PSYCHIATRIC PATIENTS IN MEDICAL OPDs: A PHYSICIANS' DILEMMA

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ABSTRACT

Aim:

The aim of this article is to categorically document a neglected aspect of medical care: the practise of a large number of psychiatric patients claiming to have medical issues, reporting to medical outpatient departments (OPDs) and burdening an already overburdened team of health are given especially doctors.

Setting:

Medical OPD, Department of Medicine UnitII (Ward 6), Jinnah Postgraduate Medical Centre (JPMC), Karachi.

Materials& Method:

A total of 1570 consecutive patients were enrolled in this study after following a strict inclusion and exclusion criteria, over a period of 6 months from 1st January 2016 - 30th June, 2016 . The inclusion criteria consisted of consenting adults of all ages and gender, regardless of socio-economic and educational status. Exclusion criteria consisted of patients with frank psychosis and (proven and/or suspected) major organic diseases.

Results:

Out of 1570 patients that were enrolled in this study, 1049 (63.5%) patients met the inclusion criteria, whereas the remaining 521(36.5%) patients were seen to be suffering from some major medical illness. Of the former, 357 patients (35%) had Irritable Bowel Syndrome (IBS) , 275 patients (27%) hadsomatization disorder, 204 patients (20%) had depression, 122 patients (12%) had hypochondriasis, 71 patients (7%) had conversion disorder and 20 patients (3%) were found to haveglobushystericus. The study revealed no significant impact of age, gender, socioeconomicoreducation status upon the results.

Conclusion:

The results of this study were consistent with the fact that psychiatric illness constitutes a significant bulk of medical suffering in humans. This fact was found to be reflected over and over again throughout the six months of this study in medical OPDs where such mental disorders are commonly seen and addressed.It can therefore be inferred that psychiatric illnesses do in fact present themselves very commonly in medical OPDs and prove to be a dilemma for consulting physicians regarding how they should be approached and subsequently handled.

Keywords:

Irritable Bowel Syndrome (IBS),somatization disorder, depression, hypochondriasis, conversion disorder, globus hystericus.

INTRODUCTION

In general, there are a few queries made by patients in outpatient departments (OPDs) which if not addressed properly, result in patients visiting several doctors again and again in order to get a distinct diagnosis; a diagnosis which is mostly self anticipated by patients themselves[1]. These queries being non specific, and more often than not undocumented and lacking any evidence, usually fetch a vague or unsatisfactory answer from the physician and ultimately lead to a hostile relationship between the doctors and such patients and their relatives. These non specific questions which understandably have no satisfactory answers include (but are not restricted to) the following:

- Fever (never documented by patients themselves) [2]
- Migraine, generally as a status symbol
- Edema of the feet and even generalized edema
- Bloating
- Feeling upset or having a low mood (20%) [3,4]
- Indigestion
- Headaches
- Dizziness, generally due to hypertension or hypotension
- Self explained low blood sugar
- Easy fatiguability

- Self explained high and low blood pressure as symptoms.

- Vague chest pain mostly pointing towards cardiac pain.

- Generalized body ache.

By presenting in this manner, they (patients and their attendants) often want to dictate the terms of the consultation with respect to diagnosis. They also tend to suggest which investigations should be advised and what treatment should be offered. This is a very tricky and admittedly difficult situation, because any attempt by the physicians to adopt a blunt or strict approach can be a source of uneasiness, even major conflict. On the other hand, conceding to the patients will or dictation (in terms of their management) can result in a huge burden on health resources, for example: unnecessary laboratory services and treatment.[3]Such situations lead to a standstill of sorts, where the physicians are often unwilling to cater to fanciful whims while the patients are unwilling to budge on the preconceived notions about their (suspected) illness. As a result,a feeling of discontent towards thedoctor, their parent instituteand often times the entire system develops which, however uncalled for, reflects negatively upon the field of medicine.

It therefore comes as no surprise that a carefully tactical yet individualized approach is needed to finesse such situations and one has to camouflage the truth in a very diplomatic way. These patients, whose number isconsiderably large, want and often end up acquiring the diagnosis, diagnostic tests and eventreatment of their liking. This happens because of several reasons some of which include a lack of knowledge and thus incompetency of doctors, overworked physicians who have to address a staggering bulk of patients (as is evident in government set ups), and sometimes the commercial approach of private institutes obsessed with 'money making'.

Ultimately, all such needless diagnostic tests and often times unnecessary management bears no fruit whatsoever but instead simply becomes a source of tension, hostility and frustration for both parties, especially doctors.[5]These unexplained symptoms may be seen in distinct disorders, alone or in combination, [6]yet have no proven organic basis.

Briefly discussed below are the six major medical illnesses which patients enrolled in this study were found to be suffering from[7]:

Irritable Bowel Syndrome: Although IBS is easy to diagnose, it is, however, difficult to treat and even difficult to convey the diagnosis to the patient. This is because they tend to press for investigations and treatment of their choice, and if not satisfactorily entertained, become annoyed and sometimes aggressive with the physician and even the institute.[8]

Somatization disorder:Patients present with a distinct focus on a particular symptom or symptoms such as pain and weakness all over the body [9]. These patients are generally resistant to analgesics.[10]

Depression may occur in isolation and/or in combination with other disorders. Patients present with vague weakness and pain, specifically at the inter-scapular region the latter is universally the most common symtoms.[10,11]

Hypochondriasis is a condition in which a very sensitive patient gives a long history of gastrointestinal complaints especially pain in right and/or left hypochondrium dating back several years. These patients have a constant fear that they are suffering from some grave disease.[7]

