Pre-registration house officers' psychiatric knowledge in practice

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Psychiatric distress is commonly found in general hospital patients and is associated with a poorer outcome and increased complexity of care. It is important for non-psychiatric hospital doctors to possess skills of assessment and treatment of common psychiatric problems. This survey of all house officers in their first pre-registration posts in three large teaching hospitals found that junior doctors rarely ask about or consider the presence of psychiatric problems in their patients. Where psychiatric problems are found, house officers often feel they lack the appropriate skills of assessment and management. This has important implications for medical school course content and emphasis.

Considerable psychiatric illness and emotional distress exists in general hospital patients and this is often unrecognised by hospital doctors (Mayou & Hawton, 1986). Psychiatric illness increases the distress of patients when faced with physical illness and affects outcome (Williams & Snaith, 1995). In a study of 453 medical in-patients, 14.6% were found to have an affective disorder using the Present State Examination (Feldman *et al*, 1987). House officers identified 50% of these cases but considerably underestimated the severity of emotional disability. In order to detect distress and psychiatric morbidity it is important not only that doctors use routine screening questions, but also a style of questioning which is open, empathic and non-judgemental (Maguire, 1994). The recent joint report of the Royal Colleges of Physicians and Psychiatrists (1995) stresses the importance of the detection of psychiatric problems among medical in-patients, yet acknowledges that case detection and treatment is as yet far from adequate.

Why does emotional distress remain unacknowledged in many general hospital patients? Mayou & Hawton (1986) suggested that a greater awareness of psychiatric disorders and systematic history taking with psychiatric diagnoses in mind would detect more psychiatric illness without excessive demands on time or the need for sophisticated research measures. We investigated whether newly qualified doctors are considering the possibility of a psychiatric component to the presentation in their assessment of patients.

The study

The study questionnaire was completed by all first year pre-registration house officers during two weeks of their first medical or surgical job at each of the three central Leeds teaching hospitals. Fifty questionnaires were completed with a 100% return rate.

The first part of the questionnaire asked "Which questions do you routinely ask in your systematic review of systems when admitting a patient or seeing someone for the first time?" This was followed by a checklist of symptoms as recommended in *McClouds' Clinical Examination* (Munro & Edwards, 1990), including symptoms of anxiety and depression.

Findings

Table 1 illustrates a sample of screening questions asked, and reveals the wide variability in the content of the routine clinical clerking shown by the house officers. Most house officers routinely asked patients about a wide range of 'physical' symptoms, with certain key symptoms such as the presence of coughs and chest pain being asked by every doctor. One possible difficulty in any clinical assessment is that some symptoms may be primarily caused or influenced by psychiatric factors, e.g. decreased appetite and weight loss (possible markers of depression), or result from somatic anxiety such as the presence of urinary frequency or palpitations. The proper assessment of these symptoms requires a consideration of the possible contribution of psychological factors to the overall presentation. In spite of this, it is very rare for the psychiatric screening questions to be asked which would have then enabled the doctor to properly assess whether psychological factors have a part to play in any aspects of the physical presentation.

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Our findings revealed that only four (8%) of the house officers routinely asked patients if they were anxious or panicky, three (6%) enquired about depressed mood and only one (2%) regularly asked about suicidal ideas. It is likely then that these common psychiatric factors are not routinely asked by the junior doctors. Are the doctors at least considering whether these symptoms are present? The findings show that they are not. Anxiety was never or rarely considered by 72%, and 94% never or rarely considered depression in their differential diagnoses. This focusing on the factual presence of symptoms rather than considering their actual relevance to the case is illustrated by the finding that although 45 (90%) of the doctors asked for information about relationships (e.g. "Are you married?") only ten (20%) asked how this affected the patient emotionally.

As well as being able to detect psychiatric problems, it is also important that once detected, the doctors feel able to offer effective treatment interventions. We wanted to know whether the house officers felt they possessed the clinical skills needed to assess and treat common psychiatric conditions. We presented three common clinical scenarios:

1) When presented with the problem of a 50-year-old woman on the ward who seems depressed and weepy, 92% of house officers said that they would feel comfortable talking with her about her problems, 46% felt competent to assess the severity of her depression and 68% the presence of suicidal ideas. However, only 8% felt they could confidently treat her depression.

