Revalidation: Are we Meeting Training Needs? Training and its Influence on the Practice of Child Psychiatry and Psychotherapy

Arun N.R. Kishore, Shaji K.S.[1], Praveenlal K.[1]

ABSTRACT

Revalidation and renewal of registration are issues of concern to most psychiatrists. Keeping up-to-date with current knowledge is an essential part of the renewal of license to practice. Training needs of psychiatrists are addressed in postgraduate courses and the gaps in training and updating of knowledge addressed through continuing medical education programs. This study aims to look at whether the training needs of psychiatrists working in the state of Kerala are being met. Two aspects of training and practice, child and adolescent psychiatry and psychotherapy, were assessed using a questionnaire. A significant number of respondents had not received any training in either of these areas in their postgraduate training. This did not affect their practice; most respondents continued to practice psychotherapy and see child patients despite not being trained. These two areas can thus be identified as lacunae in the curriculum as well as a need which should be addressed through Continuation Medical education programs.

Key words: *Child and adolescent psychiatry, continuing medical education, psychotherapy, relicensing, revalidation, training needs*

INTRODUCTION

The directives of the Medical Council sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action.[1] Principles of good medical practice exhorts practitioners to keep up-to-date in knowledge and skills, familiarize themselves with developments in their field, and take part in educational activities that maintain and further their competence. These are the basic aims of revalidation too. Revalidation is the process by which doctors will have to demonstrate to the Medical Council that they are up to date and fit to practice and that they are complying with the relevant professional standards.[2] Revalidation has two elements: relicensing and recertification.

The purpose of recertification is to show that practicing doctors who undertake specialist practice continue to meet the particular standards that apply to their medical specialty or area of practice.[3] Basic knowledge and skills, while fundamentally important, will not be enough on their own. As undergraduate and postgraduate education may be insufficient to ensure lifelong physicians' competencies, it is essential to remedy gaps in skills, and to enable professionals to respond to the challenges of rapidly growing knowledge and technologies, changing health needs and the social, political and economic factors in the practice of medicine. Continuing professional development (CPD) is the basic process to identify gaps in professionals development and help them fill these gaps. This is a continuous process of acquiring new knowledge and skills throughout one's professional life. In contrast to continuing medical education (CME), which involves updating only *clinical* knowledge, CPD also embraces developing and improving a broad range of skills necessary for medical practice such as management

Sussexpartnership NHS Foundation Trust, Sussex, UK, [1]Department of Psychiatry, Medical College, Thrissur, Kerala, India

Address for correspondence: Dr. Arun N. R. Kishore,
Greenacres, Homefield Road, Worthing, West Sussex BN11 2HS, UK. E-mail: arun.kishore@sussexpartnership.nhs.uk

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skills, communication, teaching and learning skills, and knowledge of information technology.[4] CME depends highly upon learner motivation and self-directed learning skills[5]

Kerala has a comparatively large number of trained mental health personnel.

Psychiatrists working in the government sector are attached to Medical colleges, District hospitals and state run Mental hospitals. The state has a well-developed private sector with psychiatrists and clinical psychologists attached to large private medical colleges, private hospitals, private mental hospitals and clinics.

Post graduate training in psychiatry started late in Kerala. An MD psychiatry course was started in 1984. Most psychiatrists working within the state had undergone training in post-graduate centers outside the state such as NIMHANS, Bangalore, AIIMS, Delhi, CMC, Vellore, JIPMER, Pondicherry, PGI, Chandigarh, and training centers at Chennai, Mumbai, or Mangalore. The state currently has six seats for MD in psychiatry and five seats for DPM.[6] There are a few centers offering training in Dip NB (Psychiatry) within the state.

Training in general adult psychiatry (AP) is fairly uniform in most centers. Only a few centers offer formal training in psychological methods of treatment and fewer have a regular program for training in psychotherapy.

Child and adolescent patients make up a fairly significant percentage of the clients who need a psychiatrist's intervention.[7] Training in this specialty was available in a few centers outside the state. Recently a few centers within the state have started Child Guidance clinics which offer basic training in this specialty.

This paper looks at the training received by psychiatrists working within the state of Kerala with specific reference to training in child and adolescent psychiatry and psychotherapy. It also looks at the nature of practice in these two areas within the state. The aim was to identify gaps in knowledge, practice and hence and in training. This paper suggests ways in which this gap may be addressed.

