WEAVE SPRINT . PAPER III

Consultation-liaison, geriatric and transcultural psychiatry

Four questions the textbooks answer for a diagnosis and not for a person: who is asking and in whose ward, what changes at seventy-eight, what changes when the explanatory model is not biomedical, and how the examiner asks for any of it. The consult itself, taught as an act rather than a list of syndromes. Then the older patient, where the presentation misleads and the prescribing rules change. Then culture, where the idiom and the family's explanation are clinical data. Then cancer, dying and grief. It closes on the OSCE and practical exam bridge, which no other chapter in this series teaches at all. The disorders themselves are taught elsewhere and are named, not repeated.

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- The consult as an act
- What arrives on the ward
- The high-stakes settings
- What changes at seventy-eight
- The late-life presentations
- Culture and the explanatory model
- Cancer, dying and grief
- The OSCE and practical exam bridge

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Routine referrals only. This is not an emergency route.

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PAPER III

Consultation-liaison, geriatric and transcultural psychiatry

Eleven bands . one complete notes document . the last chapter of Paper III

Orientation: four questions, one patient

1 · Orientation: two doors, one patient

One patient, and four different reasons somebody wants a psychiatrist. A woman of seventy-eight is on a surgical ward. The team has sent for you, though the slip carries a bed number and the word confused. Her son has already told the ward what he believes is wrong with her, and told you what he does not want said to her. Nobody has asked what she was like a month ago. The same encounter, compressed and performed aloud, is what examiners will mark. Four questions are being put to one bedside: who asked and in whose ward, what is different because she is seventy-eight, whose account of the cause reached the room before you did, and how all of it is said aloud under observation.

This opening is the chapter's **advance organizer**. It asserts no dose, interval, threshold or figure of its own, because each belongs to the section that owns it, and it describes no syndrome, because not describing syndromes is the design rather than an omission in it. What it owns is the shape: the decision the chapter is organised around, the four questions that run through it as seams, the bands and their order, the map of what it deliberately does not carry, and the reason its last band sits where it does.

Who asked	What age changed	Whose explanation	Said aloud
THE FIRST QUESTION, AND THE SEAM RUNNING THE LENGTH OF THE GENERAL-HOSPITAL BANDS	THE SECOND QUESTION, RUNNING THROUGH BOTH OF THE LATE-LIFE BANDS	THE THIRD QUESTION, AND THE ONE THE TRANSCULTURAL BAND IS BUILT AROUND	THE FOURTH QUESTION, AND THE WHOLE SUBJECT OF THE PRACTICAL EXAMINATION BAND

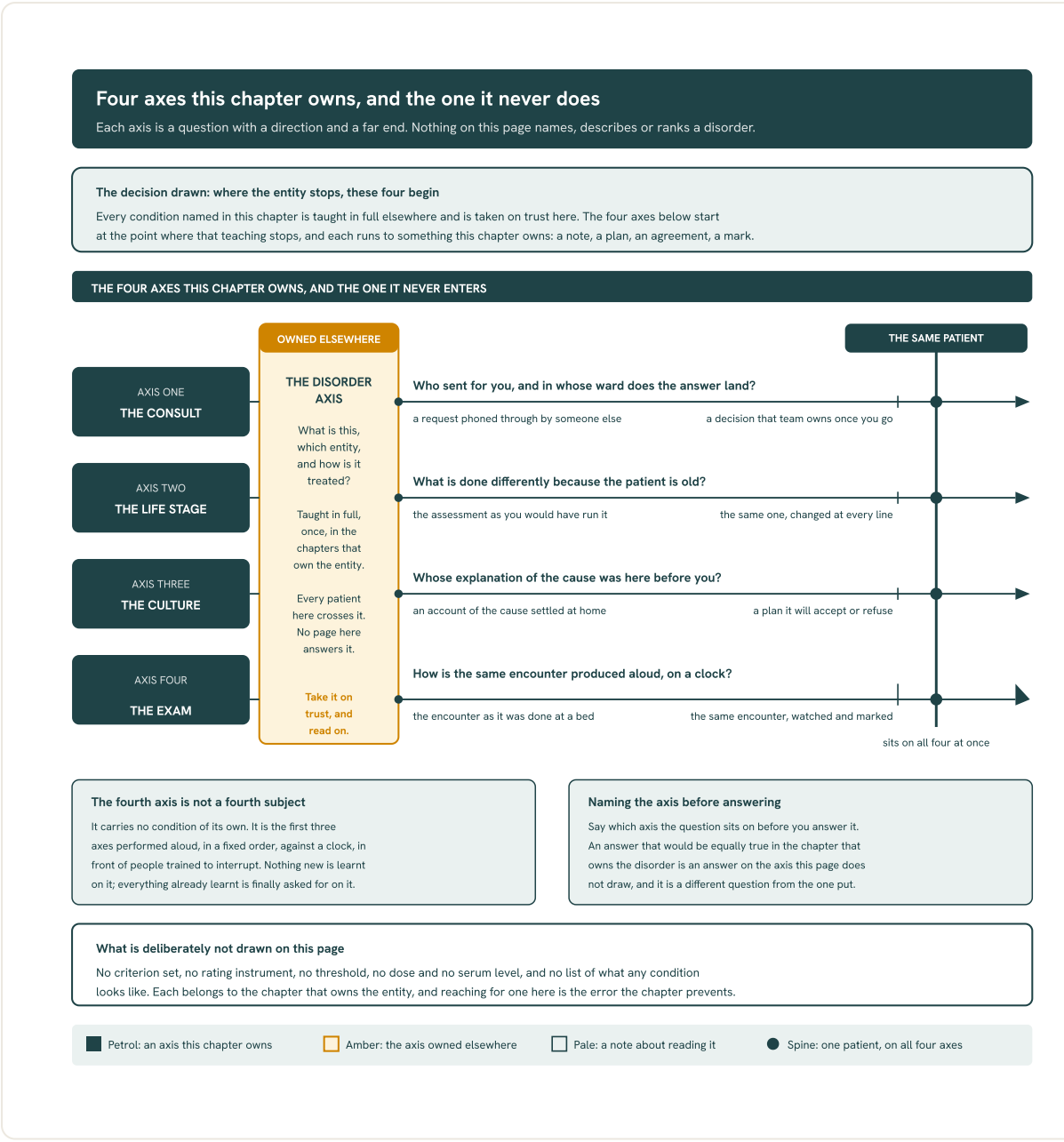


Fig 29.1. The chapter drawn as four axes rather than four topics, each one a question with a direction, running from the point at which the teaching of the condition stops to something these pages own, with the axis that asks what the condition is set alongside them as the one axis this chapter never enters, and the same patient marked as sitting on all four of the owned axes at a single bedside.

1.1 The decision this chapter is organised around

Almost every condition named in the pages ahead has already been taught properly elsewhere in these notes, with its clinical features, its differential, its investigation and its drug treatment. That body of work is the **entity**, and it is not repeated here in any form, at any length, in any box. The chapters that teach what the thing is sit largely in Paper II and Paper IV.

This chapter owns the other half, and nothing else in these notes carries it whole. That half is the **encounter**: who sent for a psychiatrist and what they actually wanted, in whose ward the patient is lying and therefore whose agreement any plan needs, what is different about the assessment because the patient is old, what the people around the bed had settled about the cause before anyone telephoned, and how all of it is produced aloud, in order, in front of somebody marking it.

The chapters that own the disorders answer *what is this*. This one answers *who asked, in whose ward, what changed because she is seventy-eight, whose explanation was already in the room, and how do I say it.*

That division is a decision and not a shortage of material. It is also the harder of the two, and the one practised badly and examined badly. A candidate who names a confusional state correctly but cannot say who to telephone first, what had to be established before walking to the bed, or which bed the patient should be in by morning has the entity right and the encounter wrong, and it is the second error the patient carries home. Every cross-reference in this chapter follows from the same division: it is a routing decision taken once, so that a subject is taught in full in one place rather than partly in three.

RULE **A section here is finished when it has said what was done, by whom and to what end. It is finished even if it has said almost nothing about the disorder.** Hold that while you read, because it settles what a complete section looks like here. A section that says little about a condition you already know is not thin: it is written on the assumption that you know it, and everything it does say is content the owning chapter does not carry. The corollary is where the marks sit. If you can describe a condition fluently but cannot say who called, what they wanted, what you would have established before the bedside, who owns the decision afterwards and when the patient is seen again, you have read the wrong half.

1.2 The four questions, and why each is a seam rather than a topic

The four questions are not four subjects placed side by side. Each is a **seam** running the length of a stretch of the chapter, so that the sections inside that stretch are variations on one question. Knowing which question your section varies is most of what makes this chapter quick to read.

The first is the **referral**. A consultation is asked for by somebody whose felt need is not the patient's, and the answer is owed to a team that will act on it with you absent. Everything in the general-hospital stretch follows from those two facts: what the request must be turned into before it can be answered, what is established before the bed rather than at it, what the written record has to settle, and who owns the next decision.

The second is what age changes. The question is not what conditions older people get, which is an entity question with owners elsewhere. It is what the clinician does differently: whose account the history now comes from and how well placed that person is to know, what must be made possible before an examination measures anything at all, what a drug decision costs in a body that handles drugs differently, and what a plan silently assumes about the household that will deliver it.

The third is the **explanatory model**. By the time most of these patients reach a psychiatrist, somebody has decided what is wrong and why, something has been tried on that basis, and a view has been taken about how much the patient should be told. Eliciting it is assessment and not courtesy, because it predicts what will be accepted and what happens next if your plan disappoints.

The fourth is the **examined performance**. An examination does not ask what you know; it asks for the encounter reproduced aloud, in a fixed order, against a clock, in front of people trained to

interrupt. The content is the same and the constraints are different, and the constraints are examinable in their own right.

MNEMONIC

Who asked. What age changed. Whose explanation. What is said aloud.

Four beats, and they are the whole chapter. **Who asked**: the request, the ward, the record, and the person who owns the decision after you leave. **What age changed**: not a new list of conditions but a changed meaning for every line you were already writing. **Whose explanation**: the account of the cause settled before the referral, in the words of the people who hold it. **What is said aloud**: the same encounter reproduced in front of examiners, which is how all of it is finally asked for.

1.3 The bands, in the order the chapter runs them

Between this opening and the close the chapter runs in nine **bands**. The order is a clinical progression rather than the syllabus taken flat, and eight of the nine carry the teaching while the ninth draws them together.

- **The consult as an act.** The consultation itself as the object rather than any setting or syndrome: what a liaison service is for, what a medical illness does to the psychiatric picture, and what a physical illness demands of the person carrying it.
- **What arrives on the ward.** The recurring short list of reasons a general-hospital team actually sends for psychiatry. Grouping them says what no single section says: the reasons are few and they repeat on every ward.
- **The high-stakes settings.** Transplantation, dialysis and intensive care, chronic infection, the organ-specific liaison work and the neurological interface: the settings in which the consult is hardest and the decision least reversible.
- **What changes at seventy-eight.** Normal ageing against pathology, the assessment that surrounds any cognitive testing, the prescribing decision, the sleep history, and the safeguarding question, which belongs inside an assessment and not in an appendix.
- **The late-life presentations that mislead.** The band's work is the differential between them, which no chapter can draw from inside a single entity it owns.
- **Culture and the explanatory model.** What changes when the account of the cause is not biomedical, run from the concept through the formulation to what a clinician does with it in an Indian clinic.
- **Cancer, dying and grief.** Recognition when the ordinary somatic signals have been taken over by advanced disease, and the conversations that carry most of the clinical work in that setting.
- **The practical examination bridge.** The observed station, the long and short case, the bedside demonstration, the difficult conversation, and the instruments a viva puts in front of you.
- **The cross-cutting synthesis.** The one place the four questions are shown converging on a single encounter and a single document.

After the ninth band come the chapter's own closers, and then one more that no earlier chapter has needed. This chapter closes Paper III, so its final section looks back across the whole paper rather than across these pages alone. The last thing you meet here is a map of ten chapters, not a summary of one.

1.4 What is deliberately not here, and where it is taught

An organizer is as much about the edge of the frame as about what sits inside it. Read the middle column of the map first: it is what this chapter does with each subject, and the reason the subject appears here at all. The right column is where the condition itself is taught, in full, once.

WHAT YOU MEET IN THESE PAGES	WHAT THIS CHAPTER TEACHES ABOUT IT	WHERE THE CONDITION ITSELF IS TAUGHT
Acute confusion, on a medical ward and in an older patient	Who calls and what the ward is actually asking for; and separately, what frailty, sensory loss and multiple drugs do to the same picture in later life	the Stroke, TBI, delirium and focal brain syndromes notes
Progressive cognitive decline in an older referral	The wider assessment it sits inside, and the behavioural picture as a reason a family or a ward asks for help	the Dementias and neurocognitive disorders notes
A first psychotic presentation late in life	What is different about assessing a first presentation at this age, and why its label has a contested history	the Other psychotic disorders, delusional syndromes and catatonia notes
Low mood late in life, and in advanced physical illness	How it is recognised when the somatic features belong to the disease or its treatment, and what age does to prescribing	the Mood disorders: pharmacotherapy notes
Fear and distress at a bedside, and after a diagnosis is disclosed	The reaction the setting itself produces, and when a reaction has become something to treat	the Anxiety, OCD and trauma-related disorders notes
Poor sleep in an older patient	The history to take before the complaint is attributed to age, and what that attribution costs when it is wrong	the Eating and sleep-wake disorders notes
Bodily symptoms without an explanation, fabricated illness, and self-harm on a medical ward	Why the team referred, what they are asking you to take off their hands, and what the note must settle before you leave	the Somatic-symptom, sexual, impulse-control disorders and suicide notes
The mental state examination, and the psychological work of a consultation	How it is performed at a busy bedside and presented aloud against a clock	the Psychotherapies, clinical assessment, MSE and nosology notes
Seizures, and the psychiatric picture around them	What a neurology team is asking psychiatry for, and where the consult enters that relationship	the Epilepsy and psychiatry notes

WHAT YOU MEET IN THESE PAGES	WHAT THIS CHAPTER TEACHES ABOUT IT	WHERE THE CONDITION ITSELF IS TAUGHT
Localisation and the bedside neurological examination	Which parts of it a general-hospital consultation requires, and when it cannot be deferred	the Neurology foundations for psychiatrists notes
Chronic infection, organ failure and the systemic disease behind a referral	The psychiatry of the setting: the unit, the team, the decision due this week, and who follows the patient afterwards	the Neuropsychiatry of systemic and neurological disease notes

Nothing in that table is an apology. A pointer here sends you to the full teaching and not to a second summary, and it expects to be followed once and then never again.

1.5 The band that is carried nowhere else

Read the last band even if you read nothing else twice. The practical examination bridge is the only band here with no clinical entity standing behind it, which is why it is placed last: from there it can look back across everything before it, and it hands directly to the close of the paper. It covers the observed station and what is being scored in it, the long and short case as they are actually presented, the demonstration of a scale or a bedside cognitive test with an examiner watching, the difficult conversation treated as an examined act, and the interpretation of investigations and instruments put in front of you without warning.

It is also the only body of material in this chapter that appears in no other chapter of any paper. Everything else here has an owner somewhere, so a reader who skips a section can pick the subject up at that owner and lose only time. This band has no owner. A candidate who skips it has read it nowhere, and meets the format for the first time in the room, where the cost is paid in marks rather than in preparation.

TRAP **Reading a short section as a low-yield section.** The length of a section here is a statement about ownership, not about yield. A section is short because the disorder it names is taught in full elsewhere, which means every line it does carry is a line no other chapter carries, and those are the lines examiners ask for. The failure has a recognisable shape across a table: asked what you would do about a patient, the candidate who skimmed produces the entity answer at speed, which is fluent, correct, and about a different question, and then has nothing left when the follow-up asks who they would telephone first and what they would write. The practical band is where this costs most, because there is no owner to fall back on.

1.6 How to read it

Three habits make the chapter read as one argument rather than as a heap of separate acquisitions, and each is a habit about what you do with a section rather than about how much of it you memorise.

- Read for what a section instructs you to do, and take the disorder it names on trust from the chapter that owns it. If you cannot recall that disorder, that is a signal to go and read it there, not a signal that this section is incomplete.

- When a section hands a point to another chapter, follow it before you answer on that point. Following a pointer here lands you on the full teaching, so it is done once and does not need repeating.
- Treat a stated absence as a finding. Where a section says that no figure is available to quote, that sentence is doing work: it stops a half-remembered number being written into an answer under pressure, which costs a candidate more than not knowing.

IN INDIA

Indian practice is the subject of this chapter, not a note appended to a Western one, and that has two consequences for reading it. Where the question is how a service is configured, who may lawfully decide, what a family expects to be told and when, or where a complaint about an older person's treatment at home is actually heard, an Indian source settles it and a familiar Western default does not substitute. And the route a patient took before reaching you, including any traditional or religious healing sought first, is a fact about access to care and a proper question to ask; it is never by itself a finding about pathology, and this chapter draws that boundary in prose, in the patient's own words and the family's own explanation, rather than in a list of features. The encounter you will be examined on is an Indian encounter, in an Indian hospital, with the relative in the room.

This chapter answers four questions about one encounter: who asked and in whose ward, what changed because the patient is old, whose account of the cause was already in the room, and how all of it is performed aloud under observation. It answers none of them by describing a disorder, because every disorder it touches is taught in full elsewhere and is named here without its features.

The consult as an act

2 · Principles and models of consultation-liaison psychiatry

Why the marks are here. Almost every other question in the syllabus asks what a condition is. This one asks what you did, in whose ward, at whose request, and what became of the decision afterwards. Liaison work is the only part of psychiatry in which the psychiatrist is a guest: the bed, the record and the plan of care belong to another team, and the patient did not ask for a psychiatrist. Procedure, unlike a syndrome, is examinable in fine detail. A candidate who lists service models without saying who telephoned, what they wanted, and who was left holding the clinical decision has answered a different question.

Two consequences follow from being a guest, and the rest of this topic works them out. First, the request is not the patient's: ordinarily the need to see a psychiatrist is a felt need of the patient or a relative, whereas here the need to appoint a psychiatrist is felt by the primary treating team, and the patient may be learning of it as you introduce yourself. Second, what you produce enters a decision that is settled with the primary team rather than announced to it. Both are set out in

the consultation-liaison chapters the Indian Journal of Psychiatry published in 2022, the fullest account of Indian general-hospital practice and the source used throughout.

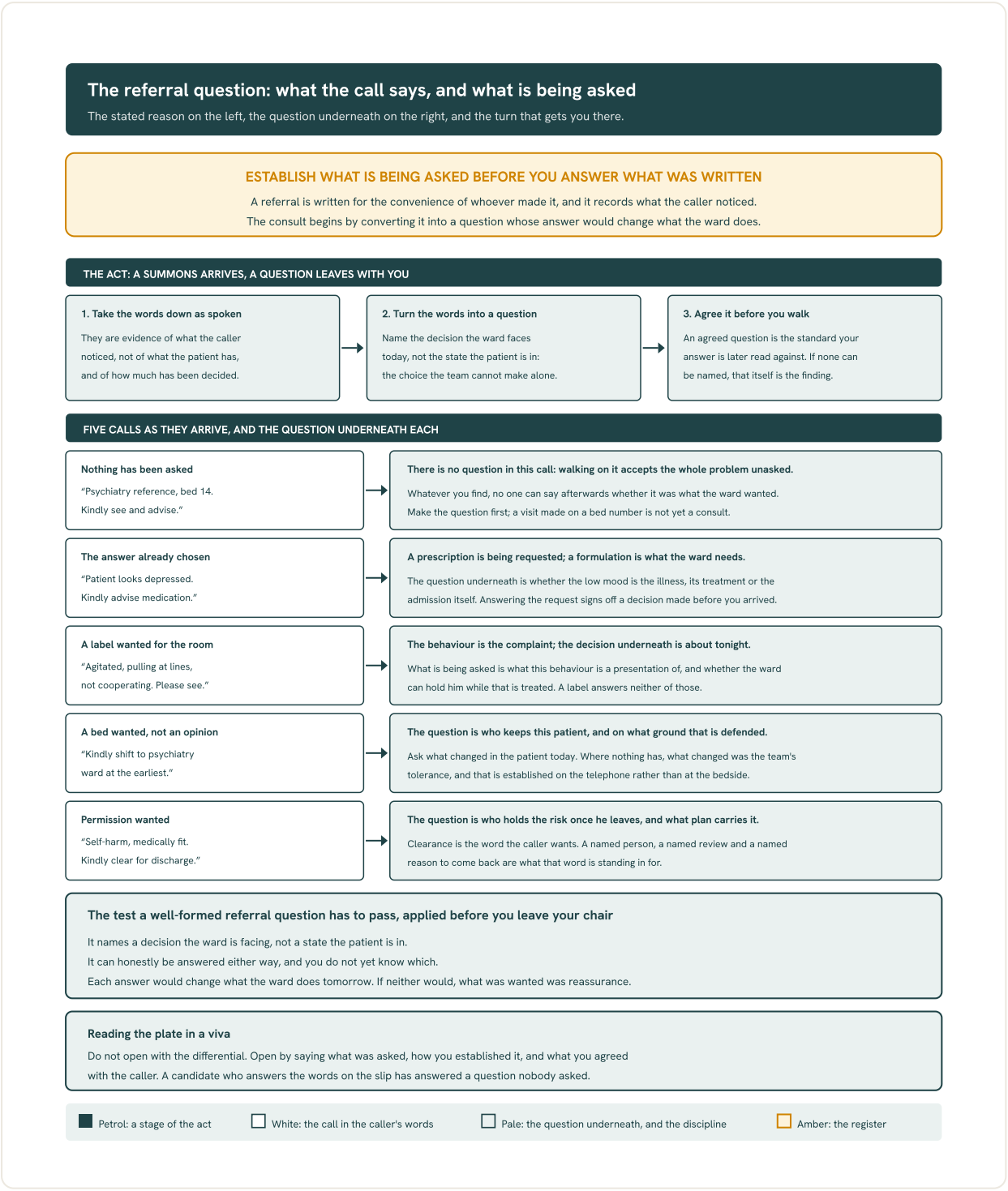


Fig 29.2. The referral question drawn as an act of extraction rather than as a list of reasons for referral, with the three stages by which a summons is turned into a question the consult can answer, five ordinary ward calls set beside what each is actually asking and what is lost by answering the words instead, and the test a well-formed referral question has to pass before the psychiatrist leaves the chair.

2.1 Whose need the consult answers, and what changes because of it

The person who telephones is the **consultee**, and naming them properly fixes three things candidates get wrong. Consent to be seen cannot be inferred from the referral, because the referral was not made by the person being seen. The referral question cannot be read off the

request, because the request was written for the convenience of whoever made it. And the output is a recommendation inside somebody else's treatment, so it must be written for a physician to implement rather than for a psychiatrist to admire.

RULE **The referral is the treating team's felt need, not the patient's request, and everything procedural in this topic follows from it.** It is why consent to be seen must be established rather than assumed, why the referral question must be extracted rather than received, why the psychiatrist speaks to the consultant and not only to the file, and why a patient may decline without anything having gone wrong. A consult conducted as though the patient had walked into a clinic is procedurally wrong even when the diagnosis is right.

2.2 Where general-hospital psychiatry began in India, and how the service is actually run

Indian psychiatric services were confined to mental hospital settings until the general hospital psychiatric unit appeared. The Indian account credits the first such unit, in the early 1930s, to **Girindra Shekhar** at R. G. Kar Medical College and Hospital, Calcutta, with rapid growth through the late 1960s and early 1970s; the source sentence dates it inconsistently within one clause, so the decade is given and no year asserted. The point is not historical. Most Indian postgraduate psychiatry training now happens inside general hospitals, and the same chapter observes that liaison work is still not emphasised within it. The trainee stands in the setting and is not taught it.

What the service looks like has been measured. A survey of ninety Indian training centres, as the 2022 overview reports it, found liaison work delivered as an on-call service in **three quarters** of institutes, with a junior resident as the initial respondent in **60 per cent** of teams. Only a handful included psychiatric nurses, psychiatric social workers or clinical psychologists. Most had no specific liaison posting for junior or senior residents, and fewer than half ran joint academic activity with other specialties. The respondents' own prescription was a dedicated liaison team.

That describes a failure mode, not simple under-resourcing. A service answered on call by its most junior member, with no protected posting and no shared teaching, can only respond: it accumulates no case-mix, no relationship with a ward, no reputation to generate the next referral. The commonest diagnostic categories across those centres were delirium, substance use disorders, self-harm and depression, the case-mix produced by whatever is loud enough for a busy team to notice.

2.3 The referral rate, and the gap it conceals

There is no single Indian referral rate, and quoting one is an error of construct rather than of arithmetic. Reviewing Indian data across institutes, Grover and Singh give it by setting: 0.01 to 3.6 per cent from the inpatient setting, 1.42 to 5.4 per cent from the emergency setting and 0.06 to 7.17 per cent from the outpatient setting, against a cross-institutional international range reported as low as under 1 per cent and as high as 13 per cent. Three settings, three denominators. An inpatient rate asks how often a ward that already holds the patient thinks of psychiatry; an outpatient rate measures a filter operating before admission.

The same discipline governs the morbidity figures the rate is compared against. Grover and Singh estimate psychiatric morbidity at about 30 per cent among medically ill inpatients and 50 per cent among primary care attenders. The overview chapter states that 20 to 46 per cent of patients with physical disorders admitted to medical or surgical wards have at least one diagnosable psychological comorbidity. The cardiology chapter puts prevalence in liaison populations at 48 to 87 per cent across cardiovascular, musculoskeletal and orthopaedic patients. These are not competing estimates of one quantity: unselected admissions, already-referred patients and single-specialty cohorts are three populations, and the population is part of the number. A percentage quoted without its denominator is not a fact.

Where the argument becomes clinical. Two Indian studies close the loop by measuring prevalence and referral in the same unit, which removes the denominator objection and makes them the most useful pair of figures in the topic.

68.5%	1.71%	65.5%	2.4%
DELIRIUM PREVALENCE MEASURED IN ONE INDIAN INTENSIVE CARE UNIT	PSYCHIATRIC REFERRAL RATE FROM THAT SAME INTENSIVE CARE UNIT	PSYCHIATRIC MORBIDITY AMONG ELDERLY ATTENDERS AT A MEDICAL EMERGENCY	PSYCHIATRIC REFERRAL RATE FROM THAT SAME EMERGENCY SETTING

TRAP **Reading a low referral rate as a low burden of psychiatric illness.** Candidates quote the Indian referral figures as though they measured the psychiatric morbidity a hospital contains. They measure how much of it is sent. The same-setting pairs settle it: the denominators are identical and the gap is not a rounding difference. A service with a very low referral rate is not a service with little to do; its case-finding has failed, and what needs interrogating is the referral pathway rather than the prevalence.

2.4 Who is referred, and what the caller owes you

The 2022 overview adopts a six-group classification of liaison patients, attributed to a consensus of the European Association of Consultation-Liaison Psychiatry and the Academy of Psychosomatic Medicine. It is the only compact answer to what a liaison service is for.

1. Comorbid physical and psychiatric disorder where managing one complicates the other.
2. **Medically unexplained symptoms** presenting in clinical services, taught as an entity in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.
3. Mental and behavioural disorders attributed to general medical conditions or to their management.
4. Psychiatric patients attending a medical setting for a diagnostic or therapeutic procedure.
5. Suicidal or self-harming behaviour arriving in an emergency or medical unit.
6. Health behaviour, personality traits, cognitive function or social circumstances that influence management of the medical condition.

What arrives is narrower than that spread. Writing about the emergency setting, Ghosal and Ray name **confusion with behavioural abnormality** as the commonest cause of referral in Indian liaison settings, and note that in intensive care it is often called intensive-care psychosis. The first

discrimination the consult owes is therefore between a neurocognitive disorder and a primary psychiatric condition presenting with behavioural disorganisation. The entity, its criteria, its screens and its treatment belong to the Stroke, TBI, delirium and focal brain syndromes notes; what belongs here is that the commonest thing you are called for is the thing most easily misfiled as psychiatric.

The Indian account also sets out what the caller should convey: who is calling, the patient's demographic details including hospital number, any anticipated language difficulty, the location in the hospital, the primary diagnosis and reason for admission, the psychiatric concern for which the opinion is sought, and the urgency. Two parallel instructions written for referring physicians are sharper still: do not initiate a call without examining the patient, and do not initiate a consultation without informing the patient or the caregiver.

IN INDIA

The Indian chapters describe the referral call not as it ought to be but as it is. Grover and Singh record that in practice it is limited to informing the psychiatrist to come and see the patient on a given bed number. There is no referral question in it, and a psychiatrist who walks to the ward on it has accepted the whole diagnostic problem without knowing what was asked. Two questions turn it back into a consult before you leave your chair: what has changed in this patient today, and what do you want from me.

2.5 Receiving the call, and the patient's right to decline

The Indian account gives the psychiatrist a checklist for the call itself, and it is not a courtesy list. Respond politely and seek clarification of the issue. Establish when the patient will actually be available, and what will obstruct communication: language, a tracheostomy, other medical devices. Ask whether the referral was discussed with the patient and the caregiver and whether consent to be seen was obtained; whether the referral is an outcome of the treating team's frustration rather than of a change in the patient; and how urgent it is.

One clause outweighs the rest and is the most examinable sentence in the procedure: the patient has the right to refuse psychiatric assessment, and this should be respected if possible. It is easy to miss, because a medical admission has already normalised examination by strangers. A patient who declines has obstructed nothing: record the refusal, tell the consultee, and leave the door open rather than persisting on the team's authority. Capacity and treatment refusal proper are taught separately; this is an operational rule that applies before any capacity question arises.

GOOD TO REMEMBER

Before writing your own note, ask the person who telephoned to write theirs: the Indian account makes it an explicit step to ask the consultee to document the reason for the call in the file. It fixes the referral question in the record rather than in your recollection, so your answer can be read against what was asked; it commits the team to having wanted something, which is what makes a later review meaningful; and where the call arose from exasperation rather than from a change in the patient, this is usually where that becomes visible.

2.6 Urgency: how it is graded, and where the grading belongs

Ghosal and Ray present the **Mental Health Triage Scale** with five colour-coded urgency bands and explicit response windows. The scope is the examinable part: it is an emergency-room instrument, offered as something emergency and primary-care personnel may be trained to use, and it is not a standard for answering a ward call.

BAND	RESPONSE WINDOW	PRESENTATION THE BAND IS WRITTEN FOR
Immediate (red)	Immediate response, with referral to security or police	Violent aggression, possession of a weapon, an attempt at self-destruction
Emergency (orange)	Usually within **four hours**	Clear intent, plan and arrangement to harm self or others; very high-risk behaviour with confusion and disorganised behaviour
Urgent (yellow)	Within twenty-four hours	Suicidal intent without a clear plan, rapidly increasing confusion, psychotic behaviour
Semi-urgent (green)	Within seventy-two hours	Mood disorder or apparent psychosis without suicidal intent, uncooperative behaviour on the ward
Nonurgent (blue)	Within four weeks	Known stable psychiatric disorder requiring follow-up

The scale's own primary publication is not available to quote, so the windows are attributed to the chapter that prints them rather than to the instrument's authors. In a recent Indian tertiary-hospital study using the scale the yellow zone was the commonest zone of referral: the modal emergency referral is genuinely urgent without being immediate, and a service configured only for the red band mishandles most of its work.

For the ordinary inpatient call there is no equivalent figure. No comparable standard is available to quote, and none is invented here. What exists is a behavioural rule rather than an interval: respond in a timely way, and tell the team the time frame in which the referral will be attended. Naming your own time frame is what converts an open-ended promise into something a ward can plan around, and it is the honest answer to an examiner.

2.7 The preparatory phase, and the consult at the bedside

Ghosal and Ray draw the sharpest structural contrast in the topic: in individual practice there is no interval between the appointment and contact with the patient, whereas the liaison setting has a compulsory **preparatory phase** the psychiatrist must complete first. Skipping it is how a competent psychiatrist produces an incompetent consult.

- The current medical diagnosis and the treatment being given.
- A review of all available papers in the chart, not the summary handed to you.
- Any past or ongoing psychiatric illness, and how it was treated.

- Direct communication with the treating or referring consultant to understand their conceptualisation of the case, what they need, and where they want the focus.
- For an inpatient, the observations of the nursing staff or the duty doctor.
- For an inpatient, word sent to a family member to be present at the interview.

The bedside sequence is a psychiatric assessment with additions that only make sense in a hospital. Review the treatment record first, including the sleep chart and the nursing observation record. Introduce yourself and take verbal consent, with caregiver consent where the patient is not competent to give it. Find a private area or quiet side-room, which on an open ward takes effort. Take the history keyed to onset, symptom type, fluctuation, and relation to events in treatment. Examine physically, then perform a detailed mental status examination; the interview and the examination themselves are taught in the Psychotherapies, clinical assessment, MSE and nosology notes. Cover, without exception, cognitive functioning, catatonic features, substance use with quantity and time of last intake, overdose and withdrawal, suicidality, sexual behaviour, poisoning, trauma, nutrition and infection.

What distinguishes this from an outpatient interview is the step candidates omit: having established the phenomenology, look deliberately for links to medications, surgery, the fact of hospitalisation, the disclosure of the diagnosis, the behaviour of the team, a mismatch between what the patient expected and what is happening, and the physical environment: lights, sound, indwelling tubes and neighbouring patients. Each is a candidate cause absent from outpatient practice, each is potentially reversible, and several are reversible by the ward rather than by the psychiatrist.

2.8 The note, and the three-way aetiological question

The Indian account itemises the liaison note, and the list is the consult's intellectual content rather than its paperwork.

- The provisional or differential diagnoses, stated by current nosology.
- The probable aetiology of the psychiatric condition against the background of the medical illness: whether there is **mutual causation, comorbidity or coincidence**.
- The probable interaction of the psychiatric treatment proposed with the ongoing medical treatment and the treatment milieu.
- A comment on the biopsychosocial background relevant to management, including developmental issues, current personal stressors and personality.
- Any evidence of immediate risk to self or others, with the need for or the decision about transfer to a psychiatric ward.
- Any adjustment needed from the treating team itself to manage uncooperative behaviour.

Build the answer around the second of those. The question is not taxonomy: each answer sends the consult somewhere different. Mutual causation makes the psychiatric problem part of the medical plan, and it is the finding that most often changes what the ward does next. Comorbidity means two conditions treated concurrently, which puts the weight on interaction and sequencing.

Coincidence means the illness would be present in this patient anywhere, so the honest recommendation may be continuity of existing treatment. A candidate who writes a diagnosis and a drug has skipped the only question that required a psychiatrist to attend.

> The consult ends when the consultant who called has been spoken to, not when the note has been written.

2.9 Feeding back, and the etiquette that keeps you invited

Writing in the file is explicitly not sufficient. Ghosal and Ray say that beyond notes on paper certain further things are advisable: the psychiatrist should communicate directly with the treating consultant, at least by telephone, resolve the team's doubts from a mental health perspective, give the overall formulation, and suggest a comprehensive treatment plan. The verbs are advisable and should rather than must, and are worth quoting as written. A note transfers information; a conversation is what lets the team say your recommendation is impossible on their ward, which is how good psychiatric advice ends up never implemented.

The same chapter reproduces ten commandments for the liaison psychiatrist, attributed to Pasnau, and they should be attributed that way, as a framework reproduced inside the Indian account, because the original is not available to quote.

MNEMONIC

Be concrete; do not obfuscate, procrastinate, preach or steal

The commandments **Pasnau** sets for the consultant, in the order a consult uses them. **Concrete:** recommendations written clearly enough for the physician to implement without translation. **Obfuscate:** no jargon and no irrelevant psychiatric detail, in simple language any physician can understand. **Procrastinate:** do not leave a call unanswered. **Preach:** do not teach or offer unnecessary advice to the physicians. **Steal:** discuss with the consultee who will be the patient's primary physician in the long term.

The last reads as manners and is not. Settling openly who holds the patient prevents two failures: a patient followed by nobody because each side assumed the other, and a team that stops referring because referral feels like losing patients.

2.10 Who keeps the patient, and who owns the decision

The request to move the patient to the psychiatry ward is the standing point of friction in liaison work, and the Indian account answers it with criteria rather than with a rule.

PRESENTATION	WHERE IT IS MANAGED	WHEN TRANSFER BECOMES APPROPRIATE
Delirium	Continues in the medical ward, with regular psychiatric observation	Not on the ground of the behavioural disturbance itself
Substance use disorder	Medical ward while medical complications are stabilised	After initial stabilisation of the medical complications
Depression, suicidality or psychosis with serious medical morbidity, where a medical emergency may emerge	Medical ward, under regular psychiatric supervision	Only in stable medical conditions, such as a patient not on any ports and not requiring oxygen therapy, and then with regular observation by the medical team

The reasoning under the first row is what an examiner tests. The transfer is requested because the behaviour is unmanageable on a medical ward; the answer is that the behaviour is the presentation of an acute medical problem: physicians and surgeons need to understand that this is a medical emergency due to an underlying medical cause, with psychiatric manifestations. Moving the patient moves them away from the investigation and treatment that will resolve it. The entity belongs to the Stroke, TBI, delirium and focal brain syndromes notes. What this topic owns is the negotiation, and the fact that the psychiatrist's job here is to decline the transfer while accepting the work.

On formal responsibility, be careful. What is stated is operational: the primary team must be told what is required before a transfer, delirium stays where it is, the consultee records the reason for the call, and the long-term primary physician is settled by explicit discussion. Whether the recommendation is formally advisory, and where clinical and legal responsibility rests once it is made, is not stated in terms by any available Indian source. No comparable statement is available to quote, and none is invented here. Describe the decision as negotiated with the primary team, and do not convert the transfer criteria into a claim about liability.

2.11 What happens after the consult

Documentation is deliberately duplicated: the consultation is documented in the primary treating team's medical records and in separate treatment records kept by the psychiatrist. The reason is structural: the team's file is where a recommendation must live if it is to be acted on, and it travels with the patient to whoever is on duty tonight, while the psychiatrist's own record is the only place a longitudinal psychiatric account survives once the chart is closed.

Two obligations follow the note. The patient is reviewed from time to time during the admission and followed up even after discharge from the inpatient unit; no review frequency is specified and none should be inferred. One interval is: where a major psychiatric diagnosis is confirmed and pharmacological treatment started, follow-up should be **within a week** at the latest, with regular psychiatry outpatient follow-up after discharge stated as obligatory. Where no definitive diagnosis was reached, the recommendation is regular follow-up with psychometric evaluation and symptomatic management rather than a diagnosis asserted to close the episode. That

distinguishes a liaison service from an opinion service: the honest output of a single ward visit is often an unfinished formulation.

2.12 Models of the service, and the case for building one

The principles and models of consultation-liaison psychiatry are set out in the Indian overview along three axes rather than one list, by focus of consultation, by function and by focus of work, with fourteen named models distributed across them. The axes matter more than the names, because they say what a service has chosen: whether the unit of attention is the patient, the crisis, the consultee or the situation; whether the psychiatrist consults, liaises, bridges or works autonomously; and whether the work is organised around critical care, biological treatment, the ward milieu or an integrated model. Competing classifications exist and are not interchangeable, so name the axis and the source rather than merging two schemes into one table.

The distinction that does most clinical work cuts across all three axes. **Reactive** practice means the patient is seen only after the primary team refers. **Proactive** practice puts the mental health professional inside a **behavioural intervention team**, a multidisciplinary consultation service attached to the medical or surgical unit itself. Its stated benefits are easy access to mental health services, reduced length of stay, early detection and treatment, education of colleagues in behavioural problems and better relationships with other specialties; the same chapter notes that in patients with combined physical and mental disorders, earlier referral to liaison psychiatry is linked to a shorter length of stay.

A service answered on call cannot detect early, so the referral rate measures the model as much as the ward's awareness. One worked Indian example exists. For psychodermatological work the preferred set-up is a clinic comprising a psychiatrist, a dermatologist and a clinical psychologist, as followed at Kasturba Medical College, Manipal, with the source's hedge preserved: because of a dearth of specialists such a composite set-up may not be possible across the country.

The economic argument, used when a service has to be funded, must be quoted with its provenance intact. The Indian overview reports that psychiatric consultation brought the average stay at Denver General Hospital down from 28 days to 16 days, as Billings reported in 1937, and that strategies training primary-care physicians to manage outpatients with hypochondriasis, reported by Smith in 1986, decreased medical costs by 49 to 53 per cent without affecting patients' health or satisfaction. Both are historical United States findings reported at second hand, and neither is an Indian cost-effectiveness result; the chapter's own position is that Indian cost-effectiveness research is what is missing. Quote them as the classic economic argument, and say so.

3 · Psychiatric aspects of medical and surgical illness

Why the marks are here. Almost every other topic in the syllabus begins with a syndrome and works outward to its causes. This one begins with a body that is already ill and works inward. The psychiatric aspects of medical and surgical illness are set as one wide question, and the answer that scores is not a catalogue of organs with a syndrome hung on each. It is an account of what recurs on every ward whatever the specialty, of the several different routes by which an ill body

generates a psychiatric presentation, and of the reading habits that stop a psychiatrist mistaking one route for another. An examiner can usually tell within two sentences whether a candidate has stood on a medical ward or only read about one.

Four neighbouring subjects are named here and deliberately not taught. The patient's own psychological work of being ill, the adaptations and reactions a serious or chronic diagnosis sets going, is taken up separately in this chapter, as are the high-stakes settings of transplantation, dialysis and intensive care, the specific cross-links between psychiatry and cardiology, dermatology and nephrology, and the psychiatric care of people with cancer. What belongs here is the general case: the signature that does not change when the ward does, read in both directions, and what it obliges you to do about it.

3.1 What a psychiatric signature is, and the four routes that produce one

A **psychiatric signature** is the recurring pattern of psychiatric presentation that a class of physical illness produces, taken across many patients rather than in one. It is a probabilistic statement and not a diagnostic one: it tells you what to look for and how high your prior should be, never what this patient has. Candidates lose marks by treating a signature as a criterion set, and lose them again by treating it as though every organ owned a private syndrome.

Four different things are folded into that single phrase, and prising them apart is most of the clinical work.

- **What the disease does.** The illness acts on the brain directly, through metabolic, inflammatory, endocrine, vascular or hypoxic mechanisms, and the psychiatric presentation is a part of the disease rather than a response to it.
- **What you gave it.** The treatment rather than the illness produces the picture: a drug, a procedure, the ward environment, or a withdrawal state manufactured by stopping something the patient was taking at home.
- **What it means.** The patient's own reading of the diagnosis, the prognosis and the lost function, which is where a great deal of the distress on a general ward actually lives, and which is taken up separately in this chapter.
- **What it hides.** The reverse case, in which what presents as a primary psychiatric disorder is the first visible sign of an undiagnosed medical disease.

MNEMONIC

What it does, what you gave it, what it means, and what it hides

The four routes in the order a ward consult meets them. **What it does:** the disease acting on the brain. **What you gave it:** the drug chart, the procedure, the environment, the withdrawal state. **What it means:** the patient's reading of what has happened. **What it hides:** a medical disease presenting psychiatrically. The first two are the ones you can establish from documents before you reach the bedside, the third is the commonest, and the fourth is the one whose miss is least forgivable.

Deciding which route is operating in a particular patient, and committing that decision to the record, belongs to the consult itself and is taught with it. What this topic supplies is the material out of which that decision is made.

3.2 The constant across specialties

The most useful single fact in this topic is that the presentations vary far less than the syllabus implies. The consultation-liaison guidance published in the Indian Journal of Psychiatry in 2022 states it without qualification: across all medical specialties and all ages, the commonest psychiatric symptoms and morbidities are stress, anxiety, depression and **somatic distress**. Not an organ-specific list. The same handful, on the cardiology ward, in the burns unit, in the renal clinic and the surgical side-room.

Two consequences are worth building an answer around. The first is procedural. If the presentations are constant, the opening move on any referral is constant too, and a candidate who cannot state that move has no method, only a memory of organ lists. The second is that the specialty is informative about mechanism and not about presentation. Knowing which ward telephoned tells you which drugs are likely to be on the chart, which metabolic derangements are plausible, what the operation did, and what the illness probably means to this patient and this family. It does not tell you what you will see when you pull the curtain back.

RULE **The specialty predicts the mechanism, not the presentation.** Whichever unit calls, you will meet stress, anxiety, depression or distress expressed in the body. What changes across the corridor is why it is there and what you may safely do about it: the disease process available to act on the brain, the drugs on that unit's chart, the procedures it performs and the meanings its diagnoses carry. An answer opening with a per-organ catalogue has inverted the subject and will run out of time before it reaches what is actually examined.

Somatic distress deserves separate attention because it is the presentation most likely to be misread by everyone in the room, by the medical team as a failure to find the lesion and by the psychiatrist as an absence of psychiatric illness. The disorders themselves are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. What belongs here is simply that a medical ward will hand you this presentation as often as it hands you low mood, and that it arrives labelled as a diagnostic failure rather than as a referral question.

3.3 The step from the community to the ward

The second grounded fact is the size of the step between a general population and a hospital population. The same Indian guidance measures that step for depression and gives a band for anxiety, and both are worth carrying into the examination hall.

about 10%	up to 30%	20 to 30%
PREVALENCE OF DEPRESSION IN THE COMMUNITY, THE GUIDANCE'S BASELINE	PREVALENCE OF DEPRESSION REPORTED IN DIFFERENT MEDICAL UNITS	PATIENTS IN MEDICAL SETTINGS PRESENTING WITH ANXIETY DISORDERS

Read those as figures for depression and anxiety specifically, not for psychiatric morbidity in general, which is a wider quantity with its own literature. The step itself is a prevalence

observation and carries no causal claim on its own: more than one of the routes above is operating simultaneously in any medical unit, and none of them is measured by a prevalence figure. Illness acts on the brain, treatment acts on the brain, and being ill means something to the person; the count cannot say in what proportion. For stress and for somatic distress the same guidance gives no comparable figure. No comparable standard is available to quote, and none is invented here.

What the step does change is your threshold for asking. If the prior probability of depression on a medical ward is several times the community figure, a negative has to be earned rather than assumed, and screening only the patients who look sad will systematically miss those whose presentation has been absorbed into the medical picture. That, and not the arithmetic, is what the figure is for.

3.4 Which way the fraction runs

The current Indian clinical practice guideline for the assessment and management of depression, published in the Indian Journal of Psychiatry in 2026 by Tripathi and colleagues, tabulates how often other conditions accompany major depressive disorder. The table is headed as the prevalence of comorbidities in major depressive disorder, and that heading fixes the direction of every fraction in it: the denominator is the depressed population, not the medically ill one.

COMORBIDITY	SHARE OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER	WHAT IT CHANGES FOR YOU
Anxiety disorder	**67 per cent**	The commonest travelling companion. A management answer for depression that never mentions anxiety has left out most of the patients it is about; the disorders themselves belong to the Anxiety, OCD and trauma-related disorders notes.
Obsessive-compulsive disorder	40 to 80 per cent	Quote it as the range it is. A band this wide is a statement about the spread of the underlying studies, not a point estimate waiting to be averaged.
Attention-deficit hyperactivity disorder	53 per cent	Inattention and restlessness in a depressed inpatient are not automatically depressive symptoms.
Substance use disorder	25 per cent	Withdrawal risk and interaction risk both change before a single dose is written up.
Irritable bowel syndrome	37 per cent	Abdominal symptoms in a depressed patient may be a comorbid disorder rather than distress expressed through the gut.
Parkinson's disease	40 to 50 per cent	The highest figure among the physical illnesses listed. The pairing is expected, not incidental, and it should never be explained to a family as a reaction to the diagnosis.
Metabolic syndrome	25 to 44 per cent	Weight and glycaemic consequences of the agent you choose are part of the treatment decision rather than an afterthought at review.
Hypertension	**27 per cent**	Blood pressure is a routine prescribing consideration in this population; the choice of agent belongs to the Mood disorders: pharmacotherapy notes.

Six further rows sit in the same table without a rate that can be quoted against them with confidence: autoimmune disease, eating disorders, epilepsy, multiple sclerosis, Alzheimer's disease and coronary artery disease. Their presence is itself the teaching point, because it tells you the pairing was thought worth tabulating. No dependable figure is available to quote for those rows, and none is invented here. Each of those conditions is taught elsewhere: epilepsy in

the Epilepsy and psychiatry notes, the degenerative dementias in the Dementias and neurocognitive disorders notes, eating disorders in the Eating and sleep-wake disorders notes.

TRAP **Quoting a comorbidity figure with the fraction inverted.** Because the table counts comorbidities within depression, its hypertension row states the share of depressed patients who also carry hypertension. It does not state the share of hypertensive patients who are depressed. Those are two quantities over two denominators, not interchangeable in either direction, and no arithmetic converts one into the other. An examiner who asks how common depression is in cardiac disease is asking for the reverse fraction, which this table does not contain; a candidate who supplies it from here has misread the title rather than the number.

3.5 The drug chart as a differential diagnosis

The most reversible cause of a psychiatric presentation on a medical ward is usually the one written on the chart at the foot of the bed. The same Indian depression guideline tabulates the drug classes reported to induce or exacerbate depression, and the practical value of that table is not that it should be memorised molecule by molecule but that it converts **medication-induced depression** from an afterthought into a standing item on the differential. The categories, as the guideline groups them, are these.

- Cardiovascular drugs and chemotherapeutics, the two classes most likely to be running when a specialty ward refers.
- Antiparkinsonian drugs, and antipsychotics, which is the row candidates forget because it names their own prescribing.
- Stimulants, where the guideline is explicit that the depressive picture usually belongs to **withdrawal** rather than to continued use, so the relevant date is the stop date and not the start date.
- Anti-microbial agents, antiretrovirals and central nervous system depressants.
- Hormonal agents, the row that names adrenocorticotropin, anabolic steroids, glucocorticoids and oral contraceptives, so that both an inflammatory prescription and a contraceptive one land in the same differential.
- A residual category holding agents that belong to no single specialty, among them cimetidine, disulfiram, phenytoin, tamoxifen and the non-steroidal anti-inflammatory drugs.

Note what the taxonomy is doing. It is organised by the ward that prescribes rather than by pharmacological mechanism, which is exactly right for a liaison psychiatrist: you are not asked to predict which receptor produced the low mood, but to read a chart written by somebody else and say which lines on it are candidate causes. The residual category matters most for that reason, since it collects the agent nobody thinks of as psychotropic, started for an unrelated indication by a team that will not connect it to the referral.

IN INDIA

The anti-microbial row is the one that changes most between a Western text and an Indian ward. It names chloroquine, cycloserine, dapsone, ethambutol, ethionamide, isoniazid and metronidazole. Those are not rarities on an Indian general ward; several are ordinary continuing treatment that arrives with the patient rather than being started in front of you, and the referring team may not list them when it telephones because it does not regard them as new. The antiretroviral row raises exactly the same issue. The obligation here is narrow and worth stating in exactly these terms: obtain the full treatment list, including what the family carries in a bag from home, before you accept that a low mood on this ward is primary.

3.6 Running the signature backwards

The fourth route turns a routine consult into a diagnostic emergency, and it is also the most reliably examinable content here, because it can be asked as a short list and marked without ambiguity. The Indian guidance sets out a small set of pairings that run from the psychiatric presentation towards an occult medical cause. Learn them as pairings and not as diseases: what earns the mark is the recognition that a particular combination of psychiatric picture and accompanying feature should send you back to the body.

PSYCHIATRIC PRESENTATION	THE FEATURE THAT SHOULD STOP YOU	CONSIDER, AND WHERE THE CONDITION ITSELF IS TAUGHT
Psychosis	Confusion, seizure, **subacute onset**	Autoimmune encephalitis, taught in the Neuropsychiatry of systemic and neurological disease notes
Depression	Weight loss with severe pain	Multiple myeloma. Not a psychiatric entity; the finding goes back to the treating team
Depression	Anorexia, nausea and abdominal pain	Gastric or pancreatic carcinoma
Depression or anxiety	Panic-like autonomic features with flushing	Paraneoplastic lung carcinoma in an older patient, phaeochromocytoma in a young one
Late-onset mood disorder	**Neuroleptic sensitivity** with a subtle movement disorder	Degenerative brain disease, taught in the Dementias and neurocognitive disorders notes
An apparently dissociative presentation	The label itself, when the psychiatric account behind it is thin	Localisation-related epilepsy, or non-motor vascular lesions including Balint, Gerstmann and Anton syndrome, taught in the Stroke, TBI, delirium and focal brain syndromes notes

Several of those rows share a structure worth naming. In each, the psychiatric diagnosis is entirely plausible on its own and the tell-tale is a feature that is out of proportion to it: weight loss too great for the mood state, pain too severe, autonomic arousal too paroxysmal, drug

sensitivity too marked for the dose given. Disproportion, rather than atypicality, is the signal. A patient whose depression is textbook except that the weight loss is extreme has a more suspicious presentation than one whose depression is merely odd.

The last two rows each carry a further lesson. Age itself narrows the differential, and the assessment of a first mood episode in later life has its own section here. An apparently dissociative presentation, meanwhile, is the psychiatric label most often applied without a positive account of why, and therefore the label under which a neurological diagnosis most easily survives untested.

GOOD TO REMEMBER

Run the reverse check at the end of the first assessment, not after the first treatment has failed. The common version of this failure is not a psychiatrist who cannot recognise an occult malignancy; it is a patient treated for depression for several weeks before anybody asks why the weight loss was out of proportion to the mood, by which time the case has acquired a history of non-response that is then read as treatment resistance. The check costs one question and belongs in the first note.

3.7 Where the per-system detail lives, and the table that is not here

A deliberate omission, and why. There is no single table in this chapter setting out the psychiatric signature organ system by organ system, and that is a decision rather than an oversight. No source consulted here carries such a table. The Indian consultation-liaison guidance distributes the material across **ten** separate organ-system chapters, each carrying its own prevalence figures, its own mechanisms and its own prescribing cautions. A single table assembled across those specialties from recollection would look authoritative and be unverifiable, so none is offered here.

What can usefully be given is the map. The organ systems treated separately in that guidance are cardiovascular, respiratory, hepatic and gastrointestinal, chronic kidney disease, endocrine, stroke and traumatic brain injury, Parkinson's disease, epilepsy, cancer, and human immunodeficiency virus infection with dermatology. The same body of guidance adds settings rather than systems: solid-organ transplantation, intensive care, bariatric surgery, the perinatal period, medication-induced psychiatric disorder and coronavirus disease. That last group is where the surgical half of this topic mostly lives, and it is the reason the subject is titled for medical and surgical illness rather than for medicine alone: an operation is an exposure in its own right, with its own environment, its own drugs and its own meanings.

Most of those are owned elsewhere and should be answered from there rather than from here. Epilepsy is taught in the Epilepsy and psychiatry notes. Stroke and traumatic brain injury are taught in the Stroke, TBI, delirium and focal brain syndromes notes, and the wider systemic and neurological diseases, endocrine disease among them, in the Neuropsychiatry of systemic and neurological disease notes. The localising and lesional groundwork behind all of those sits in the Neurology foundations for psychiatrists notes. Transplantation, dialysis and intensive care, the cardiological, dermatological and renal cross-links, infection with the human immunodeficiency virus, and cancer are each taken up separately in this chapter. What is genuinely owned at this

address is the cross-system pattern, the two directions of reading, the drug chart, and the referral habit that recurs whichever door the patient came through.

3.8 The habit that survives the specialty

Everything above collapses into a short sequence that holds whichever unit called, and it is what an examiner listens for when the question is set broadly. It is deliberately not a screening instrument; the instruments and their scoring belong to the assessment and bedside-testing material taught elsewhere. This is the order of thought.

- Establish the date on which the psychiatric change began, from somebody who saw it, and date every drug on the chart against that date rather than against the admission.
- Ask the treating team what changed in the medical illness itself inside the same window: a result, a complication, a procedure, an escalation of care.
- Ask what the patient has been told, and separately what the patient believes it means, because the two are routinely different and the second is what generates the distress.
- Before closing, run the presentation past the reverse list and satisfy yourself that nothing in front of you is out of proportion to the psychiatric diagnosis you are about to offer.

The first and second steps together are what distinguish a liaison assessment from an outpatient one. In a clinic the psychiatric history is the primary record; on a ward it competes with an obviously more urgent medical narrative, and the temporal relationship between the two is the single piece of information nobody else in the building is collecting. The clinical interview and mental state examination themselves are taught in the Psychotherapies, clinical assessment, MSE and nosology notes; what is added here is the discipline of laying two timelines side by side before interpreting either.

> Every specialty produces the same short list of presentations, so the ward tells you the mechanism and the prescribing, never the syndrome you are about to meet.

Answer the wide version of this question in that order and it holds together, and close it by conceding that the per-system detail is distributed across the specialties and should be answered from the relevant one. That concession is worth more marks than an invented table, because it is what a working liaison psychiatrist would actually say.

4 · Psychological reactions to physical illness and chronic disease

Why the marks are here. A question on the psychological reactions to physical illness is not a question about a disorder, and a candidate who answers it with a criterion set has answered something else. Almost every other topic in this area begins with a syndrome and works back to what produced it. This one begins with a person who has been told something about their body, and asks what they are now doing with that information: what the illness means to them, what it has cost them, and how much of that is visible on a ward round. The patient at the centre of it may carry no psychiatric diagnosis at the end of your assessment and still be the reason the referral was made.

Two boundaries keep the answer clean. Adjustment disorder as a diagnostic category, and the psychosomatic concept behind the two-way relation between mind and body, are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The psychiatric presentations a physical illness generates through the disease, through its treatment, or by concealing itself behind a psychiatric label, are taken up separately in this chapter. What is owned here is the patient's own work: the reaction, its trajectory across a long illness, and what both of them do to treatment.

4.1 The reaction is universal, the morbidity is not

The consultation-liaison guidance published in the Indian Journal of Psychiatry in **2022** opens this subject with a sentence worth carrying into the hall intact: all physical illnesses and their management cause a psychological reaction, and that reaction may or may not reach **morbid level**. The second half does the clinical work. Because the reaction is universal, its presence is not a finding, and a patient who appears to feel nothing has told you something about how they are managing the news rather than that no reaction occurred. What varies between patients is how far it goes, and that variation, not the reaction itself, decides whether anything needs to be done.

The same guidance runs the relation in both directions in one sentence: mental illness and stress in their turn predispose to a wide variety of physical illnesses. The consequence for a consult is that the patient's psychological state is never purely downstream of the medical one. It is also an input to the illness in front of you, which is why it is assessed rather than noted in passing.

That is why the same source lists the discrimination among the tasks of the consultation-liaison psychiatrist: the opportunity to assess the reaction to physical illness, and to differentiate it from psychiatric illness presenting in medical and surgical units. Recognising a depressive episode on a surgical ward is one skill. Recognising that the distressed man in the next bed does not have one, and saying so in terms the team can use, is another, and the guidance is explicit about where that leaves him: people referred in this setting may not fulfil the diagnostic criteria for any particular mental disorder, and may nonetheless need support for their psychological difficulties.

RULE **The reaction is universal, so the question is never whether the patient has one, but how far it has gone and what it is costing the treatment.** An assessment that concludes "no psychiatric illness" and stops has answered a question nobody asked. The referring team did not enquire whether criteria were met; it asked what to do about the patient in front of it. A reaction well below any diagnostic threshold can still be the reason a man will not sit up after his operation, and a consult that names it and says what would help has discharged its task.

4.2 Moving or stuck: the judgment the guideline actually asks for

If the threshold is not a criterion count, what is it? The current Indian clinical practice guideline for the assessment and management of depression, published in the same journal in **2026**, supplies the working rule for a response to loss, and it transfers directly to the losses a physical illness inflicts. Enquire whether the person is moving toward acceptance, or has been stuck in one place for a prolonged period. And because there are no universal ways of coping with or dealing

with stress, the comparator is not other patients: it is the **premorbid history**, and the question is whether the current response is normal or out of character for this individual patient.

Three consequences follow. The judgment is about direction rather than content, so the intensity of what you see at the bedside settles little on its own: grief that looks severe but is moving is a different clinical object from a flatter picture that has not shifted in weeks. It needs two points in time, which makes a review appointment part of the assessment. And it makes the patient their own control, which is the only comparator the guideline leaves standing.

A second decision sits behind the first: whether pharmacological help is needed, or whether psychotherapy or a support group will suffice. Notice the order. The intensity decision comes after the normality decision and not instead of it, and a candidate who reaches for an antidepressant before establishing direction and character has skipped the step the question was set to test. The choice of agent belongs to the Mood disorders: pharmacotherapy notes.

TRAP **Judging the reaction against how people are supposed to cope, rather than against how this person has always coped.** Candidates make it because a sequence of named phases reads like a timetable, and a patient who is not where the timetable says they should be looks abnormal by arithmetic alone. The guideline forecloses that reading, and what it leaves standing is the premorbid account. The practical form of the error is a diagnosis made on a stranger: a lifelong undemonstrative man recorded as flat and withdrawn by a clinician who never asked anybody who knew him beforehand.

GOOD TO REMEMBER

The comparator has to be collected, and it is not in the medical file. Before recording a reaction as abnormal, get from a relative what this person was like the last time something went badly wrong: how they took bad news, whether they talked or went quiet, whom they told. Then ask the patient what they expected to hear before they were told, because the size of a reaction usually tracks the gap between what was expected and what was said.

4.3 What the reaction costs the treatment

Why it is a treatment variable. The case for assessing any of this rests on outcome, not on sympathy. The same consultation-liaison guidance states that psychiatric morbidity in people with medical illness is associated with a set of negative outcomes:

- higher utilisation of health-care services;
- prolonged hospital stay;
- frequent hospitalisations;
- poor **adherence** with medication;
- higher and earlier mortality.

Read that as a chain rather than as five separate associations. Adherence is the hinge in the middle: a patient not taking the treatment accumulates complications, complications generate admissions, and admissions generate cost and risk. The other entries are largely what adherence

failure looks like once it has been running a while. That is what makes the psychological reaction a modifiable determinant of a medical outcome rather than a comment on the patient's mood.

The renal chapter of the same body of guidance states the mechanism in one disease with more precision. Comorbid depression adversely affects the attitude toward medication compliance and compromises sleep quality, and psychiatric comorbidity in chronic kidney disease worsens help-seeking, lifestyle and medication adherence, and so worsens the renal outcome itself. Note the phrasing: attitude toward compliance. What is affected first is not the ability to take a tablet but the reason for bothering, which is the ground the psychological reaction occupies. The direction is stated and the magnitude is not: no effect size, hazard ratio or adherence figure is attached to any of it in that guidance, and none is supplied here.

So the question you are answering is not really whether the patient is depressed. It is why this patient is not getting better, and the psychological reaction is one of the few answers to that question anybody in the building can act on.

4.4 The long illness: biographical disruption and biographical repair

A reaction to an acute illness resolves as the illness resolves. A chronic disease offers no such ending, and the reaction to it is better understood as a trajectory than as a state. The most useful frame treats chronic illness as **biographical disruption**: the illness interrupts the life a person was in the middle of living, and everything after is the work of assembling a life around it. Bury's model, as applied in a 2025 systematic review and thematic synthesis of the qualitative literature on people receiving maintenance dialysis, published in BMC Nephrology, gives that trajectory a usable shape.

59	30	2000-2024
QUALITATIVE STUDIES SYNTHESISED IN THE REVIEW THAT SUPPLIES THIS TRAJECTORY	COUNTRIES FROM WHICH THOSE INCLUDED STUDIES WERE DRAWN	PUBLICATION WINDOW OF THE STUDIES THE REVIEW INCLUDED

Two cautions. The review sits in one disease because that is where the qualitative literature is thickest, and its subject is the patient's experience rather than the psychiatry of the dialysis unit, which is taken up separately in this chapter. It is an international synthesis and not Indian guidance, so no statement about Indian practice rests on it. What travels is the sequence:

- the diagnosis itself, and the initiation of a treatment that cannot afterwards be stopped, as the point at which the biography breaks;
- disabling physical symptoms and functional limitations;
- impaired socio-occupational functioning, which is where the loss stops being private;
- uncertainty and psychological distress;
- changes in self-image and identity.

The order carries the teaching. The early losses are of function and the late one is of self, so two patients with identical results can sit at very different places on it. One still contending with symptoms and limitation is asking what can be done. One who has arrived at a changed sense of

who they are is asking something else, and answering the first question when the second was asked is how a well-meant consultation lands badly.

What the review describes next is **biographical repair**, the half candidates leave out. Repair is carried by **coping styles**, meaning the characteristic stance a person takes toward the illness, and by **coping strategies**, meaning the particular things they do. Both are modifiable, which is why naming them matters, and the factors that help or obstruct them divide into what the person brings and what the setting supplies.

FACTOR	WHERE THE REVIEW PLACES IT	WHAT IT GIVES YOU TO WORK WITH
Age and gender	Internal	Fixed, but it predicts which losses matter most: earning, marriage, caring for others, independence.
Personal beliefs and misconceptions	Internal	Separate the misconception, which is correctable, before anything is called irrational.
Feelings of shame and guilt	Internal	Ask what the patient thinks caused the illness. Self-blame is rarely volunteered and drives concealment.
Financial constraints	Internal	Placed with what the person brings, and often the largest determinant of whether a plan is followed.
Religion and spirituality	Internal	A resource in this model, not a complication. Record what the patient draws on, not only what they suffer from.
Social support	External	Establish who is actually doing it. It is usually one exhausted person, whose state predicts the patient's.
Stigma	External	Governs disclosure at work and at home, and so how much help the patient can accept.
Role of the clinical team	External	The one external factor you control. How the illness was explained is either equipment or obstacle.
Health system factors and the wider context	External	Named as the type of dialysis, the availability and quality of services, and the provision of health insurance. Read generally: what the treatment demands, what is reachable, who pays.

The table puts two entries where a candidate does not expect them. Financial constraint sits among the internal factors rather than among external circumstances, and religion and spirituality sit there too, with what the person brings.

4.5 Coping and resilience as things you assess

The companion assessment chapter in that same Indian guidance states the loop plainly. Chronic and serious medical morbidity, together with hospitalisation, increases the stress on the individual, which in a vicious cycle further worsens the outcome of the illness. To cope with that stress a person needs **resilience**, which in turn predicts a good outcome. So **perceived stress** and resilience are themselves assessed, rather than inferred from whether a diagnosis was reached. The guidance names the settings where this matters most:

- oncology;
- trauma;
- burns;
- patients waiting for transplant.

What those four share is what lets the principle travel to a ward not on the list. In each the outcome is uncertain, the waiting is long, the treatment is itself an ordeal, and the patient has time to think about all three. Those are the conditions under which coping capacity, rather than disease severity, begins to account for how a patient does. Standardised measures exist for both constructs, and the instruments and their scoring are taught in the Psychotherapies, clinical assessment, MSE and nosology notes.

An assessment recording only the presence or absence of a disorder has not examined the thing that predicts the outcome. Asking what this patient has to cope with, and what they cope by, yields something to write down even when no diagnosis is made.

4.6 The classical frameworks, and the vocabulary this section will not invent

Indian guidance points to two classical sources for the psychological reaction to illness. In a **1956** paper titled "Psychiatry and Medical Practice in a General Hospital", Bibring and Kahana classified patients into personality categories, deliberately avoiding psychiatric jargon in favour of language that would help practitioners recognise these patients in their day-to-day work, and explained what disease meant to each patient type and how doctors might best handle their predictable behaviours. The second is Groves, in two essays: one on taking care of the hateful patient, and one on the management of the borderline patient on a medical or surgical ward.

The pairing tells you what the field found it needed. The first framework answers what the illness means to a particular kind of person. The second answers what to do when the reaction has become a problem for the staff rather than a complaint from the patient, and that referral is common and rarely phrased as a psychiatric question. The call reports that the patient is refusing, or demanding, or has upset the nursing staff, and the skill lies in hearing a reaction to illness inside a complaint about behaviour.

The categories themselves are not reproduced here. The guidance pointing to these works does not carry their content in a quotable form, and a personality typology written out from recollection would look authoritative and be unverifiable. Anyone wanting to use either framework should go to the primary work.

The same discipline applies to a vocabulary this topic is often expected to produce. Three words recur in ward teaching and in model answers: denial, regression and dependency. No sourced definition, list or clinical description of them as reactions to physical illness is available at this address. No comparable standard is available to quote, and none is invented here. The better answer is available anyway: describe what the patient is doing, in their own words and the family's. What they have been told, what they say about it, what they are and are not doing about the treatment, and what has changed since the diagnosis. A behavioural description survives an examiner's follow-up question; a label attached without a source does not.

4.7 Coping in the patient's own frame

A patient's account of what has happened to them rarely arrives in the vocabulary of a textbook. It arrives as something about fate, or duty, or what the family will now have to do. A clinician who waits for it to be restated in clinical language will wait a long time, and will meanwhile record the patient as having no insight into the illness.

An Indian communication published in the Indian Journal of Endocrinology and Metabolism in 2018 demonstrates what working inside that frame looks like. It presents a curated and abridged selection of verses from the Bhagavad Gita, setting out the reactions of Arjuna to stress alongside the way Lord Krishna encourages him to develop and use positive coping skills. Diabetes is the exemplar, but the authors state that the selection is intended to be useful in any illness, and offer the verses to health-care professionals for encouraging healthy coping in people seeking medical care. It is a communication and a teaching resource; no claim about the frequency, classification or outcome of psychological reactions rests on it.

What it demonstrates is a move rather than a content. A patient's own tradition frequently contains a worked account of bearing what cannot be changed while acting where action is possible, and it will be more persuasive to them than anything constructed in a side room. The task is to find out what it is for this patient and work with it, rather than translate it into a mechanism and file it.

The clinical question about any such account is about consequence rather than content: is this belief carrying the patient toward continued treatment or away from it? The same sentence from two patients means two different things. That it is in God's hands can be what makes a decade of treatment bearable, and it can be why a man stops attending for review. Nothing in the sentence tells you which, so ask, and ask again at the next visit.

IN INDIA

Three questions belong in this assessment on an Indian ward, and none is about symptoms. Ask who is deciding about the treatment, because the answer is frequently a family group rather than the patient alone, and the reaction obstructing the plan may not be the patient's. Ask what the patient and the family are already doing that they feel is helping, and record it in the coping assessment: a practice the patient's community sanctions is not a finding, and treating it as one costs you the alliance. Ask what would make the next appointment difficult to keep, because where a chronic treatment is paid for from the family's own pocket, an interrupted course is often an economic event rather than a psychological one, and recording it as poor motivation puts the wrong problem in the notes.

4.8 What changes because of the answer

An assessment of this kind has to end in something the treating team can act on, and it resolves into three dispositions rather than a diagnosis.

Where the reaction is within character and moving, the output is a statement and not a prescription. Say plainly that this is a reaction within this person's range, name what it is a reaction to, and say what would help: information the team can supply, a change to what the patient is being asked to tolerate without explanation, contact with somebody at the same point in the same illness. Saying it clearly stops the team hunting for a disorder and starts them addressing what the patient is reacting to.

Where it is stuck, or out of character, the second decision becomes live and the intensity question is answered on its own terms. Where adherence has already been affected, name that outcome to the team in those words, because it converts an observation about mood into a statement about the medical result they are responsible for, and it is the sentence most likely to get your recommendation followed.

An examiner setting this question is testing whether you can hold two propositions in one answer: that this patient may have no psychiatric diagnosis, and that this patient needs psychiatric input. Assert only the first and you sound dismissive; assert only the second and every unhappy inpatient becomes a case. The space between them is why a general hospital keeps a liaison service.

A psychological reaction to physical illness is universal and only sometimes morbid: judge it by whether the person is moving or stuck against their own premorbid character rather than against any norm, and report it in terms of what it is costing adherence and outcome.

What arrives on the ward

5 · Delirium in the medically ill (CL perspective)

Why the marks are here. Delirium in the medically ill is examined twice over, and the two questions are not one question asked differently. The first asks what the syndrome is: its

definition, subtypes, screening instruments, causes, treatment and prevention are set out in the Stroke, TBI, delirium and focal brain syndromes notes. The second asks what a psychiatrist does when a medical team telephones about a patient who has become difficult overnight. That is the question taken up here, answered in acts rather than criteria: what the call is reporting, what can honestly be established in a single bedside visit, what the note must make happen after you leave, and who holds the decision when you go.

Two boundaries keep it honest. What ageing contributes is taken up where delirium in the elderly is dealt with in these notes; the referral pathway, the negotiation about moving a patient between wards and the models a service can be built on are taken up where the principles and models of consultation-liaison psychiatry are dealt with in these notes. What remains is narrow and heavily examined: consultation work on a condition medical in origin, psychiatric in presentation, and visible mainly to people who are not psychiatrists.

5.1 The call, and what its wording is actually reporting

A ward telephones about **disturbance**, and disturbance is not a diagnosis. The vocabulary of a referral is set by what can be seen from a nursing station across a bay: a patient who has climbed over the cot side, pulled at a cannula, refused a dressing, or simply cannot be settled. That reports an observed act and somebody's difficulty with it. Nothing in it commits the ward to a view about cause, and a candidate who reads the request as a diagnostic proposal has accepted the wrong problem before reaching the bed.

Three things are recoverable from the wording. What changed and when: a referral saying a patient has become uncooperative carries a hidden claim about a before and an after that the ward has usually not examined. Whose distress generated the call: a request from an exhausted night nurse and one from a consultant on a round differ even when the words match. And what is being asked for, which here is generally an act rather than an opinion: sedate, shift, certify, or take over. Answering the act without answering the question is how a consult becomes a prescription.

HOW THE CALL ARRIVES	WHAT THE WORDING IS REPORTING	WHAT THE CONSULT SETTLES FIRST
Not cooperating, pulling at the lines	An observed act and an interference with treatment, seen from the bedside	When it began, against what previous state, and who noticed first
Acute psychosis, please start something	A lay diagnostic label attached to disorganised behaviour by a team with no psychiatric training	That the label is the referrer's inference, and what was observed underneath it
Please sedate for the scan, or for the night	A request for an act, framed so that a refusal reads as unhelpfulness	Whether it is for the investigation, for the ward to cope, or for the patient's safety
Please shift to psychiatry, we cannot manage this	The team's judgement about its own capacity, not about the patient's diagnosis	What specifically cannot be managed, by whom, on which shift
Very quiet since yesterday, probably depressed	A change noticed only because somebody knew the patient before it	Whether the quietness is new, and what else changed the same day

RULE **The referral tells you what the ward can see from the corridor; the consult exists to convert that into something the ward can act on tonight.** Everything procedural here follows: why the wording is examined rather than obeyed, why the change over time is reconstructed from the people who were present rather than inferred from the patient before you, and why the output is instructions to a team rather than a formulation for a psychiatrist. A consult that reaches an accurate diagnosis and changes nothing the ward does overnight has failed at the one thing it was called for.

5.2 The patient who generates no call

Because a referral is generated by disturbance, the **referral filter** selects against the patient who causes no trouble. Someone withdrawn, slowed, staring at the ceiling and accepting every procedure without protest interferes with nothing, and a busy ward records that patient as tired, low, or comfortable. The consequence is structural: a service that only answers calls sees the population its callers can notice, defined by nuisance rather than by severity.

This is the difference between responding to referrals and **case-finding**, and it costs little on an Indian ward round. While on the unit for one patient, ask the nurse in charge a general question rather than a specific one: has anyone else on this bay changed since yesterday. Treat an answer such as has been very quiet since the operation as a referral, because clinically it is one and administratively it is not, and record what prompted you to look.

5.3 A screen at a bedside you will visit once

You attend once, usually in working hours, for a few minutes of a patient's week. The **observation record** kept by the nursing staff, with whatever the family attendant noticed, covers the rest. Any screen worth leaving behind must therefore be usable by those people rather than by you, because the observations that matter will be made when you are not in the building.

