

**PROPOSAL FOR RECOGNITION OF “PSYCHOSOMATIC MEDICINE” AS A
PSYCHIATRIC SUBSPECIALTY**

Submitted to the American Board of Psychiatry and Neurology

On Behalf of

The Academy of Psychosomatic Medicine

The Association for Medicine and Psychiatry

With the support of

The American Psychiatric Association

The American Association of Directors of Psychiatric Residency Training

The American Academy for Psychiatry and the Law

The Association for Academic Psychiatry

The American Psychosomatic Society

The North-American Society for Psychosocial Obstetrics and Gynecology

The International Organization for Consultation-Liaison Psychiatry

The European Society for Consultation-Liaison Psychiatry and Psychosomatics

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II. EXECUTIVE SUMMARY

“The outcome findings, coupled with the quality of care data, reinforce the overall conclusion that improving the overall quality of care for patients with psychiatric disorders in the medical sector should be a major national priority.”

(Wells K, et al, 1994)

The need for the subspecialty of “Psychosomatic Medicine” (PM)

The Academy of Psychosomatic Medicine (APM) and The Association of Medicine and Psychiatry (AMP) are applying to the American Board of Psychiatry and Neurology (ABPN), and through it to the American Board of Medical Specialties (ABMS), for the recognition of **“Psychosomatic Medicine (PM)”** as a subspecialty field of psychiatry. This application is in response to the growing body of scientific evidence demonstrating the high prevalence of psychiatric disorders in patients with medical, surgical, obstetrical and neurological conditions, particularly for patients with complex and/or chronic conditions ("the complex medically ill"), and the critical importance of addressing these disorders in managing their care. PM psychiatrists would, therefore, constitute a group of individuals in psychiatry who have specialized expertise in the diagnosis and treatment of psychiatric disorders/difficulties in complex medically ill patients.

“Complex medically ill” are patients with active medical, neurological, obstetrical or surgical condition(s) or symptoms, who also meet one of the following criteria:

- 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. Examples include acute or chronic psychiatric patients with HIV infection, organ transplantation, brittle

diabetes, heart disease, renal failure, a terminal illness, cancer, stroke, traumatic brain injury, COPD, high-risk pregnancy, among others.

- Patients with a somatoform disorder or with psychological factors affecting a physical condition (“psychosomatic condition”), as defined in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (regardless of the presence or absence of a co-morbid medical illness); or
- 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).

The available evidence confirms the following:

- The number of individuals in the United States with complex or chronic medical, surgical, neurologic, or obstetrical conditions is growing rapidly with advances in healthcare, including improved detection of these conditions, wider availability of services, and better treatments, many of which convert previously fatal conditions into chronic conditions.
- Psychiatric disorders are highly prevalent in the medically ill, across all types of underlying medical, surgical, obstetrical or neurological conditions, and all care settings. This prevalence is even higher among patients with the complex conditions outlined above, in some cases approaching 50%. A wide range of psychiatric consequences has been reported in this context.

- Psychiatric disorders have a substantial impact on medically ill patients, by causing serious mental suffering, in addition to the physical suffering; functional disability, in addition to that caused by the medical illness; a greater likelihood of poorer adherence with medical treatments; a poorer prognosis of the medical illness; a greater likelihood of hospitalization or institutionalization; a greater likelihood of healthcare service use of all types; and a greater impairment in quality of life.
- Psychiatric disorders of all types are greatly under-recognized and under-treated by non-psychiatric physicians, resulting in considerable morbidity. There is also evidence that some psychiatric conditions are inappropriately diagnosed and treated.
- The recognition, treatment, or management of psychiatric disorders in the complex medically ill is most effective when practiced by psychiatrists who have special training and experience in the psychiatric care of these patients. Examples include post-stroke depression, cryptococcal meningitis presenting as mania, or retinitis presenting with visual hallucinosis.
- In this context detailed knowledge of the medical illness, its treatments and its prognosis, becomes an essential part of the patient's psychiatric care. The psychiatrist is often called upon to educate the patient and/or medical colleagues, and other members of the care team, about the interactions of psychiatric-medical illnesses. Psychiatric interventions in the medically ill often are complex requiring a detailed understanding of drug-drug interactions between psychotropics and other medications, as well as knowledge of the effects of psychiatric treatments on co-morbid medical conditions.
- Certain psychiatric disorders, namely delirium, dementia, psychological factors affecting physical conditions, somatoform disorders (especially chronic pain), and psychiatric

syndromes due to general medical conditions are central to the care of the medically ill and often require specialized expertise for their management. Finally, substantial numbers of medically ill patients have cognitive impairments that require recognition and specialized care of the patient.

Proposal for a new psychiatric subspecialty recognized by ABPN

Well over 2,500 psychiatrists in the United States provide care to complex medically ill patients as a large part of their day-to-day practice, in a variety of healthcare settings. Of these, about 810 are active members of the Academy of Psychosomatic Medicine, the national organization dedicated to the psychiatric care of the complex medically ill. Approximately 781 psychiatrists have completed subspecialty training in this area (191 before 1991, and 590 between 1991 and 2000). Subspecialty training in this area has been available for over 25 years

In recognition of the above, we propose recognition of “Psychosomatic Medicine” as a subspecialty field for Board Certified Psychiatrists. The first purpose of this recognition is to improve the psychiatric care of patients with complex medical, surgical, obstetrical and neurological conditions. The second purpose is to improve the quality of training in the 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. The third purpose is to further stimulate and support research and teaching in PM, a natural consequence of official subspecialty status.

This application is submitted on behalf of the Academy of Psychosomatic Medicine (APM), the leading national organization for psychiatrists who specialize in the care of the complex medically ill, and the Association for Medicine and Psychiatry (AMP) which has assisted in the coordination and organization of combined residencies in Psychiatry with several other medical fields, such as Internal Medicine, Family Practice, and Neurology. These two organizations reflect the depth and breadth of the field that is Psychosomatic Medicine, and of the growing numbers of trainees and practicing psychiatrists in the field. The APM is also one of the leading international organizations in this field. Recognition of Psychosomatic Medicine as a subspecialty field of psychiatry in the USA is likely to have substantial international impact, with other nations following suit in recognizing subspecialty status (see letters from international organizations in Appendix 1).

The recognition of a subspecialty field of Psychosomatic Medicine was endorsed by the American Psychiatric Association (APA) by action of its Board of Trustees in July of 2001. As well, other psychiatric subspecialty and allied organizations have supported this recognition (see letters in Appendix 1). This application has been considered carefully by these organizations, which concur that subspecialty status for PM will not adversely affect general psychiatrists. The supporting letters also indicate the international recognition of this subspecialty within psychiatry.

A similar application was submitted to ABPN in 1992 for the creation of a “Certificate of Added Qualification in Consultation-Liaison Psychiatry”. That application did not lead to subspecialty recognition for two apparent reasons. First, at the time the Accreditation Council for Graduate Medical Education (ACGME) had declared a moratorium on new medical

subspecialties. That moratorium has now been lifted. Second, the original application had been submitted for Added Qualifications in “Consultation-Liaison Psychiatry.” The ABPN had concerns that it was inappropriately defined by a procedure common to all psychiatrists (“consultation”) and a particular site of care (the general hospital), rather than being focused on a patient population.

