Special Article

Health Care Reform and Postgraduate Psychiatric Education

Challenges and Solutions

The Medical Education Committee Group for Advancement of Psychiatry

Psychiatric educators must prepare to teach in an era in which funding for education is more difficult to obtain, all forms of treatment are shorter, patients are discharged from the hospital while they are still acutely ill, the burden of paperwork and other administrative tasks is greater, psychiatrists provide less psychotherapy, and residents are no longer able to play a primary role in the treatment of patients covered by third-party payment schemes. A surcharge on a national insurance plan could make up for funding deficits, but this is not likely to occur in the near future. A more realistic model involves billing for services of faculty who integrate direct participation in patient care with teaching and better definitions of the role that residents can play in modern patient care. Overage from clinical activities driven by faculty may provide sufficient funding for resident services that provide an opportunity for longitudinal patient experiences. Strategies for political action and for better collaborations with primary care faculty are discussed. (Academic Psychiatry 1999; 23:1–8)

One of the greatest challenges now facing academic medical centers is to attempt to coordinate the trajectory of a slowly evolving system of medical education with the rapid pace of change of the organization of clinical services occasioned by a revolution in health care financing (1–3). Since the actual reimbursement system that will emerge from health care reform is a moving target that remains difficult to visualize with any certainty (4), it makes little sense to try to make instructional approaches conform to each new mandate and constraint. Therefore, postgraduate educators must prepare graduates both to practice in today's environment and to predict and adapt to tomorrow's environment.

Thus far, medical education has performed poorly in both areas. Even generalist residents are poorly prepared to work in current managed care practices (5), and it has been asserted that it takes up to 18 months of postresidency retraining to prepare residents of any specialty to practice in such settings (6). In a survey of 4,756 physicians under the age of 45, two-thirds felt that they had received inadequate training in managed care (7). Psychiatric trainees do not seem to be any better off than their colleagues in other specialties. In response to a 1994 survey of Ginsberg Fellows (resident members) of the Group for Advancement of Psychiatry, for example, 91% of the respondents reported that economic pressures had reduced their access to continuity experiences with patients and burdened them with excessive amounts of paperwork, aversive interactions with managed care reviewers, and other nonacademic activities. Yet only one-third of the respondents felt that their postgraduate education was preparing them to deal with the fiscal realities of psychiatric practice (Medical Education Committee, unpublished data, 1994).

We discuss some of the major issues facing psychiatric educators, especially those involved in residency education in a rapidly evolving health care system. We will address likely changes in the number and size of psychiatric residencies, the clinical and educational interaction of psychiatry and primary

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care, the role of nonphysician mental health providers in future psychiatric education, and new constraints and opportunities in teaching in psychiatric settings. For each of these areas, we will attempt to develop a blueprint for a constructive response to upcoming economic, political, and clinical challenges.

FUNDING AND WORKFORCE ISSUES

Psychiatry, like all medical specialties, has traditionally relied on grants, clinical income generated by faculty, and fees for residents' services to cover the large portion of the cost of postgraduate medical education that is not supported by tuition and state and local appropriations (3,8–11). However, training grants are not available anymore, and cost shifting of research grants to support teaching is no longer permissible (12). Cutbacks in remuneration for patient care, discussed next, make it impossible to count on average clinical earnings or reimbursement for resident services any longer (13).

To counterbalance these constraints, it has been suggested that third-party payers contribute 1% of their budget toward nationally standardized resident salaries and other teaching costs, presumably with local adjustments (4,9,14,15). However, comprehensive health care reform that would include such funding mandates for medical education is not likely to be passed in the near future (5,6,10,14). Even if funding of graduate medical education (GME) from a central pool was mandated, it would in all likelihood not be sufficient to compensate for the diminished capacity of academic departments to supplement the costs of residency education, at least at its current level.

It is also time to begin examining alternative sources of support of postgraduate education. For example, Stevens et al. (16) developed a collaborative relationship with a managed care organization (MCO) in which medical school faculty had appointments to the MCO board and MCO physicians taught residents about work in a managed care setting. This kind of arrangement can provide funding for faculty involved in teaching in the MCO setting, and for residents treating MCO patients, as well as a source of patients for teaching. State and local funding for postgraduate education might be made available based on service "paybacks" after completing residency (17).

