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A Study On In-Patient And Out-Patient Referrals Including Emergencies In General Hospital Psychiatric Unit

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Abstract: *S.V.R.R hospital is a tertiary referral hospital attached to S.V Medical College, Tirupathi. All psychiatric referrals numbering 866 over a period from 1.1.1996 to 1.6.1996 were studied. Socio-demographic data, source and reason for referral, associated physical illness, diagnosis, treatment advised and mode of disposal were noted. Majority of the referrals were male patients and belonged to the productive age group of 11 years to 40 years. Referrals from General Medicine department were high (25.5%), second Casualty (18%) and third stands neurology (11%). Among in patient referrals 54% came from medicine in contrast, share of surgeons is much less 7%. Most common reason given by the non – psychiatric clinicians for the referral was for treatment advice, and management of abnormal behavior. The commonest psychiatric diagnosis was Depression(36.1%). Most common ICD-10 diagnosis seen in emergencies was in the category of mood disorders (40%). Among them manic excitement was the commonest (56.25%). Need for more dialogue and interaction between the refernng doctor and the psychiatric team member is strongly felt.*

Keywords: Consultation liaison psychiatry, general hospital psychiatric unit, Psychiatric referrals, tertiary hospital, liaison psychiatry.

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I. Introduction

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. Various studies had shown that at various clinical set ups more number of mental health problems are seen. An important change in the field of psychiatry in India which in many ways a major revolution is the emergence of psychiatric units in general hospital.

Considering these facts and keeping in mind, Studies show considerable discrepancy between the incidence of psychiatric disorders in general hospital and much lower rate of psychiatric referral.

This discrepancy have to be studied in a very systematic manner, as they also reveal the factors like attitudes of the health professionals and population in general, about the status of psychiatry as a medical specialty.

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 psychosis, neurosis, personality disorders, drug dependence, organic brain disorders etc. (Sethi & Gupta 1972, Vahia et al 1974) Referral from the inpatient services offer additional problems of psychosomatic illness (Wig & Shah 1973)

Rapid growth of general hospital psychiatric units all over India has provided impetus to the consultation-liaison work carried out by the psychiatrists in non-psychiatric departments of general hospitals.

Liaison psychiatry has acquired the status of a subspecialty within psychiatry and its development paralleled the shift of psychiatry from mental hospitals to general hospital setting. This has resulted in closer links between physical and psychological medicine and provides opportunity to the psychiatrists to be directly involved in the care of the physically ill.

Although there is convincing evidence of an increased association between physicians and psychiatric morbidity only small percent of cases with psychiatric problems are referred for psychiatric help and majority are not. The referred 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.

II. 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 psychiatric 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. The interventions that possibly happen in liaison work.
4. To study the agreement between the psychiatrist and clinical diagnoses, the level of interactions that are made with the psychiatrist in day to day case management by the clinician.
5. To enlighten the possible causes for the knowledge and ignorance.
6. To study the emergency referrals that are made, the type of emergencies that are dealt in general hospital psychiatric unit.

III. Materials & Methods:

The study was carried out in Sri Venkateswara Ramnarayan Ruia Hospital which is attached to S.V. Medical College. The hospital is a large general hospital with about 750 beds covering all disciplines like Casualty, General Medicine, Pediatrics, dermatology, STD General Surgery with Neuro surgery, Pediatric surgery, Urology, ENT, Ophthalmology etc. All departments run OPD. Maternity hospital is a separate one.

The Psychiatric unit has a bed strength of 40. 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 1996 to June 1996. All the referrals 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, psychiatry diagnoses given by the referring unit, diagnoses arrived at the department of psychiatry was prepared. All the particulars of the referred cases noted in consultation with the referring doctor. In patients and out – patient including emergencies were noted separately. The psychiatry diagnoses were made according to ICD -10 and necessary intervention done. The accumulated data was analyzed after the end of the study.

As the study is a descriptive study, no statistical methods have been used. The results were discussed at the end.

IV. Results & Discussion :

Of the total 866 psychiatry out patients, 227 were referred cases over a 6 months period. 61 were in-patients coming from various wards and the rest were out-patients of them 40 were referred from casualty.

