

Self-Perceived Incompetence in Psychiatric Practice of Practitioners from Southern Thailand: One Year Following Graduation

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Abstract

General psychiatric training is one of the essential requirements for all Thai medical doctors, as declared by the Medical Council of Thailand in 2012. Hence, psychiatric training for medical students must be fulfilled to achieve these requirements. This study was designed to examine the change of subjects and the self-perceived incompetence in psychiatric practice of a cohort of medical doctors who graduated in the academic year of 2017, in concerns to their practices one year after graduation. Most participants were female doctors, with an average age of 25.7 years, and were working in Southern Thailand. Compared with 1 year prior, they showed a statistically significant frequency of physical disorders and increasing stress from their work. The largest topic of psychiatric practice, for which they were statistically more concerned with, concerned child and adolescent psychiatry. Self-perceived incompetence in both diagnosis and treatment significantly increased from graduation, with the exceptions of diagnoses of mental retardation, attention deficit hyperactivity, and tics/Tourette's disorder. Substance-related disorders in adults, along with basic psychological support, were found to be general practice self-perceived incompetence, at both outpatient clinics and inpatient units. However, practice in adult outpatients at psychiatric clinics mostly demonstrated significantly more self-perceived competence. Moreover, emergency care, especially concerning patient suicide and multi-disciplinary practice, was shown to have increasing self-perceived competence among general practitioners having worked for a year following graduation. This information should be used as feedback for stakeholders in both medical education and mental health care.

Keywords: Competency, Psychiatry, General practitioner, Medical education

Introduction

The World Health Organization (WHO) has announced that the burden of mental illness remains on the rise, having significant impact on health in all countries around the world [1]. The gap between the need for psychiatric treatment and being able to provide it is wide, especially in low- and middle-income countries, including Thailand [1,2]. It was reported that 76 to 85 % of patients had received no psychiatric treatment [1]. Thus, WHO's Mental Health Gap Action Program (mhGAP), which was publicized in 2008, declared the need for global collaboration in the use of evidence-based technical guidance and training programs to expand these services. One of the strategies is to build up the capacity of non-specialized health-care providers, including general practitioners (GP) or M.D. graduates in Thailand, to create an integrated health care system [2].

Existing mental illness-related stigma in the healthcare system has been identified as a barrier to accessing psychiatric treatment and allowing psychological recovery, along with having an underestimation of physical illnesses, if patients have a record of any "psychiatric disorders" [3]. Between 20 - 25 % of visits to general practitioners are related to mental health problems in Quebec, Canada [4]. We used to believe that contact with professional health care providers, especially medical

doctors, should increase the potential opportunity for recognizing and identifying suicides, as well as other serious psychiatric illnesses among patients [5]. However, 82 % of suicidal patients in the UK consulted a GP 12 months before they committed suicide, and over a third had seen a psychiatrist, whilst only 2 % of them had received counseling [6]. In Canada, more than 50 % of general practitioners reported that they did not have the resources required within the mental health field [4]. Thus, it seems there are no medical education programs, nor WHO requirements from non-psychiatrist medical doctors, for the WHO's Mental Health Gap Action Programs (mhGAP).

A study conducted in India found that 98.5 % of Indian medical practitioners in primary care reported that they needed to be better trained and oriented for psychiatry [7]. Almost all of them stated that mental illness is of serious concern. However, only 79.7 % of them claimed that they did not recognize how to deal with psychiatric patients properly. In another research in India, it was reported that general practitioners felt competent, as well as confident, in recognizing the signs and symptoms of simple depression, anxiety, and psychosis, but the chief complaints they had in general practice concerned psychosomatic problems, such as sleep problems (84.2 %), appetite disturbances (84.2 %), abnormal and irrational fears (84.2 %), problems in sexual activity (72.9 %), drug addictions (62.41 %), and problems of forgetfulness (66.17 %) [6]. In addition, they noticed that psychiatric referrals were made with reluctance. This was due to social stigma among psychiatric patients and the doctors' dissatisfaction with their own competence in treating psychiatric illnesses. In Canada, family medicine groups, along with network clinics, reported that they were not getting significant outcomes from psychiatric services, even though they had tried to improve service integration by implementing local general practitioners into programs [4]. Additionally, mental disorders are mainly still treated during primary care by general practitioners (GPs), even though the ability to detect, diagnose, and treat patients with mental disorders is often considered unsatisfactory [8].

Although medical programs, along with training programs, are different among Eastern and Western countries, non-psychiatric medical practitioners are still concerned with managing patients with mental health problems in their practices. Hence, psychiatric training for medical students must be fulfilled to achieve these requirements. General psychiatric training is one of the essential requirements for all Thai medical doctors, as declared by the Medical Council of Thailand in 2012 [9].

