

# THE GENERAL PRACTITIONER — HOW MUCH PSYCHIATRIC EDUCATION?

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## INTRODUCTION

The general practitioner is in a privileged position with regards to illness in the community. He is usually the first person that people bring their symptoms to and hence he generally sees illnesses in their earliest stages. This is especially so in an urban setting with the greater concentration of practitioners and the general acceptance of doctors as primary care professionals. Greater skill is often required to recognise an illness at its inception than when it has progressed to a florid stage, but the reward lies in the far greater possibilities that are afforded for prevention.

The early treatment of a pneumonia may avert eventual bronchiectasis, an otitis media nipped in the bud may save a child's hearing, and a depression recognised and treated at the first visit may prevent a suicide. As in other branches of medicine, the difficulty lies in knowing when to intervene; in recognising when the infinite variety of the normal is left behind and the realm of the

pathological is entered. Common sense tells us that we should not treat every newly bereaved widow with anti-depressants nor every lazy adolescent as though he is a sociopath or a simple schizophrenic.

The problem in psychiatry is not only that it is difficult to determine boundaries of illness but also that the illness does not easily fit the medical model of disease. A doctor treating a pneumonia can identify the causative organism, can prescribe the appropriate antibiotics and can watch the resolution of infection on chest x-ray. The aetiology of psychiatric illnesses is never as clear cut as that. Genetic factors have been shown to play a part in psychotic illnesses, but not an exclusive part. Environmental factors are also important and there is a complex interaction between "nature and nurture". For this reason, the doctor dealing with psychiatric ill-health needs to pay far greater attention to the social environment of the patient than if he were treating a case of pneumonia. Some general practitioners rely on their own skill and insight, while yet others neglect this whole sphere. This certainly diminishes their ability to deal with psychiatric ill-health which has repeatedly been shown to make up a substantial part of general practice. Besides, time is very limited in general practice and it is therefore all the more important that a doctor becomes very able at picking out those at a risk and concentrating on them.

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## MENTAL ILLNESS IN GENERAL PRACTICE

The extent of the problem of mental ill-health in general practice may come as a surprise to those who have not had first-hand experience of it. Shepherds and Cooper (1966) in his study of a total of 14,697 patients seen in twelve general practices comprising twenty-four doctors came to the conclusion that the psychiatric morbidity was 13.9 percent. Koh (1969) in his Singapore patients assessed the morbidity as psychiatric (9 percent), psychosomatic (6 percent) and somatopsychic (5 percent). Tsoi and Chia (1972) using the questionnaires returned by a small group of general practitioners in Singapore came to the conclusion that 60 percent of the general practitioners saw more than 10 percent of patients with mental illness. Woon & Ng (1973) made an interesting study of psychiatric morbidity in a district hospital out-patient clinic, using a three-point scale to also rate the severity of psychiatric ill-health. The rate estimated by the medical officers was 6 percent and psychiatrists 32 percent respectively, thus indicating that with greater sensitivity for emotional illnesses, there is a higher chance of identifying psychiatric problems in the community.

From these studies and many more, it is clear that the management of cases of mental illness forms a substantial part of a general practitioner's work, and that only a very small and selected proportion of these patients reach hospitals with over-burdened psychiatric services. This simply means that the general practitioners not only manage the psychological accompaniments of physical illness. They also treat on an average nine out of every ten psychiatric patients in the community with or without being consciously aware of the fact. What sort of training is necessary to equip doctors technically for this task?

An answer commending general support is unfortunately not too hard. Medical schools seldom agree about the place psychiatry should have in the curriculum. A survey carried out at a W.H.O. Conference in Manila (1974) shows very considerable discrepancies in the amount of time given to psychiatric instruction, in its context, and in the number of teachers available to give it. Yet it is an obvious fact that the foundation of good general practice must be laid in medical schools.

## THE UNDERGRADUATE CURRICULUM

The Faculty of Medicine, University of Malaya was established in 1962 (Danaraj, 1966). Its first class of students graduated in 1969. The teaching programme aims at producing the totipotential medical graduate for whom there is still a greater need than there is for specialists in this country. The Department of Psychological Medicine plays an important role in this respect and contributes by providing each student with an exposure of about 300 hours to the disciplines of medical psychology and psychiatry. Their experience takes the form of classroom lectures, small group seminars, case discussions and case conferences. The students do a total of nine weeks' clerkship in the Department in the fourth and final years respectively, during which they work up in inpatient and outpatient cases and follow through with some supervision. Emphasis is also made that the patient should not only be considered as a case of psychiatry, medicine, surgery etc. but instead the student is made to consider the patient as a whole with problems that need the expertise of a particular discipline.

