Psychiatric curriculum for training physicians

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The burden of mental illness and the shortage of mental health professionals have focused attention on training basic physicians in mental healthcare.[1,2] However, current approaches impose tertiary care standards and specialist perspectives for training physicians who work in primary and secondary care settings.[3–5] These specialist conceptualizations and schemes, albeit in diluted form, have been imposed on classifications, diagnostic algorithms and treatment guidelines for use in primary care. However, the fact that such psychiatric approaches to classification for primary care (e.g. International Classification of Diseases [ICD] 10 Primary Health Care [PHC][6] and Diagnostic and Statistical Manual IV Primary Care[7]) were unheard of and unused in general and family practice speaks of their mismatch with the primary care context.[3]

We lay out the conceptual differences between primary and specialist care presentations and practice and offer a framework for recognition and management of psychiatric presentations in general medical settings. It forms a basis for the proposed curriculum for training medical students, nurses, health workers and physicians to manage psychiatric presentations in primary and secondary care.

DIFFERENT REALITY IN PRIMARY CARE

Many differences in settings, populations and perspectives between psychiatrists working in tertiary care and primary care physicians have been documented.[3–5] General practitioners (GPs) and family physicians see people with milder, non-specific symptoms, sub-syndromal and mixed presentations associated with psychosocial adversity.[8] Consequently, they favour categories such as mixed anxiety depression and adjustment difficulties to traditional psychiatric diagnosis (e.g. depression and anxiety). Population differences between settings, with a lower prevalence of classical psychiatric presentations (e.g. anxiety and depression) in primary care, often result in high false-positive rates. Physicians argue that many patients diagnosed with major depression have high rates of spontaneous remission and of placebo response and those with mild-to-moderate severity do not respond to antidepressants.[3–5]

GPs contend that the use of symptom counts sans context, employed by psychiatric diagnostic schemes, essentially flag normal distress rather than disease.[9] Consequently, family and primary care physicians use the International Classification of Primary Care-2,[10] which focuses on reasons for clinical encounters, patient data and clinical activity. Primary care physicians argue that patients seek medical help when they are disturbed or distressed, when they are in pain or are worried about the implication of their symptoms. Many such forms of distress are normal reactions to adversity and mainly require psychological and social support. They also prefer general guidelines for management to detailed, separate and specific protocols.[3–5]

Nevertheless, mixed anxiety depression, the most common psychiatric presentation in primary care, is not included in psychiatric manuals (e.g. Diagnostic and Statistical Manual-5)[11] and even in systems designed for primary care (e.g. ICD 10-PHC,[6] Mental Health Gap Action Programme diagnostic and management scheme[12]). Similarly, categories such as acute and chronic psychosis, easily identified and managed in primary care are trumped by the specialist conceptualization of schizophrenia and bipolar disorders more commonly encountered and recognized in specialist practice. Categories useful in primary care seem to be unacceptable to specialists and unsuitable in their settings and *vice versa*.[3]

Primary healthcare professionals demand caution in translating specialist concepts and classifications for use in primary care, and yet their perspectives are marginalized in official classifications, management guidelines and in curricula for training basic physicians. The many differences in patient populations and perspectives suggest a 'category fallacy' (i.e. the unwarranted assumption that psychiatric categories and diagnoses have the same meaning when carried over to a new cultural context/clinical setting with its alternative frames or systems of meaning) when specialist cultures are imposed on primary care.[13] The culture of psychiatry in primary care borrows heavily from specialist approaches and attempts to adapt it to the reality of primary care. The compromise is uneasy, unstable and difficult to apply. The low rates of recognition and treatment of mental illness in primary care across countries despite education and retraining programmes for GPs suggest the failure of tertiary care approaches in primary care.[3–5]

PSYCHIATRIC TRAINING

Despite major differences in settings, populations and perspectives, psychiatric training continues to be provided in psychiatric facilities and in tertiary care settings. The failure of specialists to recognize the differences has resulted in training programmes that are wholly inappropriate and seem to satisfy specialists rather than empower physicians.[3–5] Most programmes in psychiatry seem to transfer knowledge rather than skill and confidence, resulting in physicians unable to manage common psychiatric disorders in their clinical practice. Psychiatric training often deskills and disempowers even the most diligent of students; physicians would rather refer their patients than manage common mental distress and illness. Their failure to recognize and diagnose classical psychiatric presentations, uncommon in primary care practice, results in their inability to manage patients with mental distress and illness. Clinical practitioners, who while being unable to challenge the international psychiatric concepts and classifications for use in primary care, do not actually employ them in their practice undermining such schemes.[4,5] While specialist theories, perspectives and practice currently trump primary care approaches, they do not empower physicians working in complex and different realities.

