ORIENTATION COURSE IN PSYCHIARTY FOR THE GENERAL PRACTITIONERS*

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SUMMARY

A large proportion of clients of General practitioners suffer from psychiatric morbidity and they are either not identified at all or are only inadequately managed because their training in psychiatry at the undergraduate level is insufficient.

The training of GPs in psychiatry economically in a short course, and evaluation of such training is a challenging task. Only recently some sporadic efforts are being made to develop and evolve training programmes in an increasingly thorough manner.

A 20 weeks, once a week training programme for 30 motivated GPs was conducted at NIMHANS, Bangalore in 1979—80. This training programme which was more thoroughly structured was based on the experiences from an earlier unstructured once a month, 2 year course conducted at Bangalore in 1977-78.

The results were not only encouraging but also highlighted a few challenging areas for further work.

The wide gap between the mental health needs of the community and the psychiatric services available in India is well known. Many epidemiological studies (Sethi et al 1967, Dube 1970 Verghese et al 1973, Carstairs & Kapur 1976) and Neki's (1973) calculations prove it. Lin (1970) points out that the general practitioners (GPs) who should ideally be having a greater share in the psychiatric services to the community are ironically the least adequately trained in psychiatry in the developing countries. There is thus a great need to train the GPs in psychiatry. This need poses two related requirements. First: economy of time and effort in training in view of the great disparity between the large number of GPs and a comparatively very small size of specialist man-power. Second: Limited aims and objectives and their evaluation. Obviously the intention of such training can never be to transform GPs into miniature psychiatrists.

In India only a few training programmes are reported. Wig et al (1977) reported a one day programme; Shamasundar et al (1978, 1980) reported a once a month 2 years programme; and Kalyanasundaram et al (1980) reported a week-end programme. Shamasundar et al (1980) showed that the referral patterns of trained and untrained doctors differ suggesting a probability that the trained doctors use the knowledge gained in training in their practice. Gautam et al (1980) (please see note 1 below) showed a significant difference in knowledge between trained and untrained doctors. Though such programmes indicate that it should be possible to develop short and effective

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NOTE 1: Gautam, S., Kapur, R. L., Shamasundar, C (1980) "Evaluation of Techniques for psychiatric training of General Practitioners"—Unpublished.
training programmes they have been either too brief consisting mainly of lectures or too long drawn consisting mainly of clinical case material discussions. The evaluations of these programmes too have been relatively restricted to descriptions and to assessment of attitudes or theoretical knowledge.

This paper describes the next logical step of combining lectures and clinical case material discussions with a few methods of evaluation in the same training programme. But the task of developing the methods of training and evaluation is plagued by the disparity between the ideal and the practical even for the simplest of aims of enabling the GP to:

1. Identify 'cases' and refer
2. Treat under guidance simple medicinally treatable symptomatic neuroses without psychosocial complications.
3. Treat under guidance chronic psychoses on maintenance dose.
4. Feel able to comfortably interview a psychiatric patient (see note 2 below).

Where as the ideal method of training and evaluation is to conduct them 'live' clinical situation, the practical difficulties found by the authors are:

1. GPs do not relish the presence of a psychiatrist in their clinic during their clinical work.
2. GPs are very poor corresponders, and equally poor in maintaining records.
3. GPs generally do not prefer to refer their more 'regular' patients, and complimentarily, more 'regular' patients, of the GPs do not like to be referred (Shaila Pai et al., 1980). Moreover 'live' clinical training and evaluation is not economical.

The method of training and of evaluation are closely inter-dependent, either of them is only as good as the other. That is, any exclusive progress in either of them alone is not possible, and they can only be developed together. At least in the initial stages, the disparity between the ideal and the practicable have to be bridged by compromises.

The programme described in this paper, was conducted by the community psychiatry unit of NIMHANS from October 1979 to February 1980. It was designed with compromised and modest aims of:

A. (1) Training the GPs in clinically oriented knowledge on major psychiatric syndromes, to enable them to:
   (i) Identify cases
   (ii) Refer for specialist consultation
   (iii) Treat the cases under guidance
(2) Training the GPs in principles of interviewing

B. Evaluation of the training using pre- and post-training assessment to:
   (1) Assess the GPs' clinically oriented knowledge
   (2) Assess the GPs' interview skill
   (3) Find out if the simple attitude questionnaire measured the changes due to training. Gautam (1979) had found that the GPs' performance on attitudes discriminated those who attended the once a month, 2 years seminars from those who had not.

