

A Study on in-Patient And Out-Patient Referrals Including Emergencies in General Hospital of A Tertiary Care Hospital Psychiatric Unit



Psychiatry

KEYWORDS :

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ABSTRACT

A general practice survey found that only one in every few patients considered suitable for referral was in fact referred to a psychiatrist. Then what is the position in general hospital? Which patients are seen by psychiatrist? These questions are answered by number of studies of both inpatient and outpatient psychiatric referrals in general hospital.

AIMS:

This study is mainly a descriptive study to understand how a psychiatric unit in a general hospital functions in liaison work.

METHODS:

The study was carried out in ASRAMS Hospital, Psychiatric Unit. In-patient and out -patient referrals including emergencies were studied.

RESULTS:

— *Out of total 795 Psychiatric out patients 221 were referral cases over in a 6 month period. Diagnosis was attempted at the time of referral in 126 cases i.e. 55.5% of cases. Out of them 53.2% of diagnoses coincided with the diagnosis made according to ICD-10 in psychiatric unit during referral.*

— *No diagnosis was made in 45.5% of cases.*

— *The diagnosis was wrong in 46.8% of cases which comes to 21.1% of total referrals.*

CONCLUSION:

— *Because of the poor practical and theoretical knowledge of other physicians in psychiatry in this study it was found out that no liaison work is possible. This calls for toning up of undergrade medical training in psychiatry.*

INTRODUCTION

It is an accepted fact that the formal mental hospitals alone cannot deal with the huge problems of millions of mentally sick with limited number of beds at their disposal. During recent years there is at least a moderate increase in the strength of psychiatric beds in these hospitals and medical colleges. Neurotic & stress related non - psychotic disorders will not readily reach the mental hospitals. Various studies had shown that at various clinical set ups more number of mental health problems are seen.

Dr.Girendra Sekhar Bose who had personal contact with Freud opened the first general hospital psychiatric unit in India in R.G. Kar Medical College in 1933 The second unit was opened soon after in J.J. Hospital, Mumbai in 1938 by Dr. K.K.Masani. The other unit at KEM Hospital, Mumbai was begun by Dr. Vahia in forties (Vahia et al 1974). By 1970 over 90 such units were present in general hospitals (Khanna et al 1974). The total number must be much larger now –presently all medical colleges recognized by MCI have psychiatry units.

General hospital psychiatry units have opened up new vistas. The spectrum of psychiatric case material seen in general hospital units is much wider than seen in mental hospitals. Unlike mental hospitals, where the clinical material is predominantly psychosis, in a general hospital psychiatric unit there is a wide range of clinical problems including psychoses, neuroses, personality disorders, drug dependence, organic brain disorders etc. (Sethi & Gupta 1972, Vahia et al 1974, Khanna et al 1974). Referral from the inpatient services offer additional problems of psychosomatic illness (Wig & Shah 1973).

'Consultation' refers largely to the services performed for the physically ill patients and families, often at the bed side in the general hospital, upon the referral of the attending physician or other health professional. 'Liaison' refers to the services provided in helping the physician and staff, trying together the treatment of the patient and family using educational conferences, psychosocial teaching rounds and holistic treatment plans.

Although physicians come across quite a large no of psychiatry cases and only a small percent of cases are referred for psychiatric help and majority are not. The referral rates are much lower

than the reported prevalence of psychiatric morbidity. Lack of referrals by the non-psychiatrist has been an unfortunate negative factor in psychiatric practice. The low referral rate reflects a failure or reluctance of the non-psychiatrist to recognize psychiatric disturbance in his patients.

AIMS & OBJECTIVES OF THE STUDY

This study is mainly a descriptive study to understand how a psychiatric unit in a general hospital functions in liaison work.

The study of referrals made to psychiatry department will help us to

Know

1. What type of patients are referred, i.e. case profile.
2. Who prefers to refer them and the understanding of the referring doctor.
3. To enlighten the possible causes for the ignorance.
4. To study the emergency referrals that are made, the type of emergencies that are dealt with in general hospital psychiatric unit.