Psychiatrists, trained in tertiary care and familiar and confident in specialist approaches, assume that patients presenting to primary care will have similar presentations and will benefit from specialist perspectives. Consequently, specialists devise curricula and training programmes which are enitrely inappropriate for use in primary care thus perpetuating inadequacy and lack of confidence among physicians to manage psychiatric presentations in primary

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care.[3–5] Countries with strong traditions in general and family practice recognize these difficulties and pay lip service to the official and specialist classification, methods and treatment protocols while training physicians in primary care using general practice and family physician perspectives, principles and approaches.[14,15]

DEVELOPING A CURRICULUM

Developing a curriculum to train physicians and basic health workers to identify and manage psychiatric presentations in their practice demands that those making the curriculum are able to see the big picture. Such a curriculum should be set in the intended area of practice (i.e. primary and secondary care), identify common presentations commonly seen in such setting, use general and family practice perspectives and employ general and broad guidelines for management.[3–5,14,15] Such an approach will not only make identification of common presentations easier but will also be able to transfer skill and confidence in management.

Accepting that all psychiatric syndromes (i.e. collections of symptoms) are heterogeneous in aetiology, pathology, clinical features, treatment response, course and outcome and that all available psychiatric treatments are essentially symptomatic is a good start to navigate the complex issues of managing psychiatric presentations in general medical practice.[3–5] It demands that the approach to patient care should be tailored to the individual's personal and social context. Such an approach will allow the family physician to support people in different kinds of distress while managing their illness and treating the occasional severe mental disorders.

Milder, mixed, sub-syndromal presentations, often associated with psychosocial adversity demand that the emphasis during training should be on broad clinical presentations rather than on arriving at a specific psychiatric diagnosis.[4,5] These presentations should be easily recognizable in primary care practice making it easy for physicians to immediately identify the clinical pattern. Broad clinical patterns allow for easy identification, and for acquiring the necessary skill for diagnosis and management and thus instilling confidence in primary care physicians. The numerous categories and labels used by psychiatrists in specialist practice are difficult to distinguish in primary care and confusing for PHC professionals. The identification of the broad presentations allows for the use of general management guidelines and for the provision of appropriate care.

Medical students and health professionals already familiar with taking a history of illness should be oriented to adapting the procedure to collect details of mental health, distress and illness. An emphasis on a family and past history of mental illness, substance use, suicide/attempts, and violence will be necessary. The importance of a comprehensive physical examination and basic laboratory investigation with a focus on neurological and endocrine disease to identify/exclude and manage physical disease is crucial. Demonstrating and teaching the fundamentals of doing a mental state examination to evaluate cognitive abilities, psychotic symptoms, mood state, suicidal risk and risk of violence will be part of the training.

Table I documents the details of the knowledge and skills required to recognize and manage common psychiatric presentations in primary care. It records the level of competence required, general and specific, necessary to manage patients with such presentations and identifies situations, which would benefit from the specialist referral.

Table II lists the specific situations common in primary care and the levels of competence necessary and skills required for management. Patients who attempt suicide and those with suicide risk, angry, tearful, agitated and violent patients and those who present with grief and bereavement are common in such settings and require clinical competence to manage in clinical practice.

Table III records the common problems among children brought to primary care and family physicians with intellectual and learning disability and attention deficit and hyperactivity common among those with academic problems and difficulties. Nocturnal enuresis and temper tantrums are common behavioural problems seen in children and require management skills among physicians working in such settings.

Table IV lists the therapeutic interventions, which need to be mastered in primary care to manage common psychiatric presentations. A holistic approach to care requires the use of psychotropic medication and simple psychological interventions, which can easily be implemented in busy clinical practice.

Table V suggests a list of lectures, clinics/role plays and student seminars for 2 weeks posting during the medical course. It emphasizes holistic 'primary medical care' for common psychiatric presentations in general practice.