Globus Hystericus difficulty in swallowing. Patients believe that they have a mass in the throat or neck, etc.[12]

Conversion Disorders are a group of disorders in which patients simulate a grave disease with the intention of seeking attention and achieving relaxation and relief from their daily responsibilities.[13]

These disorders can occur alone and / or in various combinations. They are usually seen in the most discontent patients. Such patients usually have a prolonged history of sinister symptoms and multiple hospital and doctor visits. They also carry with them thick files of reports of various investigations.[14]

MATERIAL & METHODS

The study was carried out in General Medicine Ward-6, Medical Unit-II, Jinnah Post Graduate Centre, Karachi for a time period of six months.JPMC is the largest tertiary medical care facility in the metropolis of Karachi and was chosen as the centre for this study due to the largest inflow of patients in medical OPDs in the city. A total of 1,570 consecutive patients were enrolled after following a strict inclusion and exclusion criteria. Male and female adults of all ages regardless of their socio-economic and education status were included. The exclusion criteria consisted of patients suffering from frank psychosis and major organic diseases.

RESULTS

Different categories of psychiatric patients who were diagnosed in medical outpatient department (OPDs). Of such, Irritable Bowel Syndrome (IBS) somatization disorder and depression were the three most common disorders presented, and they occurred both in isolation as well as in various

combinations (see Table.1). No major differences related to age were noted. However, the results clearly demonstrated that female patients, patients belonging to a low socio-economic statusand patients with little to no education were most commonly affected (Tables.2 &3)..

Table 1: Number and percentage of patients in Medical OPD with psychiatric disorders (n =1049):

	No. of Patients	Percentage
IBS	357	34.0
Somatized Anxiety	275	26.2
Depression	204	19.4
Hypochondarism	122	11.6
Conversion Disorder	71	6.7
GlobusHystericus	20	1.9
Total	1049	104

Table 2: Age Distribution in Psychiatric patients (n= 1049)

Age Range in Years	Number	%
14-30	320	30.5
30-35	235	22.4
35-49	196	18.6
> 50	298	28.4

Table 3: Demographics of psychiatric patients in Medical OPD (n =1049)

		Number	%
Gender	Male	441	42
	Female	608	58
Education	Graduate	383	36.5
	Non-Graduate	666	63.4
Monthly Income	< 25000	686	65.3
	> 25000	363	34.60

DISCUSSION

It was observed that 64% patients who presented in Medical OPD actually had psychiatric ailments. Other studies have also documented that 50-70% of all patients in medical OPDs actually suffer from psychiatric ailments. [15,16,17]. In fact only 5-10% of psychiatric illness patients rach the psychiatric department. Like our study, other studies commonly affected[17]. Major depression was seen in 20%, which is also supported by other lstudies[10,11]. Anxiety was documented in 33% of our patients which is supported by other published studies[8,9].

Mental disorders are encountered commonly in practice. They may be primary or associated with co-morbidities[19]. It is estimated that 30% people either have psychiatric problems or substance abuse disorders [20,21]. In such cases the quality of life care can be assessed and advised based on disease seriousness [20] but only in the proper psychiatric facility. The fact that patients with a poor socio-economic status were more commonly affected points towards a clear root cause behind such inferential statistics and this can be evaluated and studied in depth in future studies.

Mental disorders consume approximately 4-10 fold of health resources (of the entire population) around the world.[22] A comprehensive psychiatric evaluation is therefore essential as most of the so-called psychiatric patients actually have non-specific symptoms.

The Diagnostic and Statistical Manuel (DSM), of Mental Health Disorders is easily available as well asPRIME-MD and a number of other diagnostic tools and questionnaires for assessment and

diagnosis of psychiatric illness. The use of such tools however, is not a part of common practicebecause patients tend to easily get offended by questionnaires asking leading or sensitive questions[23,24,25]

Suffice to say, patients with psychiatric illnesses visiting medical OPDs pose as a true test for both physicians and the system. The unnecessary utilisation of health services by these patients is a burden[26]. Also, the practice of directly or indirectly labelling a presenting complaint as a non-emergency and not of consequence has been shown to instigate hostility towards the physicians because in most cases, patients (and their overly concerned attendants) simply refuse to accept this is so, leading to the provision of an incentive for the patients to argue and opt for hostile behaviour which then proves to hinder doctors from effectively managing other patients.Such scenarios call for a need of proper counselling of the physicians and this again, is an avenue which can be further explored in future studies. This remain a major concern, that hostility on part of patient and their relatives on non issue and source of anxiety for physician atleast, their heart tend to best faster in these situation. The reason why these patients are in medical OPD , can be social stigma of being psychiatric patient, back of proper screening clinics, patient looking for excuse for their short comings or responsibilities etc.[27]

CONCLUSION

Patients coming to Medical OPDs with psychiatric illnesses are a challenge for the system and doctors. They are very difficult to diagnose (wrong persons in the wrong place) . They generally have attitude problem and want everything (i.e diagnosis, management and counseling) according to their terms. They tend to utililize a significant chunk of the health services and resources quite unnecessarily. They challenge primary physicians and the competency and ability of the physicians to differentiate patients with organic diseases from them. All this results in unfair and unnecessary usage of hospital resources which ultimately is a burden on the doctors , hospital and community. The doctors are caught in a difficult and unfortunate situation which is a source of frustration, helplessness and leads to grievances. Overall environment becomes hostile the competency and confidence of physicians is challenged at every level and they suffer from undue stress

References:

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