EDITORIAL

Depression in the Medically Ill: One Illness, Many Faces and Our Image!

Umi Adzlin S
Invited Editorial Member

“Could you please see this poorly controlled diabetic patient who is refusing to take his medications because he does not care and does not want to live anymore?”

“Please come and see this post stroke patient who has been noted to be crying from time to time. “

Those are typical consult requests. A challenging task all the way from making the right diagnosis to selecting appropriate treatment, managing depression in the medically ill is becoming more and more a part of a day’s work for psychiatrists serving in general hospitals.

To begin with, the assessment for a diagnosis in the medically ill differs from the usual assessment due to the overlapping symptoms between depression and the physical illness such as fatigue, loss of appetite and sleep difficulties (1). Sometimes what seemed to be a referral for depression may turn out to be a totally different story. It may just be miscommunication between a patient and the attending doctor or just a normal reaction of illness. It may be something more serious like a hypoactive delirium or a neuropsychiatric manifestation. On top of that, the issues surrounding depression in the medically ill differs from one illness to the other. Managing post-stroke depression is different from managing depression in pregnancy, renal failure, or cancer. What seemed to be a straightforward referral may lead to bigger issues of capacity assessment for an informed consent or an ethical decision of termination of pregnancy. The psychopharmacology of the medically ill differs as it should incorporate sound knowledge on drug-drug interaction, side effects profile and the patients’ physical limitation.

Obviously, this area is a very rich area of research opportunities as well as service development. However, less noticeably, this clinical obligation reflects the image of psychiatry and psychiatrists in the eyes of health professionals. A psychiatrist must demonstrate high competency, good communication skills and the ability to contribute meaningfully for patients’ comprehensive management. The ways we handle referrals may either positively or negatively impact our relationship with our colleagues in other medical disciplines (2). Even for inappropriate referral, we should be able to redirect than merely refuse to see them. We should be able at any time determine what we can do to help the patient and the primary team.

This area of managing depression or other psychiatric aspects of the medically ill is the interface of psychiatry and medicine which is a testing ground for the whole range of our professional skills and abilities. In conclusion, if we do it badly, the bad opinion is towards psychiatry and if we do it well, the credit is to psychiatry!
References


Corresponding Author
Dr. Umi Adzlin Silim
Department of Psychiatry and Mental Health, Hospital Putrajaya, 62250 Putrajaya

Email: umiadzlin@gmail.com