SETTING AND PROCESS

Moving psychiatric training out of specialist settings and resituating it within primary and secondary care and general medical settings will allow for the recognition of common presentations, appreciation of local reality, encourage holistic management and improve understanding of general practice and family medicine perspectives.[4,5] Encouraging psychiatrists to work in primary and secondary care and general medical settings will also allow for a liaison approach, which understands local contexts, identifies important clinical issues and determines suitable management strategies.

The curriculum should aim to not only transfer knowledge but also transmit the necessary skill and confidence for independent clinical practice. These skills will have to be mastered during basic undergraduate training and internship through the use of lectures to introduce topics, seminars to increase understanding while using small group discussion, demonstrations, and clinics to focus on developing skill and confidence. Psychiatric education set in general medical settings will allow for practice using common clinical presentations seen in these facilities, employ family physician perspectives to managing distress and illness and be attempted in busy clinical practice.

NARROWING GAPS

The specialist approaches currently used, the primary and secondary care perspectives and methods being suggested result in three kinds of gaps, which need to be bridged. These include: (i) conceptual gap between mainstream psychiatric perspectives and primary and secondary care approaches; (ii) gap between specialist and general medical practice setting as there are major differences between patient populations, available time and laboratory support; and (iii) disease–illness divide, which shows the differences in perspective between a medical understanding of disease (structural and functional abnormalities) and patient/family perspectives of illness. While all the three gaps are incommensurable, most doctors and teachers are constantly and often imperfectly crossing these divides. The proposal attempts to narrow these conceptual gaps by focusing on the identification of broad general syndromes and the use of general management guidelines rather than psychiatric labels and specific and detailed strategies. The shift in

TABLE I. Knowledge and skills required to manage common psychiatric presentations

Clinical presentation	Level of competence	General skills required	Specific skills required	Recognize need for referral
Delirium	Recognize presentation Identify common medical and neurological causes/ consequences Manage medical conditions Symptomatic management Non-ambulatory care	Recognize clinical presentation Establish rapport, acknowledge patient and family distress Elicit patient and family perspectives Focused history, perform physical examination and basic laboratory investigations Patient and family education about illness Use of medication, dose adjustment, manage side-effects Discuss role of stress as a cause/consequence of illness Elaborate coping strategies, psychosocial interventions Negotiate treatment plan Give appointment for review	Identify and manage hypo-active and hyperactive delirium	Identify situations requiring referral (e.g. severe behavioural disturbance, aggression and psychosis
Dementia			Identify and manage psychological and behavioural symptoms of dementia Identify and manage risk factors and reversible causes for dementia	Identify complex neurological and medical conditions requiring specialist intervention Identify situations requiring psychiatric referral such as severe behavioural disturbance, aggression and psychosis
Substance use/ dependence			Manage common medical consequences (e.g. injury, dehydration, vitamin deficiencies, infections, impaired liver function) Symptomatic management of withdrawal, delirium and psychosis Psychosocial management to prevent relapse	Identify hepatic encephalopathy and major complications Referral for recurrent relapse and polysubstance dependence
Psychosis			Identify and manage acute, episodic and chronic psychosis Use of medication, choice of drug, route, dose and adjustment, manage side-effects Psychosocial management including strategies to calm patient Identify and manage aggression	Identify situations requiring referral (e.g. severe psychosis, non-response to treatment, repeated relapse)
Physical symptoms, health anxiety, common mental disorders			Identify acute and chronic stress Demonstrate the link between stressful mental events and physical symptoms Identify and manage severe depression, suicidal risk Discuss coping strategies	Identify situations requiring referral (e.g. non-response to treatment, severe incapacitation, repeated relapse, serious suicidal risk)
Sexual dysfunction			Screen for sexual misconceptions, problems Explore context, personal situations, circumstances, contraception Educate about normal physiology, relationship issues Consider specific suggestions (e.g. reduction of anxiety, spectatoring, substance use, discuss squeeze technique for premature ejaculation and lubrication for vaginismus) Use of phosphodiesterase inhibitors	Identify situations requiring referral (e.g. non-response to treatment, severe marital discord)