MATERIALS & METHODS

The study was carried out in ASRAM Hospital which is attached to Alluri Sita Ramaraju Academy of Medical Sciences.

The psychiatric unit is a small one started in 2005 with bed strength of 30. As there is no mental hospital nearby, the inflow to this unit is very high. OP runs all week days, except Sundays.

In-patient and out-patient referrals including emergencies to the department of psychiatry were taken into the study over a period of 6 months from January 2014 to June 2014. All the referred cases were registered at Psychiatric OPD. Referrals coming from outside sources apart from general hospital were also included. A proforma containing all the parameters of study like demography, source of referral, reasons for referral, psychiatric diagnoses given by the referring unit, diagnoses arrived at the department of psychiatry was prepared. All the particulars of the referred cases were noted in consultation with the referring doctor. In-patients and out-patient including emergencies were

noted separately. The psychiatric diagnoses were made according to ICD-10 and necessary intervention done. The accumulated data were analyzed at the end of the study.

RESULTS & DISCUSSION

Of the total 795 psychiatric out-patients, 221 were referred cases over a 6 months period. 59 were in-patients coming from various wards and the rest were out-patients. Of them 40 were referred from casualty.

SOURCE OF REFERRAL:

Table 1

	No. of Cases	Percentage
General Hospital	151	68.3
Superspeciality Hospital (ASRAMS)	40	18.09
Practitioners with in town	4	1.8
Referrals coming from outside the town	26	11.7
Total	221	100

68.3% of cases were referred with in the hospital. 18.09% of cases came from superspeciality units of this hospital which constitute departments of neurology, neurosurgery, gastroenterology, endocrinology, urology, nephrology & cardiology etc. Only 1.8% of cases were referred from the practitioners with in town & 11.7% of cases came from other places.

Table 2

Sl.No		Total	Percentage	In-Patients	Percentage	Out-Patients	Percentage
1	General Practitioner	15	6.7	1	1.6	14	8.6
2	Medicine	55	24.8	31	52	24	14.8
3	Surgery	17	7.6	7	11.8	10	6.1
4	Casualty	40	18.09	1	1.6	39	24
5	Neurology	25	11.3	1	1.6	24	14.8
6	Neuro Surgery	13	5.8	2	3.3	11	6.7
7	Ent & Oph	10	4.5	1	1.6	9	5.5
8	Paediatrics	7	3.16	3	5.08	4	2.4
9	Cardiology	7	3.16	2	3.3	5	3
10	Chest Diseases	11	4.9	4	6.7	7	4.3
11	Psychiatry	4	1.8	-	-	4	2.4
12	Gynaecology	1	0.4	-	-	1	0.6
13	Obstetrics & other specialities	16	7.2	6	10.16	10	6.17
14	Total	221	100	59	100	162	100

Speciality wise, total referrals from medicine department were high (24.8%) second Casualty (18%) third stands neurology (11.3 %). Among in-patient referrals 52% came from medicine, in contrast, share of surgeons is much less (7%). This is understandable because psychiatry after all is an allied speciality of medicine and physicians are much more oriented to psychiatry than other specialities. Surgeons accounted for only 7% of referrals as they are always known to be less oriented and some of them positive-hostile too, towards this discipline.

Among the out-patient referrals Casualty stood first with 24% of referrals. Second were medicine and neurology. No. of referrals from Gynaec & Obstetrics was surprisingly low (only 1). The casualty referrals were separated out and the data analysed separately. Table III shows the figures.

Reasons for Referral:

Most common reason given by the non-psychiatric clinicians for the referral was for advice, and management and for abnormal be-

haviour. Among the in-patients, most of them were referred for the advice & treatment. Clinician gave some notes regarding the patient and sought advice (27.11%). Among the out-patients, no reason was given or reason was often very vague in majority of cases (17.9%). Definite psychiatric diagnoses were made only in 10.5% of cases.

Table IV shows the figures.

