PSYCHIATRIC REFERRALS FROM MEDICAL AND SURGICAL WARDS

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THE practice of psychiatry in general hospitals is increasing and some of the problems it raises have been widely discussed. Many administrative questions have received close attention (Bennett *et al.*, 1956; Smith, 1961) and the advantage to psychiatric patients of having readily available medical, surgical and laboratory facilities has been clearly seen (Gillies, 1959). It has been shown, too, that patients with mental illness can be admitted to beds in medical wards and be treated there successfully (Brook and Stafford-Clark, 1961). On the other hand, much less attention has been given to the psychiatric requirements of the general hospital itself, and there is very little information about the use that physicians, surgeons and specialists are likely to make of a psychiatric service for their own in-patients. Studies of psychiatric morbidity among general ward patients (Mittelmann *et al.*, 1945; Zwerling *et al.*, 1955) are of great interest, but they tend to shed an artificial light on the problems of practical needs and probable demands. Shepherd, Davies and Culpan (1960) have provided the most useful report so far, on the incidence of psychiatric referrals by physicians and surgeons and the clinical conditions encountered. This was the result of a one-year work-study specially set up for the purpose of investigating these questions at a general hospital in London. However, there appears to have been no account of findings based on the routine work of a hospital where a psychiatric unit has been well established.

PRESENT STUDY

We report a survey of all new referrals of inpatients for psychiatric advice at Guy's Hospital during the 5 years from July, 1955. Over this period 530 general medical, surgical and specialist beds were occupied by approximately 50,000 patients. These figures do not include paediatric, orthopaedic or neuro-surgical beds, or private and staff accommodation. The 45 beds of the psychiatric in-patient unit within the hospital (The York Clinic), which has been fully functioning since 1948, have also been excluded.

Referrals were made by physicians or surgeons to one or other of two consultant psychiatrists who saw all the patients concerned, with the exception of a small minority of urgent cases which were dealt with by registrars alone. Copies of the requests for advice and the opinions recorded were retained in all cases, and analysis of these, supplemented where necessary by reference to the complete case notes, has provided the data for this study of the incidence, sources and clinical nature of referrals, and of the advice given or action taken about them.

FINDINGS

General

Three hundred and thirty-seven patients were referred for the first time for psychiatric advice. This represents approximately 0·7 per cent. of all cases

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admitted to the general wards of the hospital over the 5 year period. The frequency of referral was very variable, but the average per week was between one and two patients.

There were 217 women and 120 men. Their ages were between 16 and 82, with a mean age of 41 years. There were 17 patients less than 20 years old; 154 between 20 and 39 years; 126 between 40 and 59; and 40 patients were aged 60 or over.

Thirty-seven patients were seen and reported on by several registrars at different stages of training. Therefore, in order to ensure reasonable consistency, especially in regard to diagnosis and decision, the further details of findings given below and set out in the tables are based upon the 300 cases seen by consultants. Three-quarters of the reports were made by one of us (J.J.F.).

Sources of Referral

Three hundred referrals were made by 36 consultants. Table I sets out the distribution of patients among the various departments of the hospital according to the type of bed occupied. It also gives the total number of admissions to each category of beds. For this purpose, specialist medical beds include those under the care of physicians in dermatology, endocrinology, neurology and venereology. We find that 245 patients (81 per cent.) were referred by physicians.

TABLE I

Sources of Referral

Type of bed occupied	Total Admissions (approx.) over 5 years	Patients referred to psychiatrist
General medical	14,000	196 (1·40%)
Specialist medical	3,000	49 (1·63%)
Surgical	23,000	37 (0·16%)
Gynaecological (and obstetric)	10,000	18 (0·18%)

Reason for Admission

One hundred and eighty-four patients were in hospital for treatment of diagnosed physical diseases. When "medical" and "surgical" conditions are grouped together according to system, the incidence of physical disorder was as follows:

Alimentary	28 patients
Neurological	27 patients
Cardiac	26 patients
Skin	20 patients
Respiratory	18 patients
Gynae./obstet.	18 patients
Endocrine	13 patients
Miscellaneous	34 patients
Total	184

Examples of conditions classed as miscellaneous were tuberculous abscess of the neck, chronic pyelonephritis and osteoarthritis of hip. Of the 18 patients referred by gynaecologists, 10 were pregnant and 7 were in the puerperium. There were 14 post-operative surgical cases.