A screen here has a different job from a diagnostic interview: detection, and fixing a time point in the record, rather than closing a question. Which instrument is used, how it is scored and what it is validated against belong to the Stroke, TBI, delirium and focal brain syndromes notes; administering one in front of an examiner is taken up where the demonstration of clinical scales and bedside tests is dealt with in these notes. What belongs here is the choice as a service decision: an instrument only a psychiatrist can administer solves nothing on a ward the psychiatrist visits once a day.

So what is handed to the ward matters more than what is performed at the bed. **Serial observation** means a small number of items, repeated by whoever is on duty, entered in the chart with a time against them. Three properties make such an instruction survive a handover:

- it can be completed by a nurse or duty doctor with no psychiatric training, inside a routine observation round;
- it is timed and written in the ward's own record rather than reported verbally, so a pattern across a day and a night becomes visible to someone who was present for neither;
- it names in advance what result should bring the psychiatrist back, so the ward is not left choosing between doing nothing and declaring an emergency.

TRAP **Reporting one lucid interview as an exclusion.** The candidate sees the patient at midday, finds them oriented and cooperative, and writes that there is no evidence of a cognitive disturbance. That reports one time point as a conclusion and overstates its own instrument: what was observed at a stated hour is a finding, while nothing is present is a claim about hours nobody sampled. It is compounded because a reassuring note stops the ward looking. Write what you saw, when you saw it, and what would change the answer.

5.4 The note as an allocation, not an opinion

What a consultation note must contain in general, and the aetiological reasoning it is built around, are set out where the principles and models of consultation-liaison psychiatry are dealt with in these notes. What is distinctive here is that almost nothing the note asks for will be done by the psychiatrist. The search for the cause belongs to the admitting team, the ward environment to the nursing staff, the drug chart to whoever prescribes on it, the investigation to the specialty that ordered it. A note written as advice, in the register of a formulation, distributes none of that. A note written as an allocation does.

MNEMONIC

Owner, act, time, trigger

The test to apply to each line before closing the file. **Owner:** the person or role, named, not the team in the abstract. **Act:** what is to be done, in terms the owner can execute without translation. **Time:** when, or by when, since a recommendation with no time attaches to nobody's shift. **Trigger:** what change should bring the psychiatrist back, in observable terms rather than a judgement about severity. A line failing any of the four is an opinion wearing the clothes of a plan.

Two further entries earn their place specifically here:

- an explicit statement of what the psychiatrist is *not* doing, since the commonest misunderstanding here is that a psychiatric opinion transfers the problem. Recording that the cause is being sought by the admitting team, and that psychiatric input runs concurrently rather than in sequence, stops the investigation stalling while each service waits for the other;
- a record of what was not concluded, because a single visit often ends without a settled answer, and naming which possibilities remain open and what would separate them is safer than a label chosen to make the page look finished.

GOOD TO REMEMBER

Write for the person who will read this at three in the morning, not for the consultant who requested it. The reader who acts on it is the night duty doctor or nurse in charge, working alone, without the conversation you had on the round. Put the acts and their owners first, the formulation beneath, in plain language. A recommendation that must be interpreted before it can be carried out will not be carried out.

5.5 Who holds the decision, and what nothing here settles

The maxim is that the consultant advises and the treating team decides, repeated widely enough that candidates state it as a rule of law. Handle it carefully. Whether a liaison recommendation is formally **advisory**, and where responsibility for accepting or declining it rests, is not stated in terms by any source available for this section. No comparable standard is available to quote, and none is invented here. What can be reasoned from the structure of the situation is examinable, and it is most of what a candidate needs.

Begin from what the psychiatrist demonstrably does not control: not the bed, not the drug chart, not the investigation list, not the discharge. Every recommendation therefore needs an act by somebody else before it becomes treatment, which makes the practical task the reduction of friction between advice and execution. Three positions follow without depending on any contested rule about responsibility:

- put the recommendation where the acting team will find it, in the record they use, not in a document only psychiatry reads;
- make disagreement visible instead of repeating yourself, since a recorded exchange protects the patient and the discussion where a second note in identical terms protects nobody;
- where the disagreement concerns risk, state it in the currency of the specialty that must act on it, because a ward moves on what it recognises as danger.

Whether the patient moves to a psychiatric bed is a separate negotiation with its own criteria, settled where the consultation-liaison service and its models are dealt with in these notes; a patient refusing assessment or treatment raises a different question again, taken up where capacity assessment and refusal of treatment in the general hospital are dealt with in these notes. The referral settles neither.

5.6 The statutory floor under the ward consult

One thing is settled, and by statute rather than custom. The service you provide on somebody else's ward is not a favour between departments; it is local delivery of an obligation placed on the state.

IN INDIA

The Mental Healthcare Act, 2017 makes the availability of mental health services a duty of the appropriate Government rather than a matter for each institution to arrange. Under section **18(6)** that duty runs to all general hospitals the Government runs or funds, with basic and emergency mental healthcare available at all community health centres and upwards in the public health system it runs or funds. The ward consult is therefore a **statutory entitlement** of the patient in that bed rather than a courtesy between colleagues, and a general hospital without psychiatric cover is a shortfall against a duty, not a local misfortune. Quote it by number and duty-holder; the range of services required is specified elsewhere in the same section.

Read the provision for what it does and does not do, because an examiner will push on that edge. It establishes that a service must exist and how far down the system it must reach. It does not create a referral pathway, staff a rota, set a response time, or tell a physician when to telephone, and it is silent on the question the previous section left open: who owns the decision once the psychiatrist has attended. It answers availability completely and authority not at all, and a candidate who says precisely that has understood it better than one who recites it.

5.7 What this section hands on

The call reports behaviour	One visit is one sample	The note allocates
THE WORDING NAMES WHAT WAS SEEN AND WHOSE DIFFICULTY IT IS, NEVER A DIAGNOSIS	A SETTLED INTERVIEW AT MIDDAY RECORDS A TIME POINT AND EXCLUDES NOTHING OUTSIDE THAT HOUR	EVERY LINE NAMES WHO ACTS, WHAT THEY DO, BY WHEN, AND WHAT BRINGS THE PSYCHIATRIST BACK

What an examiner is testing. Given a medical inpatient disturbed overnight, the discriminating answer does not begin with a definition. It begins with the call: who telephoned, what they said, what they wanted, what the wording concealed. It moves to the bedside as a sampled observation rather than a verdict, and to the instruction left for the people present when you are not. It ends with a note allocating acts to owners with times against them. Answer in that order and the entity looks after itself; answer with the entity and the question has not been addressed.

You are called about behaviour, can sample only an hour of it, and leave holding none of the levers: so the output is not a diagnosis but a set of acts, each with a named owner, a time, and a trigger to call you back.

6 · Somatic symptom and related disorders in CL settings

Why the marks are here. The heading reads like a request for a taxonomy, and answered as one it loses almost everything on offer. What these conditions are, what each diagnosis requires, how

the instruments are scored and what is prescribed all belong to the Somatic-symptom, sexual, impulse-control disorders and suicide notes, which open on this group because it carries the largest reclassification in this part of the syllabus. None of it is repeated here.

What is owed instead is the part no taxonomy answers. **Somatic symptom and related disorders** reach the psychiatrist through another doctor's exhausted enquiry rather than through anything the patient, the family or the ward has called psychiatric. That fact governs the consent, the timing, the first sentence of the interview and most of what one visit can achieve.

6.1 The referral nobody in the room asked for

Most consults on a medical ward begin with a change in the patient: new confusion, a refusal, a collapse of mood. This one begins with a change in the referring team, which has run out of investigations it can justify. The patient is usually no different that day, and often does not know the call is being made. That makes it an **unrequested referral**.

The referral is itself an event in the illness. Before you are called, somebody has told the patient something about his results, and whatever was said is the ground you will be standing on. **The handover sentence**, the actual words in which the physician explained the referral, decides whether you meet a man offered another opinion or one told his symptoms are not real. It is not in the file, and will not be volunteered.

RULE **Find out what the patient was told, and by whom, before you ask the patient anything.** The referral has already made a statement about his body and his credibility, and your interview begins as a reply to it. Treat the distance between the referring doctor's words and the patient's account of the same conversation as a clinical finding, not a misunderstanding to correct.

6.2 When the call comes, and what the timing tells you

Timing carries information the referral text does not. The point at which psychiatry is called indicates what it is being asked to absorb.

WHEN THE CALL IS MADE	WHAT THE REFERRING TEAM HAS CONCLUDED	WHAT THE CONSULT DOES FIRST
Early, with investigation still running	That a psychological contribution sits alongside an enquiry that remains open	Take the history without waiting for the work-up, and tell the team so
At the point results come back normal	That nothing has been found, and the absence is itself the answer	Establish what was said to the patient then, and in whose words
After repeated presentations across several departments	That the pattern belongs to the patient rather than any one organ	Assemble the sequence of contacts before going to the bedside
After an intervention has caused harm	That the enquiry must stop, and psychiatry will be the brake	Record by name who still holds the physical questions, so the brake is not read as closure

A referral in the last row is not a delayed version of one in the first. Each asks for a different opening act, and the wrong one spends the only visit many of these patients attend.

6.3 What the patient is being asked to accept

The referral asks two things at once and they are refused together: that the search for a physical cause is finished, and that another kind of doctor now takes it over. A patient described as unwilling to see psychiatry is more often unwilling to accept the first, so opening by explaining what psychiatrists do loses the consult in its first minute.

Two features of the setting make the position harder than in an outpatient clinic. **Investigative momentum** is the tendency of a work-up to continue because it has begun: each further negative raises the cost of stopping for the team that ordered it, so by the time psychiatry is called somebody has usually already lost an argument. And the **contact history**, the ordered account of who was seen, for what, with what result and what each said afterwards, is held by nobody; every department holds its own segment. Assembling it is the most useful thing this consult contributes.

Establish before you reach the bedside:

- whether the physical enquiry is being closed or held open, and who holds it;
- what the family was told separately, and whether the two accounts agree.

> **GOOD TO REMEMBER**
>
> Where the physician is willing, be introduced by him at the bedside instead of arriving alone. It presents the consult as something the medical team has added to its own care rather than the handover that ends it.

Where the team's difficulty is not that the enquiry is finished but that it doubts the patient's account, the question and the method have both changed. That situation is taken up where factitious presentations and malingering in the general hospital are dealt with here.

> **IN INDIA**
>
> Three features of the general hospital press on this referral. Much of the investigation is paid for from the family's own pocket, so a normal work-up is a financial loss as well as a clinical dead end. The contact history is usually long and crosses systems of medicine as well as departments, and is not offered unless asked for without disapproval. And the patient is frequently sent on without being told which speciality, so your arrival at the bedside is the disclosure, made by a stranger. No figure is attached to any of the three: no comparable standard is available to quote, and none is invented here.

6.4 How the heading is asked

Set as a short note it wants the route and the address: who refers, at what point in the medical career, why then, and where the diagnostic account belongs. Set as a long case or bedside station it arrives as a patient with a thick file and normal results, and what is watched is the opening:

whether you found out what he had been told before you began, and whether your first question was about his symptoms or his tests.

TRAP **Answering the ward's question with the classification.** Candidates do it because the taxonomy is freshly learnt and feels safe. It fails structurally: the correct diagnostic label was never the thing the referring physician could not produce, so a candidate who supplies it has answered a question nobody asked and left the patient exactly where the referral put him.

Another doctor's exhausted enquiry	Taught in full elsewhere	The words already spoken
HOW THIS GROUP REACHES THE PSYCHIATRIST	WHERE THE DIAGNOSES, THEIR CRITERIA AND THEIR INSTRUMENTS SIT	WHAT MUST BE ESTABLISHED BEFORE THE INTERVIEW OPENS

This group reaches psychiatry when a physician runs out of investigations, not when anyone identifies a psychiatric symptom, so the consult begins by establishing what the patient was already told and by whom; the diagnoses themselves, their criteria and their instruments are read in the Somatic-symptom, sexual, impulse-control disorders and suicide notes.

7 · Capacity assessment and refusal of treatment in general hospital

Why the marks are here. The referral reads: patient refusing amputation, please assess capacity. It is one of the few consults in which a psychiatrist is asked not to describe a mental state but to underwrite or to block somebody else's surgical decision. It is also the consult on which Indian candidates most reliably reproduce a foreign answer, because the schema printed in most textbooks is not the test Indian law supplies. The marks are for knowing which law is in the room, what it actually asks, who else must be brought into the decision, what has to be written in the notes, and what follows when the patient may lawfully refuse.

Capacity assessment and refusal of treatment in the general hospital is two problems wearing one name. The first is a patient with mental illness whose treatment decision falls under a statute that states how capacity is to be judged and what may be done when it is absent. The second is a physically ill adult with no mental illness who has heard the surgeon out and said no, and for whom Indian law is far less complete than examination answers pretend. Capacity, consent and confidentiality as general clinical doctrine are taught in the Psychotherapies, clinical assessment, MSE and nosology notes, and the admission pathways of the mental health legislation are not re-taught here.



Fig 29.3. The capacity decision drawn as a sequence rather than as a checklist, opening at the presumption that puts nothing on the patient to prove, passing through the gate at which the information has to be given in a form that could land before any ability is tested at all, then the three abilities asked separately and joined at a disjunction that lets any one of them carry the case, and forking into what follows when the presumption stands, where a decision others call wrong is not by itself incapacity and the note has two separate halves, and what follows when it is displaced, where the route is supported decision-making and not a relative signing in the patient's place, with the request to certify an emergency so that a competent refusal becomes a lawful yes marked as the thing the sequence refuses, and the physically ill adult whom the written test may not reach given the same sequence by an analogy that is written down as an analogy.

7.1 Which law reaches the bedside, and how far

Two hinges decide whether the mental health legislation is in the room at all, and they point in opposite directions. The first is territorial and generous. The Mental Healthcare Act, 2017 defines a **mental health establishment** in words that expressly include any general hospital or general nursing home, whether established or maintained by government, a local authority, a trust, a corporation, a society or a private person, and expressly exclude the family residential place in which a person with mental illness lives with relatives or friends. A surgical ward in a district hospital is therefore inside the Act's reach. The ward assumption that the Act begins at the door of the psychiatry unit is simply wrong.

The second hinge is subject-matter and narrow. The statutory capacity test is written for decisions a person makes regarding his own mental healthcare or treatment, and the section names the decision domain three separate times as the treatment or admission or personal assistance. So the Act follows the psychiatrist onto the medical ward, but the test it carries there is scoped to a particular kind of decision. Whether it stretches over a decision about a laparotomy in a patient who also has schizophrenia is the question every real consult turns on, and the section does not answer it. A careful answer says only what is grounded: the establishment is covered, the test is written for mental healthcare decisions, and extending it to a purely medical decision is an argument rather than a citation.

7.2 The statutory test: a presumption, then three abilities

The section gives away the answer in most cases before it states the test. Capacity is **presumed** for every person, and the Act adds the words "including a person with mental illness" so that the presumption cannot be quietly suspended by a diagnosis. A person is deemed to have capacity to make decisions regarding mental healthcare or treatment if that person has the ability to:

- understand the information that is relevant to taking the decision;
- appreciate any reasonably foreseeable consequence of the decision, or of the absence of a decision; or
- communicate the decision, by speech, expression, gesture or any other means.

Now the point that carries the mark. The abilities are **disjunctive**: the section prints **three** abilities and joins them with "or", not with "and". Read as it is written, any one of them makes capacity out. That is a markedly lower threshold than the functional schemas taught in much of the international literature, in which understanding, appreciation, the ability to reason with the information and the expression of a choice are separate hurdles and a patient who fails one has failed the test. The Indian drafting is not careless; it is aimed. The same statute asserts that persons with mental illness have capacity to make treatment decisions and may require varying levels of support in order to exercise it, so a permissive test is consistent with the instrument it sits inside.

MNEMONIC

Understand, Appreciate, Communicate, and the joiner is OR

The three abilities in the order the section prints them, with the conjunction that decides the case. A candidate who memorises the abilities and forgets the conjunction converts a permissive Indian test into a restrictive foreign one, and loses the answer where the difference mattered.

RULE **The Indian statutory test is a presumption plus three abilities joined by "or", not a checklist that has to be passed in full.** The burden sits not on the patient to demonstrate competence but on the clinician who wishes to displace the presumption, and it is discharged only by showing that none of the three abilities is available to this patient, for this decision, at this time, after the information has properly been given.

7.3 The assessment is not finished until the information has landed

A capacity assessment tests what a patient can do with information, so it is only as good as the information given. The Act makes that a duty rather than a courtesy. The information referred to in the capacity test must be given in **simple language which the person understands**, or in sign language, or through visual aids, or by any other means that enables understanding. On a medical ward this is the step most often skipped before a team records that a patient lacks capacity. The surgeon explains the operation in English at the foot of the bed, the patient nods at everything, the nurse writes that the patient seems confused, and a consult is raised. Nothing in that sequence has yet tested capacity, because the first ability was never given a fair chance to operate.

The practical translation is a short sequence the psychiatrist controls. Establish which language the patient is comfortable in, and use it or find somebody who can. Correct the reversible before testing the fixed: spectacles and hearing aids left at home, an assessment timed for the patient's best hours rather than the team's convenience, analgesia before the conversation rather than after it. Give the information in pieces, and ask the patient to say back what has been understood rather than to confirm your version. Only then does a failure to understand belong to the patient rather than to the ward.

The Act also intends the procedure to be standardised rather than left to individual style. It requires the central authority to appoint an expert committee to prepare a guidance document for medical practitioners and mental health professionals containing procedures for assessing capacity, and it obliges every medical practitioner and every mental health professional, when assessing capacity, to comply with that document and to follow the procedure specified in it. Note the reach: it binds the physician and the surgeon who assess capacity, not only the psychiatrist called to confirm it. Whether the guidance document has in fact been prepared and published is a separate question, and it is one this account does not answer in either direction: no comparable standard is available to quote, and none is invented here. State the duty, then say plainly that its implementation is unresolved: the distance between an Act and its machinery is itself an examinable point.

7.4 Refusal is not the evidence of incapacity

Almost no capacity consult is generated by a patient who cannot decide. Almost all of them are generated by a patient who has decided something the team disagrees with. The Act closes that door explicitly. Where a person makes a decision about mental healthcare or treatment that others perceive as inappropriate or wrong, that **unwise decision** does not by itself mean the person lacks capacity, so long as the abilities in the test are present. That is not a legal nicety. A test that treated disagreement as evidence would be circular, and would make capacity a function of how strongly the team feels about the recommended treatment. That is precisely how capacity assessments are misused.

What legitimately raises the question is a change in the machinery of deciding rather than in the content of the decision:

- a fluctuating level of consciousness, or an acute confusional state that waxes across the afternoon;
- an inability to hold the information long enough to do anything with it, or to communicate any decision at all;
- a psychotic belief that bears directly on this decision, such as a conviction that the operating team intends harm.

Delirium is much the commonest of these on a medical ward, and it is taught with the ward delirium material in this chapter, and in older patients with the late-life delirium material.

TRAP **Answering that the patient lacks capacity because the refusal is dangerous.** The gravity of the consequence is a reason to assess carefully, to give the information again, and to come back when the patient is at their best. It is not itself a finding. Candidates slide into it because the alternative feels like abandoning the patient, and because the team asked the question in a form that presupposes the answer. Record the finding about the abilities you tested, then record separately what you advised the team to do about the risk.

7.5 The physically ill adult who says no, and the hole in the law

Now the harder half. A man of sixty with a gangrenous foot and no psychiatric history refuses amputation. He is not a person with mental illness, so the statute discussed above is not obviously his. The highest Indian authority on his position comes from a five-judge Constitution Bench of the Supreme Court of India, whose 2018 judgment states that a person who has come of age and is of sound mind has a **right to refuse medical treatment**, and separates that right in terms from suicide, from physician-assisted suicide and from euthanasia.

Quote it with its context or you will over-claim it. The passage sits inside the Court's discussion of the terminally ill patient and the patient in a persistent vegetative state, so it is not, on its face, a rule for every refusal on every ward. It is nonetheless the sentence to cite, and the separation it draws is clinically load-bearing: a competent refusal that ends in death is not a suicide, so a patient who declines dialysis is not thereby a psychiatric emergency, and does not become one because the physician finds the decision intolerable.

Where the law runs out. The phrase "of sound mind" describes a status, not a functional test: it names the condition the person must be in without saying how to establish it for this decision on this afternoon. That is the gap at the centre of this topic, and it is a gap in the law rather than in the reading. No Indian statute or binding authority is set out here that supplies a functional capacity test for an ordinary physical-treatment decision by a patient who has no mental illness, and none that settles who decides for an adult who lacks capacity and is not a person with mental illness. No comparable standard is available to quote, and none is invented here. The examinable discipline is to say so, and not to import a foreign capacity statute or schema and present it as Indian law, or to assert an Indian best-interests doctrine you cannot cite. What a good answer does instead is reason by analogy and admit it: apply the abilities the Indian statute names as a clinical framework, record in the note that they are used by analogy because this is not a mental healthcare decision, document the reasoning and not only the conclusion, and involve the family and the treating team in a determination no single clinician has been authorised to make alone.

THE SITUATION ON THE WARD	WHAT IS REALLY BEING ASKED	WHAT INDIAN LAW SUPPLIES	WHAT IT LEAVES UNSETTLED
A patient with mental illness refusing psychiatric treatment or admission	Is the statutory test made out for this decision?	A presumption of capacity, and three abilities joined by "or"	How long a finding holds outside a supported admission
A patient with mental illness whose medical treatment cannot wait	May treatment be given now, and on whose consent?	An emergency route open to any registered medical practitioner, on three defined triggers	What happens if the ceiling expires before any establishment has assessed the person
A physically ill adult of sound mind refusing medical treatment	Must the refusal be respected?	A stated right to refuse medical treatment, in a passage about the terminally ill or persistently vegetative patient	The functional test by which soundness of mind is to be judged for an ordinary medical decision
A physically ill adult who cannot decide and has no mental illness	Who decides, and against what standard?	Nothing that can be grounded here	Who the lawful decision-maker is, and the standard the decision must satisfy

7.6 Who else is in the decision

The Indian model is not the solitary competent patient of the Western textbook, and the Act is explicit. The **nominated representative** is a person the patient may appoint, and where none has been appointed the Act supplies a default order of precedence, which is worth reading in the bare Act itself. Two rules about the appointment carry the marks. Appointing a representative, or being unable to appoint one, is expressly not to be construed as a lack of capacity. And persons with mental illness are asserted to have capacity to make mental healthcare or treatment decisions, while requiring varying levels of support from their representative.

Read together, those provisions install **supported decision-making** in place of the substituted decision-making that Indian wards mostly practise, and the distinction is the thing to show an

examiner. Substituted decision-making asks the relative what should be done. Supported decision-making asks what help this patient needs in order to decide, and treats the relative as the means of providing that help. A son who signs the consent form because it is quicker is the substituted model operating under the name of the supported one, and the Act does not authorise it merely because obtaining the patient's own decision would be laborious.

IN INDIA

Before recording that a patient lacks capacity, ask three questions and write the answers into the note: in which language was the information actually given, who was in the room when it was given, and whom has the ward been treating as the decision-maker up to now. Where an accompanying relative countersigns consent as a matter of routine, the format duty is the step that gets skipped, and the capacity opinion then rests on a conversation the patient was never properly part of. Asking the patient to explain the operation back, in their own language, is a bedside test and a legal safeguard in one act.

7.7 What must be written down, and when capacity is looked at again

Capacity is specific to a decision and to a moment, so a finding has a shelf life. The Act fixes that shelf life in one place only, and knowing where is the discrimination. Where a patient needs nearly total support and the nominated representative therefore consents on the patient's behalf during a supported admission, the officer in charge must record that consent in the medical records and review the patient's capacity to consent every **seven days**. Where the admission has run beyond thirty days, the counterpart provision requires the same recording and a review of capacity on the expiry of every fortnight. Two intervals, two admission provisions, and a question that asks which is which.

Then the absence, which is the more useful half. Both duties sit inside supported admission. The Act imposes no equivalent express recording interval on a one-off capacity opinion given as a liaison consult on a medical ward, which is the situation this topic is actually about. That silence is not permission to write once and walk away. It means the review interval is a matter of clinical judgement rather than of statute, and that the judgement has to be justified in the note. A patient found to lack capacity during an acute confusional state and never reassessed has lost a decision to an administrative accident rather than to an illness.

GOOD TO REMEMBER

A capacity note that will survive scrutiny records the specific decision it is about, the information that was given and in what language and format, what the patient could do with that information tested against each of the abilities the statute names, the conclusion for that decision at that time, who else was involved and on what footing, and when capacity will be looked at again and by whom. A note reading only "not competent, family to decide" records none of them, and it is the note that actually gets written.

7.8 When treatment cannot wait

The emergency provision is what makes the Act usable in a general hospital. Its scope is wider than most candidates expect and narrower than most wards assume. Notwithstanding anything else in the Act, any medical treatment, including treatment for mental illness, may be provided by any registered medical practitioner to a person with mental illness, either at a health establishment or in the community, subject to the informed consent of the nominated representative where one is available, and only where it is immediately necessary to prevent death or irreversible harm to the person's health, or the person inflicting serious harm on himself or on others, or the person causing serious damage to property where that behaviour is believed to flow directly from the mental illness. The Act's own explanation extends **emergency treatment** to transporting the person to the nearest mental health establishment for assessment, which is what makes a lawful transfer out of a medical ward possible.

Three limits follow immediately, and they are what a question on this section usually turns on. Nothing in the provision allows treatment that is not directly related to the emergency itself. Nothing in it allows electro-convulsive therapy to be used as a form of treatment under this power. And the authority is limited to **seventy-two hours**, or until the person has been assessed at a mental health establishment, whichever is earlier, extending to a maximum of seven days only during a disaster or emergency declared by the appropriate government.

3	Seventy-two hours	Seven days	Seven days
STATUTORY ABILITIES IN THE CAPACITY TEST, JOINED BY "OR", ANY ONE OF THEM SUFFICING	CEILING ON EMERGENCY TREATMENT, OR UNTIL ASSESSMENT AT A MENTAL HEALTH ESTABLISHMENT, WHICHEVER IS EARLIER	EXTENDED EMERGENCY CEILING DURING A DISASTER OR EMERGENCY DECLARED BY THE APPROPRIATE GOVERNMENT	INTERVAL FOR REVIEWING CAPACITY WHERE THE REPRESENTATIVE CONSENTS IN A SUPPORTED ADMISSION OF UP TO THIRTY DAYS

Now the scope limit on which a whole answer can founder. The emergency provision operates on a person with mental illness. It is not authority to treat a physically ill patient who has no mental illness and refuses, however grave the consequence of that refusal, and it is not a mechanism for converting a competent no into a lawful yes. A surgical team asking the psychiatrist to certify an emergency so that a competent refusal can be overridden is asking for something the section does not contain. The correct reply is to say so, to put it in writing, and then to help the team with the conversation that is actually needed: what the patient believes will happen to them, and who they want in the room when the decision is made.

> Capacity is presumed, the statutory abilities are joined by "or", and a decision that others regard as wrong is not by itself incapacity.

The examiner is testing whether a candidate can hold two situations apart: a statute deliberately generous to the patient and a ward that is not, and a second situation the statute does not reach, where the honest answer names the limit rather than filling it with borrowed law. Both halves are marked, and the second more often than candidates expect.

8 · Factitious disorder and malingering in the general hospital

Why the marks are here. Factitious disorder and malingering in the general hospital are examined as a sequence of acts, not as a pair of definitions. What the two conditions are, how each is separated from the other and from the unconsciously produced somatic disorders, and what the criteria require, are set out in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. The question here is narrower and much harder to answer well. A medical or surgical team has begun to believe that its own patient is producing the illness, has said so aloud on the ward, and has telephoned psychiatry. Everything that follows happens on a ward the psychiatrist does not run, inside a record several services write in, in front of a family, and almost always before anything has been established.

The hinge is a fact of geography. These presentations do not begin in a psychiatric clinic. They arrive carrying a physical complaint, first to the general physician, so the psychiatric question is raised late, by a team that has already committed a long run of investigation to a different explanation, at the point where withdrawing it costs somebody something. Where the same suspicion arises in a medico-legal assessment there is an instructing party, a documented incentive, a defined report and an established method of assessing feigning. On a ward there is none of that: only a round tomorrow morning, a bed that is needed, and a team that has already used the word.

8.1 The request, and the three different things it can mean

Wards do not refer this question in clinical language. What arrives is that the patient is putting it on, that the story keeps changing, that nothing fits, or, from the more careful units, a request to rule out malingering. Read as a clinical question, that request cannot be answered at a bedside. Read as a report of where the team has arrived, it is highly informative: something has changed on that ward, and finding out what is the first act of the consult.

Three quite different requests hide inside the same sentence, each needing a different answer.

- **A request for certainty.** The team holds an inconsistency it cannot resolve and wants it converted into a finding by a speciality thought to deal in motives. No such conversion exists at a single visit, and supplying one is where the harm begins.
- **A request for permission.** The team wants to stop investigating, stop escalating, or discharge, and is asking psychiatry to authorise that so it does not have to own it. This is the commonest of the three and the best disguised.
- **A request for relief.** The ward is angry, exhausted, or feels it has been made a fool of, and the referral puts that somewhere. It tends to arrive out of hours and in strong language.

Deciding which is actually in front of you, early and out loud, reorganises the consult, because the second and third are addressed to the team and cannot be answered by anything found at the bedside. Left unnamed, what forms instead is a **corridor diagnosis**: a word that passes between staff, hardens with each retelling, acquires the authority of repetition, and is in the notes before anybody has decided whether it is true.

8.2 What a general ward can and cannot establish about its own patient

The working method of a medical ward is **exclusion**: candidate explanations are removed one at a time until one survives. When the last has gone and none survives, the ward reads the empty result as though it were a positive finding, because every previous negative in that sequence functioned as one. Here it does not. A work-up that has explained nothing licenses the statement that the illness is not yet explained, and nothing further. The distance between not explained and deliberately produced is the entire subject, and it is crossed by evidence about production, never by exhausting the medical list.

Two further limits belong to this setting. First, inconsistency is not deception. An account that differs between the admitting doctor at night and the unit round next morning has differed; whether it differed because it was invented, because the two sets of questions were not the same, because the patient was frightened, sedated, in pain or delirious, or because the second version came from a relative, is not settled by the change itself. Second, once the suspicion exists the ward's observation stops being neutral. Behaviour that passed without comment last week is now offered to you as evidence, and observations that do not fit quietly stop being reported. You are given a filtered account by people who do not know they are filtering it.

The honest position at the end of a first visit is nearly always that the question is not settled, and that is not a failure of the consult. Managing an **unresolved suspicion** is the clinical task; producing a verdict is not, and cannot be done from a bedside chair.

RULE **A suspicion of fabrication changes what the team must do long before it changes what the patient may be called.** Everything worth doing is justified by the suspicion being unresolved and none of it by its being confirmed: slowing an invasive work-up the suspicion has itself made hard to justify, keeping the medical differential formally open under a named clinician, dating and attributing every observation so that a pattern rather than an impression survives, and bringing the disagreement out of the corridor into a meeting. A candidate who spends the answer on how to prove the deception has taken up a question the bedside cannot settle and left undone every act that protects the patient.

8.3 The record, and what a single entry can carry

This is where the consult is most exposed. A record made while a suspicion is unresolved is read later by people who were not present, for purposes nobody in the room intended: the next admitting team, the discharge summary, a certification request, an insurer, occasionally a court. The writer controls the sentence and none of its readers.

What may lawfully and ethically be entered when deception is suspected but not established, whether anything may be sought about the patient from another institution and on whose authority, and how such a conclusion is or is not communicated to the referring team, are not settled by any source available for this section. No comparable standard is available to quote, and none is invented here. What can be reasoned, and what an examiner will accept, is that entries differ in kind, and that the kinds carry very different weight once they leave your hands.

KIND OF ENTRY	WHAT IT ACTUALLY ASSERTS	WHAT IT CAN SUPPORT LATER
Timed observation of something you saw yourself	That one thing was seen, by you, at a stated hour	A pattern, if enough accumulate with times against them; alone, almost nothing
Attributed observation, naming who reported it	That a named person stated something, and that you are not the witness	Provenance: a later reader can return to the source instead of inheriting your confidence
A discrepancy between two documents, both named	A finding about the records, not yet about the patient	A reason to look further, and a trail somebody else can check
An inference about intention	Your reasoning, only as far as its steps are written out	Little; an unreasoned inference is read downstream as a conclusion
A diagnostic label entered in a summary	A settled conclusion, to every reader who was not there	Everything, including consequences outside the hospital, so it is the entry to weigh hardest

The discipline that follows is small and entirely learnable:

- write what was seen, and when, and name who saw it;
- keep reasoning visible as reasoning, with its steps shown;
- let the **permanent record** carry a conclusion only once one has been reached.

A note built this way stays useful if the suspicion proves right and harmless if it proves wrong, which is the only test a record made under uncertainty can be asked to pass.

TRAP **Letting the suspicion enter the permanent record as a diagnosis.** Asked what would be written, the candidate puts the label into the discharge summary, and it is wrong for reasons that are examinable rather than merely cautious. The label is short and the observations are laborious, so the label is what gets copied forward; it then travels further than the evidence that produced it, to readers who cannot see how thin that evidence was, and it closes the medical differential behind it. Write the observations, name their sources, state what remains open, and record who is continuing to look.

IN INDIA

Three features of the general ward press directly on this. A family attendant is at the bedside for much of the admission and is usually the only continuous observer the team has, so the account that would most change the picture is already in the room and is rarely taken systematically. Much of the admission is paid from the family's own pocket, so a request for a certificate, a fitness statement or an early discharge is not administrative; it has money attached, and that pressure reaches the note. And the questions raised here about records, and about what may be sought from anywhere else, have answers a candidate must find in the institution's own governance rather than in anything quotable. The examinable move is to say so, and to name who in your hospital answers it, rather than to invent a national rule that does not exist.

8.4 What the suspicion does to the team

The most reliable clinical sign in this situation is not on the patient. It is that the ward has divided, and it divides along concrete lines rather than temperamental ones: the clinician who admitted the patient and argued for the diagnosis against those never persuaded, the night nursing staff who carry the behaviour against the day team who see a settled patient on the round, the junior now being told, with varying kindness, that they were taken in. Each group has staked something, and the split holds because conceding costs face.

What makes it worse than ordinary clinical disagreement is the shift of **moral register**. The question stops being what is wrong with this person and becomes whether this person is honest, and once it has moved there the two available positions are naive and cruel. Nobody wants either, so the argument leaves the open forum and continues in the corridor, in handovers and in the tone of the notes, where it cannot be corrected. The **ward split** is therefore not a curiosity to observe; it determines whether the patient is investigated, and it is the liaison psychiatrist's work.

MNEMONIC

Stop, hold, name, date

The four acts an unresolved suspicion requires, in order. **Stop:** pause the escalating invasive work-up, whose justification the suspicion has itself removed. **Hold:** keep the medical differential open under one named clinician, so nobody assumes somebody else is still looking. **Name:** put the split into a meeting with both positions stated. **Date:** attribute and time every observation entered from here on. Not one of the four requires the suspicion to be true.

GOOD TO REMEMBER

Ask the ward two questions before the consult ends, and ask the group rather than the referrer alone. What would change your mind, and who is still responsible for the medical differential. The first makes the belief testable and shows the team it currently has no answer; the second stops the most dangerous thing that happens here, every service quietly assuming some other service is still investigating.

8.5 What the suspicion does to the patient's care

Once a ward believes it is being deceived, the risk to that patient rises in two opposite directions at once and a good answer names both. In one direction the admission simply stops: investigation ceases the moment the suspicion is voiced, each new symptom is attributed to the old belief before it is examined, and concurrent disease is missed because it is now expected to be absent. Suspicion and organic illness are not alternatives, and a patient may be doing both at once. In the other direction sits **iatrogenic escalation**: a team that cannot let the question go, ordering the next scan and the next procedure to settle an argument rather than to answer a clinical question. Both flow from the same unresolved belief, and the same acts make both less likely.

The third outcome is that the admission ends before the question does. A patient who senses the change in how a ward speaks to them often leaves, and a consult called to settle a suspicion has instead ended the only relationship through which anything could have been settled. Hence one

more reason for the consult to stay in a clinical register: a bedside interview conducted as an interrogation reliably closes the admission and answers nothing.

8.6 How the question is asked, and the order to answer it in

The ward is reporting itself	Exclusion proves nothing	Kind before content
THE REFERRAL DESCRIBES WHAT THE TEAM HAS COME TO BELIEVE, NOT A PROPERTY OF THE PATIENT	A WORK-UP THAT HAS EXPLAINED NOTHING LICENSES ONLY NOT YET EXPLAINED, NEVER DELIBERATELY PRODUCED	WHAT AN ENTRY CAN SUPPORT LATER IS SET BY ITS KIND, BEFORE ANYTHING IT SAYS

What an examiner is testing. Given a medical inpatient whose team suspects fabrication, the discriminating answer does not open with definitions or with how feigning is detected: both belong elsewhere and are available to anyone who has read the taxonomy. It opens with the referral, with who called, what they said and which of the three requests they were making. It moves to what can honestly be established at that bedside and says plainly that the usual answer is not yet. It then gives the acts, each standing without the suspicion being confirmed, and states what will be written and what will not. Where it reaches a standard that does not exist, it says so rather than inventing one, which reads as maturity and not as ignorance.

> The ward asks you to settle whether it is being deceived; what you can actually settle is what it must do while that stays open, and every act of the consult is justified by the suspicion being unresolved, not by its being confirmed.

The high-stakes settings

9 · Transplant, dialysis and ICU psychiatry

Why the marks are here. Transplant, dialysis and ICU psychiatry reads like three settings and is really one problem stated three times. In each, the treatment keeping the patient alive is also what generates the psychiatric presentation, and the psychiatrist works inside another team's decision, on their premises and against their timetable. And in each, the referral is rarely a request for a diagnosis: it asks that a decision be underwritten, or that a patient be made easier to treat. A candidate who answers with a differential has answered a question nobody asked.

Clear the ground first, because most of what these wards generate belongs elsewhere. The acute confusional state that dominates critical care, the decisional-ability question behind a refusal, and the standing link between an organ system and psychiatric morbidity each have an owner of their own, named below at the point where each arrives; the neurological substrate of confusion sits in the Stroke, TBI, delirium and focal brain syndromes notes. What survives those subtractions is small, specific and almost unwritten elsewhere: the evaluation before an organ is allocated, the psychiatry of a treatment room a patient returns to for life, and the state a survivor of critical illness is discharged into.

9.1 The structure the three settings share

Side by side, these settings differ less in psychopathology than in who holds the decision and what psychiatry can genuinely add. Learn the row rather than the disease: an examiner can move you between settings and expect the reasoning to transfer.

THE SETTING	WHAT IS ACTUALLY BEING ASKED	WHO HOLDS THE DECISION	WHAT PSYCHIATRY ADDS THAT NOBODY ELSE CAN
Before a transplant	Whether this person should receive a scarce organ, or whether something about them can be changed first	The transplant team and its selection process, never the psychiatrist	A statement of what is modifiable and over what interval, in place of a verdict
After a transplant	Why a patient given exactly what they wanted is not well	The treating unit, indefinitely	Separating adjustment from drug effect from acute brain syndrome, and dating each against the operation
The dialysis unit	Usually nothing, because the referral is never made	The nephrology unit, and in practice its nursing and technical staff	A detection routine the unit runs itself, since this morbidity is invisible to a service that waits to be called
The intensive care unit	Behaviour that is obstructing treatment now	The intensivist, minute by minute	A formulation that survives sedation and restraint, and a plan that does not need cooperation to begin
After intensive care	Also nothing, because nobody is looking	Nobody, and that is the finding	The question about the admission that no later clinician will otherwise ask

RULE **In each of these settings the treatment is the stressor, and the treatment cannot be withdrawn to test the hypothesis.** The usual experiment of removing the exposure and watching symptoms resolve is unavailable, so attribution rests on timeline, previous function and informant report rather than on response. The aim is not relief from the stressor, which is not on offer, but the ability to keep receiving it. And because the treatment outlasts your consult, an opinion filed once is worth far less than an arrangement the unit is still running next month.

9.2 The pre-transplant evaluation: whose question, and what kind of answer

One thing about this evaluation is settled: it happens. Psychiatric and psychosocial assessment is treated as imperative in judging whether a candidate is **suitable** as a recipient, and evaluating that suitability is described as a defined part of the psychiatrist's role in solid-organ transplantation.

Its contents are another matter, and an honest answer beats a confident one. The domains such an evaluation should cover, any structured instrument for conducting it, what separates an absolute from a relative psychiatric contraindication, and whether Indian transplantation law

imposes any requirement of psychiatric or psychological evaluation on a recipient or a living donor: no comparable standard is available to quote, and none is invented here. Two consequences are examinable. Do not import a Western programme's eligibility rule and present it as an Indian legal duty, because a condition written into one country's transplant programme is not thereby a statutory obligation in another. And establish what your own institution's process requires and who signs it, because that is what you will be asked across a table.

Dual agency changes the interview, and candidates handle it worst. You are not this patient's treating psychiatrist here; you are producing an opinion for someone else, and the patient knows what they say may cost them an organ. Under-reporting of alcohol use, low mood or a difficult household is not deception but a rational response to an incentive you created by walking in. Two moves reduce it. Say at the outset what the assessment is for, who reads it and what it cannot decide alone. And take collateral history as routine rather than as a challenge, so that corroboration is procedure and not accusation.

The output should do work rather than close a door. An opinion reading "unsuitable" gives the team nothing to act on and nothing to argue with. A useful pre-transplant opinion instead specifies:

- the decision it is addressed to, since an opinion written to no question answers none;
- what is currently a problem and whether it is changeable, stated as a condition rather than a label;
- over what interval a change could be shown and by what observable sign, because a team allocating an organ needs a date more than a diagnosis;
- what would make you revise the opinion in either direction, which turns a verdict into an assessment that can be repeated.

Where the donor is living, a second person is being evaluated for an operation that will not benefit their own health, inside a family in which the pressure to agree may never be spoken aloud. That interview belongs away from the recipient's relatives and clinician, and the question is not only whether the donor consents but whether refusal is a real option. Consent given in front of those who would be disappointed by it has not been tested.

9.3 After the graft: the work that begins when the operation succeeds

A successful transplant is not the end of a chronic illness but the exchange of one for another: lifelong immunosuppression, indefinite surveillance, and a new class of fear in which any ordinary symptom may be the start of rejection. Function returns faster than identity does, and someone whose family, work and routine were organised around being ill must renegotiate all of it while everyone celebrates. Low mood after a technically perfect operation is therefore not paradoxical, and reading it as ingratitude is the commonest failure of the ward's response.

Where the organ came from a living relative, the donor stays in the psychological field permanently. The patient carries part of someone they will meet at every family gathering, sometimes someone they had conflict with, and a sense of unpayable debt can push adherence

either way: fierce compliance as repayment, or avoidance of a relationship impossible to be ordinary in. Ask about the donor by name, and ask what the patient believes they owe.

Two things arriving now are routed rather than guessed. The acute brain syndrome after major surgery belongs where delirium in the medically ill is dealt with in these notes. The neuropsychiatric effects of the immunosuppressive regimen, and the interactions constraining what may be added to it, are prescribing matters: the antidepressant agents are set out in the Mood disorders: pharmacotherapy notes, and nothing is started without the current regimen in front of you and the transplant team told what you added.

9.4 The dialysis unit, which nothing else in these notes owns

Maintenance haemodialysis is the only treatment in this chapter that is also a place. The patient returns on a fixed recurring schedule to a shared room, is connected through a **vascular access** that is itself a source of anxiety and of repeated medical incident, sits immobile for hours beside other patients whose deterioration they watch, and lives in between under restrictions on food and fluid that reorganise a household's cooking. But nobody is admitted, so nobody is referred, and psychiatric morbidity accumulates in a population that is technically outpatient and permanently supervised. The organ-system link itself is taken up where the psycho-cardiology, psycho-dermatology and psycho-nephrology cross-links are dealt with in these notes; what is owned here is the treatment room as a place.

IN INDIA

The firmest Indian anchor is a study of 282 patients on maintenance haemodialysis across four Mumbai centres, two public charitable and two private fee-for-service, reported in the Indian Journal of Nephrology in 2025. Some degree of depression was present in **76 per cent**, and **21.28 per cent** reached the moderate-or-above band on the screening instrument. Carry the population with the number: these are prevalent patients already established on dialysis at four urban centres, of median age 55, with more men than women in the sample. It is not an all-India prevalence and must never be quoted as one.

The associations matter more at the bedside than the headline proportion. Female sex, a catheter as the vascular access and the stress of dietary restriction were each positively associated with significant depression, while being employed was protective; public charitable and private fee-for-service centres did not differ. Two repay thought. Access type is a technical variable visible on the chart and sometimes changeable by the unit, so a psychiatric risk marker here can be read off a nephrology note and acted on by a surgeon rather than by you. And employment being protective turns a medical schedule into an economic one, since the hours the treatment consumes are hours of wages; whether work protects, or better health permits work, is not separable in a cross-sectional design. Women were depressed roughly twice as often as men, 29.13 per cent against 16.76 per cent, and the study cannot tell you why.

Depression is substantially commoner in dialysis populations than in the general population, and under-recognised in both. That much is safe to say, and it is why a screening routine is justified at all. No pooled prevalence from the international meta-analytic literature is quoted here and none

is invented in its place: carry the Mumbai figures with their population attached rather than promoting them into a world number.

9.5 Why the unit does not see it, and what to examine instead

The reason offered for that invisibility is diagnostic rather than attitudinal. On its authors' account, depression here remains under-evaluated and under-addressed because the symptoms of **uraemia** mimic depressive symptoms and can mask a true depressive illness. That is a mechanism they propose, not an effect they measured. Recognising depression when advanced physical disease confounds the somatic criteria is taken up where depression, anxiety and delirium in cancer and palliative care are dealt with in these notes; what is specific here is that the confounder is not the disease alone but the treatment and its timetable.

WHAT IS OBSERVED	WHAT THE URAEMIC STATE AND THE UNIT GENERATE ON THEIR OWN	WHAT STILL DISCRIMINATES
Fatigue and loss of energy	Anaemia, the metabolic state, and the hours the treatment consumes	Whether energy recovers after a good session or stays flat across the interval
Poor appetite and weight change	Prescribed dietary and fluid restriction, altered taste, and shifts that make weight uninterpretable	Whether food the patient is permitted and used to enjoy still gives pleasure
Disturbed sleep	Restless legs, itch, cramps, and a schedule that fragments the week	Early waking with dread, and what the patient does with the waking hour
Slowed thinking and poor concentration	The metabolic state, and fluctuation around each session	A stable deficit that does not track the session, which raises a different question
Withdrawal from family and social life	Immobility, transport cost, and a timetable nobody else's life is built around	Whether the patient wants contact they cannot get, or no longer wants it

What survives the correction is interpersonal and evaluative rather than bodily: guilt, self-blame framed as being a burden, hopelessness that is absolute rather than realistically bleak, loss of pleasure in what the illness does not prevent, and whether any of it fluctuates with the treatment cycle. That last is the practical discriminator this setting hands you, since the schedule supplies a repeated natural measurement.

TRAP **Subtracting the somatic features, then treating what is left as too little to diagnose.** The candidate who has learned that uraemia mimics depression applies the correction and stops: fatigue, appetite change and sleep disturbance are discounted because the treatment explains them, and the conclusion becomes that only low mood remains, falling short of a threshold. Subtraction is half a method and useless alone. The second half is substitution: having set aside what the setting can generate, examine what it cannot and weight it more heavily than in a physically well patient. Examiners watch for the substitution, because the subtraction is the part everybody remembers.

How detection is actually done. Not by referral, which is the whole point. That study used the **PHQ-9**, and the operationally important detail is not the instrument but the administration: it was read aloud to every patient in their native language regardless of literacy. A self-report form handed out in an Indian dialysis unit measures literacy, language and eyesight at least as much as mood, and those it silently excludes are least able to complain of it. A screen that runs is one unit staff administer aloud, at a fixed point in the session, to everybody rather than to whoever looks unwell.

9.6 The referrals from the unit that are not what they say

When a dialysis unit does telephone, the request has usually been generated by an act rather than a symptom: a patient leaving sessions early, abandoning the fluid restriction, missing appointments, or saying outright that they want to stop. All arrive labelled as depression or poor motivation, and all need the same first move: establish what stopping would actually solve for this person before deciding what it means.

The pressures the answer names are often not psychiatric. The same Indian source describes the burden on these patients as physical, financial, occupational, social and dietary, and any of those can produce the behaviour with no psychiatric illness present. A man whose sessions are consuming a household's income, whose employer will not hold his job, may be making an intelligible economic decision that presents as a wish to die. Medicalising that misses a problem with a different remedy; missing depression in the same presentation is equally serious. The discriminating question is whether the wish is to stop treatment or to stop existing, and it is asked in those terms rather than inferred.

Where the refusal stands and the team wants it overridden, the question has become one about decisional ability, settled where capacity assessment and refusal of treatment in the general hospital are dealt with in these notes. What belongs here is the step before: refusing to let a capacity assessment become a device for producing compliance, since establishing that a refusal is informed and stable is a different task from establishing that it is wrong.

> **GOOD TO REMEMBER**
>
> Before leaving the unit, put four things in the note that the next person to open it can act on. What was asked of you, in the referrer's own terms. What you established about the timeline, including what changed and against what previous state. What you have asked the unit to do, named to a role rather than to the team in general, and by when. And what brings you back, stated as an observable event, so the nurse seeing the patient next knows the threshold.

9.7 Intensive care, and the state the survivor is discharged into

Inside the unit, most psychiatric work is delirium, dealt with elsewhere in these notes, and most of the rest is a request to make a sedated or restrained patient tractable. Two things there are genuinely psychiatry's: a formulation built without a usable interview, from the pre-admission history taken off relatives, the substance history that explains withdrawal states and the timeline of what was given when; and documentation of what the patient appears to be experiencing while unable to report it, which becomes the only record of that period.

More clearly this chapter's, and what candidates rarely have, is the aftermath. **Post-intensive care syndrome** is the agreed term for the residue of critical illness, settled at a multidisciplinary stakeholders conference convened by the Society of Critical Care Medicine. It denotes impairment across three domains, physical, cognitive and mental health status, the physical typically exemplified by weakness acquired in the unit and the cognitive by thinking and judgment. The qualifier does the real work: the impairment must be **new or worsening**, so a deficit present before admission does not count, and the construct rests on a baseline somebody must have recorded or reconstructed.

MNEMONIC

Body, mind, mood, and new or worse

The three domains and the qualifier, in the order that keeps them straight. **Body:** the physical domain, weakness acquired during the admission. **Mind:** the cognitive domain, thinking and judgment. **Mood:** mental health status. **New or worse:** the qualifier, because impairment carried into the unit is not this construct, and an answer without it describes any survivor of any severe illness.

How common it is, how long it lasts, how it is best detected, whether it looks the same in Indian survivors, and whether any follow-up clinic model operates in Indian tertiary practice: on all of these, no comparable standard is available to quote, and none is invented here. Resist supplying a figure: this is exactly the construct where a confidently quoted percentage is likeliest to be wrong and likeliest to be repeated.

Missing data does not remove the clinical duty, and the duty is specific. Whoever sees this patient next is usually a physician who did not treat them in the unit, working from a discharge summary that records organ support and antibiotics and nothing about the mind. The patient will not raise it, partly because the memory of the admission is fragmentary and partly because they have been told repeatedly how lucky they are. So ask, at every later contact:

- what they remember of the admission, accepting that what is remembered may not match what happened;
- what they have not got back, in function rather than in symptoms;
- what frightens them now, which is where stress symptoms surface if they are going to.

Record the answer where the next clinician will find it. Where the psychiatrist has influence over the unit's own practice, the higher-value intervention is upstream: a discharge document stating what this person was like beforehand, so the word new can later mean something.

9.8 What this section hands on

The treatment cannot stop	Detection, not referral	Subtract, then substitute	New or worsening
ATTRIBUTION RESTS ON TIMELINE, BASELINE AND INFORMANT, NEVER ON REMOVING THE EXPOSURE AND WATCHING FOR RECOVERY	THE DIALYSIS UNIT GENERATES CASES THAT NEVER BECOME REFERRALS, SO THE DELIVERABLE IS A SCREENING ROUTINE THE UNIT ITSELF ADMINISTERS	SET ASIDE THE FEATURES THE SETTING GENERATES, THEN EXAMINE AND UP-WEIGHT THE ONES IT CANNOT	A SURVIVOR'S DEFICITS ARE INTERPRETABLE ONLY AGAINST A BASELINE RECORDED BEFORE THE ADMISSION

An examiner is testing whether a candidate stays on the axis of the act. Given a transplant candidate, the discriminating answer opens not with a checklist of what to assess but with whose question it is, what the opinion is for, and how dual agency distorts what is disclosed. Given a dialysis patient, it explains why the setting hides the features rather than reciting them, which observations survive the correction, and how a unit that never refers can be made to detect. Given a survivor of critical illness, it names what is new or worsening against a baseline, and who is going to ask.

> In these settings the treatment that sustains the patient is also what generates the presentation, so the psychiatric task is not to remove the stressor but to keep the person able to receive it: an opinion naming what can change before an organ is allocated, a detection routine the dialysis unit runs without being asked, and a question about the critical-care admission at every contact that follows it.

10 · Psychiatric aspects of HIV and chronic infection

Why the marks are here. Two questions travel under the heading psychiatric aspects of HIV and chronic infection, and the answer is lost if they are not separated. One is about the brain: what a neurotropic infection does to cognition, how it is staged and what imitates it, and which antiretroviral agents carry psychiatric effects or constrain psychotropic prescribing. All of it is set out in the Neuropsychiatry of systemic and neurological disease notes. The other is the consult: a person with a lifelong transmissible diagnosis has been referred, and that question is answered in acts, not features.

They are examinable because a psychiatric interview's ordinary assumptions fail at the door. The diagnosis may not be usable in the room you are in. The treatment cannot be left to the medical team, because the psychiatric state often decides whether it continues to be taken. And the consult cannot be closed: illness and treatment outlast every relationship in the building.

10.1 Four properties, not one organism

The lens comes from the shape of the illness and of its delivery, not from virology, which is why the topic pairs one named infection with chronic infection in general. Four properties do the work, and any condition carrying all four produces the same consult:

- treatment that is lifelong, so the outcome rests on a repeated daily behaviour and never on a completed course;

- transmissibility, which makes the diagnosis partly another person's information and brings law into a clinical conversation;
- social meaning strong enough that hiding the condition is a reasonable strategy rather than a symptom;
- care delivered through a **vertical programme** with its own clinic, counsellor, register and drug supply rather than through general services.

The fourth is the property candidates omit, and it most changes practice because it settles where the patient physically is and whose cooperation any plan needs. Little of this work happens on a ward: the medical home is an outpatient clinic attended for review and supply, so a service built on inpatient referrals meets these patients only after something has gone wrong.

MNEMONIC

Lifelong, catching, shaming, separately run

The four properties, in the order they change what you do. **Lifelong:** the target is a daily act sustained for decades. **Catching:** the information is not the patient's alone, so speech and documentation are constrained. **Shaming:** hiding is rational, so it is not evidence of illness. **Separately run:** the patient belongs to a programme clinic, where any durable arrangement is made.

Where a condition carries only some of the four the lens shortens predictably: a long treatment nobody can catch generates the adherence work without the disclosure work. Taking on a chronic diagnosis is dealt with where psychological reactions to physical illness and chronic disease are taken up in these notes; added here is what changes when the diagnosis is also a secret.

10.2 The disclosure map is drawn before the interview, not during it

Disclosure is not one event that has either happened or not. It is a set of separate permissions, each granted or withheld before you were called, each governing a different part of what you may say and write. Neither the referral nor the file records them reliably, because a file holds what was written down rather than what was understood.

WHO MAY HOLD IT	WHAT THEIR KNOWING DECIDES	THE ASSUMPTION THAT COSTS MARKS
The patient	Whether they can name their condition, and in which words, which fixes the interview's vocabulary	That an explanation recorded as given was understood
The accompanying relative	Whether a supervised dose or collected supply is possible, the attendant being the working unit of care on an Indian ward	That whoever brought the patient in knows why
The sexual partner	The one relationship where the patient's interest and another's can diverge, and the only one with a separate answer in law	That the clinical and the legal question are one
The employer and neighbourhood	Where loss of work, housing and standing is generated, and so what is protected	That secrecy outside the hospital signals shame rather than calculation
The record you are about to write	A note in a shared chart discloses to every later reader, many with no clinical role	That documentation is neutral because it is routine

RULE **Nothing in this consult is information about the patient alone, and nothing in it ends when you leave.** The first half governs speech and documentation: what may be said, in front of whom, and what may safely appear in a chart other people read. The second governs the output: an opinion filed once is worth little against a treatment measured in decades, so the deliverable is an arrangement somebody else runs.

10.3 Where the law enters, and the consult it generates

Candidates treat the serological test as an investigation like any other and are caught by the question that follows. The commonest consult on this axis is a consent question: a patient too unwell or too frightened to agree, and a team asking whether the agreement it holds is worth anything.

IN INDIA

Consent for this test and this treatment has a place of its own in central legislation. The HIV and AIDS (Prevention and Control) Act of **2017**, as recorded in the India Code maintained by the Legislative Department of the Ministry of Law and Justice, gives section **5** the heading informed consent for undertaking HIV test or treatment. What that section requires in operative terms, what conditions it attaches, and what national counselling guidance in turn requires of a clinic: on all of these, no comparable standard is available to quote, and none is invented here. The structural fact is the examinable one. A legislature that gives consent for one test a section to itself has taken it out of ordinary medical custom, so arranging that test for a patient who cannot presently agree is a governed act and not a courtesy.

The psychiatric half is **capacity**, and the bedside assessment is dealt with where capacity assessment and refusal of treatment in the general hospital are taken up in these notes. Two additions are specific here. A result, once it exists, must be given to somebody, somewhere its consequences can be absorbed, so an opinion answering only whether the patient can consent has answered half the referral. And whether anyone may be told without the patient's agreement is a separate statutory question, settled in Indian law and not at the bedside.

What belongs to psychiatry is the preparation preceding any disclosure, and it is concrete. Establish what the patient believes will follow, separating a realistic fear of violence or destitution from a catastrophic one. Rehearse the actual sentence, in their own language. Offer to be in the room. Let them fix the timing, because a disclosure made to a clinician's deadline is one they live beside afterwards without you.

10.4 Stigma predicts behaviour, it does not decorate the answer

Handled as sociology, stigma ornaments an answer and changes nothing at the bedside. Handled as a clinical variable, it predicts what this patient will do. Three forms do different work:

- what the patient has met: the refused tenancy, the relative who stopped visiting, the staff member whose manner changed, which is history and can usually be dated;
- **anticipated stigma**, a prediction rather than an experience, which governs behaviour whether or not events confirm it;
- **internalised stigma**, where the community's judgement has been accepted as accurate and turned inward.

The second reaches the medical outcome, because it produces **concealment**: where tablets are kept, whether they travel, whether a clinic visit can be explained at home. Concealment answers a real hazard, and recording it as denial costs you the next problem the patient would have brought.

The third is most often mistaken for a mood disorder, and the distinction changes what you do: one calls for treatment of an illness, the other for work on a belief taken from other people. Where advanced disease confounds the somatic features, recognising depressive illness is dealt with where depression, anxiety and delirium in cancer and palliative care are taken up in these notes.

10.5 Adherence has links, and the repair follows from which one broke

Asking whether a patient is adherent yields a proportion and no plan. **Adherence** to a lifelong regimen is a chain of separable behaviours: knowing why, obtaining the supply, remembering the hour, having somewhere unobserved, and doing it again tomorrow. Each psychiatric problem attacks a particular link, so the useful question is which link.

WHAT THE ASSESSMENT FINDS	THE LINK IT DISABLES	WHAT THE CONSULT ASKS FOR
Depressive illness	Valuing the future the treatment is taken for, so the tablet is remembered but stops feeling worth it	Treatment of the mood disorder itself, and a named person who asks about tablets next visit
Alcohol or other substance use	The regularity of the day, so the dose is not to hand at the same hour	Quantification without a moral frame, and a plan that works during continued use
Cognitive impairment	Remembering, sequencing and self-monitoring, so the failure is of machinery rather than will	External structure: a supervised dose, a box filled by someone else, a shorter review interval
Psychotic illness	The meaning of the tablet, absorbed into the patient's account of what is being done to them	Work on the meaning before any argument about compliance, and a supply not conditional on agreement
Concealment	Doing it where it could be seen, the link no motivation repairs	A dosing hour and place kept unobserved, and collection that does not announce itself

Two constraints govern prescribing. Cognitive impairment here may or may not be attributable to the infection: its classification, staging and detection are set out in the Neuropsychiatry of systemic and neurological disease notes, while the consult contributes the timeline and the functional consequence, taken from an informant against a stated previous level of function. And no psychotropic is started without the current antiretroviral regimen in front of you, since safe combination and those drugs' own psychiatric effects sit in the same place. **Attribution** settled before the history is taken is the error this topic punishes.

TRAP **Answering the referral as written instead of the referral as meant.** The note says assess for depression; the unstated request is usually make him take his tablets, or get her to tell her husband. Answer the written words and you produce a diagnosis nobody needed. Deliver the unstated request and you have accepted a job psychiatry cannot honestly do, because an outcome cannot be extracted from a patient on another team's behalf. The discriminating answer names the real question aloud, says which part is psychiatry's, and hands the remainder back with a reason.

10.6 The durable output is an arrangement with the treating clinic

Because these patients are mostly not inpatients, this is service design rather than bedside technique, and the unit of work is a standing arrangement that is renewed and audited. The clinic already holds a counsellor known to the patient and present at every visit, so supervision, shared triage and joint review of the difficult few use a psychiatrist far better than a parallel clinic nobody attends.

That role is governed centrally, and knowing so changes how you approach the clinic. The National AIDS Control Organisation, within the Ministry of Health and Family Welfare, is the source of the national reference set for this work: a handbook for HIV and STI counsellors, a handbook on the prevention and management of stigma and discrimination, and a guideline for

HIV counselling and testing services. Their contents are neither reproduced nor characterised here. What follows is practical: establish what the clinic is already mandated to do before proposing anything, because a plan duplicating a programme requirement is dropped and one cutting across it is ignored.

Four things a workable arrangement specifies, in order:

- who screens, with what, and at which point in the visit, since a screen offered after the drugs are collected is never completed;
- what result escalates, how fast and by which route, so whoever screens never chooses between doing nothing and declaring a crisis;
- where the psychiatric record will live, given what a shared chart discloses;
- who notices and who acts when a patient stops attending, since disengagement is invisible to a service that sees only attenders.

Where these arrangements fail. On geography and timing far more often than on clinical disagreement. A referral requiring a second journey, to another building on another date, is one a patient paid by the day will not make, and the non-attendance is then recorded as poor motivation. **Same-visit access** decides whether the arrangement functions, and it costs a room and a fixed hour rather than a new post.

GOOD TO REMEMBER

Settle the documentation before the note is written. Decide which facts must sit in the shared record for the team to treat safely, which belong somewhere with narrower access, and what the patient has been told about who reads each. Then write, and tell them what you wrote. Put the follow-up arrangement in the same note, named to a role and carrying a date.

10.7 What this section hands on

Map before you speak	Name the broken link	Stigma is a predictor	Contract, do not visit
WHO HOLDS THE DIAGNOSIS IS ESTABLISHED PERSON BY PERSON, BECAUSE NO RECORD CARRIES IT	EACH PROBLEM DISABLES A DIFFERENT STEP OF THE DAILY ACT, AND THE REPAIR FOLLOWS	ANTICIPATED STIGMA PRODUCES CONCEALMENT, WHICH IS WHAT REACHES THE MEDICAL OUTCOME	THE DELIVERABLE IS AN ARRANGEMENT THE CLINIC RUNS AND AUDITS AFTER YOU HAVE GONE

An examiner is watching whether the candidate keeps the consult and the entity apart. The answer does not open with the neurocognitive syndrome. It opens with who knows and who is in the room, moves to consent and to what the referral is really asking, treats stigma as a predictor rather than as sympathy, identifies which link in the daily act has broken, checks the medical prescription before writing a psychiatric one, and closes with an arrangement rather than an opinion.

Psychiatry is not called here for the infection but for what the infection generates: a disclosure map governing every word said and written, a daily act that must survive decades of psychiatric weather, and a working contract with the clinic that outlasts the consult.

11 · Psycho-cardiology, psycho-dermatology and psycho-nephrology cross-links

Why the marks are here. Three medical specialties send psychiatry a steady stream of referrals, and each sends them for a different reason. Cardiology refers because a mood state is altering a cardiac outcome. Dermatology refers because a substantial share of its clinic is carrying a psychiatric problem dressed as a skin complaint. Nephrology refers because a treatment that will not end has become intolerable to the person receiving it. A candidate who answers all three with one generic account of depression in the medically ill has not answered any of them, because what is examined here is the specific traffic between psychiatry and each organ: who refers and at what point in the illness, what the psychiatric finding does to the physical prognosis, and what the psychiatrist's own prescription does back to the organ.

Three boundaries first, because this topic sits between several others in this chapter. The general psychological work of adjusting to physical illness, including denial, adherence and the shifts in identity a chronic disease brings, belongs to the companion topic on psychological reactions to physical illness and chronic disease. How a consult is requested, negotiated, answered and recorded belongs to the companion topic on principles and models of consultation-liaison psychiatry. The dialysis unit, the transplant work-up and the intensive care bed considered as settings belong to the companion topic on transplant, dialysis and ICU psychiatry. What is taught here is the organ-specific link itself: the size of each interface, its prognostic weight, the classification the referring specialty actually uses, and the drug traffic running in both directions.

1.6 to 2.7 fold	Under 15%	30% to 40%	21.4%
INCREASE IN MORTALITY RISK REPORTED WHEN DEPRESSION FOLLOWS MYOCARDIAL INFARCTION	DEPRESSION IN CORONARY ARTERY DISEASE THAT IS ACTUALLY DIAGNOSED	DERMATOLOGY OUTPATIENTS WITH AN UNDERLYING PSYCHIATRIC ISSUE	DEPRESSION REPORTED ACROSS CHRONIC KIDNEY DISEASE STAGES ONE TO FIVE

11.1 What a cross-link is, and what to call it

An organ cross-link is not a disorder and not a service. It is a relationship between two specialties around one organ system, and it has four parts worth separating before any of the three is discussed: how much psychiatric morbidity that clinic carries, how much of it is recognised, what the psychiatric state does to the physical outcome, and what each specialty's drugs do to the other's territory. Every examinable point in this topic is one of those four.

The names themselves need a word of caution, because they are used with different degrees of authority. Of the three head terms psycho-cardiology, psycho-dermatology and psycho-nephrology, only the dermatological one is securely attested in Indian guidance: **psychodermatology**, with its cognates psychocutaneous and psychodermatological, is the language the Indian guideline uses for that field, including in the heading under which it teaches the subject. The corresponding cardiac and renal terms did not appear in the body text of the two

Indian chapters read for this account. That is a statement about two documents and not about the literature: the cardiac and renal chapters title themselves as the management of psychiatric disorders in patients with cardiovascular diseases and in patients with chronic kidney diseases respectively, which is descriptive rather than terminological. Use psycho-cardiology and psycho-nephrology as convenient labels for a field of work, keep confident terminological claims for the dermatological one, and do not assert in a viva that the other two are established technical terms.

RULE **The clinically important number at every one of these interfaces is not the prevalence but the gap between the prevalence and the proportion diagnosed.** A physician who is told that a fifth of their clinic is depressed will reasonably reply that they have not seen it, and they are usually right, because they have not. That is the argument for a proactive arrangement rather than a referral-only one: a service that waits to be asked is measuring the referring team's recognition, not the ward's morbidity, and on these three interfaces those two quantities are known to be far apart.

11.2 Psycho-cardiology: how much depression, and in which cardiac patient

The cardiac interface is the best quantified of the three, and the Indian guideline published in 2022 gives figures at each stage of coronary disease rather than a single global rate. Depression is present in fifteen to twenty per cent of patients with coronary artery disease, in fifteen per cent of patients after coronary artery bypass grafting, and in twenty per cent of patients with congestive heart failure. After myocardial infarction the figure depends entirely on what is being counted: at least sixty-five per cent report depressive symptoms while twenty per cent fulfil criteria for a major depressive episode. Those are not two estimates of one quantity but two different quantities, and the distinction is the most examinable thing here.

Two modifiers are worth carrying. Risk is roughly two-fold in women compared with men, and particularly so under the age of sixty, which matters because the younger woman with cardiac disease is precisely the patient a busy unit is least likely to think of as depressed. And device recipients carry an anxiety burden of their own: around thirty per cent of patients with an implanted cardioverter defibrillator have clinically relevant anxiety, which is intelligible once you consider what the device does when it fires and how little warning the patient has.

Course is the part candidates omit. Depression at a cardiac index event is not a transient reaction that resolves as the patient recovers. At follow-up, the illness was chronic or relapsing in almost half of those who had a major depression at the index episode, and forty per cent of those with only minor depressive symptoms had progressed to a major episode within one year. The second half of that sentence is the reason a cardiac unit cannot safely apply a watch-and-wait rule to subthreshold mood symptoms, and it is the justification for a follow-up appointment rather than a single consult note.

TRAP **Quoting a symptom prevalence as though it were a disorder prevalence.** The commonest version of this error is the flat assertion that most patients after myocardial infarction are depressed, which takes a symptom-report figure and reads it as a diagnosis rate that is more than three times the true one. Candidates make it because the larger number is more striking and because the source sentence carries both figures and only the first is remembered. Always state the denominator with the number: symptoms reported, or criteria met. An examiner who hears a bare percentage for post-infarction depression will ask which one it is, and that follow-up is the whole point of the question.

11.3 Psycho-cardiology: why it is a prognostic problem, and the one procedural constraint

What makes cardiology different from the other two interfaces is that the psychiatric finding is a prognostic variable in its own right. Depression is described as an independent risk factor for coronary artery disease carrying a **bidirectional** relationship with it, meaning that the association runs in both directions and cannot be dismissed as understandable distress in a sick population. The mortality multiplier reported for depression following myocardial infarction is set out above; it should be quoted as the guideline reports it, because no confidence interval, no source study and no follow-up period accompanies it, so it is a reported range and not a pooled estimate you can defend as such.

The prognostic weight is not confined to depression. Stress, anxiety, panic and post-traumatic states are reported to increase mortality in cardiovascular disorder with a relative risk of 2.0 to 4.0, and post-traumatic stress disorder following an acute coronary syndrome carries a relative risk of 2.0 for relapse of that syndrome over one to three years. Severe mental illness belongs in the same frame: cardiovascular mortality in bipolar disorder is described as roughly doubled, with a relative risk of 1.5 to 2. That last figure is the one to have ready when a viva turns from the general hospital to the psychiatric outpatient, because it converts routine cardiovascular monitoring in a long-term patient from good practice into a mortality intervention.

One procedural constraint belongs here and only here, because it is a cardiac fact rather than a technique question. There are no absolute contraindications to electroconvulsive therapy, and recent unstable angina or myocardial infarction within **30 days** is a relative contraindication, with procedural precautions specified alongside it. The reasoning to show is why a relative contraindication with a time window is the right form for this rule: the haemodynamic surge is brief and manageable, the vulnerable myocardium is not, and the window closes.

11.4 Psycho-dermatology: the size of the interface and the Indian evidence

The dermatological interface is the largest of the three by proportion of the clinic and the least served by psychiatry. The headline proportion of dermatology attenders with an underlying psychiatric issue is given above, and what turns that figure into teaching is the Indian evidence sitting behind it, which is unusually good for a subject this neglected. Psychiatric morbidity is reported in thirty-five per cent of patients with acne and in **fifty-two per cent** of patients with chronic dermatoses, and depression in around thirty per cent of those with alopecia areata. The chronicity gradient in those three figures is the finding: the longer the skin disease has been visible, the larger the psychiatric fraction.

Stress as a trigger is measured separately and the two measurements should not be merged. Stressful life events in the year before onset or exacerbation were recorded in twenty-six per cent of patients with psoriasis vulgaris and sixteen per cent of those with chronic urticaria. Patient-reported emotional triggers run far higher, at fifty per cent in acne and almost all patients with hyperhidrosis. The hedge on that last one is part of the claim and should be reproduced with it. The gap between a documented life event and a reported trigger is not evidence that patients are wrong: it reflects two different questions, one asked of a record and one of a person.

IN INDIA

These dermatological figures are Indian studies quoted in an Indian guideline, and that is what makes them usable in an Indian viva without an apology. The decision they support is a service decision. A dermatology outpatient in a general hospital sees very large numbers in a short clinic and has no time to open a psychiatric enquiry, so a psychiatric problem in that clinic is found only if someone has arranged for it to be looked for. The renal chapter states the same requirement in plainer words, closing with the statement that collaborative work between the nephrologist and the psychiatrist is required; it was itself co-authored with a nephrologist. Asked how you would set this up, describe an arrangement in which psychiatry attends the other specialty's clinic, because the alternative depends on a referral that the figures above show is mostly not made.

11.5 Classifying the psychocutaneous disorders

Dermatology is the one interface where the classification itself is examinable, because the referring question changes completely depending on which class the patient falls into. Indian guidance adopts the classification attributed to Koo and Lee, which sorts psychocutaneous disorders into **three** types and adds a separate group of sensory presentations.

CLASS	WHAT DEFINES IT	NAMED EXAMPLES
Psychophysiologic (type 1)	Dermatological disorders that flare during stress	Alopecia areata, atopic dermatitis, acne, psoriasis, psychogenic purpura, rosacea, seborrhoeic dermatitis, urticaria
Primary psychocutaneous (type 2)	A psychiatric disorder is the root of the dermatological condition	Skin picking disorder, trichotillomania, delusional parasitosis, body dysmorphic disorder, factitious dermatitis
Secondary psychocutaneous (type 3)	Psychological problems arising from chronic skin disease or disfigurement	Alopecia areata, cystic acne, haemangioma, psoriasis, vitiligo, ichthyosis, Kaposi's sarcoma
Cutaneous sensory disorders	Unpleasant skin sensations with no known dermatological cause	Commonest on the face, scalp and perineum; includes glossodynia and vulvodynia

MNEMONIC

Flares, Drives, Scars

The three types in order and in the direction each runs. Type 1 is the skin disease that **flares** under stress. Type 2 is the psychiatric disorder that **drives** the skin lesion, so the lesion is produced by behaviour or by belief. Type 3 is the skin disease that **scars** the person, the psychological problem arising from chronic disease or disfigurement.

Two features of the table are worth arguing rather than memorising. First, alopecia areata and psoriasis appear in two classes each, and that is in the source's own table rather than an error to be tidied away. It is the most useful thing in the classification, because it says that one disease can both flare with stress and disfigure the person who has it, and that the two mechanisms need separate management in the same patient. Second, the type 2 examples are entities other chapters own: delusional parasitosis is taught in the Other psychotic disorders, delusional syndromes and catatonia notes, and skin picking, trichotillomania and body dysmorphic disorder in the Anxiety, OCD and trauma-related disorders notes, while factitious presentations are taken up in the companion topic on factitious disorder and malingering. What belongs here is the referral logic: a type 2 patient reaches psychiatry through a dermatologist who has usually already been consulted several times. The **matchbox sign**, the patient bringing collected specimens of the supposed organism to the appointment, is named in that guidance and is a cross-link observation rather than a psychopathological one: the dermatologist sees it first.

