tertiary-level university hospital. The data were obtained from the medical records, categorized by the researchers according to the quantitative-interpretative method, and analyzed in terms of frequency and percentage by McNemar's test and degree of agreement between the evaluators by the Kappa Coefficient of Agreement. 104 inter-consultation requests made between March 2017 and March 2018 were evaluated, with a predominance of female patients (59.8), over 50 years of age (63%), and professionally inactive (61.9%). Most requests originated from the medical clinic (80.8%) and a patient with a chronic condition (52.9%). The results found were described in 11 categories. It was noted that there was greater agreement among caregivers in recognition of emotional symptoms as a justification for psychological intervention, which found correspondence with the available scientific literature. Disagreements were noted in the perception of demands among professionals, especially regarding emotional suffering related to difficulties in understanding the diagnosis and/or treatment, little family/social support, problems of adaptation to hospitalization, and emotional problems unrelated to the disease. We conclude that the multi-professional perspective is an important strategy to promote integral attention to the patient, with inter-consultation as an effective possibility, and that the approach to the patient presents different perspectives linked to each team component's knowledge. The need to invest in training for emotional problem identification and management, communication and a good doctor-patient relationship, and aspects of the individual history that can contribute to a good treatment outcome is emphasized. Also, it is important that academic training equips professionals to work in a multi-professional team, which requires communication skills, sensitivity, and an understanding of the complementarity of knowledge.

Keywords: Interdisciplinary health team, Interprofessional education, Mental health assistance, Hospitalization, Referral and consultation.

INTRODUCTION

The process of falling ill is linked to psychological changes and the emergence of new demands for patients, which are aggravated if there is a need for hospitalization. Emotional symptoms directly related to the disease, difficulty in accepting or understanding the clinical condition, and the reappearance of pre-existing psychological problems can be identified. Thus, the observation of the psychological status has a relevant impact on health follow-up and recovery from clinical conditions [1–3].

Considering the importance of a comprehensive approach to patient health, the existence of a multi-professional team aggregates different knowledge to supply tools that provide the best care. When it comes to the recognition and intervention focused on the patient's psychological demands, multi-professional teamwork can improve the treatment outcome, including during the hospitalization period [4]. In highly complex services, the existence of the multi-professional team becomes even more essential due to the difficulty of the procedures, diagnoses, and treatments performed and

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to the structuring of the team idea itself. Considering the reality of health services in Brazil, with the scarcity of human resources, the composition of a multi-professional team in all services is not always feasible, and therefore, it is necessary to have alternatives for these patients' care [5].

The development of psychological inter-consultation services is a possibility to enable an integrated care model for patients from a multi-professional perspective. The psychological inter-consultation is based on the care provided by a mental health professional, in this case, the psychologist, to an inpatient as requested by someone directly responsible for the physical illness treatment. Thus, its purpose is to perform an observation of the psychological conditions and their impacts on the clinical conditions and to help the team in proposing improvements in patient care [6,7]. According to the definition, psychological inter-consultation is characterized by brief and focused care and requires interaction with those responsible for the patient's care. It is an appropriate proposal for services with high demand and short hospital stays, and it is also a mechanism for approximation and exchange of knowledge among professionals, according to their areas of expertise [8,9].

The doctor is generally responsible for recognizing the psychological demands and also for requesting follow-up by a mental health team within a multi-professional care. However, after the patient's meeting with the mental health professional, it is usual that other demands are identified [10,11]. The divergence between the demand identified by the requesting professional and the need assessed by the inter-consultant professional can negatively impact the inter-consultation consolidation in the hospital, as it makes communication between professionals difficult, frustrates expectations regarding the service, and reduces the acknowledgment of the psychological inter-consultation service role, resulting in weakening of the trust and bond between the teams [8,9].

Some difficulties in the implementation of psychological inter-consultation are frequent, such as communication gaps between professionals and information recording, especially in the request process, and the low recognition of the impact of mental health and inter-consultation care on the clinical condition of patients by physicians. In addition, the support given by the institutions is not always ideal, with recurrent structuring problems. The literature on the subject is scarce and based on the psychiatric inter-consultation model, which presents different objectives and definitions [8,9,12].