MATERIALS AND METHODS

A questionnaire was developed to look at the training received by psychiatrists practicing in Kerala. It enquired about the training they received during their post-graduate years as well as their current practice. The focus was on training in child and adolescent psychiatry and psychotherapy.

The questionnaire consisted of 32 questions of which the first 7 addressed basic background data such as the nature and place of practice, number of years of practice as well as issues about place of training. The next 25 questions enquired about training in child and adolescent psychiatry and psychotherapy as well as the methods of practice in these two areas. All questions had multiple choices as answers. The respondents were allowed to make specific comments on each question if required.

The questionnaire was sent out to 227 psychiatrists within the state. An attempt was made to contact those who did not respond initially.

RESULTS

A total of 227 questionnaires were sent out of which 84 were returned completed indicating a response rate of 37%.

The respondents fell into the age range of 29 to 65 years (mean of 44.2). There were 78 males and 6 female respondents. The number of years of practice ranged from 1 to 31 (a mean of 18). 44 (52%) worked in the private sector and 40 (48%) in the government sector. A further break up of their places of work is given in Table 1.

Training

Of the respondents, 32 (38%) had been trained in post-graduate centers within the state and 52 (61%) had been trained outside the state. 33 (39.3%) had an MD in psychiatry and 51 (60.7%) had a Diploma in Psychological medicine.

Of the respondents, 54 (64.3%) of the total said that they had received training in psychological methods of therapy and 30 (35.7%) had received none.

40 (47.6%) had received training in Child and Adolescent Psychiatry and 44 (52.4%) had no such training.

Practice of psychotherapy

Of the respondents, 72 (85.7%) said that they used psychotherapy as a treatment modality in their daily practice while 12 (14.3%) did not.

Of the respondents, 10 (11.9%) estimated that less than 25% of their patients would require some form of

Table 1: Distribution of respondents (place of work)

Sector	Mental hospitals	Medical education	General hospitals	Others
Government	26 (30.9%)	14 (16.6%)	0	0
Private	12 (14.3%)	0	28 (33.3%)	4 (4.9%)

psychotherapy, 42 (50%) of the respondents estimated that between 25 and 50% of their clients would require psychotherapy, and 32 (38.1%) felt that more than 50% of their clients would require such a service.

One third of the respondents had received no formal training in psychotherapy, yet 85% of them said that they practiced it. On comparing the training received and the practice of psychotherapy, we found that the distribution was not significant.

Most practitioners employed more than one method of therapy. Cognitive therapy, behavior therapy and family therapy were the techniques commonly used [Table 2]. Among the others were existential therapy, logotherapy, hypnotherapy and play therapy.

Of the respondents, 31(36.9%) had a clinical psychologist practicing with them, 53(63.1%) had none though they could access the services of a psychologist through referral practice.

Child and adolescent psychiatry practice

74 (88.9%) of the respondents said that they saw children during their regular practice, 10 (11.9%) did not. An estimate of the number of children seen during a week is given in Table 3.

Half the respondents (50%) saw at least one child a week in their daily practice.

The most common type of problem seen in children was thought to be mental retardation followed by conduct disorders.

Of the respondents, 68 (80.9%) said that they used medications as a first line of treatment in most cases while 6 (19.1%) said that they would use none.

Of the respondents, 72 (85.7%) had no liaison with schools regarding the children they saw.

Less than half the respondents had received training in child and adolescent psychiatry yet 88% said that they see children regularly in their practice, half of the number seeing at least one child a week. On comparing the training received in child and adolescent psychiatry and its practice, the distribution was not significant.

DISCUSSION

In this study the response rate was low but is in keeping with responses to most questionnaire surveys.[8] The sample of respondents seemed to be evenly distributed in terms of the government and private sectors. The sample is skewed in terms of gender which is possibly a reflection of the gender skew in practitioners within the state where there is a preponderance of male psychiatrists.

A large number of the respondents had been trained in centers outside the state. Post-graduate training in psychiatry started in Kerala in 1976 with the introduction of a DPM course in the Government Medical College, Thiruvananthapuram. An MD course in psychiatry was started in the Government Medical College, Kozhikode, in 1984.