11.6 The arm that runs back: drugs, skin and the psychiatrist's duty

The dermatological interface is the clearest illustration of traffic in both directions, and both directions carry drugs. Running from dermatology into psychiatry, the same Indian guidance sets out a further and more recent classification of psychodermatological disorders, cut differently from the one above and to be named separately rather than merged with it. That newer scheme includes a category the first does not: psychiatric complications of the drugs dermatologists prescribe.

- **Depersonalisation** is named with minocycline.
- **Mood disorders** are named with isotretinoin, methotrexate and systemic steroids.
- **Psychoses** are named with dapsone and hydroxychloroquine.

The use of that list is a habit rather than a fact. In any patient referred from a skin clinic with a new psychiatric presentation, the drug chart is part of the mental state examination, and the temporal relation between starting a dermatological agent and the onset of the symptom is the first thing to establish, because it is the one that will not be recoverable later.

Running the other way, psychotropics can produce **severe cutaneous adverse reactions**, which the Indian guidance describes as potentially lethal, rare and sudden in onset. This account deliberately prints no rates, no onset windows and no per-syndrome mortality figures for them, because the tabulated values available here disagree with the same document's own prose and one of the cells is corrupted, so no comparable standard is available to quote, and none is invented

here. What survives that caution is the part that changes behaviour, and the guidance states it explicitly: the prescriber must warn the patient and the attendants, so that a rash is brought back rather than watched. That instruction is the examinable content. A psychiatrist who has started a psychotropic on a medical ward is responsible for recognising a serious skin reaction to it and acting on it, and cannot make a rash the dermatologist's problem because it is on the skin.

11.7 Psycho-nephrology: the burden along the disease course

The renal interface differs from the other two in that the psychiatric burden is described stage by stage along a trajectory that ends in either lifelong dialysis or transplantation, and it does not fall after transplantation.

- **Depression** is reported in 22.8 per cent of patients with advanced chronic kidney disease and 25.7 per cent of kidney transplant recipients, the stage-wide figure being given above.
- **Anxiety** is reported in 24.8 to 34.3 per cent of patients in stages three to five, and 26.6 per cent of transplant patients.
- **Cognitive impairment** reaches **up to 60 per cent** in advanced disease and in patients on haemodialysis, with deficits described in attention, concentration, orientation and executive function, and low serum albumin associated with decline in delayed memory, visuospatial skills, language and general cognition.

Two points follow. That transplantation does not return these rates to the population baseline is the finding most often assumed away, and it is the argument for continuing psychiatric follow-up after a successful graft rather than discharging at that point. And the cognitive figure is large enough to change how the rest of the assessment is conducted: a patient with that degree of impairment cannot reliably give a history of mood over months, cannot be assumed to have understood a consent discussion about modality, and may be misread as depressed on the basis of psychomotor slowing that is cognitive in origin. Where that impairment needs to be worked up as a neurocognitive presentation in its own right, the substrate belongs to the Neuropsychiatry of systemic and neurological disease notes.

The distress in end-stage disease has named sources rather than a general miserableness, and the guideline lists them: compromised health, dependence on others, regular frequent dialysis, the continued cost of treatment, and uncertainty about transplant. Two of those five are structural rather than psychological, and in Indian practice they are the two that dominate, because a family financing dialysis indefinitely and waiting on an uncertain transplant is not experiencing a distorted cognition that can be restructured. Naming them accurately is what separates a formulation from a diagnosis here.

Treatment at this interface has one grounded drug signal and one grounded psychological one, and the rest is deliberately not given. Citalopram increases the risk of sudden cardiac arrest in patients undergoing haemodialysis, significantly more than other selective serotonin reuptake inhibitors, with no effect size stated and none supplied here. On the psychological side, a meta-analysis supports the efficacy of cognitive behavioural therapy for depression in patients with renal disease on dialysis, which is worth quoting because it is a positive treatment claim in a

population where most trials are small. What is not printed here is any dose, any clearance threshold and any drug-by-drug schedule for prescribing in renal impairment; that material has its own owner and no fragment of it is reproduced here, while the general principles of antidepressant selection belong to the Mood disorders: pharmacotherapy notes.

11.8 Reading the three together

The comparison an examiner is actually testing. Asked to compare these interfaces, most answers list three sets of prevalences and stop. The better answer compares them on what the referring team wants, which differs in each case, and on what the psychiatrist's own decisions do to the organ.

INTERFACE	WHAT THE REFERRING TEAM IS ACTUALLY ASKING	THE PSYCHIATRIC ARM	THE ARM RUNNING BACK INTO THE ORGAN
Cardiology	Will this mood state change the cardiac outcome, and can it be treated safely here	Depression at every stage of coronary disease, mostly undiagnosed, often chronic or relapsing	An independent risk factor with a bidirectional relationship, plus the time-limited constraint on electroconvulsive therapy after an acute coronary event
Dermatology	Is the skin disease the problem here, or is the patient	A large minority of the clinic carries psychiatric morbidity, and the class decides the pathway	Dermatological drugs producing psychiatric syndromes, and psychotropics producing severe cutaneous reactions the prescriber must warn about
Nephrology	Why is this patient not tolerating a treatment they cannot stop	Depression, anxiety and substantial cognitive impairment across stages, persisting after transplantation	One drug-specific arrhythmia signal on haemodialysis, and clearance questions belonging to prescribing in renal impairment

GOOD TO REMEMBER

Two lines that candidates routinely omit should be in the consult note before it is closed on any of these three wards. The first states what the finding means for the physical illness, not only its psychiatric label, because that is the sentence the referring team can act on. The second states what has been done about the drug traffic in both directions: what the existing physical medication may be contributing to the mental state, and what warning the patient and the attendants have been given about the psychotropic just started.

Every organ cross-link has two arms: what the physical illness and its drugs do to psychiatric morbidity, and what the psychiatric disorder and its drugs do back to the heart, the skin or the kidney, and an answer that travels in only one direction has answered half the question.

12 · Psychiatric aspects of epilepsy and neurological disorders

Why the referral arrives at all. The neurology team has finished its investigations, reached its own view, and written one line at the foot of the chart: please see, query psychiatric. Nothing in that request is a question, and a psychiatrist who treats it as one ratifies a decision somebody else has already made. The psychiatric aspects of epilepsy and neurological disorders are taught in full elsewhere: what epilepsy is, how seizures are classified, which psychiatric presentations cluster around them and how the drugs behave belong to the Epilepsy and psychiatry notes; the rest of the neurological interface is listed below. What is owed here is the neurological instance: how the request is generated, what must be established before it can honestly be answered, and who holds which decision afterwards.

The examination question has the same shape. It is rarely a request to list the psychiatric complications of a neurological disease; it is a station in which a neurological patient has a behavioural problem and a team that wants an answer today. A candidate who reaches for the syndrome list has answered a question about the disease. The question was about the consultation.

Observed	Attributed	Owned
WHAT THE CONSULTATION ADDS THAT THE CHART DOES NOT	THE DECISION MADE INSIDE THE REFERRAL BEFORE THE PSYCHIATRIST ARRIVES	WHICH TEAM CARRIES WHICH DECISION AFTERWARDS

12.1 The referral question is not the question in the referral

The written reason for referral is a compressed account of the referring team's reasoning, and it almost always carries an **attribution** already made: this behaviour belongs to the brain disease, or it does not, and therefore it is yours. The **referral question** is the clinical decision actually pending on the ward, and the two are frequently different. The gap widens where the presentation is **paroxysmal behavioural disturbance**, because a paroxysm invites several competing explanations at once and the referring team has usually settled on one. The psychiatrist's value is not a better guess at the mechanism; it is the obligation to return to what was seen before deciding what it was.

WHAT THE REFERRAL SAYS	WHAT IS ACTUALLY BEING ASKED	WHAT HAS TO BE SETTLED FIRST
Please see, query psychiatric, investigations normal	Confirm a negative the team has already reached	Whether anyone has yet described an episode to a psychiatrist
Please see, low mood since the diagnosis	Is this the illness, the treatment, or a disorder in its own right	The sequence in time and the drug record, from a source that watched rather than inferred
Please see before discharge	Share a risk the team will not carry alone	What decision is pending, who may make it, and what the family has been told

12.2 What has to be established before an opinion is worth having

None of it is a mental state finding. A **witness account** is worth more than the ward's account of the same episodes, because a team's summary is where the attribution gets smuggled in, and the sequence in time must be recorded as observation, not as a label, since that labelling is taught with the entity. The **drug record** earns its place because a recent change nobody has connected to the presentation is a common explanation on a neurology ward, and because that record is seldom complete.

MNEMONIC

Witness, timing, list, owner

Witness: who watched an episode, quoted in their own words. **Timing**: where the disturbance sat in relation to the episodes, as sequence and not category. **List**: the drug record with dates, including what was stopped. **Owner**: whoever makes the next decision on each problem, named. An opinion with no named decision-maker is a paragraph, not a consultation.

IN INDIA

Outside the medical colleges and the metropolitan private sector neurology is thinly distributed, and the patient with paroxysmal episodes often reaches a psychiatrist first. The drug history often arrives with no prescription and no record of who started it or when, so it has to be reconstructed rather than assumed. And referrals go unanswered in both directions, so the working relationship with the neurology or medical team is built, not inherited. A national standard would settle how quickly and in what form these consultations happen; no comparable standard is available to quote, and none is invented here.

12.3 Shared care, and the decisions the psychiatrist declines

This patient is the standing example of **shared care**, which fails in a specific way: both teams assume the other is holding a decision, and nobody is. By convention rather than by rule, the seizure diagnosis, the anticonvulsant regimen and the advice about driving and occupation that follows from the seizures stay with **the primary team**. The psychiatric diagnosis, the psychotropic decision, the risk formulation and the psychological plan are the psychiatrist's. Where the two collide, chiefly in prescribing, the decision is joint and is recorded as joint, with a named person on each side.

Declining is an active clinical act, not a retreat. A psychiatrist asked to adjudicate whether the episodes are seizures at all should record that the question belongs to the referring team, state what they observed that bears on it, and set a **review point**. Silence is read as agreement, and an undeclined question tends to be answered by default in whichever direction the ward was leaning.

RULE **Answer the psychiatric question, decline the neurological one, and write both down.** The consultation's authority comes from a visible boundary. An opinion that quietly extends into the seizure diagnosis invites the referring team to stop thinking about it; one that withholds the psychiatric decision leaves the patient with two clinicians and no plan. Neither is visible unless the note says which question was taken and which returned.

12.4 What the examiner tests, and where the rest is taught

How the marks are allocated. A neurological patient is set before a psychiatry candidate to see whether two illnesses and two teams can be held in mind without collapsing either into the other. What is scored is the sequence, the sourcing of the history, the explicit attribution and the handover. Entity knowledge is assumed and examined elsewhere, which is why fluent recitation earns less than a candidate expects.

- Seizure classification, the psychiatric presentations related to seizures, and the anticonvulsants: the Epilepsy and psychiatry notes.
- Examination, investigation and localisation: the Neurology foundations for psychiatrists notes.
- Stroke, head injury and focal brain syndromes: the Stroke, TBI, delirium and focal brain syndromes notes.
- The neurocognitive disorders: the Dementias and neurocognitive disorders notes.
- Systemic disease with neuropsychiatric presentations: the Neuropsychiatry of systemic and neurological disease notes.

TRAP **Answering the referral's attribution instead of testing it.** Candidates make it because the attribution is usually reasonable, comes from a specialist team, and is the only framing the request supplies. It is also the check a psychiatrist is well placed to make, having no stake in the conclusion already drawn. The correction is not scepticism about neurology; it is separating, in the note, what was observed from what was concluded.

A consultation on a neurological ward is discharged by naming what was observed and by whom, what is and is not attributed to the neurological illness, and who carries which decision from here.

What changes at seventy-eight

13 · Normal ageing and psychiatric assessment of the elderly

Why the marks are here. The examiner who turns to the older patient is rarely asking what dementia is, or what late-life depression looks like; those have their own questions and their own answers. This one asks something harder to prepare for. Here is a person of eighty: show me how you assess them, and then tell me which of your findings is the illness and which is simply the age. The second half is where answers collapse, because a candidate with no defensible account of what ageing normally does has nothing to measure abnormality against, and every finding in the

interview becomes uninterpretable in both directions at once. Slowness gets called depression. Forgetting a name gets called dementia. A genuine early deficit gets waved through as expected for age.

The topic has an awkward shape for a reader. Almost everything written about older people concerns their diseases, so the normal baseline is the least rehearsed part of the subject and simultaneously the part every diagnosis silently rests on. That is why normal ageing and psychiatric assessment of an older person belong in one answer rather than two: a procedure is only as good as the norms it is read against.

13.1 The instrument does not change; the weights inside it do

Begin where the guidance begins, because it is unusually blunt. A clinical practice guideline on older people presenting with psychiatric emergencies, published in the Indian Journal of Psychiatry in 2023, states that the basic principles of psychiatric assessment remain the same in old age, and then names them: thorough history taking, physical examination, mental state examination, and carrying out the investigations required. **Four** parts, in the order every candidate already knows. Nothing is deleted because the patient is old, nothing exotic is inserted, and there is no separate geriatric interview to name.

What changes sits inside the first part. The same guideline directs that in taking the history the clinician should not confine attention to the psychiatric history but must also cover **comorbid physical illness**. Read that as a statement about weight and not about coverage. An adult history asks about physical illness too, but handles it as background against which the psychiatric story is told. In later life it stops being background and becomes a second history of equal standing, taken with the same care, the same chronology and the same insistence on detail as the psychiatric one.

Four reasons make that shift defensible rather than merely dutiful, and a good answer gives at least two. The physical illness is more often the cause of the presentation than a context for it. It frequently dictates what treatment is available, so a plan written before the physical history is complete may have to be abandoned. It changes the reading of the mental state, since fatigue, poor appetite, disturbed sleep and slowing all have honest medical explanations in a patient with several active diagnoses. And it is the part the patient is least likely to volunteer, having normalised it over years and having come to see a psychiatrist.

RULE **The skeleton of the assessment is age-invariant; the weight distributed across it is not.** Anyone who answers this question by describing a special geriatric interview has misread it. The examinable content is which parts of a familiar structure grow, what gets added to the history because of the patient's age, and against what baseline the mental state findings are then read. Say the structure is unchanged in your first sentence, and spend the rest of the answer on the redistribution.

One qualification belongs in the answer. The document stating the principle most crisply is written for the emergency presentation, so its setting is the acutely disturbed older patient rather than the routine outpatient. That sentence about the structure is itself general and travels, but a candidate who names the source should name its scope too.

PART OF THE ASSESSMENT	WHAT IS UNCHANGED	WHAT THE PATIENT'S AGE ADDS
History	The same sequence, the same headings, the same discipline about chronology	Physical comorbidity taken as a full second history; three added domains an adult clerking omits; an informant account that is rarely optional
Physical examination	The examination itself	It cannot be deferred to another team, because its findings now enter the psychiatric formulation rather than sitting beside it
Mental state examination	The same structure, the same terminology, the same descriptive discipline	Every finding is read against a normal-ageing baseline before it is called abnormal, and correctable sensory deficit is dealt with before cognition is tested at all
Investigations	Those the assessment has shown to be required	The physical differential raised by the history is longer, so the list is driven by that differential rather than by a fixed panel

13.2 The premise underneath all of it: reduced reserve

A single line in the same guideline carries the physiology for the entire subject. Older people have a lower level of **physiological reserve**, and the consequence drawn from it is that any tiny change should be given due importance. The guideline says this while instructing the reader how to evaluate drug intoxication and withdrawal, which is where a small change is most easily dismissed, but the premise is not specific to drugs and the reasoning generalises across the assessment.

Reserve is the distance between what a system does at rest and the most it can produce under load. Ageing narrows that distance across several systems at once, and the corollary is worth memorising: a perturbation absorbed silently in a younger patient produces a disproportionate effect here. Two things follow for the assessment.

- The size of the trigger stops predicting the size of the effect, so a search that stops because nothing impressive has been found has stopped too early, and a small complaint is pursued rather than filed.
- A change in mental state becomes a system-level signal rather than a psychiatric one, and it earns a physical review before it earns a psychiatric label.

What is deliberately not supplied here is the arithmetic. How far renal clearance falls per decade, and what happens to hepatic metabolism, lean body mass, total body water, albumin and receptor sensitivity, are exactly the figures a candidate reaches for at this point. For each of them no comparable standard is available to quote, and none is invented here. Those numbers belong to prescribing rather than to assessment, and are taken up where the principles of

psychopharmacology in later life are dealt with in these notes. In an assessment answer the qualitative statement is what earns the mark.

13.3 Normal cognitive ageing is a pattern, not a slope

The most useful correction to make early is that normal ageing is not global decline. A review of normal cognitive ageing published in Clinics in Geriatric Medicine in 2013 frames it as a split. Some abilities are resilient to brain ageing and may even improve with age, vocabulary being the standing example. Others decline gradually across time, and the three the review names are conceptual reasoning, memory and processing speed. The rate at which any of this happens varies widely between individuals, which is the reason chronological age predicts a given person's performance so poorly and the reason a normative table can never replace a premorbid baseline.

The same review puts numbers on the two trajectories, and they are the only quantified ones offered here. The abilities it groups as fluid, naming executive function, processing speed, memory and psychomotor ability, peak in the third decade of life and thereafter decline at an estimated **0.02** standard deviations a year. The crystallised abilities remain stable or gradually improve, at a rate the review prints as **0.02 to 0.003** standard deviations a year, through the sixth and seventh decades of life. Notice what that pairing means: across middle and later adulthood the two curves move in opposite directions inside the same skull, so a single global impression of a patient as sharp or as failing is almost always wrong about one half of them.

The fluid and crystallised distinction itself, its origin, its lifespan trajectory and the hold versus no-hold logic of testing that follows from it belong with the psychology of intelligence and are not re-derived here. What this section owes is the clinical use of the split. Preserved crystallised performance is what allows an estimate of what the patient used to be, and the gap between that estimate and current fluid performance is the quantity a cognitive assessment is really trying to measure. A patient whose vocabulary and general knowledge have gone is not showing you an exaggerated version of ageing; they are showing you something ageing does not do.

DOMAIN	WHAT NORMAL AGEING DOES TO IT	HOW TO READ A POOR PERFORMANCE
Overall language	Remains intact	A genuine language deficit is a finding, not a concession to age
Vocabulary	Resilient, and may improve with age	Loss here is among the strongest arguments against normal ageing
Visual confrontation naming	About the same until age 70, declining in subsequent years	Interpret against age before calling it anomia in an older patient
Verbal fluency	Declines	Weak on its own, and confounded by slowing
Processing speed	Begins declining in the third decade and continues through life	The likeliest single explanation for a broad, shallow, timed-test deficit

DOMAIN	WHAT NORMAL AGEING DOES TO IT	HOW TO READ A POOR PERFORMANCE
Rate of acquisition	Declines across the lifespan	Slow learning of a word list is compatible with normal ageing
Retention of what was learned	Preserved where cognition is healthy	Failure to hold material that was demonstrably learned is not ageing
Delayed free recall, source and prospective memory, retrieval	Decline with normal age	Expected; weigh them lightly without a retention failure alongside
Recognition memory with cueing, temporal order memory, procedural memory	Stable with normal age	Deficits here carry more weight than an equivalent recall deficit
Simple auditory attention span	Falls only slightly, and late	A markedly reduced simple span deserves an explanation
Selective attention, divided attention, working memory	Decline more noticeably	Poor performance under distraction or dual demand is weak evidence of disease
Conceptual reasoning	Declines gradually	Expected, and heterogeneous enough that a single score means little

13.4 Slowing is the common cause, and it contaminates the rest

The point that changes how you read a score. **Processing speed** is not one deficit sitting alongside the others. The review is explicit that many of the cognitive changes reported in healthy older adults are the result of slowed speed, and that the slowing depresses performance on tests built to measure entirely different domains, verbal fluency among them. That single observation reorganises the whole of bedside cognitive interpretation.

The mechanism is not mysterious. Almost every cognitive instrument is timed, or carries an implicit time limit set by the examiner's patience, or asks the patient to hold material while operating on it. Each of those designs converts slowness into a lower score without any deficit in the domain being tested. The patient who produces fewer words in a minute may have intact semantic access and a slower retrieval engine. A profile of shallow deficits spread evenly across many domains is therefore the signature of a speed effect, and reads quite differently from a deep deficit in one domain with the rest preserved.

Two things follow at the bedside, and both are things the examiner can ask you to do rather than describe. Give time, and say in the note that you did, because a result obtained under time pressure and a result obtained without it are different measurements. And when a score comes out low, ask what proportion of that instrument's marks depended on producing something quickly before you record a domain deficit against the patient's name.

TRAP **Reading a low score as a domain deficit when it is a speed artefact.** Candidates learn cognitive testing as a map of domains and assume each subtest measures the domain it is named after. In an older person that assumption fails in a specific direction, because slowing pulls down scores across instruments that have nothing to do with speed. The answer that wins the mark names slowed processing speed as a competing explanation for the whole profile, rather than accepting the profile at face value and reporting a scattered multi-domain impairment.

13.5 Memory in normal ageing: slower to learn, not quicker to forget

The memory findings are the most examinable material in the topic, because they are the ones that separate an expected complaint from a diagnostic one. Normal ageing reduces the **rate of acquisition**: material takes more exposures and more time to get in. What it does not do is dissolve material that got in. Retention of information that has been successfully learned is preserved in cognitively healthy older adults, and that asymmetry is the baseline against which any complaint of memory failure has to be read.

The practical consequence is that the interesting question is never whether the patient forgot something. It is whether the item was ever learned. A patient who could not repeat a name back at the time of registration has not forgotten it thirty minutes later, and the examiner who watches a candidate record that as delayed recall failure has already found the mark. This is why an adequate registration step is not a formality, and why an examination that skips it produces a delayed recall figure that cannot be interpreted.

The direction of the normal changes is worth holding as two lists rather than one, because the second list is what makes a finding meaningful. Declining with normal age: delayed free recall, source memory, prospective memory, the rate of acquisition and retrieval. Stable with normal age: **recognition memory** when cueing is given, temporal order memory and procedural memory. A patient who cannot retrieve a word list freely but recognises every item when choices are offered is displaying a retrieval pattern, which is what ageing produces. One who does not recognise them even when offered has failed at something ageing does not touch.

Two boundaries belong here and are not crossed. What a rapidly failing memory in a patient with psychotic symptoms should push you towards is dealt with where late-onset psychosis is taken up in these notes, and the fine-grained cued-recall discriminators between the neurocognitive disorders belong to the Dementias and neurocognitive disorders notes. What this section supplies is the thing both of them stand on: the description of what memory does when nothing is wrong.

13.6 Language and attention: where candidates over-call and under-call

Language is the domain most often mishandled in both directions. Overall language ability remains intact with ageing, and vocabulary remains stable or improves, so a genuine language deficit in an older patient is a finding to be explained rather than a concession to be made. Against that, the review names two exceptions and both are common enough to trip an unwary examination. **Visual confrontation naming** stays about the same until the age of **70** and declines in the years after it, so naming failures in the eighties are read against a moving norm. And **verbal fluency** declines, which matters doubly because fluency tasks are also timed and therefore carry the speed confound described above.

Attention divides along a similar line. Simple auditory attention span shows only a slight decline in late life, whereas selective attention, divided attention and working memory decline more noticeably. That asymmetry is directly useful in a busy clinic. A patient who cannot hold a short span of digits at all has produced an abnormal finding worth pursuing; a patient who loses the thread when two things are asked at once, or when a corridor conversation intrudes, has produced an expected one. It also explains why the same patient looks impaired on a ward round and unimpaired in a quiet room, with no change in their brain between the two.

Sensory, frailty, abuse	3rd	0.02	2
THE HISTORY DOMAINS ADDED BECAUSE THE PATIENT IS OLD, THE LAST OF THEM NEEDING SUSPICION RATHER THAN ENQUIRY	DECADE OF LIFE IN WHICH FLUID ABILITIES PEAK, BEFORE THEIR LONG DECLINE	STANDARD DEVIATIONS A YEAR, THE ESTIMATED RATE OF THAT FLUID DECLINE	EXCEPTIONS TO OTHERWISE PRESERVED LANGUAGE: CONFRONTATION NAMING AFTER 70, AND VERBAL FLUENCY

13.7 The history items that exist only because the patient is old

Beyond the redistribution of weight, the geriatric history acquires domains an adult history does not routinely ask about. The same national guideline names them, and they are worth memorising as a set because a candidate who produces all three has demonstrated the point of the whole question. Due importance is to be given to the assessment of **sensory deprivation**, visual or auditory, and to a review of frailty; and the assessment of elder abuse requires a high index of suspicion.

Take the modal verbs seriously, because they differ. Sensory status and frailty are enquiries you make. Elder abuse is not an enquiry that succeeds by being made, since nobody volunteers it and the person who brought the patient may be the person concerned; what is asked for is active suspicion, the possibility raised by the clinician on the strength of discrepancy rather than of complaint. That topic's forms, its named instrument and what a clinician is then obliged to do are taken up where elder abuse and neglect are dealt with in these notes.

Sensory deprivation earns its place for two separate reasons and only one of them is about the patient's experience. Degraded hearing and vision impoverish the information reaching an older person, so more of the world has to be inferred and less of it is received. Independently of that, an uncorrected deficit invalidates the examination you are about to perform: a patient who cannot hear an instruction looks inattentive, and one who cannot see an object looks unable to name it. What that does at the bedside of a confused inpatient belongs to the section on delirium in later life. What belongs here is the history step and its order: establish what the patient normally uses, establish whether they have it, and correct it before the mental state examination rather than after.

On the sensory changes themselves, this section stops short deliberately. What normally happens to hearing and to vision with age, the pattern in which it happens, the age at which it becomes clinically material, and how many older adults in India are affected are all facts a complete answer would carry, and for each of them no comparable standard is available to quote, and none is invented here. Say what is defensible: that sensory decline is expected, that it is frequently

correctable, and that its uncorrected presence makes a cognitive result uninterpretable. Do not attach a prevalence or an age threshold you cannot source, because that is precisely the sentence an examiner will ask you to justify.

Frailty is named here as a review, not as a construct to be taught. Its definition, its scoring and the multidisciplinary assessment it triggers are dealt with where the comprehensive geriatric assessment is taken up in these notes; in the psychiatric history it is a question about reserve.

MNEMONIC

Hear it, Weigh it, Count it, Suspect it

The four acts that turn an adult history into a geriatric one. **Hear** it: establish and correct sensory deprivation before any cognitive item is administered. **Weigh** it: give the comorbid physical history the same weight as the psychiatric one, and review frailty as part of it. **Count** it: produce a cumulative anticholinergic total from the drug history rather than a list of drugs. **Suspect** it: raise elder abuse yourself, because it is not volunteered.

13.8 The medication history has to produce a total, not a list

Every candidate takes a drug history. The geriatric requirement is different in kind: the guideline treats assessment of the **total anticholinergic burden** of all ongoing medications as a critical part of evaluating the medication history, and gives the reason plainly, which is that a high burden is one of the crucial causes of delirium. The output of the history is therefore a quantity, not an inventory, and an answer that says the drug history was taken without saying what it produced has not met the requirement.

The word doing the work is total. The clinical problem is rarely one strongly anticholinergic agent prescribed in error, which anyone would spot. It is the sum of several mild contributors accumulated across years and across prescribers, each individually defensible, none individually alarming, and nobody holding the addition. Note what is owed here and what is not: the assessment step is to arrive at the total. How that total then constrains prescribing, and what scales exist for scoring it, belong to the section on psychopharmacology in later life.

IN INDIA

Whose drugs get counted is where an Indian history diverges from the textbook version. The same guideline explicitly extends the medication history to medications from other pathies, naming homeopathy and ayurvedic preparations, alongside what has been bought over the counter. In practice the older Indian patient arrives on a physician's prescription, something from a second system of medicine that the family regards as harmless and so does not mention, a sleeping tablet running for years on repeat, and a topical or ophthalmic preparation nobody counts as a drug at all. The question that recovers all of it is not what medicines are you taking. It is a request to bring in every strip, bottle, sachet and tube in the house, from every doctor and every shop.

13.9 What the assessment has to leave behind

Because none of this is a separate procedure with its own form, what marks a geriatric assessment as competently done is what appears in the record at the end of it. Four entries carry the topic,

and each of them is the written trace of something taught above.

- The premorbid cognitive and functional baseline, with its source named, since a current performance without a baseline is a number without a comparator.
- The physical history and examination findings placed inside the psychiatric formulation rather than appended after it, with the differential they raise made explicit.
- A reconciled drug list from every source, with its cumulative anticholinergic burden stated as a judgement.
- A sentence saying which of the findings you have read as ageing and which as illness, and on what grounds, because that is the reasoning the question was testing and it is invisible unless written.

Two habits of conduct make those entries possible and are worth naming in a viva. Interview at the patient's pace, which is not courtesy but measurement discipline, given how much of what looks like deficit is slowing. And take an informant history routinely rather than as a rescue when the patient proves a poor historian, because the baseline everything else is read against usually exists only in somebody else's memory.

GOOD TO REMEMBER

Before the words cognitive impairment go into an older patient's notes, two sentences have to precede them: what this person was like before, and who told you. If neither is there, what has been recorded is a performance and not a finding, and every clinician who reads the note afterwards will inherit the conclusion without the evidence that would let them revise it.

Whatever form the question takes, it asks whether you can hold two frames at once. A candidate with only the assessment produces a competent adult clerking of an old person; one with only the norms produces a lecture on gerontology. The mark is in the join.

In normal ageing the rate of acquisition falls while retention of what was successfully learned is preserved, and vocabulary holds or improves while processing speed has been falling since early adulthood: so slow learning and slow performance are age, and losing what was learned or losing words is not.

14 · Principles of psychopharmacology in the elderly

Why the marks sit here. A prescription for a woman of seventy-eight is not a smaller version of the prescription for a woman of thirty with the same syndrome. The drug may be identical and the arithmetic is still different, because the body it enters has changed in how much arrives, how long it stays and how hard it lands.

The principles of psychopharmacology in the elderly are prescribing logic rather than a drug list; the agents belong to the Mood disorders: pharmacotherapy notes and the Anxiety, OCD and trauma-related disorders notes. Four things change with age: the kinetics, the dynamics, the number of other drugs already in the patient, and the prescriber's willingness to stop one.

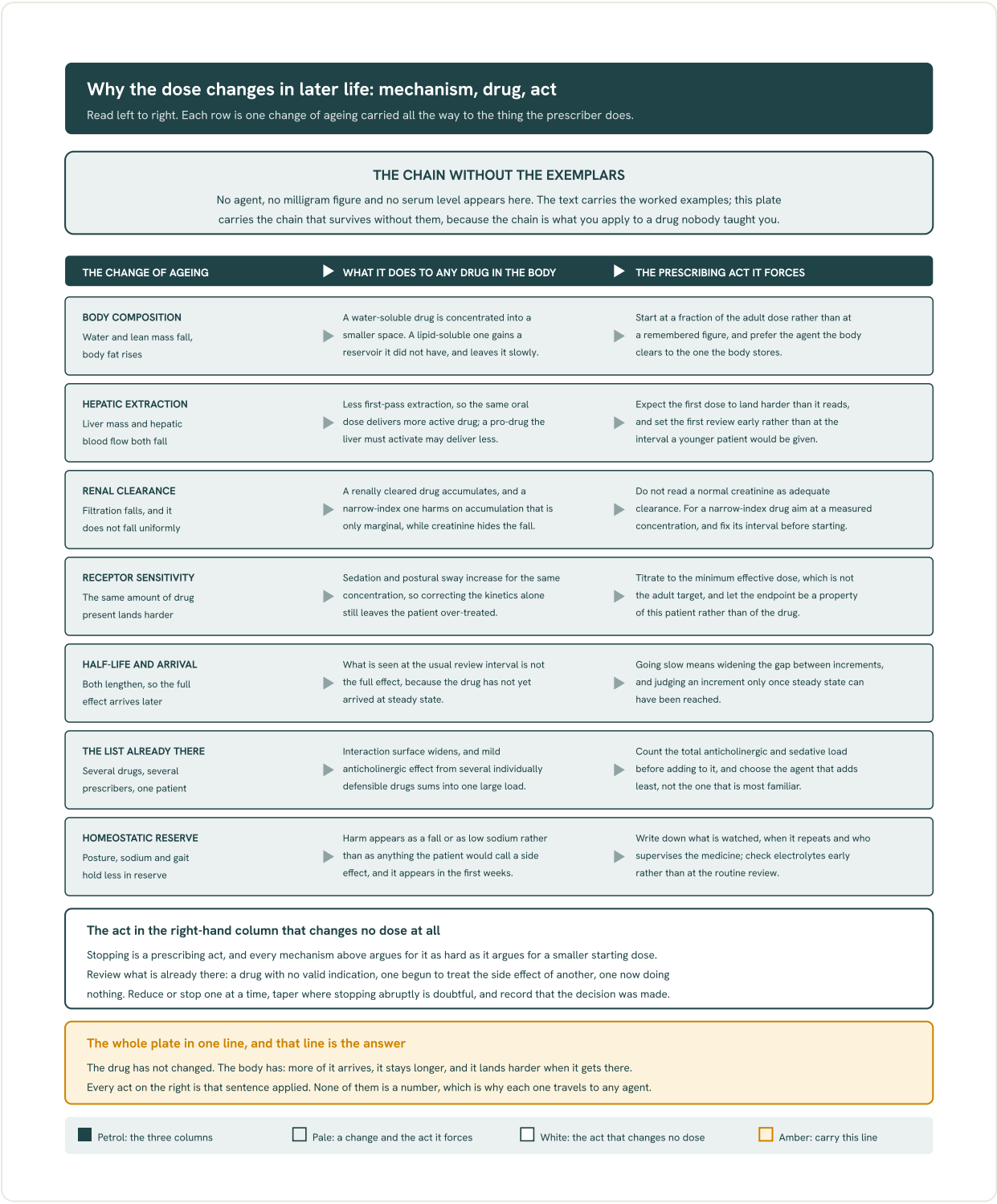


Fig 29.4. Why the prescription changes in later life, drawn as seven chains rather than as a list of changes, each beginning with one pharmacokinetic or pharmacodynamic shift of ageing, passing through what that shift does to any drug in the body, and ending in the act it forces on the prescriber, with no agent, milligram figure or serum concentration anywhere on the plate, and with the act that adjusts no dose at all, the review and withdrawal of what is already there, given its own panel because every mechanism above argues for it.

14.1 The kinetic shift

The whole kinetic change states in one line. Renal clearance falls, hepatic clearance falls, the **volume of distribution** rises for lipid-soluble drugs, and elimination half-life lengthens as a consequence. The review that states it this way also names psychotropic drugs, with anticoagulants and cardiovascular agents, as a class to which sensitivity is altered and usually

increased, which is why this is a psychiatric topic and not only a geriatric-medicine one. It hedges throughout, and a candidate who hardens its "probably" into a mechanism has overstated it.

WHAT CHANGES WITH AGE	CONSEQUENCE FOR THE PRESCRIPTION
Body water and lean mass fall, fat rises	Smaller volume of distribution for water-soluble agents; larger volume and longer half-life for lipid-soluble ones, diazepam the exemplar, so the sedative cleared by breakfast at forty still circulates at teatime at eighty
Liver mass and hepatic blood flow fall	First-pass metabolism reduced, so bioavailability can rise for a drug extensively cleared on first pass, while a pro-drug the liver must activate might be activated more slowly
Renal flow and filtration fall, not uniformly	Clearance falls for renally cleared agents, lithium among them, and marginal accumulation of a narrow-index drug harms
Sensitivity to several classes is altered upward	Sedation and postural sway increase with diazepam and postural sway with temazepam, so the same plasma level buys a bigger effect

PITFALL

A normal serum creatinine in an older patient is not evidence of adequate renal function. Filtration falls while plasma creatinine does not rise, because muscle mass falls in parallel, so creatinine is not a reliable indicator of glomerular filtration rate in the elderly subject, and serum cystatin C offers no significant advantage over it. The same source is explicit that the decline is not uniform or consistent, which warns against the familiar per-decade figure. No rate of decline is asserted here, and no percentage for the fall in body water, lean mass or liver blood flow: none of those magnitudes is available to quote, and none is invented here.

14.2 The pharmacodynamic shift

Kinetics can be reasoned from first principles. Dynamics cannot, and the honest source says so: because the effect of age on drug sensitivity varies with the drug studied and with the response measured, generalisations are often difficult. Quote that rather than paraphrase it. Within the caution the direction is loud for the benzodiazepines: one at seventy-eight is not merely longer-acting but intrinsically more destabilising at the same concentration. It is not loud everywhere: the same table's scopolamine row runs the other way, its effect on cognitive function decreasing with age.

MNEMONIC

Fewer litres, slower exit, sharper target

Fewer litres is the body-composition shift, **slower exit** the fall in clearance and the longer half-life, **sharper target** the rise in sensitivity that includes psychotropics.

14.3 Start low and go slow, as a quantity

Start low, go slow heads the Indian list of general prescribing principles for the elderly. Quoted alone it is nearly useless: it says nothing about how low or how slow. Current Indian guidelines do quantify it, and differently for different drug classes, which is the examinable point rather than an inconsistency to smooth away.

half OF THE ADULT STARTING AND TARGET DOSE FOR ANTIDEPRESSANTS IN THE ELDERLY, INDIAN DEPRESSION GUIDELINE	**25 to 50% lower** THAN THE ADULT ANTIPSYCHOTIC STARTING DOSE IN OLDER ADULTS, INDIAN SCHIZOPHRENIA GUIDELINE	**more than 5** MEDICATIONS, THE POLYPHARMACY COUNT TRIGGERING A DEPRESCRIBING REVIEW IN INDIA	**every 6 months** OR MORE FREQUENTLY, THE GENERAL FILTRATION AND THYROID SCHEDULE ON LITHIUM, OLDER AGE BEING A REASON TO GO MORE OFTEN

The first two figures are not the same rule. The antidepressant rule is a flat halving that moves the target dose as well as the start, so the destination itself moves; the antipsychotic rule is a range of reduction, stated for the starting dose only. Neither states an upper ceiling for older adults and neither states a milligram figure, so a correct answer attaches the class and the guideline to each figure.

Going slow has an endpoint as well as a rate, and the endpoint is what candidates drop. The Indian obsessive-compulsive disorder guideline states it plainly for older adults: start low, increase slowly, stabilise at the **minimum effective dose**, which is not the adult target. It also says clomipramine may be avoided on cardiac, sedative, constipating and falls grounds, and that high-dose selective serotonin reuptake inhibitors should be used cautiously because of falls and hyponatraemia, "high dose" meaning the supratherapeutic anti-obsessive range that guideline itself recommends.

The clearest quantified illustration of slowness is not a psychotropic. For digoxin, time to steady state rises from 7 days in the young to 12 days in the elderly, so digoxin loading doses should be **reduced by approximately 20 per cent**. The arithmetic transfers: such a drug cannot be titrated on a younger patient's schedule.

RULE **The age adjustment is a fraction, not a figure.** Every quantified dose rule for older adults in current Indian guidance is a proportion of the adult dose or a serum-concentration target, and none states an absolute milligram starting dose: the adult dose is the only fixed point guideline and prescriber share.

TRAP **Converting a relative instruction into a remembered absolute one.** Told the elderly antidepressant dose is half the adult dose, a candidate reaches for a milligram number. The instruction has no milligram content; the moment it acquires one, it came from the candidate and not the guideline.

In an older adult the starting dose is a fraction of the adult dose, the titration endpoint is the minimum effective dose rather than the adult target, and the monitoring that decides the outcome is sodium, renal function and the ability to stand up without falling.

14.4 Lithium, and a guideline that disagrees with itself

Lithium is where every strand of this topic meets. It is renally cleared, its clearance falls with age, and it is separately named with the aminoglycosides and digoxin as a drug of **narrow therapeutic index** likely to cause serious adverse effects if it accumulates only marginally more than intended. Those two properties together are the argument for a lower target in old age.

PHASE AND POPULATION	SERUM LITHIUM TARGET AS PRINTED	WHERE THE GUIDELINE STATES IT
Acute mania, medically healthy	0.8 to 1.0 meq/l	the acute-mania dosing table
Acute mania, older adults or relevant medical issues	0.6 to 0.8 meq/l	the same dosing table
Acute phase, general	0.6 to 1.2 meq/l	the lithium narrative of the same document
Acute phase, older adults	0.4 to 0.8 meq/l, which the guideline says "may suffice"	the same narrative
Maintenance, medically healthy	0.6 to 0.8 meq/l	the maintenance section
Maintenance, older adults or relevant medical issues	0.4 to 0.6 meq/l	the same section

Two things there need saying aloud. First, the current Indian bipolar disorder guideline states the older-adult acute target in two places and they do not agree: the dosing table sets the lower bound at 0.6 meq/l while the narrative of the same document sets it at 0.4 meq/l, both agreeing on an upper bound of 0.8 meq/l. Averaging them gains nothing: name the location you quote, or give both ranges. The narrative also carries the softer modal verb, that the lower range "may suffice" rather than that it should be aimed for.

Second, what the guideline does not say. The dosing table prints a milligram-per-day range for the adult and prints no milligram-per-day figure for the older adult at all, so the older-adult figure available to quote is a serum concentration and never a starting dose. A candidate asked for milligrams of lithium at seventy-eight should name the serum target and the monitoring, and say the dose is whatever achieves that level.

Monitoring is where the age effect refuses to become an interval, and the population is the trap. Six-monthly is the general schedule for filtration and thyroid function on lithium, with or more frequently attached, not an older adult's schedule. For the older adult the guideline says only that more frequent monitoring of urea and creatinine may be needed, in older adults and where a diuretic, a non-steroidal anti-inflammatory drug or an angiotensin converting enzyme inhibitor is co-prescribed or there is renal impairment. May be needed is the source's own modal, and how much more often is nowhere stated.

14.5 Anticholinergic burden: a mandate without an instrument

Indian guidance makes assessment of the total **anticholinergic burden** of all ongoing medications a critical part of the medication history in an older patient, and gives the reason as delirium: high anticholinergic burden is one of its crucial causes. The word total is load-bearing: the problem is rarely one strongly anticholinergic drug prescribed in error, but the cumulative effect of several mild ones from several prescribers, each defensible alone.

The same guidance names no scale, no score and no cut-off, and a candidate should say so. Instruments exist outside India: the **Anticholinergic Cognitive Burden scale**, the Anticholinergic Drug Scale and the Anticholinergic Risk Scale, the first the most frequently validated of the expert-based scales against adverse outcomes. No numeric threshold from any of them is asserted here: no comparable standard is available to quote, and none is invented here.

Two practical consequences follow even without a score. The Indian schizophrenia guideline makes lower anticholinergic burden and lower sedative property the selection criteria for a first-line antipsychotic in older adults, gives the purpose as preventing falls, tells the prescriber to avoid anticholinergic co-prescription so far as possible, and requires more frequent metabolic monitoring without saying how much more. Anticholinergics are also the one class Indian deprescribing guidance names as generally high risk in the elderly. The cognitive endpoint belongs to the Dementias and neurocognitive disorders notes.

14.6 Falls and hyponatraemia

When Indian guidance quantifies the elderly antidepressant rule it attaches two monitoring targets and only two: hyponatraemia and falls. They are the two adverse effects that turn a psychiatric improvement into a medical admission. On falls, the drug-side risks named are the need for a mobility aid, sedative medication, and drugs causing a postural fall in blood pressure; after a fall the history asked for is structured:

- where the fall happened, what the patient was doing, and the type of fall
- dizziness or fainting around it
- weakness on changing posture, such as standing from sitting or lying
- walking difficulty, recent previous falls, and visual or auditory impairment, each a checklist item in its own right

No falls instrument or score is named in the Indian sources, so naming a falls tool goes beyond them. On hyponatraemia the mechanism is stated: these drugs are associated with it through the **syndrome of inappropriate secretion of antidiuretic hormone**, and the risk factors begin with old age, then female sex, co-administration of drugs that themselves cause hyponatraemia, reduced filtration and comorbidity. Timing is as examinable as mechanism: in elderly and frail patients the risk sits especially in the first weeks of treatment, which is why electrolytes are checked early rather than at a later review. First weeks is not a number of weeks. Referral to a specialist is set at a serum sodium **below 125 mmol/L**, a laboratory threshold and not a dose.

A third harm needs a clause because its age relevance is inferential rather than stated. These agents may increase the risk of upper gastrointestinal bleeding, particularly with non-steroidal anti-inflammatory drugs or antiplatelet agents, and caution is advised where aspirin or oral anticoagulants are co-administered. The source does not stratify that risk by age; what makes it geriatric is that those co-prescriptions are commonplace at seventy-eight.

GOOD TO REMEMBER

Two answers must be in the note before an older patient leaves with a new prescription: who will supervise the medication, and which investigations repeat and when.

14.7 Interactions, class choice and the citalopram trade-off

Interaction matters here for an unglamorous reason, and Indian guidance names it: the elderly are likely to be on many medications for other medical conditions. All selective serotonin reuptake inhibitors are metabolised by the cytochrome P450 system, and they divide in two:

- fluoxetine, fluvoxamine and paroxetine also significantly inhibit P450 enzymes, so they may interfere with a wide variety of other medications
- citalopram, escitalopram and sertraline do not substantially inhibit those enzymes and are associated with fewer drug interactions

That reads as a clean recommendation until you turn to the same guideline's cardiac table. As a class these drugs are reported to have no effect on QTc and no association with arrhythmia, with one exception: citalopram and escitalopram show a dose-related increase in QTc and torsades de pointes in overdose and should be used with caution in those at risk for arrhythmia, while sertraline appears safest. Two of the three interaction-safer agents are therefore the conduction-riskier ones, and an answer naming one ground must carry the other.

What that guideline does not supply is a number: no millisecond QTc threshold and no age-specific dose cap appear in it, so Indian guidance cannot be cited for a QTc cut-off. The only age-triggered maximum available comes from elsewhere and it is a ceiling rather than a starting point. Secondary reports of a United States regulatory safety communication describe it as advising against citalopram above 40 mg per day generally, and as reducing the maximum to 20 mg per day in older patients, in hepatic impairment, in CYP2C19 poor metabolisers, and with a CYP2C19 inhibitor, the age threshold being sixty years in both reports, and neither report attaches that ceiling to any single indication, obsessive-compulsive disorder included. Three limits belong with that figure: it is a daily maximum and carries no starting dose; the reports are not the issuing regulator's own document but a journal article and a second country's medicines agency stating the same cap; and they disagree over whether a patient of exactly sixty falls inside the ceiling, so neither wording is adopted here. Which of these agents a given older patient is started on, and at what dose for which disorder, is settled in the notes that own the antidepressants; what belongs here is only that age by itself lowers a ceiling.

Class choice may itself shift with age. The current Indian depression guideline states that in older adults these agents may be less effective and that serotonin and noradrenaline reuptake

inhibitors such as duloxetine may be more suitable, while the obsessive-compulsive disorder guideline reports that in older adults they appear to be as effective as in the adult population. Between them they make the flat sentence that these drugs are first-line in the elderly unsafe to write: attach the disorder, and keep the modal verb.

14.8 Deprescribing: stopping as a prescribing act

Why stopping is the harder skill. Every incentive in a consultation favours addition, and stopping a drug someone else started means owning a decision you did not make. **Deprescribing** is defined in Indian guidance as a systematic process of recognising, dose-reducing, stopping or replacing medicines when the risks of continuing outweigh the benefits, judged against this patient's medical morbidity, functioning, values and preferences, its stated aim being not necessarily to stop medications entirely but their judicious use. The same principle appears independently in the current Indian bipolar disorder guideline, among its principles for polypharmacy generally rather than in any geriatric section: periodically reassess the need for multiple agents and taper the non-essential or non-effective ones through careful review of history and shared decision making, which may reduce adverse-effect burden and increase adherence. That statement names no branded framework and attributes its principles to non-Indian work, so a framework name offered as the Indian position would be an invention.

Operationally the guidance answers three questions. *When*: nine triggers are listed, the first numeric, receiving more than five medications, with older age and frailty each counting in their own right alongside multimorbidity, renal impairment, multiple prescribers and transient care, non-adherence, limited life expectancy and dementia. Read the operator: more than five, not five or more, and a threshold for review rather than a permitted maximum. *Which* drug: those with no valid indication, those contributing to the presentation, those generally high risk in the elderly, ineffective ones, preventive drugs in a patient now palliative, and those begun as a **prescribing cascade**, meaning a medication started to treat a side effect of another medication. *How*: stop first the drugs causing or most likely to cause harm and those of most concern to the patient; stop one drug at a time, unless an adverse reaction is suspected or withdrawal risk is minimal, when two or more may go together. Where there is any doubt about stopping abruptly it is safer to taper over weeks to months, the plan being shaped by severity of risk, duration of use with benzodiazepines flagged, dose and half-life, and the likelihood of an adverse withdrawal reaction.

Explicit lists naming drugs as **potentially inappropriate medication** in older adults sit alongside this reasoning rather than replacing it. One such list is the American Geriatrics Society Beers Criteria, whose 2023 update places the non-benzodiazepine benzodiazepine-receptor-agonist hypnotics at Avoid, because their adverse events in older adults resemble those of benzodiazepines, including delirium, falls and fractures, for minimal improvement in sleep latency and duration. Two caveats travel with it: the copy available was a third-party mirror rather than the issuing society's own document, so its strength-of-recommendation labels are not asserted here, and neither an Indian equivalent list nor any other explicit-criteria set is described here: no comparable standard is available to quote, and none is invented here.

14.9 The Indian frame, and what is not available to quote

Indian guidance on prescribing to older adults is explicit and entirely qualitative. The canonical statement is a table of **fifteen** general principles headed by start low and go slow, not one of which carries a number. Among them: mandatory baseline investigations; review of all prescriptions including over-the-counter medicines; review of the anticholinergic load before prescribing; evaluation for sensory deprivation as a determinant of adherence; the simplest possible prescription; identifying who will supervise it; avoiding polypharmacy; the shortest possible duration; and regular monitoring of investigations.

IN INDIA

Two scope facts change how that table is cited. It was written for the emergency setting and states that it can also be applied to elderly patients seen in a consultation-liaison setting, so calling it an outpatient prescribing guideline overstates it. And it is published in the Indian Journal of Psychiatry, the official publication of the Indian Psychiatric Society, which makes it the Indian answer rather than an imported one.

Indian guidelines do name Indian constraints in terms, though none of the examples is specific to older adults. One current guideline records an agent approved abroad for agitation in bipolar disorder as not yet introduced in India, and another states that selective serotonin reuptake inhibitors are preferred first-line for obsessive-compulsive disorder in the Indian context because resources for delivering cognitive behavioural therapy are limited. The second is the Indian formulary argument in miniature: what counts as first-line here is decided partly by what can be delivered here. For the older adult specifically, the facts a prescriber would most want, whether marketed strengths permit a clean halving, whether liquid or dispersible formulations exist, and what any of it costs out of pocket, are not established here and none is invented here.

The last piece of currency is the state of the evidence, which one guideline states without flattery for its own disorder. Specific management strategies for older adults with obsessive-compulsive disorder have not been evaluated; the pharmacological evidence comes primarily from open-label trials and case studies; and because of high rates of physical illness and multiple medications, psychological approaches are often recommended first-line in this age group. That is disorder-specific and must not be lifted into a general claim, but its logic is portable: where the evidence in old age is thin and the risk thick, the threshold for reaching for the prescription pad rises. One caution on currency: the kinetic and dynamic account rests on a review published in 2004, which should be qualified rather than assumed current.

15 · Elder abuse and neglect

Why the marks are here. Elder abuse and neglect is the geriatric topic where a candidate can know the clinical picture well and still lose the question, because what is examined is a sequence of acts: how the possibility is raised, how a history is taken when the person who brought the patient may be the person harming them, which instrument is named, and what the clinician is then obliged to do and on whose authority. The last of those is where most answers collapse,

because they are written by analogy with child protection, and that analogy does not hold in India.

The subject also carries an unusual split in its evidence. The clinical half is largely unlegislated and the legal half is largely unclinical, so the two parts of a complete answer come from different kinds of authority and carry different force. An answer that keeps them apart, and says which is which, is doing precisely what the question tests.

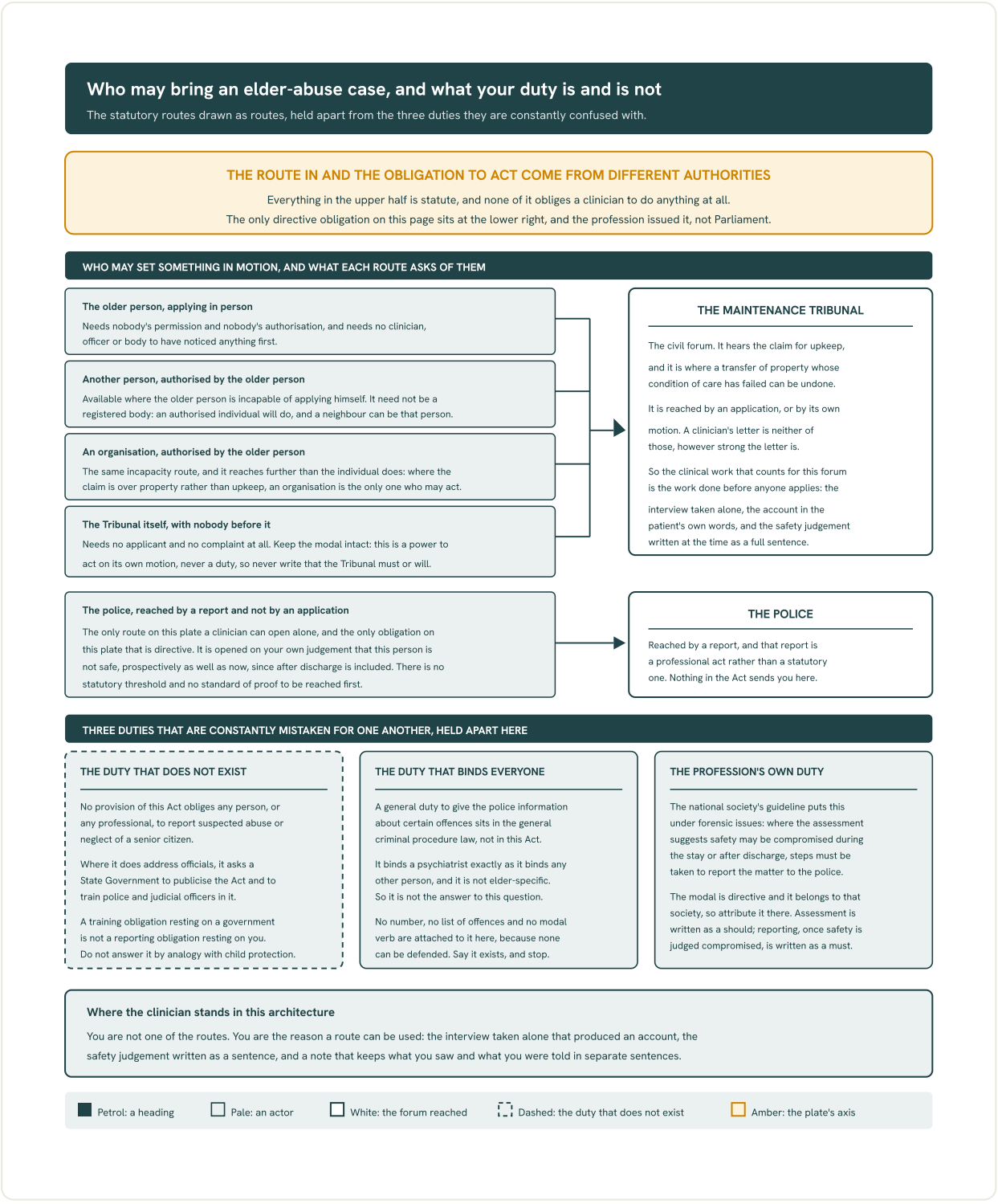


Fig 29.5. Who may set an elder-abuse matter in motion, drawn actor by actor rather than provision by provision: the older person applying in person, an authorised individual where he is incapable, an authorised organisation which alone reaches the property protections, and the Tribunal acting with nobody before it, all converging on the maintenance forum, with the police shown as a separate destination reached by a report rather than by an application, and the three duties that are constantly mistaken for one another set out beneath, the elder-specific reporting duty that does not exist, the general duty that binds every person and is not elder-specific, and the professional obligation whose trigger is the clinician's own judgement that safety is compromised.

15.1 The definition you will be asked for, and what it leaves out

The most quotable Indian definition sits inside a parenthesis in the 2023 clinical practice guideline on older patients presenting with psychiatric emergencies, issued by the Indian Psychiatric Society and published in the Indian Journal of Psychiatry. It treats **elder abuse** as

acts of omission that result in harm, or threatened harm, to the health or welfare of an older person.

Three phrases do the work. Threatened harm sets the threshold at risk rather than damage, so a clinician need not wait for an injury, and an arrangement that has not yet hurt anybody can still meet it. Health or welfare is wider than health alone, and welfare is where loss of money, of a home and of company enter a definition that would otherwise read as a purely medical one. And the harm is defined against the older person rather than against a relationship, so it does not depend on establishing who did it, which matters because attribution is usually the last thing to become clear.

Then say plainly what it does not cover, because a viva will push on exactly that. As printed, the parenthesis captures omission: the things not done. Elder abuse in ordinary clinical use also covers acts of commission, so offering that parenthesis as a complete definition narrows the subject in the act of defining it. Quote it, attribute it to the guideline it comes from, and add that acts of commission are conventionally included. For how common any of this is in India, no comparable standard is available to quote, and none is invented here; estimates move very widely with the definition and the instrument used.

15.2 The forms it takes, and the discrimination each one demands

Categories help only when each is paired with the thing it is actually confused with, and in Indian practice the confusable is rarely another form of abuse. It is a normal feature of family life, or a shortage of money. The grouping below is a working clinical frame rather than a quoted national standard.

FORM	HOW IT REACHES A PSYCHIATRIST	WHAT IT MUST BE DISCRIMINATED FROM
Physical	Injuries of different ages, marks of restraint, a mechanism that does not fit the injury, sedation used to keep someone manageable	Falls, fragile skin and anticoagulation. Not whether the sign is explicable, but whether the explanation is proportionate to it
Psychological	Threats, humiliation, being discussed in the third person while present, isolation from visitors, the telephone taken away	Ordinary family friction. Pattern, an intent to control and the effect on the person separate the two
Financial and material	Pension or bank account operated by another, an abrupt transfer or change of will, a patient who cannot afford drugs in a household that can	Pooled family income, normal in Indian households. Consent and benefit are the tests, not who holds the passbook
Sexual	Very rarely disclosed. May arrive as unexplained genital injury, or as changed behaviour around one particular person	Behavioural change attributed wholesale to a neurocognitive disorder
Neglect	Dehydration, pressure damage, untreated conditions, spectacles or a hearing aid never repaired, appointments missed	Poverty. The test is whether care available to the household is withheld from this member
Abandonment	Left at a hospital, an institution or a public place. Nobody collects the patient once discharge is ready	A genuine collapse of resources, which is a social problem and not an intention
Institutional	In residential care: rigid routines, restraint by drug or by rule, no privacy, no route to complain	Understaffing. Both need action; only one is answered by naming an individual

Two rows carry most of the difficulty in an Indian clinic. Financial control inside a joint household is not by itself abuse, and treating it as such will end the consultation; what makes it abuse is that the older person neither agreed to the arrangement nor benefits from it. And neglect cannot be diagnosed from the standard of care alone, because a household with nothing cannot care well for anyone. What identifies neglect is a gradient inside the household: food, medicine, warmth and attention reaching everybody except the oldest person there.

15.3 Recognition: it does not present as abuse

Nobody arrives complaining of elder abuse and neglect. It arrives as a fall, a confusional episode, weight loss, poor adherence, a request for admission the family is unusually keen on, or a discharge that keeps being deferred. Every one of those has an ageing explanation immediately available, and that is the diagnostic problem: an innocent alternative is always to hand, so the finding is never forced on the clinician and must be looked for.

What can be looked for is discrepancy, better taught as one discipline than as a list of signs. Between the injury and the mechanism described. Between the severity of a problem and the delay before help was sought. Between the family's resources and the patient's condition. Between the account given alone and the account given with relatives present. Between what the carer says the patient can do and what the patient is seen doing on the ward. None of these proves anything; each is a reason to take the history again, separately.

The interaction in the room is itself evidence. Watch who answers, whether the patient looks at the accompanying person before replying, whether that person declines to leave, whether the account becomes fuller once the door closes, and whether the minimising sounds rehearsed. Note too that the direction of harm is not fixed: the carer may be exhausted, unwell and unsupported, and may also be the one being struck, which happens in dementia care and is taken up with the behavioural and psychological symptoms in the Dementias and neurocognitive disorders notes. A formulation that identifies a villain and stops has missed how the household works.

PITFALL

Writing a suspicion into the record as a finding. What was observed and what was alleged belong in different sentences, with the source named for each: the bruise you saw is your observation, the explanation for it is somebody's account. Notes that fuse the two are useless as evidence and unfair to a family that may have done nothing.

15.4 Taking the history: the patient is seen alone

The procedural point that is actually marked. The same national guideline calls this a sensitive matter whose history should be carefully evaluated, and gives one instruction about technique: the patient should be interviewed separately and given time and reassurance to open up. Keep that modal in mind, because it changes later in the same document.

The separate interview carries such weight because this topic inverts the usual value of collateral history. Across geriatric psychiatry the accompanying relative is the safeguard, supplying what the patient cannot; here that same person may be the hazard, and the more dependent the patient, the more completely the account is theirs to shape. Time and reassurance are in the instruction for a reason too: someone who depends on that household for food, medicine and shelter is being asked to put all three at risk, and will not do it inside two minutes of brisk questioning.

Practically, separate the interview for a reason that is not about the family. An examination, a blood pressure, a walk to the ward toilet: any of these routinises the separation without announcing a suspicion to people you may still have to work with. Three things must come out of it.

- The patient's own account, in the patient's own words, of how the injury or the shortage or the arrangement came about.
- Whether the patient feels safe returning to where they came from, asked directly and answered before anyone else re-enters the room.

- What the patient wants done, which is frequently much less than the clinician wants done, and which is recorded even when it will not be followed.

Where cognitive impairment or acute illness prevents an account, the assessment does not stop; its source changes. The questions move to observable care, to informants outside the household, and to what the ward sees over a few nights. Whether the patient can make the decisions that follow is a capacity question, assessed as one, using the approach set out for the general hospital elsewhere in these notes.

GOOD TO REMEMBER

The step that gets skipped is the simplest. At some point in the encounter the patient has been alone with a clinician, and the note says so in as many words. If that sentence is missing, no conclusion about safety at home is defensible, because every account in the record was given in front of the people the question is about.

15.5 The named instrument, and the limits of what it gives you

The same guideline carries a table of suggested rating scales, and against the elder abuse domain it puts the **Caregiver Abuse Screen Evaluation**. The guideline names the instrument and gives nothing else about it: no item count, no cut-off and no validation data, and none are supplied here. Scales as a class, with their construction and psychometrics, belong to the Psychotherapies, clinical assessment, MSE and nosology notes.

Two things follow. The instrument's own title puts the caregiver, and not only the patient, inside the frame of the screen. And the guideline attaches a qualifier to that whole table: the selection of scales is influenced by the diagnosis and by the need of the individual patient. Read alongside the absence of any published threshold, that makes the screen a prompt to ask rather than a test to pass. Naming it earns the mark; treating it as though a score settled the question does not.

15.6 What Indian law does not provide

Here is the finding most answers get wrong. The Maintenance and Welfare of Parents and Senior Citizens Act, **2007**, the central Indian statute on this subject, creates no elder-abuse-specific mandatory reporting duty. It contains no provision of the kind familiar from child protection legislation obliging any person, or any professional, to report suspected abuse or neglect of a senior citizen.

Where the Act does address officials, at section 21, what it asks for is different in kind. The State Government is to ensure wide publicity for the Act, and to ensure that Central and State Government officers, including police officers and members of the judicial service, are given periodic sensitisation and awareness training on the issues relating to it. That is a training obligation resting on a government, not a reporting obligation resting on a clinician, and the distinction is worth having ready.

Scope the negative correctly, because it is easy to overstate. It concerns this Act. It is not the wider claim that no reporting obligation of any kind can reach a doctor in India: a general duty to give the police information about certain offences sits in the general criminal procedure law rather

than in this Act, and binds a psychiatrist as it binds any other person. For the text of that provision, its section number, the closed list of offences it is keyed to and its modal verb, no comparable standard is available to quote, and none is invented here. Say that a general duty exists and is not elder-abuse-specific, and attach no number to it you cannot defend.

RULE **The safeguarding answer for an older person has two halves, and only one of them is law.** The statute supplies remedies and names who may seek them; it does not tell a clinician when to act. Professional guidance supplies the trigger to act and carries no legal force. A complete answer gives both, says which is which, and never lets the modal verb of one migrate into the other.

TRAP **Answering by analogy with child protection.** Candidates have been drilled on a safeguarding architecture in which a named statute imposes a reporting duty on a named professional, with a penalty for failing. Transplanted onto an older person it produces a confident, well-organised answer that is factually wrong, and wrong in the direction that costs most: it invents an obligation and leaves the routes that do exist untaught.

15.7 The obligation that does exist, and where it comes from

The directive half of the answer comes from the profession rather than from Parliament. The 2023 national guideline places elder abuse under a heading of forensic issues, and states that where the assessment suggests the patient's safety may be compromised during the hospital stay or after discharge, appropriate steps must be taken to report the matter to the police to initiate legal action. The modal is directive, and it belongs to the society that issued the guidance. Attribute it there, not to a statute.

Three features repay attention. The trigger is the clinician's own judgement that safety may be compromised, not a statutory threshold and not a standard of proof, so what the note must answer is what made you think this person would not be safe. It is prospective as well as present, since after discharge is expressly included, so the assessment must reach into the household the patient is going back to. And no timeline, form or consequence for not reporting is specified, which cuts both ways: it leaves the judgement with the clinician, and leaves the clinician with nothing but the record to show it was exercised.

Notice the internal grading, examinable in itself. Assessment of abuse is written as a should; reporting to the police, once safety is judged compromised, is written as a must. That is a sensible hierarchy: asking is always appropriate, escalation is reserved for the point at which the answer is that the person is not safe.

IN INDIA

There is no adult protective service to refer to. Two doors exist in practice: the police, where the national guideline points once safety is in doubt, and the maintenance machinery of the senior citizens Act, which handles food, shelter, money and property. That Act is national legislation, assented in December 2007, and as enacted its extent excluded one State; it commences in a State on a date that State Government notifies, so the machinery a patient can reach is state machinery. The respondent is usually the relative who accompanied the patient and will take them home again, which is why the sequence of separate interview, record, safety judgement and only then escalation matters more here than the escalation itself.

15.8 How a case actually starts, when nobody is obliged to report

If there is no reporter, something else must begin the process, and this Act's answer is an application rather than a report. Under section 5(1), an application for maintenance may be made by the senior citizen or parent, or, where he is incapable, by any other person or organisation authorised by him. Read that second route carefully: it is not confined to registered bodies, and an authorised individual will do, though the condition of authorisation attaches to individual and organisation alike.

The widest route needs no applicant at all. The Tribunal may take cognizance **suo motu**, which is the honest answer to the follow-up about what happens when nobody complains. Keep the modal intact: this is a power and not a duty, so the correct sentence is that the Tribunal may act on its own motion, never that it must or will.

Where the Act uses the word **organisation**, the Explanation to that sub-section defines it, for the purposes of that section, as any voluntary association registered under the Societies Registration Act, 1860, or under any other law for the time being in force. Those closing words keep the definition open to bodies registered under other statutes rather than tying it to one register.

5	23	24	25
SECTION OF THE SENIOR CITIZENS MAINTENANCE AND WELFARE ACT SETTING OUT WHO MAY BRING THE APPLICATION	SECTION UNDER WHICH A PROPERTY TRANSFER IS VOIDED WHEN ITS CARE CONDITION FAILS	SECTION OF THAT SAME ACT PENALISING THE ABANDONING OF A SENIOR CITIZEN	SECTION MAKING EVERY OFFENCE UNDER IT COGNIZABLE, BAILABLE AND TRIABLE SUMMARILY

PROVISION	WHAT IT DOES	WHO MAY SET IT IN MOTION
Section 5(1)(a)	Brings the application for maintenance	The senior citizen or parent
Section 5(1)(b)	The same application where the senior citizen is incapable	Any other person or organisation authorised by him
Section 5(1)(c)	Starts the matter with no application before it	The Tribunal, on its own motion
Explanation to section 5(1)	Defines organisation for that section only	Any registered voluntary association, on the terms set out above
Section 23(1)	Voids a property transfer whose condition of care has been broken	The transferor, at whose option the Tribunal declares it void
Section 23(3)	Enforces those property protections where the senior citizen cannot	Organisations only, as defined in that Explanation
Section 24	Makes exposure and abandonment of a senior citizen an offence	Prosecution, on an intention of wholly abandoning
Section 25	Makes every offence under the Act cognizable and bailable, and triable summarily	A Magistrate

One sentence of your answer should carry the structural point. Under this Act there is no report and no reporter; there is an applicant, or a Tribunal acting on its own motion, and the clinician's contribution is to make that application possible and to document what would support it.

15.9 Property, and the provision that does the proving for you

The commonest financial abuse a psychiatrist meets in Indian practice has a specific legal answer. A parent transfers a house or land to a child on the understanding that they will be looked after, and then is not. Section 23(1) provides that where a senior citizen has transferred property after the commencement of the Act, by gift or otherwise, subject to the condition that the transferee provide the basic amenities and basic physical needs of the transferor, and that transferee then refuses or fails to provide them, the transfer is deemed to have been made by fraud or coercion or undue influence, and shall, at the option of the transferor, be declared void by the Tribunal.

Two points are examinable and both are commonly stated backwards. The first is the **deeming provision**: the older person does not have to prove fraud, coercion or undue influence as a matter of fact, because the Act deems it once the condition of care has been broken. That converts an almost unwinnable evidential problem into a simpler factual question about whether basic amenities and basic physical needs were provided. The second is that avoidance is at the transferor's option, so the transfer is not an automatic nullity; it is a right the older person may choose to exercise, and one who wants the relationship more than the property may decline to.

Where the senior citizen cannot enforce those property rights, action may be taken on his behalf by any of the organisations referred to in that Explanation. Set it against the maintenance route and get the difference the right way round: the incapacity route in the earlier section admits an authorised individual as well as a body, while this one admits organisations only and reaches only the property protections. A neighbour who could carry a maintenance application cannot, on this provision, carry the property one.

The psychiatric contribution here is evidential rather than therapeutic. Whether an older person understood a transfer, and whether they were free when they made it, arrive as capacity and undue-influence questions, and a contemporaneous note of the mental state and of the patient's own account is often the only usable evidence years afterwards.

15.10 Abandonment as an offence, and how it is tried

Section 24 carries the Act's penal provision, and its wording is narrow. Whoever, having the care or protection of a senior citizen, leaves that senior citizen in any place with the **intention of wholly abandoning** them is punishable with imprisonment of either description which may extend to **three months**, or with a fine which may extend to **five thousand rupees**, or with both.

The mental element is where answers fail, and they fail predictably. The offence requires an intention of wholly abandoning, so neglect falling short of that intention is not this offence, however grave it is clinically. A family whose care is poor, or whose care keeps failing, has not committed it; a family that leaves a parent at a hospital gate and does not come back has. That gap between what is clinically serious and what is criminally caught is why the professional and civil routes carry most of the weight in practice, and saying so is a better answer than implying the penal section covers the field.

How such an offence is handled sits in section 25, which operates notwithstanding the Code of Criminal Procedure, 1973. Every offence under the Act is **cognizable** and **bailable**, and is tried summarily by a Magistrate. In Indian criminal procedure those words describe a deliberately light route: the police may take the matter up directly, the accused is not held pending trial as a matter of course, and the trial is the short form. For a clinician a report to the police can therefore start something, and what it starts is quick and small rather than grave.

MNEMONIC

Start it, Undo it, Punish it, Try it

The four provisions of the senior citizens Act to be able to place without hesitating. **Start** it: section 5, who may apply, and the Tribunal's own motion. **Undo** it: section 23, the conditional property transfer set aside. **Punish** it: section 24, exposure and abandonment. **Try** it: section 25, cognizable, bailable and summary.

15.11 What the encounter has to leave behind

Because nothing here is triggered by a statutory form, the record is the only durable product of the encounter, and it is what a tribunal, a police officer or a colleague reading months later will work from. Three entries are not negotiable.

- That the patient was interviewed alone, with their own account in their own words.
- The safety judgement as a full sentence, saying what led to it and whether it concerns the admission, the discharge or both, since that judgement is what the obligation to report turns on.
- What was done next: whom you informed, what you told the patient and the family, what the patient wanted, and when the question will be reviewed.

None of that needs a service that does not exist, a statute that has not been passed, or an instrument with a threshold nobody has published. It needs what the whole topic needs: that the possibility was raised deliberately, asked about privately, judged explicitly and written down.

> There is no elder-abuse-specific mandatory reporting duty in the Indian senior citizens Act; the obligation to act is professional, its trigger is your own judgement that safety is compromised, and the statutory route is an application to the Maintenance Tribunal or the Tribunal taking cognizance on its own motion.

16 · Sleep disturbances in the elderly

Why the marks are here. A referral about an older patient's sleep usually arrives with its own answer attached: she is seventy-eight, she sleeps badly, and the age is offered as the explanation. That sentence is where the marks are lost. What is examined here is the reasoning a clinician runs when the complaint is made at seventy-eight: which features of this patient's sleep are the ordinary arithmetic of ageing, which belong to the diseases and the drugs that arrive alongside ageing, whether the complaint is overstated or quietly understated, and what to do about the hypnotic that is often already being taken.

The entity work is done elsewhere. Insomnia disorder and the primary sleep disorders, with their criteria, instruments and drug treatment, are taught in the Eating and sleep-wake disorders notes, and sleep physiology from the neurological side in the Neurology foundations for psychiatrists notes. Sleep disturbance as a feature of a neurodegenerative illness belongs with the Dementias and neurocognitive disorders notes, and a new nocturnal disturbance with fluctuating attention is a delirium question before it is a sleep question, taught with the delirium material in this chapter. What follows is the geriatric lens on sleep disturbances in the elderly: what changes, when it changed, what may be attributed to age, and what each answer obliges you to do at the bedside.

16.1 What changes with age, and when the change actually happened

The standard list names six changes, and it is not closed. Sleep timing advances, nocturnal sleep shortens, daytime naps become more frequent, awakenings within the night become more numerous, the total time spent awake during the night increases, and **slow-wave sleep** is reduced. Candidates reproduce that list and then stop, which is where its clinical value is thrown away, because the same work adds a second finding that reverses the meaning of the first: most of that change occurs between young and middle adulthood, and among healthy older adults the parameters are largely unchanged.

RULE **By the time a patient is old, the age-related change in sleep has mostly already happened.** Ageing rearranges sleep in the middle of life rather than in later life, so a change the patient dates to the last year or two is a change ageing does not account for. This is why "poor sleep at her age" is not a formulation: it invokes a process that had largely finished before the patient reached the age being blamed, and it makes the one informative feature of the history, the date of onset, disappear.

The parameters below are drawn from a 2017 review of sleep in normal ageing in Sleep Medicine Clinics. Read the location column before the direction column, because in the consultation the direction of a change matters far less than where in the lifespan it is located. Three parameters carry a quantified rate. The most quoted, **wake after sleep onset**, matters less for its rate than for its age window.