This research aimed to compare the psychological demands identified by the physician in the request for psychological inter-consultation with the demands assessed by the psychologist in the first care of hospitalized patients in a highly complex service, identifying the difference in frequency and the degree of agreement in each type of demand seen by the professional. Based on the data obtained, an attempt was made to understand the results and justifications for possible divergences, linked to professional practice or to the inter-consultation process itself.

METHODOLOGY

This is a descriptive documentary study with qualitative and quantitative data analysis. The inter-consultation requests made to the Psychology Service of the Clinics Hospital of the School of Medicine of Ribeirão Preto of the University of São Paulo (HCFMRPUSP), a tertiary-level university hospital located in São Paulo state inner-state, from March 2017 to March 2018, were evaluated. All requests handled during this time period were included and there were no exclusion criteria in the research.

The analysis of the records in the patients' electronic medical records sought to identify the sociodemographic data and the psychological demands that justified the request for inter-consultation, identified in the request made by the physician and in the first visit made by the psychologist.

STUDY CONTEXT

The Psychological Inter-consultation Service belongs to the Psychology Outpatient Clinic of the HCFMRPUSP and is made up of one psychologist under contract (supervisor) and three resident psychologists (students from the post-graduation program in Professional Training). This outpatient

clinic is responsible for responding to inter-consultation requests from patients admitted to the General Practice wards (Dermatology, Rheumatology, Immunology, Nutrology, Geriatrics, and Nephrology), General Gynecology, Gynecological Urology, General Surgery, Thoracic Surgery, Plastic Surgery, and Vascular Surgery.

Requests for psychological care are made through a specific form called "Inter-consultation Request" (IR), which contains data related to the patient's characterization, ward of origin, a brief description of the clinical diagnosis, and the purpose of the inter-consultation request, which with regard to psychological inter-consultation, refers to the identification of demands for psychological care by the requesting professional. This request must be answered within a maximum of 48 hours.

After receiving the inter-consultation request, the psychologist responsible for the case must perform an initial evaluation, to clarify the demand and collect information about the case, which is registered in the patient's medical record. Then, if the presence of demands is confirmed, the patient will follow in psychological care, in which psychological interventions will be carried out, as well as return and orientation to the health team and necessary referrals.

DATA ANALYSIS

In the analysis of the information contained in the patients' medical records, the demands described by the requesting physician and the inter-consulting psychologist were coded and categorized by the researchers according to the quantitative-interpretative method, proposed by Biasoli-Alves [13]. The medical records were read repeatedly, in an attempt to identify the regularities and differences for the creation of categories. This categorization took into account the criteria of (1) exhaustiveness, encompassing all types of content present in the records, (2) exclusivity, with each category grouping a set of responses that clearly differs from another, and (3) maintenance of the same level of inference and/or interpretation among all categories verified.

In order to ensure methodological control, the coding of the demands identified after the analysis of the records was performed by two independent evaluators in order to verify the agreement between the evaluators. In case of any disagreement in the coding, the procedure adopted was a joint discussion with a third researcher, aiming to establish a consensus. The data relating to the clinical picture and the medical request were evaluated by two fifth-year medical students, and the data related to the first psychological visit were evaluated by two psychologists hired by the psychology service. Thus, the research was able to obtain a broader perception among the different professionals, considering their areas of training and their interpretations of the records.

The categorization results were analyzed quantitatively in terms of frequencies and percentages, which were compared using McNemar's statistical test. This test makes it possible to observe the quantitative difference in the recognition of each psychological demand by the physician and psychologist. The significance level adopted was $p<0.05$.

In addition, they were submitted to the Kappa Coefficient of Concordance, which sought to quantify to what degree the physician and the psychologist recognized the same psychological demand in each inter-consultation request and service. This test was based on the intervals proposed by Landis and Koch in 197714, as shown in Figure 1.

