

Psychosomatic Medicine: A new psychiatric subspecialty

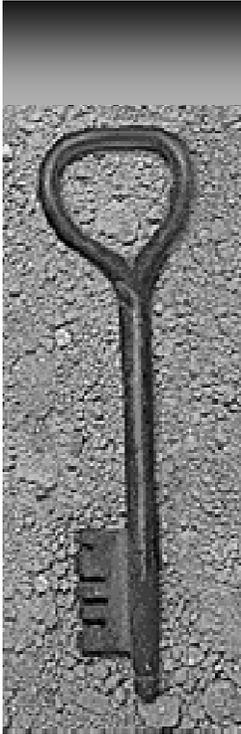


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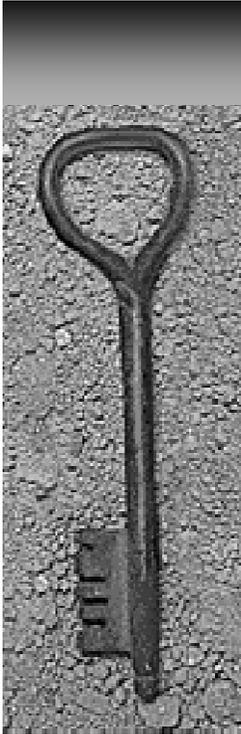
The Johns Hopkins University



Credits

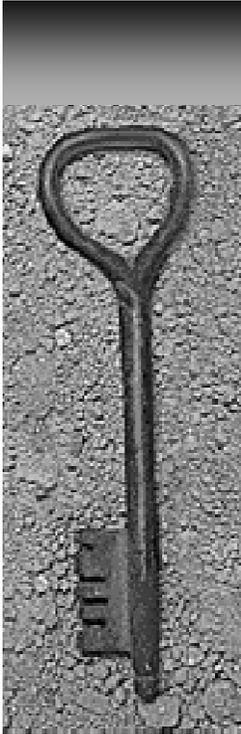
- ◆ James Levenson, MD
- ◆ Thomas Wise, MD
- ◆ David Gitlin, MD
- ◆ APM Task Force on Subspecialization

- ◆ Paul Appelbaum, MD, APA
- ◆ Michelle Riba, MD, APA



References

- ◆ PM application to ABMS (APM Website)
- ◆ Giltin D, Levenson J, Lyketsos C.
Psychosomatic Medicine: a new psychiatric subspecialty, *Academic Psychiatry* in press (Oct 2003)



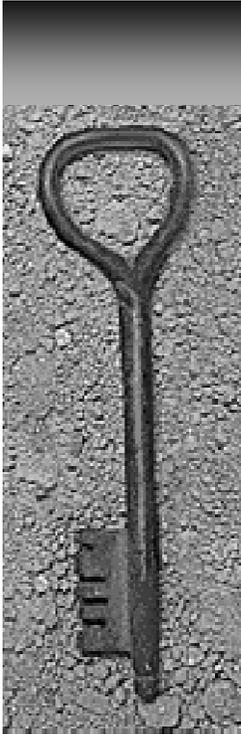
Notable Recent Events

◆ December 11-12th, 2002

The Depression and Bipolar Support Alliance, one of the major US patient advocacy groups, devotes its annual national conference to the effects of depression on medical illness. (Proceedings in *Biological Psychiatry* July 2003)

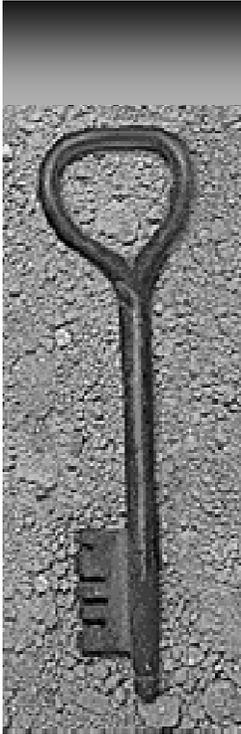
◆ March 20th, 2003

The American Board of Medical Specialties recognizes “Psychosomatic Medicine” as the newest psychiatric subspecialty.