METHODS

In order to eliminate the possible bias of motivation and to stimulate a sense of commitment, this training was offered to the GPs who had a minimum qualification of M.B.,B.S. on payment of a registration fee of Rs. 150/-.

The programme consisted of 20, once a week session of two hours each.

NOTE 2: During the 2 years' seminars on psychiatry for GPs, most of them complained to the first author that once they know or suspect that a patient is psychiatrically ill, they do not know how to proceed further. They feel similarly when a patient presents only with somatic symptoms.
The following topics were covered by nine staff members.

1. Principles of interview
2. Neuroses
3. Schizophrenias
4. ‘Depressions’ including MDP
5. Psychogenic somatic conditions
6. Epilepsy
7. Psychiatric emergencies
8. Organic psychiatric conditions
9. Mental Retardation and childhood psychiatric conditions
10. Personality disorders, and addictions

In order to emphasise on clinically oriented knowledge, sessions on each major psychiatric syndrome consisted of:

a) Initial brief lecture describing the commonest symptoms and signs, important clinical features, and major lines of management.
b) Presentation of 4 to 5 clinical case materials by staff exemplifying the above.
c) Discussions, inviting the GPs to talk about similar ‘cases’ they might have come across.

For the assessment of the GP’s clinically orientated knowledge, it was assumed that the GP’s clinical ability would be reflected in the way he arrives at a diagnosis and line of management from a set of clinical data in vitro. For this purpose structured clinical stories for the eight major syndromes specially developed for this purpose were used for both pre- and post-training assessment. There were alternate stories for each syndrome so that the same GP will not get exactly the same story twice. For each story, the GP was asked:

(i) What the diagnosis was
(ii) Based on what data in the story he arrived at the diagnosis
(iii) What further information he would like to seek
(iv) How would he manage
(v) On what issues he likes to counsel if he chooses to counsel.

The pre- and post-training assessment answer sheets were coded and randomly mixed, and the answers were assessed independently by at least two assessors using a set criteria.

The session on the principles of interview consisted of brief lecture on principles of interview with examples. Also, on four subsequent occasions, there were discussions on a pre-video recorded interview between a participant GP and a patient. The emphasis in the lecture and in the discussions was on how the GP might and does very easily miss the subtle clues offered by the patient in the interview.

For assessment of the interview skill, it was assumed that the GP’s skill will be reflected in his ability to identify the patient’s subtle clues from sample material. Therefore, the question paper for the pre- and post-training assessment consisted of parts of two interviews between GP and his patient selected from two books (see note below). The two samples shown in appendix ‘A’ were selected because they were similar in the way they contained clues from the patient. The trainee GPs were asked to comment on what they understood from the interview and how they would have liked to respond if they were the interviewing doctors. The first author scored the responses using two criteria:

(1) To what extent GP has identified the patient’s clues.
(2) How appropriate is the GP’s substitute responses.

Pre- and post-training assessment also contained questions shown in appendix ‘B’ relating to ‘attitudes’ about mental illness, and about the aetiological and diagnostic factors for mental illness and epilepsy. It was hoped that the simple procedure of assessment of attitudes may serve as a measure of change due to training. For the assessment, the GP’s responses were scored according to a set of
'model' answers derived by majority responses of 3 staff psychiatrists who participated in the training.

Towards the end of the programme, it was decided to see how the trained GPs function in 'live' clinical situations. The willing volunteers were invited to attend the psychiatric outpatient clinic in a general hospital a few times in batches of 3 to 4 each. Every participant was required to examine a psychiatric patient and present his findings for discussion, to participate in 3 to 4 such discussions, and to submit himself to assessment of his performance at the end similar to the 'clinicals' of the residents. The performance was assessed independently by two psychiatrists on the following criteria using 4 point scale for each item.

a) How inherently easy or difficult the case was
b) To what extent important clinical features are identified
c) How correct the diagnosis is
d) How appropriate is the GPs proposed line of management
e) Over all impression.