TABLE II. Clinical issues that require specific management

Clinical issue, situation	Level of competence	General skills required	Specific skills required	Recognizing need for referral
Attempted suicide and suicidal risk	Screening for and recognition of problems Ability to explore context Ability to identify specific and general stress Discuss coping strategies Making a plan	Recognize clinical presentation Establish rapport, acknowledge patient and family distress Elicit patient and family perspectives Focused history, physical examination and basic laboratory investigations Patient and family education about illness Use of medication, dose adjustment, manage side-effects Discuss role of stress as a cause/consequence of illness Elaborate coping, psychosocial interventions Negotiating treatment plan Give appointment for review	Identify level of risk Provide appropriate supervision and support Counselling Medication for severe depression	Life-threatening attempt requiring hospitalization Repetitive serious attempts Non-response to treatment for psychiatric problem
Angry or tearful patient			Admission of responsibility and apology, if grievance genuine Shifting focus from issue to person	
Disturbed, violent patient			Assessment of risk of violence Ensure safety Parenteral and oral medication for psychosis and severe agitation Verbal and non-verbal interventions to calm patient Use of restraints	Extreme and repeated violence Underlying refractory mental illness
Grief and bereavement			Recognize normal grief Understand stages of grief Ensure safety Exclude psychosis, suicidal risk Provision of support Sleep hygiene and use of hypnotics for brief duration	High suicidal risk Chronic grief and incapacitation

TABLE III. Common clinical presentations in children

Clinical presentation	Level of competence	General skills required	Specific skills required	Recognizing need for referral
Intellectual disability Learning disability Attention deficit hyperactivity	Recognize presentation Identify common medical and neurological causes/ consequences Manage medical conditions Symptomatic management	Recognize clinical presentation Establish rapport, acknowledge patient and family distress Elicit patient and family perspectives Focused history, physical examination and basic laboratory investigations Patient and family education about illness Use of medication, dose adjustment, manage side-effects Discuss role of stress as a cause/ consequence of illness Elaborate coping, psychosocial interventions	Elicit developmental milestones, fix approximate mental age; calculate approximate intelligence quotient Identify specific disability, behavioural problems, psychosis Consider medication for psychosis, severe behavioural problems Discuss daily schedules, reinforcement for good behaviour Discuss academic support, education, training, rehabilitation	Severe behavioural problems or psychosis Requiring multidisciplinary management Specific curricular assessments and advice Advanced academic support
Nocturnal enuresis Temper tantrums		Negotiate treatment plan Give appointment for review	Assess intellectual ability, developmental age Exclude neurologic and urinary tract problems Explore stress Control fluid intake/output Discuss daily schedules, reinforcement for good behaviour Discuss need for attention, consistent discipline	Refractory problems

TABLE IV. Use of psychotropic medication and psychosocial interventions

Intervention	Level of competence	Skills required
Antipsychotic medication Antidepressant medication Benzodiazepines	Understand indications, dose, range, increase, adverse effects, maintenance treatment and common drug interactions	Choice of drug, titration, prophylaxis, withdrawal, toxicity, overdose
Communication and counselling skills	Ensure privacy	Establish rapport
	Facilitate dialogue	Allow ventilation
	Recognize emotions	Identify and avoid common errors
	Discuss implications	Provision of support
	Make a plan	
Breaking bad news	Explore patient's awareness	Recognize common difficult situations
	Establish gap with reality	Individualize disclosure, (amount of information, time for absorption, allowing expression of emotions, clarification of doubts, etc.)
	Provide information	
	Provision of support	
	Review	
Problem-solving and crisis intervention	Explore problem area/crisis	Listening skills
	Identify specific problems	Empathy
	Define goals	Compassion
	Explore alternatives	
	Identify possible solutions	
	Appointment for review	
Sleep hygiene	Evaluate sleep duration, cycle	
	Identify specific causes of sleep disturbance (medical and psychiatric problems, treatments, substance abuse)	
	Explore stress	
	Examine sleeping arrangements, activities	

setting of training when coupled with a collaborative approach between psychiatrists and primary care, general and family physicians will allow for bidirectional learning related to mental health, distress, illness and disease and their psychosocial and economic context.

