Foreign Report

Developments in Psychiatric Care in India

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At the National Institute for Mental Health and Neuro-Sciences (NIMHANS) in Bangalore, where Dr R. L. Kapur is the senior Professor of Psychiatry, the working day begins at 8 o'clock. This, as a number of distinguished visitors have been surprised to learn, is the time for formal lectures; seminars, case-conferences and book or journal review sessions—in each of which residents in training do most of the work—take place in the afternoon. The hours from 9 to 3 are devoted to clinical work in the wards of NIMHANS, which house some 500 patients, and in the busy out-patient department. NIMHANS is currently building a new OPD in order to escape the overcrowding in its present premises, where three senior staff members share one large room, reviewing the work-up of new cases presented by the residents and then joining in the surveillance of follow-up cases. From Monday to Saturday one of six clinical teams, each with three senior psychiatrists, four or five residents in psychiatry and a changing array of clinical psychology and social work trainees, will see about ten new cases per day and up to 90 follow-ups. It will be appreciated that residents have to learn how to work fast while still completing a thorough initial work-up under the watchful eyes of their consultants.

Things are somewhat similar in the Department of Psychiatry of the Postgraduate Institute for Medical Education and Research (PGI for short) in Chandigarh, except that during the height of the hot weather, from May to July, the working day begins at 7 a.m. and ends at 1.30 p.m. Here again, visiting lecturers are given the privilege of starting the day's work.

Overcrowding and long periods of waiting tend to be the rule in nearly all Indian out-patient departments. Here NIMHANS and the PGI have made a valuable contribution by separating the tasks of two clinical teams, working simultaneously. One of these teams constitutes the 'walk-in clinic' in which patients who arrive without previous appointment are quickly assessed and either admitted, if the need is urgent, or given an appointment in the following week for a more thorough case taking. In the interval they are often prescribed initial doses of phenothiazine or antidepressant medication. The other team works through a list of new patients to be seen by appointment. Because quite a number of patients do not come back after their first interview at the walk-in-clinic, it is customary to overbook the regular clinic by some 30 per cent. Another factor which has cut down overcrowding has been the institution of separate clinics for the supervision of patients on long-term lithium or depot phenothiazine medication.

The present Director of the Postgraduate Institute of Chandigarh is Dr J. S. Neki, regarded by many as India's leading psychiatrist. The Department of Psychiatry was started in 1964 by Professor N. N. Wig whose training was in Bangalore, at the Maudsley and with Dr Henry Brosin in Pittsburgh. Professor Wig's leadership in research has given his department an international repute out of all proportion to its modest size; but in June, 1980 he reluctantly said goodbye to his colleagues there, in order to take the Chair at the All-India Institute of Medical Sciences (AIIMS) in New Delhi, where the Department of Psychiatry has been built up over the past fifteen years by Professor Neki.

There is one more major centre of postgraduate training in psychiatry, at the Central Institute of Psychiatry, Ranchi, headed by Professor S. K. Pande, who has had several years of training and experience in the USA. In addition, more than a score of undergraduate medical colleges have been able to establish postgraduate degree courses in psychiatry; of these the most securely established are in Bombay, Calcutta, Madras, Lucknow, Agra, Vellore, Madurai and Goa.

All this represents a major change from 1949, since which year I have been an intermittent participant observer of Indian psychiatry. At that time India had only 26 fully recognized medical schools inherited from the British regime. Now there are 108. About half of these colleges have an academic department of psychiatry, still, in some places, a subordinate division of the Department of Medicine.

The introduction of psychiatric services into the general hospitals has been the principal means of expanding the scope of clinical psychiatry, which used to be practised only in India's relatively few (33 in all) and rather forbidding mental hospitals. A by-product of the establishment of general hospital psychiatry has been the steady growth, during the last twenty years, of private practice in psychiatry in the major cities, accompanied by a growing number of nursing homes, many of which admit both physically and mentally ill patients.