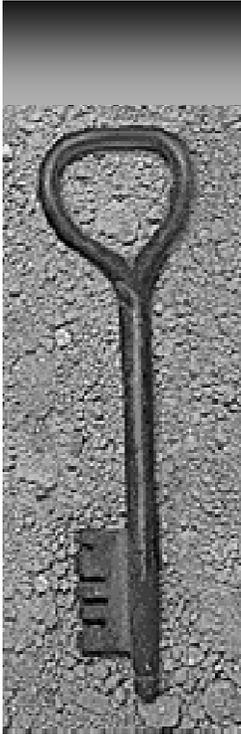
Motivations for subspecialization in the USA

- ◆ Loss of care delivery for “complex medically ill”
 - Payment and insurance “carve out”
 - Erosion of reimbursement for hospital work
- ◆ Loss of fellowship positions and applicants
 - 55 to 32 over 5 years
- ◆ Reductions in NIH funding
- ◆ Field diffusion:
 - Teachers
 - Researchers
 - Especially into geriatric psychiatry
- ◆ Intrusion of psychology



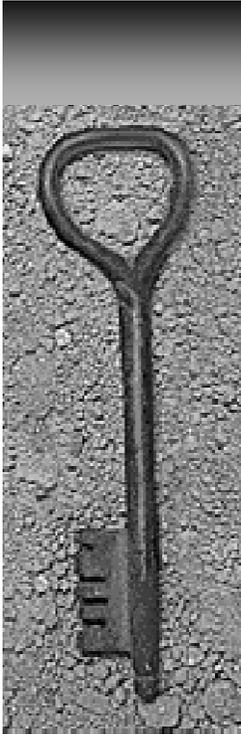
The process

- ◆ Fall 1999: Task Force Appointed
 - Explore ABPN route
 - Consider APM driven certification process
- ◆ Spring 2000: Decision to apply to ABPN
- ◆ December 2000: Application submitted
- ◆ Summer 2001: **APA approval**
- ◆ October 2001: ABPN approval
- ◆ March 2003: ABMS approval



Big issues

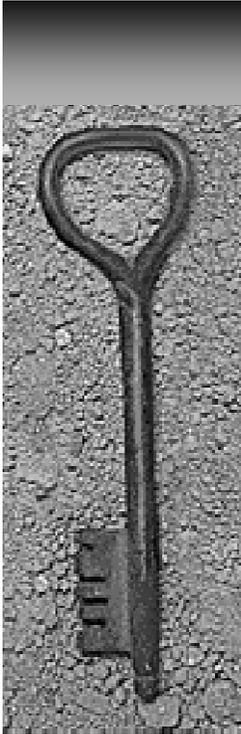
- ◆ Get our own house in order
- ◆ Name of the field
- ◆ Support from general psychiatry, esp. APA
 - Other subspecialties
- ◆ Focus of the field
 - Patient population vs service delivery
- ◆ What is the essence of the field



American Board of Medical Specialties

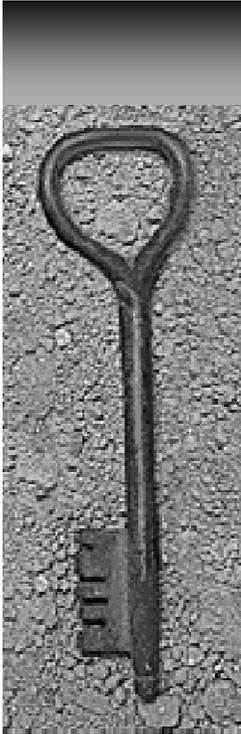
Criteria

- ◆ Purpose
- ◆ Professional and scientific status



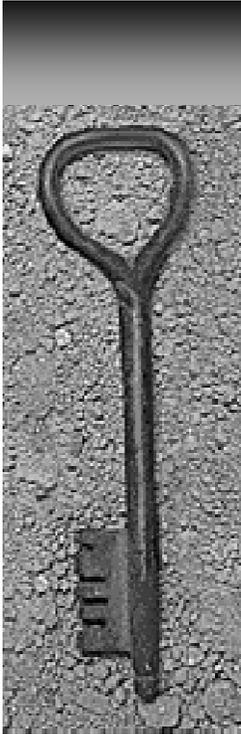
Purpose of the field

1. *To improve the psychiatric care of patients with complex medical, surgical, obstetrical and neurological conditions*
2. *To improve the quality of training in PM field*
 - “ *An important result will be the retention, improvement and enlargement of a national cadre of qualified teachers and academicians who will educate medical students, psychiatry residents, residents in psychiatry combined with internal medicine/family practice/pediatrics/neurology, and PM fellows in this subspecialty area*
3. *To further stimulate and support research and teaching in PM, a natural consequence of official subspecialty status*



