Residents

Medical Training During Psychiatric Residency

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Abstract: In light of recent discussions regarding the structure of psychiatric residency training, this article examines the importance of good medical training for psychiatric residents. Medical training enables residents to provide holistic patient care, to identify medical emergencies, to provide better psychiatric care to medically ill patients, to solidify their identity as physicians and to advance our field. Research and resident experience suggests that any changes in the structure of residency training should be carefully considered to ensure that adequate medical training is maintained.

Provide Holistic Patient Care

Physical illness is found in 33 to 46 per cent of psychiatric inpatients, in nine to 43 per cent of outpatients and in 50 per cent of patients in day treatment programs (2). Psychiatric treatments have the potential for medical complications. For instance, glucose dysregulation and hyperlipidemia have been associated with atypical antipsychotics, whereas hyponatremia may occur in elderly patients on selective serotonin reuptake inhibitors (SSRIs; 3).

Despite the significant chance of medical complications, countertransference feelings in referring physicians may decrease the probability of our patients’ receiving comprehensive medical care. The psychiatrist may be the primary physician caring for the patient, particularly in the inner city, rural settings and inpatient wards in psychiatric hospitals. Psychiatrists must be able to recognize and to treat basic medical problems and know when referral to others is needed.

Identify Medical Emergencies

In the emergency room and inpatient setting, missed medical problems can have potentially serious consequences. For example, delirium, a medical emergency, may be mistaken for a psychotic illness. These patients may therefore be mistakenly admitted to psychiatry units. The psychiatrist must have the ability to distinguish between the two and ensure appropriate care.

In 2000, Reeves and others reviewed 64 cases with unrecognized medical emergencies. These patients were inappropriately admitted to psychiatric units from emergency departments (4). All patients met DSM-IV criteria for delirium and were transferred to medical units within 24 hours of psychiatric admission. Of the patients, 43 per cent had an inadequate physical exam, and 34 per cent had insufficient laboratory work done while in the emergency room.
With 67 per cent of patients carrying a previous diagnosis of mental illness, the authors concluded, “some psychiatric patients are given a less-detailed evaluation than are other patients, possibly because their changes in mental status are too quickly assumed to be caused by their mental illness.”

Recent examples show that psychiatry residents have been instrumental in identifying a gastrointestinal bleed, an intracerebral hemorrhage, a brain tumour and a myocardial infarction in patients who were “medically cleared” and referred to psychiatry services. These patients would have been deprived of proper medical care if it were not for psychiatry residents trained to watch for organic etiologies of psychiatric presentations.

Psychiatric medications can also cause uncommon but potentially fatal emergencies, such as serotonin syndrome and neuroleptic malignant syndrome (5). The ability to recognize, to possibly treat or to refer these patients to our medical colleagues is critical. Solid medical training provides the psychiatric resident with the skills and the confidence to diagnose and triage these complex cases.

Provide Psychiatric Treatment to Medically Ill Patients
Psychiatric illnesses are commonly seen in patients with physical illness. Five to 10 per cent of patients seen in primary care settings and 10 to 14 per cent of medical inpatients have experienced depression (6). The prevalence of depression is nine to 27 per cent in patients with diabetes, 10 to 37 per cent in those with Parkinson’s disease and 18 to 39 per cent in cancer populations (7). A link between depression and poor course of illness has been found in cardiovascular disease (8), stroke, diabetes and cancer (7).

In the context of physical ill health, many patients are referred to a psychiatrist for the first time. They fear the stigma around of health issues.

A good understanding of a patient’s medical illness and treatment helps the psychiatrist to build rapport and to explain emotional symptoms in the context of physical illness. This may improve compliance. This knowledge also aids in differentiating between normal coping and abnormal illness response. Further, it helps to distinguish between organic symptoms and somatization. A breadth of medical knowledge enhances psychiatrists’ ability to formulate and to treat these patients, using the biopsychosocial approach.

Solidify Identity as Physicians
A psychiatrist is not just the member of the mental health team who prescribes the pill. Like other physicians, psychiatrists make and test differential diagnoses that are relevant to a patient’s presentation. To do so, psychiatrists must know when physical exams or laboratory tests are required and how to interpret them. They must have exposure to imaging techniques and feel confident in recognizing the possibility of medical illness in a patient during residency. They require exposure to patients who are seen in neurology and endocrinology and in pediatric and geriatric clinics.

To fully understand the medical–psychiatric interface, a firm foundation in neurobiology, genetics and pharmacology—as it applies to thought, feeling and behaviour—must be taught. Through exposure to these areas, residents learn the requirements of physicians who request a psychiatric consultation. Our medical colleagues appreciate and respect a well-rounded, practical approach to the psychiatric needs of medical patients.

Move the Field Forward
A huge interplay exists between medical and psychiatric illness. Genetic and metabolic contributions to psychiatric illnesses are being explored. If our field is to continue to move ahead, psychiatric trainees must integrate and build on our new understanding of these areas. A restricted, overly specialized approach to behavioural disorders will likely lead to impoverished understanding and care of our patients.

Without adequate awareness of the medical–psychiatric interface and its theoretical and practical foundations, we will miss key research findings that link mental health with medical and neurological illness. Our patients will be further marginalized, thus leaving our field separated from other areas of medicine at a time when integrating work from other fields holds such promise of benefiting our patients.

Application to Training Structure
To date, there is no national consensus on the goals and objectives for PGY-1 or on the nature of general medical competency required for the general psychiatrist (9). The content of the PGY-1 year varies considerably within the 16 postgraduate programs in Canada (9).

As stated by Martin and others in a recent article about residency training, “regardless of one’s viewpoint, the brain and body will play a far more central role in psychiatry in the years ahead . . . Programs must prepare residents for this inevitability” (10). The recent proposal to shorten the rotating internship, offered by many postgraduate programs, has the potential to dilute resident experiences in other areas of medicine and to hinder residents from obtaining the medical knowledge needed to care for psychiatric patients.

Acknowledgments
Thanks to Dr. Jon Hunter, Dr. Karen Saperson and Dr. Khrista Boylan for their helpful feedback on this article.

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Social Phobia


Specific Phobias


Video Resources


To view a more comprehensive resource list, please go to www.cpa-apc.org/Publications/Archives/Bulletin/2003/august/antony.asp or visit www.martinantony.com

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