Current challenges in practice of psychiatry in India

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Honorable immediate past President Dr. T.V. Asokan, members of the Executive Committee, all the zonal, state, regional and local branch office bearers of the IPS and above all most revered life fellows, fellows and members of the IPS.

On the eve of my presidency, IPS is at its most glorious era. Two of alumni have held or are holding Presidentship of international organizations, an active member is the secretary general of the WPA, four of our members are holding high offices at the WPA and one IPS member has been bestowed with a prestigious international award.

First of all I am assuming office when Dr. Asokan with his vision, modesty and skill has led the IPS to a position which makes my task easier for the coming year.

I have chosen my topic as current challenges in practice of psychiatry in India because that defines my life of last 38 years as a psychiatrist and as an individual. What better way to describe my expertise and experience than this, which may guide younger colleagues in practice of psychiatry.

MY EARLY DAYS

I entered this magnificent branch of medicine as a postgraduate student in 1974 which was the era of Diagnostic and Statistical Manual of Mental Disorders, Second Edition (DSM II) and International Classification of Diseases 9 (ICD 9). Mental illness was understood and interpreted in terms of psychodynamics of the symptoms. My interest in psychodynamic theory did not help me to convert it into any therapeutic success. However, it helped me to nurture my interest in theatre. As a physician then attached to Film and Television Institute of India at Pune, I had an opportunity to associate and interact with many theater and film personalities such as Girish Karnad, Dr. Jabbar Patel, Naseeruddin Shah, Satish Alekar and Dr. Mohan Agashe. This association helped me immensely in my practice. I acquired better communication skills and learned to apply it effectively to psychoeducate patients and caregivers. The enhanced communication skills helped me not only in my doctor-patient relationship but also to communicate effectively with fellow professionals.

However, that was not a substitute for a search for better understanding and improved treatment skills. My seniors and colleagues would often come up with innovative ideas, which contributed to improved patient care.

NEW CHALLENGES

The field of psychiatry has since witnessed major strides. We now have adequate data to claim that mental illness is a disease of the brain. Neuroimaging and success of pharmacology raised hopes of a significant breakthrough which is yet to become a reality.

Today, we face multiple challenges and criticism from within (and outside the field of medicine in general and psychiatry, in particular) that threaten the practice of psychiatry.

The new mental health legislation is awaiting Parliament’s approval. My predecessors have made relentless efforts to get the voice of IPS reaches the lawmakers. Insurance companies do not acknowledge the needs of the mentally ill. The trend is changing but yet a lot more needs to be done.

Closer to our clinical needs, DSM V is published. It was launched by our own alumni Dr. Dilip Jeste. Mastering
the new classification will require much learning and re-orientation. ICD 11 is likely to be published in 2017. That will need some more new learning for all of us. Criticism against professionalism and alleged moral corruption by doctors is now being published in the world media and scientific literature. At a global level, the graph curves for cure, life expectancy and quality of life for patients of many serious and potentially life-threatening illnesses have shown major trend for the better. However the prevalence, morbidity and quality of life curves for mental illness have not shown any such bend for the better.

Suicide rates, disability rates and eventual improvement rates of mental illness have not shown any significant improvement in the past three decades. Dr. Thomas Insel mentioned at his presentation at the APA last year (and I quote) “that the diagnosis of mental illness is by symptom cluster, etiology is presumptive and treatment is by trial and error and most of all there is no accountability.” Doctors blame the administrators, administrators blame the governing policies and government blames the medical practitioners, thus completing the circle with advantage to none.

Humans now live longer. The current social structure (with disintegrating joint families) is not geared to deal with the rise in the ageing population. Human genome project failed to contribute to the improved understanding of mental illness. Psycho-pharmacology has a useful yet controversial role. Because of treatment emergent adverse effects there are certain reservations regarding prescribing psychotropic drugs as a first line of treatment. All this adds to the ambivalence against psychiatry.

There appears to be a paradigm shift from the focus on morbidities of mental health to propagating positive mental health. This innovative concept of positive psychiatry is now receiving global accolades.

PRACTICE OF PSYCHIATRY

Psychiatry clinic and hospital
Twenty-first century has witnessed the emergence of corporate hospitals. I work in a multi-disciplinary trust hospital in Pune. From the beginning, I have been fortunate to work in a group practice with other mental health professionals such as other psychiatrist colleagues, psychologists, social workers, nurses and technicians. The advantage is that of more effective management of all types of psychiatric disorders with the team work approach.

Currently Poona Hospital and Research Centre has cardiology, neurology and intensive care services available 24/7. This has helped me to manage complicated patients with medical co-morbidities. Furthermore, any anesthia related complication during electroconvulsive therapy (ECT) can be tackled successfully.