Seventy-one patients were admitted for investigation which had yielded negative or as yet inconclusive results. Over half of these had presented with alimentary complaints (15 patients) or "neurological" symptoms (22 patients) such as "blackouts" or paresis. The rest of this group had an assortment of

complaints including unexplained pyrexia, backache, ulcers of the foot and joint pains.

Thirty-six patients had been taken into hospital as a result of suicidal attempts and although they were in coma or some degree of physical distress at the time of admission, the psychiatric basis of their state had soon been recognized. It should be noted incidentally that by no means all cases of suicidal attempt admitted to general wards were referred to psychiatrists over this period (Woodside, 1958). Nine other patients had been admitted for treatment of obvious psychiatric illness: 7 with anorexia nervosa, and 2 who had presented themselves with amnesia.

The reasons for admission may therefore be stated as follows:

Organic disease	61%
For investigation of unexplained symptoms	24%
Psychiatric disorder (including suicidal attempts) ..	15%

Reasons for Referral

The various reasons that were given for requesting a psychiatric opinion could be grouped according to the arbitrary classification shown in Table II. The largest group of patients were referred because no organic cause had been found for their symptoms—such as headaches, loss of weight, abdominal pain—and a psychiatric basis was now in question. Distinct from these, and listed under "? Psychogenesis", were those conditions which had been diagnosed as organic, but for which an opinion was required about whether or to what degree psychological factors might be operating. These included many of the "psychosomatic" group such as peptic ulcer or asthma, but there were also such conditions as skin lesions aggravated by scratching or thought to be self-inflicted, and excessive complaints of pain at the site of definite lesions in any system. These two sorts of requests for help in the diagnosis or assessment of bodily complaints together constituted 31 per cent. of referrals.

TABLE II

Reason for Referral	Number	%
No organic cause	65	22
Minor psychiatric symptoms	59	20
Major psychiatric symptoms	54	18
Suicidal attempt	37	12
Disturbing behaviour	27	9
? Psychogenesis of organic states	27	9
Fitness for operation	12	4
Miscellaneous	19	6
Total ..	300	100%

Nearly half of the patients (47 per cent.) however, were referred primarily because psychiatric symptoms had been observed or elicited in hospital. It is convenient to consider these under three heads: Minor symptoms consisting of predominantly subjective distress and including phobias, poor sleep, low spirits, and the bodily expressions of anxiety; Major symptoms such as delusions, hallucinations, confusion and refusal to talk, which gave obvious evidence of mental illness; and Disturbing behaviour, such as repeated wandering, shouting, and interference with the apparatus of treatment or with the comfort of other patients. More than a quarter (27 per cent.) of the requests were prompted by gross psychiatric symptoms within these two latter categories, which had seldom been evident or anticipated at the time of admission.

Of the 37 patients who had attempted suicide, all had been admitted for this reason except one who made the attempt following an operation. There were 12 requests for advice about the fitness or suitability of patients for operation. Examples of these were the unexpected occurrence of severe pre-operative anxiety, a request by a patient for amputation instead of the more conservative treatment recommended, and a history of mental illness which might have given rise to post-operative complications. A penny-swallower who had already undergone 6 laparotomies and had now swallowed his seventh penny is also included. Among the 19 miscellaneous reasons for referral were such problems as the grounds for terminating pregnancy and the capacity of a brain-damaged woman to manage her own affairs.

Psychiatric Diagnosis

No diagnosis was made or no psychiatric abnormality was found in 8 per cent. of patients seen. In regard to a further 4 per cent. no more was indicated than that a psychogenic factor was important in the production of symptoms. The categories of the remaining 89 per cent. of patients are shown in Table III.

TABLE III

Diagnosis	Patients referred Number	Patients referred % (approx.)	% psychiat. inpatients (all sources) over 5 years.
Depression	65	22	33 (including mania)
Hysteria	45	15	7
Psychopathy	37	12	13
Organic reaction	35	12	10
Anxiety state	17	6	12
Schizophrenia	14	5	8
Paranoid state	12	4	5
Other psychoneuroses	10	3	7
Subnormal intelligence	8	3	< 1
Hypochondriasis	7	2	4
Anorexia nervosa	7	2	(not classed separately)
Puerperal psychosis	5	2	(not classed separately)
Manic states	2	<1	(not classed separately)
"Psychogenesis"	13	4	(not classed separately)
No diagnosis	12	4	<1
No psychiat. abnormality	11	4	<1
Totals	300	100	100

