Letters

Neurological competences in the graduating psychiatrist

Sir: Graduates presenting for specialist examinations in psychiatry are expected to manifest competency in clinical neurology. For those concerned, certain pertinent questions arise: how important is this requirement, in practical terms; what should this competency comprise; and how best can such competency be attained? In an attempt to address these issues, the views of specialist psychiatrists were solicited by questionnaire.

The questionnaire comprised three parts and was mailed to 184 of the 196 psychiatrists

listed in the 1981 South African Medical and Dental Council register. Part 1 included items relating to professional background. In Part 2, specialists were asked to rate 38 items of neurological competence as either "essential", "desirable" or "not required" in the graduating psychiatrist (table). These categories were assigned values of 2, 1 and 0, respectively. Part 3 sought comments on the design of neurology training programmes for psychiatrists. Of the 120 (65%) respondents, 85 were hospital affiliated, 51 practised privately and 16 resided abroad. Aggregated ratings for the 38 items of competence are shown in the table. The overall mean rating score was 69.5% (SD15; range, 19-100) with 110 (90%)

respondents recording a score of 50% or more. There was no significant difference ($p > 0.05$, Student *t* test) between mean rating score of psychiatrists whose neurology training had been more (71.5%, $n = 88$) or less (65.5%, $n = 24$) than 3 months, or who had (70.5%, $n = 40$) or had not (69%, $n = 80$) assumed clinical responsibility. Replies to Part 3 of the questionnaire were recorded by 60 respondents and are reported in detail elsewhere.²

The results of this study affirm that a certain proficiency in clinical neurology is integral to a training in psychiatry. That this opinion is shared by psychiatrists whether or not clinical neurology had featured prominently in their own training adds to its validity. The study has also identified those clinical neurological competences most relevant to professional psychiatric practice. For the neurologist, as teacher and examiner, such data offer a sound basis for defining educational objectives, thereby allowing programme contents to be rationally determined, teaching methods to be selected and pertinent assessment procedures to be devised.³

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Table: Part 2 of questionnaire, with aggregated ratings of the 120 psychiatrists expressed as percentages*

Item	Neurological competence	Essential	Desirable	Not required
1	Elicit history, perform neurologic examination	85	15	0
2	Interpret abnormal physical signs	67.5	31.5	1
3	Evaluate apraxia, agnosia, aphasia, disorders of memory	70	27.5	2.5
4	Differentiate physical disability from simulation	91	9	0
<i>Recognise characteristic presentations</i>				
5	Intrinsic, extrinsic myelopathies	20.5	64	15.5
6	Motor neuron disease	33	53	14
7	Cranial, peripheral neuropathies	34.5	58	7.5
8	Nerve root syndromes	29	54	17
9	Myasthenia gravis	41.5	51	7.5
10	Polymyositis	22.5	55.5	22
11	Muscular dystrophies	22.5	55.5	22
<i>Judgement, evaluation, management</i>				
12	Transient loss of consciousness, coma	85	14	1
13	Headache, facial pain	70.5	28	1.5
14	Dizziness, vertigo	63	33.5	3.5
15	Pain syndromes	56.5	40	3.5
16	Involuntary movements	67	32	1
<i>Specified areas of knowledge</i>				
17	Cranio-cerebral trauma	63	33.5	3.5
18	The epilepsies	89	11	0
19	The dementias	96	4	0
20	Cerebrovascular disorders	67.5	31.5	1
21	Parkinsonism	70	29	1
22	Multiple sclerosis	49.5	43.5	7
23	CNS infections	52.5	43.5	4
24	Metabolic encephalopathies	56	40.5	3.5
25	Sleep disorders, narcolepsy	75	24	1
26	Drugs in common use	82.5	17.5	0
27	Existence less common disorders	6	70	24
28	Awareness research trends	12.5	67	20.5
29	Inheritance pattern common hereditary disorders	27.5	56	16.5
<i>Special investigations</i>				
30	Skull X-ray: basic principles interpretation	57	29	14
31	EEG: features normal record	50.5	43	6.5
32	Isotope encephalogram: basic features normal patterns	21.5	55	23.5
33	CT brain scan: basic features normal appearance	29	48	23
34	Lumbar puncture: indications contraindications	75	21.5	3.5
35	Rationale for ordering: Electromyography	15	45	40
36	Caloric responses	16	41.5	42.5
37	Visual evoked potentials	16	49	35
38	Auditory evoked potentials	11.5	53.5	35

*To nearest 0.5%

References

- 1 Todorov AB, Knopke HJ, Goodwin BB. The current status of neurology in family practice residency programs. *Neurology* (Ny) 1981;31:597-9.
- 2 Gledhill RF. Clinical neurology and psychiatry training. *S Afr Med J* 1983;63:392.
- 3 Walton HJ. *Conference on the objectives of basic medical education*. London: General Medical Council, 1977:6-9.

Accepted 14 April 1983

Benign unilateral seizures or epilepsy?

Sir: A benign form of "hemiconvulsive epilepsy with hemiplegia" has been recently reported in children.¹ We describe a patient who presented with a unilateral status epilepticus in childhood and an isolated relapse after a 17 year seizure- and drug-free interval.

A 21½-year-old left-handed man with no family history of major disease was born after a normal pregnancy with vertex delivery and normal neo-natal psychomotor development. At the age of 2½ months he developed a non-febrile unilateral left tonic-clonic status epilepticus (see fig A).