I wish to highlight the usefulness of ECT in our clinical practice.

We have a special theatre to administer ECT which is adjacent to my chamber. In my opinion, ECT is extremely cost effective and beneficial treatment to a variety of psychiatric disorders. Along with standard indications such as severe or suicidal depression, psychotic depression, catatonic states in psychoses and mood disorders, I have found ECT effective in acute mania and schizophrenia.

Phutane et al.[3] have reported that in a survey of the practice of ECT in teaching hospitals in India, schizophrenia is the most common diagnosis for which patients receive ECT. Further, they found that in schizophrenia the most common indication was augmentation of pharmacotherapy.

Some of the other unusual conditions where I found ECT was useful are the following:

- Resistant conversion symptoms
- Disruptive behavior symptoms in mentally retarded individual
- Severe psychiatric co-morbidity in Parkinson’s disease
- Severe behavioral and psychological symptoms in dementia.

Even though these are isolated case reports, which I have not published, similar findings have been reported elsewhere.

For example in a retrospective, systematic chart review in Maclean Hospital, USA the authors identified 16 patients who had received ECT for agitation and aggression in dementia. The mean age was 67 years, and they had received a mean of 9 bilateral ECT. All (except one) showed significant improvement and post ECT confusion was severe in only two patients.[2]

In the opinion of many psychiatrists in India and abroad, ECT is being underused in practice. Is there a need to promote more invasive procedures like deep brain stimulation and vagus nerve stimulation while keeping ECT in a cupboard?

ECT is completely safe even in elderly and those with medical co-morbidity, provided the infrastructure is well-equipped. The complications with ECT are few and relatively uncommon.

We have reported a case of “lorazepam-induced prolonged apnea after ECT-induced prolonged seizure” in Indian Journal of Psychiatry.[3]

Ms. R, a 20-year-old 45 kg woman with a DSM IV diagnosis of schizophreniform psychosis received ECT thrice weekly. During the 6th ECT, she had prolonged seizure, and the
anesthetist injected intravenous lorazepam 4 mg, which was repeated again after 1 min to terminate the seizure. The seizure disappeared, but spontaneous respiration did not resume. She was shifted to Intensive Care Unit (ICU) and put on a ventilator. She was successfully weaned off the ventilator next day, and she improved progressively. The only explanation for prolonged apnea was benzodiazepine-induced respiratory depression.

Emergency room physicians have standard operating procedures (SOPs) for patients who are brought in an unconscious state. These are a set of practices that are required to be initiated and followed when specific circumstances arise. Similarly, SOPs in psychiatry are required for special settings such as in the ECT unit. Here, SOPs are required not only for routines related to consenting and investigating fitness for ECT but also for emergency situations that may arise, as in the case discussed earlier.[4]

Pharmacotherapy

The advances in psychiatry were propelled by the discovery of new atypical antipsychotic drugs as well as newer antidepressants, beginning with selective serotonin reuptake inhibitors.

However, except for the difference in adverse effect profile the current research has not established any significant superiority in their efficacy over previously used drugs such as typical antipsychotics and tricyclic or heterocyclic antidepressants. Choice of drug is essentially the treating clinician's prerogative.

Though clozapine was described as a dirty drug for its extensive neuroreceptor affinity, the drug has proved to be a class apart. I use it extensively. Furthermore, I use clozapine if a course of ECT and other antipsychotics have not produced a satisfactory response.

In a recent study on the attitude of practicing psychiatrists toward clozapine, the authors reported surprising results with 64% psychiatrists opting to combine two antipsychotics rather than go for clozapine, in spite of treatment guidelines recommending otherwise.

Clozapine’s use mandates blood monitoring which may perhaps be seen as a barrier against its more frequent use, even though the incidence of agranulocytosis is now reported to be as low as 0.38%.[5]

Nevertheless, statistics does not count when the adverse event actually occurs in an individual.

I cite a case to emphasize the importance of caution.

A 45-year-old female patient of chronic schizophrenia was started on clozapine and showed excellent response on a daily dose of 300 mg built over time. The blood count during first 3 months was normal. One day she complained of fever, tachycardia and mild confusion. Her blood count was repeated which showed total white blood cell (WBC) count of 2000. Clozapine was stopped. She was admitted and referred to a hematologist for treatment. However, on 4th day the total WBC count dropped down further to 100. Even though I was feeling anxious, the hematologist assured me that she will recover. Similarly, I counselled the patient’s family by my twice daily hospital visits. She was discharged after 10 days and was completely well.