Depression heads the list of individual diagnoses but when all the psychoneuroses are taken together these formed the largest category (24 per cent.). Hysteria, however, is listed separately because of its conspicuously high incidence among patients from this source. Of the small number of patients with other neuroses, 17 had anxiety states and 10 had obsessional disorder or a neurosis which was not otherwise specified. Psychopathy, the predominant disorder in 12 per cent. of patients, includes, in this context, all cases of personality disorder and several of alcoholism and abuse of drugs. The 35 patients with organic reactions consisted of 16 with delirium or confusional state, 15 with dementia and 4 others with

organic mental features in association with epilepsy, cerebral syphilis, untreated myxoedema and an obscure neuroendocrine disorder. Schizophrenia was definitely present in 14 patients but the possibility that this was an underestimate is raised by the inclusion of 19 patients in the less clearly defined categories of Paranoid state and Hypochondriasis, among which schizophrenic patients are often found.

The cases listed under Subnormal intelligence are those in whom this was held to be the predominant factor. Patients who exhibited any psychotic illness during the puerperium have been withheld from the several diagnostic groups into which they might have strayed and are all collected under Puerperal psychosis.

Table III also gives the comparable percentage figures that are available for patients from all sources who were admitted to the psychiatric unit at this hospital over the 5-year period 1950 to 1954 (Woodside, 1957). As this unit aims to admit a reasonably representative selection of patients for treatment, the comparison emphasizes the incidence of certain conditions found in general wards. In particular, although the incidence of all psychoneurosis and psychopathy was much the same in both groups, hysteria occurred more than twice as often among referrals than among psychiatric in-patients.

Psychiatric Advice

The decisions and recommendations that were made are set out in Table IV. In one-third of the cases it was advised that the patients should attend the psychiatric out-patient department at the hospital for further investigation or treatment. A little less than a quarter of the patients were moved to a psychiatric

TABLE IV

Psychiatric Advice		Patients Number	Patients %
Referral to Psychiatric Out-patients		101	34
Transfer to Psychiatric bed	Clinic 55 / Mental Hospital 12*	67†	22
Advice on management		53	18
Opinion only		28	9
Psychiatric treatment *in situ*		27	9
P.S.W. only		12	4
Other recommendations		12	4
	Total	300	100%

* Compulsory admission, 3
† Neurosis and psychopathy, 35%
Schizophrenia, puerperal and other psychoses, 30%
Depression, 20%
Organic reactions, 15%

bed and the diagnostic distribution of these is shown in Table IV. The transfer was usually made within the hospital by admission to the York Clinic. When transfer to a mental hospital was advised the reasons for this were various. Sometimes the need for transfer was urgent but the patient rejected the offer of a bed. Compulsory admission, however, was only rarely needed. There were a few patients with chronic mental illness for whom long-term care elsewhere was appropriate, and occasionally the patient had just been discharged from a mental hospital to which his readmission was the most suitable course. On a few occasions it was not found possible to obtain a bed in the York Clinic for emergency

transfer from a general ward. This situation has since been remedied. To compute psychiatric bed requirements for general ward patients, we have also taken into account the 37 extra referrals, 11 of whom moved to psychiatric beds. Thus, 1 in 600 medical and surgical admissions were transferred to psychiatric in-patient care.

Some referrals (18 per cent.) simply resulted in advice on such items of management as sedation or other medication, nursing care, occupational therapy, or special attention of some kind to be carried out or supervised by the doctors in charge of the patient. A smaller number of patients (9 per cent.) were given specific forms of treatment such as E.C.T., hypnosis or general psychotherapy which were carried out in the wards or side rooms. Some of these patients went to the York Clinic for each treatment but otherwise remained where they were.

There were 28 occasions when no more than an opinion was offered. These usually concerned such questions as fitness for operation or to sign an affidavit, and included all reports of negative findings. Help from the psychiatric social worker was sought for many patients but for a few (4 per cent.) this was judged to be the only necessary contribution.

There remains a small assortment of other recommendations. For example: referral to a psychiatrist elsewhere when the patient lived at a distance; transfer to a geriatric unit; a convalescent holiday.

The number of requests for patients to be seen by the clinical psychologist has not been calculated, but they were often made, and when it was inconvenient for the patient to move it was sometimes possible for adequate testing to be done on the ward.