Table 3

Sl. No.	Reason	Total	Out-patients	Percentage	In-patients	Percentage
1.	Abnormal behaviour behavior	38	27	16.66	11	18.64
2	For Advice, Treatment, counselling	43	27	16.66	16	27.11
3.	No organic basis	24	19	11.72	5	08.47
4.	Vague complaints	7	7	04.32	0	-
5.	Functional overlay	18	13	08.02	5	08.47
6.	Definite psychiatric diagnosis	24	15	09.25	9	15.25
7.	Suicidal thinking/attempt	12	7	04.32	5	08.47
8.	No reason given	30	29	17.09	1	01.69
9.	Reason not clear	14	10	6.17	4	06.77
10.	Old case of psychiatry	11	8	04.93	3	05.08
	Total :	221	162	100.00	59	100.00

Reasons for referral make an interesting study. No organic cause, vague complaints, functional such reasons were given by the non-psychiatric clinician during referral. Pejorative terms like mental, functional were often used. Some eye catching terms like,

1. "Personal sexual & mental depression",
2. "Psychoneurotic behavioral disturbance with unbalanced talking",
3. "Minor psychiatric behaviour",
4. "Depressive behavioral psychosis" were used.

In these situations, the specialist's desperate attempt to delineate some physical cause for the symptom, is illustrated aptly. These vague complaints also mean the same i.e. lack of physical finding to corroborate the symptom. The referral to psychiatry is indicative of his failure in his attempt to find a significant physical cause. The practice though deplorable, yet as a matter of fact is very common

amongst the physically oriented specialists. This also stresses the need of psychosomatic clinics in general hospitals.

Diagnosis made by Referring Doctor: Table 4

Sl. No.	Diagnosis	Number of Cases	Percentage
1.	Diagnosis attempted	121	54.75
2.	No diagnosis attempted	100	45.24
3.	Correct diagnosis	65	53.71
4.	Wrong diagnosis	56	46.28

Diagnosis was attempted by the non psychiatric physicians in 121 cases i.e. 54.75% of cases. Of them 53.71% of cases diagnosis coincided with our diagnosis which was made according to ICD-10. No diagnosis was made in 45.5% of cases. The non-psychiatric clinician's diagnosis was wrong in 46.28% of cases which comes to 21.1% of total referrals. Most common diagnosis made by referring doctor was conversion (23.96%), depression & psychosis (18.18%) were next each with equal no. of cases.

Table 5

Diagnoses	Number of Cases	Percentage
Conversion	29	23.96
Depression	21	17.35
Psychosis	22	18.18
Suicide	19	15.70
Anxiety	12	09.91
Others	18	14.87
Total	121	100.00

Diagnosis made by psychiatrist Table 7

S.no	I.C.D CODE	Diagnosis	Total referrals		In- patients		Out- patients	
			Number	percentage	Number	Percentage	Number	Percentage
1	F00-09	Organic including symptomatic mental disorder	18	8.1	8	13.5	10	6.17
2	F10-19	Mental behavioral disorder due to psychoactive substance abuse.	4	1.8	2	3.3	2	1.2
3	F20-29	Schizophrenia, delusional disorders, other psychotic disorders	30	13.5	5	8.4	25	15.4
4	F30-39	Mood disorders	77	34.8	17	28.8	60	37.03
5	F40-48	neurotic, stress related and somato form disorder	41	18.5	8	13.5	33	20.3
6	F60-69	Disorders of adult personality behavior	3	1.3	1	1.69	2	1.2
7	F70-79	Mental retardation	10	4.5	8	13.5	2	1.2
8	F90-98	Behavioral emotional disorder in child hood.	1	0.4	-	-	1	0.6
9	X code	Suicidal, psycho-social problems	8	3.6	3	5.08	5	3.08
10	Z code	Nil psychiatric problem	12	5.4	2	3.3	10	6.17
11	G code	Not yet diagnosed	17	7.6	5	8.4	12	7.4
	Total		221	100	59	100	162	100

Regarding the diagnosis and treatment made by referring doctor, only in approximately half of the cases diagnosis was attempted, of them approximately half proved to be correct. Though conversion was made commonly, depression was common according to ICD-10 followed by the psychiatrist. This discrepancy shows that the underlying depression was often missed and the conversion as a symptom recognized.