There are few studies on clozapine in the Indian subcontinent, and most of these are case reports. Among them was a case of a young patient who developed total absence of granulocytes during the 4th month of treatment with clozapine and who was successfully treated with granulocyte colony-stimulating factor.[6]

Personally, this was a lesson in crisis management and the role of consultation-liaison psychiatrist. It reinforced the relevance of continuous interaction with other specialists and the patient’s family during periods of spontaneous and iatrogenic crisis. It also brought home the point that professionalism mandates leadership attributes, initiative and acceptance of responsibilities without preoccupation with fears of legal implication and adverse publicity.

Consultation-liaison psychiatry as a superspecialty is the area of clinical psychiatry that encompasses clinical, teaching and research activities of psychiatrists and allied mental health professionals of a general hospital.[7] Consultation refers to the provision of expert opinion and liaison refers to linking up of groups for the purpose of effective collaboration. Hence for consultation to be most effective, the consultant psychiatrist needs to have personal contact with both the patient (including his family) and the specialists.

Where pharmacotherapy is concerned what is the current prescription pattern of psychiatrist in our country?

Grover et al.[8] conducted the Indian Psychiatric Society multicentric study which aimed to assess the first prescription handed over to psychiatrically ill patients whenever they contact a psychiatrist. Escitalopram and sertraline are the most commonly prescribed anti-depressants, olanzapine and risperidone are the most commonly prescribed antipsychotics and clonazepam are the most commonly prescribed benzodiazepine. There are very few variations in prescription patterns across various centers in the country.

It is important to emphasize the efficacy of older antipsychotics as well as antidepressants in treatment resistant states. For example, short-term use of haloperidol and imipramine in appropriate conditions can be useful though currently there are not many systematic studies to support it.
Similarly, use of lithium needs to be put in a proper perspective. I have used lithium extensively in bipolar disorders (both mania and depression) and in schizoaffective disorder.

Much like clozapine, lithium monitoring should be routinely followed but many patients, as well as doctors, fail to comply.

Even though a patient may be on low or normal doses of lithium, it is important to do periodic lithium and renal function assessments.

In practice, therefore, we are likely to come across unexpected and unusual side effects or adverse drug reactions (ADRs) of psychotropic drugs. These must be reported.

It is important for psychiatrists to be aware of the process involved in identifying and reporting ADRs, especially those that are new or unrecognized. These processes form the basis for the medical discipline of pharmacovigilance. Any psychiatrist can report adverse effects. A standard form is available which can be downloaded from CDSCO website. The positive effects of pharmacovigilance in psychiatry are the obvious benefits both to the patient and to the clinician.

**Legal and media perspectives**

An emerging challenge to every clinician and psychiatrist is the risk of being subjected to legal action. This risk is now a reality. At this time and juncture, surgical branches and gynecologists are at a higher risk than the psychiatrist.

In my practice of over three decades, I was fortunate not to face any medico-legal action. However, I had to face one enquiry by MMC. This was initiated by my female patient who was a diagnosed case of delusional disorder. She alleged that I had issued a false certificate to prove her being mentally ill. Actually, an admission note was given as she was nonadherent to treatment. Naturally, this enquiry was suspended.

Unexpected complications, even death, can occur in patients under our treatment.

A 60-year-old male patient with alcohol-induced psychotic disorder was brought to Poona hospital for treatment after a gap of 10 years. He was found to have breathlessness and hence referred to a cardiologist. I did not see the patient till the next day morning when he was brought dead to the hospital. On enquiry, I found that his computed tomography thorax done on the previous day had showed presence of pulmonary embolism, but the patient did not collect the report and went home without informing anyone. I did not involve anyone in blame game and talked to the family and signed the death certificate.

It is not unusual for a family or friends to become disturbed or even violent under such circumstances, and the doctor may even be assaulted. In Maharashtra, there is a new act which has been in force now to prevent such occurrences by a penalty of up to Rs. 50,000 and/or imprisonment. This offense of assaulting a medical or nursing staff is a non-bailable offence.

I have been called as a witness in over 50 plus occasions, most often to depose in cases of marital discord over past mental illness in one of the spouses. I have never avoided attending court even though it is time-consuming and fruitless. I have found that if you carry patient’s record and give your deposition sincerely, most of the judges respect you and follow your advice. I would recommend you all to keep proper documentation and do not try to avoid a court appearance or even avoid treatment of cases where this is likely.

Needless to remind you all that photocopy of the case records and/or a certificate should not be given to anyone except the patient or the courts.

The way we practice has already been affected since the introduction of Consumer Protection Act. Going further, our practice is likely to be dictated by number of new acts or laws pertaining to doctors. E.g., introduction of mental health care bill in the present format is likely to make treatment of uncooperative patients and their admission procedure more difficult. There is an apprehension (probably justified) that the stigma of visiting a psychiatric clinic or hospital will increase.