Whether central funding for postgraduate education comes from a "tax" on a national insurance fund or the current, extensive indirect funding from state, local, and federal sources such as Medicare and the Veterans Affairs (11,15,18), it will be important to do a better job of educating the public and our nonpsychiatric colleagues to mobilize greater support for psychiatry receiving its fair share at a time when all medical specialties will be competing for a shrinking pool of resources nationally and within academic medical centers (19).

In the competition for support of postgraduate education, psychiatry may be hampered by a number of interacting factors that will reduce the number of psychiatric residency positions (19,20). At a time when the number of graduates of American medical schools entering psychiatry is the lowest since 1929 (21), pressure is mounting to decrease the number of new postgraduate year-1 residents by about 7,000 per year (4,5,19) and to reduce the number of international medical graduate residents (22), who comprise 35% of psychiatric residents (18). Concurrently, the number of all specialist residents is being progressively reduced as the percentage of primary (generalist) care (family medicine, primary care internal medicine, and general pediatrics) residency positions is being increased, from the current level of 20%–30% of all positions (23), to at least 50% by the turn of the century (4,9,24). The Graduate Medical National Advisory Council (GMNAC) and the Council on General Medical Education recommended that because psychiatry is a specialty with a shortage, the number of psychiatric residency positions should not be changed (19,24) during this redistribution. However, since the United States currently has 13–15 psychiatrists in clinical practice for every 100,000 people—more than any other industrialized nation (19)—it is unclear whether there is a shortage or a surplus of psychiatrists (23).

Another point to consider in planning for psychiatric residency class size is that an increasing proportion of mental health services once provided by psychiatrists is now provided by nonphysician mental health providers and primary care physicians (PCPs) (3,9,10,25,26). Only 20% of the average panel of mental health providers are psychiatrists, whereas 40% are psychologists and 40% social workers (18). It has been estimated that delegation of psychosocial interventions to these practitioners, and of simpler regimens of pharmacotherapy to primary care phy-

sicians would—under a capitated mental health care system with gatekeeping by PCPs—reduce the number of psychiatrists needed nationally from more than 35,000 to just 9,000 (3,19,27–29). Independent of political considerations, the possibility of underemployment of psychiatrists in the twenty-first century would be a reason to reduce the number of residency positions (5).

In view of the disparity between estimates like those of GMNAC and later estimates (10) of psychiatric workforce requirements, the first step in planning future psychiatric residency class size is to gather reliable data on workplace needs and available funding, perhaps through an organization such as the American Psychiatric Association, which is not directly involved in the ''business'' of educating residents and might not have a vested interest in the results. If a consensus emerged that the number of graduates of psychiatric residencies should be reduced, the next step would be to decide whether a generalized downsizing of residency programs or the closing of some psychiatric residencies would make the most of the available resources. Neither of these decisions would be easy for departments of psychiatry that depend on residents to provide clinical services, Medicare funding for hospital operations, or academic prestige. However, the alternative, which is to blindly advocate for the status quo in an environment that will no longer support it, seems even more dangerous.

PSYCHIATRY AND PRIMARY CARE

PCPs already provide a good deal of mental healh care (14,30,31), and they will undoubtedly play an even more important role as disincentives for referral to the specialist are increased by ''gatekeeper'' systems of capitated health care. Psychiatric educators want to participate actively in postgraduate generalist education to improve the capacity of PCPs to meet these demands. However, despite a few successful educational programs by organized psychiatry (32–36) and the demonstrated capacity of psychiatrists to improve the psychiatric skills of motivated PCPs (29,37), primary care practitioners have generally remained reluctant to collaborate clinically with psychiatrists, let alone be taught psychiatry by them. Even in academic settings, departments of primary care have preferred to hire their own practitioners, usually psychologists (29). These practitioners are viewed as cheaper, more responsive, and perhaps less competitive with the PCP than psychiatrists.

One result of a system in which PCPs are not regularly educated about psychiatry by practitioners of that specialty is that PCPs, especially those in prepaid medical plans, have difficulty recognizing psychiatric disorders, lack confidence in their psychotherapeutic skills, use inadequate doses of most psychotropic medications (38–42), do not attend to psychosocial issues in depressed patients, and do not achieve the same results as psychiatrists in the treatment of depression (37,42). Unless psychiatric educators can play a more fundamental role in the psychiatric education of PCPs, future generations of psychiatrists may have to be taught how to cope with these and other results of their intellectual estrangement from primary care systems.

