

# “Is it Urgent?”: Seeking Medical Assistance for Mental Health during a Pandemic

## REFLECTION

### AUTHOR

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### BACKGROUND

In March 2020, I was halfway through my first year as a medical student. Following a three-month episode of feeling severely anxious and depressed, I finally told myself that what I was going through was not normal. I reluctantly decided to reach out to my GP for support. I went for a walk somewhere quiet where no-one could hear me and apprehensively made the call, shaking. I was directed to a receptionist, who asked me what the problem was. I explained the issue in as little detail as possible. She responded with a simple question, but one that resonated within me. “Is it urgent?”, she asked. I paused, not expecting this to be their first response. I asked what she meant by urgent, to which she responded with a second question, “Have you had thoughts of hurting yourself or someone else?”. I said the truth, that I had not. However, I was seriously concerned that I eventually might. She told me that because of a high volume of calls related to Covid-19, they were unable to take non-urgent appointments and that I’d have to call back another time. Our conversation ended there.

It was another six months before I built up the confidence to make another call, by which time my mood had deteriorated further. In this piece I will reflect on my experience of being turned away based on my case being classed as non-urgent while exploring methods of mental health triage in the UK primary sector, and the language used by mental health care providers.

### FEELINGS

After the call ended, I felt completely isolated. I felt that my personal issues were not worthy of their time and that what I was going through was not important enough to satisfy their definition. “Is it urgent?”, I kept asking myself. I felt unqualified to answer such a question. A debilitating state of depression that controlled every aspect of my life certainly felt urgent at the time. I felt as though I was being categorised rather than being listened to. Her choice of words reminded me of a parent’s response to a nagging child calling for their attention, to which they shout back impatiently, “Is it important this time?”. No, it’s probably not urgent, I told myself. I falsely accepted that what I was going through was in part my own fault,

that I was somehow not strong enough to pull myself together. My thought process fluctuated between blaming that receptionist for undermining my problem and joining her in doing so. The short relief I felt from finally addressing the issue by making the call was instantly shut down. Although I knew that the best thing for me was to see a professional as soon as possible, I was quick to accept a negative outcome because my symptoms were making me pessimistic. Despite being a medical student, and despite the unique circumstances of the pandemic, I think my trust in the medical profession was tarnished by this experience.

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I was worried that based on what the receptionist told me, my symptoms needed to deteriorate significantly to be deemed worthy of treatment unless I was somehow able to cure myself. In hindsight, I may have downplayed my symptoms in the initial call. Maybe this was because of the stigma attached to mental health, having grown up in an environment where it was not a common topic of discussion and is usually dismissed as a sign of weakness. After educating myself to fight that stigma, I found myself taking a large backward step after the urgency of my complaint was put into question.

I kept on asking myself the same question, "Is it urgent?". Of course, my preconceptions played a part in the logical response I produced over time. Surely it is the doctor, not the patient, who decides the urgency of a patient's presenting symptoms, I assumed. Medical school taught me that early intervention of my condition would have led to a better outcome than delaying it until my case became urgent. We are told that chronic diseases may not always be immediately urgent, but delayed treatment leads to a worse

prognosis for patients and an increased financial burden to the NHS. On reflection, I could have pushed to have a same-day doctor's appointment or called back once demand had eased, but like most patients with symptoms of depression, but I felt trapped in the mindset that I was not worthy of their time. I didn't have the knowledge or the resilience to make such a demand at the time.

Having the opportunity to write this piece allowed me to reflect on and process my experience. My newfound knowledge allowed me to answer some key questions about how my case was handled, and in terms of what I can now do to help other patients in similar unfortunate positions. Based on my research, I believe I was correct in assuming that the doctor was best placed to judge the urgency for themselves. I may have been wrong to pin the blame directly on the receptionist; I now believe my experience highlights much a broader issue related to inconsistency in staff training in primary care. My emotions evidently and understandably played a strong part in my response.

## DISCUSSION

I believe that the way my surgery prioritised patients in this instance (i.e., by judging solely based on urgency) had limitations that reflect a wider issue in primary care. This triage approach neglects the vital factor of importance in determining priority. Unlike urgency, importance is not time-sensitive but is a subjective factor that considers the significance of symptoms on patients' lives.

Eisenhower's matrix of time management takes its origins from President Dwight Eisenhower's system of prioritisation, which comes from his address to the Century Association in 1961:

*"Especially whenever our affairs seem to be in crisis, we are almost compelled to give our first attention to the urgent present rather than to the important future."* (3)

It hypothesises that tasks that are of high importance and low urgency should be prioritised over those which are of low importance and high urgency. (1) Clinically, we can replace the term 'tasks' with 'symptoms'. (Fig. 1) Under this model, most chronic diseases, such as the depression indicated by my presenting symptoms, would be prioritised over more time-sensitive cases that have a less significant impact on the patient's quality of life. This model has some limitations in the context of primary care where health is often a race against time. However, it indicates that urgency is not the only factor that should be considered in mental health triage.