Many of the psychiatrists had received some training in psychotherapy. When asked about the need for psychological methods of treatment in their patients, psychiatrists felt that most of their patients needed psychotherapy (88%). Whether trained or not, most psychiatrists practiced psychotherapy with their clients (85.7%). Indeed we see that trainings in psychotherapy and the practice are not correlated [Table 4]. This possibly reflects the need of the community and the psychiatrists' response to this need. It may reflect the awareness of these practitioners about various issues related to mental health problems and perhaps helps dispel the myth that psychiatrists are purely "biologically minded" and are unaware of the multifaceted nature of mental health problems.

Behavior therapy is a technique which is popular and widely used. Most centers offer some training in this. Cognitive therapy which is becoming increasingly popular has fewer centers offering training in these

Table 2: Methods of psychotherapy commonly employed

Methods	Number
Psychodynamic psychotherapy	22 (26.2%)
Cognitive therapy	40 (47.6%)
Behavior therapy	44 (52.4%)
Family therapy	44 (52.4%)
Other	10 (11.9%)

Table 3: Number of children seen weekly

None	10 (11.9%)
< 1 child/ week	32 (38.1%)
1-5 children a week	26 (30.9%)
5-10 children a week	14 (16.7%)
>10 children a week	2 (2.4%)

Table 4: Comparison of training in psychotherapy and its practice

	Trained	Not trained	Total
Practicing	48 (57.1%)	24 (28.6%)	72 (85.7%)
Not practicing	6 (7.1%)	6 (7.1%)	12 (14.3%)
Total	54 (64.3%)	30 (35.7%)	84 (100%)

Chi square=1.244 Df=1 $P \leq 1$, The distribution is not significant

methods. Training in family therapy is offered in a few centers. Most centers offer a mixture of different methods under the broad rubric of "Eclectic" therapy.[9]

A working knowledge of psychotherapy is an integral part of being a psychiatrist and this must be reflected in training in psychiatry. All trainees should gain knowledge, skills, and attitudes to be competent in psychotherapy to a sufficient level.[10] Skills should be gained in at least one recognized form of psychotherapy and broad knowledge should be gained in the other forms of psychotherapy to allow the trainee to evaluate suitability for referral to specialist psychotherapist.

Psychiatric practice involves the use of various therapeutic strategies ranging from pharmacotherapy to the psychological therapies. In reality, the individual practitioner uses a judicious mix of these therapies depending on their training, the needs of the patient as well as the time available. A few psychiatrists work in teams with other mental health professionals.

Most psychiatrists practicing in the state see children as a part of their daily practice. The number of children seen varies, but it is interesting to note that more than half of the respondents see at least one child a day. This is irrespective of the fact whether they had received training in child and adolescent psychiatry (CAP) [Table 5]. This possibly reflects the need of the community.

CAP and AP are two separate specialties in the field of psychiatry, although the two are closely linked. CAP is closely linked to AP. Both specialties use biological, psychotherapeutic, and social methods of evaluation and treatment. The practice of child and adolescent psychiatry calls for particular sensitivity to and caution in the use of pharmacotherapy and for an awareness of psychological methods of treatment. This was why this study focuses on psychotherapy and child and adolescent psychiatry. Most respondents (80%) used pharmacological interventions with children as first line treatment; very few had a liaison with schools.

The results of this study have implications for curriculum development as well as for the design of CME programs. The needs of practitioners are not being met through formal training in post graduate courses. This therefore needs to be supplemented through CME programs. CME is part of the process of lifelong learning and has traditionally been viewed by the medical profession in terms of updating their knowledge This will become increasingly important in relation to renewal of licensing, which is at present providing the impetus for CME to become mandatory.[1]

We need to ask: do current CME programs address these gaps in training[11]? Unfortunately very few CME sessions are devoted to psychotherapy issues or the practice of child and adolescent psychiatry. CME schemes are currently based on acquiring credits. It should be the quality and relevance of the activities that is important, not the quantity. The undifferentiated pursuit of credits provides a false security blanket that may bear little or no relation to the real outcomes of activities aimed at professional development. There needs to be a shift away from credit counting towards a process of self accreditation and reflection, recording learning that has occurred, identifying gaps in knowledge and focusing on making up these deficits.[11] This study should hopefully provide an impetus into such needs.

Table 5: Comparison of training in child and adolescent psychiatry and its practice

	Trained	Not trained	Total
Practicing	35 (41%)	39 (46.4%)	74 (88.1%)
Not practicing	5 (5.9%)	5 (5.9%)	10 (11.9%)
Total	40 (47.6%)	44 (52.4%)	84 (100%)

Chi square 0.0257; Df=1; $P \leq 1$, The distribution is not significant

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