One place to begin a renewed effort to become more effectively involved in primary care education would be to conduct focus groups with primary care ''consumers'' of psychiatric education. Intensive discussions with students and educators in primary care may provide a more accurate view of the kinds of psychiatric skills primary care physicians really need to acquire, and the best way to impart these skills. One point that might emerge is that psychiatrists working in primary care clinics who have the opportunity to form ongoing relationships organized around patient care with trainees and practitioners may be more effective than didactic methods. If primary care educators find a psychiatric educator useful, they may be willing to support this position; if not, exploring this reluctance may facilitate an alliance between psychiatrists and PCPs. Another way to engage primary care educators might be to develop joint applications to general hospitals and foundations for support of coordinated teaching activities.

An important goal of any discussions with primary care educators is to develop a consensus about the level of expertise a primary care physician needs to treat psychiatric disorders and the indications for referral to the specialist. These standards could be incorporated into a core primary care curriculum and a protocol for the recertification of competence in psychiatric skills, making such skills as important as any other medical therapy. Discussions of disagreements between psychiatric and primary care educators

about what should be taught and who should teach it should be encouraged instead of keeping them within the confines of each specialty.

The integration of psychiatry and primary care could be further facilitated by involving primary care faculty more intimately in postgraduate psychiatric education. Faculty in primary care fields may be in the best position to teach psychiatrists how to interact with physicians and patients in their specialties. They may also help us to develop realistic standards for the medical evaluation of psychiatric patients, a topic of great interest to a field with a high rate of unrecognized medical morbidity (31,43).

EDUCATION IN THE PSYCHIATRIC SETTING

Today's teaching environment bears little resemblance to the services of the past in which psychiatric faculty learned psychiatry. One of the most important changes has been in the nature of participation of residents in patient care. Under most reimbursement schedules, it is increasingly difficult to bill for resident services, and attending physicians cannot bill for treatment in which they do not directly participate. Proprietary hospitals are competing for patients traditionally treated in academic medical centers, and many MCOs are reluctant to send patients to academic settings, which they consider to be cost-ineffective (18). When they do contract with academic departments, MCOs do not want residents to be primary care providers, and they may be reluctant for residents to be involved with their patients at all (29,44). Residents are necessarily slower and less efficient than experienced faculty and have a lower threshold for admitting patients to more expensive inpatient settings because they are less able to assess acutely ill patients accurately and expeditiously.

As the majority of clinical teaching comes to involve patients covered by managed care or capitated contracts, these issues may relegate the resident to a secondary or even irrelevant role (13,14), a drastic change from traditional teaching methods in which residents try out different approaches and learn at their own paces (45). In addition to reducing opportunities for active learning, limitations on the autonomy of the trainee may lead persons with high levels of drive and responsibility to seek other careers (45), an ironic turn of events at a time when psychiatry has more than ever to offer intellectually and therapeutically.

It will never be possible for health care delivery in a system that educates students and residents as it does today to be as cost-effective as a system that uses only experienced clinicians. In an era in which academic medical centers must offer aggressive pricing and rapid results to survive, the traditional model of clinical teaching in which residents provide first-line care will have to be modified if academic departments are to survive. One strategy is for faculty members to see each of their residents' patients briefly with the residents, rotating from room to room as in any other medical clinic or observing more than one treatment episode at a time through one-way screens. This model has much to offer in the way of immediate feedback and an opportunity for faculty to compare the resident's description of the patient with the faculty member's own perception. It may be possible to support with professional fees individual supervision that occurs in the context of treatment in which the faculty directly participates now that supervision at a distance is no longer reimbursable. The resident is less independent in this approach, and the faculty member must spend more time personally participating in the care of residents' patients, leaving less time for didactic teaching, research, and treatment of their own patients. However, "bedside" teaching may substitute for a significant amount of lecturing. Residents at an earlier stage of their education may have to function more or less as apprentices to clinical faculties who actually provided direct patient care, but more experienced trainees could be given more independent responsibility once it had been demonstrated to third-party payors that they could function effectively with less direct supervision.