The revised application has several differences from the original one:

- (1) The style and content of the application conforms to the published subspecialty requirements of the ABPN (ABPN Subspecialty Requirements) and the ABMS (Bylaws, Article X: Certification);
- (2) The name of the proposed subspecialty has been changed to “Psychosomatic Medicine” (PM). This has been done in order to emphasize the historical origins of the subspecialty field and its focus on a population of patients, the complex medically ill, rather than around the performance of a psychiatric procedure (“Consultation” or “Liaison”) or a specific site of care (e.g., the general hospital). Alternative names were considered for the field, including: “Medical-Surgical Psychiatry” and “Psychiatry of the Medically Ill.” The latter names might inaccurately imply that other areas of Psychiatry are not medical fields or that other psychiatrists are not qualified to treat medically ill patients.
- (3) There is detailed discussion of the potential effects that the awarding of subspecialty status to Psychosomatic Medicine would have on the practice of general psychiatry and of the other recognized psychiatric subspecialties.

This application proposes that ABPN and ABMS develop a subspecialty certification process and an examination for Psychosomatic Medicine. *Candidates for recognition as subspecialists*

would be Board Certified Psychiatrists who complete requisite training in an accredited fellowship. The Academy of Psychosomatic Medicine has already developed guidelines for Fellowship training in Consultation-Liaison Psychiatry (Appendix 2) and currently oversees the activities of 32 Fellowship programs (Appendix 3). It is anticipated that these Fellowships will revise their curricula to meet content requirements for the proposed “Subspecialty Certificate in the Psychosomatic Medicine”. In this process, the Academy of Psychosomatic Medicine and the Association of Medicine and Psychiatry will work with the Residency Review Commission for Psychiatry (RRC), with the Accreditation Council for Graduate Medical Education (ACGME), and with the appropriate other medical boards to develop guidelines for the requisite Fellowship and combined residency training programs.

Following the recognition of the subspecialty field there will be a five year “grandfathering” period, as has been the practice with previously approved subspecialties, to allow for the development of a fellowship curriculum, an accreditation process, and the initial accreditation of the new PM fellowships. During this period, and only during this period, psychiatrists who have completed existing Consultation-Liaison Fellowships OR Combined Residencies OR who have practiced Psychosomatic Medicine (Consultation-Liaison Psychiatry) as a major part of their clinical activity will be allowed to sit for the subspecialty examination.

Many such individuals will be members of the Academy of Psychosomatic Medicine. A July 2000 survey of a random sample of APM members indicated that 77% would apply for subspecialty certification if it were offered by ABPN. This suggests that at least 600 psychiatrists-APM members would sit for the examination in the first few years of available certification based on “grandfathering.” Further, since at least an additional 1,500 psychiatrists in

the USA practice C-L (PM) psychiatry on a regular basis, it is likely that a large portion would be eligible to apply for certification in the first few years. The Academy of Psychosomatic Medicine is committed to assisting the ABPN/ABMS in developing and administering certification examinations and in preparing eligible psychiatrists to take them.

The Association for Medicine and Psychiatry is composed of members representing many of the 48 combined residency programs (Appendix 3). While there are fewer graduates of these programs because they have only recently been formally approved by participating specialty boards, it is anticipated that many of the graduates of these programs will choose to identify themselves as specialists in Psychosomatic Medicine by sitting for the board examination during this grandfathering period.

After this initial grandfathering period, ***only candidates who have completed an accredited PM Fellowship will be allowed to sit for the examination.*** The APM and the AMP will work with the ACGME and the appropriate other medical boards to modify the curricula of existing and new Fellowships to ensure that trainees of these programs complete eligibility requirements for subspecialty certification in Psychosomatic Medicine.

The APM C-L fellowships and the combined residencies graduate approximately 110 (60 Fellowship and 50 Combined Residency graduates) trainees every year, all practitioners in the proposed subspecialty field of Psychosomatic Medicine. This number has been growing steadily over the past ten years, starting from about 80 per year in 1990 to the current number. With subspecialty designation and growth in clinical demand for individuals who specialize in complex medical patients with comorbid illness, it is anticipated that the number of individuals choosing to gain expertise in PM will increase in coming years. The vast majority of graduating

trainees from the combined residency programs will apply enter fellowship and sit the proposed subspecialty certification examination in PM.

This application meets the American Board of Psychiatry and Neurology (ABPN) Subspecialty Requirements, last revised by ABPN on July 22, 2000, as outlined below:

- (1) The application is being submitted by subspecialty organizations comprised primarily of ABPN certified psychiatrists, the Academy of Psychosomatic Medicine and the Association of Medicine and Psychiatry.
- (2) Evidence is provided in section III.3 and III.12 of this application—and supported in other areas of the application—that the subspecialty of Psychosomatic Medicine will not dilute the general fields of Neurology or Psychiatry and that the function cannot be equally met by members certified in general psychiatry.
- (3) The minimum number of physicians practicing in the field of PM psychiatry is more than 810 and may be as high as 1,500, as shown in section III.3.e. This is well above the minimum number of 500 for a psychiatric subspecialty set by ABPN.
- (4) The currently existing fellowship and combined residency training programs are distributed widely in all geographic regions of the United States (Section III.4 and Appendix 3).
- (5) The number of physicians continuously practicing in the field, as evidenced by the growing numbers of graduates of Consultation-Liaison Psychiatry fellowship training programs and of combined residencies of psychiatry with other medical specialties has continuously increased in the past ten years. For example, before 1991 there were 191

graduates and between 1991 and 2000 there were an additional 590 graduates of training programs.

- (6) There are several national societies dedicated to the field such as the Academy of Psychosomatic Medicine, the Association for Medicine and Psychiatry, the American Psychosomatic Society, and others (see Section III.3.f).
- (7) Academic degrees for candidates for certification in the PM subspecialty are identified in section III.8. A Medical Doctor or Doctor of Osteopathy degree is required, as is completion of an ACGME-accredited general psychiatric residency.
- (8) Minimum length of training in PM is one year at the Fellowship level. Training sequence, essentials and core competencies are specified in section III.5 and Appendix 2.
- (9) The proposed subspecialty is practiced entirely by physicians, as noted throughout this application.
- (10) There are currently in operation 32 PM (C-L) fellowship programs. There are likely to be as many as 50 fellowship training programs in PM psychiatry if subspecialty recognition is granted (see Section III.4). This is well above the minimum of 25 set by the ABPN.
- (11) There are at least 66 available training positions, and likely as many as 75 that will provide fellowship training in PM (C-L) psychiatry (see Section III.4). This is well above the minimum of 25 set by the ABPN.
- (12) An average of 59 trainees per year have graduated from C-L Psychiatry (PM) training programs in the past ten years, well above the minimum of 20 set by the ABPN. These

figures do not include the growing number of graduates from combined residency training.

- (13) Section III.12 provides objective evidence of the projected need for psychiatric subspecialists in Psychosomatic Medicine.
- (14) There are many more Fellowship programs in existence than the ABPN minimum number required. In addition, the application shows how this number of programs is likely to grow if subspecialty status is recognized for the PM field (Section III.6).
- (15) Faculty engaged in training of PM psychiatrists are regularly engaged in training and research in addition to clinical activities (see section III.3.e).

III. DISCUSSION OF THE APPLICATION LINKED TO ARTICLE X (SECTION 10.3.B) OF THE ABMS BYLAWS

1. NAME OF THE PROPOSED SUBSPECIALTY FIELD

The proposed field of certification is “Psychosomatic Medicine.” This name reflects the historical origins of the field and fact that it exists at the interface of psychiatry and medicine. It also alludes to the principal focus of the field, namely the psychiatric care of patients with complex and/or chronic medical, surgical, or neurological conditions (“medical illnesses”). Finally, both leading Journals in the field carry the name “Psychosomatic” as does the Academy of Psychosomatic Medicine that is the lead organization in this application.

