

Educating Trainees About Common Mental Health Problems in Primary Care: A (Not So) Modest Proposal

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At least 25% of all outpatients have mental health problems, more than hypertension and diabetes combined. We treat most of these individuals in primary care (PC), which has become our “de facto mental health services system.”¹ Fewer than one in four receive any mental health care, and fewer still receive recommended care. Presidential commissions and the public have long complained about substandard care but have not always sought, or appreciated, its causes. I propose that we as educators share some of the blame because—simply put—we do not adequately train our students and residents to manage common diagnoses like depression, anxiety, medically unexplained symptoms, eating disorders, and substance misuse.

During medical school, most students receive only six to eight weeks of instruction in interviewing during their first year and four to eight weeks of training in psychiatry in their third year. The latter often occurs during inpatient experiences with severely dysfunctional patients who are quite unlike those our trainees will care for in a typical ambulatory practice. Except for a few other brief courses, these two experiences are the extent of training many medical students receive in psychosocial and mental health medicine. Most residents receive even less.

Many educators question the adequacy of a strictly disease-based, biomedical approach as preparation for a career in PC medicine. Without the psychological and social skills needed to manage mental health problems, PC physicians operate at a distinct disadvantage. Encouragingly, most educators have incorporated the biopsychosocial (BPS) model into their mission statements and have added medical interviewing, its basic skill, to their curricula.

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Pressing societal needs² for better mental health care, however, now require a quantum leap forward in BPS training, rather than an incremental approach—no small task in medical education.³ I propose that we develop evidence-based standards and train students and residents so that they are as competent in treating common mental health problems as they are in treating physical problems—for example, as effective in managing depression as diabetes. Four initial requirements are necessary for effecting this extensive change:

1. I estimate that we will need 200 to 250 contact hours distributed across all four years of medical school and another 200 to 250 hours across all years of residency. Most of the increase will entail providing mental health experiences for trainees in PC clinics, the community, and/or medical inpatient units. Such profound curricular change will require a courageous parallel commitment to training in these different settings and to fostering attitudes and values that place the interest of the public first.²
2. Competency-based learning objectives, experiential methods, assessment tools, and practical dissemination packages will require development. The new curriculum will need to be evidence based and rigorously evaluated.
3. Given the current absence of a cadre of teachers and role models in PC mental health, creating and offering a range of professional development activities will be necessary for preparing current medical faculty to deliver the new curriculum. I estimate that they will need training to the fellowship level across one to two years, and that 6 to 10 such core faculty will be the minimum requirement for each institution. These core medical teaching faculty will conduct much of the teaching, educational research, and subsequent faculty development. Many will have academic careers in BPS medicine.
4. If we are to make fundamental pedagogical changes, parallel changes in funding must occur.⁴ Greatly increased expenditures for PC mental health, educational research, and training will

help meet national priorities for better health care.

Our major immediate challenge is to greatly extend the boundaries of the current system.³ We must be guided by the understanding that we are addressing a critical public need.² Our work and that of others in PC, consultation–liaison psychiatry, and multidisciplinary pain clinics can provide initial guidance in the specifics of developing mental health care models for study and eventual dissemination. An ambitious goal is to set plans for having one-third to one-half of all programs producing graduates as skilled in mental health care as they are in medical care by 2025.

Solving the multifactorial problem of poor mental health care also requires the continuation of current yeoman efforts (e.g., addressing physicians’ competing demands and reimbursement issues; implementing a chronic care model; employing a team-based, collaborative approach; and expanding the patient-centered medical home). These efforts can complement the remaining-to-be-addressed piece of this multidimensional systems puzzle: the poorly prepared PC physician.

Effectively training the physician to care for common mental health problems can put the final and most difficult piece of this puzzle in place. By correcting the malalignment of medical education and patients’ mental health care needs,³ we can restore medicine’s ability to provide the highest quality of care and meet one of society’s greatest needs.

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