SLEEP PARAMETER	DIRECTION WITH AGE	WHERE THE CHANGE IS ACTUALLY LOCATED	WHAT THAT MEANS AT SEVENTY-EIGHT
Timing of the sleep period	Advances to earlier hours	Mostly before old age	Early evening sleepiness and early waking, not a new illness
Nocturnal sleep duration	Shortens	Mostly before old age	A short night is not by itself a disorder
Daytime naps	More frequent	Mostly before old age	Ask what the naps are costing the night
Wake after sleep onset	Rises	Quantified from 30 to 60 years, then mostly unchanged after 60	The rate does not reach a patient of seventy-eight
Proportions of NREM stage 1 and stage 2 in nocturnal sleep	Both rise	Not significant among healthy adults above 60	A fragmented hypnogram is not explained by age alone
Proportion of slow-wave sleep	Falls	1.7 per cent per decade in men, and no change with age in women in one cohort	The blanket claim needs a sex qualifier
Proportion of REM sleep	Falls, at 0.6 per cent per decade	From 19 to 75 years, with small increases between 75 and 85	The band that contains seventy-eight is not a band of decline
REM latency	Association with age is minimal	Reported without an age window	A shortened REM latency asks for another explanation

TRAP **Quoting the rate of increase in wake after sleep onset as though it applied to the patient in front of you.** It is the most quotable figure in this field, carrying the largest effect size of any sleep parameter studied, and it is **ten minutes per decade**. The sentence that supplies it also supplies its window, beyond which the parameter is reported as mostly unchanged. Carried forward to a patient of seventy-eight, a mid-life rate becomes an allowance for wakefulness that no measurement supports, and that allowance licenses precisely the reassurance the patient should not be given.

One caution belongs with this table rather than with the disorders. The loss of slow-wave sleep is not uniform between the sexes: one European cohort found no change at all in women against a measurable per-decade fall in men, and the review concludes only that men may be more prone to that decline. It also leaves a tension unresolved, since the meta-analysis it cites has women carrying a greater proportion of slow-wave sleep than age-matched men; levels compared at one age are not rates of change compared across ages, and the two must not be read as one. Knowing that a well-worn one-liner is contested is worth more than reciting it.

16.2 Why the patient is awake before dawn: the circadian account

The commonest presenting complaint in this age group is not difficulty getting to sleep but waking too early, and it has a candidate mechanism that is not a diagnosis. Older people commonly feel sleepy earlier in the evening and wake earlier than they wish. That earlier timing may be due to an age-related **phase advance** in the circadian rhythm, and the hedge is the source's own. The advance is **about one hour** across the markers together, and it is not confined to the sleep-wake cycle. The body temperature rhythm and the timing of melatonin and cortisol secretion are advanced with it, which marks it as a shift in the clock rather than in the bedroom.

Two refinements stop this becoming a lazy explanation for everything. The advance in sleep timing is larger than the advance in the other circadian markers, which is why **sleep homeostasis** is offered as an example of what else may be involved rather than as a settled answer. And overall melatonin secretion falls with ageing, with the nocturnal rise significantly reduced against young adults while daytime melatonin, already at a low base, may be unchanged. Be exact about what that second observation is: a mechanism, not a prescription. The therapeutic use of melatonin is taught in the Eating and sleep-wake disorders notes, and nothing in the physiology above licenses it at the bedside.

This account changes the target. A patient who falls asleep in the early evening and wakes long before dawn has slept a normal quantity at an abnormal hour, so the complaint is about the hour: a problem of timing and of what fills the evening, and not one answered by a drug that shortens sleep latency in a patient whose latency was never the problem.

16.3 Age, or what arrives with age: what the prevalence figures actually attribute

This is where the referral letter is answered, and the answer is an attribution rather than a number. Sleep complaints are genuinely common in later life, and the same literature says the excess does not belong to the age.

About 50% OF OLDER ADULTS HAVE INSOMNIA SYMPTOMS, A PREVALENCE ATTRIBUTED TO COMORBIDITY RATHER THAN TO AGE	**Up to 50 to 60%** REPORT POOR SLEEP QUALITY, A WIDER CONSTRUCT THAN INSOMNIA SYMPTOMS	**About 67%** OF OLDER ADULTS CARRY MULTIPLE COMORBIDITIES, IN UNITED STATES DATA	**About 90%** OF ADULTS AGED 65 AND OVER TAKE PRESCRIPTION DRUGS, AGAIN IN UNITED STATES DATA

The decisive sentence is the comparison, not the prevalence. Medical and psychological comorbidity is what the review holds responsible for the insomnia-symptom figure, and in older adults in excellent health the prevalence of insomnia is similar to that of younger adults. Age with

nothing else attached does not raise it. The two figures must not be collapsed into one: self-reported poor sleep quality and insomnia symptoms are different constructs, and averaging them loses the distinction.

The same review states in terms that poor sleep quality and sleep disturbance in older people are not necessarily due to ageing alone, even though schedule, quantity and architecture do change with age. What it lists alongside age is, in effect, the history you are obliged to take:

- medical conditions
- psychiatric conditions
- the environment the patient sleeps in
- social engagement and lifestyle change

One boundary keeps this honest: those architecture findings describe adults who are healthy and ageing well, so a frail multimorbid inpatient is not who they were measured in.

16.4 The reporting gap, and it runs in both directions

The consultation has a measurement problem before it has a treatment problem. Older adults are less likely, not more likely, than younger people to report poor sleep, especially once comorbidity and health are controlled for, and one offered explanation is that they may expect less consolidated sleep with age and may accept the change as normal. Set against that, among 150 healthy older adults who reported no sleep problem at all, **33 per cent** of the women and 16 per cent of the men had impaired **objectively measured sleep**.

So the discordance runs two ways, and each direction carries its own error:

- the complaint may be absent while measured sleep is impaired, so an unremarkable history does not establish unremarkable sleep
- the complaint may be understated when it is present, so sleep has to be asked about rather than waited for

Two provisos belong with that pair of proportions. The sample was healthy, selected because it reported no trouble, and not Indian, and the figures reach the review second-hand from work one of its own authors conducted, so they support a direction rather than a rate. The instruction survives both provisos: ask about sleep in the systems review, and do not let a patient's acceptance of her sleep stand as evidence that it is intact. Measured impairment in a patient who has no complaint is not by itself a reason to prescribe.

16.5 The drug chart is part of the sleep history

What this changes at the bedside. Medication burden in this age group is not a footnote to the sleep history, it is a substantial part of it. **More than a third** of older adults who take prescription drugs routinely take over five medications, and multiple medications can produce three separable outcomes: **excessive daytime sleepiness**, worsening of a primary sleep disorder already present, and **comorbid insomnia**. Three problems with three different next steps:

collapsing them into "the tablets are affecting her sleep" throws away the distinction that earns the mark.

The reasoning matters more than the figures, and it is circular. A drug that produces daytime sleepiness produces daytime sleep; daytime sleep shortens the following night; the shortened night is reported as insomnia; and the insomnia is treated with a further drug that produces daytime sleepiness. Somewhere in that loop a clinician has to read the chart rather than the complaint. The figures quoted are United States data, and the population is part of the number: they establish that the burden is large, not what proportion of your clinic carries it.

GOOD TO REMEMBER

Before "should she have something to help her sleep" is even reached, three things belong in the note: the medication list with the time each dose is actually taken, what the patient took last night as against what is prescribed, and how much she slept between waking and the evening. A sleep plan written without those three is a plan written about a night nobody has described.

16.6 The hypnotic that is already being taken

The reflex this topic exists to interrupt is the prescription, and in this age group the harder question is usually not whether to start a hypnotic but what to do about one taken for years. **Deprescribing** in an older person is a planned act rather than a decision taken at the door, and among the things Indian guidance requires such a plan to weigh is the **duration of use**, where benzodiazepines are named as the particular concern. Read that as a statement about which patient is difficult: the long-standing hypnotic is the hard case.

That is why the reflex is wrong twice over. Starting a hypnotic at seventy-eight creates, in one prescription, the patient the guidance warns about, in a person likely to be taking several other drugs and sleeping in the afternoon. And withdrawing one already established is not a matter of stopping it: the order in which drugs come off and how slowly is taught with the geriatric prescribing material in this chapter, while hypnotic doses belong to the Eating and sleep-wake disorders notes. What belongs here is the decision preceding both, that a sleep complaint at this age is an invitation to review the drugs already present before adding one.

IN INDIA

The Indian anchor here is the 2023 clinical practice guideline on the assessment and management of elderly patients presenting with psychiatric emergencies, published in the Indian Journal of Psychiatry, which is where the deprescribing plan and its benzodiazepine flag sit. Notice what it does not supply: no duration beyond which use counts as long, no taper rate, no dose. Since the flag turns on duration, the history must establish it explicitly, including who first prescribed the drug, when, and whether it has been continued from any source other than the prescription in front of you. The prevalence and architecture figures here are Western. For the Indian older population there are no normative polysomnographic values, no prevalence figure for the sleep complaint, no professional standard on sleep in old age, and nothing on whether customary Indian sleep-wake schedules and shared sleeping arrangements alter how the phase advance presents: no comparable standard is available to quote, and none is invented here.

A new sleep complaint at seventy-eight is a symptom to be explained, not an age to be accepted.

17 · Comprehensive geriatric assessment and cognitive screening (MMSE, MoCA, ACE)

Why the marks are here. Comprehensive geriatric assessment and cognitive screening is a question most candidates answer by reciting instruments, which is the smallest and least defensible part of the subject. What is examined is a procedure: which older patients enter it, who carries it out, across which domains, what document it produces, and what obliges anyone to open that document again. A cognitive screen is one line inside one of those domains, and a candidate who reaches for it first has answered a different question.

The instruments themselves belong to other chapters and are named here without being taught. Administration, scoring and interpretation of the Mini-Mental State Examination, the Montreal Cognitive Assessment and the Addenbrooke's Cognitive Examination, with the bedside batteries and formal neuropsychological testing, are taught with the dementia material and with the rating-scale and higher-mental-function material: the Dementias and neurocognitive disorders notes and the Psychotherapies, clinical assessment, MSE and nosology notes. What follows is the assessment they sit inside, which a psychiatrist is more often asked to contribute to than to lead.

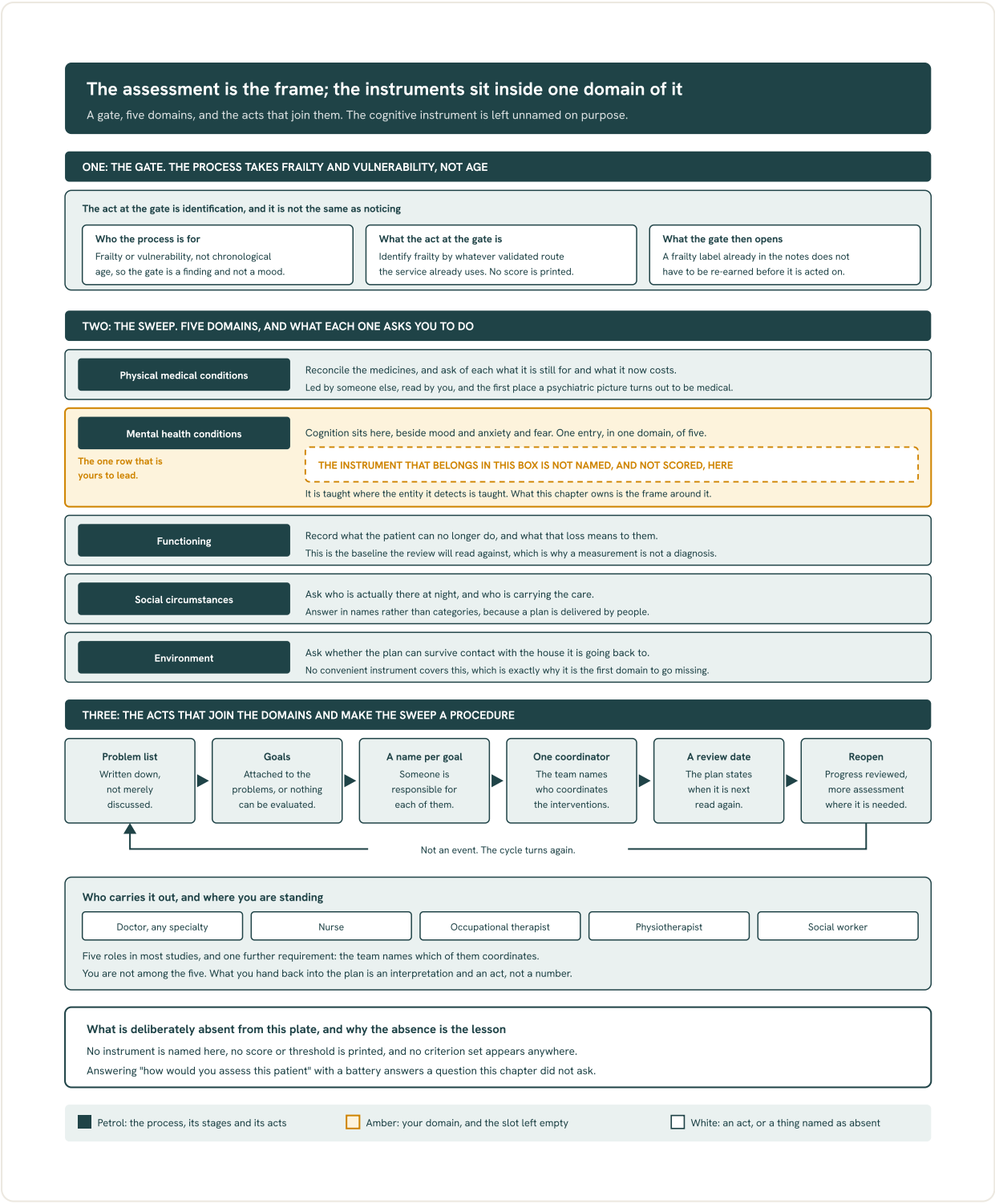


Fig 29.6. The comprehensive geriatric assessment drawn as a frame rather than as a battery: the gate that admits a patient to the process, the five domains swept across it with the act each one asks for rather than the contents each one holds, the chain of joining acts that turns a sweep into a procedure and then returns it to its own beginning, and the team that carries it, with the cognitive instrument shown as one deliberately unnamed and unscored box inside a single domain, because the instrument belongs to another chapter and the frame around it belongs to this one.

17.1 The definition, and the two adjectives that carry it

Comprehensive geriatric assessment is a process used to manage frail or vulnerable older people, and every word of that is load-bearing. A process is not an encounter, so it cannot be finished in an afternoon or written on a proforma. Its target is frailty or vulnerability rather than chronological age, so identifying frailty is the gate and not an incidental finding. And it manages

a patient rather than describing one, so an assessment that ends in a description has stopped short of the definition.

Two adjectives are given explicit meanings in that definition and both are examinable. **Interdisciplinary** means the assessment takes in what nurses and allied health professionals contribute and not only what doctors contribute. **Multidimensional** means it takes in functional impairment and the environmental and social circumstances bearing on wellbeing, and not only medical diagnoses. Candidates routinely use the two as synonyms: one is about who is in the room, the other about what is being asked.

A 2014 article for the non-specialist in the International Journal of Clinical Practice, the source of this definition, is blunt about one misreading. The term is often taken as a synonym for geriatric medicine, and it is not one. Geriatric medicine is a specialty; this is a method, and a method can be run by people who are not geriatricians in settings that have none. The same literature carries an older name for it, **geriatric evaluation and management**, worth recognising when it appears in trial titles.

RULE **A comprehensive geriatric assessment is defined by its product and its cycle, not by its content list.** Any clinician can generate a list of domains. What separates this from a thorough clerking is that it terminates in a written plan with named goals, named responsibility and a review date, and that the plan is then reopened. A candidate who can describe the domains but cannot say what document was produced, who owns it and when it is next read has not understood the procedure.

17.2 What it produces, and why that makes it a procedure

The output is where this topic earns its marks. The assessment generates a **problem list**, develops goal-driven interventions against those problems, and then provides and coordinates an integrated plan spanning treatment, rehabilitation, support and long-term care. Problems first, goals second, coordination last but not optional. A plan naming interventions without the goals they serve cannot be evaluated, and a plan nobody coordinates is a set of separate referrals under one heading.

It is explicitly not a one-off event but an iterative process. A **case manager** carries responsibility for ensuring a care plan exists at all, and that plan must state explicit goals, state who is responsible for each, and state a timeline for review. Progress is then reviewed, further assessment is done where needed, and the cycle turns again. This is what most distinguishes the method from the multidisciplinary meeting a candidate has actually attended, where a great deal is discussed and nothing is owned.

The settings in which it has been studied show it is not confined to a geriatric ward:

- in hospital, where it can start on admission, and where it has been evaluated in emergency departments, medical admissions units and trauma and orthopaedic wards
- in the community, in patients' own homes, in long-term care, in community hospitals and in intermediate care

On outcomes, be careful in the way the evidence requires. Hospital-based assessment of this kind has been reported in systematic review to reduce the combined outcome of death or functional decline, and to raise the chance that a patient is alive and living in their own home rather than in residential care. No effect estimate is printed here. The figures usually quoted reach the reader secondhand through review articles, and the systematic review behind them has been updated since the version those figures came from. Quoting a superseded odds ratio confidently is a worse error than saying the direction of effect is established and the current magnitude must be read at origin.

17.3 The five domains of health, and where a cognitive screen actually sits

The structure of the assessment is set out as domains of health, and the psychiatrist's contribution is confined to part of one of them. That is the answer this item is really asking for, and it is structural rather than psychometric.

5
DOMAINS OF HEALTH ACROSS WHICH A COMPREHENSIVE GERIATRIC ASSESSMENT IS ORGANISED

5
PROFESSIONAL ROLES NAMED AS THE CORE ASSESSMENT TEAM IN MOST STUDIES OF THE METHOD

18
DOMAINS ENUMERATED IN A MULTIFACTORIAL FALLS RISK ASSESSMENT FOR A HIGH-RISK OLDER ADULT

60
AGE IN YEARS FROM WHICH ANNUAL OPPORTUNISTIC FALLS SCREENING IS ADVISED IN LOW- AND MIDDLE-INCOME SETTINGS

DOMAIN	WHAT THE SOURCE PLACES INSIDE IT	WHAT THE PSYCHIATRIST READS OR SUPPLIES
Physical medical conditions	Comorbid conditions and disease severity, medication review, nutritional status, the problem list	The drug chart, and the medical contributions to a psychiatric presentation
Mental health conditions	Cognition, mood and anxiety, fears	The whole of this row, and it is the only row the psychiatrist owns
Functioning	Core functions such as mobility and balance, activities of daily living, life roles important to the patient	What the patient can no longer do, and what that loss means to them
Social circumstances	Social networks, meaning informal support from family, the wider network of friends and contacts, and statutory care; poverty	Who is available at night, and who is bearing the care
Environment	Housing including comfort, facilities and safety; use or potential use of telehealth technology; transport; accessibility to local resources	Whether the plan can survive contact with the home it is going to

Read the second row carefully, because it settles the relationship this item exists to teach. Cognition appears as one entry under mental health conditions, alongside mood and anxiety and

fears. A cognitive screen therefore samples a small fraction of the territory the assessment covers, and a normal screen closes almost none of it.

The same source warns against the opposite error. Standardised scales encourage consistent practice, but they can also be time consuming and clinically constraining. That caution names the failure mode of an instrument-led assessment: the domains with no convenient scale, chiefly the patient's own life roles and the environment they are returning to, quietly drop out.

TRAP **Answering "how would you perform a comprehensive geriatric assessment" with a list of scales.** Candidates make this error because the instruments are the part they have been drilled on. But a battery is not an assessment, and the method is explicitly not the specialty that popularised it. The answer that survives a follow-up names the domains, the team, the problem list and the plan, and places the cognitive screen inside one domain and downstream of the reason for asking.

17.4 Who is in the team, and where the psychiatrist stands in it

The method is by necessity multidisciplinary and cannot be practised by a geriatrician, a nurse or a therapist in isolation. Most studies report a core team of five roles, each with a defined remit: a doctor, who need not be a geriatrician, to ensure medical treatments are given safely; a nurse covering all aspects of care; an occupational therapist for activities, aids and appliances; a physiotherapist focused on transfers and mobility; and a social worker for social support mechanisms and the interventions that follow from them. One further requirement is easy to skip and is exactly what a viva turns on: the team identifies which member is in charge of coordinating the various interventions. Composition varies with the setting, and these five describe a well-resourced health system.

The psychiatrist is not in that list, and this is the teachable point rather than an oversight: on this model the psychiatrist contributes one domain to somebody else's process. Two consequences follow. An opinion asked for inside a geriatric assessment is being asked for cognition, mood, anxiety or fear, so it should be returned in a form the plan can use, meaning an interpretation and a recommended action rather than a score. And the occupational therapist's account of activities and the physiotherapist's account of transfers usually hold the functional evidence a psychiatrist needs; ignoring them repeats work already done better.

17.5 Measuring function: the instruments that are actually yours to use

What this changes at the bedside. The functional domain, unlike the cognitive one, has instruments a psychiatrist is expected to name and use without trespassing. Indian guidance on assessing older patients presenting with psychiatric emergencies, published in the Indian Journal of Psychiatry in 2023, names them by purpose: the **Katz Index of Independence in Activities of Daily Living** for basic activities of daily living, the **Lawton Instrumental Activities of Daily Living Scale** for instrumental activities, and a Frailty Index for frailty. The same guidance makes the wider point that structured scales apply not only to the mental state but to the history and the physical examination.

What is grounded is the mapping of instrument to purpose and nothing more: no item content, no scoring method and no cut-off for these three instruments is available to quote, and none is supplied from memory. That matters less than it looks: the mark is usually for choosing the right instrument for the right question, not for reciting its items.

One boundary needs stating plainly, because instrumental activities are used in two different ways. As a diagnostic hinge, the point at which a person needs help with complex instrumental tasks marks the step from a milder to a major neurocognitive disorder, and that use belongs to the Dementias and neurocognitive disorders notes. Inside this assessment the same construct is a measurement step: it establishes where the patient currently sits, so the plan has a baseline and the review has something to compare against. Treating the measurement as the diagnosis is the commonest way a functional assessment gets misreported.

17.6 Frailty: the entry criterion, defined and then scored

Since the assessment targets frail or vulnerable older people, frailty is the entry criterion and needs a definition rather than an impression. Indian guidance defines **frailty** as a biological syndrome characterised by lower reserve and lower resistance to stress, arising from cumulative functional decline across multiple physiological systems and leading to vulnerability to adverse outcomes. Two things repay attention. It is a syndrome of reserve, so the frail patient is not necessarily the sick patient but the one with nothing left over when something goes wrong; and it is multisystem by definition, so no single organ measurement identifies it. The same source names its consequences: frailty is associated with falls, hospitalisation and mortality.

Its characteristic features are unintentional weight loss, impaired grip strength, self-reported exhaustion, slow walking speed and reduced physical activity. The 2022 World guidelines for falls prevention and management for older adults, published in Age and Ageing, describe the same five as a frailty phenotype and attach a scoring rule: **three or more** of the five categorises a person as frail, one or two as prefrail, and none as not frail. That an Indian and a global guideline converge on the same five is worth knowing; neither text read here attributes them to a named author, so no eponym is attached to them.

MNEMONIC

Slow, Weak, Thin, Tired, Still

The five phenotype criteria as they present: **slow** walking speed, **weak** grip or muscle weakness, **thin** from unintentional weight loss, **tired** from self-reported exhaustion, **still** from low physical activity. Count them rather than impressing them: the count carries the threshold.

The alternative in routine use is the Clinical Frailty Scale, a semi-quantitative scale with pictograms running from very fit at one end to terminally ill at the other, on which a score of **4 or above** is considered frail. For risk stratification the falls guideline accepts either previously identified frailty or a positive result on a validated instrument used to detect it, a permission worth having: a frailty label already in the notes does not have to be re-earned before it can be acted on.

17.7 Falls: the single question, the definitions, and the triage before the assessment

Falls enter the assessment through one question, and the reason is a measurement problem rather than a clinical one. Falls are often not reported spontaneously, which is why asking about them routinely is a strong recommendation at GRADE 1A. Older adults in contact with healthcare for any reason should be asked at least once a year about a fall in the last 12 months, and about the frequency, characteristics, context, severity and consequences of any fall; conditionally, also about dizziness, loss of consciousness or disturbance of gait or balance, and about concerns regarding falling that limit usual activities. The asymmetry is examinable: asking at all is a strong recommendation, while the detail of what to ask carries only GRADE E, the expert-recommendation tier. Anyone answering yes should be offered an objective assessment of gait and balance, again at GRADE 1A.

Four definitions give that history a denominator. A fall is an unexpected event in which a person comes to rest on the ground, floor or a lower level. **Recurrent falls** means **two or more** falls reported in the previous 12 months. A severe fall is one with injuries needing a physician consultation, or leaving the person on the ground unable to get up for at least an hour, or prompting an emergency visit, or associated with loss of consciousness. An unexplained fall is one where a multifactorial risk assessment finds no apparent cause. Without these, "she has had a few falls" is an unusable history.

The objective test that follows carries the two printable numbers of this topic. Assessment of gait and balance is recommended at GRADE 1B. For stratification the guideline recommends gait speed, with a cut-off of **below 0.8 m/s**, at GRADE 1A, chosen for predictive ability and simplicity and measured over a 4-metre walking length. The Timed Up and Go test is the stated alternative, with a cut-off of **more than 15 seconds** at GRADE 1B, and the guideline says in the same breath that evidence for its use in fall risk stratification is mixed. Quote that cut-off with the qualification attached or not at all.

What those tests feed is a triage, not an assessment. Low risk is an older adult with no history of falling, or a single non-severe fall and no gait or balance problem; the response is education about falls prevention and exercise with annual reassessment, on the explicit ground that low risk does not mean no risk at all. Intermediate risk is a single non-severe fall together with gait or balance problems, answered by strength and balance exercise or physiotherapy referral. High risk is a fall plus any of five features: accompanying injury, two or more falls in the previous 12 months, known frailty, inability to get up unaided for at least an hour, or suspected transient loss of consciousness. Only the high-risk tier is offered the full multifactorial assessment, and suspicion of a syncopal fall triggers syncope evaluation and management instead.

GOOD TO REMEMBER

Before an older patient leaves any clinical encounter, one question and its answer belong in the note: has there been a fall in the last 12 months. It costs nothing, it is a strong recommendation, and it is the only step here a solo psychiatrist without a team can complete unaided. If the answer is yes, the obligation that follows is equally single: an objective look at gait and balance, before any conclusion about why the patient fell.

17.8 Inside the multifactorial assessment, and why its components are not equal

The **multifactorial falls risk assessment** is offered to community-dwelling older adults identified as high risk, as a multiprofessional assessment intended to guide tailored interventions, at GRADE 1B. Its domains are enumerated in a single sentence, and the list is long: gait and balance; muscle strength; medications; cardiovascular disorders including orthostatic hypotension; dizziness; functional ability and walking aids; vision and hearing; musculoskeletal disorders; foot problems and footwear; neurocognitive disorders, glossed as including delirium, depression, dementia and behavioural issues such as impulsiveness and agitation; neurological disorders; underlying acute and chronic disease; concerns about falling; environmental hazards; nutritional status including protein intake and vitamin D; alcohol consumption; urinary incontinence; and pain.

The most important sentence here is the disclaimer following that list: the strength of the evidence differs per component. The grade attaches to the recommendation to offer the assessment, not to each domain, and reading the enumeration as a set of equally strong recommendations misstates the source. The component recommendations span the full width of the grading scheme.

COMPONENT	WHAT THE GUIDELINE ASKS TO BE DONE	GRADE OF THAT COMPONENT'S OWN RECOMMENDATION
Concerns about falling	Use a standardised instrument	1A
Gait and balance	Assess; use gait speed for stratification	1B for assessment, with the stratifying cut-off at 1A
Cognition	Assess as a component of the falls workup	1B
Cardiovascular	Cardiac history, auscultation, lying and standing orthostatic blood pressure, and a surface electrocardiogram	1B
Environmental hazards	Identify the hazards where the person lives and assess their capacities and behaviours in relation to those hazards, by a clinician trained to do it	1B
Fall-risk-increasing drugs	Use a validated tool	1C

COMPONENT	WHAT THE GUIDELINE ASKS TO BE DONE	GRADE OF THAT COMPONENT'S OWN RECOMMENDATION
Vision, and hearing separately	Enquire about impairment, measure visual acuity, examine for hemianopia and neglect where appropriate; enquire about hearing, measure, examine and refer where appropriate	E
Urinary symptoms and incontinence	Enquire, with no instrument, threshold or referral trigger specified	E
Dizziness, pain, depression and nutrition	Assess, each under its own component recommendation	E
Footwear and environment in low- and middle-income settings	Prioritise these as risk factors; screen for inappropriate footwear including bare-footedness, assess foot problems, consider podiatry referral	2C, a conditional recommendation

Two things follow that a careful candidate can use. Vision, hearing, dizziness, urinary symptoms, pain, depression and nutrition rest on expert recommendation rather than trial evidence, so presenting them as strongly evidenced is wrong about the source even when it is right about the practice. And the cardiovascular component, where an unexplained fall most often turns out to have its answer, is not merely a blood pressure reading: if the initial cardiovascular assessment is normal no further cardiovascular assessment is required unless syncope is suspected, and further assessment of an unexplained fall should be the same as for syncope, at GRADE 1A.

Bone health is the one thing candidates expect here and do not find, and its absence is deliberate. The guideline states that managing fall-related injury is beyond its scope and treats bone health as a separate, reciprocal assessment: adults with low-trauma fractures or osteoporosis should have a falls risk assessment, and conversely those at moderate to high falls risk should have a bone health assessment using local protocols. The named fracture-risk tools are FRAX, Garvan and QFracture, with bone densitometry to confirm osteoporosis. So do not list bone health as a domain of the multifactorial assessment, and attach no grade to that reciprocal pairing, which is given as justification and not as a graded recommendation.

Falls work is joined to the wider assessment explicitly. The falls guideline describes its own product as identifying and measuring risk factors across multiple domains to indicate potentially modifiable areas for intervention, and states that this combines with the other components of a comprehensive geriatric assessment to enable a person-centred approach, while declining to cover the rest of that assessment. It also supplies the sentence that makes falls a psychiatric concern rather than an orthopaedic one: a fall in an older adult, particularly one living with frailty, should be treated as a warning sign of potentially unidentified underlying conditions, and may be the presenting feature of an acute medical illness.

17.9 The Indian and low-resource reading, and what is missing from it

Two of these sources speak directly to practice in a resource-constrained system. The falls guideline carries recommendations written for low- and middle-income countries, a class that includes India on the classification the guideline itself uses. Community-dwelling adults aged 60 years and over should be screened opportunistically for fall risk during any clinical encounter, at least once a year, by asking about falls in the past 12 months, and a strong recommendation at GRADE 1B requires local context to be considered when falls-prevention programmes are implemented in such settings. Alongside it sits the conditional recommendation at GRADE 2C to prioritise cognitive impairment, obesity including sarcopenic obesity, diabetes, lack of appropriate footwear and environmental hazards as risk factors. Footwear is the component most directly transferable to an Indian clinic, and the guideline's own word for the exposure, bare-footedness, is the one to carry; it also notes that footwear practices and environmental safety differ culturally and that assessment and education should account for that difference.

The Indian guidance contributes the history rather than the triage, and the two are complementary rather than competing. When an older patient presents with a fall, it asks for the place of the fall, the activity the patient was engaged in, the type of fall, and symptoms such as dizziness, fainting and weakness on change of posture. It also names who is predisposed: older people who need mobility aids to walk, who take sedative medication, or who take drugs that can produce a postural fall in blood pressure, with substance intoxication and psychotropic-induced postural hypotension named alongside. That last clause is the uncomfortable one, because the prescriber of the drug producing the postural drop is frequently the person taking the falls history.

IN INDIA

The assessment process, its team and its falls component are taught above from a 2014 explanatory article in a British journal and a 2022 global consensus guideline. The Indian contribution is the 2023 clinical practice guidance in the Indian Journal of Psychiatry, supplying the falls history, the frailty definition and the functional instruments, plus the global guideline's low- and middle-income-country recommendations, which are internationally recommended practice applicable to Indian settings and are not an Indian standard. For an Indian national statement that this assessment is expected practice, for an Indian multidisciplinary staffing norm, and for an Indian falls-screening cadence, no comparable standard is available to quote, and none is invented here. Say that in a viva rather than inventing a programme requirement.

The practical consequence is for the ward rather than the examination. Where the five-role team does not exist, the method does not become unavailable; the division of labour does. The domains still have to be covered, the problem list written, someone named as coordinating it, and the plan given a review date. A clinician running the process alone is doing something harder than the model describes, not something different, and the first thing to slip is the review, which is the feature the definition insists on.

A comprehensive geriatric assessment is a process with a named coordinator, a written goal-driven plan and a review date; the cognitive screen is one line inside one of its domains.

The late-life presentations

18 · Dementia in the elderly (overview, behavioural and psychological symptoms)

Why the bracket is the instruction. The heading is set as dementia in the elderly (overview, behavioural and psychological symptoms), and a candidate who reads it as a request for an account of the disease has read past the only unusual part of it. What the condition is, how it is classified, how it is investigated and staged, and what is prescribed for it and for the behavioural disturbance belong to the Dementias and neurocognitive disorders notes, which carry all of it, the work with families included. A compressed second version of an account that exists in full is a rival, not a summary, so none of it is repeated here.

What is left over is what these notes owe. Most headings in psychiatry name something a patient is referred for; this one names something a patient usually already has when they are referred for something else, and that difference organises everything below.

18.1 Where the condition sits once the question is about later life

These notes are built around who is asking, in whose ward, and what changes when the patient is old. Read that way, this is seldom the question asked and almost always the **background condition** it is asked against. The acute confusion arriving on a brain already changing is taken up where delirium in later life is dealt with here; the flat, slowed presentation read as decline, and the decline read as depression, where late-onset depression and the depressive presentation that mimics it are dealt with. The suspiciousness in a person living alone, the prescribing decision for a patient who cannot report an adverse effect, the nocturnal disturbance that is an evening behavioural pattern, and the neglect unreported because the only witness cannot describe it each have their own place here. In every one the answer moves when this condition is in the background, and that is why the subject belongs here at all.

RULE **Treat it as the context of the consultation, not as its subject.** A geriatric station rarely opens with a request to diagnose the condition; it opens with a behaviour, a family, a fall, a drug or a crisis, in a person who has it. A candidate who begins by establishing the diagnosis is answering a question settled before anyone was called, and runs out of time before the one that was not.

18.2 What actually generates the consultation

Who decides that today is the day. The **referral threshold** is set by what the household can absorb, not by how impaired the patient is. People equally affected reach a clinic years apart, one living with a daughter who has given up paid work, the other with a spouse who is himself unwell. The corollary is examinable: a referral carries as much information about **carer capacity** as about the patient's brain, and a request arriving abruptly after years of stability usually records a change in the household rather than in the illness.

So why now is answered by asking about the house, and answering it badly is why a consultation yields a prescription and no plan. Establish these before the cognitive examination, not after:

- what changed recently, in the patient, in the household or on the drug chart, and in what order;
- who is present by day, who is present at night, and who has lately stopped being present;
- which behaviour the household has decided it cannot absorb, in their own words rather than as a symptom list.

IN INDIA

The family is the service. Most districts have no old-age psychiatric provision to refer on to, so the request reaches a general psychiatrist and the plan must be one the household can run. **Diagnostic delay** is built in: presentation comes by way of a crisis, a wandering episode or a bodily complaint rather than a memory complaint, because forgetfulness in an old person is heard as ordinary and the diagnostic word carries the weight of madness in everyday speech. Neither the provision nor the delay is given a figure here: no comparable standard is available to quote, and none is invented here. That inverts **disclosure**, which is asked for upward, to relatives, before the person it concerns, and families often ask that nothing be named at all; how that conversation is conducted is taken up where breaking bad news is dealt with in these notes. The work is usually done unpaid by a woman in the same house, so asking what the household can sustain is an enquiry into her, and it is where the protection question first appears, dealt with where elder abuse and neglect are taken up.

18.3 Where each part of the subject is taught

A reader wanting the disease is sent, not served a thinner copy, including the **behavioural and psychological symptoms** in the bracket, whose description and pharmacology are the owner's.

WHAT IS BEING ASKED FOR	WHERE THE FULL ACCOUNT SITS	WHAT THESE NOTES ADD
Definition, criteria, subtypes, investigation, staging, and the behavioural symptoms with their pharmacology	**the Dementias and neurocognitive disorders notes**	Nothing but the reason the referral came when it did
Cognitive instruments and neuropsychological testing	**the Psychotherapies, clinical assessment, MSE and nosology notes**	The assessment they sit inside, taken up with geriatric assessment here
Telling it from an acute confusional state	**the Stroke, TBI, delirium and focal brain syndromes notes**	What ageing contributes, taken up with delirium in later life
Telling it from a depressive presentation	**the Mood disorders: pharmacotherapy notes**	The discrimination as examined, with the depressive mimic here

18.4 How the heading is asked

Set as a short note it wants breadth held briefly, and the marks go missing when a candidate spends the answer on classification and never reaches the bracket. Set as a long case or a viva it is

never asked alone: it arrives attached to an old patient with a behaviour, and the condition is the frame the case is read through rather than the thing to be diagnosed. Either way:

- name the condition and where its account belongs, in a sentence, without lingering;
- say what its presence changes about the question actually asked;
- finish on **the pending decision** and on who carries it.

TRAP **Examining the patient thoroughly and never examining the household.** Candidates make it because the patient is in front of them, the cognitive examination is rehearsed and scoreable, and the family is treated as a source of history rather than as a subject of assessment. The result is an immaculate account of impairment that explains none of the timing, and a plan that could have been written before the patient arrived.

Context, not subject	The household, not the stage	Named and handed on
WHAT THE CONDITION IS IN A CONSULTATION FRAMED BY THE ENCOUNTER	WHAT DECIDES WHEN THE REFERRAL IS ACTUALLY MADE	WHAT THESE NOTES DO WITH THE ENTITY ITSELF

Dementia enters here as the condition an older patient already has when the consultation is called: the entity, its criteria, its instruments and its drugs are read in the Dementias and neurocognitive disorders notes, and what is answered here is why the referral came now, what changes because it is there, and who decides.

19 · Late-onset depression and its features

Why it matters clinically. An older patient with depression is a common presentation and the syndrome is well described, so the marks here are not for describing it. They are for the question that follows: is this the first time in this person's life it has happened, and if it is, what does that oblige you to do that a recurrence would not? The syndrome, its criteria, the screening instruments and their scoring, and the agent-by-agent geriatric prescribing caveats are set out in the Mood disorders: pharmacotherapy notes. What is taken up here is the part candidates skip: onset.

19.1 Onset, not age, is the variable

Two patients of the same age sit in the same clinic with the same complaints. One has had episodes since her twenties and is having another. The other has never been depressed in his life and is depressed now. They may be indistinguishable on the mental state examination, and only the history separates them. **Late-onset depression** means a first episode arising in later life; a long-standing illness whose current episode merely falls in later life is **early-onset recurrent depression** in an older person, a different clinical problem wearing the same face. What makes late-onset depression and its features examinable is not the symptom list but the fact that the timing of the first episode changes the workup, what the family is told, and what follow-up is for.

The age at which an episode counts as late-onset is a matter of convention and the conventions differ: no cut-off is available to quote here, and none is invented. Nothing below depends on a

number, only on whether an episode has happened before, which is a historical fact rather than a threshold.

RULE **Establish whether this is a first episode before you decide anything else about the case.** Onset is not a descriptive detail collected for completeness. It is the variable on which the direction of the assessment, the weight given to the medical enquiry, what the family is told about recovery and the content of follow-up all turn. Every later decision inherits the answer, so an onset settled late is settled after the plan was written.

WHAT IS BEING DECIDED	FIRST EPISODE, ARISING NOW	OLD ILLNESS, RECURRING NOW
What the history must establish	That no earlier episode occurred at any age, checked with someone who knew the patient young	When the episodes fell, what was given, and how well the patient was between them
Where the diagnostic effort goes	Into why this brain and body have produced the syndrome now, never having done so before	Into why it has recurred, and what was lost from whatever had been holding it
What the family is asked for	The patient as they were decades ago, which nobody has asked them to describe	The pattern they have already watched, usually given in a sentence
What the treatment decision rests on	Published guidance and physiology, there being no record of what worked	The agent and dose that produced remission before, if tolerability allows
What follow-up is for	Resolving the question the first episode raised, which the treatment response does not	Preventing the next recurrence of an illness whose course is known

TRAP **Recording a first episode on the patient's word alone.** Candidates make this error because the patient is often the only informant in the room and answers confidently. An episode decades earlier that was never named as an illness, that a physician treated as weakness or a stomach complaint, or that was simply endured at home, leaves no record and no memory the patient recognises as psychiatric. Everything above rests on that one fact, which makes it worth a telephone call to a sibling or an old neighbour, and the note should say who supplied it.

19.2 The presentation that misleads, and who it misleads

Why the mask works better the first time. That older patients present with bodily and cognitive complaints rather than with a complaint of sadness, and the rule of recognition built on it, belong to the Mood disorders: pharmacotherapy notes. What onset adds is why the same mask defeats everybody in a first episode and almost nobody in a recurrence. In a long-standing illness the family has watched this before; they often make the diagnosis themselves and say so in the first minute. In a first episode nobody has seen them like this, so nobody holds a template, and everyone in the room has a non-psychiatric explanation that fits the facts: the physical illness that began around the same time, a bereavement, a move into a child's household, the end of working life, or simply age. The patient offers one first, because it is the only account they have, and the presentation is filed under the explanation rather than examined.

This is why the referral, when it comes, arrives from a physician rather than the family, often after an investigation for weight loss, pain, giddiness or forgetfulness returned nothing. Read that sequence as information: the complaints were taken seriously by someone competent and were not explained, and the illness is older than the date on the letter.

An **informant history** settles onset, and a general enquiry about past psychiatric illness will not get it, because the informant is being asked about labels when what you need is behaviour. Ask instead:

- whether there was ever a stretch of adult life, however explained then, when the patient stopped working, stopped going out or stayed in bed for weeks;
- whether they were taken to a doctor for sleep, nerves, weakness or a stomach nobody could account for, and what was given;
- whether anything of the kind followed a childbirth, a bereavement or a surgical illness decades ago;
- what the patient was like as a young adult, since a first episode is measured against a person and not a norm.

19.3 Why a first episode reframes the assessment

A syndrome that has never occurred across a long life and occurs now is, on its face, a statement that something is different now. That does not make the depression secondary to anything, and it does not license leaving the mood alone while the physicians work. It changes where the diagnostic effort goes, and when. In a recurrent illness the medical and drug review is a safety check run alongside treatment; in an **index episode** it is the main line of the assessment, done now rather than after an antidepressant has failed, because a contribution found late has cost the patient a trial.

The mimics, the drugs that lower mood and the investigations that exclude them sit in the Mood disorders: pharmacotherapy notes, and systemic and neurological contributions in the Neuropsychiatry of systemic and neurological disease notes. Two asymmetries belong here. A positive finding does not close the case: an untreated endocrine abnormality or a recently started drug may contribute to an episode without accounting for it, so the mood disorder is still treated on its own terms. A negative panel does not close it either, because the contribution that matters most here may be cerebral rather than systemic, and nothing routine reports on it.

19.4 The vascular contribution as a question about substrate

The proposal that cerebrovascular disease predisposes to, precipitates or perpetuates some late-life depressive syndromes, the phenotype that goes with it and the treatment expectations that follow all belong to the Mood disorders: pharmacotherapy notes; cerebrovascular disease itself to the Stroke, TBI, delirium and focal brain syndromes notes. **Vascular depression** is named at this address for one reason: it is an argument about onset and not about age, and the two are routinely conflated.

Consider the same finding in two patients. In a woman depressed since her twenties, cerebrovascular disease and long-standing hypertension found now are comorbidity: real, worth treating, and no explanation of an illness that predates them by decades. In a man depressed for the first time in old age the identical findings are a candidate explanation. The difference lies wholly in the history, which is why a substrate hypothesis is never raised or dismissed from a scan report.

Treating that hypothesis as live has three consequences, and each is an act rather than a conclusion:

- vascular risk factors become part of the psychiatric plan rather than another team's business, because you are the one who has just made them relevant to the mood;
- what the family is told about the shape of recovery is worded carefully, since a slower or more partial course is possible and neither promising nor excluding it is defensible;
- the cognitive picture is reviewed once the mood has moved rather than settled during the episode, because the treatment response alone does not answer the question the first episode raised.

The opposite error shadows all of this. Executive slowing and poor test performance get read as an early degenerative process, the mood is treated half-heartedly, and the patient is followed as a dementia. Telling those apart is taken up where pseudodementia and dementia are compared in these notes. What belongs here is that a first episode is where both mistakes are available at once, because no earlier episode exists to argue against either.

19.5 The frailty-aware decision, and a position that has moved

In a first late-life episode the treatment decision is made without the information that usually makes it easy. In a recurrent illness the agent that produced remission before, and the dose at which it did so, are most of the plan. Here there is no such record, so the decision rests on published guidance and this patient's physiology alone.

The Indian clinical practice guideline for the assessment and management of depression, published in the Indian Journal of Psychiatry in January 2026, gives the older patient a rule of its own and attaches a quantity to it: a low start, slow titration, and a dose usually **half** the adult figure at the start and at the intended destination alike, with hyponatraemia and falls named as what to monitor. The rate, the endpoint and that monitoring are worked through where the principles of psychopharmacology in the elderly are set out in these notes. What belongs here is what a moved destination does to the judgement of a trial in a patient with no treatment history.

It does this. A patient sitting at a reduced **target dose** who has not improved, and a patient quietly under-treated out of caution, generate identical entries in a record, and the next clinician cannot tell a deliberate ceiling from an abandoned titration. The remedy is administrative: before titration starts, write down the dose you intend to reach and the date the trial will be judged. That is the only way a failed trial is later told apart from an untried one.

IN INDIA

The same guideline also states that age influences the choice of agent, and here the expected answer is no longer the safe one. In older adults an SSRI may be less effective, and an SNRI such as duloxetine may be more suitable. Both clauses are hedged and the hedge is the content: this is not an instruction to prefer an SNRI in older patients, and an answer that converts it into one asserts what the guideline declined to assert. An earlier Indian position places the SSRIs first-line in late-life depression with a reduced start and slow titration, and is recorded in the Mood disorders: pharmacotherapy notes. Both are set out here and neither is adjudicated: whether the later document displaces the earlier or simply differs from it is not established, the earlier document is not examined at this address, and no supersession is asserted. State both, name the hedge, then say which you would follow for this patient and why.

GOOD TO REMEMBER

Three lines in the record of a first depressive episode in an older patient do more work than the rest: that this is a first episode, and who established it; that a medical, drug and cerebral contribution was considered, what was done and what came back; and the dose you intend to reach, with the date you will judge the trial. The third is routinely left out, and without it nobody reading the file afterwards, including you, can tell a cautious plan from an abandoned one.

19.6 What this section decides, and what it hands on

Two boundaries were not named above. The structured functional and frailty workup this reasoning sits inside belongs where the comprehensive geriatric assessment is dealt with in these notes, and formal risk assessment in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. Everything else routed above stays routed: nothing here describes the syndrome, scores an instrument or names a milligram.

What is left is the reasoning, and it runs in one direction. An examiner presenting an older patient with depression is testing whether you settle onset first and from whom; what a first episode obliges you to look for that a recurrence does not, and why that enquiry precedes the trial; whether you grasp that a substrate question changes the follow-up and not merely the workup; and whether you can state the current Indian dose position and its hedged statement on agent choice without over-reading either. Answer from onset to substrate to dose to follow-up, and the description of the syndrome becomes the least of what you say.

Onset before anything else

WHETHER THIS IS A FIRST EPISODE IS A HISTORICAL FACT TAKEN FROM AN INFORMANT, NOT A JUDGEMENT MADE FROM THE MENTAL STATE

A first episode is a question

A SYNDROME NEVER SEEN BEFORE IN A LONG LIFE ASKS WHY NOW, AND THE MEDICAL, DRUG AND CEREBRAL ENQUIRY ANSWERS THAT

The ground has moved

THE CURRENT INDIAN DEPRESSION GUIDELINE HEDGES RATHER THAN ASSERTS THE CHOICE OF AGENT IN OLDER ADULTS

In an older patient with depression, settle first whether this is the first episode of their life: a first episode makes the medical, drug and cerebral enquiry the main line of the assessment rather than a safety check, keeps the substrate question open into follow-up instead of closing it on the treatment response, and is treated on published guidance alone, so the intended target dose and the date of judgement are written down before titration starts.

20 · Late-onset psychosis and paraphrenia

Why it matters clinically. When a psychosis declares itself for the first time in someone who has lived seven decades without one, the diagnostic label is the smallest part of the work and the last part of it. The entity itself, meaning the onset bands, the delusional content, the sex ratio and the sensory and social background, is set out in the Other psychotic disorders, delusional syndromes and catatonia notes and is not repeated here. What is taken up under late-onset psychosis and paraphrenia in this chapter is the act: the order a clinician works in on the day this patient arrives, what an Indian guideline requires to be excluded before anything is called primary, when imaging is owed, and what the patient's age does to every treatment decision that follows.

The examined version of this topic is procedural far more often than descriptive. A candidate who can recite the onset bands but cannot say what they would reconcile, request and arrange before writing a diagnosis has answered the smaller half of the question. The half that carries the marks is a sequence, it has an Indian source, and it is short enough to hold.

20.1 The word, and what is left for the clinician to do with it

Paraphrenia reaches a modern answer as an inheritance rather than as a working category. Its coinage, the reason the syndrome it named was separated from the deteriorating psychosis of youth, its later revival as a late-life term, and the modern onset bands that absorbed it all belong to the Other psychotic disorders, delusional syndromes and catatonia notes. Retelling that history is not what earns credit here.

What the word still does is prime recognition. It carries a clinical stereotype, and a stereotype earns its place at the door of a clinic, because it makes a clinician look properly at a patient who might otherwise be sent home as eccentric. What it must never do is close the assessment. That is the hazard of an old and vivid label: it feels like a conclusion, it is easy to write, and once it is in the file every later reader treats the question as settled. The word describes; it excludes nothing.

Where the label sits, or sat, inside a formal classification is a separate question, and this section deliberately leaves it unstated rather than guessed at: no code and no inclusion term is named here. What a classification does with the presentation, as against with the word, belongs with the nosology in the notes named above. In an answer, give the lineage a clause, say plainly that the term is historical, and spend the remaining time on the workup.

20.2 The exclusion list runs first, and it is a sequence rather than a differential

Current Indian guidance on schizophrenia in older adults does not open with treatment. It opens by requiring a thorough evaluation for a defined set of alternatives before the presentation is

treated as primary, and that set is best learnt as a sequence of acts rather than as conditions to bear in mind. A differential is something a clinician holds; a sequence is something a clinician completes and records. The enumeration is an affective psychosis, delirium, a dementia, a psychosis caused by medication, and a psychosis caused by a psychoactive substance, and its value lies in how specific it becomes at the two ends candidates skip.

At the dementia end it does not stop at the word: Alzheimer's disease, the frontotemporal group, Parkinson's disease, Lewy body disease, vascular disease and mixed pathology are each named. That granularity matters because these are not one exclusion but several, with different tempos and different first clues, and the differentiation itself is taught in the Dementias and neurocognitive disorders notes. At the pharmacological end, **medication-induced psychosis** is given as named drug classes rather than as a gesture at polypharmacy, and this is the part almost nobody has ready.

WHAT MUST BE EXCLUDED BEFORE THE WORD PRIMARY IS USED	WHY IT STAYS LIVE IN AN OLDER PATIENT	THE ACT THAT SETTLES IT, AND WHERE THE ENTITY IS TAUGHT
An affective psychosis	Mood is under-elicited in older patients, and psychotic content is louder than the affective change underneath it	Take a mood history from patient and informant across the whole episode, not the current week; the disorders belong to the Mood disorders: pharmacotherapy notes
Delirium	The referral arrives worded as psychosis, which describes content and says nothing about attention or fluctuation	Get a timed account of onset and of variation across the day from someone present; the syndrome is taught in the Stroke, TBI, delirium and focal brain syndromes notes
A dementia: Alzheimer's, frontotemporal, Parkinson's, Lewy body, vascular or mixed	Several can produce psychotic features before the cognitive complaint is what brings the family in	Establish the premorbid baseline and trajectory from an informant, then assess cognition formally; the differentiation is in the Dementias and neurocognitive disorders notes
Medication-induced psychosis: antihistaminergics or anticholinergics at higher doses, steroids, dopamine agonists, antimalarials, antiretrovirals, opioid analgesics, fluoroquinolones, ACE inhibitors and beta-blockers	Every class here is in ordinary use in older Indian patients, and several are bought without a prescription or continued from another prescriber	Reconcile the full drug chart yourself, including whatever the family brings in a bag, and date every start and stop against the onset of symptoms
Psychoactive substance-induced psychosis	Substance use is under-asked at this age because the clinician does not expect it, and withdrawal states are missed for the same reason	Ask patient and informant separately, about current use and about anything recently stopped

TRAP **Treating the exclusion list as a differential to consider rather than a sequence to complete, so the drug chart is never actually reconciled.** The mark is lost predictably: the referral says psychosis, the assessment therefore runs as a psychosis assessment, and the medication list is read as background rather than as evidence. It is the one item on the list that is fully reversible, and the one the Indian source makes specific by naming classes. Saying the word iatrogenic does not answer it; naming which agents you would look for, and dating each start against the onset, does.

Four places on an older patient's drug history repay being asked about by name, because none reliably appears on a chart:

- anything started or increased in the weeks before symptoms began, including by another treating team;
- anything stopped abruptly in the same window, since a withdrawal state presents as readily as an addition;
- anything bought over the counter or continued from an old prescription, which is where the sedating antihistamines and the anticholinergics usually sit;
- anything taken alongside the prescribed list, whether traditional, complementary or given by a relative, which is not volunteered unless it is asked for without judgement.

20.3 The imaging instruction, and what it converts

From an imperative to an instruction. Every textbook tells a clinician to exclude an organic cause in a late-life psychosis, which is a sentiment rather than an order, because it says neither what to do nor when. The Indian guideline is more useful. It states that neuroimaging is indicated, and attaches the emphasis to a specific situation: a first episode presenting at an elderly age, which it puts at **after 60**. That age is being used as an investigation trigger and not as a nosological boundary; where the onset bands come from is a separate matter, taught with the entity.

A trigger survives contact with a busy service in a way a sentiment does not. An instruction to consider organic causes is discharged by a clinician who considered them; an instruction that imaging is indicated at this age either happened or did not, and the note shows which.

IN INDIA

The exclusion list, the imaging trigger and the treatment changes in this section are taken from the current Indian clinical practice guideline for the management of schizophrenia, published in the Indian Journal of Psychiatry in 2025, in the row of its special-populations table dealing with older adults. Naming a national source is worth a mark in a viva, where a recalled Western habit is not. Two local frictions recur, and neither justifies skipping a step. Imaging is an out-of-pocket cost a family may defer or decline, so record the indication, the explanation given and the refusal, then arrange it again at review. And the drug history arrives as strips, folded prescriptions and several prescribers rather than as a chart, so it must be assembled by the assessing clinician and cannot be delegated to the referral letter.

20.4 What changes because the patient is seventy-eight

Once the exclusions are worked and the presentation is being treated as a primary psychosis, the age changes the treatment decision at its first step rather than its last. In a younger adult a drug is chosen for what it is expected to do, and its adverse effects are then managed. Here the order inverts: **selection is driven by the side-effect profile**, because comorbidity is the rule at this age and the adverse event being avoided is the one that ends a person's independence.

RULE **In a late-life psychosis the agent is chosen by what it must not do.** The first-line preference is for agents with **lower anticholinergic burden** and lower sedative property, and the guideline states the purpose rather than leaving it to be inferred: to prevent falls. Read that reason forward and the rest follows from it. Sedation and anticholinergic load are the two properties that produce a fall, so the same logic bars **anticholinergic co-prescription** so far as it can be avoided, which matters because that is precisely the reflex a prescriber reaches for when extrapyramidal effects appear.

Two further changes complete the picture. The starting dose is set lower than in an adult, and monitoring for metabolic adverse effects is more frequent. The quantified dose reduction, the anticholinergic burden scales, the falls evaluation and what more frequent monitoring means in practice all sit where the principles of psychopharmacology in later life are dealt with in these notes; the agents themselves belong with the entity. What belongs here is the reasoning that ties them together: one stated purpose, the prevention of falls, generates the selection rule, the co-prescription rule and the dose rule at once. That is what an examiner is listening for, and it is one sentence.

20.5 Who brought the patient, and where the treatment actually happens

The guideline does not stop at the drug. It records that the psychosocial challenges of this group are distinctive and often need psychosocial intervention in their own right, and here that clause carries more weight than it appears to, because of who is standing in the room. The patient has usually not referred themselves. The complaint has been made by a family member, a neighbour or a landlord, and the person best placed to supervise medication is frequently the person the patient's complaint is about. A plan written without noticing that is a plan for a household which does not exist.

Three consequences follow, each an act rather than an attitude. The alliance is built with the patient about something the patient wants changed, which is rarely the belief and is often sleep, safety or being left alone; arguing the belief costs the alliance and buys nothing. **Supervised administration** then has to be arranged by name, because an older person living alone with a persecutory belief will not reliably take a drug handed over by someone they distrust, and recording who holds the medication, and where, is part of the prescription. And the isolation and sensory deficits that so often accompany this presentation are targets rather than context: a hearing aid obtained is an intervention.

GOOD TO REMEMBER

Four things should exist before this first consultation ends, and none will exist unless you make it. A reconciled medication list with dates, assembled by you rather than copied from the referral. A named informant with a telephone number, recorded as the source of the premorbid baseline. A written statement of whether imaging was requested, obtained, deferred or refused, with the reason. And a named person who will actually give the medication, with the arrangement written down. Each is what the next clinician will need, and none can be recovered later.

20.6 The diagnosis is made over time, so the note has to be re-openable

What finally separates this presentation from a first psychosis in a young adult is that the exclusion list contains conditions which do not all declare themselves at once. A dementia early enough to produce psychotic features before a cognitive complaint need not be visible at a first assessment, and a medication effect becomes obvious only once the agent is withdrawn and the picture watched. The workup therefore has a component running after the consultation, and a diagnosis recorded as settled at first contact quietly removes it.

How often a late-life psychosis is later reclassified, and how long a clinician should watch before treating the diagnosis as stable, are questions this section cannot put a figure or an interval on: no comparable standard is available to quote, and none is invented here. What can be taught is the consequence for the record. Write the diagnosis with its grounds visible: what was excluded and how, what was not yet excluded and why, and what would cause it to be revisited. A colleague reading that in six months can re-open it; a colleague reading a bare label cannot, and will not.

The list before the label
THE INDIAN GUIDELINE PUTS A THOROUGH EXCLUSION EVALUATION AHEAD OF CALLING A LATE-LIFE PSYCHOSIS PRIMARY

Imaging has a trigger
A FIRST PRESENTATION IN OLD AGE CONVERTS THE EXCLUDE-AN-ORGANIC-CAUSE SENTIMENT INTO AN INVESTIGATION THAT EITHER HAPPENED OR DID NOT

Chosen by what it must not do
LOW ANTICHOLINERGIC AND LOW SEDATIVE SELECTION, NO ANTICHOLINERGIC CO-PRESCRIPTION AND A LOWER START, ALL GENERATED BY ONE STATED PURPOSE

In a first psychosis of late life the examinable work is a sequence and not a label: complete the guideline's exclusions with the drug classes named and the drug chart reconciled by you, treat a first episode at an elderly age as an indication for neuroimaging, then choose the antipsychotic by its side-effect profile and start it low, because the fall is the outcome that ends independence.

21 · Delirium in the elderly

Why it matters clinically. Delirium was the commonest psychiatric disorder in one Indian study of elderly patients screened at emergency medical outpatient settings, present in **34.1%**, and the examinable question about the confused older inpatient is almost never what delirium is. It is why this patient, why now, and what follows. The entity, its criteria, its subtypes and its treatment belong to the Stroke, TBI, delirium and focal brain syndromes notes, and telling it apart from dementia and from depression belongs to the Dementias and neurocognitive disorders notes.

What is taken up here is narrower: what ageing itself contributes, so that the same syndrome in an older person has a lower threshold, a different set of precipitants, a harder point of comparison and a longer tail.

Keep this apart from the ward referral. The call that arrives as behavioural disturbance on somebody else's service, the bedside screen, the consult note and the ownership of the decision afterwards are taken up where delirium in the medically ill is dealt with in these notes. That section answers what a liaison psychiatrist does when called; this one answers why the call is so often about the oldest patient on the ward.

21.1 What ageing brings to the bedside

Delirium in later life turns on how much insult the brain could absorb before this illness began, and on how large the insult is. The first quantity is **physiological reserve**, and its progressive loss across several organ systems at once is what **frailty** names. Frailty is not chronological age and not a long problem list: one older person can carry several diagnoses and retain reserve, another few and have almost none. Its clinical content is that homeostatic responses have narrowed, so a perturbation a younger patient corrects silently is corrected slowly or not at all. The brain sits downstream of all of them, which is why cerebral dysfunction is so often the first system to declare a failure that began elsewhere.

RULE **The frailer the brain, the smaller the precipitant needed, and the less the precipitant tells you.** In a frail older patient the trigger may be trivial by the standards of a younger ward, so a search that stops when nothing impressive is found has stopped too early. The corollary is the more examinable part: when delirium appears in a robust older person with no cognitive history, the insult was probably not trivial, and the response is to look harder, not to be reassured.

Reasoning in late life therefore runs from trajectory to trigger. The Indian Psychiatric Society's 2023 guidelines on psychiatric emergencies in the elderly list advanced age over **70 years**, cognitive impairment, a previous episode and sensory impairment among the risk factors and weight none of them, so what follows are mechanisms rather than weights, and what each earns is an act that must precede the examination.

WHAT AGEING BRINGS	WHY IT LOWERS THE THRESHOLD	WHAT IT CHANGES AT THE BEDSIDE
Loss of reserve, expressed as frailty	Correction is slower and less complete, so a modest insult is not absorbed	Search wide for a small precipitant; do not stop because nothing dramatic is found
Uncorrected hearing and vision loss	Input is impoverished and ambiguous, so more must be inferred from less	Restore the aid and spectacles before testing, and record that you did
A long and layered drug chart	Altered handling and cumulative central load make the precipitant often iatrogenic	Reconcile every agent, including whatever the family brings in
Cognitive impairment already present, recognised or not	The vulnerable substrate is there already, so less is needed to decompensate it	Get the premorbid baseline before interpreting the state in front of you

21.2 The unaided ear, and the test that is not valid

Uncorrected sensory loss acts in separate ways, and it is the second that catches candidates. The first is a contribution to vulnerability: when hearing and vision are degraded, the information reaching the patient is sparse and ambiguous, and more of their experience must be inferred than received. Ask that of someone in an unfamiliar room, with unfamiliar voices and no visual anchors, and **sensory deprivation** of this ordinary, correctable kind becomes a condition under which misinterpretation is likely. It explains why the same patient is settled with a daughter present in daylight and disorganised in a dim side room at night, with no change in the underlying illness.

The second effect is diagnostic, and it invalidates assessments rather than causing disease. A patient who cannot hear the instruction appears not to attend to it; one who cannot see the object appears not to name it. Each failure is indistinguishable from the failures that matter, and each gets recorded as a cognitive finding by whoever tested without checking. An unaided examination yields a result that cannot be interpreted in either direction. Which ward measures prevent delirium is the owning chapter's; assessing an older person generally is taken up where normal ageing and psychiatric assessment are dealt with in these notes.

> **GOOD TO REMEMBER**
>
> Before a single cognitive item is administered to an older inpatient: ask what they normally use, get it on, and get the light on. Then write that the hearing aid was in place and the spectacles worn, or that they were unavailable and the examination is limited for that reason. An unqualified cognitive result on an unaided patient is not a finding, and it follows the patient through every later team.

21.3 The drug chart as part of the physical examination

Polypharmacy earns its place for reasons that call for different acts. It is a marker: a long chart usually indicates multimorbidity, therefore reduced reserve, and the same guidelines put multiple physical illnesses and polypharmacy among the things that raise the risk. It is also the most reversible precipitant on the ward. Older patients accumulate centrally acting agents across years

and across prescribers, and the cumulative anticholinergic and sedative load of a chart assembled that way is often greater than any single entry suggests. How ageing changes the handling of each agent is taken up where the principles of psychopharmacology in later life are dealt with in these notes. Read the chart before accepting anybody's account of what precipitated this.

These places on a chart repay specific attention, because each is easy to miss on a ward round:

- the agent started most recently, including one added by another team during this admission;
- the agent stopped most recently, since abrupt withdrawal of something long established precipitates as readily as an addition;
- the agent being taken but absent from the chart, whether over the counter, traditional, or brought from home in a strip;
- the agent continued unchanged at a dose set years ago, when the patient handled it differently.

IN INDIA

The ordinary Indian bedside changes how this is done. A family attendant is almost always present, and is usually the only source of the premorbid baseline and the only person who will notice a change at night: name them in the note and ask them directly, not through the ward staff. The drug history sits across more than one prescriber and arrives as strips and folded prescriptions rather than a chart, so ask for all of it and reconcile it yourself. Glasses, hearing aids and dentures live at home: ask whether they came in with the patient at all. Each closes a diagnostic gap that nothing later in the admission will close for you.

21.4 Delirium on a brain that was already changing

An episode in a person who already has a dementia is to be expected rather than treated as a special case, and **delirium superimposed on dementia** generates most of the diagnostic difficulty in geriatric practice. The reason is structural: the diagnosis rests on an acute change from a previous state, and when that state was already abnormal, the change is invisible unless someone can describe what the patient was like beforehand. On a busy ward the enquiry stops at a sentence to the effect that the patient has been confused for a while, which is equally compatible with a stable dementia, a slow decline and an acute deterioration on top of either. It separates none of them, and it is usually the only history taken. Which of delirium, dementia and depression best explains a presentation is taught in the Dementias and neurocognitive disorders notes; what belongs here is that in an older patient the answer is often more than one of them at once, and that the **baseline** is the instrument for that judgement.

A **collateral history** taken for this purpose has to establish particular things, and a general enquiry about memory establishes none of them:

- what the person could do without help before this admission, in concrete terms rather than impressions;
- whether memory, orientation or self-care were already impaired, and for how long;
- whether the current change came on over hours or days rather than over months;

- who first noticed it and what they noticed, since the earliest observation is the most diagnostic and is rarely in the notes.

TRAP **Reading a confused older patient as the natural course of their dementia.** Candidates make this error because it is available: the label is already in the file, it accounts for the findings, and it requires no telephone call. The failure is one of history-taking, not of phenomenology, and examining the patient more carefully does not repair it, because the acute change is not in the current mental state. It is in somebody's memory of last week. The error runs in reverse when a first episode in an older person is treated as evidence of a dementia nobody has assessed.

21.5 Sundowning is a word about the clock

Why the term misleads. **Sundowning** is a ward word for agitation, disorientation or restlessness that appears or worsens as the evening comes on. It carries no agreed definition that can be quoted, and none is invented here; what it describes is timing, not a mechanism, a diagnosis or an explanation. Its usefulness lies in what it prompts you to ask, because several different situations get recorded under it: the evening exacerbation of a delirium present all day that becomes visible once structure and staffing thin out; evening behavioural disturbance in an established dementia with no delirium, which belongs with the behavioural and psychological symptoms taken up where dementia is placed in the geriatric frame in these notes; and an artefact of the ward evening itself: handover, reduced supervision, dim light, and the withdrawal of the attendant who had been orienting the patient all day.

Because the pattern is temporal, it is established by documentation across the whole cycle rather than by an impression formed on one evening: timed observations across the day and night discriminate between those situations, while a note recording that a patient was disturbed at night discriminates nothing. And because the evening presentation invites a sedating response at the hour when supervision is lowest, the reflex to prescribe rather than to look is strongest exactly when the diagnostic information is thinnest. What changes about sleep with age, and what to do with the reflex to prescribe at night, are taken up where sleep in later life is dealt with in these notes.

21.6 The tail: what happens after the ward

The assumption that quietly governs discharge planning is that the episode ends when the illness that triggered it ends. In an older person that assumption is not safe to make, and what rests on it is what the family is told, when cognition can fairly be re-examined, and what the next clinician gets from your note. Features still present on the day of discharge are easily recorded as the patient's new normal, particularly when the discharging team never knew the old one. Whether recovery tracks the medical problem, and how much of the later functional and cognitive trajectory belongs to the episode rather than to the frailty that permitted it, is exactly where a candidate is tempted to supply a proportion: no comparable standard is available to quote, and none is invented here, so the consequence for practice is taught instead.

A frail brain needs a small insult	The baseline is the instrument	Discharge is not the day to certify recovery
WHY AN INFECTION A YOUNGER PATIENT ABSORBS SILENTLY DECLARES ITSELF AS CONFUSION IN AN OLDER ONE	THE ACUTE CHANGE IS ESTABLISHED FROM SOMEONE WHO KNEW THE PATIENT, NOT FROM THE STATE IN FRONT OF YOU	THE NOTE CARRIES THE PREMORBID BASELINE AND AN ARRANGED REVIEW, NOT A JUDGEMENT MADE ON THE DAY

What the discharge summary carries decides whether any of this survives the admission. These entries are worth insisting on, and none is standard:

- that an episode occurred, named as such, with its dates and precipitant, because a summary recording only the treated infection loses the cognitive event;
- the premorbid baseline established, and from whom, so the next clinician has the comparison you had;
- whether cognition at discharge had returned to that baseline, was short of it, or could not be assessed, with an arranged review rather than a reassurance.

21.7 What this section decides, and what it hands on

The boundaries are worth stating plainly. The syndrome itself, with its criteria, subtypes, instruments, causes, treatment and prevention measures, is set out in the Stroke, TBI, delirium and focal brain syndromes notes. Prescribing belongs where psychopharmacology in later life is dealt with, and the structured assessment these vulnerabilities are measured inside belongs where the comprehensive geriatric assessment is dealt with.

What is left is the reasoning: an examiner who gives you an older patient with new confusion is testing whether you can say what made this brain vulnerable before the illness arrived, what small thing was enough to tip it, how you would establish that anything had changed, and what you would arrange for afterwards. Answer in that order, from reserve to precipitant to baseline to outcome, and the entity looks after itself.

> Delirium in the elderly is a statement about reserve as much as about the illness that triggered it: establish the baseline from someone who knew it, read the drug chart as part of the examination, restore the hearing aid and spectacles before testing, and hand the episode on in the discharge note rather than closing it on the day.

22 · Pseudodementia versus dementia (depression in the elderly)

Why a comparison settled elsewhere still needs an address. The heading is set as pseudodementia versus dementia (depression in the elderly), and it names a discrimination made at the bedside, quickly, before any specialist service has seen the patient. The construct is **depressive pseudodementia**: a depressive illness in an older person whose presenting complaint is of failing memory, concentration and intellect, set beside a degenerative process capable of the same appearance. Its features, the formal differentiation from a true dementia, and the discriminators laid out side by side are given in the Dementias and neurocognitive disorders

notes and in the Mood disorders: pharmacotherapy notes. Neither is condensed here: a shortened comparison competes with the full one.

Those accounts do not use the same name for it, and no preferred term is adopted here; the label is settled where the construct is taught. What is owed at this address is what no comparison table carries: who makes the call and in what setting, what the error costs in each direction, and what the consultation must produce when it cannot answer on the day.

22.1 Both errors are available, and they do not cost the same

Reading a depressive illness as a degenerative one withholds a treatment that could return the person to their previous level, and it does more: the household is told to expect decline, the plan turns custodial, and the **provisional label** in the first case sheet is seldom reopened by whoever reads it later. The opposite error, reading an early degenerative process as depression alone, is not harmless either: the safety review, the driving and financial conversations and the family's preparation are all deferred while a treatment is given time to work.

The pair is not symmetrical, and the asymmetry is the examinable point: the depressive possibility must be actively excluded rather than hoped for, because it is the only member in which the deficit may lift. That is about the order of the work, not the odds.

RULE **Where the two cannot be separated at the first sitting, treat the reversible possibility and name the date on which the answer will be read.** The discrimination is often completed by what happens over a treated interval, not by anything a single examination yields, so a consultation closing with a verdict and no review point has answered a question nobody asked.

22.2 How the question reaches you, and whose account decides it

The request almost never uses the word. It arrives as a son saying his father has become forgetful since the mother died, or as a medical unit wanting an opinion before a discharge the family is resisting. What is tested is whether you notice the question is available at all: the referral names a deficit, and the referrer has already decided which of the two it is. A third possibility is easily lost between them: an **acute confusional state** gives a similar appearance, and it is taken up where delirium in later life is dealt with here.

Whose account settles it is decided before the examination, not during it. An older patient's own report of their memory cannot close the question alone, so the household's version is not corroboration but a second history, separately sourced and recorded. Where the family has already named the illness, that naming is itself clinical material: it tells you what they will agree to. Three things belong in the note before the cognitive examination begins.

- Who gave each part of the history, and which parts rest on the patient alone.
- What has already been named to the family, by whom, and what they have stopped expecting.
- Who will bring the patient back for review, and whether they are able to.

IN INDIA

Most districts have no memory service to refer to, so the discrimination is made, and then owned, by whoever the family reached first. The provisional label travels onward in a case sheet the family carries, and the next consultation is often with a different clinician in a different hospital, so nobody is placed to revise it: **diagnostic inertia** here is a property of how care is delivered, not of anybody's carelessness. The two words also land differently in a family's hearing, one as a terminal sentence and the other as weakness of character, so the review appointment must be explained as part of the diagnosis, not offered as an optional return. What proportion proves reversible, and how much old-age provision exists to refer to, are not quantified: no comparable standard is available to quote, and none is invented here.

22.3 Where each part is taught, and how the heading is set

WHAT IS BEING ASKED FOR	WHERE THE FULL ACCOUNT SITS	WHAT THESE NOTES ADD
The construct, its features, and the formal differentiation from a true dementia	**the Dementias and neurocognitive disorders notes**	Nothing; the reader is sent
The discriminators side by side, inside the depressive illness they belong to	**the Mood disorders: pharmacotherapy notes**	Nothing; the reader is sent
Cognitive instruments and their scoring	**the Psychotherapies, clinical assessment, MSE and nosology notes**	The workup they sit inside, with geriatric assessment here
The acute confusional state as the third possibility	**the Stroke, TBI, delirium and focal brain syndromes notes**	What age contributes, with delirium in later life

As a short note the marks sit in the comparison, so answer it from the owning account rather than improvising at the desk. As a viva or long case it is never asked in the abstract: an older patient with a cognitive complaint and a mood history is put before you, and the examiner watches whether both possibilities survive to the end. What scores is a fixed order.

- Name both possibilities, and the third one, before examining for either.
- Say whose history you took for each, and what you could not obtain.
- Close on the treatment you are starting and the date the label will be tested.

TRAP **Reproducing the comparison and stopping there.** Candidates make it because the side-by-side account is compact, memorable and the part that was revised, so it feels like the answer. What it produces is an answer with no decision in it: no treatment begun, no informant named, no date at which the label is tested.

GOOD TO REMEMBER

Write the review date in the same sentence as the provisional diagnosis, in the case sheet the family carries. A label with a date invites the next clinician to test it; without one it reads as settled, and where that clinician is a stranger, this is the difference between a diagnosis and a verdict.