“Complex medically ill” are patients with active medical, neurological, obstetrical or surgical condition(s) or symptoms who also meet one of the following criteria:

- 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. Examples include acute or chronic psychiatric patients with HIV infection, organ transplantation, brittle diabetes, heart disease, renal failure, a terminal illness, cancer, stroke, traumatic brain injury, COPD, high-risk pregnancy, among others.
- Patients with a somatoform disorder or psychological factors affecting a physical condition (“psychosomatic condition”), as defined in the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (regardless of the presence or absence of a co-morbid medical illness); or,

- Patients with a mental 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).

While general psychiatrists encounter patients with co-morbid medical illnesses on a regular basis, for most of these patients the co-morbid medical condition does not greatly complicate their psychiatric evaluation or treatment (and vice versa). However, for patients with complex and/or chronic medical illnesses, the comorbid general medical condition may complicate the psychiatric care. For example, in many complex patients, the medical illness is the cause or exacerbates the psychiatric disturbance (as with delirium, dementia, or secondary mental disorders). In others, somatization is at the center of the psychiatric morbidity. In a third group, the medical morbidity is chronic and severe and has complex interactions with the patient's psychological state, at the same time that the psychological state affects the outcome of the medical illness.

Psychiatric disorders frequently affect patients with complex medical illnesses (Appendix 4). In general, 30-50% (and at times as many as 70%) of patients with complex medical illness suffer from a comorbid psychiatric disorder. Most common are mood disorders, anxiety disorders, delirium, or dementia. A wide range of secondary psychiatric disorders has also been described. In select patient populations, such as patients with HIV or chronic pain, substance use disorders are frequent as well.

In individual patients with complex medical illnesses and psychiatric disorders, there is at times uncertainty about the etiology of the psychiatric condition. There is a need to disentangle the psychiatric disturbances that are secondary to the medical illness (or medications used for its

treatment) from those that are primary or “idiopathic.” Patients with chronic medical illnesses also develop characterologic traits and behaviors that are not commonly seen in general psychiatric practice and that require specialized knowledge to manage and treat.

In this context detailed knowledge of the medical illness, its treatments and its prognosis, becomes an essential part of the patient's psychiatric care. The psychiatrist is often called upon to educate the patient and/or medical colleagues, and other members of the care team, about the psychiatric-medical interactions. Psychiatric interventions in the medically ill often are complex requiring a detailed understanding of drug-drug interactions between psychotropics and other medications, as well as knowledge of the effects of psychiatric treatments on co-morbid medical conditions.

Certain psychiatric disorders, namely delirium, , psychological factors affecting physical conditions, somatoform disorders, dementia, and psychiatric syndromes due to general medical conditions are central to the care of the medically ill and often require specialized expertise for their management. Finally, substantial numbers of medically ill patients have cognitive impairments that require recognition and specialized care of the patient and caregiver.

It should be pointed out that the proposed field carries the name “Psychosomatic Medicine” while most of the training programs in the field currently carry the name “Consultation-Liaison Psychiatry.” It is intended, as will be evident in this proposal (Appendix 1 and elsewhere), that in the future fellowship training programs that wish to be accredited in this specialty field change their name and adapt their content to the training requirements that are developed by the ACGME. In fact, the training programs in question already provide the necessary training to their trainees so that any name change will have minimal impact on existing teaching practices.

In a recent survey, by APM, program directors unanimously accepted a proposed name change, in support of this application for subspecialty recognition. At the most recent meeting of the AMP (November, 2000), with most attendees being graduates of, or trainees in, combined training programs, AMP members definitively affirmed that that the concept and content of this proposal aptly describes the field which is the primary focus of their work and training.

2. PURPOSE OF THE NEW PROPOSED SUBSPECIALTY FIELD

The first purpose of the recognition of the subspecialty of “Psychosomatic Medicine” (PM) is to improve the psychiatric care of patients with complex medical, surgical, obstetrical and neurological conditions. These patients, regardless of the setting that they are in (e.g., general hospital, primary care, specialists’ offices, home health care, etc.) have significant psychiatric care needs and constitute a large psychiatrically underserved population. They generally receive no psychiatric care, or receive care from non-psychiatric physicians or allied professionals, neither of whom have sufficient training to deal with their complex presentations.

This primary goal will be accomplished by recognition of PM as one of the psychiatric subspecialties. This will draw greater attention to the complex psychiatric needs of the medically ill leading to efforts to improve their care. It will also improve the training of psychiatrists who care for medically ill psychiatric patients.

Subspecialty recognition will also lead to the expansion of successful medical-psychiatric care environments, such as outpatient conjoint medical-psychiatric clinics, inpatient medical psychiatric units, and the development of innovative new care environments that are most conducive to the care of medically ill patients with psychiatric disorders. These are organized care delivery service models that include the integration of psychiatric care provided by highly trained and qualified psychiatric subspecialists.

It should be noted that the non-approval of the application for Added Qualifications Certification in Consultation-Liaison Psychiatry in the early 1990s has had a significant negative impact on the training of qualified psychiatrists in this field. This underscores the difficulties of an essential subspecialty within psychiatry that has not been granted such a designation by the

ABPN/ABMS. Without such a formal designation, Health Care Financing Administration funding for such fellowship training is not available. This makes institutions reluctant to continue or develop training in this field. The number of C-L Fellowships has declined from 55 only five years ago to 32 at present. Fortunately, the number of psychiatry residencies combined with other medical fields has grown to 48 to compensate for this decline. This reflects how many trainees have opted for combined training in psychiatry and another medical field so as to obtain Board certification of their additional expertise in the psychiatric care of medically ill populations.

To empirically document the problems facing this subspecialty, all Consultation-Liaison fellowship programs were surveyed in June 2000. All 32 programs that presently offer Consultation-Liaison fellowship training responded. Trainees ranged from one to eight fellows per program. In total there were 52 fellows presently in training. The majority of program directors reported that applications had declined during the past five years, and many attributed this decline to the lack of formal subspecialty designation.

The funding sources for C-L fellowship programs varied but were often combinations of hospital support and some residency training funds with a few programs utilizing endowment funding. About half the programs were having trouble funding their fellowships. Three of the 32 programs were considering closing due to the lack of funding. Most of the directors reported that some applicants to these fellowships had decided to go to fellowships in subspecialties that were formally qualified and thus had lost such potential trainees, even though the trainees' first choice was to pursue a career in PM. The number of qualified applicants who chose other formally designated subspecialty areas was substantial, over 150 potential trainees over a five-year period,

or at least 30 per year. Furthermore, the lack of formal subspecialty status created major immigration visa problems for 21 of the programs that tried to recruit International Medical Graduates. Health and malpractice insurance coverage for fellows was compromised in five programs since there was no formal subspecialty status.

Non-medical allied fields have recognized this change and have begun the process of providing mental health care for complex medically ill patients. Health psychologists, hospital social workers, and psychiatric liaison nurses all have made valuable contributions to the care of medically ill patients with complex psychosocial and psychiatric problems. Their training differs substantially from that of PM psychiatrists. Health care systems may be tempted to substitute them for psychiatrists (who cost more). A shortage of qualified psychiatrists in the PM field makes this more likely.

