Editorial

Rethinking Medical Education About Mood Disorders

I teach medical students as well as residents. Every 2 months in the didactic portion of our Family Practice Clerkship, I spend 3 hours describing how one's approach to psychiatric illness must be different in primary care. We talk about how patients arrive in the exam room largely undifferentiated diagnostically and how proper assessment begins first with probing about symptoms. Then, as the context of the illness is ferreted out, more specific determinants of diagnosis become clear. I also take pains to describe the stress-diathesis theory of illness and ask these young doctors to take the widest possible lens into patient care, avoiding the judgment seat and the projection of one's own "normalcy" onto others who do not share similar families of origin, health beliefs, or psychosocial context, not to mention biological pedigrees and morbid diatheses.

Today, the response to my entreaties is mostly stunned amazement. The 19 or so listening digest with difficulty the news that not everyone is at risk for mood disorders, that stressors may time episodes of illness, but do not alone determine who gets sick. Particularly loathsome is my suggestion that borderline personality disorder is, as Akiskal has so well described, "an adjective in search of a noun."[1] Is it really possible to be *both* bipolar *and* borderline? Several students are sure I must be out of my mind. Only 15 years' head start in practice and 3 clinical cases dent the skepticism. My academic standing means little. After all, I'm just a family physician.

Resident physicians are more amenable to teaching in this regard. Having selected family medicine out of the other possible specialties, they seem more aware of complex presentations and the comorbidity of general medical and psychiatric conditions. They are more willing to hear my preaching—but not at first. For interns, anxiety about blood gas interpretation, ECG interpretation, potassium replacement, and advanced life-support algorithms drowns out a broader perspective. Only after several years and thousands of patient interactions does this new dawning become visible, the impracticality of mind-body dualism thus demonstrated. Once disenchantment with that failed paradigm takes hold (typically in the third year of residency), doctors about to be tossed out of the training nest are more willing to listen to messages of integration, alliance, and the family as the primary unit of patient care.

The audiences most receptive to this new paradigm are my colleagues engaged in day-to-day clinical practice. They are living the struggle resulting from a medical education bearing little relation to reality. At both accredited CME offerings and those pharmaceutical company–sponsored get-togethers, I am deluged with questions like "Why didn't they teach me this in medical school?" and statements like "Sounds like you've been sitting in my waiting room. I wish I had known this years ago."

It is clear to me that those in the trenches are listening to the "experts." In 1993, the list of the top 25 medications prescribed to Tennessee Medicaid patients contained not a single antidepressant—generic or otherwise.[2] (Diazepam and lorazepam were in the top 10.) Last year by comparison, 2 brand name antidepressants were in the top 10; 1 in the top 5.[3] Clearly, prescribing patterns have changed in Tennessee. I suspect we are not alone.

There are other evidences of change. *The Journal of Family Practice* recently (December 1999)[4] devoted an entire issue to publishing investigations funded by the MacArthur Foun-

dation about depression in primary care. The results of the investigations did not surprise me. One study described how primary care physicians actually demonstrate a very high rate of attention to psychosocial concerns and questioning about depression. Another documented the fact that antidepressants are effective treatments in many syndromes that are often comorbid or pseudonymous with depressive illness in clinical practice—headache, fibromyalgia, functional GI complaints, chronic fatigue, idiopathic pain, and tinnitus. One study suggested that teaching physicians a systematic approach to patient assessment might improve outcomes. Also not surprising was the finding that interested physicians can hone their skills through focused education, and it is this aspect of motivation toward clinical skills development that is the real, if not belated, point of my musings.

The Surgeon General has targeted mental health care for greater attention. Since primary care—much of it rural—is where the greatest percentage of this mental health care takes place, it follows that this clinical setting be the focus of much of the Surgeon General's attention. However, as Jack Geller has noted, "Conspicuously absent from most of these studies, commissioned reports and policy papers [of primary care and mental health] is the voice of the rural primary care provider."[5(p326)] In his report of a focus group of rural primary care providers, Geller describes the frustrations of clinicians treating sometimes severely affected patients. They are comfortable with the role of mental health care provider, though with anxieties about how they are stretched to provide care at the limits of their resources and expertise. They make use of midlevel providers to provide patients with "counseling," not "psychotherapy." There are feelings of animosity toward mental health specialists who are described as distant, different, and disinterested in providing feedback even to the physicians who are their referral sources. Though not expressly stated in the article, rural primary care providers evidenced a desire for peer respect, consultation availability, and continuing medical education that is clinically relevant.

Medical education about mental illness is very nearly backwards—"bassackwards" is the Southern expression. The students with the least motivation toward the material live closest to the medical schoolhouse, are bound by the threat of truancy, and learn from the patients with the least typical illness. Those with the greatest motivation to learn and who see the typical illness presentations either are too busy to come to school or live too far away. Since they find it difficult to come to us, we must go to them. By we, I mean clinician/teachers with useful information, but also with an attitude of meekness manifested by being teachable ourselves. That's the stuff of integration and alliance.

—J.S.M.

REFERENCES

1. Akiskal HS, Chen SE, Davis GC, et al. Borderline: an adjective in search of a noun. J Clin Psychiatry 1985;46:41–48
2. Tennessee Medicaid Drug Utilization Review Board Proceedings, Memphis, Tenn; March 1993
3. Tennessee Drug Utilization Review. Behavioral Health Drug Utilization Board Proceedings, Memphis, Tenn; December 1999
4. The Journal of Family Practice 1999;48:945–979
5. Geller JM. Rural primary care providers' perceptions of their roles in the provision of mental health services: voices from the plains. J Rural Health 1999;15:326–334