Treatment given by Referring Doctor:

Table 6

	In-Patients	Out-Patients	Total	Percentage
Antipsychotics	2	5	7	14.89
Tranquilizers	9	16	25	53.19
Antidepressants	-	2	2	04.26
Other	4	9	13	27.66
Total	15	32	47	100

Some Psychiatric treatment was started by the referring doctor in 47 cases (20.7%) and in the rest no intervention was done. Tranquilizers like benzodiazepines were most frequently used by them (53%). The intervention was inadequate and only a half-hearted attempt by the non-psychiatric clinician. Regarding the out-patients, treatment details were not known. The general practitioner should know the procedure to take psychiatric history, conduct a psychological examination and also how to use psychiatric drugs and their side effects.

According to ICD-10 diagnoses made by the psychiatrist were shown in Table VII, mood disorders by far were the commonest disabilities referred to psychiatrist (34.8%). These were mostly moderate depression with somatic features category next stood neurotic, stress related and somatoform disorders (18.5%). In about 5.4% referrals no psychiatric diagnosis was made, as they were thought to be psychiatrically normal. The depression was the most common disorder referred to psychiatry (Lipowski, 1981). The 1/5th of the referred patients had a diagnosis of depression (Crisp, 1968). The present study agrees with this. But neurosis was common diagnosis in earlier few Indian studies (Savitha Malhotra, Jindal, Chatterjee & Kutty) in Western studies (Eilenberg). In a considerable portion of cases no psychiatric diagnosis was made. Though it was a positive point that they were making use of psychiatric services, it also reflect that the cases were sent without prior investigations. In fact, it has been officially acknowledged that the training of the doctor, both at under graduate level and later levels is deficient in knowledge and practical skills in psychiatry and mental health though this is an essential element in his future daily practice (Maheswari, 1979).

The above review & discussion amply demonstrate that psychiatrist's help is called not simply to answer the questions of functional Vs organic but for many other problems like help in diagnosis and management. This problem does not end by merely referring a case but one should also be able to manage, particularly in emergencies. The synthesis of medical specialities with psychiatry is often needed because psychological and physical influences lie in a continuum that determine the onset, course and prognosis of medical disease.

In India, there is a need and scope for expansion of the liaison psychiatry. Perhaps, the present-status is a reflection of the man power that we have. It becomes evident that there is an urgent need to restructure the under graduate medical curriculum,

more so because there is a shortage of trained psychiatrists in our country. And also as the number of psychiatrists increase, psychiatry should permeate the various disciplines.

CONCLUSIONS

0.9% of the out-patients and 0.55% of the in-patients of the AS-RAM Hospital were referred for psychiatric opinion during the study period.

Depression was the most common diagnosis among the referred (34.8%). Most of the referred came for advice and management (27.11%), no reason was given in (18%).

Referring doctor made diagnosis in 54.75%. Of them 53.71% were correct. Interventions tried were inadequate (20.7%) Benzodiazepines were most frequently used (53%).

44% of the referred patients had a concomitant physical disorder.

After the first referral note, no clinician was interested or made an attempt to make any true liaison with the department of psychiatry.

Emergencies constitute 24% of total out-patient referrals. In 27.5% cases no reason was given for the referral. Manic excitement was the commonest disorder diagnosed (56.25%) among the mood disorders (40%) which represented most of the referrals. Diagnosis attempted by the referring doctor was correct in 62.5% cases. But intervention was tried in only 17.5% of cases.

Because of the poor practical and theoretical knowledge in psychiatry, in this study it was found out that no liaison work is possible. Even follow up of the referrals is also poor. This calls for toning up of under graduate medical training in psychiatry.

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