Discussion

Many factors influence the incidence of psychiatric referrals in a hospital at any one time. Fashion plays its part, and it is a familiar feature of this work to find that the referral rate of particular clinical conditions varies considerably. This occurs not only from one country or hospital to another at a given time, but also from a single doctor over a fair period of time. The degree of awareness of psychiatric symptoms and of the psychological factors in disease is a well-known variable, and as Creak (1959) has nicely shown in regard to emotional factors in children's diseases, clinical material varies less than doctors' opinions of it. But it is equally important to recognize the effect that the psychiatric service itself will have on the readiness of other hospital staff to make use of it. This is not only a question of relationships, the quality or availability of the service provided, nor the extent to which it is backed up by beds that are sufficiently accessible to allow a referring doctor to maintain contact with his patient after a transfer has been made. All these are important and some are self-evident. Less obvious is the factor of familiarity. After the introduction of new psychiatric facilities there may be a testing period of months or even years during which supply can stimulate demand and in which caution or enthusiasm finally give way to a level of referring that is consonant with the abilities, interests and equipment of the psychiatric staff concerned. As far as can be judged, a steady state of this kind has obtained at this hospital for some time, and the 5-year review reported here can claim to have this advantage. It is not surprising, therefore, that our findings differ in several respects from some already published which lacked this condition. Thus the overall incidence of referrals here—0·7 per cent.—is low compared with 1·3 per cent. reported by Shepherd and his colleagues (1960). An incidence of 4·3 per cent. given by Rud (1953) was the product of such special

circumstances at the General Hospital in Bergen that it scarcely justifies comparison.

There is nothing new or unexpected in the observation that physicians call for psychiatric consultations more often than surgeons. Again, the reasons are various. The one most commonly given is that physicians are more concerned with conditions in which psychological factors are important. This may be true so far as causes of illness are concerned, but it must be less relevant in regard to the mental *effects* of bodily disease. Greater tolerance of mental symptoms is also held to account for the relatively small need for psychiatric advice shown by surgeons. This is supported by our finding that roughly two-thirds of surgical referrals were on account of major syndromes or disruptive behaviour, whereas only a quarter of all cases seen were referred for these reasons. Nevertheless, there is another reason for this discrepancy which may be of overriding importance. The surgical patients in this series had an average length of stay in hospital which was only about half that of medical patients. There was far less time for their mental disorders to develop, or for their symptoms to be observed.

We have been impressed by the high proportion of hysterical states and by how frequently the really gross hysterical disorders of motor and sensory function have been met among these ward patients; substantially more often, we suspect than in patients from any other source.

By contrast, the incidence of organic reactions seems low—12 per cent. as against 35 per cent. previously reported (Shepherd *et al.*, 1960)—especially as toxic and other types of confusional state accounted for only 5 per cent. of referrals. No doubt this is partly due to improved medical, anaesthetic and surgical techniques; but there is also earlier recognition and control of these reversible reactions, and this may be one of the cumulative benefits of long-term work in this field. Regarding all our clinical findings, we believe that they are only representative of general hospital work. Substantially different figures may be expected from studies confined to particular departments of medicine or surgery which emphasize different psychiatric problems. In this connection it is hoped to publish the report of a similar study concerning orthopaedic patients.

It is of interest that the largest category of patients requiring psychiatric in-patient care comprised those with neurosis and personality disorder, and that whereas about one in four of all patients seen needed transfer to a psychiatric bed a distinctly higher proportion of referrals had shown severe mental disturbance. It is clear enough that a properly equipped hospital should have an adequate number of beds available for the reception of its own acutely disturbed patients. Our experience here also supports the view that patients with the less obtrusive forms of mental illness can have an equal if not greater need for the special facilities that only a psychiatric unit can provide.

Summary

A survey was made of all new referrals for psychiatric advice from the medical and surgical wards of a general teaching hospital over a period of 5 years.

Salient finds were:

(*i*) 0·7 per cent. of 50,000 admissions were referred to psychiatrists.

(*ii*) 80 per cent. were referred by physicians; 20 per cent. by surgeons and gynaecologists.

(*iii*) 40 per cent. of patients seen had no known organic disease.

(*iv*) Nearly a third of referrals were for aid in assessment of bodily complaints.

(*v*) Almost half were referred on account of overt mental disorder.

(*vi*) There was a high incidence of hysteria (15 per cent.) among patients from this source, but depression was the syndrome most often encountered.

(*vii*) 5 per cent. had toxic or other types of confusional state.

(*viii*) A third of patients seen were advised to attend the hospital's psychiatric out-patient department.

(*ix*) Transfer to a psychiatric bed was necessary for 23 per cent., which represents nearly 1 in 600 admissions to medical and surgical beds.

(*x*) 1 per cent. required compulsory admission to mental hospitals.

Some of the questions raised by these findings are discussed.

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