Another approach to adapting resident education to fiscal realities would be to establish teaching services distinct from other clinical services. Treatment primarily directed by residents on these services would take longer, but it would be more comprehensive. Given the current direction of health care financing, it seems unlikely that third-party payors would have much interest in underwriting a teaching service. However, under capitated mental health "carve outs," departments of psychiatry would have the option of funding teaching services for complicated patients with high rates of recidivism who would cost more to treat in a typical managed care

setting (3). Funds might also be made available from the "tax" on health care mentioned earlier or from block grants for indigent care that included a teaching subsidy.

The economics of health care have made other changes in the milieu in which residents learn psychiatry. Psychiatric hospitalizations have become briefer, with the primary goal of inpatient care being rapid diagnostic assessment, resolution of acute life-threatening crises, and discharge (2). Nationally, average lengths of inpatient stays in psychiatric hospitals decreased from 40 to 20 days in 1986, from 10 to 7 days in 1990 (3,13), and even less in the second half of the 1990s (30,46). Severity of illness must be greater to justify hospitalization, and most patients are discharged so quickly that it is rarely certain that they are well or even safe. Briefer hospitalizations of sicker patients treated with focused inpatient therapies and discharged when they are only marginally compensated (30) can generate anxiety that interferes with learning in residents assigned to modern inpatient services. In addition, residents who do not have the opportunity to observe resolution of acute symptoms before a patient is discharged from the hospital may think that treatments applied in this setting are not effective.

Outpatient psychiatric care is now brief and oriented toward avoiding hospitalization (48). The functions of the psychiatrist increasingly have involved prescribing medications, consulting, and serving as team leader in the outpatient management of the chronically mentally ill (29). As in the inpatient unit, episodic treatment of acute recurrences is primarily aimed only at restoring premorbid functioning (18,47), an approach that may be cost-effective but makes it difficult for trainees to observe the longitudinal course of psychiatric disorders that is not truncated by shortening one phase of overall treatment (10). Knowledge of the evolution of psychiatric disorders will be further hampered by rapid referral of acutely ill patients back to MCO case managers once the acute illness has been stabilized.

Another possible educational complication of the current trend toward brief intermittant psychiatric treatments is that, with insufficient time to appreciate their complexities, residents may think that focused treatment approaches involve only the rote application of ritualized protocols. If there is not enough time to find out about the patient as a person, residents could become mechanistic in their approach to patients, failing to learn how to make use of the rich data inherent in the observation of the doctor–patient relationship. It can be argued that residents should learn to practice within the new, more limited, scope of the doctor–patient relationship that has been defined by managed care. However, it requires more skill to manage a brief physician–patient interaction than an extended one. For the resident, time spent achieving a firm grounding in the evaluation of the doctor–patient relationship during training is necessary for more efficient use of this modality in the pressured atmosphere of later practice.

To develop an integrated concept of disorders that are encountered in one phase in the hospital, and in a different phase in the outpatient clinic or emergency department, often with no therapy in between treatment episodes, residents should follow patients over an extended period of time through various locations (29). One way to accomplish this goal is to assign residents to integrated programs or systems (e.g., affective disorders or chronic mental illness) or to continuous treatment teams organized along diagnostic lines instead of treatment locations (e.g., inpatient or outpatient). As an alternative to traditional assignments of supervisors who cover all of a resident's patients, faculty skilled in the treatment of certain kinds of problems could supervise the treatment of the same patients throughout this kind of continuity experience.

In addition to being brief, today's treatment of psychiatric patients carries a heavy burden of paperwork that is often delegated to residents (10,45). Resentment about this assignment and antagonistic relationships with third-party utilization reviewers (10) can make any treatment epoch feel aversive, and insufficient time for reading and contemplation may aggravate residents' feelings of being dehumanized, feelings that can easily be passed on to the patient (49).

While it is necessary to provide formal course work and practical experience to teach psychiatric residents to negotiate the managed care system (2), it is probably not an educational necessity for residents to spend inordinate amounts of time obtaining precertification, coordinating treatment with MCO case managers, and completing forms. These kinds of administrative tasks can be performed more efficiently and cheaply by nonphysician practitioners, relieving

residents and faculty of some of the paperwork and other service burdens that limit time available for direct teaching. Nonphysician professionals are playing an increasingly important role in psychiatric health care delivery in academic medical centers as well as everywhere else (50,51), providing triage in the emergency department, case management in the psychiatric hospital, and behavioral and psychosocial therapies in the outpatient clinic (3,52). Since they do not rotate off service, they can form more enduring relationships with external reviewers, who are usually members of the same discipline (9). Collaborating with these providers can help residents to learn the kinds of management skills that will enable them to coordinate and integrate the work of a multidisciplinary team.