2) A 20-year-old patient with asthma and feelings of anxiety and panic is admitted for the fourth time. It is thought that hyperventilation and emotional factors are leading her to present repeatedly to casualty. In this case scenario, 84% of house officers felt able to discuss their beliefs about aetiology with the patient, yet only 14% believed they possessed the skills needed to offer her treatment for anxiety. Only half were confident in giving patients advice about hyperventilation.

3) Only 32% of house officers felt they possessed the skills required to effectively help a 40-year-old man with alcohol abuse diagnosed following his admission with a chest infection. At the same time, only 22% could confidently recall the three components of Wernicke's triad. In contrast, current alcohol consumption and smoking was asked by 98% of house officers, yet only 8% regularly asked about illicit drug use.

Table 1. Questions asked routinely by house officers

Cough	50	(100%)
Wheeze	45	(90%)
Phlegm	46	(92%)
Orthopnoea	48	(96%)
Paroxysmal nocturnal dyspnoea	42	(84%)
Ankle oedema	50	(100%)
Claudication	32	(64%)
Nausea	46	(92%)
Decreased appetite	49	(98%)
Frequency of urine	46	(92%)
Tingling/paraesthesia	20	(40%)
Chest pain	50	(100%)
Palpitations	46	(92%)

Comment

Our findings suggest that most pre-registration house officers do not ask their patients about symptoms of anxiety and depression and rarely even consider psychiatric disorders in their differential diagnosis. The possible contribution of psychiatric factors to the physical presentation is likely to be overlooked under these circumstances. This is important because psychopathology is associated with increased morbidity for the patient, and also increased length of stay and complexity of medical care (House *et al*, 1995). Our findings are worrying, yet may actually underestimate the extent to which house officers fail to address the presence of psychiatric problems among their patients. Because the study relies on self-reported responses, it is possible that in some cases an overly positive response bias may occur in spite of the anonymity of the reply sheets and reassurance that this was a study examining medical education rather than the doctors themselves. For example, the finding that 98% of house officers routinely take an alcohol and smoking history seems to be unlikely and overly optimistic in the face of knowledge from clinical practice and other research. In one study within a general hospital setting, the case notes of 296 patients admitted to a general hospital over a ten-day period were reviewed to identify the questions asked during the admission procedure (Awad & Wattis, 1990). The findings revealed that a quantitative or descriptive drinking history was recorded in only 52.7% of notes, and that no mention of the alcohol intake was made in 47.3% of case notes. The same authors found that a smoking history was recorded in only 22.3% of their case note sample. This suggests that if anything, the findings that we have reported may actually underestimate the extent of the problem.

The General Medical Council's (1993) report stresses that the aim of medical education is "equipping the newly qualified doctor to begin the first year pre-registration house officer post." The ability to carry out a mental state examination is

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one of the few specified necessary core skills stated in their report. In addition students are expected to know about patients' reactions to illness, illness behaviour and the social determinants of disease. In the light of this, our findings are disappointing. Most house officers in our survey were not confident in treating common psychiatric disorders likely to present on general hospital wards.

Has the undergraduate curriculum failed to teach these doctors the requisite skills? The reasons why psychiatric illness is unrecognised in many patients in general hospitals are likely to be complex and include such factors as workload and the prevailing culture with the dominance of a mechanistic paradigm for disease (Ketterer, 1993). A change in the emphasis of psychiatric undergraduate teaching based on the major psychiatric disorders to that based on the emotional aspects of illness presenting to general practitioners and to general hospitals may better equip junior doctors to recognise and treat patients who have a psychiatric disorder. Many medical schools are reviewing their curricula in order to implement the changes of tomorrow's doctors (Crisp, 1994). This offers the opportunity to emphasise the importance of a full psychosocial assessment by medical students and doctors as part of the routine assessment procedure. Skills that are not used wither. In order for curriculum change to lead to significant changes in student and junior doctors' behaviour, it seems likely that the relevance of such an assessment will need to be reinforced on ward rounds, and in formal examinations at both undergraduate and postgraduate levels (Williams & Curran, 1995). For change to occur, the emphasis on a whole-person assessment needs to expand beyond just general practice and psychiatry, to include other major specialities such as general medicine and surgery. These changes will not be rapid. Many factors in medical teaching and hospital life will need to alter. We all have our part to play in achieving these changes.

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