Referral Rate:

Table 1:

Sl. No.		In-Patients	Out-Patients
1.	Total Hospital admission/ attendance-6 months period	11762	25191
2.	Total psychiatry OP attendance (New Cases)	-	866
3.	Total referrals	61	227
4.	Percentage of total hospital admissions/ attendance	0.52%	0.9%
5.	Percentage of psychiatry attendance	-	26.2%

Table 1 shows the number of total referrals in comparison to the total hospital admissions/ attendance (only fresh cases) and also in comparison to attendance at psychiatry OPD. The Proportion of all the patients referred to psychiatry varies from country to country. The referral rates are lower in U.K. ranging from 0.7% to 1.3% than U.S.A. 2.2% to 9%. The referral rate was indeed poor in this study compared to other studies conducted in India. The in-patient referral rate in the present study was 0.52% as compared to 1.4% in the study of Prabhakaran & 0.66% is the study of Parekh et al (1968). 1.54% in the study of Chatterjee & Kutty (1977). The out-patient referral rate in the present study was 0.9% compared to 2.64% in the study of Chatterjee & Kutty (1977)

Source of Referral:

Table II (a)

	No.of Cases	Percentage
General Hospital	153	67.4
Super specialty Hospital nearby (SVIMS)	43	18.9
Practitioners with in the town	4	1.7
Referrals coming from outside the town	27	11.9

67.4% of cases were referred with in the hospital. 18.9% of cases came from a super specialty hospital nearby to the department which constitutes departments of neurology, neurosurgery, gastroenterology, endocrinology, urology, nephrology etc. only 1.7% of cases were referred from the practitioners within town & 11.8% of cases came from other places.

Table II (b)

Sl. No		Total	Percentage	In-patients	Percentage	Out Patients	Percentage
1.	General Practitioner	16	7	1	1.6	15	9
2.	General Medicine	58	25.5	33	54	25	15
3.	Surgery	17	7.4	7	11.5	10	6
4.	Casualty	41	18.6	1	1.6	40	24
5.	Neurology	25	11	1	1.6	24	14.4
6.	Neurosurgery	13	5.7	2	3.2	11	6.6
7.	ENT & Ophthalmology	10	4.4	1	1.6	9	5.4
8.	Pediatrics	7	3	3	4.9	4	2.4
9.	Cardiology	7	3	2	3.2	5	3
10.	Chest Diseases	12	5.2	4	6.6	8	4.8
11.	Psychiatry	4	1.7	-	-	4	2.4
12.	Gynecology & Obstetrics	1	0.4	-	-	1	0.6
13.	Other Specialties	16	7	6	10	10	6
	Total	**227**		**61**		**166**	

Specialty wise, total referrals from General Medicine department were high (25.5%) second Casualty (18%) third stands neurology (11%). Among in patient referrals 54% came from medicine in contrast, share of surgeons is much less 7%. This is understandable because psychiatry after all is an allied specialty of medicine and physicians are much more oriented to psychiatry than other specialties. Surgeons accounted only 7% as they are always known to be less oriented and some of them positively hostile too, towards this discipline.

Among the out-patient referrals casualty stood first with 24% of referrals. Second were medicine and neurology. Number of referrals from OBG was surprisingly low (only1). The casualty referrals were separated out and the date analyzed separately.

Reasons for Referral*:*

Most common reason given by the non – psychiatric clinicians for the referral was for treatment advice, and management of abnormal behavior. Among the in-patients, most of them were referred for the advice & treatment. Clinician gave some notes regarding the patient and seeked advice (26.2%). Among the out-patients, no reason was given or reason was often very vague in majority of cases (18%). Definite psychiatric diagnoses was made only in 1.5% of cases.
Table III shows the figures.