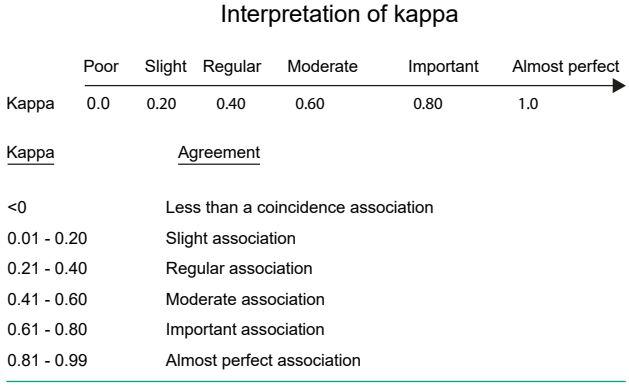

Figure 1: Parameters for interpretation of Kappa's Coefficient of Concordance, proposed by Landis and Koch

The present research was reviewed and approved by the Research Ethics Committee, according to Resolution n.466/2013, under process number 2.667.078/2018.

RESULTS

A total of 104 inter-consultation requests (I.R.) to the Psychology Service, made by resident physicians from March 2017 to March 2018, were analyzed. In five of these cases, more than one I.R. was requested for the same patient, due to subsequent hospitalizations or due to a change of medical specialty within the hospital institution, resulting in a total of 97 patients seen during this interval. Regarding the sociodemographic variables, 59.8% of the patients were female, 63% were 50 years old or older, and 61.9% were professionally inactive (retired, pensioners, or unemployed). The origin of 80.8% of the I.R.s was from medical specialties and 19.2% from surgical specialties. The clinical picture of the patient was chronic in 52.9% of the cases, under-diagnosis in 26%, acute in 17.3%, and palliative in 2.9%.

According to the quantitative-interpretative method, the researchers analyzed the psychological demands described by the requesting physician and the inter-consulting psychologist and established 11 categories, presented below and exemplified with excerpts from the records. In parentheses are the frequencies in which each category was identified by the physician (fM) and the psychologist (fP).

Category 1: Emotional symptoms related to the disease. Includes symptoms of anxiety and depression related to the illness, fear of procedures, expectations regarding the diagnosis, and excessive crying, among others (fM=55; fP=56).

"Feeling of sadness, agitation, despair, and frequent crying since the onset of symptoms" (Patient 1)

"Patient related her illness history, referring to nervousness and fear in the face of scheduled surgery" (Patient 28)

"Assessment of 82-year-old patient admitted for evaluation of abdominal pain and diarrhea, with complaint of easy crying, sadness, and inappetence" (Patient 59)

"Patient reported feelings of sadness, anger and said she perceives herself to be 'cold' (SIC) since receiving a cancer diagnosis" (Patient 83)

Category 2: Adherence to treatment. Problems related to difficulties observed or reported by the patient or family member to follow the health team's guidelines (fM=14; fP=9).

"Patient with poor adherence to lupus treatment, with multiple reactivations, due to discomfort that the medications cause" (Patient 4)

"Assessment of patient hospitalized for worsening pemphigus foliaceus, with a history of depression and difficult treatment compliance" (Patient 13)

"Assessment of a patient admitted for coronary artery bypass graft surgery. Presented with psychomotor agitation, aggressiveness, and refusal to take medications" (Patient 30)

Category 3: Lifestyle changes. Covers patient difficulties in engaging in healthy habits, such as exercise, proper eating patterns, and smoking cessation (fM=9; fP=7).

"Told that since the amputation he has been smoking free. Demonstrated willingness to quit smoking upon discharge and understands that smoking worsens his disease" (Patient 35)

"Assessment and follow-up of a patient trying to lose weight, with important psychological demands" (Patient 93)

Category 4: Difficulty in accepting the disease. Refers to cases in which the psychological demand was specifically described as a difficulty in accepting the disease or the losses resulting from it (fM=6; fP=9).

"I request assessment for patient after amputation of right lower limb due to thromboangiitis obliterans, for better acceptance of sequela" (Patient 6)

"Patient reported difficulty in accepting the disease due to physical appearance. She was a butcher and can no longer work" (Patient 44)

Category 5: Psychiatric illness follow-up. Refers to cases of patients diagnosed with psychiatric illness in whom psychological follow-up is requested to mitigate psychiatric illness symptoms and effects during the current hospitalization (fM=5; fP=5).

