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TRAINING GENERAL PRACTITIONERS IN PSYCHIATRY – A NEW VENTURE

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SUMMARY

Formal training programmes in psychiatry for general practitioners (GPs) by Psychiatrists so far reported have involved MBBS graduates. But, a considerable proportion of registered medical practitioners who serve the community are non-MBBS about whose training needs, no experience is yet available. This paper describes a training programme in which an attempt was made to know the training needs of the non-MBBS GPs and also to assess the potential of the previously trained GPs to complementarily assist the psychiatrists in such training programmes.

Introduction

An effective model for training General Practitioners (GPs) through short courses is available and has been tested in the ICMR Multicentre project (Shamasundar 1983). But, such training programmes have so far been directed only at MBBS-GPs (Shamasundar 1986). Yet, a large proportion of Registered Medical Practitioners (RMPs) serving the community, especially in villages are non-MBBS graduates. The success of the National Mental Health Programme (DGHS 1982) depends as much on these non-MBBS practitioners as on the MBBS ones. Sooner or later, the sooner the better, attempts must also be made to train these non-MBBS GPs in Psychiatry. However, their training needs in terms of content and method are probably different. Therefore, there is an urgent necessity to assess their training needs in comparision to MBBS-GPs.

Apart from the possible differences in the training needs of the MBBS and non-MBBS GPs, the more fundamental issue of a GPs training needs is crucial. That the training needs of a GP are different from what a psychiatrist is usually trained to offer is well documented in the west (Pond 1964, Balint 1964, Feldman 1978). Similar has been the experience during the training programmes conducted by NIMHANS (Shamasundar 1986). With as increasing awareness of such a difference (in what is needed and what is otherwise offerable), it is morally incumbent on the psychiatrists to attempt to find ways and means to cater for this difference. One such method that is easy is to recruit the participation of previously trained GPs (PT-GPs) in the post-lecture discussions so that they contribute from their clinical experience.

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This paper reports a training programme in Psychiatry for GPs where attempts were made to find: (i) the differences in the training needs of MBBS and non-MBBS GPs, and (ii) the usefulness of PT-GPs as discussants in the training programmes.

Material and Methods

In the beginning of 1986, the authors formed a group to pursue their interest in the cause of training GPs in Psychiatry. Their objectives were: (i) to progressively and innovatively evolve more and more efficient, cost-effective models of training GPs in psychiatry, and eventually (ii) to develop such models for non-psychiatrist specialists and even medical undergraduates. They regularly met once a week to formulate the strategies, monitor their implementation and review the progress. The training programme covered in this paper is their first joint venture.

A medical voluntary agency, Vaidhya Bharathi Medical Foundation undertook to look after the organisational aspects of this training programme, and the authors undertook to conduct the training.

The training programme consisted of 15 afternoon sessions of 2 hours each, at two sessions a week. The first session was devoted to (i) the introduction to the programme (ii) pre-training assessment using vignettes, and (iii) a few questions about the GP's practice. The last session was devoted to post-training assessment which included the participants opinions about the programme. The remaining sessions covered the following topics:

History taking, major symptoms and signs,
Interviewing
Psychoses
Mental Retardation
Neuroses
Psychosexual problems
Psychosomatic problems
Addictions
Psychiatric emergencies
Psychopharmacology
Principles of Counselling.

Comparatively more sessions were devoted to those conditions which the GPs more commonly encounter, like neuroses, somatic presentations, psycho-sexual conditions etc., Each session generally consisted of an initial brief lecture by a psychiatrist covering practically oriented information followed by discussions. The discussions were encouraged to be clinically orientated by inviting the GPs to discuss about their patients for whom any of the points covered in the lectures applied. The GPs were also given a copy each of the cyclostyled manual of about 100 pages. The lectures were based on this manual which had progressively evolved over the previous nine training programmes.

Eight GPs who were previously trained in psychiatry (PT-GPs) agreed to participate in this training programme as observers during lectures, and as active discussants during the post-lecture discussions. They were briefed about their role. These PT-GPs were selected because they had also underwent an year's training (once a week) in psychotherapeutic orientation (Shamasundar 1987), and they had been conducting regular clinical case discussions among themselves about their psychiatric cases.

All the authors attended the sessions. The first author took the lectures, and others participated in the discussions in addition to functioning as observer-evaluators, reviewing the proceedings after each session. At the end of the training in consultation with them, the

the GPs-in-training (GPs-IT) were divided into six groups and assigned to each author for once a month follow-up meeting to discuss: (i) How the GPs were applying their new knowledge into their practice (ii) difficulties they were encountering. These monthly follow-ups were carried out for 6 months.

Results

The training was conducted in May-June 1986. 11 GPs attended the programme. 7 of them, all males, were MBBS-GPs. The remaining 4 (3 males and 1 female) were non-MBBS, (BAMS). Only 9 GPs, 6 MBBS and 3 non-MBBS completed the post-training assessment also. The age ranges of MBBS and non-MBBS GPs were 35 to 43 years and 28 to 34 years respectively. They had been in practice for 8 to 13 years and 2 to 8 years respectively. 6 of the PT-GPs attended the sessions regularly and they were also administered post-training assessment for comparison.

