Psychosomatics 2015:56:319–328

Review Article

Readings on Psychosomatic Medicine: Survey of Resources for Trainees

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Background: *As systems of care become more complex and comorbid medical and psychiatric illness becomes more evident, it is essential to prepare psychiatric trainees for practice in more integrated models of care.* **Objective:** *We sought to identify readings available for residency training in consultation-liaison (C-L) psychiatry/psychosomatic medicine with the intent to help educators and trainees identify appropriate and essential learning resources within the field.* **Methods:** *We reviewed readings available to the residents (including commonly used textbooks in C-L psychiatry and C-L training programs' required reading lists) and identified areas of consensus regarding the topics germane to the care of patients with comorbid medical and psychiatric illness (namely depression, dementia, and delirium) and the education of trainees.* **Results:** *There was considerable variation in the references cited by well-regarded textbooks and by reading lists created for trainees in C-L psychiatry. In the 4 textbooks reviewed, there were 83 shared citations on delirium (including 10 citations that were common to all 4 textbooks and 17 citations shared by 3 textbooks). Markedly less overlap was noted in the chapters on depression (only 2 references cited in all of the textbooks with relevant content) and dementia (only 7 shared references).* **Conclusion:** *Given the paucity of overlap of citations in commonly used textbooks, we recommend that practical topical reviews or textbook chapters be used as core (required) or recommended readings for residents on C-L psychiatry rotations, supplemented by a small number of studies or case series that illustrate key teaching points on each essential topic.*

(Psychosomatics 2015; 56:319–328)

INTRODUCTION

Psychosomatic medicine (PM)/consultation-liaison (C-L) psychiatry is a subspecialty of psychiatry that is centered on the identification, diagnosis, and management of patients with comorbid medical/obstetric/surgical and psychiatric conditions. As medical knowledge in this area has burgeoned, and as active efforts in health care reform place a growing emphasis on the integration of medical and psychiatric care, it is increasingly important to expose psychiatric trainees to core content. Moreover, as systems of care become more complex, it is essential to enhance the education and facilitate the competence of psychiatric trainees, who may then provide excellent care to patients with coexisting medical and psychiatric conditions.[1]

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The Accreditation Council for Graduate Medical Education, which oversees the training and education for psychiatric residents and fellows in the United States, requires that training programs expose residents to C-L psychiatry. However, few specific recommendations have been offered on how this should be achieved beyond a "two-month full-time equivalent rotation in which residents provide supervised consultations on medical and surgical services."[2] Furthermore, the Accreditation Council for Graduate Medical Education has established 6 core requirements (i.e., patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice) that cover essential educational components for all trainees in psychiatry.[2]

Since the Academy for Psychosomatic Medicine (APM) was established in 1953, it has focused on the education and training of PM/C-L psychiatrists. In 1993, the Academy created a task force focused on the development of recommendations for C-L training within adult psychiatry residency programs. Those guidelines, published in 1996, reviewed structural (e.g., prerequisite, length of C-L rotations, faculty supervision, and the postgraduate year training number for C-L trainees) and content-based aspects of the C-L rotation (e.g., clinical topics of importance, skills, attitudes, and learning resources).[3] An emphasis was placed on the creation of standardized training settings across psychiatry residency programs and on assisting programs with the development of a unified educational curriculum for rotating residents.

In 2007, a European Association of Consultation-Liaison Psychiatry workgroup provided guidelines for C-L residency training based on a 2001 survey of 20 C-L experts from 16 European countries.[4] Much as in the United States, training was highly variable, with respect to most of the aspects of PM/C-L training (e.g., whether C-L training was mandatory or recommended and whether a specific number of cases should be required) and specific guidelines regarding knowledge/skill needed by trainees. A paucity of full-time, C-L-trained psychiatrists to supervise and teach trainees was noted, as was a marked heterogeneity in the quality of teaching provided. Similar to the 1996 APM Task Force recommendations, the European Association of Consultation-Liaison Psychiatry's report concluded with guidelines that intended to facilitate a consistent approach across training programs, and outlined specific areas of knowledge, skills, and attitudes thought to be essential for training in C-L psychiatry.

More recently (2013), Heinrich et al. surveyed United States–based psychiatry residency program directors to review the status of C-L training practices and assessed how closely training practices approximated those proposed by the APM's 1996 guidelines.[5] Of the 206 directors of general psychiatry and combined residency programs invited to participate, 92 (45%) responded to the survey. Similar to the 1996 report, they noted a significant variation in the requirements for C-L training, including discrepancies in the duration of training required, the year of training in which C-L psychiatry was done, and the overall structure of the C-L rotation. Although most of the programs met the Accreditation Council for Graduate Medical Education requirement of minimum of 2 months allocated for C-L psychiatry training, only 58% of the programs surveyed met the 3-month 1996 APM recommendations. Similarly, marked discrepancies were noted in the quality and content of the education provided. Although 77% of the programs surveyed described having a formal curriculum in C-L psychiatry, there was significant variation noted regarding the amount of time dedicated to C-L–based educational activities. Didactics dedicated to C-L–specific educational content varied from 1–5 hours to 41–50 hours within the 4 years of training (average: 11–15 h). Only 36% of programs described resident involvement in C-L–focused journal club activities, and only 64% of the programs noted that their trainees participated in C-L psychiatry clinical case conferences.

Following this survey, the APM presented revised and updated residency training recommendations in early 2014.[6] These recommendations included specific guidelines on structural issues (e.g., length of rotation, the ideal year for the C-L rotation, the preferred clinical volume of cases, rotation sites, and faculty supervision), educational guidelines, and core competencies (i.e., patient care, medical knowledge, interpersonal/communication skills, professionalism, practice-based learning and improvement, and systems-based practice). With regard to the content of medical knowledge needed during the C-L rotation, we identified 6 broad knowledge areas considered as essential for the education of psychiatry residents and 3 advanced knowledge areas considered optional for resident education. Table 1 summarizes the 2014 APM-recommended knowledge areas alongside the 2007 European Association for Consultation-Liaison Psychiatry and Psychosomatics recommendations.