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Training matters

Training primary care medical officers in mental health care: assessment using a structured clinical examination

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Mental health problems in primary care settings have received wider attention in recent years (Wilkinson, 1985). In India, the National Mental Health Programme (NMHP) was formulated with the purpose of promoting mental health care through primary health care (National Mental Health Programme, 1982). As part of the implementation of NMHP, training programmes for medical officers and health workers have been initiated in a number of centres in the country (National Mental Health Programme for India, Progress Report, 1988). At the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, a monthly training programme for doctors and health workers of primary health centres has been carried out since 1982. In order to evaluate the gain in knowledge and clinical skills, a multiple-choice questionnaire and case vignettes have been standardised (Sriram *et al*, in press). The doctors are also evaluated through a structured clinical examination which is carried out on the last training day. The focus of the present report is to evaluate the clinical skills of medical officers using the structured clinical examination.

The study

The training for medical officers in mental health care is of two weeks duration and provides exposure to commonly encountered mental health problems through lectures, case demonstrations, case work-ups and role play (Sriram *et al*, in press). On the first day of training pre-training assessment is carried out using multiple-choice questionnaire and case vignettes. On the last day these assessments are repeated.

In addition, the doctors are assessed using a structured clinical examination as follows: patients presenting to the psychiatric out-patient services are first screened by the consultant to assess their suitability for inclusion for the doctors' assessment. The patients are then randomly allocated to the doctors who are required to assess the patients, taking a maximum time of half an hour. They are then required to respond to a structured response sheet which contains 12 response categories, namely the diagnosis, the drug of choice, dosage, side effects, management of side effects, non-pharmacological management, the specific advice to be given about illness, treatment and work, the duration of treatment, the prognosis that can be expected at the end of six months, and the specific situation which warrants referral to a specialist. A maximum score of 14 is provided for the assessment.

Thirty-eight medical officers were evaluated using the structured clinical examination. Both quantitative and qualitative assessments of the responses were carried out. Errors in the doctors' responses were categorised as 'major errors' and 'minor errors'. For example, in the case of a patient with neurotic depression, if the doctor had chosen an antipsychotic drug, the error would be categorised as 'major'; if he had chosen a minor tranquilliser instead of an antidepressant drug, the error would be categorised as 'minor'.

Findings

Out of the 38 doctors, 29 (76%) were males. The mean $\pm$ s.d. age of the total group was 35.0 ± 8.6. Only 15 (39%) of the doctors reported having had prior exposure to psychiatry in the undergraduate training. The mean $\pm$ s.d. duration of service of the doctors in the government health department was 8.2 ± 8.1.

The diagnostic break-up of the patients ($n = 38$) who were assigned for doctors' evaluation was as follows: schizophrenia 17; depressive neurosis 12; manic-depressive psychosis, depression 3; manic-depressive psychosis, mania 1; anxiety neurosis 2; obsessive compulsive neurosis 2; phobic neurosis 1.

The medical officers' scores on the clinical examination ranged from 7–13. The mean ± s.d. post-training score was 11.2 ± 1.6. Twenty-six (68%) of the doctors scored above 75%. When this group was compared with the remaining 12 doctors, no significant differences emerged. Qualitative evaluation of the responses revealed that, out of 456 possible responses, there were no major errors and 16 (35%) minor errors. In another 22 instances (4.8%) no answers were written. These response categories mainly included management of side effects, non-pharmacological aspects of management, duration of treatment and the specific advice that was to be provided about illness and treatment. The most commonly noticed error was an inability to distinguish between anxiety neurosis and depressive neurosis.

Comment

Clinical examination as a method of assessment would seem to have face value as the most appropriate method of assessing clinical skills. However certain of the limitations of clinical examination have to be overcome to make it more valid. The first problem is the frequently observed heterogeneity of patient characteristics. Patients often differ with respect to their manifest symptomatology, cooperativeness, and ability to convey the required information in the most appropriate manner to arrive at a diagnosis. Since these are likely to influence trainees' performance, it is necessary for the assessor to ensure adequate homogeneity of the patients. This was ensured in the present investigation by prior screening of patients. The second problem pertains to the rating of trainees' performance in an objective manner. To ensure this, a structured response sheet was used.

The results of the present investigation suggest that primary care physicians can effectively recognise and manage mental health problems. Clinical errors are infrequent and are of a minor nature. However, it is not implied that more serious errors would never occur in the doctors' practice since there will often be difficult clinical situations. The doctors might refer such problems to a specialist. Alternatively they might carefully monitor the patient's progress and revise the diagnosis and treatment. Finally there is the remote possibility that a major error would go unrecognised. This highlights the need for an evaluation of the doctors' diagnostic and therapeutic practices during their actual practice following training.

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Extending management training for senior registrars

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It is recognised that the consultants of the future will have a greater management role than those of the past. The Griffiths report (1983) regarded doctors as 'natural managers', although this has been challenged by some authors. They suggest that medical training, with its emphasis on the individual case and rapid