The Clinical Establishment Act 2010 has been passed by the cabinet. This lays down basic criteria for operationalizing clinics, hospitals, laboratories, etc., What would this mean? Among other objections by the medical fraternity, this would increase the cost of running a clinic or hospital and in turn, make healthcare more expensive. The only silver lining is that each state is free to modify it.

In this age of media hype and trial by media, doctors need to be media savvy. This involves giving quick interviews on the telephone to reporters about any incident which has occurred, writing informative articles in newspaper and magazine and promoting mental health by participating in public talks and debates on TV or stage. Recently, in the press, we are constantly getting negative publicity about so-called unethical and corrupt practices. How do we set these things right? This is another challenge which we need to take up.

**PSYCHIATRIC ASSOCIATIONS**

My maximum participation has been with the city level Poona Psychiatrists’ Association, which is one of the oldest psychiatric associations in the country. We have our regular monthly meetings with different case conferences, symposia as well as new drug launches. The Poona Psychiatrists’
Association trained me to deliver talks, to assume leadership roles and to sharpen presentation skills.

It is my earnest request to young psychiatrists to participate in all local and zonal activities which will also help in your continued professional development.

I believe this helps in bonding with your colleagues and reduces professional jealousy and unethical competition. Most importantly, it will go a long way toward making Indian Psychiatric Society a strong force and a united professional body which can determine the mental health policies in this country.

MARKET FORCES

It is an undeniable fact that doctors in practice are being lured by variable market forces under the guise of sponsorship to various meetings in India and abroad as well as offering expensive gifts and entertainment.

According to current Medical Council of India recommendations, this is unethical. Such favors adversely affect prescription patterns and ultimately patient care. In the West, already guidelines are in place regarding pharma-doctor relationship and strict punishment can be given to doctors who violate these guidelines. Even in India, there are instances where registration of doctors has been suspended for periods varying from 6 months to 3 years.

A copy-cat acceptance of unethical enticement could endanger individual career, social repute and personal credibility. It is time now for us to accept financial responsibility for our professional development and refuse the temptations which are on offer.

PEEP INTO FUTURE OF PSYCHIATRY

The field of psychiatry is still growing. One of them is the increase in postgraduate seats in DPM, M.D. and D.N.B. Two super specialty courses in psychiatry were started, e.g. DM in geriatric mental health and DM in child and adolescent psychiatry. Among other courses awaiting approval is DM in addiction medicine. Perhaps some of the younger psychiatrists will choose their way ahead in terms of further specialization. This will offer additional expertise to our patients.

We the IPS members are all busy practitioners. Most of our professional time is spent in examination, diagnosis and treatment of patients. Few among us are able to spend time in meticulous record keeping, studying the data or carrying out original research. It is indeed unfortunate that the wealth of clinical data have remained underutilized. It is ironical that some of the significant contributors of original research are of Indian origin but have blossomed overseas.

MY MISSION AND VISION FOR THE ENSUING YEAR

During my tenure, I propose to give impetus to an initiative of the IPS. I propose to explore the hidden talents of Indian Psychiatry and harness their energy through various IPS committees especially those that involve research, planning and coordination. I am also exploring the possibility of encouraging IPS members’ data bank of unusual clinical cases in practice. This might be a rich source of research, similar to APA’s data bank.

Now an important step has been taken by the IPS that a state of the art clinic-based software program has been offered to every member of the IPS entirely free of cost. At the IPS council, we visualize and trust that this activity will encourage and establish Indian norms even as it would provide an opportunity to generate “make in India” original research. The obvious advantage would be to share clinical experience between members in practice and facilitate learning.

Ladies and gentlemen, I have sat through long winded Presidential address in India and abroad. I am aware of their sequel.

Can anyone list the notable achievements of the Indian Psychiatric Society in the past 50 years? This question was raised in the e-ips and has generated much debate. I am sure each of you have different opinions. In response, I have to add that if we believe we are what make the IPS, then your achievements are those of the IPS! As was famously said "do not expect what the IPS can do for you, rather what you can do for IPS.”

Ambitions know no bounds, aspirations are many. May the God support us and promote our growth. The collective strength of the IPS is indeed a force to be that can rub shoulders with the best in the world.

Ladies and gentlemen, let us stand united in the singular task of setting up a platform that will be the envy of all. God bless the IPS and guide us to great heights of achievements!

Long live IPS!

ACKNOWLEDGMENTS

We would like to acknowledge Dr. Vihang Vahia, Dr. Dattatreya Dhavale, Dr. Sujala Watve and Dr. Mohan Agashe.

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