However, psychiatric training for general practitioners may promote insufficient self-perceived competence within the first year after graduation. Keeping this in mind, Thai medical education for undergraduates should consider up-to-date curricula for both responses and recommendations for new M.D. graduates and follow them up 1 year after they have completed their psychiatric training as general practitioners.

Additionally, no prior study on either competence or concerning psychiatric training among either medical graduates or general practitioners has been reported in Thailand. Thus, datasets from surveys should be created to provide more information, as this will be beneficial for both medical education and mental health care services, especially in Southern Thailand.

This study was the second phase (phase II) of a cohort study; the first phase (phase I) was a descriptive, cross-sectional survey of all M.D. graduates who were approached at graduation rehearsal for the first data collection [10]. In the academic year of 2017, medical doctors, who graduated from the Prince of Songkla University, perceived their own self-perceived incompetence towards outpatient training at psychiatric clinics and for the prescription of psychiatric drugs. They also demonstrated that they were most concerned with emergency management and child psychiatric practice. Additionally, these doctors stated they felt the most incompetence towards patients with substance-related disorders [10].

This phase of the cohort study aimed to examine the change of subjects and the self-perceived incompetence scales of psychiatric practice in medical doctors who graduated in the academic year of 2017, concerning their general practices after one-year of graduation.

Materials and methods

Measurement

- 1) Personal information and details regarding their medical career was approved by 3 experts.
- 2) Subjects and self-perceived competence of psychiatric training concerning general practices. The subjects followed topics and objectives of the psychiatry curriculum for externs, endorsed by the Faculty of Medicine, Prince of Songkla University. A self-perceived competence scale was inside the items of the self-administered questionnaires. This was scored from 1 - 4. Score 1 meant the participants felt no concern about their competence at all, and score 4 meant they were concerned with and self-perceived total incompetence in psychiatric practice.

Data collection

Researchers asked for permission from the Student Affairs Division on behalf of graduation rehearsal (18 September 2018) for the first phase of data collection. Every research-assistant was trained by the researchers before administering the questionnaires. Participants were approached by researchers, who were psychiatrists or research assistants, and they completed the self-administered questionnaires after their usual activities. The completed questionnaires were kept in sealed envelopes for confidentiality and tagged with a concealed code for the second phase analysis [10].

Regarding the second phase, the researchers made inquiries to the Medical Education Division as they send workload and competence feedback to all M.D.s who graduate every year. Self-administered questionnaires were sent to every Doctor of Medicine that had completed the questionnaire of the phase I data collection by mail. The second phase data collection was a self-administered questionnaire which was attached to these documents. This was sent back by the participants themselves to the division during the periods of June to August 2019. All questionnaires were checked for completeness and consistency; double data entry was entered monthly using EpiData software.

Data analysis

All statistical procedures were performed using the R software package.

- 1) Descriptive statistics were presented as demographic characteristics of the samples in frequency, percentage, articulate mean, and standard deviation.
- 2) Correlation analysis was conducted by Chi-square and Fisher's exact test.

Results and discussion

Personal information, workload, and life burden

From the 31 general practitioners (GPs) who graduated in the academic year of 2017 and participated one year after (**Table 1**), most were female (58.1 %), with an average age of 25.7 years. Their workplaces were mostly located in Southern Thailand (87.1 %). As per **Table 2**, from these participants, 82.1 % of the GPs reported significant stress from their work, which increased statistically (Chi-square's p-value = 0.000). Additionally, 26.7 % of them stated that they had physical diseases, increased from 11.1 % (p-value = 0.041). Although mental disorders did not surge significantly statistically, 6.9 % of participants following graduation reported these, compared with 0.9 % one year prior.

Table 1 Personal information.

Personal information	N (%)	
	Graduation (n = 118)	One-year follow up (n = 31)
Gender		
Male	42 (35.6)	13 (41.9)
Female	76 (64.4)	18 (58.1)
Age		
Mean±SD (Minimum-Maximum)	24.5±0.6 (23 - 27)	25.7±0.7 (25 - 27)
Workplace		
Songkhla	55 (46.6)	20 (64.5)
Other provinces in Southern Thailand	37 (31.4)	5 (16.1)
The south border provinces	14 (11.9)	2 (6.5)
Other parts of Thailand	12 (10.2)	4 (12.9)

Table 2 Comparison of workload and life burden between M.D. graduates and one year following.