This is not a unique concern. Throughout medical care there are pressures to replace physicians with less expensive, less trained professionals. Often, under the rubric of “behavioral medicine,” health psychologists have increasingly been providing care to patients with complex medical illness. Health Psychology is a section within the American Psychological Association, and is a subspecialty recognized by the American Board of Professional Psychology. Health Psychologists have moved into hospital settings, as well as ambulatory forums to work in areas of pain control, contingency management for improved compliance, and a wide variety of clinical roles that have traditionally been provided by physicians as represented by PM psychiatrists.

The second purpose of the recognition of the subspecialty of “Psychosomatic Medicine” (PM) is to improve the quality of training in the PM field. This will affect both subspecialists as

well as general psychiatrists. Subspecialty status will lead to improvement of existing national standards for subspecialty training in this area and for residency training of general psychiatry residents in this proposed subspecialty field. The Accreditation Council for Graduate Medical Education (ACGME) will, of course, continue to oversee these standards. Already psychiatric residents are required to undergo training in Consultation-Liaison Psychiatry (PM). The Academy of Psychosomatic Medicine developed this training curriculum. Subspecialty recognition for PM will increase the weight of these standards and improve the quality of the education for all psychiatrists in caring for medically ill patients.

An important result of the latter 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. Such psychiatrist-teachers already participate frequently in the education of residents of other specialties, especially primary care. Thus, improvements will result in the training of both psychiatric and non-psychiatric physicians in the care of the medically ill.

The third purpose of the proposal of the proposed subspecialty recognition of PM is to further stimulate and support research and teaching in PM, a natural consequence of official subspecialty status. As the field has been growing over the last 20-30 years, a core cadre of researchers and educators in the field has emerged. However, its numbers are still estimated to be rather small (2,500-3,000 nationwide) relative to the projected needs for the next few decades (See section III.12). The National Institute for Mental Health (NIMH) recognized this 15 years ago when it began a series of initiatives to develop more investigators among psychiatrists of the

complex medically ill. This has included a series of Research Development Workshops, presented annually at the meeting of the Academy of Psychosomatic Medicine.

The National Institutes of Health (NIH) has increasingly recognized in its funding allocations the large number of important research questions in the PM field. Subspecialty status will encourage young physicians to choose careers in this area and to become teachers and researchers in a burgeoning field of medical practice and inquiry. This is imperative in the face of increasing evidence regarding chronic medical conditions that are major public health problems.

To name just a few examples, it is now well established that depression is both a risk factor and a poor prognosticator in coronary artery disease. Depression and anxiety disorders compound the disability associated with stroke. Psychiatric disorders worsen the prognosis and quality of life of cancer patients. Psychiatric disorders are linked to non-adherence with anti-retroviral therapy, adversely affecting the survival of HIV-infected patients. Psychiatric disorders are also linked to non-adherence with “safe” sex and with use of sterile needles in injection drug users, thus having major public health implications.

3. DOCUMENTATION OF THE PROFESSIONAL AND SCIENTIFIC STATUS OF THE SPECIAL FIELD OF PSYCHOSOMATIC MEDICINE (PM)

The subspecialty field of Psychosomatic Medicine (PM) is practically and conceptually defined by three elements:

- The population which it serves;
- The ongoing development and application of a specialized body of knowledge and skills;

- The role it plays inter-relating psychiatry with other medical specialties.

In addition, the coherence of PM is documented by the existence of:

- A large cadre of clinicians, educators, and researchers in the field;
- A training infrastructure for new entrants to the field;
- Textbooks, books, journals, and other publications;
- National and international professional societies dedicated to this field.

This section discusses these elements in detail. It begins by an overview of the conceptual and practical foundations of the field and is followed by a discussion of its scientific basis, practitioners, and professional organizations.

The literature supporting these arguments is contained in Appendix 4.

a. The population served by Psychosomatic Medicine (PM).

PM serves patients with medical illnesses, particularly complex medical conditions, as previously defined in this application. These patients are encountered in general or chronic hospitals, in home healthcare settings, in the offices of primary care or specialist physicians, and in other healthcare environments (e.g., free standing clinics). Extensive research (see Appendix 4) documents psychiatric morbidity in these patient populations, the serious consequences of the psychiatric morbidity, and the benefits to patients and the healthcare system of having psychiatric care provided to these patients by highly trained psychiatrists, experts in the PM field.

These facts and the practices of PM are well documented in the most recent textbooks in the field by Stoudemire, Fogel and Greenberg's (Psychiatric Care of the Medically Ill), Rundell and

Wise's (Textbook of Consultation-Liaison Psychiatry), Cassem and colleagues' (The Massachusetts General Hospital Handbook of General Hospital Psychiatry), and by Stern, Herman and Slavin's (The MGH Guide to Psychiatry in Primary Care). This discussion will illustrate the population served by PM by focusing on the general hospital setting in which the field of PM developed. However, similar examples exist for PM patients in all other medical settings.

Patients in the general hospital have the highest rate of psychiatric disorders when compared to community samples or patients in ambulatory primary care. Compared to community samples, depressive disorders in the general hospital are more than twice as common, major depression two to three times as common, substance abuse two to three times as common and somatization disorder, more than 10 times as common. Delirium occurs in 18% of patients, a rate much higher than one would expect in the community.

These high rates of psychiatric disorders in the general hospital may result from several factors:

- Reactions to or complications from medical disorders or their treatments;
- A higher rate of medical co-morbidity among patients with psychiatric disorders due to psychophysiological factors (e.g. depression in cardiovascular disease);
- Unhealthy life styles among patients with psychiatric disorders (smoking, self-care neglect etc.);
- Disproportionately large use of medical services by persons with mental disorders, especially somatoform disorders.

The higher concentration of patients with psychiatric disorders in the general hospital provides a critical opportunity to identify and begin treatment for this important group of patients who might otherwise go undiagnosed and untreated. Huyse in the Netherlands has referred to the general hospital as a filter that can identify the high concentration of patients with psychiatric disorders. The patients who pass through its portals, need to be diagnosed, have treatment initiated, and then be referred to the longer term psychiatric care they would otherwise fail to receive.

Failure to identify, evaluate, diagnose, treat, or achieve symptom resolution results in significant adverse outcomes. Failure to treat is associated with poor or even dire outcomes. For example, depression, dementia and delirium, three common secondary disorders found in the general hospital are associated with worse medical outcomes and higher utilization of medical care, both in the hospital (over 30% longer lengths of stay), and after discharge.

Yet failure to treat occurs all too frequently. Less than one in five of patients with agitated delirium receive neuroleptic treatment in the hospital although it is the treatment of choice. According to Levkoff, this failure to treat is all the more significant in view of the findings that only 17% of patients with new onset delirium in the hospital are free of symptoms of delirium six months after discharge. According to Rogers, patients with delirium are significantly less likely to improve in function, compared to patients without delirium. Delirium is also associated with worse outcomes after surgery, even after controlling for severity of medical illness. When delirium is unrecognized and untreated in the hospital, it results in unnecessary placement in nursing homes instead of discharge to home.

Patients with depression who are not diagnosed and do not have treatment begun during their medical hospitalization have only an 11% chance of receiving treatment for their depression in the year following discharge. Untreated depression is associated with higher medical utilization after hospital discharge and with higher mortality and morbidity in coronary disease, hypertension, diabetes and strokes.

Despite the evidence showing the importance of the identification and initiation of treatment of psychiatric disorders in the general hospital (and in primary care settings), in the absence of an active on-site PM Service, the rate of referral to psychiatry is distressingly low. While the incidence of psychiatric disorders in the general hospital has been reported as 30-40 %, the rate of psychiatric referral is 1-2%. The referral rate rises to 8-14% when an active PM Service is integrated with the medical/surgical staff in collaborative programs to identify and initiate treatment for psychiatric disorders. In other words, the referral rate for psychiatric disorders in the general hospital increases 4 to 10 fold.