"Evaluation of patient admitted to hospital to investigate syncope and palpitations 5 years ago. Patient presented possible dissociative and somatization disorder during hospitalization, assessed by psychiatry, which directed psychotherapeutic follow-up" (Patient 11).

"Psychological evaluation of patient with a previous diagnosis of major depressive disorder" (Patient 67).

"Patient evaluated by psychiatry and diagnosed with Borderline Personality Disorder with antisocial traits + dependence syndrome associated with Cannabis use. Indicated follow-up with psychology" (Patient 88).

Category 6: Difficulty in adapting to hospitalization. It covers issues related more to hospitalization than to the disease itself, such as difficulties in adapting to the hospital environment and intense desire to be discharged (fM=4; fP=22).

"Uncommunicative and saddened patient, having difficulty accepting hospitalization due to distance from her son" (Patient 2)

"Patient was in respiratory contact isolation, complaining of difficulty adapting due to the environment, feeling trapped and stressed" (Patient 26)

"Assessment of quadriplegic patient admitted to the 9th-floor ward for plastic surgery. He is accompanied by his wife who reports conflict between the couple due to long hospitalization" (Patient 27)

Category 7: Little family and/or social support. When the psychological demand, in the physician's or psychologist's assessment, was related to the lack of family and/or social support (fM=3; fP=10).

"Assessment of patient with attempted self-extermination with caustic soda ingestion evolving with stenosis and need for gastrostomy. She does not ingest anything orally. She reports financial difficulties in acquiring food and that family members use food that should be hers alone. Patient reports preferring to stay hospitalized due to relationship difficulties with family members" (Patient 23).

"Referred to not having a person she could count on, ask for help. Presented depressed mood in some moments, due to the fact of feeling alone and helpless" (Patient 68).

Category 8: Family member embracement. It includes cases in which the psychological care was performed with the patient and his/her relative, or only with the relative when the main demand for psychological inter-consultation was from the latter or when there was no possibility of direct care to the patient (by refusal, lowered level of consciousness or some disability preventing contact) (fM=3; fP=23).

"I request assistance with patient's family members in palliative care, lowered consciousness with pulmonary nodules highly suggestive of malignancy" (Patient 5).

"Daughter told about mother's illness history with good understanding about diagnosis and treatment. She appeared overwhelmed with care» (Patient 54).

"Patient unresponsive to the proposed treatment, entering palliative care process. Daughter is manifesting behaviors related to non-acceptance of her mother's condition. I request psychological care for her" (Patient 66).

Category 9: Poor understanding of diagnosis, prognosis, or treatment. It includes problems in doctor-patient communication, low patient understanding of their health condition, which can be observed or referred, and inter-consultations aimed at joint communication of diagnoses and bad news (fM=2; fP=19).

"Assessment of patient with recent HIV diagnosis. I request to inform joint diagnosis" (Patient 2).

"Patient understands pathology of uterus agenesis, however, holds concerns about surgery. She reports being afraid and worried, however, she can't say exactly what she is afraid of" (Patient 9).

Category 10: Emotional problems not related to the disease. It includes cases in which, after professional assessment, the conclusion is that the psychological demands are associated with previous factors and not related to the disease or hospitalization (fM=0; fP=27).

"Patient reported sadness and anxiety since her father passed away 3 years ago, feeling distress and wanting to cry if she is left alone since then" (Patient 1).

"[She] reported that the anguish is because of missing one of her children who lives abroad" (Patient 30).

Category 11: No detail in the records. Cases in which the requesting professional's record in the inter-consultation protocol analyzed did not contain enough information to define the case demand (fM=10; fP=5).

"Evaluation of patient who was in a car accident in August 2016 and has been care-dependent since then. Patient with hypoacusis and low visual acuity" (Patient 14).

"32-year-old patient with localized form scleroderma diagnosis, internal for investigation of dyspnea and hoarseness condition" (Patient 64).

