ASSESSMENT OF FUNCTIONING OF NON-PSYCHIATRIC PHYSICIANS IN THE MANAGEMENT OF PSYCHIATRIC EMERGENCIES

ADITYANJEE¹
N. N. WIG²
D. MOHAN³

The literature from India is conspicuous by paucity of well-planned studies on psychiatric emergencies. Trivedi and Gupta (1982) in a retrospective study found that 2.9% of the total patients coming to emergency room of a general hospital were diagnosed to be having psychiatric illness. In a prospective study by Kelkar et al (1982) the figure was 5.4%. However, both of these studies have not addressed the issue of management of psychiatric emergencies by non-psychiatric physicians. We studied this aspect of psychiatric emergencies in a descriptive study of four months duration conducted at the Casualty Department of All-India Institute of Medical Sciences, New Delhi.

Material and Methods

Using a screening proforma which included information about the nature of the problem, diagnosis and management given by the non-psychiatric medical staff assessment was done for total 167 cases. The resident-investigator personally observed the functioning of non-psychiatric physicians in the management of psychiatric emergencies.

Results

We observed that the average time spent by the casualty medical staff on each case of psychiatric emergencies for history-taking, mental status examination, physical examination and actual treatment, was only four minutes (Range 1-21 min).

Approximately 13% of cases were not seen at all (less than one minute) and were referred to psychiatry resident straight away. Identificational inaccuracies were seen in 13.7% of cases (false positive 5.4% and false negative in 8.4%). In approximately half of the cases the diagnosis made by non-psychiatric physicians were in the right direction. However in approximately 27% of cases, though the psychiatric illness had been indentified by non-psychiatric physicians, they were either reluctant or unable to make any diagnosis. This reluctance on their part is probably due to lack of proper training in psychiatry, hence the use of pejorative terms like functional complaints, psychiatric problem or functional overlay in approximately 14% of cases. In 20% cases psychiatric diagnosis were grossly wrong. This category included those patients also in which the psychiatric illness had been missed. In 69% of cases the non-psychiatric physicians were either unable or reluctant to suggest any immediate management for the cases in the emergency room and tended to refer these cases to the psychiatry resident for purpose of diagnosis and management. This reluctance on the part of casualty medical staff to

¹ Senior Resident.
² Formerly Head of the Department.
³ Associate Professor and Head.

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give any immediate management to psychiatric emergencies can easily be attributed to inadequate knowledge and training in psychiatry.

**Discussion**

These observed deficiencies originate from a basic lack of understanding of psychiatry as a specialty and reflect poor didactic teaching and practical training in psychiatry of undergraduate medical students. In fact, it has been officially acknowledged that during his training the doctor, both at undergraduate level and even later on, receives almost no knowledge and certainly no practical skill in psychiatry and mental health though this is an essential element in his future daily practice (Maheshwari 1979). According to recent Medical Council of India's rules the obligatory psychiatric training during 5 years' undergraduate career is only two weeks in a psychiatric center, which is usually a distant mental hospital. The mean hours devoted to psychiatry and behavioural sciences during 5 years are approximately 40, inclusive of clinical clerkship.

Compared to this in U.S., a survey done in 1966 revealed that the time devoted to psychiatry and behavioural sciences in the medical school curriculum had increased up to 458 hours in 1966 from an average of 27 hours in 1914 (Langsley et al 1977).

Considering these facts, it becomes evident that there is an urgent need to restructure the undergraduate medical curriculum, more so because there is a shortage of trained psychiatrists in our country (National Mental Health Programme, 1982) and non-psychiatric physicians are being increasingly called to look after emotional and psychological problems.

There is a good amount of evidence to say that almost 30% of all patients who seek help in general health services, are going there for emotional and psychosocial problems (National Mental Health Programme 1982).

Therefore, from the point of view of planning for mental health services in future and keeping in view the Alma Atadeclaration of 1978, it becomes imperative that the undergraduate medical curriculum should be restructured giving more opportunities for developing practical skills in dealing with patients with mental health problems.

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