Tan (1970) in his evaluation of the curriculum states that the students are reasonably satisfied with the teaching programme but he is uncertain as to whether the kind of comprehensive teaching contributed to producing the type of graduates who can not only deal with psychiatric problems in general practice or at the district hospital level with confidence, but also show a willingness to care for such cases rather than referring them for specialist care. He was also hopeful that more graduates would choose to do psychiatry as their life's work.

Many years have passed since this hopeful note. No systematic assessment has been conducted to evaluate the effectiveness of the curriculum. We cannot claim to have converted many of our graduates into budding psychiatrists. In fact the response has been poor. My impression is that the actual practice of psychiatry among our graduates is also very limited once they leave the cloister of their teaching hospital. There are many reasons for this state of affairs.

Family practitioners need to learn about psychosis, neurosis and behavioural disorders. However, they usually see patients with overt

psychopathology at different stages and in different forms and contexts than the psychiatrist or the psychiatrist service sees them. Family practitioners more often deal with the psychological problems of everyday life, which are interwoven with a variety of illnesses, rather than with overt psychiatric symptoms. A number of studies have begun the attempt to define psychiatric parameters of family practice. One study by Werkman *et al*, (1976), administered questionnaires to 202 family practitioners who attended week long post-graduate seminars in Family Practice, in order to determine the frequency of psychiatric problems they encountered in their day to day practice. Marital and sexual problems were first on their list of frequency, followed by depressive disorders, hypochondriasis, alcoholism, emotional problems related to chronic illness and last of all anxiety-tension states. The group felt strongly that they be given opportunities to gain a greater familiarity with patients who have psychiatric problems. This is not surprising since there are studies to show a significant increase in interest in psychiatry after medical school on the part of the community physicians.

Psychiatric consultants, on the other hand, respond mainly to pre-selected cases of the referring physician or general practitioner. Thus, they become the problem solvers rather than the teachers of physicians in the processes of diagnosis, evaluation, and management in physician-patient situations. Psychiatric advice is usually directed to only the most immediate problems and often the more complex ones as well. Students exposed to this highly selected patient-population often end up feeling that psychiatry equals schizophrenia or chronic "battle-scarred" emotional problems, and their management, a bottomless pit. This is further compounded by the fact that psychiatry is not practiced as an integral part of medicine within the teaching hospital as a whole. A time-study of bedside teaching showed that attention to the patient as a person is usually eclipsed by the preoccupation of clinical teachers with laboratory findings and their interpretation. Under these circumstances, the majority of students are unlikely to respect the discipline sufficiently to acquire psychiatric knowledge and skills as a substantial component of their professional equipment.

It is also well-known that students themselves differ considerably in their attitudes to the

emotional aspects of illness. In an interesting statistical study of 112 medical students graduating at Edinburgh, Walton *et al* (1964) using delegate analysis, were able to distinguish four characteristic types of students representative of different student personalities. Type one recognises and acknowledges the existence of functional disorders but he does not want to have to treat patients with such disorders himself. Type two finds it difficult to get on with people and to relate to patients and is actively hostile to patients with psychological disorders. Type three is primarily interested in science, research and technical proficiency and although he gets on with all patients, he has no special interest in patients with psychological disorders. Lastly, type four is mainly interested in patients as people and is strongly aware of the psychological aspects of illness. This raises the important question whether and how students' attitudes can be changed during their training so that more of them develop an interest in the emotional aspects of illness alongside their scientific training.

The teachers of psychiatry like the staff of other medical school departments, not uncommonly operate within a departmental atmosphere made confusing by the lack of any clear specification of the general goals of undergraduate instruction. Students trying to grasp the subject often find their teachers confronting them with a puzzling contradiction of didactic view-points. Objectives such as increasing students' psychological perceptiveness, thus developing their sensitivity to patient's personality differences and emotional responses, training students how to relate to patients so that they recognize the therapeutic significance of the doctor-patient relationship, are often superceded by narrow and vague objectives and more detailed intellectual information on psychiatric syndromes. Thus, too often psychiatry is presented to undergraduates as an abstract and largely verbal exercise. Such instruction is unacceptable to the somatically-orientated student: he requires direct involvement.