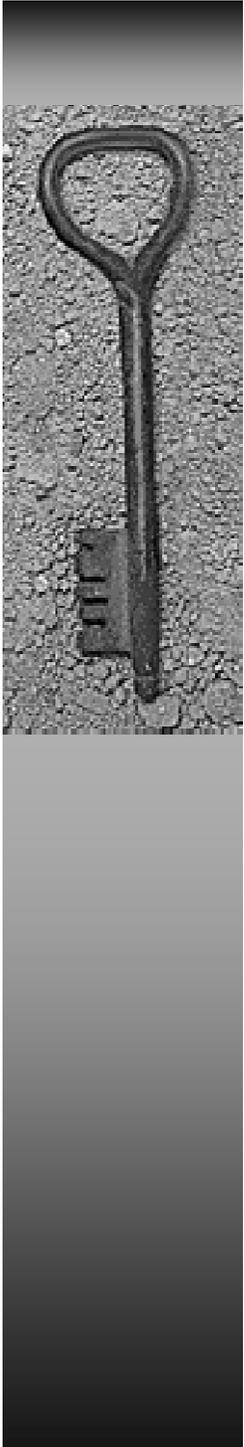
Professional and Scientific Status

- ◆ Population of patients
- ◆ Specialized body of knowledge and skills
- ◆ Scientific medical knowledge that is more detailed than other areas of certification
- ◆ Body of practicing subspecialist physicians
- ◆ Professional societies, Textbooks, Journals
- ◆ Active medical school and hospital departments

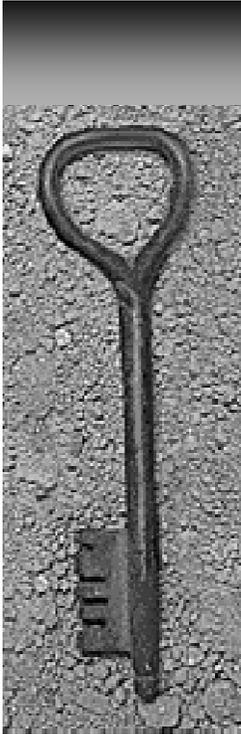


Complex Medically Ill (CMI)

1. Patients with an acute or chronic medical, neurological, or surgical illness in which psychiatric morbidity is actively affecting their medical care and/or quality of life.
2. Patients with a somatoform disorder or with psychological factors affecting a physical condition (“psychosomatic condition”), regardless of the presence or absence of a co-morbid medical illness;
3. Patients with a psychiatric disorder that is the direct consequence of a primary medical condition(s), as defined in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). e.g., Delirium, Dementia, “Organic”

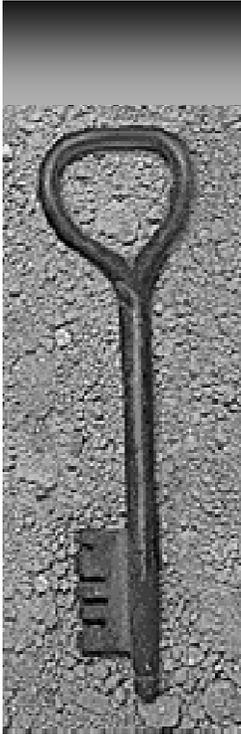


Why focus on these patients?



Premise

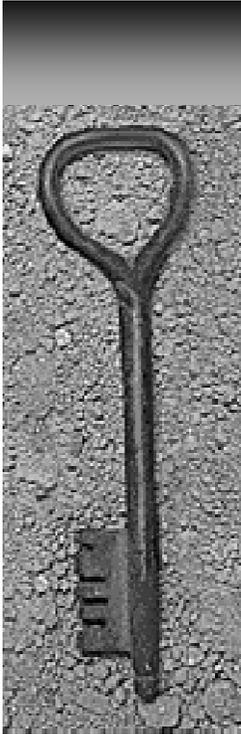
- ◆ Psychiatric morbidity common in CMI
- ◆ Psychiatric morbidity has serious consequences in this setting
- ◆ Treatment is effective and often reverses its consequences