Table III

Sl. No.	**Reason**	**Total**	**Out-Patients**	**Percentage**	**In-Patients**	**Percentage**
1.	Abnormal behavior	39	27	16.30	12	19.67
2.	For Advice, treatment, counseling	43	27	16.30	16	26.22
3.	No organic basis	24	19	11.45	5	08.19
4.	Vague complaints	7	7	04.21	0	-
5.	Functional overlay	19	14	08.43	5	08.19
6.	Definite psychiatric diagnosis	24	15	09.03	9	14.75
7.	Suicidal	14	8	04.82	6	09.83
8.	No reason given	31	30	18.07	1	01.63
9.	Reason not clear	15	9	05.42	4	06.55
10.	Old case of psychiatry	11	8	04.82	3	04.91
	Total	**227**	**166**	**100.00**	**61**	**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 behavior”
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 IV

Sl.No.	Diagnosis	Number of Cases	Percentage
1.	Diagnosis attempted	126	55.50
2.	No diagnosis attempted	101	44.50
3.	Correct diagnosis	67	53.20
4.	Wrong diagnosis	59	46.80

Diagnosis was attempted in 126 cases i.e. 55.5% of cases. Of them 53.2% 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 46.8% of cases which comes to 21.1% of total referrals. Most common diagnosis made by referring doctor was conversion (24.6%), depression & psychosis (17.5%) were next each with equal number of cases.

Table V

Sl.No.	Diagnosis	Number of Cases	Percentage
1.	Conversion	31	24.60
2.	Depression	22	17.50
3.	Psychosis	22	17.50
4.	Suicide	20	15.90
5.	Anxiety	12	09.50
6.	Others	19	15.00
	Total	126	100.00

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 IC-10 followed by the psychiatrist. This discrepancy shows that the underlying depression was often missed and the conversion as a symptom recognized.

Diagnosis made by the Psychiatrist:

Table VI

ICD Code	Diagnosis	Total Referrals		In-Patients		Out Patients	
		Number	Percentage	Number	Percentage	Number	Percentage
F00-09	Organic including symptomatic mental disorder	18	7.9	8	13.1	10	6.0
F10-19	Mental behavioral disorder due to psychoactive substance abuse	4	1.7	2	3.2	2	1.2
F20-29	Schizophrenia, delusional disorders & other psychotic disorders	30	13.2	5	8.1	25	15.0
F30-39	Mood disorders	82	36.1	19	31.1	63	38.0
F40-48	Neurotic, stress related and somatoform disorder	41	18	8	13.1	33	19.9
F60-69	Disorders of adult personality & behavior	2	1.3	1	1.63	2	1.2
F70-79	Mental Retardation	2	1.3	1	1.63	2	1.2
X code Z code G code	Suicidal, psycho-social problems	9	3.9	3	4.9	6	3.6
	Nil Psychiatric problem	21	9.2	9	14.7	12	6.0
	Net yet diagnosed	15	6.6	5	8.1	10	7.2

According to ICD-10 diagnosis made by the psychiatrist were shown in Table VII, mood disorders by far were the commonest disabilities referred to psychiatrist (36.1%). These were mostly moderate depression with somatic features category next stood neurotic, stress related and somatoform disorders (18%). In about 9.2% of 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 present study agrees with this. But neurosis was common diagnosis in earlier few Indian studies (Savitha Malhothra, Jindal, Chatterjee and Kutty) in Western studies (Eilenberg) in 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 reflects that the cases were sent without prior investigations.

Level of Interactions:

The written consultation is an official doctor to doctor communication. Once the referral was made no clinician was interested or made an attempt to contact either through writings or discussion regarding the case. Among the in-patients, this sort of team approach and follow up together was possible in very few cases (13%). This shows that 'active' liaison work is not undertaken in this hospital. This observed deficiencies originate from a basic lack of understanding as a specialty.

Emergencies:

Table VII

(a) Reasons for Referral:

Sl.No.	Reason	No.of Cases	Percentage
1.	Abnormal behavior	10	25.00
2.	Definite psychiatric diagnosis	10	25.00
3.	No reason given	11	27.50
4.	Suicidal attempt/poisoning	4	10.00
5.	No organic cause	2	05.00
6.	Old case	3	07.50

24% of total referrals were emergencies called for psychiatrist resident who was no round the clock duty. In 27.5% of cases much time was not spent on them and they were with no reason given referred to psychiatric resident with a note 'Ref. to Psychiatry'. This proportion is considerably significant. Others were seen by duty physician or CMO earlier, later sent to psychiatrist. Most common reason for referral was Abnormal behavior (25%). Suicidal attempts (Poisoning etc) were (12.5%). This satiation, is no different from other studies from India about psychiatric emergencies in a general hospital.