Workload and life burden	N (%)		P-value Fisher's exact test
	Graduation (n = 118)	One-year follow-up (n = 31)	
Perceived stress from work			0.000 ^a
No	109 (92.4)	5 (17.9)	
Yes	9 (7.6)	23 (82.1)	
Work time/week (Mean±SD)	-	63.6±27.1	
Physical disorder*			0.041
No	104 (88.9)	22 (73.3)	
Yes	13 (11.1)	8 (26.7)	
Psychological disorder			0.102
No	115 (99.1)	27 (93.1)	
Yes	1 (0.9)	2 (6.9)	

Note: ^a Chi-square's p-value; * Significant p-value

Self-perceived incompetence in psychiatric practice

One year following M.D. graduation, general practitioners' self-perceived incompetence mostly concerned child psychiatric practice. Treatment of tics/ Tourette's disorder and functional enuresis (65.5 and 65.5 %, respectively) and diagnosis of learning disorders (68.9 %) were the most common issues they were concerned with (**Table 3**).

The respondents also reported that they mostly self-perceived incompetence in giving psychological support in both inpatient units and outpatient clinics (48.3 and 55.2 %, respectively). Moreover, substance-related disorders were the mental disorders they felt most concerned about in adult patients. In the emergency room, the general practitioners reported their own perception of incompetence in dealing with aggressive and violent patients (51.7 %).

However, the GPs stated they perceived less self-perceived incompetence in the history-taking of psychiatric issues (10.0 %) and in outpatient clinic practice (17.2 % for diagnosis and 13.8 % for treatment, respectively). Depressive disorder (10.3 %) and anxiety disorder (13.8 %) were the most common mental diseases they felt competent in handling.

Table 3 Comparison of self-perceived incompetence in psychiatric practice between M.D. graduation and one year follow-up.

Self-perceived incompetence in psychiatric practice	Self-perceived incompetence (score 3 - 4) N (%)		P-value Fisher's exact test
	Graduation (n = 118)	One year follow-up (n = 31)	
History-taking, physical, and mental status examination			
1. History-taking and physical examination	10 (9.0)	3 (10.0)	1
2. Mental status examination	18 (16.4)	7 (23.3)	0.422
Outpatient unit care			
3. Overall diagnosis at outpatient unit	23 (19.5)	5 (17.2)	1
4. Depressive disorder diagnosis	18 (15.3)	3 (10.3)	0.767
5. Bipolar disorder diagnosis	25 (21.2)	6 (20.7)	1
6. Psychotic disorder diagnosis	27 (23.1)	7 (24.1)	1
7. Organic mental disorder diagnosis	31 (26.3)	7 (24.1)	1
8. Anxiety disorder diagnosis	18 (15.2)	4 (13.8)	1
9. Overall patient unit treatment	20 (16.9)	4 (13.8)	0.786
10. Pharmacotherapy	38 (32.2)	11 (37.9)	0.661
11. Basic Psychological Support	33 (27.9)	16 (55.2)	0.008*
Child and adolescent psychiatry			
12. Overall diagnosis in children and adolescents	43 (36.4)	12 (41.4)	0.671
13. Attention deficit hyperactivity diagnosis	27 (22.9)	12 (40.0)	0.066
14. Autistic spectrum diagnosis	34 (29.1)	15 (50.0)	0.049*
15. Tic and Tourette disorder diagnosis	33 (27.9)	13 (44.8)	0.116
16. Functional enuresis diagnosis	33 (27.9)	17 (58.6)	0.004*
17. Learning disorder diagnosis	38 (32.2)	20 (68.9)	0.001*
18. Mental retardation diagnosis	40 (33.9)	16 (55.2)	0.053
19. Overall treatment in children and adolescents	40 (33.9)	18 (60.0)	0.012*
20. Attention deficit hyperactivity treatment	29 (25.0)	18 (60.0)	0.001*
21. Autistic spectrum treatment	41 (34.7)	17 (56.7)	0.036*
22. Tic and Tourette disorder treatment	40 (33.9)	19 (65.5)	0.003*
23. Functional enuresis treatment	43 (36.4)	19 (65.5)	0.006*
24. Learning disorder treatment	44 (37.3)	18 (62.1)	0.021*
25. Mental retardation treatment	45 (38.1)	17 (58.6)	0.059
Inpatient unit care			
26. Overall inpatient unit care	22 (18.6)	7 (24.1)	0.602
27. Pharmacotherapy	35 (29.7)	10 (34.5)	0.656
28. Basic psychological support	29 (24.6)	14 (48.3)	0.021*
Emergency psychiatry			
29. Overall emergency care	46 (38.9)	10 (34.5)	0.831
30. Suicide	56 (47.9)	13 (44.8)	0.837
31. Aggressive behavior and violence	59 (50.4)	15 (51.7)	1
Miscellaneous			
32. Community-based care	20 (16.9)	6 (21.4)	0.587