Named and handed on	Excluded, not hoped away	A date, not a verdict
WHAT THESE NOTES DO WITH THE COMPARISON ITSELF	HOW THE TREATABLE MEMBER OF THE PAIR IS HANDLED	WHAT THE CONSULTATION IS OBLIGED TO PRODUCE

The comparison is read in the Dementias and neurocognitive disorders notes and in the Mood disorders: pharmacotherapy notes; what is decided here is that the treatable possibility is excluded rather than hoped away, and that the provisional label leaves the room with a date on which it will be tested.

Culture and the explanatory model

23 · Concepts of culture, illness and culture-bound syndromes

Why a heading whose framework is taught elsewhere still carries marks. This heading asks for a vocabulary before it asks for anything clinical, and the vocabulary was rebuilt once already. DSM-5 moved from **culture-bound syndromes** to **cultural concepts of distress**, an umbrella that holds **three** distinct ways culture shapes suffering rather than only the syndrome-shaped one. That framework is taught in full, with its definitions, its worked examples and the assessment instrument built on it, in the Psychotherapies, clinical assessment, MSE and nosology notes. Nothing here repeats it, and an answer that stops at the framework has recited a vocabulary and left the clinical question untouched.

What is left over is what these notes owe. A concept of illness is not general knowledge sitting beside the diagnosis: it decides what counts as a symptom, who is entitled to describe it, and which account of the cause a clinician has to work with before any treatment is accepted. That is a consultation problem, and it is examined as one.

23.1 Where the framework is taught, and what is deliberately not repeated

The umbrella's parts are a **cultural syndrome**, a **cultural idiom of distress** and a **cultural explanation** or perceived cause. Each is defined, discriminated from its neighbours and illustrated in those notes, alongside the classic named syndromes as a definitions list and the structured formulation that elicits all of it. This section names the parts and stops there, because a compressed definition is a worse version of a definition that already exists, and because the reader who needs the definitions needs them in one place rather than in competing versions. The argument the classification made for the change is set out with the framework and is not restated here, in any shortened form.

RULE **Name the umbrella before you name an example.** An examiner who asks about concepts of culture, illness and culture-bound syndromes is asking whether you hold a framework, and the exotic examples are the part of the answer that needs no help. A candidate who opens with a roster of syndromes has answered a question about content with a question about geography, and has to be led back to the framework by the examiner, which is the only part of the exchange that is ever remembered.

WHAT THE READER IS LOOKING FOR	WHERE THE FULL ACCOUNT SITS	WHAT THESE NOTES ADD
The terminology shift, and the parts of the umbrella	**the Psychotherapies, clinical assessment, MSE and nosology notes**	Nothing. It is named here and handed on
The classic named syndromes, as definitions	**the Psychotherapies, clinical assessment, MSE and nosology notes**	How such a presentation actually arrives, and the negotiation that follows it
Dhat syndrome, at length	**the Somatic-symptom, sexual, impulse-control disorders and suicide notes**	Named here only as the one most likely to arrive in an Indian clinic
The cultural formulation and the interview built for it	**the Psychotherapies, clinical assessment, MSE and nosology notes**	Where it belongs inside an assessment done in a general hospital
Migration, ethnicity and acculturation	**These notes, in full**	The whole of it, since it sits with the encounter and not with the taxonomy

23.2 What a chapter that owns the encounter does with culture instead

The organising question. Every other heading in psychiatry teaches what a thing is. These notes teach who asks, in whose ward, what changes with age, whose account of the cause is already in the room, and how an examiner asks for all of it. Culture enters that scheme not as a topic but as a seam that runs through the rest of it, which is why the concept is named here and then reappears, in clinical form, wherever it does work. It reappears in these notes as:

- the encounter with the classic presentations, meaning how such a presentation actually walks into a clinic and how the negotiation with a family that has already settled on an explanation is conducted;
- the structured formulation and its interview, placed where an assessment would reach for them rather than taught again;
- the patient's vocabulary for suffering, and the account of cause that vocabulary carries;
- migration, ethnicity and acculturation, which these notes carry in full;
- religion, spirituality and the healing that happens before the clinic is ever reached.

GOOD TO REMEMBER

Before writing a cultural label into the record, ask what the label changes. If it changes nothing about the plan, it is a description and not a diagnosis, and the note still has to name the disorder being treated and the account of cause being worked with. A record that says only that the presentation was cultural has documented the clinician's impression of the patient's background and no decision at all.

23.3 How the heading is asked, and the order the answer takes

Asked as a short note or a viva opener, this heading rewards a sequence rather than a store of examples: the current umbrella and why it replaced the older term, the parts it holds, the address of the definitions if a definition is wanted, and then the move to the encounter, where the marks for judgement sit. Asked as a long question, it is almost never asked alone. It arrives attached to a case, and the concept is the frame the case is read through, so the candidate who has treated the framework as a glossary has nothing to say when the case turns out to be a treatable disorder wearing an unfamiliar explanation.

TRAP **Answering a question about concepts with a catalogue of syndromes.** The catalogue is memorable, regionally exotic and easy to revise, while the framework is abstract and easy to skip, so the catalogue is what surfaces under pressure. The same error runs the other way in the clinic: a name is attached, everyone relaxes, and the assessment stops at the point where it should have begun.

IN INDIA

The older vocabulary is still the working vocabulary here. It survives in teaching, in ward usage and in the wording of examination questions, so a candidate meets the superseded label and the current umbrella in the same viva and needs fluency in the relationship between them rather than loyalty to one. Expect the examples to be Indian and the expectation to be that you move from the term to the clinic, since a roster recited to an Indian examiner invites the follow-up question of what you would do with the patient in front of you.

Named and handed on	Definitions elsewhere	The encounter
WHAT THIS SECTION DOES WITH THE FRAMEWORK	WHERE A DEFINITION IS TO BE READ	WHAT THESE NOTES ADD IN ITS PLACE

Cultural concepts of distress is the current umbrella and it replaced culture-bound syndromes, which covered only the syndrome-shaped part of it; the definitions and examples belong to the Psychotherapies, clinical assessment, MSE and nosology notes, and what these notes add is the encounter the concept is used in.

24 · Culture-bound syndromes (dhat, koro, amok, latah and others)

Why the encounter is examined here and the definitions are not. No group of headings is memorised as reliably, or handled as badly, as the culture-bound syndromes (dhat, koro, amok, latah and others). A candidate can produce the roster on demand and then have nothing to say when one of them is sitting across the table, because a name is worth little in a clinic: it tells you what the patient calls his trouble, not what he has, what he has already swallowed for it, or who sent him. The definitions, the umbrella term that replaced the older one, the classic list and the placement of these presentations in the classifications are taught in the Psychotherapies, clinical assessment, MSE and nosology notes, and dhat syndrome at length, with its figures and its

management, in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. None of that is rebuilt here.

What is left over is the clinical encounter, and it holds both the marks and the mistakes: which door such a presentation comes through in India, what the man and his household already believe by the time a psychiatrist meets them, how a negotiation between two accounts of one complaint is conducted, and what arrives that the classic list never mentions. One discipline runs through all of it. The Indian evidence here is a few single-centre clinic series and individual case reports, so every figure in this field is a proportion of the people who attended one clinic, and the honest answer teaches a method rather than a set of rates.

24.1 Which door it comes through, and why the psychiatrist is not the first clinician

Begin where the patient begins, because the **help-seeking pathway** explains most of what looks puzzling about these presentations. The Indian phenomenological description this section leans on studied **100** men, and it did not recruit them from a psychiatry outpatient department at all: they were attending a sex and marriage counselling clinic run from a community medicine department at a single tertiary centre in New Delhi, and the work was published in the Indian Journal of Psychiatry in 2016. Its method is as instructive as its findings. The investigators ran focus groups with specialists in dermatology, community medicine, medicine, surgery and endocrinology, and when focus groups with traditional practitioners proved impossible to assemble, interviewed three ayurvedic and two homeopathic practitioners individually. Read that as a map of the doors this complaint knocks on before it reaches you.

The other two Indian reports say the same thing from different directions. A pair of cases of **anthropophobia** reached an obsessive-compulsive disorder clinic rather than a general psychiatry clinic, and a man with a koro-like presentation and dhat was assessed, and re-assessed, before the treatable disorder underneath was identified. By the time a psychiatrist sees such a patient, several other people have already explained it to him, so the psychiatric account is not the first one offered but a competing one arriving late.

One methodological detail of the clinic series has to travel with it, because it is a trap in both directions. Psychotic illness was an exclusion criterion, so anyone whose conviction might have reached delusional intensity was screened out before the study began. That bounds what the series describes, and it also means this sample cannot be used to settle the argument about whether such an attribution is a belief or a delusion. That argument belongs with the definitions and is taken up there.

24.2 What he has already been told, and what he has already taken

Where the belief was learned is a clinical fact, not an anthropological one, because it tells you who else has to be persuaded. The same clinic series records that this knowledge is acquired from friends, relatives and colleagues, from roadside advertisements and lay magazines, and from Hakims and Vaids. Not one of those is a clinician in the sense a hospital uses the word, and every one is more available, cheaper and less humiliating to consult than an outpatient department.

The **Hakims and Vaids** in that list are practitioners with their own coherent systems, their own diagnostic vocabulary, and a treatment they will hand over at the first visit.

The second half of that record is what patients themselves count as cures, and it is the more useful half. Reported **perceived cures** run from desi medicines and herbs, and the advice of Hakims and Vaids, through dietary correction with protein-rich and iron-rich food, B-complex tablets or injections, antibiotics, anti-anxiety drugs and aphrodisiacs, to marriage itself. Look at the two ends of it. An injection is the most concrete thing a patient can be given. Marriage is not a prescription a clinician can write and is very often one the family has already written. So he arrives with a settled expectation that something energising will be supplied, and with a household committed to a plan of its own.

How commonly that expectation is held, and in what proportion of such patients, is a figure this account will not give you: no comparable standard is available to quote, and none is invented here. The qualitative fact is enough to work with, and it is the part that changes the consultation.

IN INDIA

The parallel market is not a curiosity at the edge of the case, it is the referral pathway. A roadside advertisement, a lay magazine and a neighbouring practitioner have between them supplied a diagnosis, a mechanism and a treatment before you are consulted, at a price already paid. Two questions belong in the first interview and are almost never asked: who did you consult before coming here, and what did they give you. The answers name what has already failed, what the family counts as a real treatment, and whatever is currently being swallowed. A record stating that the patient is on no medication, when he is taking a tonic and tablets bought over a counter, is inaccurate in a way that matters.

24.3 The family's account, and why you ask for it rather than assume it

The family is not an accompanying party in these presentations, it is usually the referrer. In the Delhi report of anthropophobia, the man managed the problem himself by avoidance, and the change that produced a consultation was functional: he stopped going to work, and it was his family who noticed and who brought him to the clinic. That is the ordinary Indian route into psychiatric care in one sentence. Distress alone does not generate a referral; loss of role does, and the person who converts it into an appointment is a relative.

It follows that the household arrives with an account of the illness already formed, and that the account is a clinical object rather than background colour. What is not available is any measurement of it. Nothing here establishes what proportion of Indian families holds a biomedical explanation, whether families commonly hold several explanations at once, whether a non-medical account predicts a worse outcome, or whether it predicts that the tablets get taken. Those are exactly the propositions a clinician feels certain about. So the instruction below is argued as good practice, from the structure of the encounter, and must not be dressed up as an evidence-based intervention in an answer.

MNEMONIC

Where did you hear it? What have you taken? What do you want me to do?

Three questions, asked in that order, before any explanation is offered. The first locates the source of the belief and therefore who else holds it. The second uncovers the treatments already tried, which is both a history of failure and a current drug history. The third surfaces the expectation you are about to disappoint, which is the single most useful thing to know before you speak, because an expectation that is named can be negotiated and one that is not simply ends the consultation at the door.

24.4 Conducting the negotiation

The consultation is a meeting of two accounts of one complaint, and the psychiatric account has the less authority in the room. The patient and the practitioners he has already seen understand the trouble as a bodily disorder; the **allopathic** clinician he has now reached understands it as a psychological one. Neither party is unreasonable, and the encounter fails when the difference is treated as ignorance to be corrected first and treated afterwards. A workable sequence looks like this.

- Examine him. The complaint is bodily, and a physical examination that is skipped tells the patient more clearly than any sentence that you did not take it seriously.
- Take the history of what has already been consulted and consumed before you offer any account of your own, so that your explanation lands after his rather than instead of it.
- Do not open by correcting the belief. Correction at the first meeting costs the follow-up and buys nothing, because the belief is held by people who are not in the room.
- Say what you will do and, explicitly, what you will not do. A tonic or an injection given to satisfy the model purchases this consultation and sells the next one, since it confirms that the complaint was the kind of thing an injection treats.
- Name in the record the disorder you are actually treating, and treat it. Where the pathway has already passed through a temple, a shrine or a healer, the negotiation with that part of it is taken up in these notes under religion, spirituality and faith healing.

RULE **The name tells you what he calls it, not what he has.** A culture-named presentation is a presentation and not a diagnosis, so attaching the name completes nothing. The task after the name is the ordinary one: identify the treatable disorder, if there is one, and the expectation that will decide whether treatment is accepted. An answer, or a note, that stops at the name has recorded the patient's vocabulary and made no decision. This is also the axis the long essay is marked on, because the roster is the part that needs no help.

GOOD TO REMEMBER

Four things belong in the note and are usually missing from it: the patient's own words for the complaint, his account of what caused it, what he has already taken and from whom, and the sentence in which you told him what you would and would not prescribe. The last matters most at the next visit, because a patient who does not return has usually been refused something without being told what he was offered instead, and the clinician who sees him next cannot know that unless it was written down.

24.5 The long tail: what walks in that the roster does not list

The classic list is a list of names collected historically, not a census of what presents. The clearest Indian demonstration is a case series from Delhi, published in the Indian Journal of Psychological Medicine in 2021, reporting **two** cases of anthropophobia, a presentation classically indexed to Japan. Its authors state that to their knowledge no such case had previously been reported in the Indian context, and that hedge is theirs and should survive into any use you make of it: it is a statement about the reported literature, not about how often this occurs. Two cases license an existence claim and a narrative of how they reached care. They license nothing epidemiological whatever.

The teaching point carries into any question on this heading. The name records where a presentation was first described and described often, which is a fact about the history of psychiatry rather than about the distribution of human distress. Presentations cross those boundaries, and an Indian clinic meets what the roster does not list.

The Indian literature also carries its own named presentations outside that roster, and the Psychotherapies, clinical assessment, MSE and nosology notes name suchi-bai, the ascetic syndrome, nuptial psychosis and jhinjhinia. They are named here and nothing more is said about them. No phenomenology, no region, no sex distribution and no frequency is offered for any of the four: no dependable account of them is available to quote, and none is invented here. This is precisely the material that gets written from memory, with great confidence and no basis.

THE INDIAN REPORT	WHERE IT PRESENTED	HOW HE REACHED IT	WHAT IT CAN CARRY, AND WHAT IT CANNOT
A clinic series of 100 men, tertiary centre, New Delhi	A sex and marriage counselling clinic run from a community medicine department, not a psychiatry clinic	**Attending a non-psychiatric clinic; psychotic illness was an exclusion criterion**	The information ecology and the expected remedy. Not a population rate, and not the question of delusional conviction, since those patients were excluded
A case series of two, Delhi	An obsessive-compulsive disorder clinic	**Managed alone by avoidance, then noticed by relatives, then brought in by the family once he stopped working**	That a presentation crosses the boundary it is named for, and the Indian route into care. Nothing epidemiological
A single case letter, rural West Bengal	Assessed with two culture-named presentations at once	**Comorbid obsessive-compulsive disorder emerged only on an unscheduled review**	That these presentations ride on ordinary disorders. Not a description of the epidemic itself, which reaches this account second-hand

24.6 They ride on ordinary disorders, and the first assessment can miss it

The most useful single Indian case in this area is a letter from rural West Bengal, published in the Indian Journal of Psychiatry in 2020, describing one man who presented with two culture-named complaints together and in whom obsessive-compulsive disorder was camouflaged at the initial examination by those complaints and detected only on a later, unscheduled review. Two things in that sentence are worth more than the diagnosis itself: the comorbidity was present from the start and was not visible, and what made it visible was a second look rather than a better first one.

The authors also record that what the man showed was **koro-like** rather than classical, which is the ordinary situation and not the exception. Textbook descriptions are drawn from the clearest published cases; clinics see partial, mixed and attenuated versions, and a presentation that fails to match the description is not thereby excluded from being one. They set the case against an epidemic background they date to 2010 and describe as involving several Indian states. That background is stated here as their attribution: the epidemic report itself is not available to this account, so the epidemic is not asserted as a free-standing fact and its extent is not quantified.

Their recommendation follows, and its authority has to be carried with it. The authors of that letter state their belief that all koro and especially koro-like cases with a subacute or chronic presentation should be screened for the obsessive-compulsive spectrum. That is the opinion of a case report, carrying the modal verb its authors chose. It is worth acting on and it is not a guideline, and the difference is examinable. Obsessive-compulsive disorder itself, its assessment and its treatment, belongs to the Anxiety, OCD and trauma-related disorders notes.

TRAP **Treating the culture-named presentation as the whole diagnosis and stopping the assessment there.** The name is satisfying, it explains the striking part of the history, and once it is attached everyone in the room relaxes, including the clinician. Meanwhile the treatable disorder sits underneath it and can be invisible at a first assessment. In the exam this is an answer that describes a syndrome beautifully and never mentions screening for comorbidity; in the clinic it is a patient who was labelled, reassured and not treated.

24.7 What a number in this literature can bear

The discipline that separates a safe answer from a confident one. Every figure available in this field is bound to the group it was counted in, and the **denominator** is part of the number rather than a footnote to it. The clinic series above is 100 men attending one clinic at one tertiary hospital, so what it describes is that clinic's attenders and no wider group. The boundary-crossing report is two cases. The comorbidity report is a single letter. Where a proportion for dhat is quoted in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, it is a proportion of men attending clinics and not a rate in any population.

Say that plainly in a viva. A candidate who states that a figure describes clinic attenders rather than a population, and then declines to convert it into a prevalence, has shown exactly the judgement the question is testing.

100 men, one clinic	Two cases	One case letter	No population rate
THE INDIAN PHENOMENOLOGY SERIES THIS ACCOUNT RESTS ON, AND ITS WHOLE DENOMINATOR	THE INDIAN REPORTED EXPERIENCE OF ANTHROPOPHOBIA AT THE TIME OF THAT REPORT	THE EVIDENCE FOR CULTURE-NAMED PRESENTATIONS RIDING ON A COMORBID DISORDER	WHAT NONE OF THOSE DENOMINATORS CAN BE CONVERTED INTO

PITFALL

Do not print a prevalence for a culture-named presentation, in an answer or in a note. Nothing available here samples a population: the sources are clinic attenders, a pair of cases and a single letter, and a number from any of them describes the people who walked through one door. The error is attractive because a percentage looks like scholarship, and because the figure quoted is usually a real number lifted out of its denominator. Asked where it comes from, you will produce either the denominator or silence, and silence costs more than quoting nothing.

24.8 How the heading is asked, and what an essay needs from here

This heading is asked in three recurring forms, and they want different things. As a full essay it appears as a bare instruction to discuss the culture-bound syndromes, which a western-India state health-sciences university has set in that bare form in 2011, 2015 and 2017. As a shorter question it appears as an instruction to enumerate them and then describe dhat syndrome in detail, set that way by the same university in 2013 and 2018. And it appears as a short note on the heading alone, set in 2017.

The enumeration and the detailed account of dhat are the parts that come from elsewhere. The list of classic syndromes with their definitions is in the Psychotherapies, clinical assessment, MSE

and nosology notes, and dhat in full, including its figures, its classification and its management, is in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. Those two chapters will carry the first half of a short question by themselves.

What they will not carry is the essay, because an essay answered entirely from them is a glossary with an introduction and is marked as one. This section is the second half of that answer and the part that separates candidates: the doors these presentations come through in India, the information ecology behind the belief and the remedies already tried, the family as referrer and its own account, the negotiation and what is put in the record, the comorbid disorder that must be looked for a second time, the presentations that cross the boundaries they are named for, and the denominator discipline that stops an answer ending on an invented rate. Let the definitions occupy the essay's opening rather than its body, and spend the body here.

Expect two follow-ups. Asked what you would actually do with such a patient, do not answer with a classification: answer with the sequence, examination first, elicitation of what has been consulted and consumed second, explanation third. Asked what is contested, say that the boundaries the names imply do not hold, that those who report these cases recommend screening for comorbidity, and that the Indian evidence is too thin for any prevalence to be quoted from it.

> These presentations reach an Indian psychiatrist late and through non-psychiatric doors, with a belief learned from family, advertisements and traditional practitioners, a course of energising remedies already taken, and a family that referred him when he stopped working; the name is his word for the complaint and not a diagnosis, the treatable disorder underneath it must be looked for a second time, and every figure in this literature is a proportion of one clinic's attenders rather than a rate in any population.

25 · Cultural formulation and DSM-5 cultural formulation interview

Why an instrument taught in full elsewhere still has to be placed here. The heading cultural formulation and DSM-5 cultural formulation interview names two things, and candidates routinely merge them into one. The **Outline for Cultural Formulation** is the organising outline that tells an assessment what it must account for; the **Cultural Formulation Interview** is the instrument built to gather that material from the patient at the bedside. Their domains, the core question set and the additional modules that extend it for particular populations are set out in full in the Psychotherapies, clinical assessment, MSE and nosology notes, and no part of that account is repeated here.

What is owed here is the part no instrument manual supplies. A structured formulation is worth only what its placement in a real consultation is worth: who is actually asked, what survives when the clinic offers far less time than the full instrument assumes, and what has to reach the record for the exercise to have changed anything. That is also where the marks sit: a memorised roster of domains takes one sentence to deliver and demonstrates nothing.

Outline, then interview
THE TWO SEPARATE THINGS THIS HEADING NAMES

Taught in full elsewhere
WHERE THE DOMAINS AND THE QUESTION SET ARE SET OUT

Placement and use
WHAT THESE NOTES ADD IN THEIR PLACE

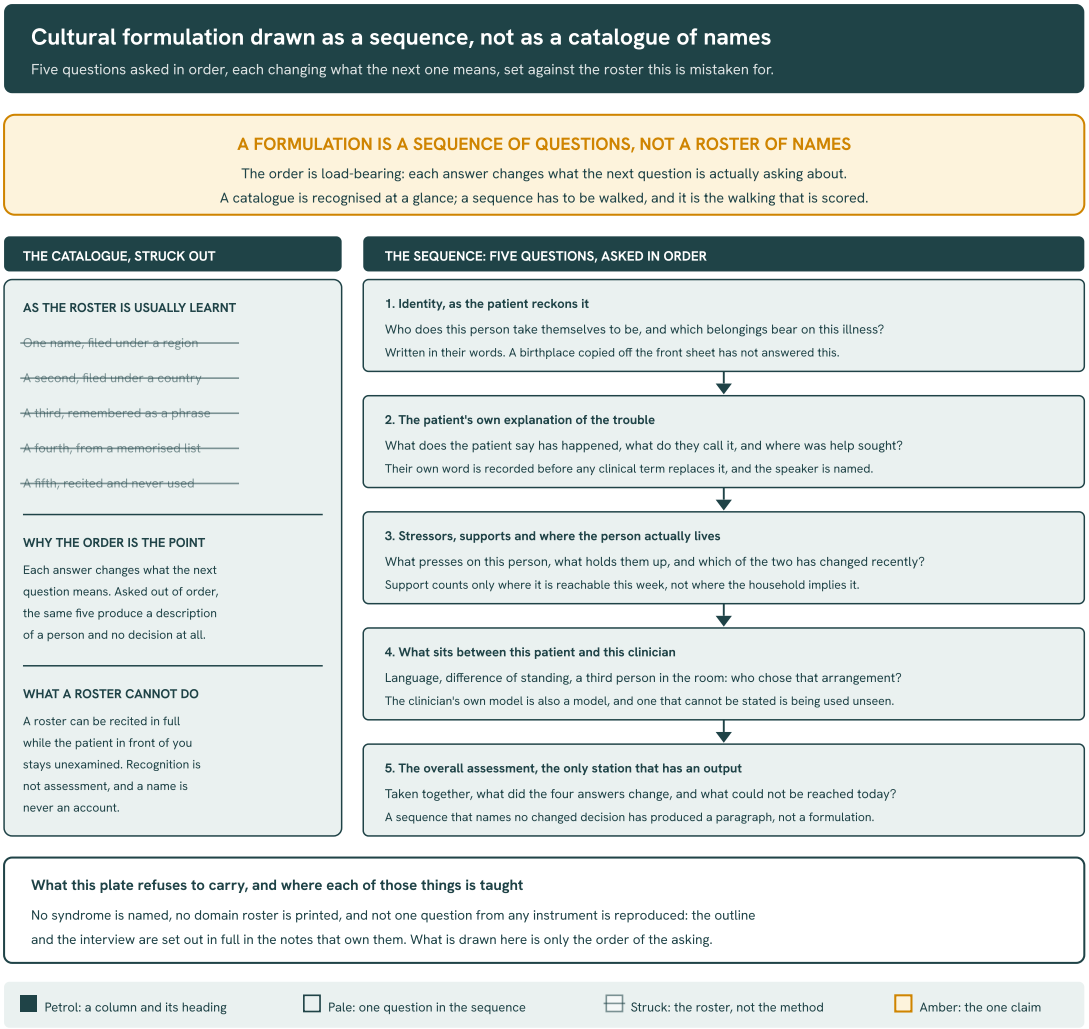


Fig 29.7. The cultural formulation drawn as five questions asked in a fixed order, from who the patient takes themselves to be, through their own account of what has happened, the pressures and the supports that are actually reachable, and what stands between this patient and this clinician, to an overall assessment that is the only station obliged to produce a changed decision, the whole set against a struck-out roster of names to show that a catalogue is recognised while a sequence has to be walked, with no syndrome named and no question from any instrument reproduced.

25.1 The outline, the interview, and the address of the full account

The outline and the interview are one construct in two forms, and the division between them decides where each belongs in a working assessment. The outline is the shape the written formulation takes, which puts it beside the **diagnostic formulation** rather than inside the history. The interview is the means of obtaining what the outline asks for, which puts it inside the assessment, before any formulation can be written. Everything that follows from that division is taught once and in one place; a compressed copy carried here would be the dangerous version,

not the convenient one. A half-remembered outline reliably produces the same failed assessment: the clinician asks the patient where they are from, records the answer, and files it as a cultural assessment.

25.2 Where the formulation belongs inside a working assessment

The placement is the whole of the difficulty. Two errors sit at opposite ends of it. The first treats the formulation as a supplement written after the plan is settled, so it is decorative and everybody knows it. The second treats it as a substitute for diagnosis, so a treatable disorder is admired as a cultural presentation and left untreated. The instrument is neutral between them; the clinician's placement of it is not.

RULE **The cultural formulation is appended to the diagnostic formulation, never substituted for it, and it must name the one thing in the plan that it changed.** Without a named consequence the exercise cannot be audited, by an examiner or by the clinician who inherits the patient. If the account genuinely changed nothing, write that too: a recorded negative tells the next reader the question was put, and a silence tells them nothing.

Whose account is being taken is the second decision, and it is settled before the first question, not during the interview. The patient's own account and the family's are frequently different, and the difference is often the clinical material. Where the interview passes through a relative, that relative is at once informant, interpreter and a stakeholder in the explanation, so the **collateral account** and the patient's cannot be recorded as one voice. Time forces the third decision. When the full instrument cannot be administered, the honest compromise is not to shorten every part equally but to take the questions whose answers could change what you do, and to record what was left undone.

POINT IN THE ENCOUNTER	WHAT THE CULTURAL ACCOUNT CHANGES THERE	WHAT THE NOTE MUST CARRY
Before the first question	Who will speak, in which language, and who chose that arrangement	Who interpreted, and their relationship to the patient
The complaint	Whether the patient's word for the trouble and the clinician's word mean the same thing	The complaint quoted, before it is translated into a symptom
The account of cause	What the patient and the family believe has happened, and where help was sought before this clinic	The **explanatory model** as given, and who in the room holds it
The plan	Whether an agreed plan can survive contact with the explanation the family already holds	What was negotiated, what was declined, and the review point

IN INDIA

The instrument assumes a patient who speaks for himself, in his own language, to a clinician who shares it. In a general hospital clinic here the family commonly speaks first and speaks most, the interview is often conducted in a second or third language for one or both parties, and a healer or a shrine has often been reached before the outpatient department was. None of that makes the formulation less usable; it makes the sourcing of each account the thing that must be written down, because a record that merges patient, relative and interpreter into one narrator cannot afterwards be untangled. A national protocol setting out how these instruments are to be used, translated and validated in Indian practice would settle several of these questions; no comparable standard is available to quote, and none is invented here.

25.3 What the examiner is actually scoring

As a short note it is a definition question with a practical tail, and the tail is where the discrimination shows. As a long case or a bedside station it is never asked in the abstract: a patient whose account of the illness is not biomedical is put in front of you, and the examiner watches whether the assessment bends around that account or ignores it. The answer that scores runs in a fixed order.

- Name both, and say which is the outline and which the interview.
- Place the formulation beside the diagnostic formulation, and say what it is for.
- Name whose account you obtained, and whose you did not.
- State what the account changed in the plan.
- Say what you could not complete, and when it will be finished.

GOOD TO REMEMBER

Record the parts of the formulation you did not reach, by name. A partial formulation that says so is usable by the next clinician; one that does not is indistinguishable from a completed one with negative findings, and the missing questions are then never asked at all.

TRAP **Reserving the formulation for the visibly different patient.** Candidates make this error because the instrument is introduced with unfamiliar examples, so it is filed as a tool for other people's patients. The consequence is that the majority-culture patient's account of cause is never examined, and the clinician's own model is treated as though it were not a model at all. Every patient arrives with an explanation; the only variable is whether the clinician noticed that it differed from his own.

Name the outline and the interview separately, obtain the account before the plan rather than after it, source it to the person who gave it, and write down the one decision it changed.

26 · Migration, ethnicity and mental health

Why this sits in a transcultural chapter and not in an aetiology one. Migrant status is one of the most reproducible social signals in psychiatric epidemiology, and one of the most abused. The

figures are quoted as though they described a mechanism, and attached to patients whose move bears no resemblance to the moves that generated them. The cultural concepts of distress themselves, and the cultural formulation built to elicit them, are taught in the Psychotherapies, clinical assessment, MSE and nosology notes; what belongs here is the frame around them, the epidemiology of the transcultural axis, migration and acculturation, which is to say who moves, why they move, what the population figures license, and what changes in the room when the person in front of you has had their social world reorganised by a move. Migration, ethnicity and mental health sit in one section and not three, because the literature that raises the question uses the three words almost interchangeably and the clinic has to take them apart again.

One seam runs through the whole topic and decides most of the marks: the epidemiology that makes migration famous is host-country epidemiology, and the Indian answer is not inside it. So this account teaches the reasoning and the frame, and it does not put a risk multiple on the page in either direction: no dependable figure for the risk of psychotic illness in migrants is available to quote, and none is invented here.

26.1 What the migration question is actually asking

Migration is not a state a person is in, it is a process a person has been through, and the psychiatric question separates into parts a history has to answer independently. Who left, and what were they like before they left. What the leaving and the journey consisted of, including whether it was chosen. And what the arrival is like now, which is usually where the illness sits. Collapsing them is the commonest error in a formulation, because each supports a different causal story and only the third is modifiable by anything a clinician does.

The word also covers movements with almost nothing in common. A doctor who takes a post in another country, a woman who moves into her husband's household in the next district at marriage, a seasonal labourer who spends most of the year on a construction site in another state, and a person who has fled and cannot return are all migrants. They differ in whether the move was chosen, whether it can be reversed, whether the family moved with them, whether language and food and worship changed, and whether they are legally secure where they now live. Any of those differences can plausibly matter more than the fact of movement, which is why "migration" on its own is a poor formulation term and a good screening question.

RULE **Migrant status is an epidemiological signal, not a mechanism and not an explanation.** A raised rate in a migrant group tells you where to look and nothing about what to look for. The clinical work is to name which of the many things bundled inside the word applies to this patient: a selection effect operating before departure, a loss sustained during the move, a social position occupied after arrival, or a diagnostic process happening in front of you. A formulation that stops at "migrant, therefore at risk" has taken an epidemiological label and used it as a substitute for the history.

26.2 What the international literature establishes, and what it does not

Migration has been treated in the international psychiatric literature as a risk factor for psychotic illness for decades, and the claim is made in two places at once: for people who moved, and for

people born in the host country to parents who moved. That is the shape of the finding, and no magnitude is attached to it here for either generation.

That is a more useful position than it looks, because it lets the frame be taught instead of the digits. Four things bound any such figure and none is optional: which diagnosis was counted, since an estimate for schizophrenia and one for all non-organic psychotic disorders are different quantities; which host countries the studies were done in; which generation it belongs to; and how wide the interval was, since an estimate resting on a handful of studies can be compatible with a risk barely above the population and with one many times it. A multiple recited without those four is a decoration.

The argument that changed the field concerns **second-generation migrants**. Those people did not migrate: their exposure is being the child of migrants rather than the act of moving. A purely selective account predicts that the signal belongs to the generation that left and fades in the children who never did. Raised risk is discussed in that second generation as well, which is why the field moved from arguing about who migrates to arguing about what happens after arrival. The reasoning is what an examiner listens for: a signal in people who never moved is not explained by selection at departure. What it cannot do is size that risk, and an answer that makes the second generation the higher one has gone past what can be shown.

One feature of the sampling frame belongs with the claim wherever you meet it. Those studies concern international migration into predominantly Western, high-income host countries, so what is counted is the crossing of an international border into a society in which the arriving group is a visible minority. That bounds what they are estimates of, and it is what decides the Indian question.

26.3 Ethnicity: what the second word is doing, and what it marks

The second word in the title does different work from the first, and candidates treat the two as synonyms. Migration is an event and it has a date. **Ethnicity** here is a position a person occupies in the society they are currently in, meaningful only relative to that society: the same person is majority in one place and minority in another. So when a host-country literature reports higher rates in some migrant or minority groups than in others, the comparison is not between kinds of people. It is between kinds of position.

Two disciplines follow. A subgroup contrast inside a pooled literature is the weakest thing that literature produces: groups were not randomised into their origins, studies differ in how cases were found, and the diagnostic habits of host-country services differ by the ethnicity of the patient in front of them, so a subgroup difference can be manufactured by the measuring instrument rather than found in the risk. No subgroup magnitudes appear here, for that reason and because none is available to quote. The second discipline is that the careless reading of any such gradient is racial where the careful reading is social: what it marks is the position of the arriving group in the receiving society, not a property of the people who arrived.

For Indian practice the useful move is to ask what the local analogue of that position is, because it is not usually skin colour. Caste, language group, tribal status, religion and the rural origin of an

urban worker all mark a family out in an Indian city, and any of them can place a household in the position host-country studies describe. No Indian figure of that kind is available to quote along those axes, and none is invented here, so they are asked about in a history rather than scored.

26.4 Treated incidence, and what a rate from a host country is a rate of

The modern replacement for that older literature is the multinational first-episode incidence study, in which psychosis is counted prospectively across catchment areas in several countries at once. Treated incidence varies markedly from one catchment area to another, and within those areas rates are reported as raised in racial or ethnic minority groups. Whether the variation between places is larger than the difference within them is not settled here: no dependable figures are available to quote, and none are invented here. What a large between-place variation does establish is a direction for thinking. Whatever raises the rate is partly something about places and about positions within them, so minority status reads better as a marker of occupying a bad position than as a cause in its own right.

Then there is the word treated. These are **treated incidence** rates, counted from people who reached services, so any difference in how easily a group reaches care sits inside the estimate alongside any difference in how often the disorder occurs. A group arriving late, by way of the police rather than a first-contact clinician, can generate a higher treated rate without a higher true incidence. Treated incidence cannot separate the two, which is why an answer that ignores the point is incomplete. And there is no Indian catchment area anywhere in this literature, so the ethnicity axis is grounded entirely in host-country settings.

AXIS OF COMPARISON	THE MIGRATION QUESTION	THE MINORITY QUESTION
What the estimate is of	Risk of psychotic illness in people who moved and in their children, against the population they settled among	Treated incidence of psychotic disorders, against the majority of the same catchment area
Exposure that defines the group	Having migrated, or being the child of migrants	Belonging to a racial or ethnic minority group where one lives
Where the evidence was gathered	Incidence studies of migration into predominantly Western, high-income host countries	Catchment areas in several countries, not one of them Indian
What it can support	That raised risk in the generation that never moved is not explained by selection at departure alone	That variation between places is large, so place and social position belong in any explanation
What it cannot support	Any statement about internal migration, and any magnitude this account can print	Any separation of true incidence from access to care, and anything at all about India

26.5 Arguing the mechanisms without overclaiming

How to structure the answer when asked why the rate is raised. Three families of explanation compete, and a good answer names all three, says what each predicts, and then says which

prediction the data have already tested.

- **Selection.** The people who migrate differ from those who stay, whether by illness already present, by early prodromal drift, or by traits associated with risk. This predicts that the signal belongs to the generation that left and fades in their children, and the second-generation discussion is the reason it cannot be the whole story.
- **Post-migration adversity.** Something about occupying a disadvantaged, visibly different position after arrival raises risk: chronic exclusion, insecure work and housing, and the accumulated experience of being treated as an outsider. This predicts a gradient by visible difference and disadvantage rather than by distance moved, and by place rather than by person, which is the direction the host-country literature points in.
- **The diagnostic encounter.** Some of the excess is made in the clinic, by unfamiliarity with how distress is expressed, by interpreting culturally normative belief or behaviour as psychotic, and by differences in the route through which a group reaches care. Treated incidence cannot exclude this, which is why an answer that ignores it is incomplete.

What the evidence cannot yet adjudicate is worth stating as plainly as what it can. Whether living among many others of the same background protects a person is a real question, and it is not answered here: no dependable estimate of it is available to quote, and none is invented here. An answer that names the question and leaves it open is stronger than one asserting a protective effect it cannot cite.

26.6 Cultural bereavement: naming what the move actually cost

The concept that links the move to the illness at the level of one person is **cultural bereavement**, a term worth having because nothing else in the psychiatric lexicon names what it names. The idea is grief for a way of life rather than for a person. What a move takes from someone is the ordinary machinery of a life: the norms that told them how to behave, the religious observance that organised the year, the people consulted when a household member fell ill, the language spoken around them, and the standing they held in a community that already knew them. It is not the bereavement that follows a death, which belongs with grief and end-of-life care rather than here.

Two disciplines matter when using it. The first is modal. That cultural bereavement is what converts a move into an illness is a hypothesis, it is written here as one, and it is not an established causal pathway; write it the same way in an answer and in a formulation, because no dependable account of the pathway is available to quote, and none is invented here. The second is that there is no uniform migrant effect to claim. Where raised rates are discussed they are discussed for some migrant groups rather than as a property of migration itself, and a candidate who flattens that into a single migrant risk has strengthened the claim past anything that can be shown.

Clinically the concept earns its place because it converts a demographic fact into questions. What did this person do on a given day of the week that they can no longer do. Who did they consult when a child was ill, and is that person reachable now. What did they eat, what did they hear

spoken around them, and at what point in the year did the household do something together. These are not pleasantries. They locate what has been lost with enough precision that it can be named in front of the patient, and often they explain the timing of a presentation better than any life event on a checklist.

GOOD TO REMEMBER

Two sentences change the quality of a migrant patient's record. Write which move you are talking about, dated, with who moved and who did not. And write what has not been replaced since: the person consulted first about illness, the place of worship, the language spoken at home, the work that matches the training. A note that says "migrant" and stops has recorded a category. A note that records the move and the unreplaced losses has recorded an exposure, and the next clinician can act on it.

26.7 Acculturation: two questions, four strategies, and the limits of the typology

What happens after arrival is usually taught through **acculturation**, and specifically through the two-dimensional model associated with Berry. It rests on two independent questions rather than one continuum running from foreign to assimilated. The first asks whether the person places value on holding on to their own culture and identity. The second asks whether they place value on relationships with the wider society they now live in. Because the two answers are independent, they generate four positions rather than a scale, and the four are positions a person can occupy rather than stages a person passes through.

VALUES MAINTAINING OWN CULTURE	VALUES RELATIONSHIPS WITH THE LARGER SOCIETY	STRATEGY	WHAT IT LOOKS LIKE IN THE ROOM
Yes	Yes	Integration, or biculturalism	The host culture is adopted while the culture of origin is maintained; the patient moves between two settings without treating either as a betrayal of the other
No	Yes	Assimilation	The host culture is adopted in place of the culture of origin; distress often surfaces around the family left behind, or around a child being raised differently
Yes	No	Separation	The host culture is rejected in favour of the culture of origin; the practical cost is usually access, to services and to work, rather than identity
No	No	Marginalisation	Both are rejected; the person belongs to neither reference group, which is the position that most often warrants a closer look in an assessment

MNEMONIC

Keep mine? Join theirs?

Two questions, answered yes or no, give the four positions and their names. Yes and yes is integration. No and yes is assimilation. Yes and no is separation. No and no is marginalisation. Answer the two questions in that order and the names follow, which is safer than carrying them as a list.

Now the qualifications, which are as examinable as the model. The same person can use different strategies in private and in public life, so a man who is entirely separated at home and functionally assimilated at work has not contradicted himself and is not a diagnostic puzzle. A model borrowed from cross-cultural psychology also carries its own frame: it was built around individuals moving between two identifiable cultures, which is a poor description of a household in which three generations are moving at different rates and in different directions, and a poorer

one still of a woman who has moved between two districts of the same state and two versions of the same religion.

TRAP **Presenting the four strategies as a validated typology, or as a single scale.** The two questions are independent, so what they generate is a two-by-two and not a continuum running from foreign to assimilated, and a candidate who recites the four as an ordered list loses the discrimination between separation and marginalisation. The heavier error is predictive: the scheme has been criticised for having very little predictive validity, because people do not always fall neatly into those categories. Use it to say precisely where a person stands, never as an instrument that tells you what will happen to them.

26.8 Migration in India: the scale, the reasons, and the outcome evidence that does not exist

India is not a footnote on this topic, it is a different topic. The **migration rate** at the all-India level from the Periodic Labour Force Survey of 2020 to 2021 was **28.9 per cent**, and the reasons split sharply by sex. Marriage accounted for about **86.8 per cent** of all female migrants. Migration in search of employment or better employment was the largest single reason among male migrants, at **22.8 per cent**. Read those last two carefully, because their denominator is migrants and not the population: they say what the people who moved moved for, not what proportion of women or of men has moved.

28.9%	86.8%	22.8%
ALL-INDIA MIGRATION RATE FROM THE NATIONAL LABOUR-FORCE SURVEY OF 2020 TO 2021	SHARE OF ALL FEMALE MIGRANTS WHOSE REASON FOR MOVING WAS MARRIAGE	SHARE OF MALE MIGRANTS MOVING FOR EMPLOYMENT OR BETTER EMPLOYMENT

Sit with what that does to the picture. Migration in India is predominantly the marriage migration of women, and the **labour migration** that the word "migrant" summons in a Western clinic is not the dominant pattern here and is mostly a male one. So the commonest migrant in an Indian outpatient clinic is a young woman who has moved at marriage into a household not her own, frequently into a different language area, having left the people she would previously have consulted when unwell, and with no legal or administrative marker of having migrated at all. Nobody labels her a migrant. Every element of cultural bereavement is nonetheless available to be asked about, and the reason for her move is precisely the relationship inside which her distress is now occurring.

Then the hard part, which is what the epidemiology does not give us. All of the incidence evidence discussed above concerns international migration into high-income host countries. What is established for India is the scale of internal movement, with no comparable Indian outcome estimate to quote, and none is invented here. No national picture of internal migrants, of rural-to-urban migrants or of interstate labour migrants is available to cite, in incidence, prevalence or morbidity, so this topic carries Indian scale without Indian outcome. The honest examination answer states that gap rather than filling it, and notes that what is missing concerns the commonest kind of movement in the country.

PITFALL

Do not carry a host-country risk figure across to an Indian internal migrant. Every risk estimate in this literature comes from host-country studies where the exposure was crossing an international border, being the child of someone who did, or being counted as a racial or ethnic minority there. An interstate labour migrant from Bihar working in Karnataka, or a woman who moved two districts at marriage, is not that exposure, and no Indian study licenses the transfer. Quoting a remembered ratio and then applying it to the patient in front of you is the single most likely way to be wrong in this topic, and it is wrong in the direction of pathologising ordinary Indian mobility.

IN INDIA

There is no Indian guideline cover for this topic. The Indian Psychiatric Society clinical practice guidelines of 2025 for schizophrenia, depression, bipolar disorder and obsessive-compulsive disorder carry no recommendation on migration or acculturation, so no transcultural position can be attributed to them and every India-specific figure in this topic comes from official statistics rather than from clinical guidance. Nor is there a dedicated national migration survey: the rate above comes from a labour-force survey, and the Ministry of Statistics and Programme Implementation has proposed a Survey on Migration for July 2026 to June 2027. The consequence for practice is direct. If the guideline does not prompt the question and the record does not code the move, the migration history exists only if the clinician takes it.

26.9 What the examiner is testing, and the answer that survives a follow-up

Questions on this topic are marked on whether the candidate can hold a reproducible finding and a weak inference in the same hand. Three moves earn most of the marks, in this order.

- **Give the finding with its frame, and let the frame do the work.** Raised rates of psychotic illness are reported in migrants and in the children of migrants, from population-based incidence studies of migration into mostly Western, high-income host countries. If you quote a multiple you have met elsewhere, be ready to bound it on the four axes set out earlier; if you cannot, give the direction and decline the magnitude.
- **Use the second generation as an argument, not a decoration.** Say what it excludes and why it excludes it, because the examiner is listening for the inference rather than for a number.
- **Move from person to place.** Incidence varies markedly between catchment areas, so ethnicity is best read as a marker of social position in a particular place rather than as a property of a group, and treated incidence keeps access to care inside every one of these estimates.

Then land the Indian answer, because that is where most candidates stop and repeat the Western figure. Give the national migration rate, give the split by sex between marriage and employment as reasons, and say that no Indian outcome estimate exists onto which the risk figures could be transferred. An examiner who hears the gap named accurately learns more about the candidate's reasoning than any recalled ratio can show.

Two further follow-ups are common enough to prepare. Asked for a mechanism, give cultural bereavement, name the losses, and keep the modal verb hypothesised. Asked what you would do

differently, do not answer with a scale. Answer with the history: which move, who moved, what has not been replaced, and where this person now sits on the two acculturation questions. That answer is clinical, it is defensible, and it does not require a number that has not been measured in this country.

Migrant status is an epidemiological signal and not a mechanism: raised rates are reported in migrants and in their host-country-born children, so selection at departure cannot be a sufficient explanation; the mechanism is offered as the hypothesis of cultural bereavement, the aftermath is described by two acculturation questions with four positions, and in India the scale of internal migration is known while its mental-health outcomes are not.

27 · Idioms of distress and explanatory models of illness

Why two definitions taught elsewhere still have to be placed inside the encounter. The heading idioms of distress and explanatory models of illness names two constructs that stand side by side and are routinely collapsed into one. An **idiom of distress** is the vocabulary a patient and those around him use for suffering, a way of saying. An **explanatory model** is his own theory of what has gone wrong and why, a claimed cause, and it is the construct Kleinman attached to that third kind of cultural concept. Eliciting it is not a courtesy at the end of the history; it is the engine of the cultural assessment. Both constructs, the family of cultural concepts they belong to, and the questions that draw the model out are set out in full in the Psychotherapies, clinical assessment, MSE and nosology notes, and none of that is reproduced here.

What is owed in a chapter about the consultation is what a definition cannot carry. An idiom governs how you listen and how you record. A model governs what the patient will accept, what he does next, and when he decides he is well. Different levers, and marks are lost by pulling one and calling it the other.

A way of saying	A claimed cause	Defined in full elsewhere
WHAT AN IDIOM OF DISTRESS IS	WHAT AN EXPLANATORY MODEL IS	WHERE THE DEFINITIONS AND ELICITING QUESTIONS SIT

27.1 The division, and where the definitions sit

The two travel differently, which is why they must be kept apart. An idiom is usually shared: a language community may use one bodily phrase for everything from ordinary demoralisation to psychosis, so hearing it tells you little about severity and a good deal about how the complaint will be worded. A model is particular. Two patients using the same phrase may hold different accounts of its cause, and the household may hold a third. Collapse the two and you get the classic incomplete assessment: the clinician has learned the family's word for the trouble, assumed he therefore knows what they believe caused it, and never asked.

27.2 The idiom in the room: two wrong translations

An idiom fails clinically in two opposite ways, both examined. In **over-translation** the clinician hears a bodily or metaphorical phrase, converts it at once into the nearest symptom term, and

records only the conversion. Lost are the severity gradient the phrase carried and any later ability to check the translation; where the idiom is somatic, the same reflex converts a way of speaking into a somatic disorder. In **under-translation** the phrase is recognised as culturally shaped, the presentation is filed as a cultural matter rather than a clinical one, and a treatable disorder is admired instead of treated. Opposite mechanics, identical result: the assessment stops at the vocabulary.

RULE **An idiom is a form of words, so its presence neither establishes a disorder nor excludes one.** Record the complaint verbatim in the patient's own phrase before you translate it, keep both lines in the note, and decide the diagnosis on phenomenology as for any patient. Translate without leaving the original and you destroy the only thing that would let the next clinician find your error.

27.3 What the explanatory model predicts

The payoff is prediction, not description. Each part of a model forecasts a behaviour you will otherwise meet as an unexplained non-attendance. Ask for the parts separately: patients rarely volunteer them as a set.

WHAT THE MODEL ANSWERS	WHAT IT FORECASTS	WHAT THE CLINICIAN DOES WITH IT
What the trouble is, and its name	Which complaints get reported and which are thought irrelevant	Ask directly for what is not being mentioned
Why it began, and why now	Whether treatment must address a cause or a consequence	Say openly which of the two the plan offers
What it does to the body or the life	The course and severity expected, often not yours	Set the trajectory before the first prescription
Who can treat it, and who was consulted already	Whether treatment runs alongside another form of help	Ask what else is being done, without requiring it to stop
What counts as cured, and when treatment may stop	The point of unilateral discontinuation	Negotiate review against the patient's stopping rule

GOOD TO REMEMBER

Ask what the patient believes is wrong and what he believes will help before you offer the plan, never after. Asked afterwards it reads as an audit of a decision already taken and earns a polite answer. Asked before, it tells you which part of the plan will be quietly dropped, while there is still time to negotiate it.

What must reach the record, and rarely does:

- the untranslated complaint, quoted;
- the account of cause, and who in the room holds it;
- help sought earlier, and whether it continues;
- his own criterion for being well again;

- the single point where his account and yours disagree.

IN INDIA

Three features of ordinary practice make this heading unusually practical. The model is commonly held by the family rather than the patient alone, so the account you elicit may not be the one deciding whether tablets are given at home. The route to an outpatient department has usually passed through other forms of help, so the useful question is what runs alongside your treatment, not what was given up for it. And the idiom is generally spoken in a language the record is not written in, with a relative translating, so the phrase is lost at the first hop unless somebody preserves it. A measured national figure for how often help is sought elsewhere first would sharpen all three; no comparable standard is available to quote, and none is invented here.

27.4 How the heading is asked

As a short note it is a discrimination question: define both, keep them apart, attribute the model correctly, and close with what eliciting it changes. As a long case or a bedside station it is never asked as a definition. A patient whose account of his illness is not biomedical is put in front of you, and the examiner watches whether you obtained that account before proposing a plan, whether you can state it back in his own words, and whether you can name the one place the two accounts diverge. Revise only the definitions and you can name the constructs and say nothing about the divergence, which is the whole question.

TRAP **Eliciting the model and then correcting it.** The sequence feels like thoroughness and is its opposite: having asked for the belief, the clinician explains why it is mistaken, and it goes underground rather than changing. It survives, stops being reported, and now acts on adherence invisibly. The aim is a plan that can coexist with the account already in the room, not a conversion.

An idiom of distress is how the trouble is said and an explanatory model is what the patient holds to have caused it; their definitions belong to the Psychotherapies, clinical assessment, MSE and nosology notes, and what these notes add is that the model forecasts help-seeking, adherence and when the patient decides he is cured.

28 · Religion, spirituality, faith healing and mental health in India

Why the route a patient took before reaching you is a clinical fact and never a verdict on them. Of every heading in this chapter, religion, spirituality, faith healing and mental health in India is the one where the Indian answer is not a local variation of a Western one but the whole of the subject. A great deal of psychiatric help-seeking in this country begins at a religious site, and not at one kind of site: the single sustained piece of Indian research in this area opens by observing that people troubled by emotional distress or by more serious mental illness go to Hindu, Muslim, Christian and other religious centres, and that the healing power identified with these institutions may reside in the site itself rather than in the religious leader or in any medicines provided at the site. Keep that modal verb where the authors put it. It is a proposition

they advance about where a tradition locates its own power, not a finding they went on to establish.

Two failures of register are available here and both are penalised. The first is dismissal, in which the healing pathway is recorded as ignorance or delay, and the family, having heard the tone, stops mentioning it. The second is romanticisation, in which a practice is admired rather than assessed and a treatable psychotic illness is left untreated somewhere that has no doctor. What makes the topic examinable is that the evidence bearing on it is mixed, thin and almost entirely Indian, and that the boundary between a **sanctioned religious practice** and a disorder has to be drawn somewhere. It is drawn here, in the patient's words and the family's account, and not in a list of features.

28.1 Religion in the history: four different things wearing one word

Religion enters a psychiatric history in at least four ways that behave differently, and a candidate who runs them together will give one answer where four were wanted. It can be a source of structure and support, a daily and weekly scaffolding that survives when everything else has stopped. It can be the vocabulary in which suffering is spoken, the words a family reaches for before any clinical term is available to them. It can be the explanation held for the illness, the account of what has gone wrong and why. And it can be the pathway, the sequence of places help was actually sought, of which your outpatient department is usually not the first.

Only the last two change a management plan, and only the last two are commonly missing from the record. The explanatory model as a construct, and the structured way of eliciting it, belong to the cultural assessment set out in the Psychotherapies, clinical assessment, MSE and nosology notes, and none of that is reproduced here.

- Where has help been sought already, in what order, and who in the family chose each place.
- What is still going on alongside this consultation, because the commonest situation is concurrent rather than sequential use.
- What the family understood from what was done there, since that account, and not yours, is the one operating at home.
- Whether anything is currently being restricted: food, fluids, movement, sleep, or medication already prescribed.
- What would count as being well, in their terms, because that is the point at which treatment will be stopped without telling you.

GOOD TO REMEMBER

Ask these before you offer a plan, not after it. Asked afterwards, the pathway question reads as an audit of a decision already taken and earns a courteous denial. Two lines in the record change what the next clinician can do: the sequence of places help was sought, dated, and what is still running alongside. A note that records only that the patient "went to a temple first" has recorded a stereotype. A note that records who took him, what was done, what is continuing and what is being restricted has recorded an exposure and a risk.

28.2 The boundary between a sanctioned practice and a disorder

This is the discrimination the rest of the syllabus hands to this chapter, and it is easier to state than to perform. The question is never whether the belief is true, and it is never whether the practice is rational. Those are not clinical questions and no examiner is asking them. The question is whether what you are being shown is a form the person's own community recognises and sanctions, occurring in its proper setting, or whether something has broken out of that frame.

The method follows from that. You do not settle it against a textbook description, which was written from published cases and not from this community. You settle it by asking the people who would know. Does the family recognise what they are seeing as the thing their tradition does, or as something that frightened them because it was not that. Does it begin and end with the occasion, or has it stopped ending. Is the person able to do what they were doing before, outside the setting, or has role function fallen away. And, most simply, is the person themselves distressed by it, and unable to stop it when they wish to. Those four questions are asked of the family and of the patient in their own words, and their answers are recorded in those words before any translation into clinical terminology.

RULE **Whether a practice is sanctioned is a question for the patient's community; whether this person is ill is a question for you; and the two are answered separately.** The error in both directions is to let one answer settle the other. A sanctioned practice does not exclude a disorder in the person performing it, and an unfamiliar practice does not establish one. Take the community's answer on the first question as authoritative, because on that question it is, then do the diagnostic work on phenomenology exactly as you would for any other patient.

PITFALL

The compression failure. A religious practice summarised into a list of features has, in the act of summarising, been converted into a symptom cluster, and the reader who learns it that way will recognise the practice and diagnose it. The same reflex reaches backwards: it is a short step from an ethnographic account of a revered figure to naming a disorder in that figure, and it is a step with no clinical purpose and a real cost to the relationship with the family sitting in front of you. Describe the practice in the community's terms, quote the patient, and keep the diagnostic reasoning in the phenomenology where it belongs.

28.3 The one measured Indian study: the site, and what the temple actually does

Almost everything quoted about faith healing in Indian psychiatry traces to a single report published in the BMJ in 2002 by Raguram, Venkateswaran, Ramakrishna and Weiss. It is worth reading at origin rather than recalling, because what it says is more interesting and more careful than what it is usually made to say. The setting was a Hindu **healing temple** in South India: the temple of Muthusamy in the village of Velayuthampalayampudur, Dindugal District, Tamil Nadu, in the foothills of the Palani range of the Western Ghats, built more than 60 years before the study, on the outskirts of the village in the middle of a graveyard, over the tomb of Muthuswamy. One site.

The tradition's account of its own origin is that towards the end of his life a mere touch of Muthuswamy's hand was noticed to cure many ailments, especially mental illnesses, and stories spread about his healing powers; the temple was built over his tomb after his death. That is recorded as ethnography, as the community's memory of a revered figure, and it carries no diagnostic content of any kind.

What the temple does is unusually well described, and two of its features matter clinically. People may stay without charge, and a close relative stays with them and takes care of their daily needs: the family is not relieved of the person, it moves in with them. And the paper records something in both directions at once, which is the reason it can be trusted on this point. Physical restraints for agitated people are used at many other healing temples, and are not used at this one. Neither half may be quoted alone. Taken together they say that a healing site is a particular institution with particular practices, not a category with uniform standards, and that where a patient stayed is a question with an answer.

28.4 Who was studied, and what they had already tried

Read the denominator before the result, because it governs everything the study can be used for. Thirty-one people sought help and stayed at the temple over the course of the study. Twenty-three were diagnosed with paranoid schizophrenia, six with delusional disorders and two with bipolar disorder with a current manic episode. Twenty-one were male farm labourers from rural areas, and all were Hindu. There is no non-psychotic presentation in the group at all, so this work says nothing about common mental disorders, distress states or possession presentations at religious sites.

The exposure history is the second half of the picture. The average duration of illness was 71 weeks, the mean duration of stay in the temple six weeks with a range of 1 to 24 weeks, and only one of the group had ever received any prior medical care, that being from a general practitioner rather than a psychiatrist. This is therefore a largely **treatment-naive** group with illnesses of well over a year's standing, observed across a stay of a few weeks. That is what makes the group informative and it is also precisely what limits it, because natural course and regression towards the mean are left entirely uncontrolled.

31	29	6 weeks	1
PEOPLE STUDIED AT THE HEALING TEMPLE, THE DENOMINATOR FOR EVERY RESULT THE STUDY REPORTS	OF THAT GROUP CARRYING A NON-AFFECTIVE PSYCHOTIC DIAGNOSIS, PARANOID SCHIZOPHRENIA OR DELUSIONAL DISORDER	MEAN DURATION OF STAY IN THE TEMPLE ACROSS THE WHOLE GROUP STUDIED	NUMBER IN THAT GROUP WHO HAD EVER RECEIVED ANY PRIOR MEDICAL CARE, AND THAT FROM A GENERAL PRACTITIONER

28.5 What changed, and the spread that cannot be taught

The same rater assessed everyone on arrival and again at departure using the **brief psychiatric rating scale**. The mean total fell from **52.9** on arrival to **42.9** at departure, $P < 0.001$, a relative reduction of **18.9 per cent**, which the paper itself describes as nearly 20 per cent. Two standard deviations are printed in the same sentence, and they cannot be reconciled with the paper's own subscale table, so the dispersion of the total score is not established and no figure for it is asserted

here. That is not a quibble: a pre-post mean difference whose spread is unknown cannot be turned into an effect size, and much of what this study is used to argue depends on one nobody can compute from it.

SUBSCALE	ON ARRIVAL, MEAN (SD)	AT DEPARTURE, MEAN (SD)	T	P
Thinking disturbance	12.45 (3.21)	9.81 (4.42)	3.701	0.001
Hostile suspiciousness	12.26 (4.30)	9.39 (4.90)	4.631	< 0.001
Withdrawal retardation	8.32 (5.31)	7.16 (5.03)	3.574	0.001
Anxious depression	7.32 (5.09)	6.58 (4.74)	2.101	0.044

Values are as the paper prints them. All four factors fell, which is the honest headline, and the internal pattern repays a second look. The largest absolute movement is in thinking disturbance, from 12.45 to 9.81, and the strongest test is hostile suspiciousness at t 4.631. The one nobody should lean on is anxious depression, at P 0.044, which would not survive any correction for four comparisons. Note also, so that you do not file it as an error, that the four factor subscales do not cover all 18 items of the scale, which is why the subscale means do not add up to the printed totals.

There is a second outcome, and it needs its denominator kept in view. According to the evaluation by family caregivers, 22 of the group had improved and three had recovered fully, which accounts for 25 of the 31. The rating offered four options: recovered, improved, no change and worsened. Two categories existed for people who did not do well, neither is ever reported, and the remaining six are not accounted for in the printed result. This rating is also unblinded and made by the same relatives who brought the person and lived with them throughout, so it is not independent of the scale change and is not a second confirmation of it.

28.6 The exposure under study, and where the authors locate the healing

Here the paper becomes genuinely surprising, and this is the part most often lost when it is quoted. The people studied received no psychopharmacological or other somatic intervention during their stay in the temple. And no specific ceremonies were performed to promote anyone's recovery: residents merely attended the simple morning prayers, the puja, at the shrine for about **15 minutes**, and spent the rest of the time in light maintenance routines of the temple. So the exposure under study was not a healing rite and was not a drug. It was residence in a valued place, with a relative present, a short daily prayer, and something useful to do.

That is also, remarkably, what the tradition itself says. The community's own account, in the technical sense of an internal view of illness held by patients and by the local population as against the external view of doctors and epidemiologists, is that it is the experience of residing in the temple for a period of time, rather than therapy provided by a healer, that brings relief from

mental illnesses. The tradition and the researchers point at the same thing from opposite directions, and neither points at a procedure performed on a person.

MNEMONIC

Residence, Relative, Routine; no Rite, no Restraint

The five features of the exposure that was actually measured, and the reason a candidate should never describe this study as an evaluation of a healing ritual. Residence over a period of weeks; a close relative living alongside; light daily routines of the temple; no ceremony performed for anyone's recovery; and no physical restraint at this particular site, though the paper is explicit that restraint is used at many others.

The authors' own conclusion is hedged, and the hedges are the most examinable words in the paper. Their summary is that the research shows that a brief stay at one healing temple in South India improved objective measures of clinical psychopathology; that, in the absence of any specific healing rituals, the observed benefits appeared to result from a **supportive non-threatening environment**; and that this may indicate the value of a **culturally valued refuge** for people with severe mental illness. Not shows that a supportive environment causes recovery. Not demonstrates the value of refuge. An answer that strengthens those verbs has misreported the source, and an examiner who knows the paper will hear it.

28.7 The comparability claim, and the authors' own bar on their findings

The sentence that made this paper famous is the authors' interpretation, not their finding: that the observed reduction of nearly 20 per cent represents a level of clinical improvement matching that achieved by many psychotropic agents, including the newer atypical agents. Two things must be said whenever it is used. It is attributed to the authors, and its entire support is a single citation, Umbricht and Kane's 1995 review of the efficacy and safety of risperidone, Schizophrenia Bulletin 1995;21:593 to 606: one atypical agent, reviewed seven years earlier, in a different population under a different design. There was no drug arm in the temple study, so what is being compared is a milieu against a medicine, across two literatures, and not one against the other in the same patients.

TRAP **Quoting the twenty per cent as evidence that temple healing works as well as antipsychotic medication.** Candidates do this in good faith, because that is how the study circulates. Three facts dismantle it in one sentence each: the design is an **uncontrolled pre-post comparison** at a single site with the same rater at both time points; the group was largely treatment-naive with illness of over a year's standing, so natural course and regression to the mean are untested alternatives; and the comparison with medication is the authors' interpretation resting on one review of one drug. Say instead that a real and statistically significant pre-post change was observed under a design that cannot attribute it, which is also what the authors say.

Because they do say it. Theirs is the first study to use a standard clinical assessment to evaluate the effectiveness of temple healing, and their own verdict on their findings is that they are only suggestive owing to the limitations of their methods: there were no comparison groups, and although they endeavoured to keep the second assessment by the same rater independent of the

first, standards fell clearly short of rigorous double blind research methods. A candidate who reports the finding and the authors' own caveat in the same breath is doing better history of the paper than most published citations of it.

Two further disciplines belong here. The first is the authors' bar on generalising: because temples operate in different ways, they hold that it would be inappropriate to generalise findings from the study of one site to other regions or to other healing temples in the same region. The study is therefore expressly not about temple healing as a class, which is the one thing it is habitually used to talk about. Their further argument, that comparison groups and randomisation would be difficult to incorporate and would add little to the generalisability of findings, deserves careful reading rather than agreement or dismissal. It is an argument about external validity, reasonable on its own terms, and it does not answer the internal validity problem that a comparison group would have addressed and that they concede separately. The second discipline is arithmetical vigilance: the paper's Discussion refers to a stay of five weeks and to a mean duration of illness of one year, neither of which matches its own Findings, and the paper never reconciles them. Teach the Findings values.

28.8 Acceptability rather than access, and what a service does about it

The most consequential sentence in the whole report is one that gets quoted least. Set against those illness durations, only one of the people studied had ever consulted a doctor in the government primary health centre, which is located in the same village as the temple. The biomedical alternative was not distant. It was adjacent, and it was unused.

That single fact moves the question from access to **acceptability**, and the distinction is the examinable one. An access problem is solved by putting a service somewhere. An acceptability problem is not, because the service is already there and is not what people found usable, intelligible or trustworthy for this kind of trouble. Nothing in that observation implies error on anyone's part: a family choosing a place where a relative may stay free of charge, where they may stay alongside, and where the trouble is described in words they already use has made a defensible choice about a real problem. The service-development question that follows is what a primary health centre would have to change to become a place that family would use, and it is a question about explanation, continuity, cost and welcome rather than about siting.

IN INDIA

Three practical consequences follow for Indian practice. First, ask the pathway question of every patient and record the answer, because there is no register, no coding field and no guideline prompt that will do it for you. Second, treat concurrent religious help as the normal case rather than as non-compliance: a plan that requires the family to abandon the shrine before treatment begins is usually the plan that gets abandoned. Third, the safety line is not the belief and not the site, it is what is being done to the person. Restriction of food, prolonged restraint, restriction of prescribed medication or confinement is a safeguarding matter wherever it occurs, and where the pathway has passed through such a setting the clinician asks about it directly. How commonly Indians seek religious healing first, how long it delays psychiatric contact, and how common custodial practice is at religious healing institutions are all questions a service planner needs answered; no comparable standard is available to quote, and none is invented here.

28.9 Working alongside the pathway, and how the topic is asked

How to answer when this comes up, in a long note or across a viva table. The examiner is testing whether you can hold reverence and rigour in the same hand, and the answer that fails is the one that picks a side. Open with the position rather than the study: religious help-seeking is a fact about the route to care and a legitimate question in every history, never in itself a finding about pathology. State the boundary and how you draw it, in the community's terms. Then give the evidence, and give it accurately, which means naming it as one uncontrolled study at one site, giving the direction and the significance of the change, giving the authors' own hedged attribution to a supportive environment and their own refusal to generalise from it, and saying that no comparable measured evaluation exists for a shrine of any other faith.

Clinically, the working posture is collaboration without endorsement and without confrontation. You do not have to agree with an explanation to work alongside it, and you do not have to displace it to treat. What you must do is make your part of the plan compatible with the rest of the person's life: name what your treatment addresses and what it does not, agree what would count as improvement and by when, and keep the door open so that when a family returns from a shrine they return to you rather than to nobody. Where the religious setting is providing what the study describes, a place to stay, a family alongside, and something useful to do, the honest clinical judgement is that these are not the enemies of treatment; the enemy of treatment is untreated psychosis, and the two can occupy the same weeks.

Finally, be exact about what is not known, because on this heading the gaps are large and stating them is not weakness. There is no measured Indian evaluation of a dargah, a church or any non-Hindu healing site with a standard clinical instrument. There is no outcome evidence at all for the non-psychotic presentations that make up most of a real clinic. There is no Indian guideline position on collaboration with religious healers to attribute to anyone. And there is no quantified national picture of how often, or for how long, the religious pathway is travelled before psychiatric contact. A candidate who names those gaps precisely has shown the examiner something no recalled percentage can show.

Religious help-seeking is a fact about the pathway to care and never in itself a finding about pathology: the only measured Indian evaluation is an uncontrolled single-site study of a South Indian healing temple in which the mean brief psychiatric rating scale total fell from 52.9 to 42.9 in 31 largely treatment-naive people who received no drug and attended no healing ceremony, whose authors attribute the change, hedged, to a supportive non-threatening environment and expressly forbid generalising it to other temples.

Cancer, dying and grief

29 · Psychological reactions to cancer diagnosis and treatment

Why the marks are here. A candidate is asked about the psychological reaction to cancer because it is the commonest situation in which a psychiatrist is called to see a patient who is not, in the ordinary sense, mentally ill. The referral says distress. The task is to decide whether what you are looking at is a person adjusting to catastrophic news or a disorder that has grown out of it, and then to do something about the conversation in which the news was delivered, or was not delivered at all. In an Indian oncology ward the second half of that task usually arrives first, because the person who knows the diagnosis is often not the person who has it.

Psycho-oncology is the mental health of the patient with cancer and of the family around them: adjustment reactions, depression and demoralisation, anxiety about procedures and about prognosis, delirium in advanced disease, and the communication and palliative-care skills that carry all of it. What this topic owns is the psychological reactions to cancer diagnosis and treatment, and the conversation in which those reactions begin. The recognition and treatment of depression, anxiety and delirium in a patient with advanced disease, grief and end-of-life care, and demoralisation and the wish for death are each taught in companion topics of this chapter, and the adjustment disorders as a diagnostic category belong to the Anxiety, OCD and trauma-related disorders notes.



Fig 29.8. The reaction to cancer drawn along one axis as five stations, from diagnosis and staging through active treatment, the end of treatment and survivorship, recurrence and the change of goal, to the end of life, with each station carrying what is expected there set against what would put the reaction past adjustment, and one threshold question stated for each rather than a list of diagnoses, the whole gated by the prior question of what this patient has been permitted to know, and with criteria, instruments and cut-offs named as absent because they belong to the chapters that own the entities.

29.1 The reaction as a trajectory, and what a trajectory is not

The reaction to hearing that one has cancer is conventionally described as a sequence: shock and disbelief, then anger, depression, loss and grief. The description is clinically useful and worth

being able to reproduce, but be careful what you claim for it. It is a textbook account of what is commonly seen rather than a staged model with evidence behind it, so it carries no timings, no obligatory order, and no implication that a patient who has arrived at anger has finished with disbelief. Patients move back and forth across it and many never look angry at all. Recited as a schedule it becomes a way of not listening, because the clinician then checks the patient against the stage instead of asking what the patient has actually understood.

What the sequence is genuinely good for is vocabulary. It tells you that the affect in front of you at the second visit is not necessarily the affect that will be there at the fourth, that anger directed at the treating team is usually part of the reaction rather than a complaint about the team, and that loss and grief begin long before anyone dies. The anticipatory grief of a patient still under active treatment, and the grief of the family afterwards, are taught with the grief and end-of-life material in this chapter.

RULE **The reaction is normal until it is not, and in Indian practice you cannot judge which until you know what the patient has been permitted to know.** Distress that is exactly calibrated to a fact the patient has not been told is not distress out of proportion to the illness; it is distress about something else, and it will not respond to reassurance about the illness. Establish what has been disclosed, and by whom, before you decide whether the reaction in front of you is disordered.

29.2 Adjustment or disorder, which is the discrimination that carries the marks

The most useful single thing to know about psychiatric morbidity in cancer is which diagnosis sits at the top of it, and it is adjustment disorder and not depression. An Indian cross-sectional survey of consecutively admitted adult cancer inpatients in the radiotherapy department of a tertiary teaching hospital in Kerala, over 2011 and 2012, found a substantial minority carrying a psychiatric diagnosis, and the largest single group within that minority was the adjustment disorders, a clearly bigger group than major depressive disorder in the same sample.

384	41.7%	22.6%	10.9%
ADULT CANCER INPATIENTS ASSESSED, INDIAN TERTIARY RADIOTHERAPY SERVICE	CARRIED ANY PSYCHIATRIC DISORDER, SAME INPATIENT SAMPLE	ADJUSTMENT DISORDERS, THE LARGEST SINGLE DIAGNOSTIC GROUP	MAJOR DEPRESSIVE DISORDER IN THAT SAME SAMPLE

What the setting does to the number. These are inpatients on a radiotherapy service in one tertiary centre. They are not a community sample, not an all-India figure, and not an advanced-disease or hospice population, and a palliative inpatient unit would not be expected to look like this. Quote the proportion with its setting attached or do not quote it at all, because a figure from a treatment ward asserted about the dying is a different claim. Two further features are worth carrying into a viva. Diagnoses were made by structured diagnostic interview, using the MINI International Neuropsychiatric Interview rather than a distress screen, which matters because screening instruments in oncology count symptoms while diagnostic interviews count disorders, and the space between those two operations is where inflated prevalence claims are manufactured. And the sample was consecutive rather than referred, so it is not the enriched population a liaison psychiatrist meets on a consult list.

Conceptually the **adjustment disorders** are emotional and behavioural symptoms arising in response to an identifiable stressor, and in an oncology clinic the stressor is never in doubt. That is what makes the category both easy to reach for and easy to misuse. The examinable discrimination is not between sadness and depression as lists of symptoms, which the mood and anxiety chapters own; it is between a reaction that tracks the illness and a syndrome that has acquired its own autonomy. The reaction moves with events, remits when the news improves, leaves the capacity for pleasure intact between episodes of distress, and responds to information, time and company. The syndrome persists when the news improves, colours the day as a whole, holds a fixed view of the self rather than of the situation, and does not lift when the family arrives.

The practical consequence of adjustment being the commonest finding is that the commonest correct action is not a prescription. It is time, accurate information at a pace the patient sets, a named person to contact, and a review appointment that actually exists. The two errors that follow from getting this wrong are symmetrical and both are common: medicating every appropriate reaction, which teaches the oncology team that the psychiatrist is a source of sedation, and dismissing every reaction as understandable, which is how a treatable depression in a patient with cancer goes untreated on the grounds that anyone would be sad.

29.3 What the treatment itself does to the reaction

The reaction is not one event at one interview. Diagnosis, staging, surgery, each cycle of chemotherapy, the scan taken before a review appointment, the end of treatment when the structure of weekly attendance disappears, and any suggestion of recurrence are each a fresh disclosure, and each can reopen the whole sequence. This is why a patient who coped well at diagnosis can present in crisis at what the team regards as good news, and why the end of treatment can be a point of collapse rather than of relief.

One transition reorganises the psychological work more than the others, and it is the one where the goal of treatment changes. The Indian review that names the communication problem in this setting singles out two moments at which it surfaces: **the curative-to-palliative transition**, and the point at which death and dying enter the conversation at all. Both are moments when what the patient has been told stops being sufficient, because the plan the patient was given no longer matches the plan the team is following.