In spite of these inherent problems, I am of the opinion that our graduates leave the medical school with a much broader understanding of psychological medicine. However, I seriously question their ability to apply psychiatric principles into every dimension of patient-care in the

ambulant setting. Thus, the time has come for a re-evaluation of the undergraduate psychiatric curriculum so that the psychiatric training adequately prepares the students for a more psychosomatic approach towards the practice of medicine in the community.

## **PSYCHIATRIC TRAINING AND THE GENERAL PRACTITIONER**

Rajakumar (1974), in a very enlightening article has explored the various trends in the training of undergraduates in relationship to the special role of the general practitioner in the community. He does reflect upon some of the shortcomings with the present day medical education, due to accelerated fragmentation of medical science into super-specialities, the attitude of young doctors in the age of hurried ambitions and quick rewards, and other realistic problems in producing doctors of "broad learning, culture and humanity." To overcome some of these problems I am in total agreement with him over two matters, (i) creating a department of general practice in medical schools, so that general practice becomes an established vocation in its own rights and (ii) the College contributing actively in the vocational training programmes.

If the future family physician is to be more skillful in recognizing and managing the psychiatric problems encountered in his daily practice, then I feel a training programme must slowly evolve with psychiatrists and other behavioural scientists collaborating to develop learning of relevance and substance in this area. Although we psychiatrists often fail to communicate adequately with our associates in medicine, we do have certain skills and a body of knowledge that can be appropriately introduced into the overall armamentarium of general practice. The primary care physician must be knowledgeable in such areas as interviewing, counselling, the effects of the physician's role and attitude on the health of his patients, patient compliance, personality issues in health and illness, psycho-physiological diseases, emotional stress secondary to illness and hospitalization, drug dependence, marital dysfunction and faulty child-rearing patterns, if he is to be fully competent in the practice of his profession. These are areas in which psychiatry has accumulated a body of theoretical knowledge and techniques of intervention.

Furthermore, the training programme must attempt to enhance the physicians understanding of himself as a person in relationship to his wife and family. This insight does help them a long way with patients undergoing a great deal of distress due to marital and sexual problems. They learn how to motivate families to change with the limited time and resources available. Given this opportunity for training, in time to come a small number of general practitioners would express a wish to gain training in more refined psychiatric techniques that would prepare them to offer inclusive care to patients with more complex psychiatric problems. In this context, Lee (1975), and others have pointed out that many patients with emotional problems are much happier being treated by family physicians than by specialists in institutions.

## **CONCLUSION**

To summarise what has been discussed, many patients treated in general practice of medicine suffer from psychiatric symptoms. There is very little systematic information available about the nature of these concerns in our country. Although useful leads have developed from studies abroad, much more information of a specific nature is needed, for it has been established that a large percentage of a family practitioner's day, variously estimated at 20 percent to over 30 percent of his time, is taken up with the handling of emotional and psychological problems.

The undergraduate teaching programme at the Faculty of Medicine, University of Malaya exposes students to nearly 300 hours of basic psychology and psychiatry. The curriculum though impressive is unsatisfactory owing to lack of common goals in teaching, over-specialisation, pre-selected teaching material and neglect of basic psychiatric principles in the total practice of medicine by the teachers in the other disciplines.

An accelerated interest in psychiatric problems seems to take place when a graduate ventures into the role of a primary care physician, the reason being that a general practitioner is exposed to the commoner problems of human living and striving. He is perhaps by now married with a family of his own. Thus, marital and family problems causing emotional and physical distress, sexual problems, drug and alcohol dependence, anxiety-depressive syndromes, and psycho-social problems related to

chronic illness, form a large part of the practitioner's case-load. Only a very small percentage of these patients ever reach the hospital psychiatric services.

The future family physician needs more skills in recognizing and managing psychiatric problems as the demands of medical care caused by psychosocial stresses increase. To equip doctors with these skills, the educational process has to be tackled from within the medical school, and without. This involves the modification of the undergraduate curriculum, the establishment of a department of general-practice in the teaching institution and the active participation of the College of General Practitioners in upgrading their educational programmes and status. As society becomes more knowledgeable, the demands on the doctor to provide much more than a "prescription-slip" will increase proportionately. Thus, to remain complacent is being short-sighted.

In most parts of the world, there is a renewed emphasis on family practice and the development of new training programmes in primary care. I envisage similar trends in this country. Thus, the primary care physician must have expertise in interviewing, counselling, psychophysiological diseases etc., all areas in which psychiatry has a body of knowledge and intervention techniques.

I hope in time to come, educational programmes are evolved so that we can combine our skills, techniques and information, that are of utmost relevance to general practice.

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