RESULTS AND DISCUSSION

Of the 80 doctors who responded to a single advertisement, 2 were specialists, one a dentist, and 5 ayurvedic graduates. 30 M. B., B. S. doctors were enrolled on first come first serve basis, of which 4 were lady doctors, and 4 were working in industrial and private hospitals. More than 60% of them were below 40 years age.

3 GPs from 30 to 50 km outside Bangalore, and one city GP dropped out. The remaining 26 doctors completed the course, but only 21 of them attended the post training assessment so that the pre- and post-training performances of only 21 doctors were available for evaluation. Only 11 doctors participated in the 'live' clinical training-cum-assessment programme conducted towards the end.

Table 1 shows the results of assessment of the participant's responses to the structured clinical stories which discriminated the pre and post-training performance to a significance level of less than 0.05. Before the stories for all the eight diagnoses were available for use in GP training, the stories for 4 diagnoses had earlier been administered to the staff psychiatrists. On these 4 diagnoses, the post-training performance of the GPs and the performance of the NIMHANS psychiatrists differed to a significance level of less than 0.01. The inter-rater reliability as indicated by correlation coefficient for the assessment of these stories ranged from 0.9262 to 0.9661 between three independent assessors, which is an indicator that the structured clinical stories can detect change brought about by training.

The pre-and post-training performance on the interview samples did not reveal any overall significant difference, as shown in table II. Which means either that the coverage given in training for this topic is insufficient in duration or in the

| TABLE 1. Assessment on structured Clinical Stories |
|-----------------------------------------------|
|                                               |
| Pre-Post—                                    |
| N—21 N—14                                    |
| General practitioners NIMHANS Psychia-        |
| rists                                        |
| 4 diagnostic Mean 23.38 28.67 44.54           |
| stories S. D. 10.21 9.16 4.65                 |
| (Maximum scorable—50)                         |
|                                               |
| 8 diagnostic Mean 44.00 52.43 —                |
| stories S. D. 15.71 15.53 —                   |
| (Maximum scorable—100)                        |

Inter-rater reliability between 3 assessors: r=0.9269 to 0.9661.
TABLE 2. GPs’ Performance on Interview Sample (Maximum scorable=15)

|     | Pre- | Post- |
|-----|------|-------|
| N—21| 6.86 | 7.09  |
| Mean| 3.62 | 3.92  |
| S. D.|      |       |

Not significant.

method, or that the evaluation method or both need review and further development. The GP’s pre and post-training performance on attitudes did not show statistically significant difference as shown in table III.

TABLE 3. Pre and post Training Assessment of GPs’ Attitudes (Maximum scorable =41)

|     | Pre Score | Post Score |
|-----|-----------|------------|
| N—21| 23.67     | 24.33      |
| Mean| 4.97      | 3.81       |
| S. D.|          |            |

Not significant.

The first 5 attitude questions were same as used by Gautam (1979). Even for these five questions there was no differences between pre and post-training performance. Neither in this training programme nor in the 2 years programme, the attitude change was significant. It is probable that the change in attitudes is a slow process and thus incapable of serving as an item of assessment for short training courses.

Despite a small sample size precluding generalisation, the performance of the 11 volunteer GPs in the ‘live’ clinical setting showed that :

1) All the participant GPs were able to elicit important clinical features;
2) But only about 60% of them were able to arrive at correct diagnoses, and appropriate line of management; and
3) Inter-rater agreement was minimal (r=0.4021)

This area of assessment, assessing the GPs’ ability to translate his knowledge into a ‘live’ clinical situation should ideally be very useful to evaluate any other method of evaluation of GPs-training programme. This method of assessment needs further experimentation and development with larger sample size.

When the tools of assessment used in this study were compared namely :
1) the structured clinical stories
2) performance of interview sample
3) attitude questions, and
4) the assessment in live-setting, there was no cross-correlation between them. In respect of the interviewing skill and the attitudes, the reasons are obvious and already explained. But, it has yet been difficult to understand why the GPs performance in live setting did not correspond with their respective performances on structured clinical stories, which alone discriminated the pre and post-training performances. However, out of 21 GPs, only 11 participated in the ‘live’ programme, and the possible sample bias has to be considered.