Some of the treatment-related material a full account would want is not settled enough to quote here. Body image after mastectomy or head and neck surgery, sexual function, fear of recurrence as a persisting preoccupation, distress at the end of treatment and in survivorship, and the financial catastrophe that treatment inflicts on an Indian family are all real clinical themes and all belong in a history, but no comparable Indian standard is available to quote for their magnitude, and none is invented here. Procedural and prognostic anxiety, and delirium arising in the course of advanced disease and its treatment, are taught in the companion topic of this chapter on depression, anxiety and delirium in cancer and palliative care.

29.4 Collusion, which is the name for what is actually happening

Collusion is the name for information about diagnosis, prognosis or medical detail being withheld, or shared selectively, within the triangle of patient, family and treating team. Its most important property is that it is graded rather than binary. The family may allow the physician to tell the patient about the recommended treatment while asking that the diagnosis not be revealed, or the physician may disclose the diagnosis to the patient and withhold what is known about the prognosis. So describing a case requires three answers and not one: who is being kept in the dark, what exactly is being withheld, and how complete the withholding is. The review that names the construct puts the point memorably: "Collusion is not always a conspiracy of silence, it may be a conspiracy of lopsided communication as well!"

Two patterns are named in the same source and both are worth recognising by name in a viva, because both look like coping and neither is. In **the recovery plot**, patient and relatives together focus on treatment and recovery and do not address prognosis, disability, relapse or death; the conversation is busy, hopeful and entirely about the next appointment. In **medical activism**, the doctor does exactly the same thing, offering the next investigation and the next line of treatment in place of the conversation that is due. The second is the more dangerous, because it is the one the team mistakes for professionalism.

WHAT IS WITHHELD	WHO IS KEPT IN THE DARK	HOW IT LOOKS AT THE BEDSIDE	THE CLINICIAN'S FIRST MOVE
The diagnosis, while treatment is openly discussed	The patient	Consent is given for radiotherapy without the word cancer being used; the patient asks the nurse what the machine is for	Establish what the patient already believes is wrong, before answering anything
The prognosis, after the diagnosis has been given	The patient	The patient plans as though cure were certain; the relatives already know it is not	Ask what the patient understands this treatment is trying to achieve
Everything, completely	The patient	Relatives answer for the patient throughout the consultation; the patient stays silent and watchful	Interview the family first by agreement, then see the patient alone
The patient's own knowledge and fear	The family	The patient knows, protects the relatives from knowing that they know, and each side performs hope for the other	Offer to be present when the two of them speak openly for the first time

Note what the last row does to the standard teaching. **Partial collusion** is not always the family protecting the patient. It runs in the other direction often enough that assuming the patient is the ignorant party is itself a clinical error, and the family is not the only possible party in the dark:

the treating team can be the one that has not been told, when the patient and relatives have agreed between themselves what the doctor will be allowed to hear.

29.5 The Indian family-disclosure reality, in numbers

Two structural facts make collusion the ordinary case in Indian oncology rather than the exception. An Indian palliative-care review reports that nearly one half of patients seeking cancer treatment in India are unaware of their diagnosis or their treatment, and that most patients attend accompanied by a close relative. That proportion is the review's own summary of the literature it surveyed rather than something it measured, so it should be quoted as a magnitude and in its own words; it does not convert into a percentage, and converting it would be inventing a measurement. The second fact does more work than the first, because the accompanying relative is not merely present. In the Indian family scenario a responsible family member is the decision-maker who directs and discusses most treatment matters, and collusion with the healthcare team follows from that structural position rather than from any wish to deceive.

The figures that make this examinable come from a prospective Indian study by Gautam and Nijhawan, which assessed 100 cancer patients, as reported in the Indian Psychiatric Society's clinical practice guideline on breaking bad news, published in the Indian Journal of Psychiatry in 2023. Among the patients who already knew about their condition, **71 per cent** wanted to be told the truth. Among relatives, **81 per cent** wanted the diagnosis disclosed to them, while **77 per cent** did not want it disclosed to the patient. Hold those three together and the shape of the problem becomes visible. The patients who know want the truth; the relatives want the truth for themselves; and the same relatives do not want the patient to have it. The contradiction is not between the doctor and the family. It sits inside the family's own position, which is why arguing with the family rarely resolves it and why naming the contradiction gently sometimes does.

TRAP **Quoting the patients' figure as though its denominator were all the patients in the study.** It is not. It is the proportion of those who already knew about their condition who wanted to be told the truth, a narrower group and one already selected for having found out somehow. The figure therefore says nothing at all about what the unaware want, and used the other way round it becomes an argument for universal disclosure that the study never made. Candidates lose the mark by dropping the denominator, and clinicians lose the argument at a family meeting for the same reason: a relative told that most patients want to know can correctly reply that their patient is not among those patients.

IN INDIA

Before any decision about disclosure, establish three things and write them down: who accompanied the patient today, who in this family actually makes treatment decisions, and what has already been said to whom. In a service where the accompanying relative is usually also the decision-maker, a clinician who opens with the diagnosis has not been brave; they have walked into a conversation whose terms were set before they arrived, and have often ended the family's willingness to leave the patient alone with the team again. The order in which you interview the patient and the relatives is a clinical decision in its own right, and it deserves to be taken deliberately rather than by whoever reaches the chair first.

29.6 The ethics, which cut both ways

The defensible position is not that family-first disclosure is simply bad practice awaiting correction. The Indian source that grounds this picture argues both sides of it, and a candidate who argues only one side has answered half the question.

What collusion costs the patient:

- It obstructs the patient's autonomy, because decisions are then made about a person by people who are better informed than that person is.
- It can deprive them of health services and care they would have accepted had they understood what was wrong.
- Trust can break when the truth is discovered later, and the discovery may be followed by fear, depression and anger directed at everyone who kept it.

What the family is protecting, and it is not nothing:

- Collusion may defend the person from potential maleficence, as this family judges what this particular person can carry.
- It may minimise the patient's concerns about the future, which is precisely what the relatives believe they are being asked to do.
- It expresses an idiom of care in which relatives are involved in making the patient get better rather than in making the patient feel better.

The two sides do not cancel out, and the source's own resolution is about timing rather than principle. What it argues is that breaking the collusion in good time matters, because a patient left unchecked is the more likely to end up distressed, morbidly anxious and depressed. That reframes the clinician's question into something answerable at the bedside. It is not whether a family may ever withhold, it is how long this particular silence can hold before it costs the patient more than it protects them, and who will be sitting with the patient when it fails.

One thing this topic deliberately does not assert. Whether any Indian regulatory instrument imposes a duty to disclose a diagnosis to the patient rather than to the family, and with what exceptions such as therapeutic privilege, is not established here: no comparable standard is available to quote, and none is invented here. Argue the ethics and the clinical consequence, keep the argument about autonomy and harm, and do not attribute to an Indian doctor a legal obligation you cannot cite.

29.7 Working through collusion, which is the clinician's actual task

The source that names collusion also describes how it is dismantled, and the description is a way of working rather than a validated protocol: it carries no acronym, no step count and no trial behind it, and it should not be recited as though it did. The reasons for the collusion are established early, because a family withholding out of terror needs something quite different from a family withholding because of a promise made at a bedside years ago. The relatives are then given an explicit undertaking that nothing will be told to the patient without their consent, and a contract to that effect. Only after that is the patient's own level of awareness assessed,

through direct questions and by following the cues the patient offers about what they think is happening to them. The observation that makes the whole sequence work is that patients usually show considerably more awareness of their condition than their relatives believe they do, which means the conversation the family is dreading has frequently already taken place inside the patient's own mind.

What follows is pacing rather than revelation. The clinician is physically present when the patient and the relative first speak openly, so that neither of them is left alone afterwards with what was said. The pace is set by what all parties can tolerate rather than by the clinician's timetable, which in practice means that a single conversation is rarely the unit of work. And the feelings of both parties are reassessed periodically, because a family that agreed to disclosure at one meeting may need the agreement rebuilt at the next, particularly after a scan.

GOOD TO REMEMBER

The undertaking to the relatives is the act that makes everything after it possible, and it is the easiest step to skip. Said aloud it sounds like this: nothing will be said to your father that you have not agreed to, and I will tell you before I say it. It costs nothing, it removes the family's reason to keep the patient away from the team, and it converts an adversarial negotiation into a shared one. Record what was agreed and with whom, so that the next clinician on the ward does not undo it by accident in the first minute of a ward round.

Before deciding what to disclose, establish what the patient already knows and what the family has agreed to keep, because in Indian practice the disclosure decision has usually been taken before the psychiatrist arrives.

The structure of a breaking-bad-news interview as an examined station, and the way such a station is marked, is taught with the practical-examination material in this chapter. What belongs here is the substance that station is testing, which is the ability to work out which of two quite different problems is in the room.

30 · Depression, anxiety and delirium in cancer and palliative care

Why the marks are here. A question about the patient with advanced cancer who has stopped eating, cannot sleep and says there is no point is not asking for a criterion set. It asks whether you can still reach a diagnosis once the illness has taken away most of the evidence diagnosis rests on, and whether you will still treat when the prognosis is short and the drug chart is crowded. Candidates fail in two opposite directions: one records a diagnosis the body has manufactured, the other declines to diagnose at all, because in a dying patient everything is attributable to the disease.

What follows is the recognition and treatment of depression, anxiety and delirium in cancer and palliative care, on the assumption that each entity has been learned elsewhere. Delirium itself, with its subtypes, instruments, causes and treatment, belongs to the Stroke, TBI, delirium and focal brain syndromes notes; the anxiety disorders as diagnostic categories to the Anxiety, OCD

and trauma-related disorders notes; antidepressant choice, dose and schedule to the Mood disorders: pharmacotherapy notes. The reaction to the diagnosis, grief and bereavement, and the wish for a hastened death are taken up in companion topics of this chapter.

30.1 The evidence the illness takes away

Ordinarily much of the case for depression is carried by the body: appetite gone, weight falling, sleep broken, energy absent, movement and speech slowed. In advanced malignancy each of those is also produced by the tumour, by cytotoxic and radiation treatment, by opioid analgesia, by anaemia, by unrelieved pain and by the metabolic disturbance of the illness. The problem this **somatic confound** creates is not that the features are hard to read in one patient. It is that they lose their discriminating power across the whole ward, and a feature everybody has separates nobody.

Two symmetrical errors follow and an examiner is usually probing for one. Count the somatic features at face value and the apparent prevalence of depression on a palliative unit approaches its census; attribute them all to the disease and nobody there is ever diagnosed. Both are failures to notice that a decision about **attribution** is being taken silently, and that whichever way it goes it fixes the answer before the interview begins. How the criteria should be handled here, whether the somatic items are discounted, replaced by affective and cognitive substitutes, or counted regardless of cause, is not settled on this page. No comparable standard is available to quote, and none is invented here.

RULE **In advanced disease the diagnosis of depression is carried by what the patient believes about themselves, not by what the body is doing, because the body is answering to the illness.** That relocation drives everything practical here: the interview turns early to self-attitude, guilt and the capacity for pleasure rather than to sleep and appetite, and the attribution reasoning goes into the note rather than staying in the clinician's head.

30.2 What still discriminates, and the order in which to look

Move the weight of the assessment onto content the disease does not manufacture. Advanced cancer explains fatigue, but not a settled belief that one is a burden who deserves what is happening; poor appetite, but not guilt about matters unconnected with the illness; withdrawal, but not **anhedonia** in the strict sense, the loss of any capacity to be pleased, including by a grandchild arriving or a scan better than expected. Hopelessness about the prognosis may be an accurate reading of the facts; hopelessness about oneself is not something a tumour produces.

The second discriminator is sequence rather than content. Distress driven by an unrelieved physical symptom generally moves when that symptom moves, so pain, breathlessness, nausea and constipation are treated first and the mood re-examined afterwards, both examinations timed and recorded. Where no investigation settles the question this is the only experiment available, and it turns an argument about attribution into an observation somebody else can check.

Which screening question or brief instrument is defensible in a patient too breathless or too exhausted for a full interview is not answerable here: no comparable standard is available to

quote, and none is invented here. What can be said is what such a screen has to survive:

- it must be answerable by someone whose concentration fails quickly, since an instrument the patient cannot finish returns nothing;
- it must stay interpretable when the patient stops because of the illness rather than the mood, a distinction almost no instrument draws for you;
- it needs somewhere to hold what the person at the bedside overnight has noticed, since that person holds most of the observation.

30.3 Whether to treat at all, and what the national guideline settles

The commonest reason depression goes untreated in advanced disease is not that it was missed but that it was recognised and judged not worth treating, on two grounds rarely said aloud:

- the prognosis is too short for an antidepressant to work, so nothing is started and the question is never revisited;
- the drug chart is already full and the oncology team will not welcome another agent on it.

The Indian position on the first is explicit. The clinical practice guideline for the assessment and management of depression in India, prepared for the Indian Psychiatric Society and published in the Indian Journal of Psychiatry in 2026, states that where depression sits alongside medical illness pharmacotherapy remains indicated. Name what that rests on as well as what it says. It cites an umbrella systematic review and meta-analysis of randomised controlled trials in major depressive disorder, spanning **27** comorbid medical conditions, in which antidepressants were more effective than placebo across a range of illnesses including myocardial infarction, coronary artery disease, stroke, inflammatory bowel disease, diabetes mellitus and cancer.

One qualification travels with that recommendation wherever it is quoted: patients with psychiatric and medical comorbidities tend to have a poorer response to antidepressants than those without. Read the wording exactly. It gives a direction and not a magnitude, and a poorer response is not an absent one. It is a reason to be honest about what to expect and to plan the review, not a reason to withhold.

The psychological arm carries its own limits and they are examinable. Despite study heterogeneity, which the guideline names in the same sentence, meta-analyses are said to support cognitive behavioural therapy and behavioural activation for patients with medical comorbidities such as coronary heart disease and neurological disorders. Those illnesses are examples, not a closed set. But cancer, named among the illnesses on the drug side, is absent from the examples on the psychological side, so offering structured psychological treatment in advanced cancer on this evidence is an extrapolation and is better presented as one.

None of this licenses the prescription itself, which belongs to the Mood disorders: pharmacotherapy notes. The constraints that actually decide the choice appear here only as questions, with no answer asserted for any: how fast an agent can act against a prognosis that may be short, impaired hepatic and renal clearance, interaction with opioids and with anti-emetics,

and anticholinergic load in a patient already close to delirium. No comparable standard is available to quote, and none is invented here.

TRAP **Carrying a treatment finding across from the population that produced it to the patient in front of you.** The trials gathered into that umbrella review recruited people with major depressive disorder and a comorbid physical illness, and such a participant is generally well enough to consent, attend and complete ratings across the study period. That is not the patient in the final phase of the illness. The direction stands and should still be quoted, but presenting the evidence as though it came from a hospice overstates it.

30.4 Anxiety, which has several sources and one appearance

Anxiety on a cancer ward looks much the same whatever generates it, and the task is to work out which process is running. Sorting it by what the fear tracks is more useful at the bedside than sorting it by severity, because the tracking tells you what will answer it. **Procedural anxiety** attaches to an event and **prognostic anxiety** to a question the patient has not been able to ask, and both are often present in the same patient at different hours.

WHERE THE FEAR COMES FROM	WHAT IT TRACKS	WHAT ANSWERS IT	WHAT IT GETS MISTAKEN FOR
An event	The cannula, the mask that immobilises the head for radiotherapy, the scan and the wait for its report; it settles once the event is over	Changing how the procedure is done and who is present	A pervasive anxiety needing regular medication
A question	Review appointments and changes of plan; it does not settle when the procedure ends, because the procedure was never what it was about	Establishing what the patient has understood and what they have not been able to ask	Poor coping, or a patient the team starts to call demanding
The body	Breathlessness, hypoxia, unrelieved pain, sepsis, and the fear that opens a delirium before anything else about it is visible	Finding and treating the physical cause, after which the fear commonly goes too	An understandable reaction to being ill, which nobody looks past
The drug chart	What was started and what was stopped; the onset dates from a dose rather than a conversation	Reviewing the chart with whoever prescribes on it, before adding to it	Worsening anxiety, answered with a further prescription

The bottom row is the one candidates leave out, and a patient who locates the fear in the legs rather than the mind points straight at it. The discrimination that carries marks, though, is the third. Fear accompanied by a fluctuating level of alertness, or by attention that slides off the

question, is managed as delirium until shown otherwise, and the anxiolytic reasonable in the first two rows is the wrong instrument there.

30.5 Delirium once the goal of treatment has changed

The decision belonging to this setting and to no other is how far to look for a cause once the illness is no longer being treated for cure. Earlier in the disease that is not in doubt. Late in it the search carries its own costs: venepuncture, a transfer for imaging, a catheter, a move back to a ward from the home the patient wanted to stay in. Its extent becomes a clinical judgement rather than a protocol.

The failure to guard against is not that too little was done but that nobody decided. The search quietly stops, no reason is entered anywhere, and afterwards the team cannot say whether a reversible cause was excluded or never sought. A recorded decision to limit investigation, carrying its reasoning and whoever took it, is defensible to a family and to an examiner; an absence of decision is defensible to neither.

Indian data are thin and must be quoted with the setting attached. A hospital-based cross-sectional survey published in the Indian Journal of Psychiatry in 2016 found delirium in **6.5 per cent** of adult cancer inpatients on a tertiary radiotherapy service in Kerala. Those patients were admitted for active treatment, so the proportion describes an oncology treatment ward and nothing beyond it. What it is in advanced or terminal disease in India is not established here: no comparable standard is available to quote, and none is invented here. The instrument is not named either, the report identifying it only in general terms.

The restlessness of the final hours is spoken of at the bedside as **terminal restlessness**. Whether it is properly a distinct entity, how it should be described, and how antipsychotic choice differs there are not settled on this page: no comparable standard is available to quote, and none is asserted. What is safe to teach is the explanation given to the family. A relative who understands that a frightened, confused patient is ill in the brain, rather than possessed or being punished, stops restraining, stops arguing with the content, and begins supplying the observations the search depends on.

IN INDIA

The continuous observer at an Indian bedside is **the family attendant**, present through the whole of a night the clinical team samples once. Two consequences follow. The history of fluctuation, of what the patient was like earlier and whether anything changed, comes in a detail no observation chart will match, provided the attendant is asked in their own language and asked about changes rather than symptoms. And the attendant usually decides whether the tablet is given after discharge, so a treatment decision explained only to the patient, or only to the referring team, may never be carried out.

30.6 What has to be settled before the interview ends

What an examiner is checking. Three questions are open in every one of these consultations and all three can be answered in a single visit. Which presenting features are being counted towards a

psychiatric diagnosis and which attributed to the disease. Whether treatment is being started, and if not, on what ground and who will look again. And whether this is a disturbance of mood, of anxiety or of consciousness, since the third rewrites the management of the other two.

The body cannot testify
APPETITE, WEIGHT, SLEEP AND ENERGY ARE ALL CLAIMED BY THE DISEASE, WHICH IS WHY THE INTERVIEW MOVES TO GUILT, WORTHLESSNESS AND THE CAPACITY FOR PLEASURE

Poorer, not absent
RESPONSE TO ANTIDEPRESSANTS TENDS TO BE POORER WHERE MEDICAL COMORBIDITY IS PRESENT, WHICH IS A REASON TO PLAN THE REVIEW AND NOT TO WITHHOLD

A decision, not a drift
LIMITING THE SEARCH FOR A CAUSE OF DELIRIUM LATE IN ILLNESS IS DEFENSIBLE WHEN IT IS RECORDED WITH ITS REASONING

GOOD TO REMEMBER

Write the decision not to treat as carefully as the decision to treat, with a reason and a review attached. An unwritten decision cannot be told apart from an oversight. The sentence that does the work is short: the low mood is judged to be driven by unrelieved pain, analgesia has been optimised, and the mood will be reassessed at the next review by the clinician named as doing it.

In advanced disease the somatic evidence belongs to the illness, so the diagnosis rests on the patient's view of themselves, and a short prognosis with an attenuated expected response is an argument for planning the review rather than for withholding treatment.

31 · Grief, bereavement and end-of-life psychiatric care

Why the marks are here. Nobody is called to see a bereaved person because bereavement is a disease. The psychiatrist is called because a team, or a family, has run out of ways of being with someone, and the examinable skill is deciding which of two very different requests has arrived: company through something ordinary and terrible, or assessment of something that has stopped being ordinary. Err towards treatment and you medicalise a family's worst month. Err towards reassurance and you leave a treatable illness inside a story everyone finds sufficient.

What follows is grief, bereavement and end-of-life psychiatric care written as a set of acts: what the clinician does before a death, in the conversation where the news is given, and in the months that follow. The entity belongs elsewhere: prolonged grief disorder as a diagnosis, the criteria and the duration written into them, and the point on which the two classification systems disagree, are taught in the Anxiety, OCD and trauma-related disorders notes. Depression, anxiety and delirium in advanced disease, and demoralisation and the wish for an earlier death, belong to the companion topics of this chapter on those subjects, and the ethics of withdrawing treatment are argued in their own place.

31.1 Grief is not the referral question

Normal grief is what most of this work consists of, and the default posture towards it is **accompaniment**: presence, accurate information, a named person to contact, and a review that actually exists. That is not a lesser intervention held in reserve. It is the intervention, and for the great majority of bereaved people it is the whole of it.

The referral is hard to read because it is rarely generated by the bereaved person. It is generated by somebody watching them: a ward sister who has run out of things to say, an adult child who wants a sedative for a parent so the household can function again. Establish who is asking, what they want changed, and what they believe happens if it is not. Many then resolve without a psychiatric formulation, because the problem was never located in the person referred.

RULE **Intensity is not the axis on which this decision is made.** Grief that looks unbearable to a watching team may be exactly proportionate to what was lost, and grief that looks restrained may conceal someone who has stopped eating and stopped speaking. The axes that carry the decision are function, safety, and whether the picture is qualitatively different from sorrow rather than merely larger than expected. A candidate who answers with adjectives about how sad the patient looked has answered a different question.

Mourning as a set of observances, and the boundary between a sanctioned religious practice and a disorder, are drawn where culture and the explanatory model are taken up in this chapter. What carries into the interview is procedural: establish what this family expects to be doing at this stage, and who is expected to do it, before deciding anything is unusual. A relative who has not left the house is obeying an instruction in one family and withdrawing in another.

31.2 Anticipatory grief, and the loss that starts before the death

Anticipatory grief is the mourning that begins while the person is still alive, once it is clear to patient or family that the illness will end in death. It is not a rehearsal and should not be sold to a family as one. What it does is redistribute the psychological work across time, so that some reorganising of roles and plans happens while the dying person can still take part. Whether it reduces the intensity or duration of what follows the death is the question this literature is built around, and no comparable standard is available to quote, and none is invented here.

Two consequences carry the marks. It is readily mistaken for coldness at the deathbed by staff who arrive late and see only the calm. The second is the hinge of this topic: a family cannot grieve in advance for a death nobody has told them is coming, and neither can the patient. Where the prognosis is held back, the work anticipatory grief would have done early and slowly is deferred whole to the hour of the death and the months after it.

31.3 Breaking the news to a family rather than to a patient

Every framework for delivering serious news that a candidate has read was designed for two people in a room, a clinician and a patient. That assumption does not hold in most Indian consulting rooms, and the Indian palliative-care literature says so directly: in filial cultures the patient is almost always accompanied, relatives are reluctant to leave when asked, and an instruction that the patient is not to be told is routine. A dyadic protocol applied unmodified there fails by putting the clinician into a negotiation with people it does not acknowledge.

The adaptation is small to state and hard to do. A cross-cultural analysis published in the Indian Journal of Palliative Care in 2009 by Chaturvedi, Loiselle and Chandra recommends conducting the disclosure with **more than one** family member present alongside the patient, because more than one relative is already involved in the care and all will want the clinical detail. The second

half is the part candidates omit. Where several relatives are in the room, the clinician identifies **the key relative** by asking whom the patient regards as the key relative or head of the family. Not the loudest voice, not whoever booked the appointment, and not the clinician's guess from the seating.

IN INDIA

Three questions before the news is given do most of the work. Who does the patient want in the room for this. Who does the patient regard as the one who speaks for the family. What has already been said, by whom, and to whom. In that order the third is usually answered without a struggle, because the family has heard they are not about to be excluded. A clinician who reaches for the diagnosis first has not been braver, only faster, and has often ended the family's willingness to leave the patient alone with the team.

There is a named hazard on the clinician's own side. The same source warns that the doctor may be quite comfortable with the recovery plot and enter this conspiracy too readily, because the conversation about the next investigation is easier than the one that is due and the family will reward it. That pattern, and the method for dismantling it, belong to the companion topic of this chapter on psychological reactions to cancer diagnosis and treatment. What belongs here is that the multi-party meeting is where a clinician joins it, invisibly to themselves.

The stepwise conduct of the interview, the order of delivery and the criticism made of that order are taught with the communication and risk-assessment station material in this chapter. No step count, expansion or sequence appears here, deliberately: what this section owns is the shape of the room, not the script.

31.4 What a silence held to the end leaves behind

Concealment has a near-term cost and a long-term one, and the second is why grief and disclosure sit in one topic. Near-term, an unaddressed silence leaves the patient morbidly anxious and depressed, and lowers the threshold for physical symptoms such as nausea and pain, so symptom relief becomes harder to achieve. That is the argument a palliative team accepts when the ethical one has failed: the concealment is interfering with the analgesia.

The long-term cost falls on the survivors. Where the silence holds to the death, what is left is **unfinished business**: practical and emotional matters never attended to, because attending to them would have meant admitting what was happening. The arrangements only the dying person could make, and the things each of them meant to say and could not without conceding the diagnosis. The source states the consequence plainly: this failure makes it harder for relatives to work toward resolving their own grief. Withholding intended as protection is therefore not neutral for the protectors. It is a debt falling due after the funeral, on the people who took it on.

TRAP **Arguing disclosure purely as the patient's right, in front of a family whose motive is love.** Candidates lose this exchange because the family is not making a claim about autonomy and cannot be defeated on one. What moves an Indian family is the consequences they already care about: symptoms harder to control while the silence holds, the things their father will not get to arrange, and the grief they will themselves be doing with all of it undone. Argue the ethics in the viva, but recognise that in the room it is the second argument that works.

31.5 The hours after a death, and what is honestly known about them

A boundary worth stating aloud. What a clinician does at a death and just afterwards, meaning how the news of the death is given, how the meeting that follows is conducted, what enters the record, whether a condolence contact is made, and which relatives are offered **bereavement follow-up** and on what basis, is not settled here. No comparable standard is available to quote, and none is invented here. That matters because it is the part of the work most often improvised.

What can be reasoned rather than quoted is a priority, and it follows from the mechanism above. If unfinished business is what makes the survivors' work harder, the families to look for afterwards are those in which the silence held: the prognosis never discussed, one relative carrying the decision to withhold alone, or disclosure too late for anything to be arranged. That is reasoning in the absence of a standard, offered as such.

Ask who is asking
THE BEREAVEMENT REFERRAL IS USUALLY RAISED BY THE OBSERVER, NOT BY THE PERSON NAMED ON IT

The room holds more than two people
DISCLOSURE IN INDIAN PRACTICE IS MULTI-PARTY BY DEFAULT, AND THE PATIENT NAMES WHO LEADS IT

Unfinished business is the debt
A SILENCE HELD TO THE DEATH MAKES THE SURVIVORS' OWN GRIEF HARDER TO RESOLVE AFTERWARDS

31.6 When accompaniment becomes assessment

This is the discrimination the examiner is testing, and it is made without the diagnostic apparatus, because in most of these encounters reaching for it is itself the error. The table is written the way a referral arrives, not the way a criterion set is.

WHAT THE REFERRAL SAYS	WHY THAT ALONE DOES NOT SETTLE IT	THE ACT THAT DOES
She cries all the time and cannot be consoled	Intensity tracks what was lost and how recently, and consolability describes the visitor as much as the patient	Ask what she has managed to do since: eating, washing, sleeping, caring for whoever depends on her
He talks to his dead wife and hears her	Such experiences occur in ordinary bereavement, and in many families are expected rather than alarming	Ask whether it is sought or intrusive, whether it is held to be real, and what the family makes of it
She says she wants to go with him	A wish to have died alongside is not an intention to act, and neither is inferred from the other	Ask the suicide question directly; the assessment is taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes
He was fine at the funeral and fell apart weeks later	The ritual period supplies structure, company and a role, so its ending is a predictable collapse point	Locate it in the trajectory: ask what changed when it began, not what is wrong now
The family wants something to help her sleep	A solution has been offered before any problem was stated, and it is often the household's problem	Establish what the sleeplessness consists of, and who is troubled by it, before any prescription
She has had a depressive illness before	Here the threshold genuinely moves, because a previous episode makes recurrence under this load likely	Assess for recurrence on its own terms; treatment of a depressive episode is set out in the Mood disorders: pharmacotherapy notes

Two further findings should move a clinician however recent the death: alcohol or sedatives recruited to get through the evenings, easy to normalise early and hard to stop later, and a settled conviction of worthlessness that is about the person rather than the loss. Neither arrives as a referral sentence, which is why neither is in the table. Both have to be asked for.

31.7 End-of-life psychiatric care as a way of working

A psychiatrist attached to a palliative service works differently from one holding an outpatient clinic, and the difference is examinable. Referrals arrive as behaviour or as communication rather than as diagnoses. Reviews are short, frequent and at the bedside with relatives present, because a patient who cannot sustain one long interview can sustain several brief ones. The drug chart is read for what is sedating the patient as much as for what is treating them. And the goal shifts from clearing a symptom to making the time tolerable, which changes what counts as a good outcome.

- What the patient has been told, by whom and when, or the next clinician repeats the disclosure or contradicts it.
- Whom the patient identified as the relative who speaks for the family, and what was agreed with that person.

- What remains unattended that the patient still has the capacity and the time to attend to.
- Who is likely to need finding afterwards, and who has agreed to look for them.

GOOD TO REMEMBER

The most useful question in an end-of-life interview is not about mood. It is a version of: is there anything you still want to say to somebody, or anything you still want arranged. A very ill patient can answer it, it takes under a minute, and it turns an abstract worry about unfinished business into a list somebody can act on this week. Whether it can be answered at all also tells you how much the patient has been allowed to know.

Grief needs accompaniment far more often than it needs treatment, and the decision to move from one to the other turns on function, safety and a qualitative change rather than on how intense the sorrow looks to whoever made the referral.

32 · Demoralization and desire for hastened death

Why the marks are here. A patient with advanced disease says, quietly and without drama, that there is no point going on and that they would rather it ended. Nothing in that sentence tells you which of several quite different clinical situations you are in, and the examiner is testing whether you can hold them apart, whether you know that one of them has a name and a literature of its own, and whether you know what the law in this country permits the treating team to do once the sentence has been said. This topic pairs demoralization and desire for hastened death because the proposal that named the first identifies the second as where it predictably leads, and because a candidate who can only reach for depression will medicate a problem that is not primarily a disorder of mood and will still not have answered the patient.

Two boundaries are worth fixing first. The recognition and treatment of depressive and anxiety disorders in a patient with advanced disease, and of delirium in that setting, belong to the companion topic of this chapter on depression, anxiety and delirium in cancer and palliative care; anticipatory grief and bereavement belong to the companion topic on grief, bereavement and end-of-life psychiatric care. The assessment and management of the suicidal patient in general psychiatric practice is taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. That subject is adjacent to this one and is not the same as it, and the difference is examined more often than the resemblance.

2001	2005	9 March 2018
YEAR THE DEMORALIZATION SYNDROME WAS FIRST PUT FORWARD AS A PALLIATIVE-CARE DIAGNOSIS	YEAR THE WRIT PETITION THAT SETTLED THE INDIAN END-OF-LIFE POSITION WAS FILED IN THE SUPREME COURT OF INDIA	DATE OF THE CONSTITUTION BENCH JUDGMENT DECIDING THAT PETITION

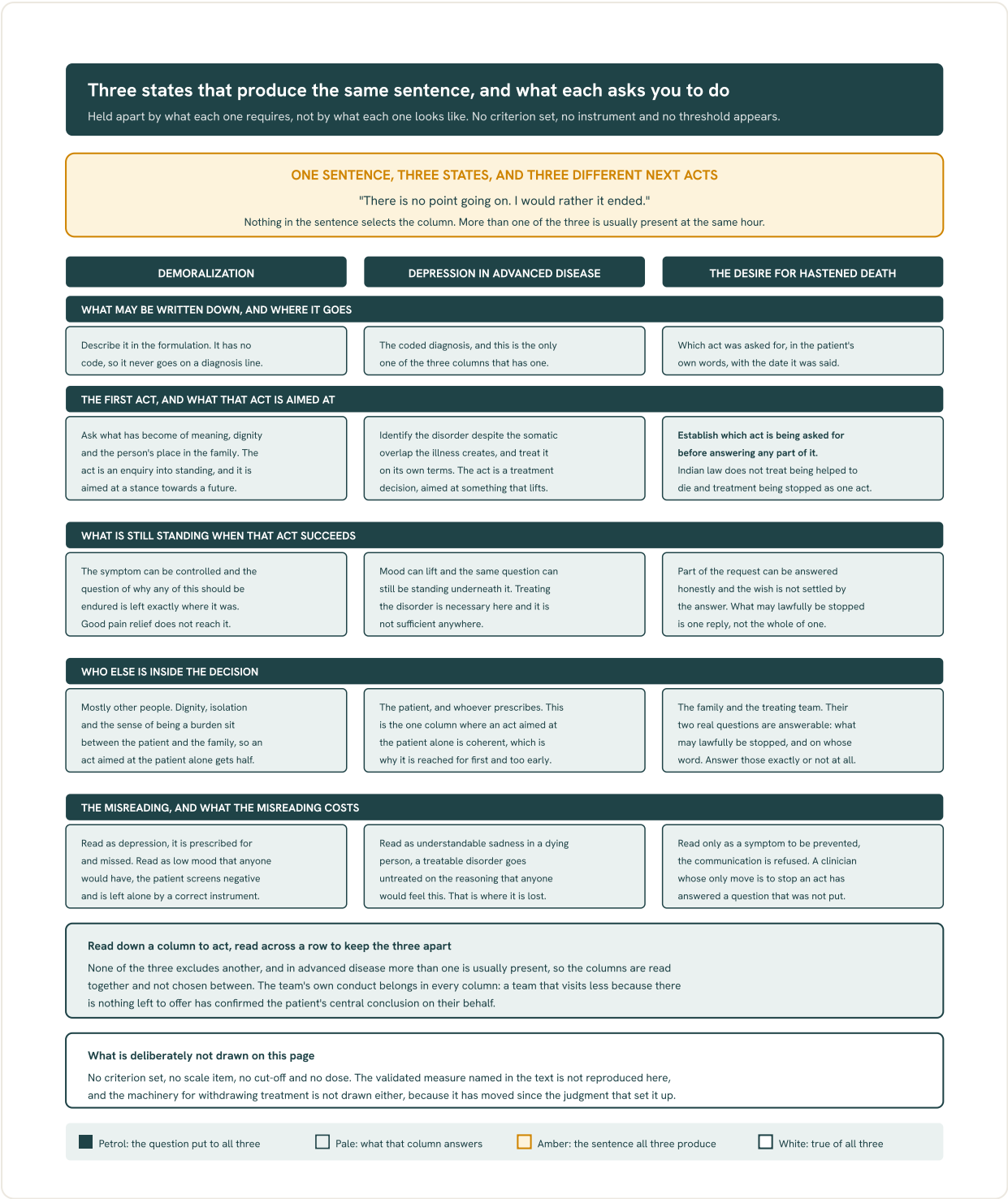


Fig 29.9. Demoralization, depression in advanced disease and the desire for hastened death set in three columns and separated by act rather than by feature, giving for each what may be written down and where it goes, what the first act is and what it is aimed at, what is still standing once that act has succeeded, who besides the patient is inside the decision, and what the characteristic misreading costs, with the single sentence all three can produce placed above them and the criteria, instruments and thresholds that belong to other chapters named as absent.

32.1 Demoralization as a named construct, not as an ordinary word

Demoralization is ordinary English, and clinical writing uses it loosely to mean discouraged, flattened, worn down. That is why the technical sense has to be introduced deliberately: a term with a colloquial meaning is read colloquially unless the reader is stopped.

One older technical use is worth knowing, and it comes from a different literature. In the account of what the psychotherapies share, **remoralization** is named as the antidote to demoralization,

the patient's restored expectancy and hope being one of the common factors that operates whatever the modality. That is a claim about every consulting room, and it is taught in the Psychotherapies, clinical assessment, MSE and nosology notes. What is added here is narrower, and belongs at the bedside of a person whose illness will not be cured.

The palliative-care proposal came from Kissane, Clarke and Street, working from a centre for palliative care in Australia, and was published in the Journal of Palliative Care. It put forward demoralization syndrome as a diagnostic category for palliative care, resting on **three** core features:

- **Hopelessness.** Not sadness about the illness, but the absence of any expectation that anything ahead can be different or better.
- **Loss of meaning.** The collapse of the answer to why this is being endured, which is a question a person under active treatment can usually answer and a person no longer under it often cannot.
- **Existential distress.** Suffering that is about the person's situation and standing in the world rather than about a symptom, and which therefore does not move when the symptom is controlled.

Read together, the three describe not a mood state but a stance towards a future, and it is that stance rather than any particular affect which the proposal argues can be separated from a depressive disorder and recognised in a palliative-care setting. The proposal went further and claimed the syndrome had satisfactory face, descriptive, predictive, construct and divergent validity, which is the argument for treating it as a diagnostic category rather than a good description. Whether that argument was accepted is dealt with below.

RULE **Hopelessness in advanced physical illness is a clinical target in its own right, not merely a severity marker of depression.** Read only as an item within a depression scale, the sole decision it can drive is whether to treat depression harder. Read as the core of a separate construct, it opens questions about meaning, dignity and the patient's position in the family, which are the questions the patient is already asking themselves.

32.2 What the construct is associated with, and the mechanism that carries it forward

The original proposal names the company demoralization keeps, and the list is worth learning in clusters rather than as a flat run of risk factors, because grouped this way it stops being a checklist and starts describing how the state is produced.

- **The illness and the body.** Chronic medical illness, disability and bodily disfigurement. What these share is permanence: each is a loss that will not be given back, and each is visible to the patient every day without any clinical event to prompt it.
- **Standing in the world.** Fear of loss of dignity and social isolation. Both are about how the person is seen and by whom, and both worsen precisely as the illness advances and the circle of people who visit contracts.

- **Position in the family.** Greater dependency on others and **the perception of being a burden**, which the proposal ties to a subjective sense of incompetence rather than to the objective level of care being provided.

That last qualification is the one candidates drop and the clinically decisive one. Burdensomeness here is a perception, not a measurement. It does not track the hours a family actually spends, and it can be most severe in a household that is coping well and complaining least. A clinician who reasons from the visible care burden to the patient's distress gets exactly those patients wrong, because a family that manages without visible strain is the family in which a patient concludes the strain is being hidden.

The mechanism the proposal offers is the hinge of this topic. Because of the sense of impotence or helplessness, those with the syndrome predictably progress to a desire to die or to suicide. That is framed not as a comorbidity but as the endpoint of a state whose defining property is that the person can no longer see themselves acting effectively on anything. The wish to die is therefore the far end of a process that began with meaning, not an independent symptom that happens to have arrived.

32.3 Demoralization and depression, and the limits of what can be claimed

The differentiability of the two is the examinable claim, and it should be stated at the strength its source states it. The proposal holds that demoralization syndrome can be differentiated from depression and is recognisable in palliative-care settings. It does not hold that they are mutually exclusive, and nothing here permits saying that a demoralized patient is therefore not depressed. Both can be present, and in advanced disease both often are.

What is useful in an answer is why the separation was proposed at all. Depression in advanced disease is difficult to identify because its somatic criteria are confounded by the illness itself, a problem the companion topic on depression, anxiety and delirium in cancer and palliative care takes up. Demoralization does not solve it, but it names a group for whom counting somatic symptoms is beside the point: the trouble is not that they cannot enjoy things, it is that they cannot see why anything should be endured. A service screening only for depressive disorder registers them as negative, correctly by its own instrument.

How often the two dissociate is not something this account will put a number on. The proportion of patients with advanced disease who are seriously demoralized without being clinically depressed, and the correlates that predict which patients those are, have a research literature behind them, but no comparable standard is available to quote, and none is invented here. Carry the dissociation as a qualitative possibility with clinical consequences, which is what the construct's own proposal supports, and do not attach a figure to it in a viva.

TRAP **Writing demoralization syndrome on the diagnosis line as though it were a classified disorder.** It was proposed, and it has not been adopted: neither the current revision of the American classification nor the eleventh revision of the international classification carries it. Candidates err because the construct is taught in criteria-like language and because its own validity claim reads like an argument already won. Describe the state in the formulation, use the accepted category for whatever disorder the patient also meets, and say in a viva that this is a proposed construct and not a coded diagnosis. That is not a hedge; it is the accurate answer.

32.4 The desire for hastened death as a presentation

The wish to die in a person whose death is already expected is a different clinical object from suicidal ideation in general psychiatric practice, where the wish is understood as a symptom of a treatable disorder in someone who would otherwise be expected to live. Here the person is dying anyway, the request is often about manner and timing rather than the fact, and the reasons given are more often about meaning, dignity and dependency than about mood. None of that removes the psychiatric task; it changes what the task is, because a clinician whose only move is to prevent an act has misread a communication.

What the same sentence can carry. At least three different things arrive in the same words. There is the wish to be dead, which is a state and not a plan. There is a request for assistance in dying, which asks another person to act. And there is a request that treatment be stopped, which asks another person to desist. These are not gradations of one thing: Indian law, set out below, treats the second and the third as different acts, so confusing them is a legal error and not only a clinical one. The enquiry that separates them, meaning the wording, the order of the questions and what follows from each answer, is not settled by any source quoted here and is not invented here. Published instruments and interview approaches exist for this purpose and a candidate should read one; a plausible protocol manufactured from memory would be a procedure nothing supports.

The same restraint applies to what such a request means in this country, and here the gap is larger. No Indian study of the desire for hastened death in advanced illness is available to quote here, and none is invented. That absence matters, because the meaning of the request is not constant across jurisdictions. Where assisted dying is lawfully available it can be a step in a defined process. Where it is not, the same words cannot be a procedural request at all and are doing something else: expressing suffering, testing whether the clinician will stay in the room, or asking that a burden be lifted from a family. Importing a Western prevalence figure, or a response framework built around a legal option that does not exist here, describes a practice that is not Indian practice.

32.5 Measurement, and what a scale can and cannot settle

A validated measure of the construct exists. The **Demoralization Scale**, developed by the same originating group, is the instrument to name if asked how demoralization is assessed formally. Name is all that is offered here: its item count, its subscale structure, its response format, its cut-offs and its later revision are not reproduced, because no comparable standard is available to

quote, and none is invented here. A candidate who quotes a threshold for this scale is quoting something unverified, and a threshold is exactly the kind of specific an examiner follows up.

What matters is what a scale of this kind is for. Demoralization was proposed because a group of patients in palliative care were being missed by the instruments already in use, so a measure of it earns its place by identifying that group rather than by grading severity within it. Two consequences follow without any numbers. A positive screen is not a diagnosis and does not by itself justify a prescription, since the construct is not a coded disorder. And a negative screen in a patient who has said they want to die settles nothing, because the request has already given you information no instrument can subtract.

32.6 What the request runs into: the Indian legal position

Every clinical response to a wish for hastened death here is bounded by one Constitution Bench judgment of the Supreme Court of India, Common Cause (A Registered Society) v. Union of India. The ethical vocabulary this area is usually taught in, meaning autonomy, double effect and the distinction between withholding treatment and actively killing, is treated with the ethics material and is not repeated here. What is set out here is the legal position itself, which is what a clinical question about a request to die turns on.

Three propositions from it are the ones to hold, and the accompanying table sets out how the Court itself characterises each of the acts they concern. The first is about **active euthanasia**, which the Court records is to be treated as legally impermissible, at least for the time being, there being no statutory law permitting it. That qualification belongs to the Court's own sentence and should be reproduced with it, because dropping it converts a dated position into a timeless one.

The second is the line between that act and **passive euthanasia**, which the judgment treats as an inherent difference rather than a matter of degree, and what follows once the second applies: when passive euthanasia becomes applicable as a situational palliative measure, the best interest of the patient overrides the State interest. That is the sentence to have ready when a viva turns to whether a ventilator may lawfully be withdrawn.

The third concerns the **advance medical directive**, for which the Court laid down a procedure in exercise of its power under **Article 142**. The consequence is the examinable point, and candidates routinely get it backwards: the Indian advance directive at the end of life rests on judicial direction and not on legislation, and the Court expressly provided that its directions remain in force only until Parliament legislates in the field.

WHAT IS BEING ASKED FOR	HOW THE COURT CHARACTERISES THE ACT	WHAT THIS ACCOUNT DOES NOT STATE
A positive act to end life	A positive affirmative act, an overt act done to end the patient's life	Whether Parliament has since legislated on the subject
That life-prolonging treatment be stopped or not started	Withdrawal of life support measures, or withholding of medical treatment meant for artificially prolonging life	The steps, authorisations and safeguards through which it is given effect
That the patient's own prior refusal be honoured	An advance medical directive, for which the Court records there was no legal framework in the country	The current form of the execution procedure and its safeguards

The last column is not decoration. The procedural machinery that judgment set up, meaning the steps by which a decision to withdraw treatment is authorised and recorded, has been revisited since, and this account does not specify it. Modal verbs are where that error does its damage: saying that a treating team shall approach a particular authority asserts a current obligation, and that is exactly what a revision changes. Know the three propositions above, know that the procedure has moved, and check the operative steps against the Court's own current text before advising a team.

One further separation must be made explicitly, because the two instruments share a name. The advance medical directive discussed here concerns life-sustaining treatment at the end of life and arises from this judgment. The advance directive under India's mental healthcare legislation is a different instrument for a different purpose, concerning a person's preferences about mental healthcare, and it is taught with that legislation. Conflating them is a serious error and an easy one to make under pressure, because both are called advance directives and both concern a decision taken ahead of incapacity.

IN INDIA

Because the Court has placed an act done to end a patient's life outside what is legally permissible, a request for one cannot be a procedural request, and the clinician is not being asked to start a process. That changes what the response is for, but not what the psychiatrist must state accurately when a family or a treating team asks, and their two real questions are answerable from the judgment: what may lawfully be stopped, and on whose word. Indian evidence on how often such requests are made and with what course is not something this account can supply, so an answer opening with an Indian prevalence figure has invented one.

32.7 What is actually done, and what the direction of travel is

The construct arrived with a treatment approach attached, and the honest statement is short: the original proposal states that an approach is described, the approach itself is not established by anything quoted in this account, and nothing is invented in its place. What can be reasoned safely is the direction, and it is named in the older literature this topic opened with. If demoralization is the state, remoralization is the movement out of it, and what does the work there is restored

expectancy and hope, a factor operating across every psychotherapy rather than belonging to one. That is not a technique. It is a specification of what any technique used here has to achieve.

Three consequences follow that a candidate can defend without a protocol. Treating a comorbid depressive disorder is necessary and not sufficient: it is indicated where the disorder is present, with the drug detail belonging to the Mood disorders: pharmacotherapy notes and its use in advanced disease to the companion topic of this chapter, but a good response in mood can leave the same unanswered question about why anything should be endured. Next, the associations here are mostly interpersonal rather than symptomatic, so an intervention aimed at the patient alone addresses the smaller half: dignity, isolation and burdensomeness sit between the patient and other people. Last, the team's own behaviour is part of the clinical field, and a team that stops visiting because there is nothing more to offer has confirmed the patient's central conclusion for them.

GOOD TO REMEMBER

Before the conversation about a wish to die goes further, be clear which act is actually in question, because Indian law does not treat them as one. A request that treatment which is only prolonging dying be withdrawn falls within a category the Supreme Court has recognised and given effect to; a request that someone act to end life does not. That is not legalism at the bedside. It is what allows a clinician to answer part of the request honestly instead of deflecting all of it.

Demoralization is hopelessness and loss of meaning in a patient who may not be depressed, its predicted endpoint is a wish to die, and in India that wish arrives in a system where a positive act to end life is impermissible while withdrawal of treatment that only prolongs dying is not.

Both halves of this topic guard against the same failure, a purely symptom-based reading. A patient is counted as not depressed and is left alone; a request to die is counted as a symptom and is only prevented. Both readings are defensible from a list of criteria and both leave the patient where they were.

The OSCE and practical exam bridge

33 · Structure of OSCE stations in psychiatry (history, MSE, management)

Why the marks sit here. Every other part of a clinical examination lets you choose your own words and your own order. An observed station does not. It hands you a written instruction, a fixed span of time and a person to work with, and scores what you are seen to do with them. That design reached Indian postgraduate psychiatry from the regulator, not from departmental custom: the national Post-Graduate Medical Education Regulations, 2023, made by the National Medical Commission's Post Graduate Medical Education Board, name the **objective structured clinical examination** inside the criterion by which the practical is passed, beside the clinical

examination and the viva voce. A component named in a pass criterion is not a teaching exercise, whatever your department has been calling it.

What follows is the structure of OSCE stations in psychiatry (history, MSE, management): what a station is built from, what each of those three task families asks you to produce, how a watched performance is scored, and where the format sits in the instruments that govern an Indian postgraduate examination. It also sets out the parts of that picture no retrievable document fixes. The topic has a firm centre and an unsettled edge, and knowing which is which beats a confident schedule that belongs to another university.

50% AGGREGATE REQUIRED ACROSS ALL FOUR THEORY PAPERS BY THE NATIONAL POST-GRADUATE MEDICAL EDUCATION REGULATIONS, 2023	**50%** REQUIRED IN THE PRACTICAL, WHICH THOSE SAME REGULATIONS DEFINE AS CLINICAL PLUS OBJECTIVE STRUCTURED CLINICAL EXAMINATION PLUS VIVA VOCE	**Nil** GRACE MARKS PERMITTED IN A POSTGRADUATE EXAMINATION, IN THEORY OR IN PRACTICAL	**Not fixed** STATIONS, MINUTES OR MARKS FOR AN OBJECTIVE STRUCTURED COMPONENT, BY ANY INSTRUMENT QUOTED ON THIS PAGE

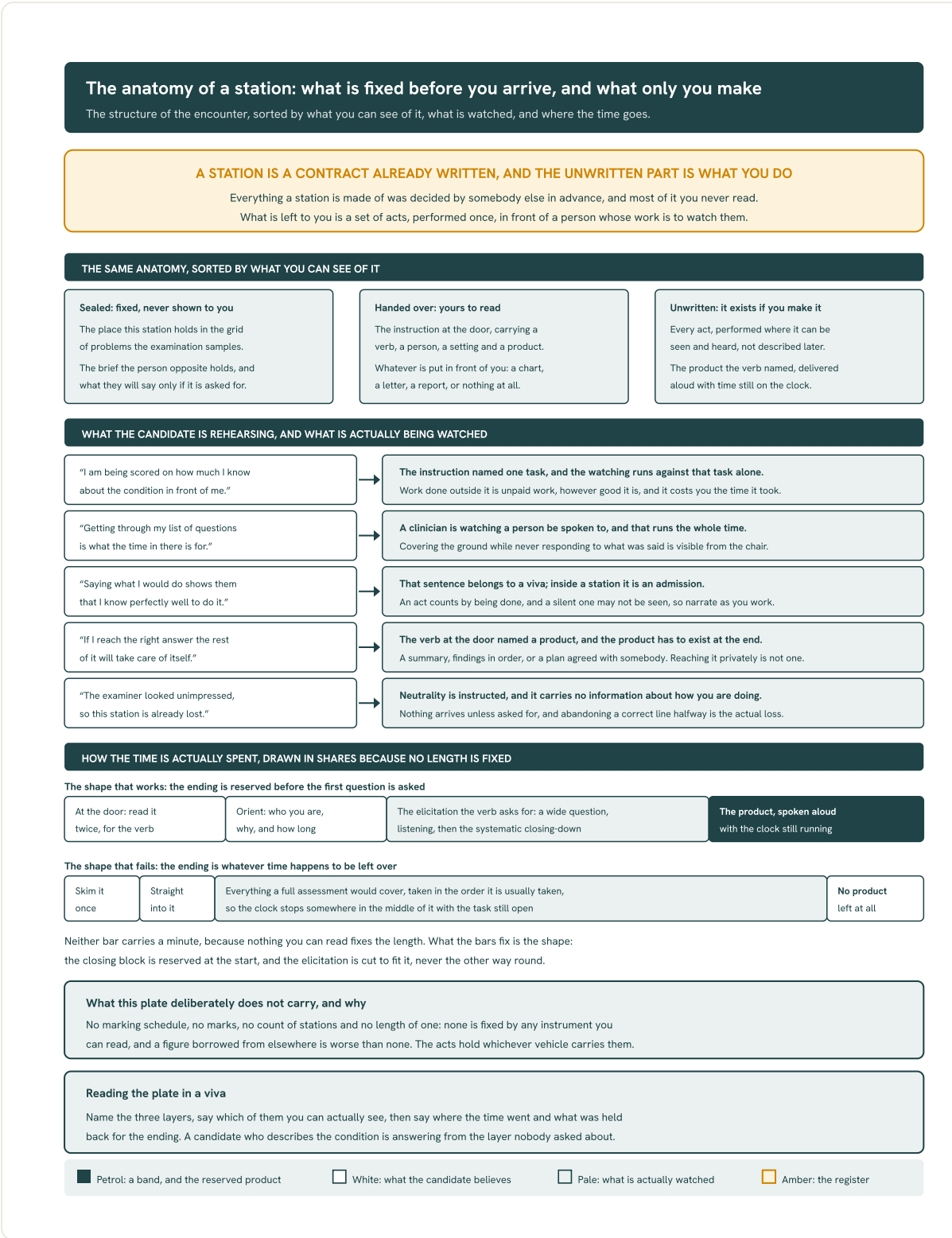


Fig 29.10. The station drawn as a structure rather than as a list of its parts, with the same anatomy sorted into what is sealed from the candidate, what is handed over at the door and what exists only if the candidate performs it, five ordinary beliefs about what is being scored set against what a watching clinician is in fact following, and the time drawn twice in shares rather than in minutes, once with the closing product reserved from the start and once with it crushed out by an elicitation that was never cut to fit.

33.1 What an objective structured station is, and the problem it was built to solve

Standardise the task, and the differences you measure become differences between candidates. In a conventional clinical examination the patient, the pathology, the examiner and the questions all vary, so two candidates given the same mark have not necessarily been asked the

same thing. A station removes those variables one at a time: every candidate meets the same written instruction, the same task, the same time and the same marking schedule, and where a real patient cannot be standardised the station substitutes a briefed person who can be.

The second gain is breadth. Clinical competence is not a single trait that transfers cleanly from one problem to another, and a candidate strong on a psychotic presentation may be weak on an alcohol history. This is **case specificity**, and it is the argument for sampling many short tasks rather than examining one case deeply: a circuit trades depth for coverage, deliberately.

So is the cost, which is why the format sits beside the traditional clinical rather than replacing it. A short task cannot test a whole clinical argument: the summary that stands alone, the differential defended against its alternatives, the formulation that earns the plan. Those need a long case, and that presentation is taken up in the section of these notes on long and short case presentation.

33.2 The anatomy of a single station

Six things exist before you arrive, and five of them are written down. Knowing them tells you where the marks are, because each is something somebody had to decide in advance:

- the place it occupies in the **blueprint**, the grid of problems and skills the examination has undertaken to sample, which is why stations feel unrelated to one another;
- the **candidate instruction** posted at the door: the task, the person, the setting, and what must exist by the time you leave;
- the brief carried by the patient or the **simulated patient**: an opening statement, information released only when asked for, cues shown rather than volunteered;
- the setting and any material handed to you, which may be a chart, a prescription, a report or nothing;
- the marking schedule the examiner holds, itemised against the task rather than against the diagnosis;
- the standard that schedule is read against, a decision of the examining board and not of the examiner in the chair.

Two consequences follow. Because the patient's information is released on request, silence is yours to fill: the person opposite is not withholding, they are waiting to be asked. And because the schedule is written against the task, material that is clinically excellent but outside it earns nothing. A station is a contract, and the instruction at the door is its text.

MNEMONIC

Instruction, Introduction, Information, Interpretation, Invitation

The five acts of any station, in order. **Instruction**: read it twice at the door, naming the verb, the person and the product. **Introduction**: name, role, purpose, consent, time. **Information**: the elicitation the verb asks for, and nothing outside it. **Interpretation**: say aloud what you found and what you make of it. **Invitation**: hand back to the patient with a question and to the examiner with a finished product. A station that fails has usually skipped the first or the fourth.

33.3 The task verb, and why the whole station turns on it

Read the instruction for its task verb before its clinical content. The verb names the product that must exist when time runs out, and the station is scored against that product. "Take a focused history of" asks for a defined territory covered and a closing summary. "Elicit and describe" asks for a technique performed in front of somebody and findings reported in the language of the phenomenon. "Explain" and "discuss with" ask for something delivered to a person who must understand it, which means checking that they did. "Assess" asks for a judgement, stated, not for the material from which one could be made.

Candidates lose stations by substituting an adjacent verb they have practised more. Asked to explain a plan, they take a history first, because history-taking is what they are fluent in. Asked to assess, they gather and never conclude. Asked for a focused history, they run the full ward assessment and reach the end of the time somewhere in the personal history. The correction is mechanical: after reading the instruction, say the product to yourself in one sentence, and let that sentence dictate your first question.

33.4 The history station: a focused history is not a shortened long case

A focused history is defined by what it deliberately leaves out. The long-case history is comprehensive because there is time to be, and because the argument you build later needs all of it. A history station names a territory and expects it covered to the depth a decision would require, with everything outside it acknowledged rather than explored. Where the instruction says a focused history of a first-episode psychosis, the marks are in onset and course, the phenomena, substance use, organic screening, risk and the effect on function and family, not in a developmental history that leaves no time for any of them.

Open by orienting the patient: who you are, why you are speaking to them, and how long you have. This is a scored act, not politeness, and it buys you the right to interrupt later. Then work from open to closed: a question wide enough to let the person say what is actually wrong, a period of listening without steering, then the systematic closing-down that covers the territory. Signpost the change of gear, and it reads as method rather than impatience.

Two elements are forgotten under time pressure and are almost always on the schedule. Risk is one: ask it, in plain words, wherever the presentation admits it, rather than saving it for a station labelled as a risk station. Corroboration is the other: an informant is rarely available inside a

station, so say whom you would seek, what you would ask and why it would change your view. Naming the collateral you cannot obtain scores; assuming it does not.

33.5 The mental state station: examining rather than interviewing

In this station the examination has to be made visible. The mental state examination as a construct, its domains and the vocabulary of its findings, is taught in the Psychotherapies, clinical assessment, MSE and nosology notes and is not repeated here. What changes when it becomes a station is that the examiner must be able to see you doing it. On the ward much of the mental state is gathered passively while you talk about something else; under observation, passive gathering is indistinguishable from not having gathered.

So the work becomes explicit. Separate what you observed from what you elicited, and say which is which. Where you find a phenomenon, probe it far enough to establish its form rather than its content alone, then stop: the schedule credits the probe, not the tour. Ask the discriminating questions: whether the voice was heard through the ears or inside the head, whether the belief is held against evidence the patient accepts as evidence. Then report in a fixed order, so nothing is lost to improvisation.

Two boundaries. A mental state station often reaches cognition, and the conduct of a named scale or bedside cognitive test under observation is set out in the section of these notes on demonstrating clinical scales and bedside tests. And the examiner is watching for damage as well as coverage: a probe pressed too hard on a frightened patient scores on the schedule and sinks the overall judgement, and both marks come from the same station.

33.6 The management station: a plan spoken to a person

Management is examined as an act of communication, not as a list. This station puts you with a patient, a relative or a colleague and asks you to explain what you propose and reach agreement about it, and the same plan delivered to those three is three different performances. The clinical content is the easy half. What is scored is whether the plan arrived in a form the person could act on: in sequence, the immediate step first, what happens where and who does it, the risks that matter to this person rather than a recitation of all of them, and an explicit invitation to disagree.

Structure it so nothing essential is crowded out. Safety and the immediate decision first, because if time runs out that is the part that must already have been said. Then the setting of care and why. Then the plan proper, biological, psychological and social, each in a sentence. Then follow-up: who reviews, when, and what brings the person back sooner. Then ask them to tell you what they have understood, the most reliably credited act in the station and the one most often skipped.

Two neighbouring station types are not developed here. Where delivering serious news or conducting a risk assessment is the whole purpose, those conversations are set out in the section of these notes on communication, breaking bad news and risk-assessment stations; where the task is to interpret something handed across the table, in the section on interpreting investigations and instruments.

STATION FAMILY	WHAT THE INSTRUCTION ASKS FOR	WHAT IS ACTUALLY SCORED	THE PRODUCT DUE BEFORE TIME ENDS
History	A defined territory covered to the depth a decision needs, with risk and missing collateral named	Question craft: open before closed, signposting, the discriminating question at the right moment	**A spoken summary, and what you would seek next**
Mental state	An examination performed and reported, observation separated from elicitation	Whether it was visibly done, whether phenomena were probed to their form, and the manner of the probing	**Findings in a fixed order, with domains not examined named as such**
Management	A plan explained to a named person and agreed with them	Sequence, specificity to this person, the invitation to disagree, the check of understanding	**An agreed immediate step, a follow-up, and a trigger for earlier review**

33.7 How a watched performance is scored

Two instruments, one performance. Observed clinical assessment is conventionally marked in two layers at once. The first is itemised: a schedule of acts specific to the task, ticked as they occur, which makes the format reproducible between examiners. The second is a **global rating**, one overall judgement made by a clinician asking whether they would be content to have this seen by a colleague at this stage of training. Neither alone is sufficient: an itemised schedule alone rewards a candidate who never notices the person answering, and an overall impression alone reintroduces the variability the format was built to remove.

Three consequences follow. An act you did not perform is not credited because you said you would have performed it, so do the thing rather than describe it. An act performed silently may not be credited either, so narrate the examination as you conduct it. And the examiner is usually instructed not to help: silence is not disapproval, and information will not arrive unless it is asked for. Candidates read that neutrality as failure and abandon a correct line halfway through.

The limit of all this should be explicit. No Indian regulatory instrument retrievable for this chapter prescribes a marking schedule, a rubric or a standard-setting method for a psychiatry station. What is written above is the general logic of observed assessment, not your board's published rubric, because no comparable standard is available to quote, and none is invented here.

RULE **A station scores the act, not the knowledge behind it.** This is the difference between a station and a viva, and where prepared candidates lose marks they had the knowledge to earn. In a viva, saying what you would do is the performance. In a station, it is an admission that you did not do it. Convert preparation into sentences you would say to a patient and acts you would perform, and rehearse it in that form.

PITFALL

Performing to the schedule and losing the person. A candidate who has memorised a list of questions gets through it, ticks a satisfying number of items and is still marked down, because the overall judgement is made by a clinician who has just watched a distressed person be processed. The tell is a station run without a pause and without any response to what the patient said. Cover the schedule by knowing the territory, not by reciting a sequence.

33.8 Where the station sits in the Indian postgraduate practical

Three instruments govern this, a fourth is only a contrast case, and they span a generation. The oldest is the MD Psychiatry ordinance of a Karnataka state health-sciences university, dated 2000. It makes no provision at all for an objective structured clinical examination, its clinical examination being entirely long cases and short cases. That is a finding about the document, not about your examination, and it is superseded on this point.

The national regulations of 2023 changed the position by naming the objective structured clinical examination inside the practical pass criterion, alongside the clinical and the viva voce. That placement is load-bearing: a component named in the sentence deciding whether the practical is passed is part of the practical. Then the state health-sciences university acted. By a notification dated 16 December 2024, made under section 35(1) of its governing Act of 1994 as amended in 2013 after a special meeting of its Syndicate on 22 November 2024, it decided to apply the 2023 regulations to the 2021-22 academic batch and to the upcoming broad-specialty postgraduate examinations, subject to relaxations on attendance, publications, the district residency programme and the courses in research methodology, ethics and cardiac life support. What carries new regulations onto candidates admitted before they were made is recorded in the same notification: the university states that it received a clarification from the National Medical Commission dated 28 November 2024, that the 2023 regulations apply to all students appearing in the forthcoming postgraduate examination. That is the university's account of the letter, not the letter itself.

The operative clause on the station is narrower than candidates assume. The notification provides that an objective structured clinical examination or a short case shall be included from the ensuing postgraduate examinations. The obligation is mandatory and the vehicle disjunctive: one or the other shall be included, and nothing establishes that you will face a circuit rather than a short case. The same notification puts valuation of theory scripts and computation of results under the 2023 regulations, and a 2025 judgment of that state's High Court records that evaluation of marks is governed by the notification of 16 December 2024, confirming it is in force and not a proposal.

INSTRUMENT	DATE	WHAT IT SETTLES ABOUT THE STATION	WHAT IT LEAVES OPEN
MD Psychiatry ordinance of a Karnataka state health-sciences university	2000	Nothing: no objective structured component, and a clinical examination of long cases and short cases only	**Superseded on this point, and never a source for a station's format**
MD Psychiatry ordinance of a private university in Karnataka	edition year 2019-20	That one institution listed it among training activities, a weekly interviewing-skills programme with no mark line	**Everything about examination use: a contrast case, not evidence of anybody else's practice**
National Post-Graduate Medical Education Regulations	2023	That it is named inside the practical pass criterion, beside the clinical examination and the viva voce	**Station number, length, marks and marking schedule**
Notification of the state health-sciences university applying the 2023 regulations	16 December 2024	That an objective structured clinical examination or a short case shall be included from the ensuing examinations, so such a component is now mandatory	**Which vehicle, and the weight of either: the division of practical marks is referred to a board of studies**

IN INDIA

Because the clause is disjunctive and the marks division referred onward, the answer for your own examination sits in a departmental decision rather than in any document you can read. Put three questions to your department and the examination section, in writing, early enough that the answers can still change your plan: whether a station component will be conducted at all or the requirement discharged by a short case; if stations, how many and how long; and how those marks sit inside the practical total. Expect the answer late or informally, and prepare for the heavier possibility meanwhile.

TRAP **Reading the acronym instead of the instrument.** The same four words denote two different things in two Indian documents: a component named inside the national practical pass criterion of 2023, and a weekly interviewing-skills training programme with no mark line at all in a private university's ordinance of 2019-20. Candidates take their seniors' usage for the regulation's, hear that the station in their department is a teaching session, and conclude nothing is at stake. What decides it is the instrument governing your own examination, read in its own words.

33.9 The arithmetic that decides the result, and where a station's marks land

Three conditions, all of them conjunctive. Under the 2023 national regulations, passing the examination as a whole requires a minimum of **40 per cent** in each theory paper, then the aggregate across all four papers set out in the strip above, and then the separate line in the

practical. Failing any one fails the examination: a strong practical does not repair a paper below the per-paper floor. That floor is the new element. Under the superseded ordinance of 2000 the rule was not less than half the marks in each of two heads of passing, theory, and practical including clinical and viva voce, with no per-paper requirement, so a weak paper could be carried by strong ones. It cannot now.

Where a station's marks land follows from that criterion's wording. Because the practical is expressly composed of the clinical examination, the objective structured clinical examination and the viva voce, marks won or lost in a station sit inside the same practical line as your long case. There is no separate station threshold and no separate station failure, which is also why the station cannot rationally be written off.

Two further provisions decide results. No grace mark is permitted in a postgraduate examination, in theory or in practical, so a shortfall is a shortfall. And scripts are handled under the national machinery the notification adopted: every theory script receives two valuations, a third follows where the two differ by **15 per cent** or more of that paper's total marks, the best two are then averaged, and there is no revaluation once results are declared.

The board is fixed by the same regulations: at least **four** examiners for a postgraduate examination, of whom at least two shall be external, and at least one of those external examiners shall be from a different university outside the state. At least half the people marking you have never taught you and will read an unexplained local abbreviation as an error rather than a convention.

One point of revision strategy belongs with that floor. The older ordinance placed consultation-liaison psychiatry, geriatric psychiatry and psycho-oncology in the second theory paper and cultural psychiatry in the third, adding that its distribution of topics against papers is suggestive only. Its fourth paper is displaced: under the current instruments the fourth carries recent advances and the first basic medical science. With a floor in every paper, recent advances cannot be written off against strength elsewhere.

GOOD TO REMEMBER

Convert revision into rehearsal by building your own stations. Write a one-sentence instruction on a card carrying the verb, the person and the time. Give it to a colleague, let them hold the clock and play the patient from a brief you did not write, and require yourself to deliver the product aloud before time ends: the summary, the reported findings, or the agreed plan. Then swap, and mark each other against what the instruction asked for rather than what you would have liked to say. This does more for a practical than the same hours spent reading: the failures that cost marks here are failures of shape, and shape only changes under a clock.

33.10 What is not settled, and how to prepare when the format is not fixed

Name the unknowns rather than guessing them. Four things about an Indian postgraduate psychiatry station are not established by any instrument quoted here, and a confident figure for any of them is somebody's local arrangement until you have seen the document it comes from:

- how many stations a circuit contains, if a circuit is used at all;
- how long a single station runs;
- what a station is worth, as marks or as a share of the practical, the division of practical marks being referred to a board of studies;
- whether the requirement will be discharged by stations or by a short case, the instrument being disjunctive on its face.

That is unsatisfying, and better than the alternative. Numbers circulate for all four, usually borrowed from another state or from an undergraduate examination, and a schedule built on a borrowed pattern is worse than one built on none. What is settled is enough to work from: such a component is now mandatory, its marks sit inside the practical line, and the acts it scores are the same whichever vehicle carries them.

That last point is the resolution. A short case and a station both put you in front of a person with a narrow brief and an examiner watching, and both score the performance rather than the account of it. So prepare the behaviour, not the format: read instructions for their verb, introduce yourself and take consent, ask before assuming, narrate the examination as you do it, reach a stated conclusion before time ends, and check that you were understood.

> A station scores what you are seen to do, inside one practical pass line that also holds your long case and your viva; the component is mandatory for the ensuing examinations while its vehicle, count, length and marks are fixed by nothing you can read, so rehearse the acts under a clock and ask your department which vehicle it will use.

34 · Long case and short case presentation format

Why the marks sit here. The clinical examination is the one part of a postgraduate examination that cannot be got up in the week before it, and the part that decides whether a candidate is judged fit to work unsupervised. Its purpose is stated in the regulations, not left to custom: the clinical examination in a clinical-science subject is conducted to test the candidate's knowledge and competence for undertaking independent work as a specialist and teacher. That aim tells you what is being listened for: not whether you can take a history, which is assumed by this stage of training, but whether the account you give of the patient afterwards could be handed to a ward and safely acted upon.

Two formats carry that assessment. The **long case** gives you one patient and expects a whole clinical argument, from the history to a plan in sequence. The **short case** gives you a narrow task and expects competence rather than narrative: elicit this, demonstrate that, interpret what you find, answer for it. The examiner's attention moves accordingly, from your reasoning in the first to your hands and your questions in the second. What follows is the long case and short case presentation format itself, from the shape of the time with the patient to the last answer you give.

1 + 2	2 + 2	300	100
LONG CASE PLUS SHORT CASES REQUIRED OF A CLINICAL-SCIENCE SUBJECT BY THE NATIONAL POST-GRADUATE MEDICAL EDUCATION REGULATIONS, 2023	LONG CASES PLUS SHORT CASES SET BY THE MD PSYCHIATRY ORDINANCE OF A KARNATAKA STATE HEALTH-SCIENCES UNIVERSITY DATED 2000, A MARK SPLIT SINCE SUPERSEDED	MARKS FOR THE PRACTICAL EXAMINATION, THESIS INCLUDED, UNDER A KARNATAKA STATE HEALTH-SCIENCES UNIVERSITY NOTIFICATION OF 16 DECEMBER 2024	MARKS FOR THE VIVA VOCE UNDER THAT SAME KARNATAKA NOTIFICATION OF 16 DECEMBER 2024

34.1 What the two formats are for, and why no single allocation is universal

The format is national; the arithmetic is local. The national regulations governing postgraduate medical education, made in 2023 by the National Medical Commission's Post Graduate Medical Education Board, state that candidates in the clinical sciences shall be examined for **one long case and two short cases**. A university ordinance can set out something heavier. One Karnataka state health-sciences university's MD Psychiatry ordinance, dated 2000, sets a second long case in neurology worth the same as the psychiatry one, with two psychiatry short cases at 25 marks each; those four cases account for the whole of that ordinance's clinical examination, which it sets at 200 marks. That split has since been overtaken at its own university: a notification of 16 December 2024 sets the practical examination at 300 marks including 20 for the thesis and the viva voce at 100, and expressly leaves the division of marks inside the practical to be settled in consultation with its board of studies. The totals are fixed and the per-case figures are not, so no long-case or short-case mark value can honestly be quoted for it now, and none from an older document may be carried across to fill the space.

The relation between the national regulation and the older ordinance is not something either text settles. The national provision is cast in the mandatory form and the older ordinance sets more cases than it specifies; whether that extra long case is a permitted enhancement of a national minimum or a divergence from a national specification is not resolved by the words of either instrument, and it is not resolved here. Prepare for the heavier pattern, because a candidate ready for two long cases is ready for one and the reverse is not true.

DOCUMENT AND DATE	LONG CASES	SHORT CASES	MARKS AND BOARD AS THAT DOCUMENT STATES THEM
The national Post-Graduate Medical Education Regulations, 2023 (India)	One	Two	**The provision that sets the case count carries no mark allocation and no board composition; both are governed by separate provisions of the same regulations**
MD Psychiatry ordinance of a Karnataka state health-sciences university, dated 2000	Two: one psychiatry at 75 marks, one neurology at 75 marks	Two, both psychiatry, 25 marks each	**Clinical examination 200 marks; a board of four members, of whom one should be a neurologist or clinical psychologist**
Notification of the same Karnataka state health-sciences university, 16 December 2024	Not stated	Not stated	**Practical 300 marks including 20 for the thesis, viva voce 100; the division of marks inside the practical is referred to consultation with the board of studies, so no per-case figure is published**

RULE **The clinical examination tests whether you can be left alone with the patient.** Both the national regulations and the university ordinance state the aim in the same terms, competence for independent work as a specialist and teacher, and every marking decision descends from it. A presentation that proves you gathered information but never commits to what happens next has answered a question nobody asked. Commit, then defend the commitment.

34.2 Read the document that governs your own examination

The act that comes before any revision. The single most useful hour of preparation is spent not on a textbook but on the **ordinance** under which your university examines, together with any later notification amending it, because between them they tell you what you are walking into, and because departmental custom drifts from both in either direction. Obtain what your university publishes for your degree and your subject, and read the examination provisions in full rather than the summary a senior has drawn from them. Extract, in writing:

- how many long cases there are, and whether one of them is a neurology case rather than a psychiatry case;
- the marks on each long case and each short case, if the governing document states them at all rather than fixing only the totals and leaving the split to be settled later;
- how many short cases there are, and whether they are drawn from psychiatry alone;

- whether any objective structured component is marked as part of the practical, which is set out in the section of these notes on the structure of objective structured stations in psychiatry;
- the composition of the examiner board, including whether a non-psychiatrist sits on it;
- how your marks are grouped when the result is decided, which is a separate provision and is treated in that same section rather than assumed here.

Do this early enough that it can still change your plan.

IN INDIA

Ordinances are published unevenly. A university may host a scanned regulation many years old, amended since by notifications and circulars that are not printed alongside it, while the department examines to a pattern that has moved on again. Two consequences follow. The published instruments, ordinance and amendment together, are what an appeal, a grievance or a query to the examination section has to rest on, so read them even where you expect them to be stale. And ask the department directly, in writing if you can, whether the pattern in force differs from what is published, well before the final months.