In addition to the psychiatric disorders in medical-surgical patients in the general hospital described above, some patients with specific medical illnesses have higher rates of psychiatric comorbidity. These patients may require psychiatric evaluation and treatment that would not be available in the absence of PM Services working closely with their medical and surgical colleagues.

Dialysis patients experience difficulties in adjusting to dialysis, such as placement of the shunt, dependence on a machine, multiple needle sticks, and blood circulating outside their bodies. Problems with compliance must be dealt with since failure to adhere to a strict diet or a

need for frequent dialysis can be fatal. Delirium and dementia may result from the dialysis itself. Depression is common, and independently predicts a lower survival rate.

Organ transplant programs all require psychosocial evaluation of transplant candidates, with psychiatrists playing a vital role pre- and post- transplant. Psychopathology adversely affects patients during the long wait for an organ. Even relatively minor disruptions in compliance with immunosuppressant medication may result in graft rejection and death. Delirium during the postoperative period can be especially severe. Psychopharmacologic treatment in transplant patients is particularly complicated. Most general psychiatrists are unfamiliar with the immunosuppressant medications used in these patients, and their implications for the development and treatment of psychiatric disorders. Transplantation programs typically require ongoing expert psychiatric collaboration, as they select transplantation recipients. PM psychiatrists additionally manage the complex post-transplant psychiatric morbidity that not only adversely affects life quality but also interferes with medical and surgical management.

Cancer patients may need psychiatric intervention at all stages of disease. Specialized problems include chemotherapy-induced delirium, conditioned nausea and vomiting, CNS paraneoplastic and metastatic syndromes, antiemetic akathisia, and neuropsychiatric complications of radiation therapy and bone marrow transplantation. PM psychiatrists play a leading role in pain management and palliative care.

PM services working in collaboration with oncology services help address the psychiatric morbidity frequently seen in this setting. Psychiatric expertise is often required to help patients deal with the process of death and dying in terminal illness. It is also required at times to address the traumatic impact of a cancer diagnosis. For example, psychiatric care is invaluable in cases

of acute leukemia that abruptly convert a previously healthy individual, through a devastating series of tests and treatments such as bone marrow transplantation, into a patient teetering precariously between remission and life, or failure and death.

HIV/AIDS patients present special diagnostic and treatment challenges for psychiatrists, including both acute (e.g., mania, delirium, psychosis) and chronic syndromes (e.g., apathy, dementia, depression) that may be caused by the HIV virus itself, opportunistic infections, neoplasm, or antiviral drugs. Psychiatric disorders are associated with non-adherence with behaviors that limit the spread of HIV and with treatment using antiviral drugs. This has profound implications for both the treatment of the HIV/AIDS patient and the population at large. Serious psychopathology and substance abuse are greatly over-represented in HIV patient populations. PM psychiatrists, including members of the Academy of Psychosomatic Medicine, have developed a range of programs that provide care for patients with HIV/AIDS and recently developed a Practice Guideline for the Care of Patients with HIV/AIDS (*American Journal of Psychiatry*, November 2000 issue).

Many other specialized patient populations are a focus of care by PM psychiatrists. Space does not permit a full listing, but illustrative examples include post-cardiac surgery delirium; anxiety syndromes in patients with defibrillators, balloon pumps, and other cardiac assist devices; psychosocial issues in infertility programs; and psychopathology caused by neurologic diseases like stroke, traumatic brain injury, multiple sclerosis and Parkinson's disease.

Appendix 4 contains a recently published database of papers and studies illustrating the depth and breadth of the PM field.

b. The application of a specialized body of knowledge and skills

All board-eligible psychiatrists trained in accredited residencies receive several months of training in Consultation-Liaison Psychiatry (PM) as part of their general training. PM psychiatrists receive additional training in fellowships or in combined medicine-psychiatry residency, or have acquired extensive experience by devoting a significant portion of their professional lives working with psychiatric disorders among patients in medical-surgical settings. They acquire added clinical expertise and specialized knowledge in the following areas:

- Psychiatric complications of medical illnesses;
- Psychiatric complications of medical treatments, especially medications, new surgical or medical procedures, transplantation, and a range of experimental therapies;
- Typical and atypical presentations of psychiatric disorders that are due to medical, neurological, and surgical illnesses;
- How to evaluate and manage delirium, dementia, and secondary (“organic”) psychiatric disorders;
- How to evaluate and manage somatoform disorders, and chronic pain;
- How to assess the capacity to give informed consent for medical and surgical procedures in the presence of cognitive impairment;
- How to provide non-pharmacologic interventions, such as cognitive-behavioral psychotherapy, interpersonal psychotherapy as well as focused, short term psychotherapy in patients suffering the effects of complex medical disorders or their treatments;
- Indications for, and use of, psychotropics in specific medical, neurological, obstetrical, and surgical conditions;

- Interactions between psychotropic medications and the full range of medications used for a variety of medical and surgical conditions.

In addition to the above knowledge, PM psychiatrists develop additional educational and systems skills that are essential to the process of case finding and the subsequent treatment of co-morbid psychiatric conditions in the medical settings. These include:

- How to collaborate with other physicians, and other members of the multidisciplinary treatment team;
- Teaching other physicians and other members of the multidisciplinary team how to recognize and respond to various psychiatric disorders;
- How to lead an integrated psychosocial health care team in the medical setting.

All psychiatrists graduating from accredited training programs are exposed to these generic skills in introductory training in PM psychiatry. However, the psychiatrist with advanced training in PM has more specialized knowledge and more developed skills for the diagnosis and management of the broad range of psychopathology seen in the medically ill. These might include the post-surgical patient with a hip replacement whose agitation may cause dislocation of the prosthesis, or the myocardial infarction patient who insists on continuing his regimen of vigorous push-ups before his scar has fibrosed sufficiently to prevent aneurysm formation.

PM psychiatrists have also been active in elaborating and refining the skills required in the medical setting by assessing clinical outcomes in research studies. These efforts have been recognized and supported by the National Institute of Mental Health (NIMH) and the American Psychiatric Association (APA). For example, in 1984, The Biometry and Clinical Application

Branch of the Division of Biometry and Applied Sciences at NIMH, in collaboration with the APA launched an initiative to encourage methodologically sound research on outcomes in PM Psychiatry.

The rapid growth and evolution of outcomes research examining PM followed this. Studies documenting the frequency and impact of psychiatric co-morbidity on medical outcomes and cost of care were followed by large randomized controlled intervention trials. These studies demonstrated that psychopathology worsens outcome and dramatically increases costs, and that psychiatric intervention improves the quality of care and cost effectiveness. Ironically, during the same period these studies were demonstrating the value of PM, managed care diverted many of these patients with both medical and psychiatric illnesses away from psychiatric subspecialists. As Sturm & Wells noted in 1995, “the trend away from mental health specialty care and toward general medical provider care under current treatment patterns reduces costs, worsens outcomes, and does not increase the value of health care spending in terms of health improvement per dollar.”

These findings emphasize the clear advantages for case-finding and treatment outcomes by PM services composed of subspecialists who have the skills to interact with medical staff. Katon and his collaborators have shown in their analysis of intervention outcome studies that the PM psychiatrist needs to effect significant structural change in the way the medical team delivers care if case finding and treatment are to demonstrate significant improvements in outcome. These conditions can only be consistently met by psychiatrists in the PM subspecialty working in a wide range of medical, surgical, neurological, and obstetrical settings, including general hospitals, specialty or primary care clinics, nursing homes, etc..

