Medical psychiatry: The skill of integrating medical and psychiatric care

Paul Summergrad, MD

When I started to think about training in psychiatry, I was just completing my internal medicine residency at Boston City Hospital. As I interviewed up and down the east coast, programs often defined themselves as being 'biological' or 'psychodynamic.'

Although the meaning of these terms varied from department to department, *biologically oriented programs*—influenced by Eli Robins and Samuel Guze and DSM-III—were focused on descriptive psychiatry: reliable, observable, and symptom-based elements of psychiatric illness. Related and important elements were a focus on psychopharmacologic treatments, genetics, epidemiology, and putative mechanisms for both diseases and treatments. *Psychodynamic programs* had a primary focus on psychodynamic theory, with extensive training in long-term, depth-oriented psychotherapy. Many of these are programs employed charismatic and brilliant teachers whose supervisory and interviewing skills were legendary. And, of course, all the programs claimed they did everything and did it well.

However, none of these programs were exactly what I was looking for. Although I had a long-standing interest in psychodynamics and was fascinated by the implications of—what was then a far more nascent—neurobiology, I was looking for a program that had all of these elements, but also had a focus on, what I thought of as, "medical psychiatry." Although this may have meant different things to others, and was known as "psychosomatic medicine" or "consultation-liaison psychiatry," to me, it was about the psychiatric manifestations of medical and neurologic disorders.

My years training in internal medicine were full of patients with neuropsychiatric illness due to a host of general medical and neurologic disorders. When I was an intern, the most common admitting diagnosis was what we called "Delta MS"—change in mental status. As I advanced in my residency and focused on a subspecialty of internal medicine, it became clear that whichever illnesses I studied, conditions such as anxiety disorders in Grave's disease or the

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psychotic symptoms in lupus held my interest. Finally, the only specialty left was psychiatry.

The only program I found that seemed to understand medical psychiatry at the time was at Massachusetts General Hospital (MGH). MGH not only had eminent psychiatrists in every area of the field, it seemed, but also a special focus on training psychiatrists in medical settings and as medical experts. My first Chief of Psychiatry was Thomas P. Hackett, MD—a brilliant clinician, raconteur, and polymath—who had written a *cri de coeur* on the importance of medical skills and training in psychiatry.[1] At last, I had found a place where I could remain a physician and think and learn about every aspect of psychiatry, especially medical psychiatry.

What is medical psychiatry, and why is it relevant now?

There has been substantial and increasing interest in the integration of medical and psychiatric care. Whether it is collaborative care or co-location models, the recognition of the high rate of combined medical and psychiatric illnesses and associated increased mortality and total health care costs of these patients requires psychiatrists to be deeply familiar with the interactions among medical and psychiatric conditions.

Building on long-developed expertise in consultation-liaison psychiatry and other forms of medical psychiatric training, such as double-board medicine–psychiatry programs, medical psychiatry includes several specific areas of knowledge and skill sets, including understanding the impact that psychiatric illnesses and the medications used to treat them can have on medical illnesses and the ways in which the presence of medical disorders can change the presentation of psychiatric illnesses. Similarly, the psychiatric impact of the general medical pharmacopeia and the ways in which psychiatric illness can affect the presentation of medical illness are important for all psychiatrists to know. Most importantly, medical psychiatry should focus on the medical and neurologic causes of psychiatric illnesses. Many general medical conditions produce symptoms, which, in whole or in part, mimic psychiatric illnesses and, in some cases, could lead to psychiatric disorders, which makes identification of the underlying cause difficult.

Whether due to infectious, autoimmune, metabolic, or endocrinologic disorders, being aware of these conditions and, where clinical circumstances warrant, be able to diagnose them, with other specialists as needed, and ensure they are appropriately treated should be an essential skill for psychiatrists.

An illustrative case

I remember a case from early in my training of a woman with a late-onset mood disorder with abulia, wide-based gait, and urinary incontinence, in addition to withdrawal and loss of pleasure. Despite the skepticism of the neurology team, at autopsy she was found to have arteriosclerosis of the deep, penetrating arterioles causing white matter hyperintensities—Binswanger's disease. There was no question that despite the neurologic cause of her symptoms treating her depression with antidepressants was needed and helpful. It also was important that her family was aware of her underlying medical condition and its implications for her care.[2]

Medicine is our calling

Many of these illnesses, even when identified, require expert psychiatric management of psychiatric symptoms. This should not be surprising to psychiatrists or other clinicians. No one expects a cardiologist to beg off the care of a patient with heart failure caused by alcohol abuse or a virus rather than

vascular heart disease, and psychiatrists likewise need to manage psychosis due to steroid use or *N*-methyl-D-aspartate receptor antibodies as well as other causes. Pursuing this understanding is important from another perspective. As we consider other potential mechanisms for onset of psychiatric illness (eg, inflammation), our understanding of the mechanisms associated with general medical conditions may provide unexpected insight into the etiology of psychiatric illnesses where no general medical cause has been found. No other physician specialists are as attuned to the nuances of psychiatric illnesses, their typical and atypical presentations as psychiatrists. It is incumbent on us to pursue the medical differential of patients when we think it is needed, even if other physicians disagree.

Medical psychiatry has a broader and more inclusive perspective than what we generally mean by "biological psychiatry," if by the latter, we mean a focus on the neurobiology and psychopharmacology of "primary" psychiatric conditions that are not secondary to other medical or neurologic disorders. As important and fundamental as deep understanding of neurobiology, genetics, and psychopharmacology are, medical psychiatry embeds our work more broadly in all of human biology and requires the full breadth of our medical training.

At a time when political battles over prescriptive privileges by non-medically trained mental health clinicians engage legislatures and professional organizations, medical psychiatry is a powerful reminder that prescribing or not prescribing medications is the final step in, what should be, an extensive, clinical evaluation including a thorough medical work up and consideration of the medical–psychiatric interactions and the differential diagnosis of these illnesses. It is, after all, what physicians do and is essential to our calling as psychiatric physicians. If psychiatrists are not at home in medicine, as Tom Hackett reminded us in 1977[1]—at a time when psychiatry had temporarily eliminated the requirement for medical internships—then, indeed, psychiatry would be "homeless."

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