

PSYCHIATRIC REFERRALS IN MULTISPECIALITY HOSPITAL

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ABSTRACT

K.L.E.S. hospital is a new multispeciality referral hospital attached to J.N. Medical College, Belgaum. All psychiatric referrals numbering 338 over a period from 1.7.1996 to 30.6.1997 were retrospectively studied. Socio-demographic data, source and reason for referral, diagnosis and treatment advised were noted. More than two-third of the referrals were male patients and belonged to the productive age group of 16 years to 45 years. 83.17% of the patients were referred from general medicine, medicine allied and medical superspeciality departments. Unexplained physical symptoms was the commonest reason for referral (64.44%). The commonest psychiatric diagnosis was neurotic, stress related, somatoform disorders (45.54%). Next common diagnosis was mood disorders (20.92%). Need for more dialogue and interaction between the referring doctor and the psychiatric team member is strongly felt.

Key words : Psychiatric referrals, multispeciality hospital, liaison psychiatry

General hospital psychiatry units have given increased opportunities for interaction between psychiatrists and other medical specialists making consultation-liaison psychiatry more meaningful. The establishment of General Hospital Psychiatry Units (GHPU) proved an impetus for Indian studies on psychiatric morbidity in medical-surgical inpatients (Avasthi et al., 1998). The spectrum of psychiatric case material seen in general hospital psychiatry units is much wider than seen in mental hospitals. Unlike mental hospitals, where the clinical material is predominantly psychosis, in a general hospital psychiatry 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 inpatient services offers additional area for study in psychosomatic illness (Wig & Shah, 1973). According to De & Kar (1998), the rate of psychiatric morbidity in medical inpatients suffering from chronic physical illness is high.

Similarly high prevalence of psychiatric morbidity amongst general hospital OPD patients was reported by Krishnamurthy et al. (36%) (1981) and by Sriram et al. (10.4%) (1987). Murthy (1998) in his editorial stated that the developments in the twentieth century have dramatically changed concepts of mental health care as a result of new knowledge and saw a shift from mental illness to mental health. He stressed the importance of the role of emotional reactions to physical problems for example major depression is part of cancer (20%), post MI (20 to 50%), stroke (25 to 50%).

Era of high-tech multispeciality hospital is just dawning in our country. Since the last two years, K.L.E. Society which runs the J.N. Medical College, Belgaum has commissioned a new multispeciality referral hospital, which is also a teaching hospital. The consultation-liaison psychiatry in such hospital appears to be somewhat different. Special problems regarding general hospital psychiatry were pointed out by Kuruvilla (1993) in his editorial on 'Challenges in

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General Hospital Psychiatry'. Swenson et al. (1993) after surveying Canadian psychiatrists reported that more than 55% respondents agreed that consultation-liaison psychiatry should receive designation as a psychiatric sub-speciality. Kurosawa et al. (1993) stated that the consultation-liaison (C-L) psychiatry has been developing for the past 10 years as a new clinical service field in Japan. Similar reports on consultation-liaison psychiatry service and experience are there from different parts of the world. It was therefore thought that the experience gained in the new multispeciality hospital in Belgaum could be scientifically studied from consultation-liaison-psychiatry point of view.

The aims of this study were (i) to know the socio-demographic characteristics and the reasons for referral; (ii) to study the pattern of psychiatric diagnosis; (iii) to understand the difficulties of consultation-liaison psychiatry in new multispeciality hospital.

MATERIAL AND METHOD

K.L.E. Society is running J.N. Medical College, a private medical college since 1964 at Belgaum in Karnataka state. It is recognised by Medical Council of India and is running post-graduate courses in medicine, surgery and other major subjects since 1978. K.L.E. Society has commissioned a new high technology multispeciality referral hospital in June 1996 having super-specialities like Neuro-medicine, Cardiology, Neurology, Neurosurgery, Cardiac Surgery, Urology, Paediatric Surgery apart from the usual specialities. The new K.L.E.S. hospital is a teaching hospital too. The department of psychiatry in this hospital is managed by three consultant psychiatrists, one clinical psychologist and one medical officer.