34.3 The time with the patient, and what must be finished before it ends

The long case is decided before you open your mouth. How long you are given with the patient is set locally, and no comparable standard is available to quote, and none is invented here. What is general is how the time should be shaped. Consent and a workable rapport come first, because a patient already examined by several candidates will give a thin history to the next one unless that candidate troubles to be human about it. Then the history, taken in the order you always take it, because a familiar order is what protects you from omission under pressure. Then the examination, mental state and physical, actually performed. Then, and this is the part candidates sacrifice first, a period in which nothing new is collected and the case is turned into an argument.

That last period is not optional. It is where you write the summary you will speak, decide the diagnosis you will lead with, name the alternatives you will dismiss and the grounds for dismissing them, and rehearse your opening until it is fluent. A candidate who spends the whole allotted time collecting arrives with a full notebook and no position, and then reads it out. The corroborative history is part of this work rather than an appendix to it: seek the informant, record who they are, how long they have known the patient and how much they witnessed themselves, because **informant reliability** is a judgement the examiner expects you to have made and stated, not a box filled.

GOOD TO REMEMBER

Do the general physical and neurological examination on the long-case patient, every time, even when the case is plainly psychiatric and the time is short. It is the element most often skipped and, precisely because it is skipped, among the most reliably asked about. An examiner who finds you have not looked at the fundus, the gait, the pulse or the thyroid has been handed a way to test whether the rest of your account was gathered or assumed.

34.4 The presentation: a summary that stands on its own

The examiner should know the case by the end of your third sentence. The presentation opens with a **summary statement**, and its test is severe: if the examiner stopped you there and heard nothing else, they should be able to say what kind of illness this is, roughly how long it has run and what shape it has taken. That means the opening carries the patient's identifying particulars and social position, who gave the history and how reliable it is, the duration and the course, and the dominant syndrome named in phenomenological rather than diagnostic language. It does not carry the diagnosis yet, and it does not carry chronology for its own sake.

Two habits of speech matter as much as the content. Expand every abbreviation aloud; shorthand that saves time on a case sheet reads as imprecision when spoken, and some of it is genuinely ambiguous across specialties. And report phenomenology in the patient's own words before translating it into a technical term, so the examiner can hear the raw material and check your translation. A candidate who says the patient described a voice speaking about him in the third person, and then names the phenomenon, has shown two things. A candidate who names the phenomenon alone has shown one, and has invited the examiner to ask what the patient actually said.

MNEMONIC

Whose, What, Why, What next

The four questions a long-case presentation has to answer, in order. **Whose** problem this is: the patient, their circumstances, the informant and the reliability of the account. **What** is wrong: the phenomenology, then the diagnosis argued against its alternatives. **Why** it has happened to this person now: the formulation. **What next**: investigations and a plan in sequence, with a prognosis you can justify. A presentation that stalls does so almost always because it never left the first question.

34.5 Marshalling the evidence, including what you did not find

Group your findings by the argument they serve, not by the order you collected them. After the summary, the body of the presentation is evidence, and evidence persuades in proportion to its arrangement. Take the positives supporting your leading diagnosis together, then the features that would ordinarily point elsewhere and what you make of them, then the course and the treatment history with an explicit statement of whether previous treatment was adequate in dose and duration and whether it was actually taken. Chronology belongs inside each of these, not across the whole.

The element that separates a competent presentation from a strong one is the **pertinent negatives**: the findings you specifically sought and did not obtain. Stating them is how the examiner learns that your differential existed before your conclusion did. A candidate who says there was no head injury, no seizure, no sustained elevation of mood and no substance use in the relevant period has closed doors deliberately. A candidate who omits them leaves the examiner unable to tell whether those doors were closed or never opened, and the examiner will find out by asking. Risk belongs here too, stated rather than waited for; the assessment of suicidal risk itself

is developed in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, but the fact that you have made one, and what you concluded, is yours to say before anybody asks.

> **PITFALL**
>
> Never state a finding you did not elicit. Under pressure, and especially when an examiner asks about something the presentation omitted, there is a strong pull towards supplying the answer the case seems to require. The correct answer is that you did not ask, or did not examine for it, and, if you can, what you would ask now and why. An examiner who catches one invented detail has a reason to distrust the entire account, including the parts that were true and carefully obtained. The cost of the honest answer is one mark; the cost of the invented one is the case.

34.6 From diagnosis to formulation, which is what the second half of the questioning is about

A diagnosis is a claim, and a claim invites the question "what else?" State the diagnosis you have reached, with the classificatory system you are using, and then do the work that earns it: name the serious alternatives and give the grounds on which each is set aside. Alternatives are set aside on evidence, not on adverbs, and the evidence is what you have just presented. Where you genuinely cannot decide, say so, say what would decide it, and say what you would do in the meantime. That answer is more mature than a false confidence and is usually marked as such.

Then move to the **formulation**, which asks a different question: not what this illness is but why this person has it now, and why it is taking this shape and this course. Predisposing, precipitating, perpetuating and protective factors are the frame, and the substance is reasoning that ties them to the person in front of you, not a list applied generically. The construct itself, and how a formulation is built and written, is taught in the Psychotherapies, clinical assessment, MSE and nosology notes; what belongs here is the discipline of presenting one. Keep it short and specific to this patient, and make sure it does work: a formulation that explains nothing about the plan you are about to propose has not been used. Then give the plan in sequence, with the investigations you would send and, more searchingly, the ones you would not and why. Deciding not to investigate is a clinical decision and is examined as one.

34.7 The neurology long case, and the commonest error of preparation

Where a second long case is neurological, half the long-case marks are not psychiatric. In the Karnataka ordinance of 2000 the neurology long case carried **75** marks, exactly what the psychiatry long case carried, and that equality is the part worth holding on to even where the current figures are unpublished. A revision plan built entirely from psychiatry is therefore not cautious; it has conceded a substantial block of marks before the examination begins. This is the commonest strategic error on this format, and it is invisible to the candidate making it, because psychiatry revision feels like the responsible use of the time.

A neurological long case asks for a different sequence, and the difference is worth rehearsing rather than reading about. The history is taken to localise before it is taken to diagnose. The examination is then not merely performed but demonstrated, in a sequence the examiner can follow, with signs elicited cleanly and described in the language of the system involved. The presentation ends with an anatomical statement and then a pathological differential, in that

order: where the lesion is before what caused it. The neurological syndromes themselves, and the examination that discloses them, are taught in the Neurology foundations for psychiatrists notes and the Stroke, TBI, delirium and focal brain syndromes notes, with the seizure disorders in the Epilepsy and psychiatry notes and the cognitive syndromes in the Dementias and neurocognitive disorders notes. What is owed here is the instruction to prepare for the case as a case: on real patients, out loud, in the order you will use in the hall.

34.8 The short case: competence under a narrower brief

A short case is a task, not a story. The two instruments that state a case count agree on the number of short cases: two in the national regulations and two in the older Karnataka ordinance. What changes is not the standard of clinical work but its scope. You are given a defined brief, usually to elicit and then to show: a mental state examination of one domain, a cognitive assessment, a set of neurological signs, an interview segment with a stated purpose. The examiner is often present while you work, and that is the point: in the long case your technique is inferred from your account, in a short case it is watched.

So **demonstration** becomes the marked activity. Say what you are about to do and why, do it in a sequence, describe what you find as you find it, and offer an interpretation that is proportionate to the amount you were able to examine. Do not deliver a full formulation for a short case, and do not open with a summary designed for a long one; both read as a candidate with one script and no judgement. Where the brief involves eliciting motor or catatonic phenomena, the phenomena themselves are taught in the Other psychotic disorders, delusional syndromes and catatonia notes, and the bedside conduct of scales and structured tests is set out in the section of these notes on demonstrating clinical scales and bedside tests. What is examined here is whether you can do a small thing correctly while observed, and stop when it is done.

AXIS	THE LONG CASE	THE SHORT CASE
What you are given	One patient and an open brief: assess and present	**A narrow, stated task on a patient or an interview segment**
What you do with the patient	Full history, informant account, mental state and physical examination, then time to build the argument	**The specified elicitation or examination, performed while it is watched**
What you present	Summary, evidence with negatives, argued diagnosis, formulation, plan in sequence, prognosis	**Findings as they were obtained, then an interpretation proportionate to the brief**
What is actually marked	Clinical reasoning: whether the plan could be acted on unsupervised	**Technique and economy: whether the procedure was done correctly and cleanly**
What ends it	The examiner's questions, which begin where your argument stopped	**The completion of the task, after which a candidate should stop talking**

34.9 The board across the table, and what a mixed board changes

Not everyone examining you is a psychiatrist. Under the Karnataka ordinance of 2000, the **board of examiners** for the clinical examination consists of **four** members, one of whom should be a neurologist or a clinical psychologist. Note the ordinance's own verb: the requirement is expressed as what should be the case rather than as an absolute, so the board you actually meet may be composed either way, and preparing on the assumption of a mixed board costs nothing.

The consequence is practical. If a neurologist sits on the board, your neurological examination is watched by somebody who performs it daily and will notice a manoeuvre done for form rather than for information. If a clinical psychologist sits on it, expect more exacting questioning around assessment instruments, including what a test measures and what its result does not license you to conclude; that material is developed in the Psychotherapies, clinical assessment, MSE and nosology notes. Either way, pitch the presentation to a competent colleague from outside your own subspecialty interest, another reason to expand abbreviations and give phenomenology before jargon.

34.10 Where the marks are actually lost

The failures on this format are few and repetitive. Each is avoidable by a decision rather than by more knowledge:

- the summary never arrives, because the candidate began at the beginning of the history and is still there when the examiner intervenes;
- the negatives are missing, so the differential appears to have been constructed after the conclusion;
- the diagnosis is asserted, not argued, and the alternatives are named without grounds for dismissing them;
- the physical and neurological examination was not done, and the candidate is asked about it;
- the plan is a list of everything rather than a sequence, with no statement of what comes first and what would change it;
- risk is not mentioned until the examiner raises it.

Only one of these is a knowledge failure. The rest are failures of shape, and shape is trainable: present real cases aloud, to a colleague who will interrupt, against a clock, until the summary and the argued diagnosis arrive early enough to be heard.

TRAP **Presenting the case sheet instead of the case.** The commonest failure is to narrate the written record in the order it was written, treating completeness as the virtue being marked. It is not: the case sheet is the raw material and the presentation is the argument built from it. The candidate who reads the record runs out of time in the personal history, delivers the diagnosis and plan as bare assertions, and is then examined on precisely the reasoning that was crowded out. Write the record in full, and then present something else.

34.11 Currency, disagreement, and the part of this that does not vary

The honest position on the documents. The instruments discussed here do not sit comfortably together, and a reader is better served by seeing that than by a tidy synthesis. The Karnataka ordinance is dated 2000 and applies from that academic year, and both of its arithmetics have since moved. Its written papers were four of three hours each, carrying two long essay questions at 20 marks and six short essay questions at 10, and that pattern is not what the same university now sets: under the notification of 16 December 2024 each of the four theory papers is set at **ten questions of ten marks**. Revising to the older pattern would be revising to the wrong shape. The national regulations of 2023 supply the frame the newer notification works inside: the theory examination may be of descriptive or multiple-choice type of equal duration, the descriptive form runs to four papers, and the first and the fourth are on basic medical sciences and recent advances respectively. The newer notification does not give a paper's duration and does not say what the middle two papers contain, and neither is supplied here. What the older ordinance remains good for is shape rather than schedule: it is evidence that allocations differ between universities, not a table to memorise for your own examination.

What does not vary is what this page is for. Whether you face one long case or two, whether one of them is neurological, whatever the short cases turn out to be worth, the presentation that earns the marks has the same architecture: a summary that stands alone, evidence arranged as an argument with its negatives stated, a diagnosis defended against named alternatives, a formulation that does work, a plan in sequence, and a candidate who says what they did not find. The arithmetic, where a document publishes it, tells you how to divide your preparation. It does not change how you present a patient.

> Read the ordinance and any later notification that governs your own examination before you plan a single revision session, and prepare for the heavier of the patterns you find: how many long cases there are, whether one of them is neurological, who sits on the board, and whether the marks on each case are stated at all rather than left to be settled later.

35 · Demonstration of clinical scales and bedside tests

Why the doing is its own competence. A candidate can describe an instrument accurately, say what it was built for, and still be unable to run it on a real patient while somebody watches. Knowing an instrument and conducting one are different competencies, and only the second shows at a bedside. In the demonstration of clinical scales and bedside tests, what is on display is not the instrument's content, which could have been read the night before, but a procedure: whether you obtained permission, whether you set the conditions the instrument assumes, whether you delivered its instruction unaltered, whether the patient was left with their dignity intact, and whether you could then say out loud what you had and had not established.

Set the boundaries first. The instruments themselves, the bedside cognitive screens among them, together with the rating scales and the detailed neuropsychological batteries, are taught in the Psychotherapies, clinical assessment, MSE and nosology notes and in the Dementias and

neurocognitive disorders notes. No item, scoring rule or cut-off is reproduced here, and none is needed for the skill this section teaches. The second boundary is a silence, and it is stated at the front rather than buried: how a demonstration of this kind is called for, whether it is marked as a thing of its own, in what time, and against what weighting cannot be stated, because no comparable standard is available to quote, and none is invented here. A reader not told that will assume a marking scheme exists which they were simply never shown, and will prepare for the tariff instead of the act.

35.1 What you can be handed, and why it matters which

The instruction can arrive in more than one form, and they are not the same task. A **rating scale** is a published instrument with fixed items, a fixed order and a scoring convention, so its demonstration is mostly a question of fidelity: you are showing that you can run somebody else's procedure without deforming it. A **bedside test** is a manoeuvre drawn from the clinical examination, elicited and described rather than scored, so its demonstration is one of technique and accurate description: the burden shifts from following a script to eliciting a sign cleanly and reporting exactly what you saw.

A third instruction is thinner and carries more risk: assess this patient's cognition, or show how you would quantify this patient's depression, with no instrument named. Here the choice of instrument is itself part of what you are demonstrating, and it has to be defended in one sentence before you begin: what the question is, what the patient can physically and linguistically do, and how much the task will take out of someone who is unwell. Choosing an instrument the patient cannot complete, and discovering it mid-administration, is an avoidable failure that begins before the first item.

35.2 The conditions the instrument assumes, and whose job they are

Every instrument silently assumes conditions, and the person administering it owns all of them. A patient who cannot hear the instruction has not failed the item; the administration has. The **conditions of administration** are therefore fixed first, visibly, and named aloud so that anyone watching knows they were fixed rather than assumed:

- Spectacles and hearing aids in place and working, and if they are not available, that fact stated before the task rather than after the result.
- Adequate light on the page and on your face, and a position where the patient can see your mouth while you speak.
- A firm writing surface and a working pen for any task requiring drawing or writing, arranged before the instruction is given, not searched for mid task.
- The language of administration settled, and a decision made about whether you or somebody else will speak it.
- A patient who is awake, not in pain and not mid-procedure, with a clear agreement that the task stops if that changes.

The last is regularly skipped because it feels like a courtesy rather than a technical prerequisite. It is technical: a drowsy or distressed patient generates a result that describes the drowsiness, and reporting it as the patient's performance is a substantive error, not a soft one.

35.3 The words before the first item

The opening should be short, said once, and delivered as though the patient rather than the observer were the only person in the room. It has to do a few things at once: identify you, describe what is about to happen, warn that some tasks will feel easy and others harder, remove the sense that a wrong answer has consequences, and make explicit that the patient may stop. Then stop talking and wait for an answer, because permission that is not actually given is not permission, and a task begun while the explanation is still running was agreed to by a patient who did not yet know what they were agreeing to.

Keep this at the level of ordinary clinical courtesy. The separate legal question of the patient who cannot give a valid consent to being assessed at all is a different subject, treated on its own elsewhere in these notes. What matters here is that permission was sought, that it was audible, and that it was obtained before anything was administered.

35.4 Fidelity: the instruction as written

The core of the whole act is delivery of the instrument's own wording, at its own pace, as often as it permits and no more. **Verbatim instruction** feels stilted to a clinician who has spent years learning to speak in a patient's idiom, and the temptation to improve on it is strong. Resist it. The improved instruction is a different instruction.

RULE **An instrument administered differently is not that instrument.** Every deviation, however kindly meant, moves the result off the standard procedure the published version rests on, so the result you obtain belongs to your improvised version rather than to the instrument you are about to name in your report. This is a clinical matter and not a formality: a generous administration produces a reassuring result on a patient who is not reassured, and the next clinician to read the record has no way of knowing that it happened.

The mirror of fidelity is tolerance of failure. **Coaching** is the reflex to rescue a patient who is struggling, with a hint, a gesture, a slower repetition, an encouraging partial answer, or a generous reading of a near miss. It comes from decency and it destroys the observation. An item the patient cannot do is left undone and recorded as undone, and the discomfort of watching that happen is part of the skill. If the patient becomes distressed, the correct act is to stop the task, not to soften it: a stopped task with a stated reason is interpretable, whereas a completed task that was quietly assisted is not.

35.5 The patient and the observer in one room

A demonstration asks you to be intelligible to somebody standing behind you while remaining engaged with the person in front of you, and the tension is usually resolved badly in one direction or the other. Turning towards the observer converts the patient into an exhibit, and the discourtesy is visible. Turning away entirely leaves nobody able to tell whether the instruction was given correctly at all, which is the part an observer cannot reconstruct afterwards.

The workable answer is positional and vocal rather than verbal. Sit where your voice carries past you, keep your eyes and your body oriented to the patient, deliver instructions at a volume that carries behind you, and do all commentary about the patient after the task and away from the bed. Nothing about a finding is discussed over the patient's head. If something must be said mid-task, it is said to the patient.

GOOD TO REMEMBER

One line in the record does most of this work, and it is written at the time or not at all: which instrument and which version was used, the language it was administered in and by whom, the sensory aids that were in place, and any item not attempted with the reason it was not. A result recorded without them cannot honestly be compared with the same patient's result on another day, and a comparison you cannot trust is worse than no baseline.

35.6 The act, step by step, and what deforms each step

The table sets the sequence against its characteristic failure. The right-hand column is the operative one: each entry is a deviation that looks small at the bedside and changes what the result can be used for.

STEP	WHAT HAS TO BE VISIBLE IN THE DOING	THE ALTERATION THAT MAKES IT A DIFFERENT TEST
Permission and framing	The patient hears who you are and what the task is, and agrees, before anything is administered	Starting the first item while still explaining, so the permission covers a task the patient had not yet heard
Conditions	Aids, light, seating, writing surface and language settled and stated aloud	Running the task through an uncorrected sensory deficit and reporting the output as the patient's performance
Instruction	The instrument's own wording, at its own pace, repeated only as it permits	Paraphrasing, simplifying, repeating a single-presentation item, or translating on the spot without saying so
Response handling	What the patient did, recorded as they did it, including refusals and near misses	Rescuing a failing item with a hint, a gesture or an encouraging repetition
Failure	An item the patient cannot do left failed and noted as failed	Reading it generously because the patient is old, tired or unwell
Closure	The patient brought out of the task, thanked, and told what happens next	Turning away to report while the patient is still sitting in the middle of it
Report	Conditions, procedure, observation and limits, in that order	Opening with a total, or with a diagnosis

35.7 Stopping the task, and what the report contains

Closure is the step most often lost, because by the end of the task the candidate's attention has already moved to the report. The patient has just been asked to do things they may have done badly, in front of strangers, and leaving them there is unkind and conspicuous. Close the task explicitly, thank them, answer the question they usually ask about how they did in terms of what happens next rather than the result, and only then turn to reporting.

Conditions	Procedure	Observation	Limits
THE STATE OF THE PATIENT AND THE ROOM WHILE THE TASK WAS RUN	WHICH INSTRUMENT, IN WHICH LANGUAGE, ADMINISTERED BY WHOM	WHAT THE PATIENT ACTUALLY DID, IN THE ORDER THEY DID IT	WHAT THIS OBSERVATION CANNOT SETTLE BY ITSELF

Conditions first tell the listener how much weight the rest of the report can carry. Procedure next fixes what was actually administered. Observation is then description rather than verdict: which domains the patient managed, where the difficulty sat, and what it looked like. The limits are stated by you rather than extracted from you, and they matter, because a screening observation obtained once, at the bedside, in a patient who is acutely unwell settles very little on its own.

TRAP **Reporting a total instead of a performance.** Candidates do it because a number sounds like an answer and appears to close the task cleanly. It does neither. A single total conceals which domain the patient actually struggled in, which is the part that changes what happens next, and it puts the weight of the answer on interpreting the figure, which is a separate skill treated on its own elsewhere in these notes. Describe what the patient did, name where the difficulty sat, say what you would do next, and say what you would want before committing to any reading of the result.

35.8 When the demonstration cannot be completed as designed

The situation to expect, rather than the clean one. Real patients refuse, tire, become distressed, cannot see the page, cannot hold the pen, do not share your language, or have an attendant who answers on their behalf. **Incomplete administration** is not a failed demonstration; it is a demonstration of something harder, which is judgement under a constraint you did not choose. What converts it into a failure is concealment: an abandoned task described as though it had been completed, or a partial result presented without the conditions that made it partial. Say what you did, say where you stopped, say why, and say what you would do instead.

IN INDIA

An instrument published in English, a patient whose first language is not English, and a relative who answers on the patient's behalf are the ordinary conditions of a bedside demonstration in an Indian general hospital, and each is handled by an act rather than an apology. If a validated version in the patient's language exists and is available, use it and say which one. If it does not, say aloud that you are translating, name who is translating, and treat the output as an observation obtained under translation rather than as the instrument's own result. Where a family attendant is present, ask them courteously and audibly not to supply answers during the task, and record that you asked: an attendant's prompting is the ordinary way a bedside cognitive task quietly becomes a family interview. Schooling and literacy are recorded alongside the sensory aids as conditions of the observation. How far they move a given instrument's result is that instrument's own literature and belongs to the Psychotherapies, clinical assessment, MSE and nosology notes.

MNEMONIC

Ask, Adjust, Administer, Acknowledge, Account

The spine of the act, in the order it happens. **Ask**: name yourself, name the task, obtain permission, and wait for it. **Adjust**: aids, light, seating, surface and language settled aloud before the first item. **Administer**: the instrument's own wording, at its own pace, with failure left standing. **Acknowledge**: close the task with the patient before you turn away from them. **Account**: conditions, procedure, observation and limits, in that order, with the limits volunteered rather than extracted.

In a demonstration the product is the procedure, not the patient's score: the conditions you fixed, the instruction you gave unaltered, the performance you recorded as it happened, and the limit you placed on it yourself.

36 · Communication, breaking bad news and risk-assessment stations

Why the marks sit here. Most of a postgraduate examination asks for an account of something. Communication, breaking bad news and risk-assessment stations ask instead for the thing itself, performed once, in front of somebody whose task is to watch how it is done rather than to hear what is known about it. That difference is the whole of the assessment, and it is why these stations separate candidates whose written papers look alike. A candidate can define collusion, name a disclosure protocol and list the correlates of suicidal intent, and still be unable to sit down with a frightened man and tell him what the biopsy showed. The examination exists in part to find that out.

There is a second reason the marks are here, and it is a claim the profession makes about itself rather than an examiner's convention. The Indian Psychiatric Society's clinical practice guidelines on breaking bad news, published in 2023, record that many physicians consider psychiatrists best suited to breaking bad news, being better at handling emotions and more effective in communication skills, and that this role becomes much more important in a consultation-liaison set-up. Read the first of those exactly as written: it is a view attributed to colleagues, not a finding

about outcomes, and the guideline reports it as such. It is nonetheless why a surgical unit telephones on a Friday afternoon about a family that will not let its patient be told.

6	4	2023	13.6%
STEPS IN THE SPIKES PROTOCOL FOR BREAKING BAD NEWS	OBJECTIVES THAT SAME PROTOCOL SETS FOR THE CONVERSATION AS A WHOLE	YEAR OF THE INDIAN NATIONAL PROFESSIONAL-BODY CLINICAL PRACTICE GUIDELINE ON BREAKING BAD NEWS	OF ONE IRANIAN MEDICAL-SCIENCES UNIVERSITY'S FACULTY AND RESIDENTS FOUND TRAINED IN DELIVERING BAD NEWS; NOT AN INDIAN FIGURE

36.1 What is actually being examined, and the yardstick it is examined against

The station marks a transaction, not a recitation. What the tasks grouped as communication, breaking bad news and risk-assessment stations have in common is that an examiner is watching an exchange rather than hearing a report about one. What can be seen from outside that conversation is a short list of things: whether the patient was allowed to say what he already believed before he was told anything; whether the information was released at a rate the person in front of you could absorb; whether an emotion, when it arrived, was answered rather than talked over; and whether the two of you finished with something agreed that was not agreed at the start. Everything else is commentary. The candidate who has prepared the content of the news and not the shape of the conversation will deliver an accurate, complete and useless five minutes.

There is a published yardstick for this and it is worth holding, because it converts a vague instruction to communicate well into **four** checkable objectives: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient's **collaboration** in developing a strategy or treatment for the future. Notice that only one of the four is about telling. The first is listening, the third is emotional work, and the fourth is a joint plan. A candidate who treats the task as pure transmission has satisfied a quarter of its declared purpose and will be marked accordingly, whatever the accuracy of what was said.

36.2 Why this task falls to the psychiatrist, and why it falls hardest on the ward

The referral usually arrives after the news has already gone wrong. Two things follow from the Indian guideline's positioning of this skill. The first is that the psychiatrist is being asked to do a job other specialties own clinically: the oncologist knows the staging, the nephrologist knows what dialysis will mean, and neither is asking you to take over the disclosure so much as to make it survivable. The second is that the setting where this matters most is named, and it is the **consultation-liaison** set-up, where you are a guest on somebody else's ward with no independent authority over the patient's treatment and a very short relationship to work from. How a consultation service is configured, and what a liaison model changes about that authority, is developed in the section of these notes on the principles and models of consultation-liaison psychiatry.

That guest status is the practical difficulty, and it should shape the answer you give an examiner. You rarely control who has already spoken to the family, or what they were told. So the first act of a real consultation is almost never the disclosure. It is finding out what has already been said, by

whom, to whom and in what language, because a second version of the truth delivered by a new face is not a clarification to a frightened family: it is evidence that somebody is lying. Ask the referring team what words they used, and the patient what he has been told; the gap between those two answers is frequently the referral's actual problem.

36.3 The two ways of getting it wrong, and why the decision is not binary

Both silence and bluntness are failures, and the guideline names them symmetrically. This is the ethical spine of the topic and it is where most candidates go wrong, because they arrive holding one side of it. Withholding a diagnosis or a prognosis from the patient on the presumption that he will not be able to handle it may not always be justified in terms of the patient's autonomy and the **right to know**. Hold that modal exactly as the guideline sets it: not that withholding is never justified, but that it may not always be, which leaves the clinical judgement open rather than closing it by rule. Against that stands the opposite failure, which is **insensible disclosure**: pouring out bad news with disregard for its emotional consequences, which may harm the patient's mental health and the therapeutic relationship between patient and doctor.

Set side by side, the two propositions do something useful to the examination answer. They dispose of the question the candidate is silently asking, which is whether to tell or not to tell, and replace it with a better one: how much, to whom, at what pace, and with what support in place afterwards. The candidate who announces that the patient has an absolute right to know and proceeds to exercise it has taken half the frame. So has the candidate who defers entirely to the family. The examinable position holds both halves and then reasons about this patient, and it is available to you as a stated position of the national guideline rather than as your own opinion.

RULE **Disclosure is a process with a rate, not a decision with two options.** The clinical question is never simply whether the patient is told. It is what he already suspects, how much he is asking for today, what will be said next, and who will be with him when it lands. Framing the task as a binary is what produces both classic failures: the conspiracy of silence on one side and the corridor announcement on the other. A protocol is useful precisely because it converts a yes-or-no decision into a sequence that can be paced, paused and resumed.

36.4 The protocol, and an honest word about where this version of it comes from

Name it, then be able to do it. The protocol every examiner expects you to name is **SPIKES**, and its **six** steps are setting; perception of the condition or its seriousness; the **invitation** from the patient to give information; knowledge, meaning the giving of medical facts; exploring emotions and sympathising; and strategy and summary. The Indian guideline of 2023 describes it as the oldest and most commonly used protocol worldwide, which is the sentence to have ready if asked why this one rather than another.

One caveat belongs on the page rather than in a footnote, because a candidate who attributes a protocol wrongly in a viva has made an avoidable error. The wording of the steps given here follows a teaching adaptation issued by a Canadian university's continuing professional development office, which states in its own opening line that it is an adaptation. That document

credits the original description to Baile and colleagues in 2000 and a further account to Buckman. Saying that aloud if pressed on the source is a better answer than a confident misattribution.

MNEMONIC

SPIKES

The six steps in order. **S**etting: the room, the seat, the interruptions. **P**erception: what the patient already believes about the condition or its seriousness. **I**nvitation: the patient's own invitation to you to give the information. **K**nowledge: the medical facts themselves. **E**: explore emotions and sympathise. **S**trategy and summary: what happens next, said plainly, and a summary of what has been agreed. The order carries the teaching. Two of the first three are the patient talking, and the news does not arrive until the fourth.

36.5 The act, step by step

Each step has a condition that must be true before you may move on. The table sets out what the protocol requires and where each step is lost under examination conditions. The detail given for setting, for knowledge and for the exploration of emotion is the protocol's own; the conduct advice attached to the remaining steps is general clinical teaching and is offered as such. Setting is the step candidates believe they can skip because the room is already arranged for them. It cannot be skipped, because sitting down, silencing the interruption and asking whether the patient wants somebody present are visible acts, and the examiner is watching for them.

STEP	WHAT THE STEP REQUIRES	WHERE IT IS LOST
Setting	Arrange privacy, involve significant others, sit down, make a connection and establish rapport, and manage time constraints and interruptions	**Standing, or talking across a trolley. A candidate who stays on his feet has told the patient this will be brief before saying anything**
Perception	Establish what the patient understands of the condition or its seriousness	**Asked as a formality and then ignored. The answer should change what is said next, including whether a warning is needed at all**
Invitation	Obtain the patient's invitation to give the information	**Skipped, or made rhetorical, leaving no room for the patient to decline or to ask for less today**
Knowledge	Use language the patient understands, taking account of educational level, socio-cultural background and current emotional state; give information in small chunks; check whether the patient understood; respond to reactions as they occur; give any positive aspects first	**Delivered whole, in one breath, in the register of a case presentation. Checking understanding is the most commonly omitted act in the protocol**
Emotions	Identify the emotion the patient shows, identify its cause, allow time for it to be expressed, then respond in a way that shows you have connected the two	**Answered with reassurance or with more information. Both end the emotion rather than acknowledge it**
Strategy and summary	Agree a strategy and summarise	**Lost to the clock, because the earlier steps ran long. The patient then leaves with the news and without a plan, which is the worst possible use of the time**

Two habits make the difference on the day. Stop after each small quantity of information, because the first sentence of bad news suspends comprehension and much of what follows it is lost. And when the patient becomes tearful, the station is being marked: name what you see, connect it to its cause, and wait.

36.6 What the protocol has been criticised for, and the modifications that answer it

Know one criticism and two modifications, and the viva answer is finished. The Indian guideline records that clinicians have modified the protocol by adding steps they judged essential. In 2005 a version was published in which a preparation step was prefixed, covering the review of all information about the patient that needs to be communicated and rehearsing it if necessary. A later modification inserts the **warning shot** as a step of its own and replaces the knowledge step with a composite that juggles providing information, clarifying, and dealing with emotions.

The criticism the guideline records is that the protocol has no step on patient questions and clarifications. Be careful with the referent when you repeat it. That sentence follows immediately on the description of the version with the preparation step, so whether the criticism is aimed at the original protocol or at that modification is not settled by the text, and a candidate who asserts one reading confidently has read more into the source than it contains. The safe formulation is that the criticism attaches to this family of protocols, and that the later modification is the answer to it.

VERSION	WHAT IT ADDS	WHAT THE INDIAN GUIDELINE RECORDS
The original six-step protocol	Setting, perception, invitation, knowledge, emotions, strategy and summary	**The oldest and most commonly used worldwide**
The version published in 2005	A preparation step at the front: review everything that must be communicated, and rehearse it if necessary	**Presented as a modification clinicians made by adding a step they felt was essential**
The later modification	A warning-shot step, and an information, clarification and emotions composite in place of a plain knowledge step	**Described as a recent modification; it is the version that meets the recorded criticism about questions and clarifications**

36.7 The Indian consulting room: who is told, and who asks that the patient not be

The protocol assumes a dyad and you will usually be handed a family. In much of Indian practice the relatives receive the information first, often in the corridor, and arrive at your door having already decided what the patient will and will not be told. The request that follows is **collusion**: do not use the word for the diagnosis, tell him it is an infection, he will lose hope. This is not obstruction and it is rarely selfish. It is a protective act inside a model of illness in which the family, and not the individual, is the unit that copes, and it should be met as one.

What works is neither compliance nor confrontation. Ask the relatives what they fear will happen if the patient is told, because the answer is usually a specific and addressable dread rather than a general principle. Ask what the patient has already asked them, which frequently reveals that he knows. Offer to find out what he wants to know rather than to tell him everything, which is the invitation step doing exactly the work it was designed for, and is also the offer families most often accept. The same negotiation runs when the illness is a progressive neurocognitive one and the patient's own comprehension is in question; those syndromes are taught in the Dementias and neurocognitive disorders notes, and capacity at the bedside in the section of these notes on it in the general hospital.

IN INDIA

Do not present the family's request as an ethical error to be corrected. The national guideline's own frame gives you a better position: withholding on a presumption about what the patient can handle may not always be justified against autonomy and the right to know, and disclosure that ignores emotional consequences may damage both the patient and the therapeutic relationship. Both halves sit in the same document, so a candidate can hold the family's protective intent and the patient's entitlement in one answer without appearing to import a foreign standard. The workable route is the patient's own invitation: establish what he wants to know, tell him that much, and tell the family exactly what you did and why.

36.8 The risk-assessment station: an interview that has to arrive somewhere

A risk station examines an act of enquiry, not a list of correlates. This is the station where the mismatch between what candidates revise and what is marked is widest. The epidemiology of suicidal behaviour, the risk and protective factors and the instruments used to structure their assessment are clinical content taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes, and reciting them is not what a **risk-assessment station** is for. What is examined is whether you can ask a person directly about self-harm and death without flinching, follow what he says rather than your schedule, tolerate the answer, and then convert the conversation into a stated level of concern and a plan somebody else could act on.

Three features of the interview are visible from outside it, and all three are marked:

- whether the question was asked plainly and early enough to matter, in words the patient would use rather than in euphemism, because an oblique question invites an oblique answer and the candidate then reports an absence that was never really tested;
- whether the enquiry moved from thought to intent to plan to preparation and access to means, following the patient's disclosures rather than a checklist, and whether protective considerations were sought with the same seriousness as the risk ones;
- whether it ended anywhere at all, because a risk interview that stops at information has not finished.

That last feature is the one candidates lose. Say what you conclude, say what you will do about it now, say what would change it, and say who else needs to know before the shift ends.

TRAP **Performing the label instead of the task.** The commonest failure in both stations is the same, and it is visible from the first sentence: the candidate narrates the protocol at the examiner instead of using it on the patient. Announcing that one would establish the setting, ascertain the perception and then obtain an invitation, while the simulated patient sits unaddressed, scores nothing; nor does reciting risk factors in the examiner's direction while the person who might die that night is asked no direct question. Name the framework once if asked to, then turn your chair towards the patient and do it.

36.9 What must be in the note before you leave the ward

An unwritten risk assessment is an unmade one. On a consultation-liaison service the record is the only part of your work that persists, because the team that acts on it was not in the room. The

entry after a disclosure should state:

- who was present, and who did the speaking;
- the words actually used for the diagnosis and the prognosis, rather than a paraphrase of them;
- what the patient said he had understood;
- what he asked, and what he chose not to be told;
- what was agreed about who would be told what next, which is the line that prevents a second version of the truth reaching the family.

The entry after a risk interview needs a different spine: what was asked, what was said in reply, the level of concern reached and the reasoning that produced it, the actions taken now, and the specific changes that should trigger a fresh assessment. A note recording only that the patient denied suicidal ideation has documented an answer without documenting the question, and it protects neither the patient nor the clinician. It is also how the examiner's follow-up is answered before it is asked, because the viva after a risk station is usually a request for the plan you would write.

GOOD TO REMEMBER

Before you leave the bedside, close three loops out loud: tell the patient what happens next and when somebody will return; tell the referring team, in person where you can, what you said and which words you used, so the next clinician does not contradict you; and write the entry immediately rather than at the end of the round, while the patient's own phrasing is still available to you. The patient's words are evidence and your paraphrase of them is not.

36.10 Who teaches this, and a figure that belongs to somebody else

The guideline gives psychiatry a teaching duty, not only a clinical one. Alongside the clinical role, the Indian guideline states that psychiatrists should play a leading role in teaching communication skills and skills in breaking bad news to their fellow colleagues in other disciplines. That is a useful sentence in a viva on service development, and an unusually concrete duty for a guideline to assign: it makes the department, and not only the individual consultant, answerable for how bad news is delivered across the hospital. A candidate asked how they would improve disclosure practice in their institution has a national document to cite rather than a personal preference to defend.

Behind that duty sits an evidence problem worth understanding rather than repeating. Training in this skill is not assumed to be universal, and the guideline illustrates the point with a study of how few clinicians had been trained. The illustration comes from a population that is not ours, and it is routinely transposed.

PITFALL

The figure of **13.6 per cent** trained in delivering bad news belongs to faculty and residents at a medical-sciences university in Iran, and to nobody else. It sits close to Indian material in the same discussion, which is exactly the arrangement in which a population quietly changes on its way into an answer script. Quote it with its population attached or do not quote it at all. To assert that Indian clinicians are undertrained in this skill is a separate claim requiring Indian evidence, and no Indian figure for it is asserted anywhere on this page.

36.11 The limits of what can be said about the station itself

The honest position on the format. Everything above concerns the act. How an objective structured communication or risk-assessment station is built for an Indian postgraduate examination is a different question and should be treated separately: no comparable standard is available to quote, and none is invented here. Nothing available sets out how such a station is constructed, how long it runs or how its marks are distributed, and a candidate who rehearsed to an invented schedule would be preparing for an examination that does not exist. What is known about how objective structured stations are organised in general is set out in the section of these notes on the structure of objective structured stations in psychiatry, and the conduct of instruments at the bedside in the section on demonstrating clinical scales and bedside tests. Read your own university's ordinance for whether a structured component is examined at all, and ask the department whether the pattern in force differs from the printed document.

What does not vary is the material this page is for. Whichever format your examination uses, the same conversation is being assessed: a patient asked what he already believes before he is told anything, information released at a rate a frightened person can take, an emotion answered when it arrives, a plan made jointly rather than announced, and a record that lets the next clinician continue the same account rather than begin a new one. Practise it on real patients, with a colleague watching, and be corrected out loud. There is no other route to competence in an act, and the interview technique underpinning it is developed in the Psychotherapies, clinical assessment, MSE and nosology notes.

Ask what the patient already believes and how much he wants to be told before you tell him anything, and check what he has understood and state what happens next before you leave: the first two steps and the last two steps of the protocol are where the marks and the clinical outcome both sit, and the news itself is the easy part in the middle.

37 · Interpretation of investigations and instruments in vivas

Why the marks are here. Somewhere in almost every oral examination a piece of paper is turned around and pushed across the table: a report, a chart, a film, a printout or a completed rating form. What is tested is not whether you have memorised a reference range. It is whether you can take an object you did not order, from a patient you may not know, and convert it out loud into a clinical decision, in order, without overreaching and without going silent. The interpretation of

investigations and instruments in the viva is written into the regulations governing the examination rather than left to departmental habit.

Two boundaries first. What an abnormality signifies, what an imaging sequence demonstrates, what an electroencephalogram or a cerebrospinal fluid profile can establish, and how a rating instrument is scored and where its cut-offs fall are taught in the Neurology foundations for psychiatrists notes, in the Dementias and neurocognitive disorders notes and in the Psychotherapies, clinical assessment, MSE and nosology notes. No finding, constant or cut-off is reproduced here. The second boundary is a silence, better stated at the front than discovered late: how many such questions are put, how long you are given for one, and what share of the oral's marks they carry cannot be stated, because no comparable standard is available to quote, and none is invented here.

37.1 What the oral examination is directed at

The national regulations governing postgraduate medical education, made in 2023 by the National Medical Commission's Post Graduate Medical Education Board and applying across India, provide that the oral examination shall be thorough and shall aim at assessing the candidate's knowledge and competence about the subject, about **investigative procedures**, about therapeutic technique, and about other aspects of the specialty. That list settles an argument candidates have with themselves every year: investigations are not an intrusion of general medicine into a psychiatry viva, and the regulation places them alongside the subject itself.

A university ordinance can add how the questioning is conducted. The MD Psychiatry ordinance of a Karnataka state health-sciences university dated 2000 provides that all the examiners **will conduct the viva conjointly**, assessing comprehension, analytical approach, expression and **interpretation of data** across all components of the course contents. Interpretation of data is named there as an assessed quality rather than as a topic, so it is watched throughout and not only when a film appears; and because the questioning is conjoint, your answer must be intelligible to the whole board at once, not only to the examiner who asked.

37.2 What can be put in front of you, and why it is not folklore

That ordinance is unusually explicit about the material. It provides that candidates may also be given case reports, charts, gross specimens, histopathology slides, radiographs, ultrasound and computed tomography images for interpretation, and that **questions on the use of instruments** will be asked. Notice the two modal verbs. The interpretation material is what a candidate may be given. The instrument question is what will be asked.

The clause is not one department's tradition. It appears word for word in that ordinance of 2000 and again in the MD Psychiatry ordinance of a private university in the same state, edition year 2019-20, which marks it as inherited regulation text carried across institutions rather than a local quirk you might be spared. The material listed is therefore generic to the clinical sciences rather than tailored to psychiatry, and the candidate who protests inwardly that a slide has nothing to

do with the specialty has missed that the ward asks the psychiatrist every week to exclude a medical cause before attributing a presentation.

RULE **Describe before you interpret, and interpret before you commit.** Every recoverable answer here has that shape; every unrecoverable one skipped a stage. A description can be corrected by the examiner and the answer continues; a diagnosis offered first has nothing standing under it, so when it is wrong there is nowhere to retreat and what follows is about your error rather than the patient. The order also makes an answer auditable to a board listening conjointly.

37.3 The order of interpretation

A fixed order is faster, not slower, because it removes the decision about what to say next. The order set out below is a working discipline rather than a published convention, and it changes little with the object in front of you. One step deserves emphasis in advance because it is the one most often skipped: say whether the object is technically adequate for the question being asked of it. **Technical adequacy** decides how much weight everything said after it can carry.

STEP	WHAT THE BOARD IS LISTENING FOR	THE ANSWER THAT LOSES THE MARK
Name the object	What it is, whose it is, when it was obtained, in what context	**Reading findings aloud before establishing what is being read**
Adequacy	Whether it can answer the question asked of it at all	**Treating an inadequate study as though it were a normal one**
What is present	Description in the order the object dictates, not the order your eye jumps	**Naming the one striking abnormality and then stopping**
What is absent	The negatives the clinical question required you to look for	**Silence, which a board cannot distinguish from never having looked**
Synthesis	One sentence tying the findings to the question actually asked	**Findings with no answer, or an answer with no findings under it**
Limits and next step	What this object cannot settle, and what you would obtain next	**Closing on a conclusion the object cannot carry**

MNEMONIC

What it is, whether it reads, what is there, what is not, so what, what next

The six steps in the order they are spoken. The last two are dropped first under pressure and are the two that separate a description from an interpretation: **so what** forces the commitment, **what next** shows you know where your evidence stops.

37.4 The trap answers

The failures worth rehearsing are not failures of knowledge. They are things a well-prepared candidate says because the room is tense and a decisive-sounding answer feels safer than a careful one.

- **Accepting the premise.** An examiner who says "this patient's scan is abnormal, what is your diagnosis" has embedded a claim in the question. If you cannot see the abnormality, say what you can see and ask to be shown what is meant. Agreeing first and searching afterwards leaves you defending a finding you never identified.
- **The unpointable finding.** Never name an abnormality you could not put a finger on if the object were handed back. The follow-up is always to show it, and from there the exchange is about your credibility.
- **Supplying a number you do not hold.** A range guessed to fill a pause is the one error that survives the examination and reaches a patient. Say you would check it against the reporting laboratory's own range, which is also the correct clinical answer.
- **Reading a normal result as an exclusion.** A normal test narrows a probability; it does not delete a diagnosis. State what remains possible and what would move you.
- **Reading an instrument's total without its conditions.** A score obtained through an uncorrected sensory deficit, in a language the patient uses poorly, or with a relative supplying answers, describes the conditions rather than the patient. Ask how it was administered first.

TRAP **Leading with the diagnosis.** The commonest single error at this table, and made for an understandable reason: a named condition sounds like mastery and appears to close the question cleanly. It does the opposite. It hides the reasoning that is the only thing being marked, it invites the follow-up you are least ready for, and it leaves nowhere to fall back to when the object turns out to be something else.

37.5 Questions on the use of instruments

The instrument question is a different task and is prepared differently. It does not ask what a device measures in the abstract; it asks whether you have handled one. Which instruments a psychiatry board selects is not specified by any of the documents that create the requirement, so no list is offered here and none is guessed. What is stable is the shape of a good answer, in four moves:

- Identify the object plainly, and say so if you are unsure rather than producing a confident wrong name.
- State what it is for, in terms of the clinical decision it supports rather than its mechanism.
- Describe how it is used and what has to be true before it is used, including the check that gets skipped on a busy ward.
- Say honestly what your own experience of it is: used independently, used under supervision, or seen used. An overstatement here is tested by the next question.

GOOD TO REMEMBER

Build this answer during residency, not during revision. For every investigation you order and every instrument you handle, keep one line: why you used it in that patient, what came back, and what you did differently because of it. A candidate with that habit answers from clinical memory rather than from a list.

37.6 The dissertation viva: the one investigation that is yours

The result you cannot be handed cold. One set of findings you will certainly be asked to interpret aloud, and you generated it. The national regulations of 2023 provide that **five per cent** of the practical marks will be for the dissertation, that an external examiner from outside the state will evaluate the dissertation thesis and take the viva on it, and that marks will be given on the quality of the dissertation and on performance in the viva voce. Both halves are marked, so a sound thesis does not carry a poor defence of it.

20	Outside the state	Before it begins	100
MARKS THE THESIS SHALL BE EVALUATED FOR DURING THE PRACTICAL, UNDER A KARNATAKA STATE HEALTH-SCIENCES UNIVERSITY NOTIFICATION OF 16 DECEMBER 2024	WHERE THE EXAMINER WHO EVALUATES THE DISSERTATION AND TAKES THE VIVA ON IT COMES FROM, UNDER THE NATIONAL REGULATIONS OF 2023	WHEN A COPY OF THE THESIS SHALL REACH THE HEAD OF DEPARTMENT, RELATIVE TO THE START OF THE PRACTICAL EXAMINATION	MARKS THE VIVA VOCE IS FIXED AT BY THAT SAME 2024 NOTIFICATION, WHICH REFERS ITS INTERNAL DIVISION TO A BOARD OF STUDIES

That Karnataka state health-sciences university, by a notification of 16 December 2024 issued under section 35(1) of its 1994 Act as amended in 2013, restates that share as an absolute figure: the thesis shall be evaluated for 20 marks during the practical examinations, the student shall submit a copy to the head of department before the practical examination begins, and those marks form part of the clinical or practical examination marks. Two consequences: the submission is a deadline a candidate can miss by assuming the department will collect the copy, and a weak defence costs you in the same pot as a weak long case.

An honest word on that document. Its wording as reproduced here comes from a copy of the scanned notification rather than the university's own published file, so its authority is corroborated rather than primary: a judgment of the High Court of Karnataka dated 12 March 2025, neutral citation 2025:KHC:10432, records that evaluation of marks is governed by the notification of that date. Plan around the figures; obtain your department's copy before relying on the exact words.

Prepare the defence as an interpretation task, because that is what it is. You will be asked why this design, why this instrument and not the alternative, what the sample will and will not support, and what you would do differently. An examiner from another state shares none of your department's assumptions and no local shorthand.

37.7 Which document governs you, and what has already changed

The scope clause above is the fullest published statement of what the viva contains, and it sits in an ordinance dated 2000. Whether every part of it still governs an examination sat now is not established, and you are better served by that sentence than by a confident assurance. Some of it has certainly moved. Under the older ordinance the viva proper carried **eighty of the viva's hundred marks**; the notification of 16 December 2024 fixes the viva voce at 100 marks and refers the internal division of those marks to a board of studies, so the older split is superseded. That notification does not address the scope of the viva, so the clause listing interpretation material and instrument questions is not expressly displaced.

One further variation is named only so that it is not carried across. The MD Psychiatry ordinance of a private university in Karnataka, edition year 2019-20, splits a 100-mark viva into 80 for the viva proper and 20 for a pedagogy exercise, in which a topic is given to each candidate at the beginning of the clinical examination and presented for **eight to ten minutes**. That **pedagogy exercise** is that institution's own scheme in its own document and is not established for any other examination. Read the ordinance and any later notification your own university publishes for your degree, as the section of these notes on long and short case presentation sets out, and ask which is in force.

IN INDIA

The object pushed across the table in an Indian examination hall is usually one another unit ordered for another purpose. The report may be a line written on the film jacket rather than a formal one; the earlier study that would make the current one interpretable may never have been done, or may be travelling in a folder the family carries between hospitals. None of that is an excuse and all of it is examinable. Say what you have, say what is missing, and name what you would want beside it: the previous film for comparison, the earlier value, the reporting laboratory's own range, or an account of how the instrument was administered.

The board is not asking you to name the abnormality. It is asking you to show that a result changes what you would do next, and to say out loud where your evidence stops.

Cross-cutting synthesis

38 · Cross-cutting synthesis

Four questions, one page. These notes have taught what a consultation is and whose need it answers, what changes when the patient is old, what changes when the account of the cause was settled by the family before anyone sent for you, and how all of it is asked for across a table by examiners. That looks like four subjects. It is four questions put to a single encounter, and they converge on one object: a page written into somebody else's file and acted on tomorrow by somebody who was not in the room. That page is the **consult note**. Anything you elicited that does not reach it has not, for the purposes of the patient's care, happened.

Putting it this way is practical rather than tidy. An unfamiliar referral becomes navigable once you know the pathway it sits inside and the points at which each question has to be asked, because those points are fixed and there are few of them. Asked at the right point, each costs a few minutes. Asked late, each costs a second visit, or a plan agreed in the room and abandoned outside it, or a record that cannot show you did what you actually did.

Not the patient WHOSE FELT NEED PUT A PSYCHIATRIST AT THIS PARTICULAR BEDSIDE	**Against baseline** THE COMPARISON EVERY LATE-LIFE JUDGEMENT IN THE NOTE IS MADE AGAINST	**Already explained** WHAT THE FAMILY HAS USUALLY SETTLED ON BEFORE THE REFERRAL IS WRITTEN	**Somebody else acts** WHY THE NOTE IS AN INSTRUCTION TO ANOTHER TEAM AND NOT A RECORD OF YOUR THINKING

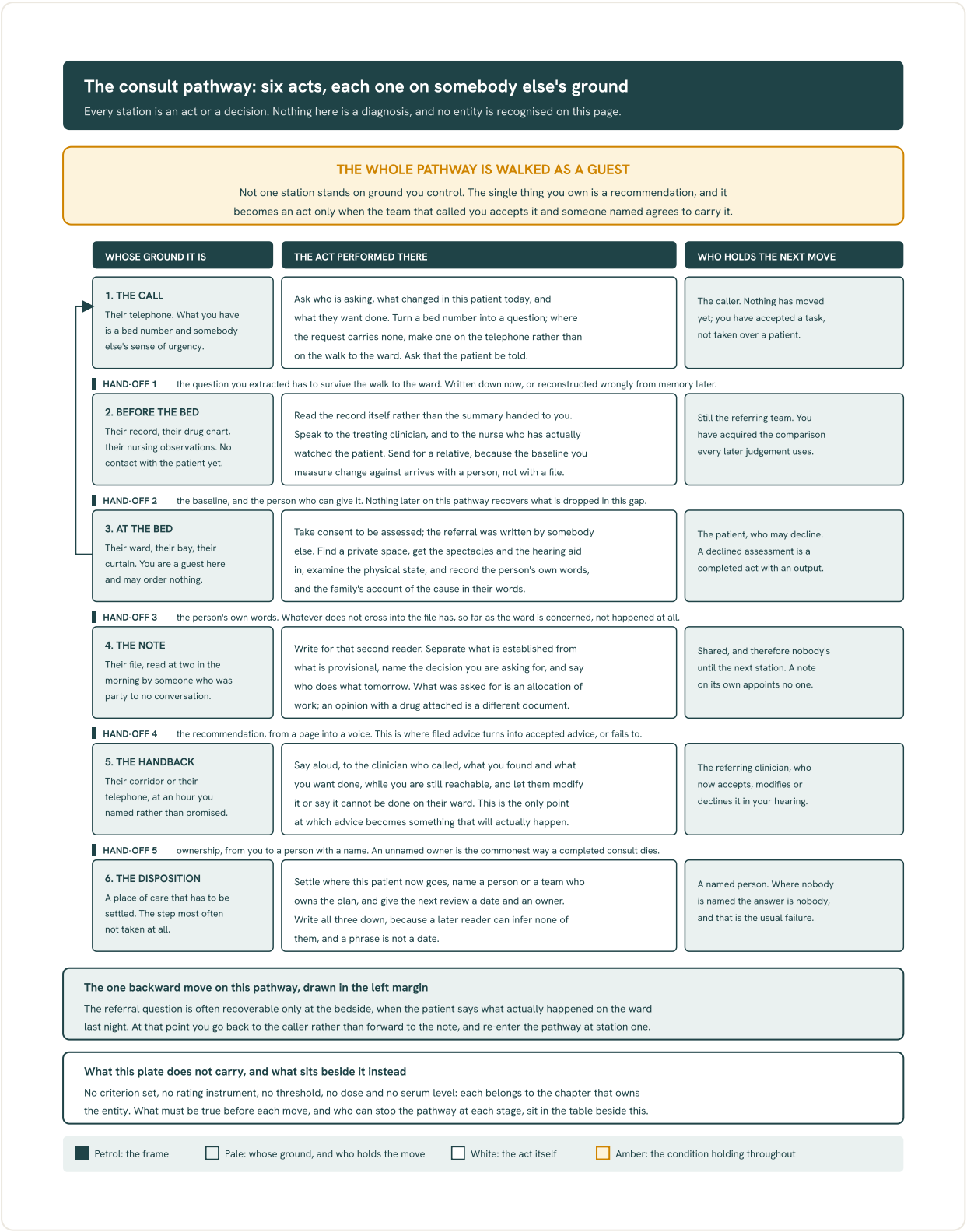


Fig 29.11. The consultation drawn as a pathway of six acts rather than as a set of entities, each station stated as something done or something decided, with the ground the act is performed on named on the left and the person who holds the next move named on the right, the five hand-offs between stations marked as the points at which information is lost, the standing condition that the whole route is walked as a guest set at the head, and the single backward move, from the bedside back to the caller, drawn in the left margin.

38.1 One artefact, and the two people who will read it

A consultation produces two outputs and they are not interchangeable. One is a conversation with the clinician who asked for you, the only point at which the team can say that what you want

is not possible on their ward, and the commonest difference between advice taken and advice filed. The other is the written record, the only output that persists after you leave the building.

The note has two readers who need different things from it. The first is the consultant who called, who wants to know whether what worried them is what you found. The second is the one nobody writes for: the **second reader**, a duty doctor at two in the morning who has never met this patient, was party to no conversation, and has your page and the drug chart. Write for the second reader and the first is served anyway. Write for the first and the note becomes a reply to a colleague, full of things that were obvious in the corridor and opaque by nightfall. That is why a good consult note names the decision it is asking for rather than gesturing at one, and separates what is established from what is provisional, since the person reading it at night cannot ask you which is which.

RULE **Everything this material teaches has to survive into a document another team will act on without you in the room.** That one constraint generates most of what looks like separate advice. Consent is established rather than assumed because a reader must be able to see the patient agreed to be seen. An informant is summoned before the visit because a judgement about change is worthless without the baseline it was measured from. The family's account of the cause is recorded in their words because the reader needs to know what will be accepted. And the decision, its owner and the next review date are written down because none of the three is inferable. An assessment that stays in your head is, to the ward, indistinguishable from no assessment.

38.2 The pathway, and the hand-offs inside it

The consult is a short sequence of acts with a hand-off between each pair, and a hand-off is where information is lost. The accompanying figure sets out the same sequence. Read the table as conditions rather than as a checklist: each row states what has to be true before you are entitled to move on, and who is placed to stop the pathway there.

STAGE	WHAT MUST BE TRUE BEFORE YOU MOVE ON	WHO CAN STOP IT HERE, AND WHAT STOPPING LOOKS LIKE
The call	You know who is asking, what has changed in this patient today, and what they want from you; and the patient has been told a psychiatrist is coming	The person who called, by leaving a bed number and nothing else. The repair is a question put back down the telephone, not a walk to the ward
Before the bed	The record has been read rather than the summary handed to you, the treating clinician has been spoken to, nursing observation is known, and word has gone to a relative to attend	You, by arriving with only the referral slip. Nothing later in the pathway recovers what this stage would have given you
At the bed	Consent taken, a private space found, hearing and language made adequate, the person's own words recorded, and the physical state examined before anything is scored	The patient, who may decline. A declined assessment is a completed act with an output, not a failure to be argued around
The note	Written into the team's own record, in implementable language, naming what is established, what is provisional, and the decision being asked for	You, by writing a diagnosis and a drug. That is an opinion; what was asked for was an allocation of work
The handback	The clinician who called has been told in words what you found and what you want done, and has had the chance to say it cannot be done here	The clock. The repair is to name the hour you will call rather than to promise that you will
The disposition	A named person owns the plan, the place of care is settled, and the next review has a date and an owner	Nobody stops this one. It is simply the step most often not taken at all

Two features of that sequence matter apart from its content. The pathway is a sequence of acts while the note is an artefact with its own spine, and the two are not the same list. And the pathway is less linear than a checklist implies: the **referral question** is often recoverable only at the bedside, when the patient says what actually happened on the ward last night, at which point you go back to the caller rather than forward to the note.

38.3 Where the other three questions enter, and what it costs to ask them late

Age, the explanatory account and decisional capacity are taught as separate subjects, which conceals what makes them manageable at a bedside: each enters this same pathway at a definite point, cheap there and expensive afterwards. The cost of lateness is not embarrassment but a specific, predictable clinical loss, and naming that loss turns three large topics into three questions you remember to ask.

THE QUESTION	WHERE IT ENTERS THE PATHWAY	WHAT IT COSTS WHEN IT ENTERS LATE
What was this person like before, and who can tell me	Before the bed, because the informant has to be summoned in advance and is rarely still there afterwards	Every cognitive and behavioural finding becomes uninterpretable. A second visit is then needed to obtain what one telephone call would have obtained
Whose account of the cause is already in the room	At the call and again at the bedside, since it governs what will be accepted; by the time the note is written the negotiation is over	A plan agreed in front of you and abandoned in the corridor. The abandonment is then misread as denial or as poor insight
Can this person make the decision actually in front of them, now	The moment a decision exists, which is usually before the referral was written	An assessment done only after a refusal reads as retaliation, and the record can no longer show capacity was presumed before it was questioned

The third row carries a trap worth spelling out. Capacity is decision-specific and time-specific, so a note recording that a patient lacks capacity, without saying which decision and on what date, has recorded nothing usable and may do harm when read months later as a settled characteristic of the person. The statutory test, the presumption it starts from and the duty to give information in a usable form are set out in the part of these notes dealing with refusal of treatment in the general hospital. What belongs here is where in the pathway the question arises, and that is earlier than most candidates place it.

38.4 What being old does to the note

Age does not add a paragraph. This is the most useful single point on the life-stage axis, and it is why appending an elderly-patient line to an otherwise unchanged note is not an answer. Age changes what the existing lines mean, and changes them in ways a reader has to be able to see.

- The history line acquires a source. Much of it comes from an informant by necessity, so the note says who gave it and how well placed they were to know: a daughter visiting monthly and a spouse in the same room are not equivalent witnesses.
- The examination line acquires preconditions. A cognitive item put to a patient who cannot hear the instruction measures hearing. Record that the spectacles and the hearing aid were in place, because a reader is otherwise entitled to disbelieve the score.
- The drug line becomes part of the physical examination rather than an administrative detail, and stopping a drug becomes a decision to be written down and justified in the same way as starting one.
- The diagnostic line becomes explicitly comparative, made against this person's own **baseline** rather than against a population, since the range of normal function in later life is wide enough that a population comparison decides nothing.
- The plan line is constrained by who will deliver it. A regimen assuming a supervising relative, a working refrigerator or a return visit next week is a proposal about a household, and the note

should say which household it assumes.

One further change is easy to miss. In an older medically ill patient much of what you write is a request for observation rather than a treatment: what the ward should watch for, when to call you back, and what would change the formulation. That is often the correct output of a single visit, and it reads as indecision only if you fail to say what the observation is for.

38.5 What a different account of the cause does to the note

By the time most of these patients meet a psychiatrist, somebody has decided what is wrong and why, something has been tried on the strength of that decision, and a view has been taken about how much the patient should be told. That is the **account already in the room**, and eliciting it is assessment rather than courtesy, because it predicts what treatment will be accepted, what the family will do next if your plan disappoints them, and what has already been spent in money, time and hope.

Getting it into the note has two halves. Record it in the patient's and the family's own words, attributed to whoever holds it, and place it beside your formulation rather than inside it. A belief held by the patient's community, expressed as that community expresses it and offered as an explanation rather than defended against evidence, is not by itself a finding of disorder; a note folding it into the phenomenology has told every later reader that it was one. The boundary between a sanctioned practice and a disorder is drawn by the ordinary questions: what changed in this person, when, whether the community itself regards the state as expected, and whether function has been lost. Drawn in those terms, the record survives being read both by someone who shares the belief and by someone who does not.

The second half is that the account must then do work. A history eliciting a prior healing episode and a family theory of causation, which then produces exactly the note that would have been written without them, has collected information and wasted it. If the family holds the cause to lie outside the body, the note should say what has been agreed about continuing what they are doing alongside treatment, because that agreement is the adherence plan and there is rarely another.

IN INDIA

The Indian pathway loads its front end. The referral commonly carries no question, so the question has to be created rather than answered. The relative is present, frequently decides, and is often told the diagnosis before the patient, so the consult happens in front of an interested third party whose agreement to the plan is in practice necessary. A patient may have spent weeks in a religious or traditional healing setting before meeting any clinician, which is a fact about the route to care and a question worth asking, never in itself a finding about pathology. Where the patient is an older person and the concern is neglect at home, the statutory route runs to a maintenance tribunal rather than to a protection service, which changes what can be promised in the room. And a consult service that looks quiet is reporting on referral behaviour, not on how much psychiatric illness the hospital holds.

38.6 Consent, capacity and the record that shows its own working

Two consent questions run through the pathway and are constantly conflated. The first is consent to be assessed, which belongs at the start and is not supplied by the referral, since the referral was not written by the person being seen. The second is capacity for a particular treatment decision, which arises only when a decision exists. A patient may agree to talk to you and still refuse the operation; a patient may refuse to talk to you at all, which ends the assessment without settling anything about capacity.

On both, the record has to show its working. What a later reader needs is not your conclusion but the route to it: that the person was told what was proposed in a form and at a time they could use, what decision was put to them, what they said in their own words, and what you concluded about that decision on that date. A refusal considered on its merits looks entirely different in a file from a refusal overridden, and the difference is visible only if the working is written down.

38.7 The handback and the disposition

The last two stages carry a disproportionate share of both the clinical value and the marks, and are the two most often left out. The **handback** is a spoken account to the clinician who called, and its purpose is not to repeat the note but to let them accept the recommendation, modify it, or say it is impossible on their ward. It is the only moment at which advice can be negotiated into something that will actually happen, and advice that cannot happen is worth nothing however correct it is.

The **disposition** answers where this patient now goes and who is responsible. It settles the place of care, the named owner of the plan and the **review interval**, and settling the owner explicitly prevents two opposite failures: a patient followed by nobody because each side assumed the other, and a team that stops referring because referral has begun to feel like losing patients.

GOOD TO REMEMBER

Before leaving the ward, make sure four sentences exist somewhere in the file, because each is the sentence whose absence causes a predictable failure. Who asked, and what for. What is established and what remains provisional. Who owns the next decision, named as a person or a team rather than as a specialty. And when this patient will be seen again, with a date rather than a phrase. If you write nothing else, write the last two: they convert an opinion into a plan somebody can be held to.

MNEMONIC

Called, changed, caused, capable, carried, called back

The spine of the note itself, as distinct from the sequence of acts that produced it. **Called**: who asked, and what they actually wanted, which is rarely what the request said. **Changed**: what is different in this person compared with their own previous state, when it changed, and who says so. **Caused**: where the psychiatric picture stands in relation to the medical illness and its treatment, which is the question that required a psychiatrist to attend at all. **Capable**: whether the person can make the decision in front of them now, and whether they were told what they needed in a form they could use. **Carried**: who does what tomorrow, named. **Called back**: when the patient is seen again, and by whom.

38.8 The same pathway as an examined performance

The examined version compresses this pathway without altering it, and knowing that is worth more than rehearsed phrasing. A short clinical station, a long case discussion and a viva question all ask you to walk the same route aloud, under observation, with the time cut down. The compression falls on the assessment, not on the beginning or the end, which is exactly where candidates cut.

- Say who asked and what for, before you say what you found. An answer opening with a diagnosis has skipped the part that establishes you understood the setting.
- Say what you would have established before going to the bedside, even when the patient was handed to you directly. Naming preparation you were not given time for is not an excuse; it shows you know the act has a shape.
- Separate the established from the provisional aloud, and say what would settle the difference. Follow-up questions land on certainty far more often than on admitted ignorance.
- Finish at a destination: the place of care, the person who owns the decision, and when the patient is seen again, in that order, then stop rather than trailing into further differentials.

The same structure answers the essay forms these subjects arrive in. Asked to write about psychiatric work in a particular ward or with a particular group of patients, an answer organised as pathway, entry points and note is complete and is visibly about practice. An answer organised as a list of the conditions found in that setting answers a different question, and usually one another part of the syllabus owns.

TRAP **Collecting the extra information and then writing the note you would have written anyway.** This is the characteristic failure of an answer that has learned the vocabulary of these subjects without the logic. The candidate asks about the shrine visit and records it under a cultural heading, then gives a formulation and a plan untouched by it. The candidate notes that the patient is old and prescribes at the adult dose. The candidate raises capacity and then proceeds exactly as if it had never been raised. Every item was elicited and nothing changed, so the extra questions worked as decoration. The test is direct: point to the line of your plan that is different because you asked. If no line is different, you did not ask the question, you performed it.

The pathway is call, preparation, bedside, note, handback and disposition; the note says who asked, what changed, what it stands in relation to, whether the person can decide, who acts tomorrow and when you see them again; and age, another account of the cause, or a decision on the table changes what those lines say rather than adding new ones.

Apply, consolidate and close the paper

39 · Applying the chapter

Four vignettes, and in every one of them the wrong answer arrives first. None of what follows tests whether you can name a condition. Each **worked case** is built so that a correct, well-organised and entirely defensible answer about a disorder is available within seconds, and so that this answer earns almost nothing. Work the case by itself first, aloud, in the sequence set out below; read the commentary only afterwards, against what you actually said.

No two of the four share a **pull**. On a general ward the pull is towards a psychiatric label. With an older patient it is towards adding something to a list nobody has read. With a family who have already settled the cause it is towards correcting them. Under observation it is towards reciting the entity, because reciting is what fluency feels like from the inside. Recognising the pull is worth more than learning the four answers: a pull recurs across cases you have never seen, and an answer does not.

Reach for the label	Add a drug	Correct the family	Recite the entity
THE PULL IN THE FIRST CASE, ON A SURGICAL WARD LATE AT NIGHT	THE PULL IN THE SECOND, WITH AN OLDER PATIENT AND A LONG LIST	THE PULL IN THE THIRD, WHERE THE CAUSE WAS SETTLED BEFORE YOU ARRIVED	THE PULL IN THE FOURTH, WHERE THE SAME MATERIAL IS PERFORMED AND SCORED

39.1 How to work a case, and what is actually being practised

What is practised here is the reassembly of an act from a situation, under the condition every referral in this chapter arrives in: most of what you need has not been given to you.

- Read only the case and stop. Read the commentary first and the exercise becomes recognition, which feels identical to knowledge and transfers nothing to a bedside.
- Say aloud, in order: who asked and what act they wanted; what you would establish before walking to the patient, and from whom; what you would do there; what you would write, and in whose record; and where this person is by morning, with a named owner.
- Name what you were not given, and who holds it. That is the part candidates leave out and the part that is marked.
- Commit. One explanation you would act on, one you are setting aside, and the ground for setting it aside. A descending list of possibilities is not a commitment and cannot be tested.
- Only then read the commentary.

RULE **A case here is a bedside with information missing, not a puzzle with an answer hidden.** What you are given is what a referral gives you: a bed number, one word, somebody else's diagnosis, a family's account. What is absent is what a clinician goes and obtains, and in all four cases below the decisive fact is one nobody has yet written down. So the first productive move is never to work out what the stem is pointing at. It is to say what you would obtain, from whom, and before which step. Answer only from the sentences supplied and you have agreed to be a reader of referrals rather than a clinician, leaving the marks exactly where they sit, which is in the questions.

39.2 A surgical ward telephones late at night

The case. A surgical ward telephones about a woman of seventy-eight, four nights after an operation on her hip. The slip carries a bed number and the word confused. The duty registrar asks whether you can start something to settle her, because she has pulled out her cannula and the night staff cannot manage her. Her son, outside, tells you she has been depressed for years and that this is her depression returning, and asks you not to say anything to her about her mind. Nothing else is offered.

Working it. Two things reached you before the patient did, and both are wrong to accept. The first is a request for an act rather than an opinion, and granting it means prescribing for the ward's difficulty. The second is a diagnosis from a relative who knows her past well and witnessed nothing of last night. A long history of depression makes her more vulnerable to almost everything; it does not explain a change over four nights.

What is missing is a **baseline** and a time. Before you leave for the ward: what she was like a fortnight ago, from whoever saw her then; when the change began, and what stands beside it on the chart, which may be the operation, the anaesthetic, a drug added since, a fever, poor urine output, or nothing yet identified; what the night staff saw, and at what hour; and what she has already been given for it. All of that is obtainable before you enter the bay and none of it afterwards, once the son has gone home and the shift has handed over.

At the bedside the order matters more than the content. Spectacles and hearing aid go on first, because an assessment conducted without them measures her hearing. Her own words are recorded before being translated into anything. Her physical state is examined. Only then is anything scored, and what a screening instrument is for on a ward is dealt with where these notes take up the consult on delirium in the medically ill.

The answer is delirium, and the discipline is that nothing in the account requires a psychiatric diagnosis. The condition itself is taught in the Stroke, TBI, delirium and focal brain syndromes notes; what belongs here is the decision that follows. She is not moved, because the cause is being sought where she already is and a transfer costs her the staff and the routine she has some chance of recognising. What you write names acts and owners: who searches for the cause, who reviews the chart, what the ward watches for overnight, and when you are to be called again. The son's request not to tell her is a second question with an owner elsewhere in these notes, and the error is to settle it by default, which is what saying nothing does.

39.3 An older man, pain in several places, and a cloth bag of tablets

The case. A man of seventy-one is referred from a cardiology clinic with a note saying his investigations are normal and he continues to complain. For most of a year he has had chest tightness, poor appetite, weight his family describe as a great deal lost, and he has stopped walking to the temple he went to every morning. He brings a cloth bag holding more strips of tablets than he can name; two prove to be the same drug under different trade names. His daughter says he has also become forgetful. He does not say he is unhappy: asked why he has come, he says his chest is not right and the doctors have found nothing.

Working it. The pull is to write an antidepressant. It is decisive, it answers the referral, and reading a bag of tablets feels like inaction beside it. Follow it and a drug joins a list that may be producing the picture, after which nothing can be attributed to anything.

The **drug list** is a history and not an administrative annex. Taken as one it yields what was started, when, by whom and for what; whether each item is still swallowed as opposed to still prescribed; what has been stopped and on whose decision; and what was added most recently before the change his family describe. The cumulative anticholinergic and sedative load of a list assembled by several prescribers over years is a recognised cause of exactly this presentation, dulled cognition and low mood together, and the agents, the burden and the arithmetic of a starting dose in later life belong to the part of these notes on prescribing in the elderly.

The presentation is the second half of the problem. He arrived complaining of his chest and his weight, which his physical illness and his tablets can equally produce, so the ordinary somatic signals are unavailable as evidence and recognition must be done another way. How that is done is taught where these notes deal with late-onset depression; the choice between agents is in the Mood disorders: pharmacotherapy notes. His daughter's word forgetful is not settled by administering a cognitive test to a man in this state, and the assessment it belongs inside is taken up where these notes deal with the comprehensive assessment of an older patient.

The act that separates a good answer here is small. Something comes off the list, or you write down why nothing does and what would change that. Then you tell the referring clinic what you altered and why, because they prescribe on it and a change they do not know about is reversed at the next visit. The review is set with the bag in the room.

39.4 A family who already know the cause

The case. A young man of twenty-four is brought by his father and his uncle. For close to a year he has spoken less, stopped work, stopped washing unless told, and spends the day on the roof of the house. The family have twice taken him to a healer some distance away and have spent a great deal doing so. They say without hesitation that someone has done this to him, that the healer confirmed it, and that he was a little better for a few weeks after the second visit. His father does not want tablets that will make his son a patient for life. The young man says almost nothing; asked what he thinks is wrong, he says his father knows.

Working it. The pull is to correct them, and it is strong because the explanation is not true and because correcting error feels like the job. Follow it and you spend your entire credit in the first

two minutes on an argument you cannot win, in front of the two people who decide whether your plan is carried out.

What is in front of you is the account already settled at home, and eliciting it is assessment. It predicts what will be accepted, what they will do if your plan disappoints, and what has already been spent, which measures their commitment to it. The questions are ordinary, and are asked in a tone that assumes the family were doing their best, because they were. Who first noticed, and what did they notice. When you went, what were you told the cause was, and what were you asked to do. Did anything change afterwards, and for how long. What do you think will happen if it stops. And then the one that does most of the work: what would you want him to be able to do again.

That question moves the encounter off the disagreement about cause and onto an agreement about function, where the family and the clinician usually want the same things. The **negotiation** that follows is not a request that they abandon their account. It is a proposal that what you offer runs alongside what they are already doing, and said in those terms it is the adherence plan; there is rarely another. Something can be conceded honestly too: his few better weeks are a real observation, worth exploring rather than dismissing, since whatever produced them may be usable.

Two further acts are owed. He has not been asked, and at some point he is seen alone, which is the only way his own view of the cause becomes recordable. And whether this is illness at all is settled by neither explanation: work and self-care have gone over close to a year, and that loss of function stands whatever anybody believes about its origin. Their words go into the record attributed to them, beside your formulation rather than inside it, so a later reader can tell which is which. The cultural framework and the formulation outline are taught in the Psychotherapies, clinical assessment, MSE and nosology notes, and the classic culturally shaped presentations where these notes take them up; what is owed here is the negotiation.

