Editorial

Reimagining Psychiatric Education for Physicians

The burden of mental illness, the shortage of mental health services and the large treatment gap in low- and middle-income countries have been debated in the literature. Projects, initiated by WHO in the 1970s and 1980s, led to the National Mental Health Programme in India.[1] Policies and plans were reviewed, revised and were upgraded.[2] Mental health service delivery was also emphasized in the 65th World Health Assembly resolution on mental health,[3] the WHO's Mental Health Gap Action Programme (mhGAP)[4] and Comprehensive Mental Health Action Plan 2013–20.[5]

Notwithstanding these much-hyped efforts, the reality on the ground for people with mental illness has hardly changed across many low- and middle-income countries including India.[6–8] While poor infrastructure, overburdened systems, professional apathy, limited finances, impoverished environments and low morale of primary healthcare staff have been identified, the problems related to training of medical students, physicians and health professionals have not received the attention they deserve. We discuss issues related to psychiatric education for health professionals.

The rise of specialist perspectives

The rise of psychiatry, as a distinct discipline, has paralleled the growth of specialist and tertiary care within medicine. Nevertheless, the increasing emphasis on specialization within the medical culture simultaneously diminished the status of basic doctors, general practitioners (GPs) and family physicians and those working in primary care. The success of capitalism coupled with the nested position of medicine within the capitalistic economic system cemented the trend making tertiary care the standard; specialist perspectives became the norm for quality of care.

Psychiatry, with its focus on aligning itself with biology and medicine, adopted the biomedical model. The biomedical perspective postulates central nervous system aetiology and pathology, suggests diagnostic criteria, offers differential diagnosis and recommends psychotropic medication. Biomedical psychiatry, to increase the reliability of diagnosis, emphasizes symptom counts, checklists and operational criteria while dismissing the person's context. Psychiatric concept of 'mental disorder', with its disease halo, sidesteps the disease–illness dichotomy while encompassing both disease and distress.

Tertiary care standards dominate the discourse on mental health across settings.[8,9] Psychiatric classifications for use in primary care were soon taken over by specialist perspectives, diagnostic labels and treatment protocols. Many specialist concepts and categories, albeit in diluted form, found their way in the International Classification of Diseases 10 for Primary Health Care (ICD 10-PHC)[10] and the Diagnostic and Statistical Manual IV for Primary Care.[11] These formulations are supported by psychiatrists and by academic GPs who have bought into specialist beliefs.

Different reality in primary care

While psychiatrists often praise specialist perspectives, primary care physicians do not usually put them into practice.[8,9] GPs oppose the de-contextualization of clinical presentations and argue that such a strategy medicalizes normal human distress.[12] Family physicians recognize the importance of psychosocial circumstances (e.g. stress, personal resources, coping, social supports and culture)[8,9] and appreciate their impact on mental well-being. They oppose attempts by psychiatry to reify common symptoms of disorders

frequently seen in specialist settings and argue that GPs, who understand local contexts, recognize multiple variants of distress.

GPs suggest that the many differences in settings, populations and perspectives between psychiatrists and PHC professionals demand caution in translating specialist concepts and classifications for use in primary care. Family physicians see people with milder, non-specific symptoms, sub-syndromal and mixed presentations associated with psychosocial adversity.[8,9] Consequently, they favour categories such as mixed anxiety depression and adjustment difficulties to traditional psychiatric diagnosis (e.g. depression and anxiety). Nevertheless, mixed anxiety and depression are not included in psychiatric manuals (e.g. Diagnostic and Statistical Manual-5) and even in systems designed for primary care (e.g. ICD 10-PHC[10] and mhGAP[4] diagnostic scheme). Categories useful in primary care seem to be unacceptable to specialists and unsuitable in their settings and vice versa.

Population differences between settings, with lower prevalence of classic 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.[8]

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.

GPs contend that the use of symptom counts and the discounting of context in psychiatric diagnosis essentially flag normal distress, especially at lower levels of severity, rather than disease. Consequently, family and primary care physicians use the International Classification of Primary Care-2,[14] 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.[8] Many such forms of distress are normal reactions to adversity and mainly require psychological and social support.

Psychiatric training in India

Psychiatry in India has been arguing its case for a greater share of the undergraduate medical curriculum. It has suggested an increase in the duration of training and the period of internship and has even demanded a university examination in the subject. Psychiatric writ, as far as training in the subject, is unchallenged in India with family medicine a relatively new field, and general practice is without a strong professional organization.

All psychiatric training is currently set in psychiatric facilities and in tertiary care settings. It employs specialist perspectives, diagnostic schemes and detailed management protocols. 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.[8,13] 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. More time during training or internship will not resolve the differences in primary and tertiary care settings, perspectives, diagnostic and therapeutic approaches.

The impasse

Despite many problems of the biomedical model including heterogeneity within diagnostic categories, their questionable validity and opposition from neuroscience[15] even for use in tertiary settings, the approach seems to have become gospel truth. Specialist power supported by the pharmaceutical and insurance industries continues to marginalize non-specialist conceptualizations. Clinical practitioners, who while being unable to challenge the international psychiatric concepts and classifications for use in primary care, do not actually use them in their practice undermining such schemes. While specialist theories, perspectives and practice currently trump primary care approaches, they do not empower physicians working in complex and different realities.

The way forward

The conflict and deadlock are not just in India but seen across nations. 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.

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 currently available psychiatric treatments are essentially symptomatic is a good start to navigate the complex issues of managing psychiatric presentations in general medical practice.[13] 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.

The need for mastery in managing psychiatric presentations is seen in primary care demands that training is necessarily situated in these settings. Moving psychiatric training out of specialist settings and resituating it within primary care will allow for the recognition of common presentations and appreciation of local reality, encourage holistic management and improve understanding of general practice and family medicine perspectives. Encouraging psychiatrists to work in primary and secondary care will also allow for a liaison approach, which understands local contexts, identifies important clinical issues and determines suitable management strategies.

An example of a curriculum for training medical students in mental health and illness, developed and set in primary and secondary care, is described in this issue.[16] It employs common psychiatric presentations seen in such settings, incorporates physician perspectives, uses common protocols for management, and has been successfully implemented for training.

While the new curriculum recently recommended by the Medical Council of India shifts the focus from knowledge to competencies and is a major advance,[17] the continued use of specialist concepts, perspectives, diagnoses and management approaches set in tertiary care facilities means that the opportunity to train basic medical doctors in recognition and management of clinical presentations commonly seen in primary and secondary care will be lost.[18]

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.[13] 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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