In 1949 the Indian Psychiatric Society was only two years old, and had 69 psychiatrist members; today its membership is about 600. This however includes a number of Indian psychiatrists who are pursuing their careers in the UK, Canada, the USA, Australia and in the oil-rich Arab countries, and it is generally agreed that they outnumber

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those who are working in India. This is one aspect of the 'brain drain' which has hindered the realization of successive national plans for basic health care for the whole population, now numbering over 640 million, so there is at most one psychiatrist for every million persons, and perhaps only one to every two million.

A WHO-sponsored workshop on the organization of mental health services in India, held in New Delhi in 1971, decided that for at least the next twenty years the highest priority should be given to the training of professionals in mental health. The workshop was preoccupied with the need for more medical personnel to deliver treatment to the rural population. During the next decade this thinking rapidly changed. From 1973 WHO began to encourage demonstration programmes designed to show how effectively medical auxiliaries can contribute to basic health care, especially in the rural areas, and during the past five years pioneer rural services making use of medical auxiliaries as well as psychiatrists have been developed in a number of centres—notably in Bangalore, Chandigarh and Vellore.

The Chandigarh field station in the village of Raipur Rani has been the base for a series of studies of local attitudes to the mentally ill, of the villagers' ability to recognize such illness, and of the prevalence of mental disorders in the area. Most of these studies, together with three current projects on the outcome of acute psychosis, on strategies for the extension of mental health care and on the psychological accompaniments of tubal ligation have been carried out in collaboration with teams in other developing countries, coordinated by Dr Tim Harding and his colleagues in WHO, Geneva.

Both Raipur Rani and the corresponding rural programme of NIHMANS, in Sakalwara village, 30 km from Bangalore, have been fortunate in each having an outstanding young psychiatrist as their principal field worker. Dr Srinivas Murthy in the former, and Dr Mohan Isaac in the latter have already been demonstrating how very different, and in many ways how much more rewarding, is psychiatric practice in the village compared with that in the hospital setting.

For many years the question has been repeatedly raised by Indian colleagues as to whether the model of the Maudsley-trained consultant psychiatrist is necessarily the best for practice in India. The importance of a sound scientific training is not disputed; but most research has been concentrated on the major psychoses, whereas epidemiological research in India—as in other countries—has shown that a substantial proportion (about 18 per cent) of the patients seen at general medical out-patient clinics are suffering from psychiatric disorders, mainly neuroses or psychosomatic disorders.

The pharmaceutical industry has not been slow to respond to this clinical finding: their salesmanship combines with the average doctor's modest amount of training in psychiatry to make psychotropic drugs (and especially the diazepines) the most over-prescribed medication in the entire pharmacopoeia.

The leading teachers of psychiatry in India are aware of the very understandable tendency to reach for the prescription pad rather than embark on a series of psychotherapeutic interviews. Several among them have addressed themselves to the problem, as can be seen in a recent National Seminar report entitled 'Psychotherapeutic Processes' (Kapur, 1979). In this report Dr Hoch (1979) contrasts her own approach with that of uneducated 'instant healers' who confidently claim to be exercising supernatural powers. Like Professor Neki, who has written extensively on how to make psychotherapy consonant with Indian cultural values (Neki, 1973; 1974; 1976; 1978), Dr Hoch appreciates the Indian patient's eagerness to adopt a dependent relationship with his or her therapist. The Indian expectation is to be allowed to remain the therapist's devoted disciple perhaps for the rest of his life. Dr N. C. Surya, the former Director of NIMHANS has also made a contribution to this theme, in his own inimitable way (Surya, 1979).