This new hospital started functioning in June, 1996. It was thought that the study of referral over one year period would help in future planning and working of the department of psychiatry. It was particularly true with regard to consultation-liaison psychiatry. Thus all those

patients who were referred to psychiatry either from indoor wards or from outpatient department of various specialities during the period from 1.7.1996 to 30.6.1997 formed the sample of the study. Case papers of all these patients were retrospectively analysed to collect the following data : age and sex distribution, social class, habits and other socio-demographic information, source and reasons for referral, physical diagnosis, treatment strategies suggested and follow up notes. It is the custom in the department of psychiatry that all referred cases should be independently examined by at least two consultant psychiatrists. The psychiatric diagnoses were made as per ICD-10 criteria. Whenever required, the clinical psychologist was requested to do the psychological evaluation. Similarly, whenever required, the referring specialist was contacted either in person or through P.G. students or on telephone and case findings were discussed. At least one follow up visit was made to the indoor patients within a week. The outdoor referred patients were advised to visit the psychiatry OPD for follow up after one week. Only those outdoor referred patients who actually came for follow up were included in the study. From indoor patients group there was no dropout because before discharge from the hospital psychiatric follow up examination was compulsorily done, at least once. Follow up visits gave an idea about patients' condition and actual treatment started by the referring consultants. Sex distribution, source of referral, reasons for referral, psychiatric diagnoses and break-up of neurotic, stress related, somatoform disorders were tabulated separately for inpatients and outpatients group.

RESULTS

Total hospital attendance during the study period was 63729 out of which 38250 (60.02%) were males and 25479 (39.98%) were females. Total hospital inpatients were 9509 out of which 5956 (62.64%) were males and 3553 (37.36%) were females. Total number of outpatients

referred to psychiatry was 153 out of which 104 (67.97%) were males and 49 (32.03%) were females. Total number of inpatients referred to psychiatry was 185 out of which 129 (69.73%) were males and 56 (30.27%) were females.

Age distribution showed that paediatric age group patients (upto 15 years age) were 7.57% from psychiatric inpatient group and 16.99% from psychiatric outpatients group. 70.26% and 70.6% of patients belonged to the 16 years to 45 years age group in the psychiatric inpatients and outpatients respectively. 65 years and above were 5.40% and 0.65%.

Only 6.21% of the psychiatric referrals were illiterate, 37.92% were from college education group, while 46.86% had school education. 54.73% of the psychiatric referrals were married, 40.53% were unmarried, 3.25% were widowed and 1.48% were either divorced or separated. 79.29% of the psychiatric referrals had no habits. 0.88% had substance use, 10.36% were using alcohol and 13.90% were using tobacco. 1.77% and 0.29% had alcohol dependence and multiple substance dependence respectively.

Indoor and outdoor patients department wise referral pattern was respectively as follows: from medicine and allied department (73.55% and 41.18%), surgery and allied (9.73% and 21.57%), obstetrics and gynaecology department (2.16% and 1.31%), neuro-medicine (6.48% and 35.29%), cardiology (3.24 and 0.65%) and nephrology (4.84% and nil). When reasons for referral were studied, it was found that the indoor and outdoor patients had following reasons for referral respectively: Unexplained physical symptoms (47.57% and 62.75%), frank psychiatric illness (25.41% and 20.91%), medico-legal (16.76% and 01.31%). Other reasons for referral included demand by the patient or relative for psychiatric treatment (4.32% and 1.96%). Analysis of the final diagnoses revealed that a large majority of the patients had neurotic, stress related, somatoform disorders. In respect of indoor referrals and outdoor referrals they formed 36.76% and 52.29% respectively. Other diagnostic categories in indoor and outdoor cases respectively were mood disorders (21.08% and 18.95%), organic disorders

TABLE 1
REASON FOR REFFERALS AND FINAL DIAGNOSIS

	Indoor (n=185) N (%)	Outdoor (n=153) N (%)
(A) Reasons		
Unexplained physical symptoms	88 (47.57)	96 (62.75)
Frank psychiatric condition	47 (25.41)	32 (20.91)
Medico-legal (suicide)	31 (16.76)	2 (01.31)
Past psychiatric disorder	11 (05.94)	20 (13.07)
Others	8 (4.32)	3 (01.96)
(B) Diagnostic categories		
Neurotic, stress related, somatoform disorders	68 (36.76)	80 (52.29)
Mood disorders	39 (21.08)	29 (18.95)
Organic & substance use	49 (26.49)	10 (06.54)
Schizophrenia and non-affective psychosis	7 (03.78)	7 (04.57)
Others	22 (11.89)	27 (17.65)

TABLE 2
CATEGORIES OF NEUROTIC, STRESS RELATED AND SOMATOFORM DISORDERS

	Indoor (N=68) N (%)	Outdoor (N=80) N (%)
Somatoform disorders	35(51.47)	19(23.75)
Adjustment disorders	7(10.29)	34(42.50)
Other anxiety disorders	16(23.53)	8(10.00)
Dissociative (conversion)	8(11.77)	15(18.75)
Others	2(02.94)	4(05.00)