Psychiatrists, currently working in liaison–consultation programmes, will be able to adapt to primary and secondary hospital settings. Regular interaction between specialists and general physicians will result in a fertilization of perspectives and practice relevant to primary medical care. However, the shift in emphasis, curriculum and setting will require a reorientation of teachers, increased linkages with primary care, networking between clinicians, identification of core skills, reading resources, etc. It would also involve the need for pilot projects, which will need to overcome teething problems and evolve into full-fledged programmes.

OWNERSHIP

Despite much-hyped efforts by psychiatrists, supported by academic GPs, to re-educate general and family practitioners in managing mental illness in primary care, there has been no improvement in recognition and management rates of mental disorders.[3] The specialist perspectives imposed on primary care (i.e. symptom counts sans context) have few takers in actual practice.

Working in primary care demands solutions based on ground reality. Such an approach will allow common presentations to be recognized and managed skilfully. It will provide confidence and professional satisfaction, which will result in the sense of ownership.[5] Psychiatrists need to work in primary care and collaborate with physicians to devise, tailor and improve psychiatric education for physicians so that they are empowered with the science and the art of clinical medicine.

THE WAY FORWARD

The psychiatric framework should make a theoretical shift from a 'diagnosis drug treatment approach', to a broader framework of 'caring for illness', understanding illness in context and taking care of the person who is sick.[5] Formulations, which focus on healing, often remain at a sub-theoretical level, are learnt by trial and error and require long years of experience, and consequently, need to be emphasized and theorised.

There is a need to create transformative educational initiatives, which provide key stakeholders the opportunity to collaborate, understand, invest and develop the care of mental distress, illness and disease in primary care. Reimagining psychiatric education for primary and secondary care practice demands the understanding of local reality, which should transform not just psychiatric practice but influence psychiatric theory.

Conflicts of interest. None declared

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TABLE V. Suggested teaching methods and clinical topics*

Session	Lecture	Clinical exposure	Student seminar
1	Introduction to psychiatric presentations in general practice	Eliciting psychosocial context	Social determinants of mental health
2	Common presentations in general practice	Physical symptoms, health anxiety, common mental disorders	Mixed anxiety depression
3	Managing physical symptoms health anxiety, common mental disorders	Physical symptoms health anxiety, common mental disorders	Specific patterns of anxiety and depression
4	Managing psychosocial distress	Physical symptoms health anxiety, common mental disorders	Stress reduction strategies (religion, yoga, meditation, exercise, hobbies)
5	Medications for common mental disorders	Physical symptoms health anxiety, common mental disorders	Medication for depression; sleep hygiene
6	Alcohol use and clinical presentations	Alcohol use and clinical presentations	Detoxification and simple de-addiction strategies
7	Suicide and deliberate self-harm	Suicide and deliberate self-harm	Assessment and management of suicidal risk
8	Managing severe depression and suicidal patient	Melancholic and recurrent depression	Differences in approach between mild and severe depression
9	Assessment and management of acute and chronic psychosis	Acute and chronic psychosis	Medication for acute and chronic psychosis
10	Assessment and management of violent patients	Acute and chronic psychosis	Medication for episodic psychosis
11	Assessment and management of dementia	Dementia	Medication and psychosocial management of dementia
12	Assessment and management of delirium	Delirium	Medication and nursing care for delirium
13	Common sexual misconceptions and dysfunction and their management	Erectile dysfunction and premature ejaculation; dyspareunia	Education, specific suggestions and medication for sexual dysfunction
14	Assessment and management of Intellectual disability	Intellectual disability	Behavioural therapy for behavioural problems
15	Assessment and management of specific learning disability	Learning disability	Dyslexia and academic difficulty
16	Assessment and management of autism spectrum disorder	Autism spectrum disorder	Use of medication in autism
17	Assessment and management of hyperactivity	Managing the hyperactive child	Use of medication in hyperactive children
18	Assessment and management of common behavioural problems	Temper tantrums, bedwetting	Simple rewards and reinforcement methods
19	Communication and counselling skills	Role plays on managing tearful, sad, angry and violent patients	Basic counselling skills
20	Breaking bad news	Role play on steps in breaking bad news	Psychoeducation
21	Psychosocial rehabilitation	Community visits	
22	Evaluation of skills		

*A 2-week posting in psychiatry during the MBBS course means 22 sessions (morning/afternoon)

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