Government endorsement of the subspecialty field of Psychosomatic Medicine has already been accomplished in some European countries. The Department of Health in Belgium funds PM staff positions based on agreed upon staff-bed ratios. The Secretary of Health in The Netherlands has also budgeted resources for PM programs based on similar predetermined ratios.

c. The role PM plays in interrelating psychiatry with other branches of medicine

While the PM subspecialty field has, from its earliest beginnings, acted as a liaison between Psychiatry and Medicine, this function was formalized at the national level by an initiative of the Psychiatry Education Branch of the NIMH in 1975. After an exhaustive review of psychiatry residency training programs, the Branch determined that an organized, sustained effort was required to strengthen the relationship between Psychiatry and the rest of Medicine. It defined Psychosomatic Medicine (at the time called Consultation-Liaison Psychiatry) as the appropriate subdivision of Psychiatry to accomplish this objective.

Teaching grants were provided to services that:

- Trained psychiatry residents in PM so that future psychiatrists would develop competence and confidence working with their medical colleagues in medical settings like the general hospital;
- Trained medical students in the basics of the psychiatric aspects of medical care so that future generations of physicians would view the field of psychiatry objectively, without stigma and learn how to utilize psychiatric services for their patients;
- Taught primary care practitioners about psychiatric aspects of medical care to reduce stigma, and enhance the collaborative care of their patients with psychiatrists. These objectives delineated by the NIMH remain core functions of PM Psychiatry.

Several additional examples of how PM psychiatry promotes positive relationships between psychiatry and other medical fields include:

- PM psychiatrists train non-psychiatric residents, particularly residents in internal medicine, family practice, pediatrics, gynecology, and neurology;
- PM psychiatrists provide collaborative care delivery for patients with complex medical illnesses. For example, they screen, evaluate and treat candidates for gastric bypass, transplantation recipients, patients with neurological disorders, patients with high-risk pregnancy, and cancer patients;
- PM psychiatrists assist with the development of practice guidelines that are widely cited and used for patients with co-morbid illness. For example, the Agency for Health Care Policy and Research (AHCPR) Guidelines for Depression in Primary Care, the AHCPR Cancer Pain Management Guideline, and the APA Guidelines for Delirium and HIV/AIDS were developed by teams led by and/or “heavily laden” with PM psychiatrists;
- PM psychiatrists advance psychiatric diagnosis and nosology, such as the role of PM psychiatrists in the development of the primary care version of DSM-IV (DMS-IV-PC), and in the revisions in diagnostic criteria used in DSM-IV for secondary psychiatric disorders;
- PM psychiatrists provide continuing medical education. For example, PM psychiatrists are developing model psychiatric curricula for the American Society for Clinical Oncology, and the National Cancer Center Network. As well, PM physicians play a significant role in teaching about psychiatric disorders at annual meetings of the American College of Physicians, the Society for General Internal Medicine, the American Association for Family Practice, the American College of Obstetrics and Gynecology, and others.

- PM psychiatrists also have played leading roles on medical center ethics committees, contributing specialized expertise regarding end of life decisions, capacity/competency, involuntary treatment, boundary violations, and other doctor-patient relationship problems. PM psychiatrists have served as chairs of hospital ethics committees far out of proportion to their numbers.

d. The scientific medical knowledge underlying the area that is more detailed than that of other areas in which certification is offered (see also Appendix 4)

The existence of the field of Psychosomatic Medicine as a separate subspecialty discipline within psychiatry, rests upon the specialized knowledge base it has developed regarding psychiatric aspects of medical illness. This body of knowledge is extensive and has been summarized in recent textbooks: Stoudemire, Fogel and Greenberg's Psychiatric Care of the Medically Ill; Rundell and Wise's Textbook of Consultation-Liaison Psychiatry; Cassem and colleagues' The Massachusetts General Hospital Handbook of General Hospital Psychiatry; and Stern, Herman and Slavins' The MGH Guide to Psychiatry in Primary Care. There are also many, more specialized PM texts as listed in Appendix 4.

In addition, numerous Journals are active in the field, including: Psychosomatics, Psychosomatic Medicine, The International Journal of Psychiatry in Medicine, General Hospital Psychiatry, Journal of Psychosomatic Research, Journal of Psychooncology, and Journal of Psychosocial Oncology, Advances in Psychosomatic Medicine, International Journal of Psychosomatics, Journal of Behavioral Medicine, Journal of Psychosomatic Obstetrics and Gynecology, Medicine and Psychiatry, Psychophysiology, Psychotherapy and Psychosomatics,

Sociology of Health and Illness, and *Stress Medicine*. These have a combined US circulation of over 20,000.

We have included in Appendix 4 a recent comprehensive bibliography of books and articles that reflects the breadth of specialized knowledge of PM, as well as a recent report of the Center for Mental Health Services on PM.

By way of overview, this body of knowledge contains information on:

- The nature and extent of psychiatric morbidity in medical illness and its treatments, as exemplified by the widely cited RAND Corporation study on depression and disability in primary care;
- The impact of comorbid psychiatric disorders on the course of medical illness, as exemplified by the association between depression and mortality after a myocardial infarction;
- The understanding of how and why patients respond to illness in the way they do, as exemplified by the work of Pilowsky on abnormal illness behavior and its management;
- The knowledge of how to provide the most appropriate treatment interventions for co-existing psychiatric disorders in the medically ill, for example the work of Robinson on the treatment of depression after stroke and the work by Rummans on the use of electroconvulsive therapy (ECT) in very ill medical patients;
- The psychological and psychiatric effects of new medical or surgical therapies, such as the development of depression after treatment of multiple sclerosis with interferons or the psychiatric consequences of coronary artery bypass surgery;

- Data on the economic aspects of psychiatric illness and its treatment in medical disease, for example the work by Katon on the recognition and treatment of depression in primary care;
- Knowledge of the nature and factors that influence the doctor patient relationship, as exemplified by the evidence that psychiatric morbidity is a major determinant of non-adherence in HIV/AIDS and post-transplantation.

Although integrated to some degree into the core knowledge of general psychiatry, much of the context of the PM field remains separate. This body of knowledge is sufficiently large that it is only relatively briefly summarized in general psychiatry textbooks. In addition, the growth of PM knowledge has been quite impressive in recent years. Much of the new knowledge of PM is presented at specialized meetings (for example the annual meetings of the Academy of Psychosomatic Medicine and the American Psychosomatic Society—see Appendix 5 for a recent annual meeting program of the APM).

PM knowledge is also published in the field's specialized journals (see above). General psychiatrists are able to keep up with broad and significant developments in the PM field, and this serves them well in the day-to-day care of straightforward medically ill patients with co-morbid medical and psychiatric illnesses. However, as with any other distinct subspecialty field within psychiatry, general psychiatrists find it difficult to keep up with all developments in the PM field and, therefore typically rely on PM psychiatrists to care for more complex medically ill patients.

Similarly, physicians in other fields of medicine, who often take care of less complex medically ill patients with psychiatric co-morbidity, do not have the time, knowledge base, or

full skills to address the needs of these complex patients and call upon their PM colleagues to assist.