The pre-and post-training assessment scores of the 9 GPs-IT when compared by the student 't' test showed a considerable gain ($t=6.1904$, df8, $P<0.001$). Their initial and final performances were 29% (mean score = 20.8889, SD = 18.0193) of the maximum scorable of 72. The performance of the 6 PT-GPs were 75.7% (mean score = 54.5, SD = 10.9138) of the maximum scorable.

Table 1 shows the reported and measured differences between the MBBS and non-MBBS GPs-IT. It is evident that the background or basic information about the psychiatric illnesses that the non-MBBS GPs generally have is much less, as well as their gain after training compared to MBBS-GPs. The authors' observation during the discussions confirmed this. A scrutiny of the post-training assessment protocols of these non-MBBS GPs showed their performance to be comparitively poor in all aspects of assessments, namely, diagnosis, drugs and dosage, minimal advise to be given etc. None of the 3 had completely read the manual. However, they seemed able to appreciate the psychosocial aspects of psychiatric illness, though comparitively less than their MBBS counterparts.

About the participation of the PT-GPs, all 9 GPs in training found their role very useful, and felt that they should similarly be involved in future training programmes. 4 of the 6 PT-GPs felt convinced that their contribution during discussion helped the GPs-IT. The other 2 were not-sure. The authors' observations were in conformity with the above opinions. The PT-GPs discussed on the basis of their personal experience in practice, and the weight of their experience lended confidence to the learning of the GPs-IT.

During the monthly follow-up discussions in which each author was to meet one or two GPs-IT, the attendance of the GPs was not regular and only 4 GPs were more regular. The discussions showed that: (i) the GPs readily put their new knowledge in to practice in their simpler cases (ii) their management approach is adequate (iii) they tend to become hesitant if their patients are slow to respond.

Discussion

The gain in the assessment scores after training can only be attributed to the effect of training, because the pre-and post-assessment protocols were mixed and randomly coded to mask their identity before scoring. The gain of about 20% of the maximum scorable in comparable to the gain in a recent training programme (Shamasundar 1983).

Table 1
Reported and measured differences between MBBS and non - MBBS GPs.
(Percentage in parenthesis refer to the maximum scorable of 72)

	MBBS GPs.	Non–MBBS GPs
	N = 6	N = 3
I. Pre-Training Opinion		
Commonest Psychiatric symptoms seen in practice.	Sleeplessness, vague pains, weakness, loss of appetite, breathlessness, fear.	Sleeplessness, Depression, Addiction.
Commonest psychiatric diagnosis in practice.	Depression, Hysteria Anxiety, Addiction.	Epilepsy
II. Post-Training Report		
Any gain by this training?	"Very much"	"Moderate" (Only one responder).
Have you read the Manual	"Yes"	"Only part of it" (Only one responder).
Which topic difficult?	"Nil"	"Symptoms & signs, history taking, interviewing, Neurosis. Psychosomatic conditions.
III. Assessment Scores by Vignettes		
Pre Training mean	26 (36.1%)	8 (11.1%)
Post Training mean	42.7 (59.1%)	17 (23.6%)
Mean Gain	16.7 (23.0%)	9 (12.5%)

Examination of the differences between the MBBS and non–MBBS GPs (Table 1) shows that the latter are probably less conversant with basic clinical concepts and methods of modern medicine like symptoms and signs, basic ideas about history taking and interviewing etc. This in itself may not completely explain their comparitively poorer performance in training. It may also be partly related to such factors as proficiency in language, their traditional orientation of understanding illness etc. What is evident, however, is that future training programmes in psychiatry for non-MBBS GPs need: (i) separate training courses specially designed for them, (ii) greater coverage of such basic topics like concept of illness, symptoms and signs, history taking and interviewing etc. (iii) limiting the goal of training to identify psychiatric illness and refer till the ability to effectively manage minor conditions by this category of GPs is repeatedly demonstrated (iv) re-evaluation of the training goals and methodology after about 3 such courses.

However, it is not possible to be certain that the 4 non-MBBS GPs in this training programme are representative of their fraternity, nor is it possible to be certain of the opposite. Hence, it is necessary to put the findings of this programme to test a few times in respect of non-MBBS-GPs.

The performance of the PT-GPs during the discussions confirmed the authors' initial assumption that these GPs should be capable of practically useful contribution to the learning of the GPs-IT.

After a training programme, the GPs need a few follow-up discussions in order to clinically guide them and foster their confidence.

It is concluded from the above that:

a) the GPs in training as a group benefited from the training.
b) non-MBBS GPs require specially designed courses.
c) previously trained GPs are potentially effective in transfer of practically orientated knowledge.

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