(b) Diagnosis by the Psychiatrist:

Sl.No.	ICD -10 code	No.of Cases	Percentage
1.	F00-09	2	05.00
2.	F10-19	1	02.50
3.	F20-29	9	22.50
4.	F30-39	16	40.00
5.	F40-48	7	17.50
6.	F60-69	-	-
7.	F70-79	-	-
8.	F90-98	-	-
9.	X Code, Z Code, G Code	4	10.00
10.	Nil Psychiatry	1	02.50

(C) Mood disorders in Emergencies:

Sl.No.	Mood Disorders	No.of Cases	Percentage
1.	Manic excitement	9	56.25
2.	Recurrent depressive disorder	1	06.25
3.	Moderate depression with conversion symptom	5	31.25
4.	Depressionwith psychotic features	1	06.25
	Total	**16**	**100.00**

Most common ICD-10 diagnosis seen in emergencies was in the category of mood disorders (40%). Among them manic excitement was the commonest (56.25%). But the clinician attending emergencies made conversion ('Hysterical' in their term) as common diagnosis (37.5%). The under lying depression or organicity was missed.

(d) Diagnosis made by referring Doctor:

Sl.No.	Mood Disorders	No.of Cases	Percentage
1.	Diagnosis attempted	16	40.00
2.	No diagnosis attempted	24	60.00
3.	Correct diagnosis	10	62.50
4.	Wrong diagnosis	6	37.50

(e) Diagnosis made by referring Doctor :

Sl.No.	Mood Disorders	No.of Cases	Percentage
1.	Conversion	6	37.50
2.	Depression	4	25.00
3.	Psychosis	1	06.25
4.	Suicide	5	18.75
	Total	**16**	**100.00**

The referring doctor attempted diagnosis in 40% of the cases. In 62.5% of cases diagnosis was correct amounting to 25% of total referred. Though the doctor's diagnosis when attempted was correct in 62.5% of cases, intervention was poor. The emergency staff probably does not have the time, initiative and the know-how to try any interventions.

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 specialties with psychiatry is often needed because psychological and physical influences lie in a continuum that determines the onset, course and prognosis of medical disease.

In India, there is aneed 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.

V. Conclusions:

1. 0.9% of the out-patients and 0.52% of the in-patients of the S.V.R.R.G.G.Hospital were referred for psychiatric opinion during the study period.
2. Depression was most common diagnosis among the referred (36.1%). Most of the referred came for advice and management (26.2 %), no reason was given in (18%).
3. Referring doctor made diagnosis in 55.5%. Of them 53.2% were
correct. Interventions tried were inadequate(20.7%) Benzodiazepines were most frequently used (53%).
4. 44% of the referred patients had a concomitant physical disorder.
5. After the first referral note no clinician was interested or made an attempt to make any true liaison with the department of psychiatry.
6. 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 (66.25%) 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.
7. 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 are also poor. This calls for toning up of under graduate medical training in psychiatry.

Recommendations & Scope for further Study:

1.Systematically screening the in-patients for evidence of co-existence or presence of a psychiatric disorder and comparing this data with actual referrals made would throw more light on the deficiencies.
2. A study to evaluate the knowledge of various clinicians working in a general hospital. before and after a CRASH - Psychiatric Orientation Course - would bring out, the lacunae that exists in the current setup.
3. MCI shall strongly insist on incorporating the basic psychiatry training in the undergraduate curriculum, as it would help us to bring out more competent basic doctors who could also care for the" Mental wellbeing" of the patients.
4. The referral shall not end in a single note, the scope for liaison in some cases with co-existing physical disorder, shall be made possible, in bigger teaching hospitals.

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