TRAP **Deciding who is in the room by reflex.** Candidates hold one of two reflexes firmly, and both are wrong. The first clears the relatives out at the start, in the name of confidentiality, and loses the only person who can say what the patient was like a month ago, whose agreement the plan needs, and who will fetch and give the tablets. The second never separates them, and then cannot ask about neglect at home, cannot hear the patient's own account of the cause, and produces a history in which the patient does not speak. Both are visible above, in a son who speaks for his mother before you reach the ward and a young man who defers to his father. The examinable act is not a preference between reflexes but a statement, made before the interview starts, of who you will see together, what you will ask each of them alone, and why.

IN INDIA

Three features of the room change how these cases are worked rather than merely colouring them. Somebody who knows the patient well is almost always in the corridor, so an answer resting on an informant who could not be reached will not be believed here; send for them before you go to the bed. The person paying is frequently not the patient and much of it is paid at the counter, so what a plan costs each month is a clinical variable and belongs inside the plan: a regimen nobody can sustain is stopped without anyone telling you. And the interview is usually in one language while the record is written in another, so the original phrase is kept beside the translation, because the phrase is what the family will repeat to the next clinician and a translated summary quietly loses the thing you were listening for.

39.5 The first case again, this time performed and scored

Nothing is removed by an examination; the middle is shortened. Take the woman of seventy-eight again, now in a practical examination. There is no chart, no nursing record, no son and no telephone. You have the patient, examiners and a clock, and one of them says: this lady had an operation last week and the ward says she is confused, take a history and tell us what you think. The material is identical and the act is different, because it is now an act of speech performed in front of people deciding something about you while you do it.

The **compression** falls on the assessment, not on the two ends. Candidates cut the opposite way, abbreviating the beginning, which establishes that they understood the setting, and abandoning the end, where the marks for the plan sit, in order to protect a middle the examiners can watch for themselves. So open on the referral: whose ward this is, who sent for you, what they wanted done. Then say what you would have established beforehand and from whom, and say plainly that you were not given it, which is a statement about the shape of the act and not an excuse. Then the assessment, briskly. Then the disposition and the review, in words, before you stop.

What the marking consists of is worth making explicit. Candidates imagine a running total of facts; it is a small number of decisions taken at identifiable moments, most of them before you have said anything at all about a diagnosis.

THE MOMENT	WHAT EARNS	WHAT LOSES
Your first sentence	The referral before anything else: whose ward this is, and what act was asked for	Opening with a diagnosis, which answers a question nobody asked
Before you touch the patient	What you would have obtained beforehand, from whom, and that it was unavailable here	Apologising for the gap, or filling it with a detail you did not elicit
The examination	Spectacles and hearing aid on, aloud and with the reason given, before anything is administered	Administering an item to a patient who has not heard the instruction, then reporting the result
The commitment	One explanation named, one serious alternative rejected, and the reason for rejecting it	A ranked list of possibilities, which gives the examiners nothing to test
The plan	Who does what, where she is by morning, and when she is seen again	A drug with no owner, no place of care and no review
The last thing you say	Stopping at a destination	Trailing into further differentials after the answer was complete

Two consequences follow, both counter-intuitive enough to rehearse. A wrong commitment defended on stated grounds is recoverable, because the questioning can go to the grounds and you can move; an absent one is not, because there is nothing there to examine. And the beginning repays rehearsal more than the middle, since several of those decisions are taken in the opening sentence and in the preparation you name, and both can be prepared word for word without sounding rehearsed.

39.6 What the four share, and how to make more of them

Set side by side, the four are one case. In each of them somebody else's account arrived before the patient did, the decisive information was held by a person nobody had asked, and a fluent answer was available that belonged to another part of these notes. Only the fluent answer and its cost differ.

THE CASE	THE PULL, AND WHY IT IS STRONG	WHAT FOLLOWING IT COSTS THE PATIENT
The confused surgical patient	A label, handed over by the ward and confirmed by a relative; it settles the night, and sedation is the act requested	Nobody hunts the cause while the picture is being suppressed
The somatic complaint in later life	Prescribing. Writing something is an act, where auditing a bag of strips looks like inertia	Attribution becomes impossible: no one afterwards can say which agent does what
The family with an explanation	Correction. The account is untrue, and putting error right feels like the clinician's proper work	They withdraw rather than argue, and treatment lapses where you cannot observe it
The same material under observation	Recitation. It is the prepared, fluent and entirely correct answer to a different question	The answer expires before any disposition, and the questioning goes straight to what was skipped

Four cases are not enough practice, and the supply is sitting in your own week. Building them is quick, and the building is itself useful, because writing a case forces you to notice what a referral actually contained.

- Take referrals your unit genuinely received, strip out every identifying particular, and write each as four sentences ending at the word the referrer used. Answer them cold a week later, once you have forgotten what happened next.
- Write the pull in beside each one before you write the answer. A case with no plausible wrong answer is not a case; it is something you already know, arranged as a question.
- Work them with a colleague playing the referrer, who may answer only what you actually ask. Most of what these cases teach is which questions you fail to ask, and that is invisible when you work alone.

MNEMONIC

Read the slip, read the sheet, read the story, read the room

Four things exist before you say a word, and in each case above the decisive fact was in one of them. **The slip**: who asked, in whose ward, and what act they want rather than what opinion. **The sheet**: the drug chart and the observation record, which between them hold when this began and what has already been given. **The story**: the account of the cause settled at home, in the words of whoever holds it. **The room**: who is present, who decides, who pays and, in the examination, who is scoring. Not one of the four is obtained by asking the patient a better question at the bedside.

GOOD TO REMEMBER

Keep a list of your own pulls rather than of your own wrong answers. After a case you get wrong, write down the move that produced it and not the answer you missed: reached for the label, did not send for the informant, added a drug instead of reading the list, corrected the family, stopped at the diagnosis. Within a few weeks the list stops growing, because there are only a handful of them and they are yours. A wrong answer teaches you one case; a named pull changes what you do at the next bedside, including the ones nobody has written a case about.

Work a case forward from what is missing: the referral and the act it asks for, the fact you would go and obtain and the person holding it, the explanation you are acting on and the one you have rejected with your reason, and who does the next thing by morning; then name the pull rather than the answer.

40 · Consolidation

A closing list earns its time only if it forces production rather than recognition. Everything below is an **ask-and-hold** pair: on the left the question in the form an examiner puts it, on the right what you must produce before you look at anything. Cover the right column, answer aloud, then read across. Recognition feels identical to knowledge from the inside and is worth little across a table from two external examiners, which is why this consolidation, the last in Paper III, is set in two columns.

The right column asks almost nothing about what a condition is, because the marks here sit in **the encounter** rather than in **the entity**: who asked, on whose ward, what changed because the patient is old, whose account of the cause was already in the room, and how the performance is scored. It closes on a register of addresses, because a reader who comes here for an entity and is not told where it is taught has been failed twice.

Ask, then hold	The encounter	Named in full	Never backwards
THE TWO COLUMNS EACH PROMPT IS BUILT FROM	WHAT AN ANSWER HERE IS MADE OF, NOT THE ENTITY	HOW THE REGISTER PRINTS EACH ONWARD DESTINATION	THE DIRECTION A POINTER MAY NOT SEND A READER

40.1 How to run the list

Work the three groups in order, because sequence is most of what is marked: the right acts in the wrong order satisfy nobody. Name who performs each act, since almost every failure here is an act nobody owned rather than one nobody knew, and keep talking until you have said where the patient goes and when they are seen again.

Mark two failures apart. A prompt you could not answer is ordinary, fixed by rereading that section. A prompt you answered by describing a condition is worse: it is the error this material exists to correct, and it feels like competence as you produce it.

RULE **Answer at the address the question was asked from.** Every heading here has two possible answers and only one earns anything. The first describes the condition: features, subtypes, how it differs from its mimics. The second describes what was done: who called and what they wanted, what was established first, in whose records it was written, who held the decision, and where the patient went. These notes own the second and name the address of the first; give the first and you have written a correct paragraph belonging elsewhere.

40.2 Ask and hold: the general hospital

These eleven share one structure: the psychiatrist is a guest, the notes belong to somebody else, and the request came from a treating team, not the patient.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Principles and models of consultation-liaison psychiatry.	The referral as a procedure: what the caller must convey, what you establish on the call including whether the patient consented, the **preparatory phase**, the note's headings, and why writing in the file is not by itself sufficient feedback.
A medical ward calls overnight about a confused patient.	That confusion with behavioural abnormality is the commonest reason an Indian liaison service is called, the discrimination made first, and that the patient stays on the medical ward under psychiatric observation.
Psychiatric aspects of medical and surgical illness.	The signature read both ways: the psychiatric presentation a medical illness produces, and the occult medical cause behind a psychiatric one, organised by system and by drug.
Psychological reactions to physical illness and chronic disease.	That a reaction is universal and does not always reach morbid level, that separating reaction from disorder is the liaison task, and adherence as the stake.
Somatic symptom disorders in a consultation-liaison setting.	How such a patient reaches psychiatry, through a physician out of investigations, and the address of the nosology.
A physically ill patient refuses treatment.	That the national mental health legislation of 2017 presumes capacity at section 4, the ability test applied to this decision now, that section 4(2) is unsatisfied until information is given in a form the person can take in, that an unwise decision is not incapacity, and that the Act expressly reaches a general hospital.
Psychiatric work in transplant, dialysis and intensive care.	What a pre-transplant psychosocial evaluation is for, why uraemic symptoms mimic and mask depression on dialysis, and the syndrome after critical illness.
Psychiatric aspects of HIV and chronic infection.	Consent for testing as a statutory question, disclosure, adherence, stigma, and how the clinic relationship is built rather than improvised.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Psychiatric aspects of cardiac, skin and kidney disease.	The bidirectional relationship in each, the burden the specialty clinic carries, the drug-safety signals constraining prescribing, and which head terms are attested.
Epilepsy and neurological disorders as they arrive on a consult.	The frame only: why they generate referrals, what is asked, and the address.
The ward believes the patient is fabricating.	What the liaison psychiatrist does and, more importantly, does not write down; and how such a referral often follows the team's frustration, itself part of the assessment.

40.3 Ask and hold: the older patient

These ten share a different structure. The condition is taught elsewhere; what is asked is what age does to the assessment, the prescription and the safeguarding question.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Psychiatric assessment of an elderly patient.	That the skeleton does not change with age and the weight given to comorbid physical illness does, the added domains of sensory deprivation, frailty and elder abuse, the last needing active suspicion, and what normal ageing does and does not take away.
Dementia in the elderly.	Its place in the geriatric frame, and the address where it is taught.
Late-onset depression.	The presentation that misleads, the somatic and cognitive mask, the vascular contribution, and that current Indian guidance holds age to influence which antidepressant is chosen.
Late-onset psychosis and paraphrenia.	The exclusions run first with the drug classes named, when neuroimaging is indicated, and what changes in management because the patient is old.
Delirium in an older person.	Ageing as the predisposition: frailty, sensory impairment, polypharmacy, delirium superimposed on dementia, and that the hearing aid and the spectacles go on before any cognitive item is administered.
Principles of psychopharmacology in the elderly.	The pharmacokinetic and pharmacodynamic changes, the starting dose as a fraction of the adult dose with the agent named, anticholinergic burden as a crucial cause of delirium, falls, and deprescribing.
Elder abuse and neglect.	Recognition against a definition including acts of omission, a history taken with the patient interviewed separately and given time and reassurance, the screening instrument, and the legal position below.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Sleep disturbance in the elderly.	What changes in timing and architecture, then the finding that reframes the heading: in older adults in excellent health insomnia prevalence resembles that in younger people, so the complaint is comorbid and a hypnotic the wrong reflex.
Comprehensive geriatric assessment.	That it is an interdisciplinary, multidimensional process for frail or vulnerable older people and not a questionnaire, its product of a problem list, goal-driven interventions and one coordinated plan, its domains with cognition one item inside the mental-health domain, and how falls risk is stratified.
Pseudodementia versus dementia.	The distinction, why it matters at the bedside, and the address of the table.

40.4 Ask and hold: the explanatory model, dying, and the examined performance

The last group holds the two hardest kinds of question. One asks you to work with an account of causation that is not biomedical and that the family has accepted; the other asks you to perform, observed, in a fixed time. Hold the scheme you perform inside: the national regulations make passing conditional on three things, not less than **40 per cent** in each theory paper, not less than **50 per cent** in aggregate across the four theory papers, and not less than 50 per cent in the practical examination, so a strong practical rescues nothing.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Concepts of culture and illness.	The current umbrella term, the parts it holds, the address of the definitions, and the move to the clinic.
The classic culturally shaped presentations.	Not the roster. How the patient arrives, what has been tried and who advised it, what the family believes the cause to be, what else may sit behind it, and how the explanation is negotiated.
Cultural formulation and its interview.	Name both, say where in an assessment they belong, give the address, print no counts.
Migration, ethnicity and mental health.	Who moves and why, with India's official migration rate and its split by sex and reason, the four acculturation strategies and the two questions generating them, and that current Indian guidelines carry nothing on migration or acculturation.
Idioms of distress and explanatory models.	Name both constructs, say what each does to a history, give the address.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Religion, spirituality and faith healing.	What happens at a healing site and in what conditions; the one measured Indian study with its design and its authors' bar on generalising; that the government primary health centre stood in the same village and had almost never been consulted; and the boundary between sanctioned practice and disorder, drawn without turning practice into a symptom list.
Psychological reaction to a cancer diagnosis.	The trajectory of the reaction, adjustment disorder as the largest single group in Indian inpatient series, and **collusion** as graded rather than binary, with the sequence for working through it and both sides of the bind.
Depression, anxiety and delirium in advanced disease.	How each is recognised when the somatic criteria are confounded, that pharmacotherapy remains indicated alongside medical comorbidity although response tends to be poorer, and how running treatment constrains the choice.
Grief, bereavement and end-of-life care.	Normal grief and when to intervene; that the standard frameworks were built for a dyad while in Indian practice the patient is almost always accompanied; and that business left unattended before a death obstructs grief after.
Demoralization and desire for hastened death.	The core features and why the construct is separable from depression; and the legal boundary, that the 2018 Constitution Bench treats active euthanasia as impermissible for the time being, absent any statute permitting it, against the passive form, withdrawal or withholding of measures sustaining life artificially.
Structure of an objective structured clinical examination station.	That it is named inside the national practical pass criterion beside the clinical and the viva voce, that the state health-sciences university has notified it shall be included from the ensuing examinations, the examiner board, that no grace mark is permitted, and that a station's weight is unsettled.
Long case and short case format.	That the national provision is one long case and two short cases, a theory examination of four papers, each of ten questions carrying ten marks, and a 300-mark practical including 20 for the thesis, with a 100-mark viva voce.
Demonstrate a scale or a bedside test.	Administration as an observed performance, not a recitation: what is said to the patient before it starts, how timing is managed, what is reported aloud, and how a refused performance is handled without abandoning it.

THE ASK	WHAT YOU MUST BE ABLE TO PRODUCE
Break bad news to this relative.	The six-step protocol with each letter unpacked, its later modifications and the criticism against them, and the ethical frame both ways: withholding on the presumption the patient cannot cope may not be justified against autonomy, and insensible disclosure may harm the patient and the relationship.
Interpret this investigation or instrument.	What the oral examination is directed at, that case reports, charts, specimens, slides and imaging are expressly examinable and questions on instruments will be asked, and the order a result is read in.

40.5 The rules that survive an unfamiliar question

Six rules run underneath every prompt above. They are worth holding because they generate an answer to a question you did not prepare for, which is the kind that decides a viva.

- **Name whose ground you stand on.** In the general hospital the records, the ward and the discharge decision belong to another team, and consent to be seen, a private space and who is spoken to afterwards all follow from that.
- **Exclude before you attribute, and harder at seventy-eight.** The commonest referral is behavioural and the first move separates a neurocognitive from a primary psychiatric explanation; reduced physiological reserve is why the same change means more in an older patient.
- **A figure belongs to a document and a population.** Quote the issuing body and the population it was measured in, or quote the reasoning and say plainly that you assert no figure. A prevalence and a referral rate differ even in the same unit, and a statistic from one country is not evidence about another.
- **Ask whose explanation is already in the room.** By the time most of these patients reach you a cause has been settled on, a treatment tried, and somebody has decided how much they are told. Eliciting that is assessment, not courtesy: it decides what will be accepted.
- **The statutory answer is usually narrower than the clinical one, so state both.** The clearest instance is elder abuse: the 2007 Indian statute on maintenance and welfare of parents and senior citizens carries no elder-abuse-specific mandatory reporting duty, and what it provides is different in kind, since the Maintenance Tribunal may take cognizance on its own motion, a power and not a duty. The obligation to act is professional: a national society guideline places elder abuse under forensic issues and directs that where assessment suggests safety may be compromised, a report to the police must be made.
- **Finish where the patient goes next.** Every answer ends with a destination, a named owner of the decision and a review interval. An answer ending at the diagnosis stops where this material begins.

MNEMONIC

Before the bed, at the bed, after the bed

The consult has three beats, and marks are lost almost entirely in the first and the third. **Before the bed**: the call is clarified, consent and willingness checked, the chart read, the referring consultant asked what they actually want, word sent for a family member. **At the bed**: introduction and consent, a private space, a history keyed to onset, fluctuation and treatment events, physical examination, then the mental state examination. **After the bed**: the consultee is spoken to directly, the note written to its headings, patient and family told the plan, the review interval set. Most answers start at the second beat and stop there.

GOOD TO REMEMBER

Two habits change what you do on the next working morning rather than what you can recite. Write the consult twice: the guideline requires **dual documentation**, in the primary team's records so the plan can be acted on and in your own so the case is retrievable when the patient returns. And set the interval before leaving the ward: where the consult starts drug treatment, review falls **within a week**, with outpatient follow-up after discharge treated as obligatory.

40.6 The cross-reference register

This material is deliberately incomplete and the register below is the other half of that decision. Every destination is printed in full so the route survives on a printed page with nothing else to hand. Read it one way only: it says where an entity is taught and is never the route back to anything owned here, since the consult, the organ cross-links, the disease-specific settings and the psycho-oncological material are owed by these notes rather than borrowed.

WHAT YOU WENT LOOKING FOR	WHERE IT IS TAUGHT
Delirium as an entity: definition, subtypes, screening, causes, management	the Stroke, TBI, delirium and focal brain syndromes notes
The dementias, and the cognitive screening instruments	the Dementias and neurocognitive disorders notes
The late-life psychosis construct with its history, and catatonia	the Other psychotic disorders, delusional syndromes and catatonia notes
Antidepressant classes, selection and switching behind a late-life prescription	the Mood disorders: pharmacotherapy notes
The anxiety and trauma-related entities, and the grief-related diagnosis	the Anxiety, OCD and trauma-related disorders notes
The sleep-wake disorders as entities, including what an older complaint proves to be	the Eating and sleep-wake disorders notes
The somatic-symptom and factitious nosology, the culturally shaped semen-loss presentation, self-harm and suicide, and the psychosomatic concept with its service-model table	the Somatic-symptom, sexual, impulse-control disorders and suicide notes

WHAT YOU WENT LOOKING FOR	WHERE IT IS TAUGHT
The cultural framework and its terminology, the formulation outline and its interview, idioms of distress, explanatory models, the mental state examination	the Psychotherapies, clinical assessment, MSE and nosology notes
Epilepsy and its psychiatric syndromes, including treatment-related ones	the Epilepsy and psychiatry notes
The neurological examination, and the investigations a viva hands you	the Neurology foundations for psychiatrists notes
The neuropsychiatry of chronic infection and systemic medical disease	the Neuropsychiatry of systemic and neurological disease notes

PITFALL

The worst thing a **register** can do is send a reader in a circle. A pointer returning somebody to the page which sent them has failed them twice: once for not teaching the thing, once for the search it cost. Building your own revision map, test every arrow by asking what the destination actually teaches rather than what its title suggests. The same holds in a viva: saying a topic belongs to another specialty is legitimate only if you can say what that specialty would do with it.

IN INDIA

Many of these prompts have an Indian answer that differs from the standard one, and saying so plainly earns more than reproducing a specification the setting cannot meet. Referral rates are low while measured morbidity in the same units is high, so a quiet consult service is evidence about referral behaviour and not about need. The composite liaison clinic the sources call preferred is qualified in the same breath by a dearth of specialists, so that it may not be possible across the country. The family is routinely the decision-maker and is often told first. The statute for an abused older person routes to a tribunal rather than a protection service. And a patient may have spent weeks in a religious healing setting before meeting any clinician, which is a fact about the pathway to care and a question to ask, never a finding about belief.

TRAP **Producing a fluent paragraph that belongs to another chapter.** Asked about delirium on a surgical ward, candidates describe delirium. Asked about depression in the elderly, they list depressive criteria. Asked about a culturally shaped presentation, they recite a roster. Each is accurate, well organised and worth very little, because the entity is taught elsewhere and the examiner knows where. The test is simple: if your answer would be equally true had the patient never been referred, never been old and never held an explanation of their own, you answered the wrong question.

Answer the encounter and name the address of the entity: who called and what they wanted, what was established before anything was done, what age or the explanatory model changed, in whose records it was written, who owns the decision now, and where the patient goes next.

41 · Drawing the ten chapters together

Paper III is closed properly only when you can say what it trained you to do. Read as a list of headings, this one looks like a miscellany: children and their development, running across the chapters at the front of the paper; mental health legislation and forensic psychiatry; forensic ethics and consent; a physical treatment and its neurostimulation relatives; the perinatal period and the psychiatric emergency; and then the consult, the older patient, culture and the examined performance. Not one of those entries is a diagnosis. No two of them share an organ, an age or a class of drug. That is worth noticing before any revision plan is made, because a candidate who revises this paper the way the disorder papers are revised will write accurate answers that score badly.

What the entries share is a predicament. In every one of them the psychiatrist has to act while somebody else holds part of the decision: a parent, a statute, a magistrate, a treating team, a family, a tribunal, an anaesthetist, a second person whose interests are engaged, or an examiner with a clock. The diagnosis is seldom the difficult part and is almost never the whole answer. The difficult part is the authority the act rests on, the consent it needs, the baseline it will be judged against, the record it leaves and the person who has to do something next. What follows sets out that shared structure, and then says where these subjects actually sit in the scheme of examination, which is not where the paper's name would lead you to expect.

Four papers	Ten by ten	Suggestive only	Superseded
THE SHAPE OF THE DESCRIPTIVE THEORY EXAMINATION UNDER THE 2023 NATIONAL REGULATIONS	QUESTIONS IN EACH PAPER, AND THE MARKS EACH QUESTION CARRIES, AS NOW NOTIFIED	WHAT THE OLD ORDINANCE CALLED ITS OWN ALLOCATION OF SUBJECTS TO PAPERS	THE STANDING OF THAT ORDINANCE FOR THE EXAMINATION NOW BEING SAT

41.1 What this paper actually trains

The other papers ask what a thing is. They reward a candidate who can define a syndrome, trace a mechanism, name a class of drug and defend a choice between two of them. This paper asks something else and rewards something else: **the defensible act**, meaning an action a psychiatrist takes that can be justified afterwards to a person who was not in the room. Who that person is varies. It may be a court, a hospital committee, an aggrieved relative, a regulator, or simply the consultant who inherits the case next week. The examiner is standing in for all of them, which is why the questions are phrased as situations rather than as topics.

An act is defensible when these can be stated without hesitation: on whose **authority** it was done, what the person or their proxy was told and agreed to, what the finding was measured against, and where the whole of it is written down. Those are not ethics-lecture abstractions. They are the substance of almost every question this paper sets, and they explain how the same clinical facts earn very different marks. Two candidates may agree entirely about the diagnosis and the drug, and only one of them will say who was entitled to make the decision and what would have followed had the family refused.

This also explains why the paper is harder to revise than it looks. A disorder can be learned once and recalled whole. An act has to be reassembled from the situation in front of you, because the constraint keeps moving: the same clinical picture in a child, in a courtroom, before a physical treatment, late in pregnancy, on somebody else's ward and in old age generates a different correct answer each time, while the underlying illness may be identical. The paper is a training set for that reassembly, and its chapters are the settings in which it is practised.

RULE **Name the authority before you name the treatment.** In every band of this paper the first marks are for establishing who is entitled to decide and on what basis, and the treatment is the second half of the answer rather than the first. A management plan offered without its authority is an opinion; the same plan with the authority named is a clinical decision, and only the second can be defended by anyone who has to stand behind it later. Candidates who open with the drug, the modality or the ward round are answering the question the disorder papers ask.

41.2 The bands, and the constraint each one works under

Grouping the paper by constraint rather than by subject is what makes it revisable in the time available. The child and developmental chapters work under a **developmental baseline**, which is the standard by which a behaviour is called abnormal at all. The legal and ethical chapters work under an instrument and a procedure. The treatment chapter works under a set of safeguards that exist precisely because the treatment is given to people who may not be in a position to ask for it. The perinatal and emergency chapter works under a clock and under a second person whose interests are engaged. The closing chapter works under somebody else's ward, another stage of life, an explanation of the illness that reached the patient before you did, and an observer with a marking sheet.

THE BAND	THE CONSTRAINT THAT IS NOT THE DIAGNOSIS	WHAT AN ANSWER IN THIS BAND MUST NAME
Child and developmental psychiatry, across the chapters that open the paper	What is expected of a person at this stage of development, and the fact that the patient did not bring themselves	The norm the behaviour is judged against, who gave the account and what their stake in it is, and the adult whose agreement makes any of it lawful
Mental health legislation and forensic psychiatry	An instrument: what it permits, in which jurisdiction, in whose hands, and with which verb	The instrument, the provision and the jurisdiction, using the source's own permissive or obligatory wording, stated before the clinical opinion rather than after it
Forensic ethics, consent and legal procedure	A procedure with its own rules of admissibility, and a relationship that may not be therapeutic at all	Whose agent you are in this encounter, what was disclosed and to whom, the limits of the opinion, and what you decline to say
ECT and neurostimulation	Safeguards around a physical treatment, and an authorisation that may not come from the patient	The indication, who authorised it and under what provision, the checks before it is given and the monitoring it obliges afterwards
Perinatal and emergency psychiatry	A clock, and a second person whose interests are engaged by the same decision	Who is at risk and over what interval, what must be settled now, what may safely be deferred, and how the two interests were weighed
The consult, the older patient, culture, and the examined performance	Another team's ward, another stage of life, an account of the cause already accepted at home, and an observer scoring the performance	Who asked and what they wanted, what age or the patient's own account changed, in whose record it is written, and where the person goes next

Read the right-hand column as an answer plan rather than as a summary. Each entry is a sentence that has to appear somewhere in what you write, and its absence is what an examiner notices first, because it is the part a textbook paragraph never contains. Its presence is also what lets you say something serviceable about a scenario you have never met, which is what a viva mostly consists of.

41.3 The questions that generate an answer anywhere in this paper

Underneath the bands the same interrogation runs, and learning it as a sequence is worth more than any single fact in the paper, because it survives an unfamiliar scenario and produces a structured answer within seconds of the question ending. Work it in order. The order is itself examinable, since several of the classic failures in this paper are the right acts performed in the wrong sequence.

- **Who permits this?** Some acts need only a professional judgement. Others need a guardian, a statutory provision, a board, a tribunal or a court, and a few need more than one of those at

once. Name the source of permission before describing what you would do, and if the permission is contested, say who resolves the contest.

- **Who consents, and to what exactly?** Consent is specific to a decision, a moment and a piece of information, not a signature filed in a chart. Say what was disclosed, in what form, who received it, whether the person could use it, and what happens to the plan if the answer is no. A plan with no described refusal branch has not been thought through.
- **What is usual here?** Nothing in this paper is abnormal in the abstract. It is abnormal against a developmental stage, a physiological state, a cultural account of causation, or the reserve an older body has left. State the comparator, because a finding without one is an impression.
- **What is written, and in whose record?** In almost every setting this paper covers, the notes belong to somebody else or will be read by somebody adversarial. Say what goes in the file, what goes in your own record, and what deliberately does not go in either.
- **Who acts next, and when is the person seen again?** Finish at the **disposition**. An answer that ends at the formulation has stopped one step before the part that is actually being marked, and in practice it is the step whose absence causes harm.

41.4 Where these subjects sit in the scheme of examination

The name of a paper is not a syllabus, and treating it as one is a revision error with a measurable cost. Under a Karnataka state health-sciences university's postgraduate ordinance of 2000, consultation-liaison psychiatry, geriatric psychiatry and psycho-oncology were placed in the second paper, and cultural psychiatry alone was placed in the third; that same ordinance then closed its own allocation by calling it **suggestive only**. Take both halves of that seriously. Most of what this closing chapter teaches sat, on that document's own reckoning, under a different paper from the one it is now revised for, and the allocation was disclaimed by its own author even while it was in force.

The position has since moved, and moved in the direction that matters for planning. That ordinance is superseded for the postgraduate broad-specialty examinations now being sat, and its placing of neurology and general medicine in the fourth paper is displaced: both the national regulations of 2023 and the state university's later notification put basic medical sciences in the first paper and recent advances in the fourth. What neither instrument does is assign any subject at all to the second or the third paper. On the documents in force, the contents of those two papers are unassigned, which is a different and more useful statement than saying the old allocation still holds.

Two practical consequences follow, and they point the same way. First, revise these subjects by name rather than by paper number: a question on the consult, on the older patient or on psycho-oncology may reach you under either of the middle papers, and being surprised by its location wastes minutes you do not have. Second, do not attempt to predict which paper a subject will appear in, because no instrument currently in force supports such a prediction; no comparable standard is available to quote, and none is invented here. The safe planning assumption is the one

the old ordinance itself invited: the boundary between the middle papers is soft, and preparation should be indifferent to it.

IN INDIA

Two instruments matter here, and they operate at different levels, which is worth knowing because candidates are usually told about only the local one. The National Medical Commission's postgraduate regulations of 2023 set the architecture: a descriptive theory examination of **four** papers, with the first on basic medical sciences and the fourth on recent advances, and with a multiple-choice format of equal duration expressly permitted as an alternative. The state health-sciences university then applies that national instrument locally: by a notification of 16 December 2024 its special Syndicate decided to apply the 2023 regulations to the upcoming broad-specialty postgraduate examinations, with stated relaxations. The reasoning that carries them onto candidates admitted long before they were made is recorded in the same notification: the university acted on a clarification from the Commission that the 2023 regulations apply to all students appearing in the forthcoming examination, irrespective of the year of admission. A candidate who prepared against the scheme a senior sat under is therefore preparing against a document that no longer governs.

41.5 What the shape of the answer now asks of your revision

The **answer unit** has changed, and revision strategy should follow it rather than tradition. The state university's notification provides for **ten questions in each paper, each carrying ten marks**. Every answer therefore has the same weight as every other, and there is no single large essay to bank a prepared performance on. The arithmetic of that is unforgiving in a way candidates underestimate: a topic you cannot begin is not a weak paragraph inside a long answer, it is an entire question surrendered, and there are not many questions in a paper to absorb such a loss.

Two further features of the current scheme bear directly on how this paper in particular is prepared. **Recent advances** now belong to the fourth paper, so the reflex of decorating every answer with the newest trial is misdirected effort here; what earns marks in this paper is the act, its authority and its record, which are stable and can be prepared once. And each paper carries its own minimum in addition to the aggregate across the papers, so a paper cannot be written off against strength elsewhere. A miscellany that a candidate quietly deprioritises because it holds no favourite disorder is precisely the paper that can fail an otherwise strong performance.

How long a paper runs is not stated by the instrument that fixes this ten-question structure, nor is the number of questions in it declared to be of one kind rather than of mixed length; no comparable standard is available to quote, and none is invented here. Plan on the safe reading instead: equal marks per question means equal minutes per question, and a candidate who spends the time of several answers on one has broken the only budget the paper actually enforces.

GOOD TO REMEMBER

Write for a second reader you will never meet. Under the valuation machinery the state university has adopted, every theory script is valued more than once, a third valuation is triggered where the first two differ by **15 per cent** or more of the paper's total marks with the best two then averaged, and there is **no revaluation** once results are declared. Two things follow on the day. Make the structure of each answer visible without reading the prose, through headings, a named instrument, a labelled plan and a stated disposition, because that is what survives two independent readers. And accept that the script is the whole of your case: there is no later stage at which you get to explain what you meant.

41.6 How this paper is lost, and what closes it

Failures here have a family resemblance. Almost none of them are failures of knowledge. A candidate loses this paper by producing a correct account of a condition when the question asked what should be done about a person; by giving a management plan with no named source of permission; by describing an assessment with no comparator, so that a finding floats free of the stage of life or the account of causation it should have been judged against; and by stopping at the formulation, leaving the examiner without a disposition, an owner or a review interval. Each of those answers reads fluently while it is being written, which is exactly why they persist.

There is one further failure, and it is the one this closing section exists to prevent: preparing for an examination that has been replaced. Schemes change quietly, the seniors who describe them are describing the one they sat, and nothing in the day-to-day of residency announces the difference. Check the instrument, not the folklore, and check it for the year you are sitting.

TRAP **Carrying a superseded scheme into a current examination.** The pattern candidates rehearse is often the one their seniors sat: under the state university's ordinance of 2000 each theory paper carried two long essay questions of twenty marks and six short essay questions of ten marks, and recent advances could be asked in any or all of the papers. Both features have gone. Practising a long-essay technique for a paper built of equal short answers wastes the scarcest resource in the hall, which is time, and reserving a recent-advances flourish for a paper that no longer wants one wastes preparation. The general form of the trap matters more than this instance: a rule about an examination is only as current as the document you read it in, and a document that has been superseded remains a perfectly accurate description of something that no longer happens.

What closes the paper is not a summary of it. It is a habit of mind that the chapters have been building one setting at a time: when a situation is put to you, resist the pull towards the diagnosis, and answer instead with the act and its warrant. That habit is portable. It works in a paediatric ward, in a magistrate's remand order, in a consent conversation before a physical treatment, in an obstetric emergency in the small hours, on a surgical ward that has called you about a confused patient, and in front of examiners who did not train you. It is also, not coincidentally, what makes a psychiatrist safe to leave alone with a difficult decision, which is what the whole examination is trying to establish.

This paper is not a set of disorders: for every situation say on whose authority you act, who consented and to what, what you judged the finding against, in whose record it is written and who does the next thing and when; and revise its subjects by name rather than by paper number, because no instrument in force assigns a subject to the middle papers at all.

Previously asked

Unlike every earlier chapter of this series, this table is not representative. Sixteen of the rows below are catalogued past questions, each carrying the year the index records against it, taken from the question index this build holds under `intel/`. The equivalent page in the Perinatal and emergency psychiatry notes had to open by declaring that no indexed bank existed for that chapter; that was true of its topics and is not true of these. **One caveat governs the whole table and is not buried:** these are another state health-sciences university's questions, catalogued from that university's own index. This series is built for the examination you sit, and no claim is made that any of these appeared on one of its papers. They are evidence of what Indian examiners ask about this material, which is a weaker and more honest claim than an attribution to your own paper would be.

The frequency is the finding. Culture-bound syndromes is the highest-yield subject in this chapter by a wide margin: four distinct question forms, seven total appearances, and three of those appearances as long answers. That measurement, which no ownership census could see, is why the culture-bound syndromes section was raised from LENS to MAJOR after the depth scheme was otherwise settled. HIV follows with two appearances of a single question form, and grief with four spread across three. Everything else in the table has appeared once.

Almost every question here is a mixed question and only one half belongs to this chapter. The naming half is taught elsewhere in the series and is expected rather than supplied: the DSM-5 cultural-concepts framework, the eight classic syndromes as definitions and the Cultural Formulation Interview by the Psychotherapies, clinical assessment, MSE and nosology notes; dhat itself by the Somatic-symptom, sexual, impulse-control disorders and suicide notes; delirium in full by the Stroke, TBI, delirium and focal brain syndromes notes; HIV-associated neurocognitive disorder and the antiretroviral interactions by the Neuropsychiatry of systemic and neurological disease notes; and prolonged grief disorder as a diagnosis by the Anxiety, OCD and trauma-related disorders notes. **Bring those.** What this chapter supplies is the other half: who asked, in whose ward, what changes at seventy-eight, what the family believes, and what the clinician actually does.

QUESTION, VERBATIM FROM THE INDEX	FORM	ASKED	OWNED HERE BY
Discuss culture bound syndromes	Long answer	2011 MD, 2015 MD, 2017 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)
Discuss neuropsychiatric aspect of HIV/AIDS	Long answer	2012 MD, 2017 MD	Psychiatric aspects of HIV and chronic infection
Enumerate culture bound syndromes. Describe Dhat syndrome in detail	Short note	2013 MD, 2018 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)
Grief / complicated Grief	Short note	2021 MD, 2011 MD	Grief, bereavement and end-of-life psychiatric care
Discuss the differential diagnosis of delirium	Long answer	2012 MD	Delirium in the medically ill (CL perspective)
Psychiatric conditions encountered in general hospital settings - discuss in detail commonly occurring conditions	Long answer	2017 MD	Psychiatric aspects of medical and surgical illness
Consultation Liaison Psychiatry	Short note	2016 MD	Principles and models of consultation-liaison psychiatry
Role of Psychiatrist in patients having Psychosomatic Medicine	Short note	2020 MD	Psychological reactions to physical illness and chronic disease
ICU Delirium	Short note	2018 MD	Transplant, dialysis and ICU psychiatry
Psychiatric evaluation of donors in organ transplant	Short note	2021 MD	Transplant, dialysis and ICU psychiatry
Psychological aspects of aging	Short note	2012 DPM	Normal ageing and psychiatric assessment of the elderly
Abuse of elders	Short note	2011 MD	Elder abuse and neglect
Culture bound syndromes	Short note	2017 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)

QUESTION, VERBATIM FROM THE INDEX	FORM	ASKED	OWNED HERE BY
Dhat syndrome	Short note	2015 MD	Culture-bound syndromes (dhat, koro, amok, latah and others)
Grief	Short note	2021 MD	Grief, bereavement and end-of-life psychiatric care
Complicated grief	Short note	2020 MD	Grief, bereavement and end-of-life psychiatric care

Sixteen catalogued questions, mapped by hand to the section that owns each in this chapter. The years are as the index records them; the mapping is this build's judgement and is stated as such.

A declared gap, in place of three figures that would otherwise have sat on this page. The number of questions the index holds, the span of years it covers, and the mark value it records against each question are all absent here, and deliberately so. Nothing in this chapter's claim ledger stands behind any of the three: their only authority would be this build's own reading of a file it happens to hold, which is not a source you can check. The mark values are the omission that matters, because they belong to another institution's scheme and not to the one that governs the paper this series is built for, whose notification sets four theory papers of ten questions each, every question carrying ten marks. The Form column carries what the omitted figure distinguished, and carries it honestly: this build renders the index's higher allocation as Long answer and its lower one as Short note, so the distinction between a question that wants an essay and one that wants a note survives without a digit from someone else's scheme being printed as though it were yours.

What has never been asked as a theory question, and why that is expected. A search this build ran across the whole of that index, for *OSCE*, *OSPE*, *objective structured*, *long case* and *short case*, returns **zero**. The five sections that close this chapter, from the structure of objective structured clinical examination stations through to the interpretation of investigations and instruments in vivas, are the practical examination itself, so their absence from a theory index is the correct result rather than a gap: they are examined in the practical and the viva voce, which the governing notification fixes at 300 marks and 100 marks while expressly leaving the division inside the practical to be settled elsewhere, and where a candidate cannot be carried by theory.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that topic's single must-hold line, so a line you cannot recover is a section to reread rather than a fact to learn here. Five things are load-bearing across the chapter. Every row answers who asked, in whose ward, what changed because the patient is seventy-eight, whose account of the cause reached the room first, and how the whole of it is produced aloud under observation; none of them answers what a

disorder is, so a row that says almost nothing about a condition you already know has been written on the assumption that you know it. The psychiatrist is a guest everywhere in the first half: the bed, the record and the discharge belong to another team, so consent to be seen is established rather than inherited and the referral question is extracted rather than received. Age changes what the existing lines of a note mean rather than adding a line to it. An account of the cause that reached the family before you did is assessment and not courtesy, because it predicts what will be accepted. And an answer here finishes at a destination: a place of care, a named owner and a review interval, in that order. The figures printed below are the ones this chapter itself owns, referral rates, intervals, thresholds, statutory sections and denominators, each carried back from the section that grounded it; every treatment dose and every figure belonging to an entity rather than to an act stays in the chapter that owns it, and those chapters are named here in words. Where the chapter declared that something could not be sourced, this page says so rather than smoothing it, because a revision table read at speed is exactly where an ungrounded number acquires a confidence nobody earned.

ASK	HOLD
THE CONSULT AS AN ACT, AND WHAT ARRIVES ON THE WARD	
WHOSE NEED THE CONSULT ANSWERS	Not the patient's. The need to appoint a psychiatrist is felt by the primary treating team, and everything procedural follows from that: consent to be seen is established rather than inferred from a referral the patient did not write, the referral question is extracted rather than read off the request, and the output is a recommendation inside somebody else's treatment, written for a physician to implement rather than for a psychiatrist to admire. A consult conducted as though the patient had walked into a clinic is procedurally wrong even where the diagnosis is right. The patient may also decline, since the right to refuse psychiatric assessment is to be respected if possible, and a refusal recorded and fed back has obstructed nothing.
THE REFERRAL RATE, AND THE GAP IT CONCEALS	There is no single Indian referral rate, and quoting one is an error of construct rather than of arithmetic: 0.01 to 3.6 per cent from the inpatient setting, 1.42 to 5.4 per cent from the emergency setting and 0.06 to 7.17 per cent from the outpatient setting, three denominators asking three different questions. The morbidity figures behave the same way, about 30 per cent in medically ill inpatients against 48 to 87 per cent in single-specialty liaison populations. What settles the argument is a pair measured in one unit: delirium in 68.5 per cent of one Indian intensive care unit against a referral rate of 1.71 per cent from the same unit. A quiet service is reporting on referral behaviour, not on how much illness the hospital holds.

ASK	HOLD
WHAT HAS TO HAPPEN BEFORE YOU WALK TO THE WARD	The call as it actually arrives is limited to informing the psychiatrist to come and see the patient on a given bed number, which contains no question, so answering it accepts the whole diagnostic problem without knowing what was asked; the caller owes their identity, the patient's identifiers, any language difficulty, the location, the primary diagnosis and reason for admission, the psychiatric concern and the urgency, and should not initiate a call without examining the patient. Then comes the compulsory preparatory phase, which individual practice has no equivalent of: current diagnosis and treatment, all available papers rather than the summary handed over, past psychiatric history, direct communication with the treating consultant about what they want, the nursing observation, and word sent to a relative to attend. Nothing later recovers it.
URGENCY: THE BANDS, AND THE SCOPE LIMIT ON THEM	Five colour-coded bands with response windows, and the scope is the examinable half: the scale is an emergency-room instrument and not a standard for answering a ward call. Immediate response with security or police for weapons, violence or an attempt at self-destruction; four hours for clear intent, plan and arrangement to harm; twenty-four hours for intent without a plan or rapidly increasing confusion; seventy-two hours for mood disorder or psychosis without intent; four weeks for a known stable disorder needing follow-up. For an ordinary inpatient call no interval is established anywhere in this chapter. What exists is behavioural: respond in a timely way and tell the team the time frame you will attend in.
THE NOTE, AND THE QUESTION THAT REQUIRED A PSYCHIATRIST TO ATTEND	Six entries, and the second is the intellectual content: the diagnoses by current nosology, then the aetiology of the psychiatric picture against the medical illness, which is mutual causation, comorbidity or coincidence, then the interaction of the proposed psychiatric treatment with the ongoing medical treatment, the biopsychosocial background relevant to management, the immediate risk with any transfer decision, and any adjustment the treating team itself needs to make. Build the answer on the second, because each verdict sends the consult somewhere different: mutual causation makes the psychiatric problem part of the medical plan, comorbidity puts the weight on sequencing, coincidence may make continuity the honest recommendation. A diagnosis and a drug has skipped it.

ASK	HOLD
WHY WRITING IN THE FILE IS NOT THE END OF THE CONSULT	It is explicitly insufficient: beyond the note the psychiatrist should communicate directly with the treating consultant, at least by telephone, resolve the team's doubts, give the formulation and suggest a comprehensive plan. The conversation is the only moment at which the team can say your recommendation is impossible on their ward. Documentation is then deliberately doubled, in the primary team's records and in separate records kept by the psychiatrist, the first because a recommendation must live where it will be acted on tonight. Where a diagnosis is confirmed and drug treatment started, follow-up falls within a week at the latest, with outpatient follow-up after discharge obligatory; where no diagnosis was reached, the output is regular review with psychometric evaluation rather than a label asserted to close the episode. Review during the admission is required only from time to time, and no frequency is specified anywhere.
WHO KEEPS THE PATIENT WHEN THE WARD ASKS YOU TO TAKE THEM	The transfer request is the standing friction, and it is answered with criteria rather than a rule. Delirium continues on the medical ward with regular psychiatric observation and not on the ground of the behavioural disturbance itself, because the behaviour is the presentation of a medical emergency due to an underlying medical cause: moving the patient moves them away from the treatment that resolves it. A substance use disorder stays until the medical complications are stabilised. Depression, suicidality or psychosis with serious medical morbidity stays under psychiatric supervision and moves only in stable medical conditions. The job is to decline the transfer while accepting the work, and the setting is not a favour: the appropriate Government must provide mental health services at all general hospitals it runs or funds.
THE SIGNATURE, READ IN BOTH DIRECTIONS	The commonest thing you are called for is confusion with behavioural abnormality, and the first discrimination owed is between a neurocognitive disorder and a primary psychiatric condition presenting with behavioural disorganisation, which is also the thing most easily misfiled as psychiatric. Read the other direction with equal discipline: the psychiatric presentation a medical illness or its treatment produces, organised by system and by drug. Across specialties the recurring picture is stress, anxiety, depression and somatic distress, with depression running about 10 per cent in the community against up to 30 per cent in medical units. The entity itself belongs to the Stroke, TBI, delirium and focal brain syndromes notes.

ASK	HOLD
REACTION AGAINST DISORDER, AND WHAT RIDES ON GETTING IT RIGHT	A psychological reaction to physical illness is universal and does not always reach morbid level, and separating reaction from disorder is the liaison task rather than a preliminary to it; patients referred here may not fulfil criteria for any mental disorder and still need support. The judgement is movement rather than content: whether the person is moving towards acceptance or is stuck, against their own premorbid history as comparator, with the further decision being whether drug treatment is needed or psychotherapy or a support group will do. The stake is adherence and the outcomes attached to it, taught directionally because no effect size for that chain is established anywhere in this chapter.
CAPACITY: A PRESUMPTION, THEN THREE ABILITIES JOINED BY "OR"	Capacity is presumed for every person including a person with mental illness, and the test is three abilities, to understand the relevant information, to appreciate any reasonably foreseeable consequence of the decision or of its absence, or to communicate the decision. The joiner carries the mark: the section prints them with "or", not with "and", so any one of them makes capacity out. Do not import the four-part functional schema of the international literature and do not add a limb about retaining information; neither is in this statute. The burden sits on the clinician who wishes to displace the presumption, and an unwise decision is not incapacity.
WHAT HAS TO HAVE HAPPENED BEFORE A CAPACITY FINDING MEANS ANYTHING	The information must have landed. It is to be given in simple language the person understands, or in sign language, or through visual aids, or by any other means that enables understanding, and on a medical ward that is the step most often skipped before a team records incapacity. Two boundaries decide reach: a general hospital is expressly inside the definition of a mental health establishment, so the Act follows you onto the surgical ward, while the test itself is written for decisions about treatment, admission or personal assistance. Extending it to a purely medical decision is an argument rather than a citation, and saying so is the answer.
THE ADULT OF SOUND MIND WHO SAYS NO, AND THE HOLE IN THE LAW	The highest authority is a 2018 Constitution Bench holding that a person who has come of age and is of sound mind has a right to refuse medical treatment, separated in terms from suicide, assisted suicide and euthanasia, so a competent refusal ending in death is not a psychiatric emergency. Quote it with its context, since the passage sits inside a discussion of the terminally ill and the persistently vegetative patient. Then name the gap plainly: no functional capacity test for an ordinary physical-treatment decision by a patient with no mental illness is established, and neither is who lawfully decides for such an adult who cannot decide. Reason by analogy, record that you are doing so, and do not import a foreign statute to fill it.

ASK	HOLD
WHEN TREATMENT CANNOT WAIT, AND THE CEILING ON IT	Any registered medical practitioner may give emergency treatment to a person with mental illness, at an establishment or in the community, subject to the nominated representative's consent where one is available, and only where it is immediately necessary to prevent death or irreversible harm, serious self-harm or harm to others, or serious damage to property flowing from the illness; the explanation extends it to transport to the nearest establishment for assessment. Three limits follow: nothing beyond what is directly related to the emergency, no electro-convulsive therapy under this power, and a ceiling of seventy-two hours or until assessment, whichever is earlier, extending to seven days only in a declared disaster. It is not a route for overriding a competent refusal.
THE RECORD'S OWN SHELF LIFE, AND WHAT THE WARD BELIEVES ABOUT RELATIVES	Capacity is decision-specific and time-specific, so a finding expires. The Act fixes an interval in one place only: where the representative consents during a supported admission the consent is recorded and capacity reviewed every seven days, and beyond thirty days on the expiry of every fortnight. No equivalent interval attaches to a one-off liaison opinion, which is what this topic is actually about, so the review interval is clinical judgement that has to be justified in the note. And the model is supported decision-making rather than substituted: a son who signs because it is quicker is the substituted model wearing the supported model's name.
THE TWO REFERRALS THE TEAM WANTS TAKEN OFF ITS HANDS	Medically unexplained symptoms and suspected fabrication arrive the same way, through a clinician out of investigations or out of patience, and in both the referral often follows the team's frustration rather than a change in the patient, which is itself part of the assessment. What the liaison psychiatrist owns is the general-hospital presentation, the documentation restraint and the team dynamics; the nosology of the somatoform and factitious disorders, the internal-versus-external incentive rule and the semen-loss presentation are taught in the Somatic-symptom, sexual, impulse-control disorders and suicide notes. On the record, what was observed and what was alleged belong in different sentences with the source named for each, and what may lawfully be entered when deception is suspected but not established is not settled anywhere in this chapter.
THE SETTINGS WHERE THE CONSULT IS HARDEST AND THE DECISION LEAST REVERSIBLE	

ASK	HOLD
THE PRE-TRANSPLANT OPINION, AND THE FOUR THINGS IT CANNOT CONTAIN	A pre-transplant psychiatric and psychosocial assessment is imperative for recipient suitability, and that is the whole of what is established. No domain list, no structured instrument, no separation of absolute from relative psychiatric contraindication, and no requirement of psychiatric evaluation under Indian transplantation law is grounded anywhere in this chapter, so an answer inventing a domain grid or an abstinence interval is inventing it. What is teachable is the form of the opinion and the dual-agency problem inside it: you are asked for a judgement that will decide access to an organ, by a team whose interests are not the patient's, about a living donor whose consent has to survive the family that produced it. Say what you can and name the rest as unsettled.
DIALYSIS: THE SYMPTOM OVERLAP, AND THE INDIAN NUMBER	Uraemic symptoms mimic and mask depressive ones, so the mechanism of under-detection is symptom overlap and the consequence is under-evaluation and under-treatment; the unit-level stressors named alongside it are physical, financial, occupational, social and dietary. The Indian measurement is worth its denominator: 282 maintenance-haemodialysis patients across four Mumbai centres, screened with a questionnaire read aloud in the patient's own language regardless of literacy, gave 21.28 per cent at the moderate threshold, and 29.13 per cent of women against 16.76 per cent of men. Public and private centres did not differ. Reading the instrument aloud is the methodological point, and it is what makes the denominator usable.
INTENSIVE CARE, AND THE SYNDROME AFTER IT	The term names three domains, physical, cognitive and mental health, and one qualifier does the work: the impairment must be new or worsening, so pre-existing impairment does not count and a baseline is required before the label can be used at all. It was agreed at a multidisciplinary stakeholders conference rather than derived from a cohort. Everything a candidate reaches for next is unavailable here: no duration criterion, no incidence figure, no instrument, nothing on whether it looks the same in Indian survivors, and no Indian follow-up clinic model. Name the construct, name its qualifier, and refuse the proportion.
CHRONIC INFECTION: THE CONSENT QUESTION IS STATUTORY, AND ITS TEXT IS NOT HERE	What is grounded is that the 2017 Indian Act on prevention and control of the infection exists and that its section 5 is headed informed consent for testing or treatment. What the section requires in operative terms, whether pre-test and post-test counselling are statutory components, what conditions attach and which modal verb it uses are not established, and the national counselling references were located and never read, so no step, interval or competency may be attributed to them. Every epidemiological figure is absent as well. Teach consent, disclosure, adherence, stigma and a clinic relationship that is built rather than improvised, and say the statutory detail is owed rather than known.

ASK	HOLD
THE CARDIAC AND RENAL INTERFACES, AS FIGURES WITH POPULATIONS	Depression runs 15 to 20 per cent in coronary artery disease and reaches a major episode in 20 per cent after myocardial infarction, while fewer than 15 per cent of those depressed in coronary disease are actually diagnosed, which is the recognition problem stated as a number rather than as a complaint. Post-infarct depression carries a 1.6 to 2.7 fold mortality risk and the relationship is bidirectional. In kidney disease depression is 22.8 per cent in advanced disease and cognitive impairment reaches 60 per cent. All of it is an Indian guideline reporting international evidence, not Indian primary data, and the head terms themselves are not all attested.
THE TWO PRESCRIBING SIGNALS, AND THE NEUROLOGICAL DOOR	Two constraints are named and neither carries a dose here. Physical treatment is relatively contraindicated within 30 days of unstable angina or infarction, with its procedural precautions taught where they belong. And citalopram in haemodialysis carries a raised risk of sudden cardiac arrest, greater than other agents of its class, with no effect size given anywhere. On the skin the severe cutaneous reactions are taught as an interface and as a duty to warn the patient and the attendants, deliberately without rates or onset windows, because the available tabulation disagreed with its own document's prose. Epilepsy arrives as a referral rather than as an entity and is taught in the Epilepsy and psychiatry notes.
WHAT CHANGES AT SEVENTY-EIGHT	
WHAT AGE CHANGES, AND WHAT IT LEAVES EXACTLY WHERE IT WAS	The skeleton does not move: history, physical examination, mental state examination and investigations, with the one shift being that comorbid physical illness now carries the weight the psychiatric history carries. Three domains are added to the history: sensory deprivation, a frailty review, and elder abuse, the last requiring a high index of suspicion rather than a complaint. Underneath sits the physiology that makes all of it matter: reduced reserve, so a small perturbation produces a disproportionate clinical effect. Two acts precede any score, and they are not politeness: the hearing aid and the spectacles go on before a single cognitive item is administered, because otherwise the item measures hearing.
NORMAL AGEING: WHAT DECLINES, WHAT HOLDS, AND THE COMMON CAUSE	The split is the teaching. Fluid abilities peak in the third decade and fall at about 0.02 standard deviations a year, while crystallised ability is stable or gradually improving at 0.02 to 0.003 standard deviations a year through the sixth and seventh decades, and vocabulary is resilient while conceptual reasoning, memory and processing speed decline at rates that differ between individuals. One change explains many findings: processing speed begins falling in the third decade and drags down scores in other domains, so a low score may be a speed artefact. Acquisition and free recall decline while recognition, temporal order and procedural memory hold, and confrontation naming stays level until about 70. No Indian norms exist for any of it.

ASK	HOLD
COMPREHENSIVE ASSESSMENT AS A PROCESS RATHER THAN A QUESTIONNAIRE	It is an interdisciplinary and multidimensional process for frail or vulnerable older people, not an event and not a synonym for the specialty, and its product is a problem list, goal-driven interventions and one coordinated plan spanning treatment, rehabilitation, support and long-term care. Its five domains are physical conditions, mental health, functioning, social circumstances and environment, and note where cognition sits: one item inside the mental-health domain, beside mood, anxiety and fears, which is the whole argument against equating geriatric assessment with a cognitive score. The core team is a doctor who need not be a geriatrician, a nurse, an occupational therapist, a physiotherapist and a social worker, and the plan must state explicit goals, who is responsible, and a review timeline.
FALLS: THE SCREEN, THE STRATIFICATION AND THE ONE MEASURED THRESHOLD	Case-finding is opportunistic and cheap: in lower and middle income settings, everyone aged 60 and over, at any clinical encounter, at least annually, asked about falls in the past twelve months. Stratification then decides the work: low risk gets education and exercise and annual reassessment because low risk is not no risk, intermediate gets strength and balance work or physiotherapy, and high risk is offered a multifactorial assessment to inform individualised interventions. One threshold is measured rather than asserted: gait speed below 0.8 metres per second over a four-metre walk, with a timed-up-and-go alternative of over 15 seconds whose fall-risk evidence the guideline itself calls mixed. The component recommendations do not carry equal evidence, and vision, hearing, pain, depression and nutrition rest on expert opinion.
PRESCRIBING AT SEVENTY-EIGHT: DIRECTIONS, THEN FRACTIONS, NEVER MILLIGRAMS	The pharmacology is taught as direction and not as percentage: renal and hepatic clearance fall, volume of distribution rises for lipid-soluble drugs, half-life lengthens, and sensitivity is altered and usually increased. Body composition drives the first half, since total body water and lean mass fall while fat rises relatively, so water-soluble agents reach higher serum levels and lipid-soluble ones linger. Renal decline is neither uniform nor consistent, and creatinine is unreliable because muscle mass has fallen too. Only two dosing quantities are established, both fractions: an antidepressant at half the adult starting dose and half the adult target dose, and an antipsychotic reduced by 25 to 50 per cent. No milligram figure and no cumulative maximum exists for any of it.

ASK	HOLD
THE HAZARDS THAT CARRY A NUMBER, AND THE THREE THAT CARRY NONE	Two thresholds are printable. Specialist referral for hyponatraemia falls at a serum sodium below 125, the risk sitting in the first weeks of treatment in the elderly and frail with no number of weeks stated, and deprescribing review is triggered above five medications, which is a trigger for a review and not a permitted ceiling. Against them, three examinable absences: the anticholinergic load must be totalled across every ongoing drug as a crucial cause of delirium, with no instrument and no score named; no numeric threshold for the corrected interval and no age-specific cap; and geriatric-specific management strategies have not been evaluated.
SLEEP: THE CHANGES HAPPENED BEFORE THE PATIENT GOT OLD	The six changes are advanced timing, shorter nocturnal sleep, more naps, more awakenings, more time awake at night and less slow-wave sleep, and the timing of the change is the mark: they occur mostly between young and middle adulthood and are largely unchanged among healthy older adults after 60. Wake after sleep onset rises 10 minutes per decade, valid between 30 and 60 years only, and the stage-proportion shifts are not significant above 60 in healthy older people. The circadian phase advances by about an hour across sleep timing, temperature, melatonin and cortisol together. So none of this explains a new complaint at seventy-eight, and using it to do so is the error the section exists to stop.
WHY A HYPNOTIC IS THE WRONG REFLEX	Because the excess is comorbidity rather than age. Insomnia symptoms run about 50 per cent in older adults, yet in those in excellent health prevalence resembles that in younger people, so the complaint points at medical and psychological comorbidity; self-reported poor sleep quality reaches 50 to 60 per cent with the review's own caution that it is not necessarily ageing alone. The drug history is half the assessment, on figures that are explicitly not Indian: about 90 per cent of those aged 65 and over take prescription drugs and more than a third take over five. Older adults also under-report poor sleep, so the complaint you hear understates the problem.
ELDER ABUSE: HOW IT ARRIVES, AND THE ACT THAT MUST APPEAR IN THE NOTE	Nobody arrives complaining of it. It arrives as a fall, a confusional episode, weight loss, poor adherence, an admission the family is unusually keen on, or a discharge that keeps being deferred, each with an ageing explanation already to hand. The definition to quote treats it as acts of omission resulting in harm or threatened harm to the health or welfare of an older person, and say in the same breath that acts of commission are conventionally included, because as printed the definition narrows the subject. The instruction that is actually marked is procedural: the patient is interviewed separately and given time and reassurance. The named screen is a caregiver abuse screen with no item count, no cut-off and no validation data attached to it anywhere.

ASK	HOLD
THE SAFEGUARDING ANSWER HAS TWO HALVES, AND ONLY ONE IS LAW	There is no elder-abuse-specific mandatory reporting duty in the 2007 senior citizens Act, and no provision of the child-protection kind obliging any person or professional to report suspected abuse. Scope that negative correctly: it concerns this Act, and a general duty to inform the police of certain offences binds a psychiatrist as it binds anyone, though its text, section number and modal verb are not established here. What the Act supplies instead is a route, not a report: an application by the senior citizen, or by any other person or organisation authorised by him where he is incapable, or the Tribunal taking cognizance on its own motion, a power and not a duty. The directive half is professional: where safety may be compromised during the stay or after discharge, a report to the police must be made.
THE LATE-LIFE PRESENTATIONS THAT MISLEAD	
DEMENTIA IN AN OLDER REFERRAL: WHAT THIS CHAPTER OWES AND WHAT IT DOES NOT	It owes the frame, not the entity: why a family or a ward asks for help, the behavioural picture as the reason the call was made, and the wider assessment the diagnosis sits inside. The disease, its subtypes, its investigation and its treatment are taught in the Dementias and neurocognitive disorders notes, and the cognitive screening instruments belong there too. Three things a candidate expects to find here are not available anywhere in this chapter and should not be improvised: any prevalence or incidence for later life, any figure for how that rises with age, and any Indian measure of diagnostic delay or of old-age psychiatric service provision. Say the scale of the problem is not quantified here rather than borrowing a number that sounds right.
LATE-ONSET DEPRESSION: THE PRESENTATION THAT MISLEADS, AND THE MODAL THAT MUST SURVIVE	The mask is somatic and cognitive and the vascular contribution is part of the picture, but the discriminating question is whether an episode has occurred before rather than any age threshold, because no age cut-off defining late onset is established and neither is the proportion of late-life presentations that are first episodes. Current Indian guidance holds that age influences which antidepressant is chosen, with agents of one class possibly less effective and another possibly more suitable in older adults: the modal is may, twice, and strengthening it into a recommendation is the error. Prescribing runs start low and go slow, at half the adult starting and target dose, watching hyponatraemia and falls. Agent selection and switching sit in the Mood disorders: pharmacotherapy notes.

ASK	HOLD
A FIRST PSYCHOSIS LATE IN LIFE: EXCLUSIONS BEFORE ANYTHING ELSE	The exclusion list is the answer and it is long: affective psychosis, delirium, the dementias, medication-induced states from anticholinergics and antihistaminergics at higher doses, steroids, dopamine agonists, antimalarials, antiretrovirals, opioid analgesics, fluoroquinolones and cardiac agents, substance-induced states, and severe nutritional and endocrine disorders. Neuroimaging is indicated, and the emphasised trigger is a first episode after 60, with no modality or sequence named. Management changes because the patient is old rather than because the illness differs: first-line choice is driven by lower anticholinergic burden and lower sedation to prevent falls, starting 25 to 50 per cent lower, avoiding anticholinergic co-prescription, with more frequent metabolic monitoring. Where the paraphrenia label sits in any classification is not asserted.
DELIRIUM AT SEVENTY-EIGHT: THE INDIAN FIGURE, AND WHAT IT DOES NOT EXTEND TO	In elderly attenders screened at Indian emergency medical outpatient settings, delirium was the commonest diagnosis at 34.1 per cent, against dementia at 9.5 per cent and any axis-one disorder at 47.4 per cent, with both delirium and dementia commoner above 70. Ageing is the predisposition rather than the cause, through the listed age-related risk factors, which carry no weight, ranking or effect size, and through multimorbidity and polypharmacy, with more than three medications listed separately as a risk factor. Delirium superimposed on dementia is named and its discriminating features are not given. Nothing about outcome after the episode is quantified, and sundowning has no quotable definition.
PSEUDODEMENTIA: AN ASYMMETRY OF CONSEQUENCE, NOT OF FREQUENCY	The discrimination matters because the two errors are not equivalent: a depressive illness read as a dementia loses a treatable condition, while a dementia read as depression costs a trial of treatment and a review date. That asymmetry is the whole argument, and it is made on the order of clinical work rather than on relative frequency, because no figure exists for how often an apparent dementia in later life proves to be a depressive illness, in India or anywhere, and none for how long the treated interval usually takes to settle it. So the answer is an act with an owner and a date rather than a probability. The comparison table itself, with its features, is taught in the Dementias and neurocognitive disorders notes.
WHOSE EXPLANATION REACHED THE ROOM FIRST, AND THE END OF LIFE	

ASK	HOLD
THE UMBRELLA TERM, AND WHY PSYCHIATRY HAS TO GO AND COLLECT IT	The current framework replaced the old roster heading with an umbrella holding three kinds of cultural concept, a syndrome, an idiom of distress and an explanation, and their definitions and the reasons for the change belong to the Psychotherapies, clinical assessment, MSE and nosology notes. What this chapter owns is the move from the concept to the clinic. The examinable point is that the three are not interchangeable: a syndrome is a cluster of features, an idiom is a way of expressing distress that need not indicate any disorder, and an explanation is a claim about cause. Answering with a list of exotic names has answered the superseded question.
THE CULTURALLY SHAPED PRESENTATION: NOT THE ROSTER, THE ROUTE	What is asked for is how the patient arrived, what has been tried and who advised it, what the family holds the cause to be, what else may sit behind it, and how the explanation is negotiated. The route is documented: information reaches such patients through friends, relatives, colleagues, roadside advertisements, lay magazines and traditional practitioners, and the cures they expect run from indigenous medicines, herbs and dietary interventions to injections, tonics and marriage. The boundaries leak both ways: a syndrome classically indexed to one country presented in two Indian cases reaching an obsessive-compulsive clinic after the family noticed it, and in another an obsessive-compulsive disorder emerged only on an unscheduled review. What is behind the presentation is the question.
THE FORMULATION, THE IDIOM AND THE MODEL: NAME THEM, THEN ROUTE THEM	Name both instruments, say where in an assessment each belongs, give the address, and print no counts: the outline's domains, the interview's questions and sections, and the supplementary modules are owned by the Psychotherapies, clinical assessment, MSE and nosology notes, and so are the definitions of an idiom of distress and an explanatory model and the eliciting questions that go with them. What this chapter adds is the clinical use. An idiom translated into a symptom loses the meaning that made it worth eliciting, and an explanatory model recorded and then not acted on has collected information and wasted it. The full instrument is seldom completed in clinic time, which is a statement about the encounter and not a licence to skip the enquiry.
MIGRATION, AT INDIAN SCALE AND WITH THE INDIAN OUTCOME MISSING	The official rate is 28.9 per cent and it is almost two different phenomena: 10.7 per cent of men against 47.9 per cent of women, with marriage accounting for about 86.8 per cent of female migration and employment for 22.8 per cent of the male, so who moves and why differs by sex before any outcome is discussed. The two questions generating the strategies are whether the person maintains their own identity and whether they maintain relations with the wider society, giving assimilation, separation, integration and marginalisation. No Indian outcome estimate for internal migrants exists, and current Indian guidelines carry nothing on migration or acculturation at all.

ASK	HOLD
THE ONE MEASURED INDIAN STUDY OF A HEALING SITE: WHAT IT DID	A single temple, 31 people, of whom 29 had a non-affective psychosis, so the study says nothing about common mental disorders or distress states. The exposure was residence with a relative in attendance, a fifteen-minute morning prayer and no ceremony performed for any individual's recovery, with no psychopharmacological or other somatic treatment at any point, over a stay of a mean of six weeks, range one to twenty-four. The rating-scale total fell from 52.9 to 42.9, a reduction the authors call nearly twenty per cent. Cost to the family was nil, and physical restraint was not used at this site though the paper records that it is at many others.
WHAT THAT STUDY DOES NOT LICENSE ANYONE TO SAY	The design is uncontrolled, single-site, unblinded, with the same rater at both assessments and no comparison group, and the authors call their own findings only suggestive. The caregiver rating was an unblinded judgement by the relatives who brought the person and stayed: 22 improved and 3 recovered, which accounts for 25 of the 31, and what happened to the remaining six is not stated. Their bar on generalising is explicit, not to other regions and not to other healing temples in the same region. The finding that matters clinically is about access: a government primary health centre stood in the same village and had been consulted by one of the thirty-one. The route to care is a question to ask, never a finding about belief.
THE REACTION TO A CANCER DIAGNOSIS, AND THE GROUP THAT IS LARGEST	The trajectory as stated runs shock and disbelief, anger, depression, loss and grief, and the diagnosis most often made is the one candidates reach for last: adjustment disorder is the commonest psychiatric syndrome in cancer patients. The Indian denominator is one tertiary inpatient sample of 384, in which 41.7 per cent had any psychiatric disorder, 22.6 per cent an adjustment disorder and 10.9 per cent a major depressive episode. No Indian community or advanced-disease prevalence exists to set beside it, and fear of recurrence, body image, sexual difficulty and financial distress carry no Indian magnitude at all.
COLLUSION: GRADED RATHER THAN BINARY, AND THE BIND STATED BOTH WAYS	It has three axes, who is kept in the dark, what is withheld, and whether it is partial or complete, and its triggers are the move from curative to palliative intent and the entry of death into the conversation; the paper's own line is that it may be a conspiracy of lopsided communication as much as one of silence. In India nearly one half of patients are unaware of their own diagnosis or treatment, while among those who already knew, 71 per cent wanted the truth, 81 per cent of relatives wanted to be told and 77 per cent did not want the patient told. Say the benefit side too: it may defend the person from harm and minimise concern about the future, against obstructed autonomy and lost trust. Working through it is a sequence, reasons first, then a no-disclosure-without-consent contract, then the patient's actual awareness, then being present when they first speak openly.

ASK	HOLD
RECOGNITION IN ADVANCED DISEASE, AND THE INSTRUCTION THAT SURVIVES COMORBIDITY	The direction is treat: pharmacotherapy remains indicated alongside medical comorbidity, on an umbrella review spanning 27 comorbid medical conditions against placebo, with a psychological arm supported for conditions such as coronary heart disease and neurological disorders. Hold the qualifier in the same sentence, since response tends to be poorer when comorbid, with the magnitude nowhere quantified. Delirium is the third presentation and it was 6.5 per cent of that same Indian inpatient sample. What is not established here: how the confounded somatic criteria should be handled, which brief screen is defensible in a breathless patient, and what constrains the choice of agent near the end.
GRIEF, AND THE PROTOCOL THAT WAS BUILT FOR THE WRONG NUMBER OF PEOPLE	The standard frameworks assume a dyad, whereas in Indian practice the patient is almost always accompanied, so more than one relative is included and the key relative is chosen by the patient's view of who that is rather than by volume or by your guess. The mechanism that makes concealment a clinical problem after the death, and not only before it, is that business left unattended before a death obstructs grief resolution in the survivors afterwards, and unchecked collusion leaves patients morbidly anxious and lowers the threshold for pain and nausea. Nothing about the after-death tasks is grounded here, and neither is any interval or risk stratification for bereavement follow-up.
DEMORALIZATION, AND THE LINE THE LAW ACTUALLY DRAWS	The core is hopelessness, loss of meaning and existential distress, ending in a desire to die, and the construct is proposed as separable from depression rather than demonstrated to be common: no proportion who are demoralized without being depressed is available, and the scale is named only, with its item count, subscales, format, cut-offs and revision all ungrounded. The legal boundary is where answers overreach. Active euthanasia is impermissible, on the basis that no statute permits it, while the passive form is withdrawal or withholding of measures that artificially prolong life, and the directions on advance directives operate as judicial directions until Parliament legislates, not as legislation.
THE SAME ENCOUNTER, PERFORMED ALOUD UNDER OBSERVATION	
A STATION SCORES THE ACT, NOT THE KNOWLEDGE BEHIND IT	That single sentence separates a station from a viva: in a viva, saying what you would do is the performance; in a station it is an admission that you did not do it. Six things exist before you arrive, five of them written: the place in the blueprint, the instruction at the door, the brief the patient carries, the material handed over, the marking schedule, and the standard it is read against. Read the instruction for its task verb before its clinical content, because the verb names the product due when time ends: take a focused history, elicit and describe, explain to, assess. Marking runs in two layers at once, an itemised schedule and one overall judgement, and neither alone is sufficient. Information is released on request, so silence is yours to fill.

ASK	HOLD
THE ARITHMETIC THAT DECIDES THE RESULT	Three conditions, all conjunctive: at least 40 per cent in each theory paper, at least 50 per cent in aggregate across the four, and at least 50 per cent in the practical, so failing any one fails the whole and a strong practical repairs nothing. The per-paper floor is the new element, absent from the superseded state ordinance whose rule was half the marks in each of two heads only. A station's marks sit inside the same practical line as your long case, because the practical is expressly composed of the clinical, the objective structured component and the viva voce. No grace mark is permitted in either head. Scripts are valued twice, a third valuation follows a difference of 15 per cent or more of the paper total, and there is no revaluation afterwards.
WHAT IS MANDATORY, AND THE FOUR THINGS NOTHING FIXES	The obligation is real and its vehicle is not settled: the notification of 16 December 2024 provides that an objective structured clinical examination or a short case shall be included from the ensuing examinations, and the clause is disjunctive on its face. It reaches candidates admitted before the rules were made because the university records a clarification that the 2023 regulations apply to all students appearing in the forthcoming examination, irrespective of admission year. Four things are established by no instrument: how many stations, how long one runs, what one is worth, and whether the requirement will be met by stations or by a short case. Numbers circulate for all four and are somebody's local arrangement. The board is at least four examiners, two of them external, one from outside the state.
LONG CASE AND SHORT CASE, AND THE MARKS NOBODY HAS PUBLISHED	The national provision is one long case and two short cases. Around it the current scheme is four papers, ten questions each, ten marks a question, with a 300-mark practical including 20 for the thesis and a 100-mark viva voce. What a long case or a short case is now worth is unpublished, because the division inside the practical is referred elsewhere, and the superseded ordinance's split is not carried forward to fill the hole. Equal marks per question means equal minutes per question, and the paper duration is not stated by the instrument that fixes the structure.
THE DEMONSTRATION, AND WHATEVER IS PUT IN FRONT OF YOU WITHOUT WARNING	Administration of a scale or a bedside test is an observed performance rather than a recitation: what is said to the patient before it starts, how timing is managed, what is reported aloud, and how a refusal is handled without abandoning the task. Whether such a demonstration is called for as a thing of its own, in what time and against what weighting, is established by nothing. The oral covers subject knowledge, investigative procedures, therapeutic technique and other aspects, and case reports, charts, specimens, slides and imaging are expressly examinable, with questions on instruments stated to be asked. How many such questions, how long for one, and what share of the viva they carry is not stated anywhere.

ASK	HOLD
BREAKING BAD NEWS AS AN EXAMINED ACT	Six steps, in the order the source prints them: setting, the patient's perception, an invitation from the patient to be given information, the knowledge itself, exploring and sympathising with emotion, then strategy and summary, with four objectives, to gather information, transmit it, provide support and elicit collaboration. Give the ethical frame both ways, because a one-sided answer loses half the marks: withholding on the presumption that the patient cannot cope may not always be justified against autonomy, and insensible disclosure may harm the patient and the relationship. One figure is printed only as a guard against transposition: the 13.6 per cent trained is an Iranian faculty and resident sample, and no Indian equivalent exists.

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Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. 23 of those rows are statutory and were read at the primary Act on India Code rather than from any textbook's summary of it, because a stale or paraphrased section changes what a clinician is legally obliged to do. Doses were read at current regulatory labelling, and each carries its own source receipt naming the regulator, the product, the label version and the retrieval date. 40 row(s) are recorded at partial confidence and 0 as a declared gap: a declared gap is a correct answer here, and no number has been supplied to fill one. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

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