"Patient was receptive and communicative during the visit. She mentioned that she was currently living with her sister-in-law and previously lived with her daughter and 3-year-old grandson. She is retired and from Ribeirão Preto" (Patient 65).

The frequencies and percentages of the demand categories were submitted to McNemar's statistical test to determine whether there was a significant difference ($p<0.05$) between the identification of some type of demand by physicians and psychologists. It is noteworthy that each I.R. analyzed may have described demands that fell into more than one category, thus the total number of demands is higher than the total number of protocols analyzed. The percentage, however, was calculated in relation to the total number of requests analyzed (n=104). The data is shown in Table 1.

Table 1

Categories of psychological demands identified by the physician and the psychologist in inter-consultation care - frequencies and percentages and results of McNemar's statistical test

Analyzed category	Physician frequency	Psychologist frequency	McNemar test
Emotional symptoms related to the disease	55 (52.9%)	56 (53.8%)	p=1
Treatment adherence	14 (13.5%)	9 (8.6%)	p=0.2673
Lifestyle changes	9 (8.7%)	7 (6.7%)	p=0.7728
Difficulty accepting the illness	6 (5.7%)	9 (8.7%)	p=0.5791
Psychiatric illness follow-up	5 (4.8%)	5 (4.8%)	p=0.6831
Difficulty in adapting to hospitalization	4 (3.8%)	22 (21.2%)	**p=0.0003**
Little family / social support	3 (2.9%)	10 (9.6%)	**p=0.0233**
Family member support	3 (2.9%)	23 (22.1%)	**p<0.0001**
Poor understanding of diagnosis, prognosis, or treatment	2 (1.9%)	19 (18.3%)	**p=0.0002**
Emotional problems unrelated to the illness	0	27 (26%)	**p<0.0001**
No detail in the records	10 (9.6%)	5 (4.8%)	p=0.2673

Source: Authors

There was a statistically significant difference ($p<0.05$) in six categories, in which the frequency of demand identification by the psychologist was higher than the identification by the physician. They were as follows: difficulty in adapting to hospitalization; little family and/or social support; family member acceptance; low understanding of diagnosis, prognosis, or treatment; and emotional problems not related to the disease.

Then, the data were evaluated by Kappa's Coefficient of Concordance to measure the level of agreement in the assessment of the demand. The results are recorded in Table 2.

Table 2

Test of agreement between the demands identified by physicians and psychologists in psychological inter-consultation care

Analyzed category	Kappa coefficient of agreement (95% CI)
Emotional symptoms related to illness	0.247 (0.060-0.434)
Treatment adherence	0.368 (0.047-0.689)
Lifestyle changes	0.189 (0-0.620)
Difficulty in accepting illness	0.069 (0-0.542)
Follow-up of psychiatric illness	0.370 (0-0.859)
Difficulty in adapting to hospitalization	0.095 (0-0.431)
Little family / social support	0.437 (0.033-0.840)
Family member's support	0.189 (0-0.509)

(continues...)

Table 2

(continuation)

Analyzed category	Kappa coefficient of agreement (95% CI)
Poor understanding of diagnosis, prognosis, or treatment	0.063 (0-0.443)
Emotional problems unrelated to the disease	0 (0-0.325) Error = 0.166
No detail in records	0.074 (0-0.545)

Source: Authors

The Kappa Coefficient of Concordance revealed a concordance index characterized as poor ($k<0.200$) in seven categories, namely: lifestyle changes; difficulty accepting the illness; difficulty adapting to hospitalization; family member's support; low understanding of diagnosis, prognosis, or treatment; emotional problems not related to the illness and no detailing in the records. The agreement is mild ($0.200<k<0.400$) in three categories (emotional symptoms related to illness; adherence to treatment and following psychiatric illness) and moderate ($0.400<k<0.600$) in one category (little family and/or social support).

DISCUSSION

Regarding the sociodemographic aspects of the patients seen in this period, it was observed that the most frequent profile was of female patients, over 50 years of age and without professional activity, similar to what was found in other studies [6-9]. The predominance of women in psychiatric samples, especially with mood disorders, has already been reported in previous studies [15], and this prevalence can, in a certain way, bias the health professionals' perception in the recognition of emotional demands in female populations.

