

Internal Medicine Residents' Inadequate Preparation in Mental Health

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Generalist physicians who recognize mental illness among their patients are on the front lines of the mental health crisis in the United States. However, current modes of education are inadequate to train non-psychiatry residents to address mental health. The reasons for this inadequacy include health system barriers, lack of interdisciplinary education, and highly variable training requirements within the various primary care specialties. For example, although family medicine requires the longitudinal supervision of mental and behavioral health training for its residents, internal medicine does not. This variability in generalists' training serves to perpetuate the mental health crisis highlighted in this special edition of *SGIM Forum*. We argue that organizations such as SGIM that focus on primary care training in the United States should challenge this by using tools developed in family medicine and pediatrics to create our own innovations to further the training of our residents in mental and behavioral health.

Generalists develop an interest in mental health at various stages of their careers—and often by chance interactions. One of our internist colleagues recalls a medical school family medicine clerkship director pointing out that “nearly half of patient issues relate to mental health, and if you close your eyes and listen, so are most of the rest.” Another physician speaks of working with a primary care physician as a medical student. The precepting family physician diagnosed his patient as having depression, walked the patient down the hall to his psychology colleague, and introduced the two. For the internist, this inter-

action represents an ideal that should be replicated in practice.

Others gain interest in residency. One physician stated that she benefited from the presence of a psychiatrist who happened to be practicing in the vicinity of her residency clinic. The availability of this psychiatrist was coincidental but gave her a great deal of added knowledge and curiosity about the topic. Still others gain interest from life experience later in their careers. A senior faculty member tells of watching his father-in-law struggle for years with untreated bipolar symptoms, causing him to rethink how he trained residents to deliver care to those suffering from mental illness. For education to improve in this area, educators must consciously and consistently teach and model ideal practice in mental health care.

Other Specialties' Examples

Residencies in family medicine and pediatrics are required to involve behavioral and/or mental health specialists in the training of residents to develop skills in behavioral medicine. In family medicine, this training is overseen by a behavioral scientist who may be a faculty psychologist, psychiatrist, or family physician. In pediatrics, subspecialists in the field of behavioral and developmental pediatrics are required to be part of residents' learning. Many of these interdisciplinary arrangements involve postdoctoral fellowships in primary care psychology. These fellowships, several of which exist around the country, offer the promise of training future leaders in primary care—physicians and psychologists—together. Internal medicine residencies at institutions with

psychology fellowships would do well to create such partnerships. Other articles in this issue describe the innovations that various residency practices are making in behavioral health training. Most of these practices use the assistance of a mental health specialist in teaching and patient care.

Another model of change is the adoption by family medicine of the biopsychosocial model. This model, developed and proposed by George L. Engel, a prominent psychiatrist from the mid-20th century, argues that all medical illness should be considered within the full context of a patient's life and surroundings and not simply as pathophysiology. This focus contributed to the recommendation by the American Academy of Family Physicians (AAFP) in 1977 that behavioral science be a core component of all three years of residency training. By adopting this model, family practice residencies have created space in their residency curriculum to teach behavioral health as a component of the evaluation and management of many medical conditions. The focus on behavioral science has proved to be sustainable for more than 35 years, and evidence suggests that family physicians are more likely than internists to feel comfortable treating mental health conditions.¹ Specific requirements for residency programs give program directors guidance in implementing change. The Accreditation Committee for Graduate Medical Education (ACGME) requires behavioral science training in family medicine to be outpatient and longitudinal across three years of residency. In addition to didactics,

continued on page 2

IN TRAINING

continued from page 1

programs are directed to supervise residents' learning either through review of videos of residents' performance or direct observation of them in patient care.²

Like internal medicine, pediatrics until recently had limited requirements for its residency programs with regard to mental and behavioral health. The American Academy of Pediatrics (AAP) addressed this in 2009 by convening a task force around mental health. This group created a list of 60 core competencies across the ACGME's six domains. The report makes the following conclusion: "Just as mental health practice in primary care settings is collaborative, the process of training primary care clinicians for primary care practice will necessarily be collaborative."³ These recommendations give the ACGME and residencies direction in bringing mental health into their curricula. ACGME requirements in internal medicine currently give no direction to programs regarding mental health. Developing core competencies for internal medicine in this manner would be highly useful.

Existing Barriers

Several reasons may help explain why internal medicine has relatively less focus on mental and behavioral health than other generalist specialties. For one, internal medicine has increasingly become a subspecialized field. The career tracks of internal medicine residents are extremely varied. Unlike pediatrics, where there is a field of behavioral and developmental pediatrics, there is no subspecialty that focuses on this realm. Residents going into subspecialties other than primary care may not feel that gaining skills in behavioral and mental health is as crucial as other skills. The potential benefits of involving psychologists in residency training may be tem-

pered by perceived lack of interest or lack of funding. Additionally, the current state of the US health care system creates many barriers to integrating mental health into general medical practice.

Although the barriers to establishing requirements for mental health are important, the reasons for changing current training patterns are compelling. In internal medicine, a common refrain among practicing internists is that their mental health training in residency has been inadequate. In one qualitative study, primary care general internists expressed high levels of distress about providing mental health care they did not feel competent to provide.⁴ Many subspecialists also struggle to provide adequate care for the subset of their patients with mental health difficulties. Examples include the high burden of depression among patients following myocardial infarction and common subspecialty conditions like irritable bowel syndrome and fibromyalgia that have strong associations with patients' mental health. These examples highlight the importance of training in mental health care for internal medicine residents regardless of future subspecialty choice.

SGIM Task Force

The current issue of *SGIM Forum* highlights some steps that clinician-educators are taking to improve teaching and clinical care for mental health within our patient populations. As leaders in general internal medicine, SGIM members are in an ideal position to take on leadership roles in the process of transforming education in mental and behavioral health in our specialty. We propose SGIM convene a task force in mental health education. A task force would allow us to draw on the significant expertise of SGIM members to outline the primary education needs

of internal medicine residents. This would enable the Society to engage colleagues in psychiatry and psychology in the process of developing new competencies and curricular requirements and open future interdisciplinary partnerships with psychology and psychiatry. The task force would also be able to engage subspecialty colleagues to ensure that competencies are relevant for the future career paths of internal medicine residents. With a strong message from SGIM and related internal medicine societies, we hope to influence future ACGME requirements for internal medicine on the way to improving our teaching and clinical care.

References

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