(26.49% and 6.54%), schizophrenia and non-affective psychosis (3.78% and 4.57%) and others (11.89% and 17.65%). When neurotic, stress related somatoform disorders were further categorised, it was found that somatoform disorders were 51.47% and 23.75%, adjustment disorders were 10.29% and 42.50%, other anxiety disorders were 23.53% and 10.00%, dissociative disorders were 11.77% and 18.75% and other disorders were 2.94% and 5.00% respectively in indoor and outdoor referrals

Associated physical illness was studied separately in indoor and outdoor referrals. It was found that 56.76% and 66.67% of the patients had no associated physical illness. Gastro-intestinal tract disorder was more commonly found in 7.03% and 9.80% patients. The next common associated physical illness was C.N.S. disease (7.03% and 7.19%) followed by C.V.S. disease (8.19% and 5.22%). Ill defined and other

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physical disorders were present in 26.48% and 19.60% of indoor and outdoor referral cases. Some patients had more than one associated physical illness. The rate of following psychiatric advice by referring specialist in indoor patients was 57.38% as compared to 91.73% in the outdoor patients.

DISCUSSION

Results suggested that in every category male patients were far in excess than female patients. Chen & Yeh (1996) in general hospital in Taiwan observed that more males (N=84) were referred as compared to females (N=79) whereas Creed et al. (1993) from UK have reported female preponderance in psychiatric referrals which supports above observation.

Age distribution showed that paediatric age group patients (upto 15 years age) were 7.57% from inpatient group and 16.99% from outpatients group. Presence of department of psychiatry in this college since 1974 could have contributed to this awareness. In both the groups, the patients belonging to age group between 16 years to 45 years together formed more than 70% of the total sample. Similar findings have been reported by Aghanwa et al. (1996) in a study from West African general hospital. They observed that most of the patients were having ages between 16 years and 45 years. Review article by Wallen et al. (1987), stated that 30% psychiatric referrals were aged above 65 years. Our study had only 5.40% and 0.65% patients above 65 years. The difference in finding could be because of lesser average life expectancy in India. Secondly, old age group patients may like to try alternate methods of treatment. In a new medical college hospital in Nepal, Jhingan (1997), reported similarly that only 8% patients were above the age of 60 years.

A large majority of the patients studied were educated. Higher level of education may be because Belgaum is having almost all types of schools, colleges and higher educational institutions for more than 30-35 years. Belgaum

was a well known educational centre even before Independence. K.L.E.S. hospital, being a private hospital, very large majority of patients was from paying group. Occupation was almost equally distributed in the following categories of businessmen, students, agriculturists and housewives. Thus even though exact social class was not determined, it can safely be said that majority of patients were middle and higher social class.

Surprisingly, there were very few (2.65%) patients having substance and alcohol dependence in this study because our hospital is a paying hospital the lower social class dependence patients did not reach this hospital. However, Canadian and West Indian studies by Michalon (1993) and Nehall and Beharry (1993) respectively reported 12% and 5% alcohol and substance dependence patients.

When referral pattern was studied, it was found that majority of the patients were from medicine and allied specialities. This findings is in agreement with that of Chen & Yeh (1996) from Taiwan hospital and Michalon (1993) from Canadian University hospital. In addition, somatisation disorder patients who came for the treatment of these 'perceived medical illness', go to medicine OPD and wards first and sensitized physicians picked up these cases and referred them. 35.29% outpatient psychiatric referrals were from neuro-medicine because headaches including tension headache, pseudo-seizures and any cognitive problem including pseudodementias were thought to be neurological diseases and attended neuro-medicine OPD first. This reason could be the cause of increased referral from neuro-medicine outpatient department. However indoor referrals from neuro-medicine were 6.48% because of selective admissions. Comparatively, referrals from nephrology and cardiology were few due to less awareness of liaison psychiatry. Referral rates from surgical units in Creed et al. (1993) study was 14% which is in agreement with this study having overall 15.65% referral from surgical and allied departments.