Regarding the data on the I.R.'s specialty of origin, there was a predominance of clinical patients, specifically with chronic conditions. Some hypotheses were raised for this result. Initially, chronic patients have more clinical comorbidities that require lifestyle changes and long-term therapeutic interventions that are often difficult to understand or adapt to. On the other hand, the care for surgical patients is shorter and focused on a punctual event by the medical professional, which may hinder the recognition of demands and the need for psychological intervention. It is also noteworthy the number of patients in the diagnostic investigation phase, which can be explained by the fact that the hospital is a tertiary level hospital, receiving many patients with specific and uncommon diseases in medical practice, which require more time for diagnosis.

Regarding the types of emotional demands identified, the findings reveal that the most prevalent emotional demand was the presence of symptoms of anxiety or depression related to the process of becoming ill, which is also observed in other studies in the literature. In a documental research carried out in a university hospital in the city of Campinas, Gazotti and Prebianch [8] analyzed the reasons for requesting psychological inter-consultation in 67 records and identified depressive symptoms in 32.83% and anxiety in 28.36% of the cases.

Mood disorders appear, in fact, as the major psychiatric problem in medical samples in studies from around the world. IsHak et al [15] reviewed articles published from 1990 to 2016 and identified that the average rate of depression occurrence in hospitalized patients was 33%. Anxiety rates range from 33% to more than 60% considering hospital samples with different diagnoses and treatments [16, 17, 18].

These disorders are related not only to difficulties in adapting to the hospital environment (lack of privacy, exposure to threatening stimuli) but also to financial concerns and other stressful situations arising from the disease [19]. Depression and anxiety are also associated with worse functional outcomes from treatment, poorer overall physical health and quality of life, higher morbidity and mortality, and increased readmissions after discharge [15,16,18]. Because of the high prevalence and negative influence on prognosis, psychiatric disorders have gained more attention from health

researchers and the importance of identifying and managing such demands in the hospital environment is stressed.

The psychological demands assessment of the hospitalized subject depends, to a great extent, on the professional's clinical view of the patient, being strongly influenced by the biases related to their training. This study revealed some fundamental disagreements in the physicians' and psychologists' perceptions, which were in charge of the same patients. At least partially, these disagreements can be explained by the professional training that physicians and psychologists receive during their undergraduate studies.

It was observed in the documents analyzed that psychologists most often reported that the patient's emotional distress was due to challenges in understanding the diagnosis, prognosis, or treatment. It is known that this is an important source of anxiety in hospitalized patients and that psychoeducational interventions have good results in reducing anxious and depressive symptoms in this scenario [20,21]. It is possible that, in these cases, the attending physician identified the anxious and/or depressive symptom, which justified his/her request for psychological inter-consultation. However, his evaluation did not reach the possible causes of the symptom and the patient's low understanding of his/her clinical status was not identified.

It is noteworthy that a good doctor-patient relationship may favor the patient's voicing of doubts and insecurities associated with the treatment and prevent the emergence of psychological symptoms. Therefore, the adoption of clear and accessible language, the offering of a space for listening and expressing questions, and the physician's availability to clarify patients' queries are fundamental for emotional disorders prevention and the promotion of good patient compliance to treatment [22]. Good communication enables the professional to better identify the patient's needs and expectations, facilitating emotional regulation, increasing diagnostic accuracy, and improving the patient's satisfaction regarding health [23]. Such abilities can - and should - be promoted during the health professional's training, in programs to develop social and communication skills [24].

There was also found a low level of agreement between physicians and psychologists in identifying problems related to the patients' adaptation to hospitalization and to the hospital environment. Once again, psychologists identified this demand more frequently than physicians, and it can be assumed that, similarly to what was previously discussed, only the signs of anxiety and depression arising from adaptation difficulties were identified by the requesting physicians, whose assessment did not reach the possible symptoms causes.