The logistics of the demand for relief of neurotic symptoms are such that sooner or later psychiatrists will have to accept the help of non-medical psychotherapists or counsellors. Already there are a few centres of training in analytically oriented psychotherapy (such as the B.M. Institute in Ahmedabad and the Institute of Psychoanalysis in Calcutta) and in counselling (such as the Christian Counselling Centre, Vellore), but the profession as a whole is still a long way from being ready to delegate this task to non-psychiatrists. In contrast there has been a lively interest in the controlled trials of behaviour therapy emanating from the Institute of Psychiatry in London, and several Indian clinical psychologists have made this their special field of interest. But still the gap between the numbers who can be so treated and the vastly greater numbers who attend the out-patient clinics or who turn, as they have always done, to traditional healers for relief remains unbridged.

In India, perhaps more than in any other country, there has been a long tradition of inquiry into human nature and more particularly into the attributes of consciousness, the cultivation of detachment and the ultimate achievement of a higher level of consciousness through disciplines of meditation. Curiously, however, it was not until the study of yoga and techniques of meditation became fashionable in the USA that Indian psychiatrists, foremost among whom were N. S. Vahia (1972; 1975) and Venkoba Rao and Parvathi Devi (1974), gave a lead in demonstrating the value of traditional forms of meditation as an adjunct to psychiatric treatment.

This reluctance to mix yogic teaching with Western psychiatry is more remarkable in view of the widespread Hindu belief that everyone should try to attain a high level of mental health in order, among other reasons, to reach a state of detachment. All over India there are many thousands of Gurus, most off whom are known only locally; but some have a national and even international fame. Others have

acquired a much larger following in the West than in India. Gurus and their disciples are found in all walks of life and at all levels of education and sophistication. There is probably no other culture (with the possible exception of some ardently communist countries, notably China) in which so many of the population devote so much time to self-betterment. Yet it is surely the expression of a similar desire for self-betterment which prompted so many middle-class Americans to undergo costly psychoanalysis during the immediate post-war decades.

Regrettably, one has to admit that there is little firm evidence that either meditation or religious observance significantly modifies the incidence of mental disorders. Nevertheless, tens of thousands of Indians, young and old, have become disciples of teachers who support them in their twofold ambition to practise right conduct in accordance with Hindu *dharma* and to enhance their personalities by following a particular technique of meditation. If it could be established, with appropriate controls, that changes in symptoms and in personality traits do come about, and in the desired direction, then the possibility of collaborating between psychiatrists and Gurus could be worth exploring.

In concluding this account I should like to record what a pleasure it has been to work with Professors J. S. Neki, N. N. Wig and R. L. Kapur* and their respective colleagues, and what an especial pleasure it has been to find their post-graduate students so hard-working, so eager to learn and so cheerful, even when carrying extremely heavy clinical loads in the crowded out-patient clinics where the greater part of Indian psychiatric care is deployed today.

*The *Journal* from time to time publishes papers from them and their teams.

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Report of a Conference on Private Consultant Practice

By Kenneth Granville-Grossman, St Mary's Hospital, London

In March 1980 the British United Provident Association (BUPA) held its second residential weekend for consultants and senior registrars who had recently started in private practice or who intended doing so. About 70 consultants and senior registrars participated, including less than a handful of psychiatrists.

The need for private medicine

The first session was devoted to the need for private medicine from the points of view of both patient and doctor. That there was an increasing demand from patients for an independent sector was clearly demonstrated by the growth of private medical insurance. The demand was increasing at a current rate of 19 per cent per annum.

The need of the profession to practise independently of the State was also argued, one reason being that the NHS did not give many doctors the facilities to practise at as high a standard as they would like nor to treat their patients on a one-to-one basis, particularly in those branches of medicine (including psychiatry) where treatment by a multi-disciplinary team was the rule. One speaker felt that it was important for him to be in control of at least part of his professional life—in the independent sector he could work hard knowing that if he were dissatisfied he had only himself to blame.

For many doctors private practice meant more money, though there was, however, a general agreement that few doctors would earn in practice anything like as much as their counterparts in Europe and the United States. One speaker pointed out that in some specialties (including perhaps