

Psychiatry resident education in psychosomatic medicine: The state of the service

Keith Huang*

Department of Physiology, Faculty of Medicine, Ilam University of Medical Sciences, Ilam, Iran

DESCRIPTION

The diagnosis and treatment of psychiatric illnesses and symptoms in medically unwell patients is the focus of consultation-liaison (C-L) or psychosomatic medicine (PM), a branch of psychiatry. C-L psychiatry is used in a wide range of clinical settings and in systems of care that are just as diverse. Since individuals with a range of comorbid or co-occurring medical and psychological illnesses have been proven to have a poorer quality of life, suboptimal medical outcomes, and higher associated costs of care, it is crucial to recognise and treat these complicated patients. In order to establish competency in PM, residents in general psychiatry training programmes must first acquire proper training. Psychiatry residency schools are required to instruct their residents in C-L psychiatry by the Accreditation Council for Graduate Medical Education (ACGME). The clinical and academic experiences, even between different rotation locations within a residency programme, vary, nonetheless, between residency programmes [1].

A number of surveys have been conducted to evaluate C-L training methods. Mendel published the first national study on education in psychiatric consultation in nonpsychiatric medical settings in 1966. Mendel's survey revealed that although 75% of 202 residency education centres did provide some instruction in consultation techniques, the majority of the instruction was delivered informally through supervised practice. According to the author, the majority of residents were receiving insufficient training in consultation psychiatry. In response to the growing emphasis on both the psychosomatic training of nonpsychiatrist physicians and the training of psychiatrists to practise in a general medical context, a 10-year follow-up survey was conducted. There was a minor but noticeable increase in the quantity of C-L instruction in psychiatric residency training programmes compared to Mendel's study performed ten years earlier. Even however, compared to previous rotations, the total amount of time spent in C-L training during residency still made up a smaller portion of the overall time. All psychiatric residents in the United States must be exposed to C-L work as per established requirements for residency training [2].

The C-L experience must consist of "...two month full-time equivalent in which residents consult under supervision on other medical and surgical services," according to the ACGME Psychiatry Program Requirements. Beyond the original 2-month minimum experience criteria established by the ACGME in 1994, there aren't many specific

Address for correspondence:

Keith Huang
Department of Physiology, Faculty of Medicine, Ilam University of
Medical Sciences, Ilam, Iran
E-mail: keithhuang@gmail.com

Word count: 1048 **Tables:** 00 **Figures:** 00 **References:** 05

Received: 01.08.2022, Manuscript No. ipaom-22-13195; **Editor assigned:** 03.08.2022, PreQC No. P-13195; **Reviewed:** 18.08.2022, QC No. Q-13195; **Revised:** 24.08.2022, Manuscript No. R-13195; **Published:** 29.08.2022

recommendations to help training directors. The Academy of Psychosomatic Medicine (APM), a global association of psychiatrists committed to the treatment of people with co-occurring mental and physical problems, was founded in 1953. The group established a task force in 1992 to create standards for C-L training in general psychiatry residency programmes. In an effort to promote coordination and uniformity among residency programs, the task force's subsequent publication put forth training guidelines that would apply to all training sites. The guidelines, which are published and made available online through the APM website, give clear suggestions for the aims and benchmarks of C-L training in residencies and support the subject matter of the curricula for C-L education. The length, scheduling, and faculty supervision of the resident rotation, as well as other structural characteristics of the rotation, were also examined. Since the APM guidelines were published in 1996, there hasn't been another survey to determine how resident training in C-L psychiatry is progressing [3].

In order to learn more about the present state of PM education and training in residency programmes across the United States, a 46-question survey was undertaken in the fall of 2010. The poll was voluntary, and all participants' answers were kept private. An exemption from institutional review board oversight for this study was approved by the institutional review boards of Froedtert Hospital and the Medical College of Wisconsin. The directors of 206 general adult psychiatric resident programmes, internal medicine-psychiatry, family medicine-psychiatry, and neurology-psychiatry combined residency programmes were asked to participate in the answers. Their email addresses were located via the ACGME and the American Medical Association's FREIDA Online database of graduate medical education programmes. This study only included the 180 residency directors of general psychiatry training programmes who were identified and issued surveys. Programme directors were requested to distribute the survey to their department if they thought someone else could be more equipped to answer the questions (i.e., the director of the psychiatric consultation service at their institution). The responses were kept secret [4].

Under the direction of the APM's Education Committee, the Residency Education Subcommittee created a Zoomerang

survey that was sent out via email to participants (original e-mail plus 2 subsequent reminders). The survey questions covered four major topics: (1) the length, distribution, and context of resident rotations in C-L; (2) the level of faculty staffing of the C-L service; (3) the presence and design of a didactic C-L curriculum; and (4) perceptions of and potential roles for the APM in C-L education. Members of the APM Residency Education Subcommittee and the Education Committee examined the survey for content validity [5].

CONCLUSION

Programs were also asked how many residents were currently enrolled in the inpatient C-L service. Of these, 32 (39%) of the 83 said that only one resident was assigned to the C-L service, 32 (39%) of the 83 said that there were two residents assigned, 16 (19%) of the 83 said there were three residents assigned, 1 (1%) of the 83 said there were four residents assigned, and 2 (2%) of the 83 said there were five or more residents assigned at once. The 81 survey participants who responded to this question provided a wide range of answers regarding how the residents spent their time while on rotation in the C-L service. The poll questioned about the months of service for each of the years as well as how many days per week the resident spent on the service in order to estimate the amount of hours spent on the service. In the programmes of the respondents, 34 (42%) of 81 residents were on the service full time during their C-L rotation, compared to 47 (58%) of 81 residents working less than full time (1.0 Full-Time Equivalent [FTE]). Although 73 (90%) of 81 residents who were on the C-L Service were planned to be "on service" more than 50% of the time each week. Only 25 (30%) of the 83 programmes that were questioned said that they provided an ambulatory psychiatric C-L experience as part of their rotation.

ACKNOWLEDGEMENT

None.

CONFLICT OF INTEREST

Author declares that they have no conflict of interest.

REFERENCES

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. Burdick WP, Jouriles NJ, D'Onofrio G et al. Emergency medicine in undergraduate education. <i>Acad Emerg Med.</i> 1998(11):1105-10. 2. Shepherd S, Zun L, Mitchell J et al. A model preclinical, clinical and graduate educational curriculum in emergency medicine for medical students and rotating residents. <i>Ann Emerg Med.</i> 1990;19(10):1159-66. 3. Wald DA, Manthey DE, Lin M et al. Clerkship directors in | <ol style="list-style-type: none"> emergency medicine: Statement of purpose. <i>Acad Emerg Med.</i> 2008;15(9):856-9. 4. Berman N, Fall LH, Smith S et al. Integration strategies for using virtual patients in clinical clerkships. <i>Acad Med.</i> 2009;84(7):942-9. 5. Nguyen HB, Daniel-Underwood L, Van Ginkel C et al. An educational course including medical simulation for early goal-directed therapy and the severe sepsis resuscitation bundle: An evaluation for medical student training. <i>Resuscitation.</i> 2009;80(6):674-9. |
|---|---|