Sir,

Naskar et al.\(^{1}\) demonstrated the importance of psychiatry in a general hospital setting. The authors highlighted the need for addressing the biopsychosocial problems while managing a psychiatric patient in an emergency. Also, it is really appreciable that the authors collected 1-year data and provided the percentage of psychiatric illness in the emergency setting of a general hospital. There are a few concerns that need to be addressed and clarified as the findings of this study could provide a false understanding of face value.

First, the authors described the concept of “Emergency Psychiatry” as the service provided with the intention of providing immediate therapeutic interventions for “any disturbance in thoughts, feelings, or actions” as per Kaplan and Sadock’s Synopsis of Psychiatry.\(^{2}\) We would like to disagree with the concept of emergency psychiatry illustrated in the article. Some Indian journals have described psychiatric emergency as an acute disturbance in thought, behavior, or mood of the patient, which, if untreated, may lead to harm, either to self or others.\(^{3,4}\) The same has been stated in international publications about the psychiatric emergency.\(^{5}\) Hence, the concept of harm to others or self, if untreated, is very important in understanding the concept of emergency psychiatry and providing care for patients in this setting.

Naskar et al.\(^{1}\) demonstrated “medically unexplained symptoms” (MUS) to be the most common presenting symptom (47.7%), which gives a false understanding that these are psychiatric emergencies. We agree that patients would be distressed due to the symptoms, but any harm to self or others is unlikely if not treated immediately. Many of these patients could have been redirected to the psychiatry outpatient settings, as this would save the effort and time of the resident or physician posted in the emergency department. The emergency resident could use this time for detailed assessment of patients with significant violence or self-harm behavior. This would also ensure comprehensive care for the patients with MUS in the outpatient setting and would also give the treating team an opportunity to explore the biopsychosocial context involved in the evolution of the MUS. Our reason to state the above point is that the readers should not mistake the concept of psychiatric emergency as any patient approaching the emergency ward.

The authors state that many previous studies, such as Kelkar et al.\(^{6}\) and Bhatia et al.,\(^{7}\) have demonstrated similar findings, which we agree with. But those were published between 1980 and 1990, and there is more awareness among psychiatrists and physicians in recent times about emergencies in psychiatry.\(^{8}\) There are many recent works on emergency psychiatry presentations which state that schizophrenia, substance use disorders, mania, and dissociative symptoms are the common presenting illnesses at the emergency department, rather than the somatoform disorder.\(^{9,12}\) These recent works on psychiatric emergency clearly state a presentation and profile of the psychiatric emergency patients, which differ largely from the profile stated in the article by Naskar et al.\(^{1}\)

The description of “Distribution of the various reasons for referral from various departments,” in Naskar et al.\(^{1}\) states that 22.38% of patients referred by other departments had a previous psychiatric illness.\(^{11}\) It would have been more informative if the authors had provided the reason for referral to the psychiatrist, as there is a possibility that the readers may misinterpret that these patients would have been sent for just repeating the prescriptions of psychotropics since they are in the hospital for other medical illnesses. It is a collaborative and holistic approach, but considering such cases as a psychiatric emergency might be misleading. Such situations would naturally tend to underestimate the prevalence of actual psychiatric emergencies such as violence, suicidal attempt or substance withdrawal, overdose/drug toxicities related to psychotropics, neuroleptic malignant syndrome, and catatonia\(^{3}\) and might lead to a false interpretation of emergency psychiatry by the readers.

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Kumar T. Santhosh, Arun Enara, Hari H. Suchandra, Guru S. Gowda

Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bengaluru, Karnataka, India

Address for correspondence: Dr. Guru S. Gowda
Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bengaluru - 560 029, Karnataka, India.
E-mail: drgsgowda@gmail.com

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Comments on “How does India Decide Insanity Pleas? A Review of High Court Judgments in the Past Decade”

Sir,
Ramamurthy et al. examined factors associated with the outcome of an insanity plea in a convenience sample, based on data extracted from the websites of 23 High Courts in India. They concluded that the “success rate of insanity plea in Indian high courts is a modest 17.6% and, lower court verdict, documentary proof of mental illness and psychiatrist’s opinion were associated with the success of insanity pleas”. In this letter, we raise concerns regarding their inferences.

The authors examined the relationship between the verdict of the lower court, documentary proof of mental illness, psychiatrist’s opinion, and High Court verdict using Pearson’s Chi-square test of independence. Pearson’s Chi-square test is a non-parametric test...