In medical terms, a case is classed as urgent if it requires immediate attention but is not a life-threatening situation, in comparison to an emergency that is life or limb-threatening and requires immediate, intensive treatment. (4) Suicidal ideation is, therefore, an emergency. This begs the question: In the context of mental health, what can be classed as urgent? My presenting symptoms seem to fall into a grey area where my life was not in immedi-

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ate danger, but I felt that my symptoms were severely affecting my quality of life.

According to Zuppello, this ambiguity is highly problematic. They claim that urgent care for non-suicidal patients does not currently exist. (5) Interestingly, the UK Primary Care Foundation avoids using the words ‘urgent’ and ‘emergency’ in clinical scenarios due to universal uncertainty in their definitions. They state that the only way in which urgency can be identified in any borderline case is by assessment from a qualified clinician and that any request from a patient for a same-day appointment should be seen as “potentially urgent”. Had I known this, I would have certainly requested one.

General practise receptionists are not only expected to identify life-threatening cases as urgent, but also every case which could benefit from early intervention. (6) Fundamentally, urgency is defined by the patient until they are assessed. This may be paradoxical in cases of mental health, especially in depressed patients who may be more likely to undermine the severity of their symptoms due to factors such as stigma and psychological symptoms including low self-worth. Nevertheless, early intervention for mental illness can reduce hospital admissions and require fewer high-cost and less intensive interventions. (7)

With a rise in mental health admissions since the start of the pandemic, my experience is highly unlikely to be an anomaly. (8) I suspect my experience might be the tip of the iceberg in a global mental health crisis.

#### **ACTION PLAN**

I called the same surgery again six months following the first call and was immediately treated with a dose of antidepressants, which I still take a year later. I track changes in my mood daily and keep in touch regularly with both my GP and a counsellor. Although relieved to receive the care I needed, there is bittersweetness in knowing I could have reached this point much sooner. On a positive note, my personal experience sparked a passion to enter the field of Psychiatry.

I will carry this experience with me in future practise by assuming that every case is at least as urgent as the patient claims until proven otherwise. I will be in a much better position to communicate with colleagues, both as a patient and healthcare practitioner, by developing an understanding of protocol for primary care staff in the identification of urgency. I will therefore keep up to date with documents from the Care Quality Commission and NICE guidelines. It is equally important to recognise that the public does not generally have a sound awareness of these resources.

Using this piece as a starting point, I will continue to tackle the stigma around mental health. I will also continue conducting extracurricular work in mental health through my roles in societies within Cardiff such as WeHeal and Drug Science who provide peer support and educational tools for the local student population.

#### **CONCLUSION**

On a wider scale, I have learned that inconsistencies exist in primary care when assessing the urgency of presenting complaints, no more so than at the height of a pandemic. I hope that reaching a wider audience of clinicians and students through this piece can raise awareness and be a step towards creating necessary and urgent changes. Perhaps more importantly, I hope this paper can be read as a form of peer support. The broader question I have produced from writing this piece is this: Are patients always capable of judging the urgency of their presenting problems? From my experience, I certainly felt that I was not.

APPENDIX 1:  
EISENHOWER'S  
MATRIX OF  
TIME MANAGE-  
MENT

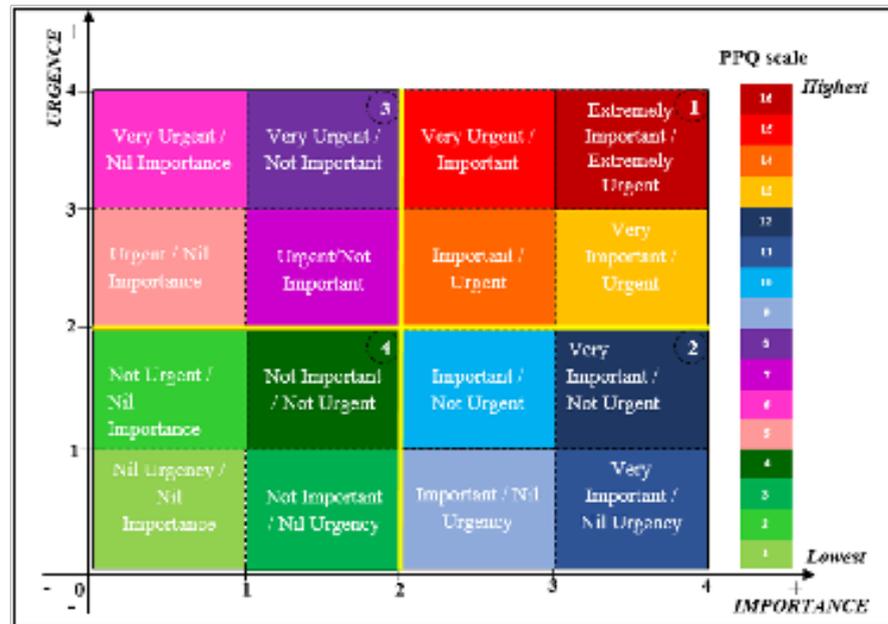


Figure 1: Eisenhower's Matrix of Time Management (2)

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