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APPENDIX 'A'

1. Interview Sample from Robert L. Khan and Charles F. Cannel (1957):—

Doctor: I want you to tell me your symptoms very clearly. What is the chief thing that is bothering you, now?

Patient: I do not have any pains now, and I feel wonderful.

Doctor: Well, what trouble had to had in the near past?

Patient: Well, this summer I had days that I did not feel so good. Lots of days I had to take it easy and kind of loof around.

Doctor: Why did you have to take it easy? What has your main problem been?

Patient: I just felt...... I really had no bad pain......I just......sort of feeling bad inside me for a long time. I felt......

Doctor: Did you have any pain at all?

Patient: I would not really say it hurt, but it felt bad like......

Doctor: Where did it feel bad?

2. Interview sample from Patrick S. Byrne and Barrie L. Long (1976):

Doctor: Well now, here you are again. How are things?

Patient: Oh, doctor, I have not been taking all those pills you gave me. They did not seem to agree with me.

Doctor: Ah, ha. Have you been getting in your exercise every day?

Patient: Oh, yes, doctor. Every morning I walk to work and I walk home at night. That is nearly four miles a day.

Doctor: Mmm. Now then, how about that leg.

Patient: Oh, that is much better now. The scar is still there though I expect it will go it time.

Doctor: How about the wife? Is she getting about alright?

Patient: Yes, she gets out of a morning and goes down to the shops. She takes the bus down to the station, you know, and walks from there.

Doctor: You are sleeping alright, are not you?

Patient: Well, I still take those tablets, doctor.

Doctor: Good. Well now, take this to the chemist. There are some different pills, different colour, you know. Let me know how things are getting on. Do not forget your umbrella. Bye-bye.
APPENDIX 'B'

(Question 1 to 4 are about how many mentally ill and epileptics the GP's saw in the previous 3 months)

5. Each of the following questions have alternative answers. Please choose the one which most approximates your belief and encircle it.

(a) Do you think that mental disorders are serious illness? Yes/No
(b) Do you think that any normal person under stress become mentally ill? Yes/No
(c) Do you believe that mental disorders can be treated by spiritual or traditional faith healers? Yes/No
(d) If given a choice would you have chosen psychiatry as your career? Yes/No
(e) Suppose, one of your close relatives develop some odd behaviour which you consider to be mental illness, would you discuss it with your friends? Yes/No

6. In table below are listed some possible factors which can be considered as causing mental illness and epilepsy respectively. Please, put a tick mark in the appropriate box according to whether you consider a factor important, moderately important or not having any role at all.

\[\checkmark = \text{Important }\]
\[\checkmark = \text{Moderately important }\]
\[0 = \text{No role.}\]

| Factors                                      | Mental Illness | Epilepsy |
|----------------------------------------------|----------------|----------|
| 1. Heredity                                  |                |          |
| 2. Witchcraft, black magic, modi etc.        |                |          |
| 3. Poverty                                   |                |          |
| 4. Masturbation or excessive sex             |                |          |
| 5. Excessive intelligence                    |                |          |
| 6. Over work                                 |                |          |
| 7. Head injury                               |                |          |
| 8. Loss of loved one                         |                |          |
| 9. Lack of faith in God                      |                |          |
| 10. Contact with mentally ill                |                |          |
| 11. Worries                                  |                |          |
| 12. Body weakness                            |                |          |
| 13. Childhood experiences                   |                |          |
| 14. Brain lesion                             |                |          |

Q.7. How important are the following factors to arrive at the diagnosis of mental illness and epilepsy respectively. Please put a tick mark according to the code.

\[\checkmark = \text{Important, }\] \[\checkmark = \text{Moderately important, }\] \[0 = \text{No role.}\]
| Factors                              | Mental Illness | Epilepsy |
|-------------------------------------|----------------|----------|
| 1. E.E.G.                           |                |          |
| 2. Blood tests                      |                |          |
| 3. History from the eye-witness who has seen the attack |                |          |
| 4. History from the patient         |                |          |
| 5. X-ray skull                      |                |          |