Public health significance

- ◆ US population is about 280,000,000
- ◆ Prevalence of chronic mental illness: 3%
 - Schizophrenia, and other “psychotic” 2,800,000
 - Severe mood disorders (bipolar and unipolar) 4,200,000
- ◆ Milder disabling conditions, w/o co-morbidity: 4%
 - Milder depressions, OCD, etc. 11,200,000
- ◆ ABOUT 18,000,000 CASES

Estimates: US Census, ECA, National Comorbidity Study



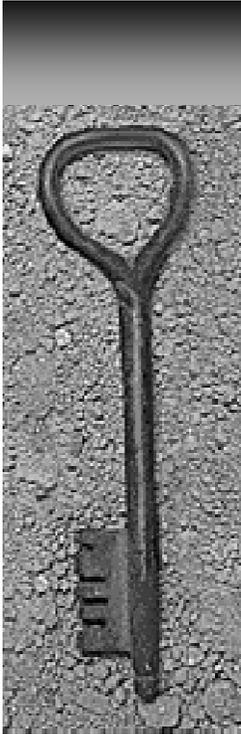
Public health significance

- ◆ US population is about 280,000,000

- ◆ Prevalence of chronic MEDICAL illness appr. 50,000,000
 - Heart disease 33,000,000
 - Stroke 21,000,000
 - Diabetes 16,000,000
 - Alzheimer's and other dementias 4,000,000
 - Many others with cancer, transplantation, end-stage renal disease, macular degeneration, HIV/AIDS, chronic pain

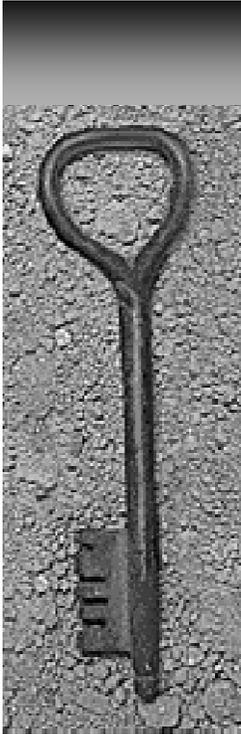
- ◆ 75% of above are chronic 32,500,000
- ◆ 25-30% have psychiatric disorders
- ◆ ABOUT 8-10,000,000 CASES

Estimates: US Census, Medical Outcomes Study



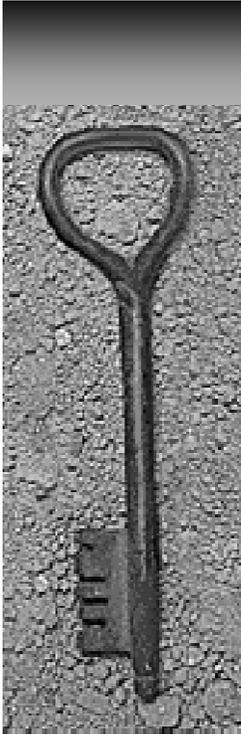
Domains of impact

- ◆ Intrinsic to being a “psychiatric case”
 - Mental suffering
 - “Dangerousness”
 - Frailty (e.g., weight loss, deconditioning)
 - Aggression
 - Suicide
- ◆ Functional outcomes
- ◆ Medical outcomes of the associated disease



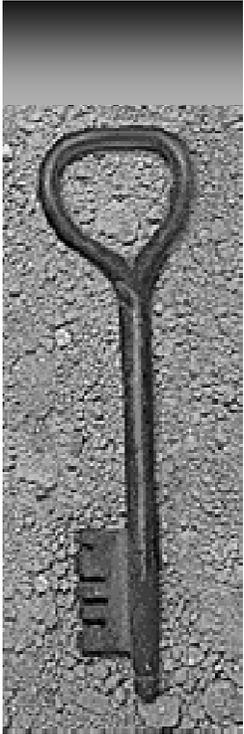
Conclusions

- ◆ Psychosomatic Medicine
 - The new growth field in psychiatry**
- ◆ Major public health importance
- ◆ The impact of psychiatric disorder on medically ill patients and medical illness is reversible
- ◆ Emerging insights into the pathogenesis of psychiatric illness
- ◆ Major challenges ahead in improving the evidence-base, service delivery, and education in the field



Come to APM Meeting in San Diego, November 19-23, 2003

- ◆ Celebrate 50 years of APM
- ◆ Inaugurate the new specialty
 - Great meeting
 - Big gala celebration
- ◆ Lovely weather in November



Thank you!

Ευχαριστω!