Of note is that in recent years, the American Psychiatric Association has called upon PM psychiatrists to summarize aspects of the body of knowledge of the PM field in the development of Practice Guidelines. The APA Practice Guidelines for Delirium and HIV/AIDS have been developed under the leadership of PM psychiatrists (Trzepacz, Breitbart, Levenson, McDaniel, Goodkin, Lyketsos, and others). In addition, PM psychiatrists are playing a major role in the development of practice guidelines for terminally ill (Chochinov-Breitbart-Schuster: APM Position Paper for End of Life Care).

Scientific origins and foundations of the PM field

Psychiatric care of the medically ill has developed a rich body of knowledge (as summarized by Levenson, 1999—Appendix 4). Its historical roots stem from a number of scholarly and scientific lines of inquiry. Freud's investigations of conversion disorder set the stage for our modern understanding of somatoform disorders. Pioneers in physiology began the scientific study of biological and physiological correlates of emotion, e.g., Cannon and the fight/flight response: Wolff & Wolff and studies of gastric secretion. Pavlov explored the field of conditioning of both the voluntary and autonomic nervous systems.

Flanders Dunbar and Franz Alexander studied personality traits as risk factors for physical illness; current studies of hostility and Type A behavior in coronary artery disease grew out of this tradition. Holmes and Rahe studied the role of life change promoting illness. Modern research fields such as psychoneuroendocrinology and psychoneuroimmunology evolved out of

these earlier areas. While many of the current investigators are not psychiatrists, their work informs psychiatric interventions in the medically ill.

Scientific influences in PM also come from advances in clinical epidemiology, neuroscience, psychopharmacology, and psychotherapy and behavioral research. Clinical epidemiology studies in PM include the investigation of psychiatric illnesses as risk factors for medical morbidity and mortality. Many have led to controlled intervention trials now underway. Neuroanatomical research has delineated the relationship of specific central nervous system (CNS) lesions to psychiatric symptoms following stroke and traumatic brain injury.

Psychopharmacologic studies tell us how to make drug treatment safe in patients with complex medical illnesses, who are also taking multiple medications. Psychotherapy research has been extended to investigate the efficacy of behavioral interventions in both general medical conditions as well as the somatoform disorders

Research areas

Initially research at the interface of medicine and psychiatry focused on a narrow range of “psychosomatic” disorders. Psychosomatic Medicine is now involved with a wide, ever-expanding spectrum of investigations looking at the medical illness-psychiatry relationship. Important contributions have occurred in AIDS, cancer, transplantation, cardiac, neurological, pulmonary, renal and GI disease, and obstetrics-gynecology. In each of these areas first generation studies identified the extent and nature of psychiatric morbidity associated with the most common diseases or hospitalization itself. More sophisticated second generation cross-sectional epidemiological studies established the prevalence rates of a broader range of psychiatric disorders in the earlier studied illnesses, as well as less common, or newly recognized

disease states. These studies have defined, for example, the complex presentations of depression in the cancer patient, the psychiatric features of several paraneoplastic syndromes, and the post-traumatic stress disorder of receiving a life-threatening diagnosis. This body of knowledge has also described the association between depression and interferon treatment, as well as the problems with fatigue, pain, sexual disorders and quality of life in breast cancer.

In some cases, a new body of research has extended our knowledge about genetic, neurochemical, and behavioral factors contributing to the development of psychiatric disorders among complex medically ill populations. This work has shown that many different mechanisms are involved. Examples include the relationship between the location of stroke and major depression, or between childhood sexual abuse and chronic pain syndromes. This has, in turn, led to more rational intervention studies focused on reducing the rate of occurrence of these disorders. Successful programs which reduce post-cardiotomy delirium, and other forms of “ICU delirium” are examples.

Of long-standing interest to the PM field has been the relationship between emotional factors and disease development. Recent studies have demonstrated the dramatic impact of coexisting psychiatric morbidity in specific medical illness on the course or outcome of these diseases. For example, depression has been shown to increase the risk of recurrence and mortality from myocardial infarction (Glassman & Shapiro), to increase the risk of stroke more than twofold in hypertensive patients (Simonsick), to worsen glycemic control in diabetic patients (Lustman), to increase physical aggression or functional dependency in Alzheimer patients (Lyketsos), and to double the mortality of stroke patients (Morris)

These findings illustrate the powerful influence of psychiatric co-morbidity on the course of medical illness. Studies have now been extended to examine their effect on health costs. Co-morbid psychiatric disorders have been shown to increase the length of hospital stay and re-hospitalization rates in numerous illnesses. Several cost-effectiveness studies have demonstrated the value of PM interventions in hospital and outpatient populations.

e. Information on the group of physicians concentrating on the practice of Psychosomatic Medicine

In an effort to estimate the level of PM activity among psychiatrists in the United States, the Academy of Psychosomatic Medicine sent a questionnaire to a random sample of 1,000 members of the American Psychiatric Association in 1991. According to estimates based on this survey, about one-quarter of psychiatrists had some practice in the Psychosomatic Medicine. However, most devoted a relatively small proportion of their time to such activity, leaving about 7.5% for whom PM was a major professional focus. Extrapolating from this random sample, it was estimated that approximately 1,000 members (3%) of the APA spent at least 50% of their time on PM clinical work, and an additional 1,500 (4.5%) spent between 25% and 50% of their time on such work.

This survey also showed that about 10% of APA members regularly provided consultation-liaison/PM services, and many engaged in teaching and research in the PM field. Psychiatrists based in general hospitals and medical schools spent more of their time in consultation-liaison/PM activities than those in private practice. Consultations involved both inpatients and outpatients, but the former comprised over 60% of the patients seen.

A survey conducted in 1996 by the American Psychiatric Association found that almost 10% of academic psychiatrists were doing research in PM psychiatry. Federal funding for this type of research comes from several divisions within the National Institutes of Mental Health. The Health and Behavior Research Branch of the Division of Basic Sciences funded most grants relevant to the PM field. Grants were also awarded by the Mood, Anxiety and Personality Disorders, the Mental Disorders in the Aging, and the Child and Adolescent Branches of the Division of Clinical Research.

In 1992, 15 PM projects were funded by the NIMH for a total of nearly 4 million dollars. This represented roughly 8% of the amount awarded to psychiatrists by this agency for that year. In the mid 1980's, the Biometry and Clinical Applications Branch of the Division of Biometry and Applied Sciences sought to stimulate outcome research in consultation-liaison psychiatry, and this branch has since funded several projects. Funding is also available through a number of private foundations.

The major US organization dedicated to the PM field, the Academy of Psychosomatic Medicine (APM) currently has approximately 810 psychiatrist members, a number that has remained essentially stable for the last 5-10 years. In addition, other organizations with a focus on PM have significant numbers of psychiatrist members: the Association of Medicine and Psychiatry with 133, the Society for Liaison Psychiatry with 135; the North American Society for Psychosomatic Obstetrics and Gynecology with 200; the Association for Academic Psychiatry Consultation-Liaison Section with 150; the American Association for General Hospital Psychiatry with 174, the American Neuropsychiatric Association with approximately 800; and the American Psychosomatic Society with 339. Thus, at a minimum, assuming some

overlap in organization membership, there are well over 2,500 psychiatrists and perhaps as many as 3,000 for whom the practice of Psychosomatic Medicine is a central part of their day-to-day activities.