Even though psychiatrists have developed and tested a number of important psychotherapies (53), less than 25% of all psychotherapy is now performed by psychiatrists (54). In the new climate of mental health care, psychiatrists will be expected to coordinate and take responsibility for psychotherapy by nonmedical clinicians while providing little direct psychotherapy themselves (47,55). But if psychiatric residents do not have the opportunity to conduct different psychotherapies, how will they learn how to prescribe them differentially, integrate them into the overall treatment plan, and predict the likely effect of each treatment? The problem of learning psychotherapy will be compounded if the psychiatric faculty, in order to compete with the private sector, also adheres primarily to a model that largely excludes psychological therapies (3).

In addition to teaching about the range of established psychotherapies that can be prescribed and integrated into the overall treatment plan, performing psychotherapy facilitates learning how to integrate psychosocial and biological perspectives—something no other medical specialist is systematically taught how to do. First-hand experience with expressive psychotherapy should be retained to teach residents about psychopathology, the vagaries of the doctor–patient relationship, and the observation of complex interactions between mind and body (17), all of which are necessary for framing comprehensive treatment plans. This kind of psychotherapy by psychiatrists could be offered as a low-cost "loss leader" approach to patients of MCOs who have contracted with departments of psychiatry for management of large numbers of patients by other methods. It is equally important for residents to learn the focal psychotherapies and behavioral therapies that have been demonstrated to be effective for depression, panic disorder, obsessive-compulsive disorder, and other conditions and that comprise the core of psychological management in the managed care setting. Since PCPs and medical specialists do not have the time or expertise to attend to the psychosocial aspects of their patients' illnesses, it will also be important for residents to become familiar with adjunctive psychosocial treatments that have been found to improve survival as well as quality of life for medical illnesses such as cancer (56,57), and to learn how to direct those therapies in patients treated in nonpsychiatric settings.

THE PSYCHIATRIC FACULTY

To impart knowledge about new treatments, the faculty must be knowledgeable about them. However, many faculty members are not involved in the development of modalities used in a managed care environment (26), and most are struggling as much as anyone else to accommodate themselves to new practice methods and constraints (1,58). As a result, faculties may feel a good deal of ambivalence about practice in the new economic climate and convey that ambivalence to their residents (2,19,59).

At a time when it is crucial for the faculty to provide a model of a truly integrated approach in a setting that can easily encourage fragmented care, increased demands on the faculty for direct clinical activity and paperwork, which were summarized earlier (6,10), are making psychiatric faculties too busy to respond to existing educational demands (60,61), let alone new ones (62).

Assistance with teaching from clinician investigators is unlikely, as these persons are too busy competing for limited extramural funding. Volunteer faculties, who have always been an important source of clinical teaching, have had to see more patients themselves to avoid even greater losses of income, making it difficult for them to afford to donate enough teaching time to compensate for decreased availability of full-time faculties (11). Given the funding constraints we have discussed, it is doubtful that universities will be able to pay volunteer faculties for

an increased teaching load, or even for the teaching they already do.

Faculty time that is available for teaching could be made more efficient by the burgeoning electronic didactic technologies. National courses in specialized areas of knowledge might be taught by faculty teams from different institutions specializing in each area. Once assembled, such courses could be disseminated by interactive television to a small enough number of institutions at a time to permit meaningful student–teacher interchange. Computerized instruction could also assume part of the burden of didactic teaching and allow more time for direct clinical supervision by the faculty (17).

Most medical schools have established tracks that recognize teaching excellence of faculty members who devote time to education at the expense of generating clinical income and research grants (63). Extending the expectation of scholarship to the development of new systems of education can increase the prestige of clinician–educator tracks. Closer integration of faculty teaching and clinical services will facilitate better financial recognition of teaching contributions. If the contributions of the faculty in responding creatively to the demand for dramatic changes in our approach to education are recognized, it will be easier for faculty to inspire residents as they face a changing practice environment.

There is no guarantee that any of the innovations suggested here will be successful. If they are not, they at least represent an initial proactive step in meeting a rapidly evolving climate of health care with vigor rather than demoralization. Considerable creativity and ongoing debate will be necessary to continue to adapt the present system to an uncertain future.

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