When reasons for referral were studied, it was found that in both indoor and outdoor groups, majority number of cases had unexplained physical symptoms for which they were sent to psychiatrist. In this study, 47.57% of indoor referrals and 62.75% of outdoor referrals had unexplained physical symptoms. This group also included those patients who had co-existing physical illness but symptoms were disproportionate to the physical condition. Creed *et al.* (1993) reported that about 30% of the psychiatric referral cases had unexplained physical symptoms. Many workers believe that somatisation is more common in developing countries, which could be the reason for high percentage of patients having unexplained physical symptoms in this study. Sartorius (1987) opined that high quality general medical care should include improved recognition and understanding of psychological aspect of physical illness including somatic presentation of psychiatric disorder. Next common reason for referral was frank psychiatric condition (indoor 25.41% and outdoor 20.91%). Creed *et al.*'s (1993) findings broadly agreed with our study's findings. Medico-legal reasons for referral were mostly attempted suicide comprising 16.76% and 1.31% of indoor and outdoor cases. But the rate was lower as compared to findings of Chen and Yeh (1986) where 33.14% patients had attempted suicide. Tay and Oh (1993) have also stated that attempted suicide was most common cause of referral in their study. Culturally 'suicide' is a taboo and is socially frowned upon. Many times suicide attempt is hidden from the therapist by the relatives. Apart from this, fear of police and the law also prevents people from disclosing attempted suicide or even bringing patients to the hospital for treatment. These could be the reasons for low percentage (combined rate 9.76%) of medico-legal reasons for referral in the present study. Other common reasons for referral were related to current or past frank psychiatric disorder which is understandable. Analysis of final diagnoses revealed that a large majority of the patients had neurotic, stress

related, somatoform disorders (indoor 36.76% and outdoor 52.29%) followed by mood disorders (indoor 21.08% and outdoor 18.95%) K.L.E.S. hospital being general hospital and referral hospital, it was expected that majority of patients will have body complaints. In a paying private hospital, there is a prompt chance of referral to psychiatry in a patient with a physical complaint without physical illness. This explains the predominance of neurotic, stress related, somatoform disorders forming altogether 45.54% - a large majority of the patients studies in this study. The review article by Wallen *et al.* (1987) found after compiling many studies that 51% patients belonged to neurosis (ICD-9 classification). Creed *et al.* (1993) found 48% patients having neurosis after using ICD-9 which is quite in agreement with our findings.

In case of indoor referrals organic disorder was present in 26.49% cases as compared to only 6.54% in case of outdoor patients. In a tertiary care hospital chronic, poor prognosis and problematic physical illness patients are expected to be admitted more frequently. In these cases organic psychiatric conditions would be higher. Therefore such discrepancies in the two groups is expected. Mood disorders were almost equally distributed in indoor (21.08%) and outdoor (18.95%) case referrals. Similarly, Poyhton (1988) and Creed *et al.* (1993) have reported that 24% and 24.5% had depression and 8% and 15% had adjustment reaction (as per ICD-9) respectively. In our study, schizophrenia and non-affective psychosis cases in both groups together were 4.31% which agrees with the findings of Neehall and Beharry (1993) that in their West Indian hospital study 5% had Schizophrenia. In our multispeciality general hospital sample, psychotic patients specially schizophrenics were expected to be less common. Further categorisation of neurotic, stress related, somatoform disorders revealed that in indoor and outdoor patients somatoform disorders were most frequent (51.47% and 23.75%). Occurrence of somatisation and its value in people in underdeveloped countries in

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getting medical attention quicker is already discussed. Our study did have 11.77% and 18.75% dissociative disorder cases in indoor and outdoor referrals. Even today in India it is common experience of psychiatrists that dissociative illness is frequent in psychiatric outpatient and in general practitioners clinic which is reflected in the present study.

Amongst associated physical illness, gastro-intestinal tract disorder was more commonly found in our patients. In our area people are generally more conscious about G.I.T. symptoms. Many have habit to blame 'gas' in their body for various complaints. This cultural belief could be responsible for many patients having associated G.I.T. complaints (indoor 7.03% and outdoor 9.80%). C.N.S. related complaints could be bordering to psychiatric complaints for which these patients were referred to the psychiatrist forming 7.03% and 7.19% referrals. In the present times, chest and heart diseases scare everyone whether a villager or a city dweller. These could be the reasons for next common associated physical illness viz. C.V.S. disease (8.19% and 5.22%).

The rate of following psychiatric advice by referring physician in indoor patients was much less (57.38%) as compared to the outdoor referrals. Usually incharge physician has less time for outpatient cases and hence psychiatric treatment advice was followed in 91.73% cases. In case of indoor referrals the incharge physicians were either not convinced or were not contacted to impress about the usefulness of psychiatric intervention in addition to their regular treatment. Perhaps it required more interaction and more discussion between the physicians and surgeons and psychiatric team member.

The shortcomings of this study are that it is a retrospective study based on case records. Moreover study was of limited period of one year only. In addition even though dropouts were not present in indoor referrals, the possible dropouts from outpatient referrals were excluded from the study. Therefore, findings of this study could only serve as guidelines for future study and definite conclusions should not be drawn.

More interaction and dialogue between psychiatric team and referring physician is a need. It is evident from this study that types of patients referred in multispeciality hospital are vastly different. Present post-graduate training in psychiatry and psychology is inadequate in this area.

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