The emotional symptoms, in these cases, do establish a demand for psychological care in the hospital. However, when the origin is associated with specific issues of hospitalization, such as reaction to aversive stimuli found in the environment or adjustment difficulties to the routine imposed in the hospital, these symptoms may be avoided or managed by the health team, with strategies that are not exclusive to the Psychology professional. For example, flexible hygiene and meal times, mediation in communication between patients who share collective wards, and environment changes with the removal of aversive stimuli when possible (such as devices that emit sounds or lights) and the availability of stimuli that may favor the patient's stay (television, books).

Another interesting divergence refers to emotional problems unrelated to the disease. In the I.R. sample analyzed, there was none in which the main demand identified by the physician was such, while psychologists identified these problems in 26% of the cases. Understanding the health-illness process with a biopsychosocial perspective includes considering the patients' mental health history, as well as addressing in the scope of clinical investigation other aspects of the subject's life, such as family relationships and social situation [22,25]. In patients with chronic comorbidities, which represent most of the sample, this becomes even more fundamental, since it is related to lifestyle changes and adherence to treatment, in the adaptation to the new scenario with the disease [3].

The family and social aspects of the illness process are very significant, especially in hospitalized patients. Approximately 10% of the patients

seen in the analyzed time period suffered from issues related to low social and family support, and in 22% of the cases, the psychologist considered it necessary to intervene with the accompanying family member, in order to address their demands associated with the patient's care and the impacts of the illness on the family.

Social support is considered a protective factor against psychiatric disorders in medical settings, as well as a facilitator of coping with the illness and a contributor to a good quality of life in hospitalized patients [26-28]. Furthermore, it may affect self-care ability and indirectly interfere with the patient's clinical responses, such as the occurrence of new adverse events and recurrent readmissions [29-31]. Thus, the physician must be able to act as a mediator between the health team and the family, facilitating the information exchange and the clarification of queries, and as a problem investigator, such as the caregiver's stress or other difficulties related to family changes resulting from hospitalization or the disease itself.

Multi-professional intervention and inter-consultation services have great potential for promoting qualified care to all these aspects of the hospitalized individual, promoting benefits to his/her physical and mental health, and also institutional benefits, such as hospitalization time and readmission rates reduction6. However, the effectiveness of psychological inter-consultation in general hospitals still faces challenges: physicians and other health professionals must be trained to accurately recognize mental health demands, as well as trained to handle some demands that require interventions not exclusive to psychologists or psychiatrists. It is also denoted the training of psychologists to act in medical contexts, in which emotional problems are associated with physical manifestations, and the traditional clinical models are not always appropriate and effective [32,33].

In the present study, the inter-consultation records in the hospital's electronic medical records were the source of data. Thus, it was verified that issues related to inter-consultation care systematization and recording are daily difficulties in these services. Record detailing is fundamental to guarantee the quality of care that, in such cases, depends largely on proper communication between requesting professionals and consultants [34]. When problematic, this can be an indicator of negative outcomes in the patient's initial approach or follow-up [35], as seen in the no record detailing category. In this regard, institutional training measures and systematic protocols for recording care should be implemented [36].

CONCLUSION

This study aimed at analyzing the psychological demands identified by physicians and psychologists in cases seen in a psychological inter-consultation service of a general hospital. The adopted methodology allowed, in addition to the observation of common and divergent aspects between the professionals' perceptions, a survey of the most frequent emotional problems in a sample of adult hospitalized patients.

Psychological inter-consultation is an effective strategy to promote integral patient care since it gathers the knowledge and perspectives of different professionals from the health teams. It also highlights the need to invest in medical and health professionals' training to enable them to effectively identify emotional problems, communicate and relate well with patients, use strategies that minimize the undesirable effects of hospitalization, and observe aspects of the patients' individual history that may contribute to a successful treatment outcome. Also, academic education must provide professionals with the tools to work in a multi-professional team, which requires communication skills, sensitivity, and an understanding of the complementarity of knowledge.

Since this is a university hospital, some limitations must be taken into consideration, such as the fact that the professionals (both requesting and consulting) are in the educational and training process, and the high turnover of the team responsible for the cases, which can lead to communication issues. Even so, the findings provide relevant knowledge about a psychological inter-consultation service, which proves to be a viable alternative for multi-professional work within hospital units.

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