Self-perceived incompetence in psychiatric practice	Self-perceived incompetence (score 3 - 4) N (%)		P-value Fisher's exact test
	Graduation (n = 118)	One year follow-up (n = 31)	
33. Substance addiction	33 (27.9)	11 (37.9)	0.366
34. Alcohol dependence	28 (23.7)	7 (24.1)	1
35. Alcohol withdrawal syndrome	22 (18.6)	6 (20.7)	0.795
36. Delirium	18 (15.3)	7 (23.3)	0.287
37. Psychoeducation	31 (26.3)	8 (27.6)	1
38. Therapeutic relationships	20 (16.9)	7 (24.1)	0.423
39. Multidisciplinary team	17 (14.4)	4 (13.8)	1

Note: *p-value < 0.05

Compared with one year prior, practice in child psychiatry was statistically significant in increased self-perceived incompetence (p-value < 0.05), in terms of Autistic spectrum, Functional enuresis diagnosis, and Learning disorders, for both diagnosis and treatment. Even though self-perceived incompetence in the diagnosis of attention deficit hyperactivity, mental retardation, and tics/Tourette's disorder were not significantly increased statistically, the treatment of attention deficit hyperactivity and tics/Tourette's disorder were (p-value = 0.001 and 0.003, respectively). In addition, the GPs reported that they perceived incompetence in giving basic psychological support to patients at both outpatient clinics and inpatient units (p-value = 0.008 and 0.021, respectively).

Discussion

According to the survey, the statistically significant surge in percentage of physical disorders and stress perceived from work was of considerable concern among young medical doctors. Due to the rise in mental disorders, from 0.9 to 6.9 % within 1 year, embracing resources for stress recovery and balancing private life with workload should be one of the topics in medical education, so as to raise well-being and build resilience [11]. A study in Thai medical doctors revealed that quality of sleep and family relationship were promoting factors of resilience, whereas Thai GPs' workload significantly disturbed them [12]. Knowledge of psychiatry has been essential for medical students, not only for patients' psychiatric problems, but also to prevent problems in the general population, either mentally or mentally combined with physically. These issues have been challenges for medical instructors in the modification of curricula for these purposes [13].

The same can be said in Germany and Australia, where child and adolescent psychiatry teaching in medical schools was comparatively small and not consistent with the size of clinical problems [13,14]. This study in Thailand showed that the GPs mostly self-perceived incompetence, and this had significantly increased. Therefore, increased involvement of academic departments of child and adolescent psychiatry in training Thai medical students, particularly between pediatric departments and child psychiatry departments, should be considered. In practice, pediatricists and child psychiatrists may have to play more of a role in consultation and referral to reassure and encourage the GPs in both diagnosis and treatment [14,15].

As well as practice in emergency psychiatry, aggressive and violent patients were of concern for the Thai GPs. Substance-related disorders were of the most concern in adult psychiatry, with most cases of aggressive patients presenting at the ER. GPs should be trained to realize their abilities and limitations, together with the creation of a criteria for referring patients to more competent professionals [16]. Moreover, "insecurity" is the cause of their apprehension. Thus, hospitals should manage security staff to respond to unexpected, violent situations immediately, to assist ER personnel if needed [16].

Basic psychological support given to patients, both at outpatient psychiatric clinics and inpatient units, had more self-perceived- competence than that of pharmacotherapy from those who graduated in the academic year of 2017. However, there was a significant increase in self-perceived incompetence

when they were GPs a year after graduation. The reasons for this may be that most psychiatric medical students counseled fewer patients under the supervision of psychiatric instructors [17]. To enhance self-perceived competence, mental health personnel should assist them during their first year after M.D. graduation. Multidisciplinary collaboration was a strength of these GPs since they had graduated [10]. Hence, more psychological support from multidisciplinary teams should be embraced into psychiatric treatments, to encourage the GPs for their self-perception of competence.

Limitation

According to uncontrollable delay in data collection, such as in practicing for post-training ceremonies, the researcher had to postpone the date of all data collection up until the delayed graduation ceremony. However, the methodology of a 1 year follow-up ought to be fixed to enhance the validity of the potential results. For these reasons, the response rate was too low, and may not illustrate the whole reality in Thailand. Due to these factors, further studies should be designed for unexpected obstacles to data collection. Online surveys may be more convenient than offline ones in such situations. Additionally, this study was only conducted at a medical school in Southern Thailand. To improve Thai M.D. curricula and general practice enrichment, researchers should collect data nationwide.

Conclusions

Southern Thai general practitioners who graduated 1 year ago had statistically more physical disease and stress compared to when they were M.D. graduates. They stated that they felt significantly more self-perceived incompetence in psychiatric practice for children and adolescents and in basic psychological support for adult patients. However, self-perceived competency was reported to be increased in outpatient practice at psychiatric clinics, emergency management, and in multi-disciplinary care.

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