Information from the membership logs of the APM suggests that PM is practiced widely in all states and all geographic regions of the USA, with a higher concentration in larger cities and around tertiary care general hospitals. The latter pattern is typical of the geographic localization of medical subspecialists..

f. Information on the national societies whose principal interest is in Psychosomatic Medicine

The *Academy of Psychosomatic Medicine* is the only national psychiatric organization primarily dedicated to Psychosomatic Medicine. The APM currently has approximately 810 members, all of whom are psychiatrists. The APA has also implicitly recognized the importance of the PM subspecialty by having provided a seat to the APM in the APA Assembly for the past seven years. The APA Board of Trustees has also recently provided the APM with a seat on its Joint Commission for Government Relations (JCGR). As well, APM and its members form the driving force in APA's Committee on Consultation-Liaison Psychiatry, part of the APA Council on Psychiatric Services.

APM members have a broad range of backgrounds and practice settings, including general hospital, community hospital, primary care, academic, and healthcare administration. APM publishes a medical journal, *Psychosomatics*, with a circulation of approximately 3,000, published every other month by the American Psychiatric Publishing Group. The APM also sponsors an annual scientific and educational meeting every November dedicated to PM.

Attendance has averaged approximately 350 attendees from all US geographic regions and many other countries (over twenty at the November 2000 meeting). A sample of the annual meeting's scientific program for the year 2000 is provided in Appendix 5.

During its annual meeting the APM presents a series of awards for distinguished accomplishments in PM, including Lectureships, Visiting Professorships, Research Awards, and others. The APM also honors its more distinguished members with Fellowship status, with approximately 10-15 new APM Fellows inducted every year. APM also awards up to five William Webb Fellowships annually to promising young psychiatrists pursuing careers in the PM field. The Webb Fellows are provided mentors in PM within the Academy and are also provided financial support to attend the Academy's annual meeting for two years. The APM, through its fellowship committee, also oversees all the C-L training programs nationwide.

The *Association of Medicine and Psychiatry*, another national organization composed of 133 members in addition to nearly 100 members-in-training, was created to improve the care of patients with combined medical/surgical and psychiatric illness, to support improved communications between physicians in non-psychiatric and psychiatric specialties, and to advance knowledge about and the treatment of psychiatric illness in the non-psychiatric setting through research, patient advocacy, and improved access to care in both medical/surgical and psychiatric settings.

It is different from the APM because it allows non-psychiatrist physician membership by those interested in treatment of patients with co-morbid illnesses. While the organization has a number of members who have training only in psychiatry or in another medical discipline, it is

largely composed of physicians who have completed combined training programs. For this reason, it is complementary to the APM.

The AMP and its members have been instrumental in moving combined residencies from an informal process with uncertain and inconsistent results to the point of being formally approved after meeting specific requirements by the specialty boards of Psychiatry and Neurology, Internal Medicine, and/or Family Practice.

Finally, the AMP and its members constitute a group singularly able to address the needs of the sickest of medical/surgical/psychiatric patients. It has been a leader in assisting in the creation of new treatment settings, such as medical psychiatry units and clinics, which greatly improve the ability of both psychiatrist and non-psychiatrist physicians to evaluate and treat patients with complicated, interactive illness. Such programs take Psychosomatic Medicine to the next level in which the specialists involved do not just consult but assume control of the care of both the medical and psychiatric aspects of patient care, instituting and coordinating treatment to maximize benefit.

The APM and AMP collaborate regularly and closely. For several years, they have convened their annual meetings in the same space at contiguous times. The AMP publishes a journal, *Medicine and Psychiatry*, a quarterly newsletter, and holds an annual meeting. Members of the AMP share ideas about the care of patients with concurrent medical/surgical and psychiatric illness through an active Listserve.

Other national societies (see previous section for psychiatric membership) with considerable involvement of PM psychiatrists include the:

- American Association for General Hospital Psychiatry;

- Society for Liaison Psychiatry;
- North American Society for Psychosomatic Obstetrics and Gynecology;
- Association for Academic Psychiatry, Consultation-Liaison Section;
- American Society for Psychosocial and Behavioral Oncology and AIDS;
- American Neuropsychiatric Association;
- American Psychosomatic Society.

There are also several international psychiatric organizations dedicated to the field of PM, all with close links to the Academy of Psychosomatic Medicine:

- European Society for Consultation-Liaison Psychiatry and Psychosomatics.
- International Organization for Consultation-Liaison Psychiatry;
- World Psychiatric Association Section of General Hospital Psychiatry;
- International College of Psychosomatic Medicine;
- International Neuropsychiatric Association;
- International Psychooncologic Society.

g. Information on medical school and hospital departments, divisions, or other units in which the principal educational effort is in the Psychosomatic Medicine (PM)

A survey conducted by the American Hospital Association in 1984 found that nearly 900 hospitals had Consultation-Liaison Psychiatry services. In 1997, a nationwide survey of 355 “general medical and surgical” hospitals was conducted by Worley et. al. using the 1996 AHA Guide to the Health Care Field. All 70 University Health System Consortium (UHC) hospitals

were included in the survey. Out of all 355, 184 hospitals identified themselves as having consultation-liaison (PM) psychiatry services (52%). As of 2001, there are 32 consultation-liaison psychiatry fellowship programs that have provided information to the Academy of Psychosomatic Medicine (Appendix 3). As well there are 48 combined residencies in Psychiatry/ with Internal Medicine/Family Practice/Pediatrics/ Neurology (Appendix 3). All accredited psychiatric residencies are required to provide Psychosomatic Medicine (C-L) experience to their trainees.

4. INSTITUTIONS PROVIDING RESIDENCY AND FELLOWSHIP EDUCATIONAL PROGRAMS IN PSYCHOSOMATIC MEDICINE (PM)

Appendix 2 contains requirements for and a model curriculum for Fellowship training in C-L Psychiatry and for Psychiatry Residencies Combined with several other medical fields. Appendix 3 contains a list of operating C-L Fellowships and of Combined Residencies. Advanced training in consultation-liaison psychiatry is available through 32 fellowship programs. These programs are widely distributed throughout the United States, in 16 states in all geographic regions (Northeast, Mid-Atlantic, South, Midwest, Southwest, and Northwest). About half of the available fellowships offer one year of training after completion of four years in general psychiatry; the other half offer an optional second year. At the present time, funding for fellowships comes mostly from hospitals, with lesser amounts from patient fees, government and private grants, and medical schools.

Fellowship programs in the United States currently offer 65 positions annually. Before July 1991, 191 fellows had completed training in consultation-liaison psychiatry. Subsequent to that, between 1991 and 2000 an additional 590 fellows graduated, an average of almost 60 per

year. Given that the proposed application is for a subspecialty named “Psychosomatic Medicine” (PM), we have sought and obtained the support of the Fellowship Committee of the Academy of Psychosomatic Medicine, and of the existing C-L fellowships, for a change of name in the fellowships should subspecialty recognition be granted (Appendix 1 for letter of support).

Another approach to obtaining special expertise in the PM field, has been through combined residencies in Internal Medicine and Psychiatry (23 programs [includes 2 military]), Family Medicine and Psychiatry (13 programs [includes 3 military]), Neurology and Psychiatry (2 programs) and Pediatrics, Psychiatry, and Child Psychiatry (10 programs). These joint training programs currently account for nearly 10% of the U.S. medical school graduates choosing psychiatry for specialty training. In the past three years alone, 156 applicants have entered these residency programs through the National Residency Match Program.

5. THE DURATION OF THE CURRICULUM OF FELLOWSHIP EDUCATIONAL PROGRAMS IN PSYCHOSOMATIC MEDICINE (PM)

This section contains a discussion of residency and fellowship training in PM. The PM training already in place during residency is reviewed briefly with greater detail in Appendix 6. Fellowship training in C-L Psychiatry, as it currently is being provided, is discussed in greater detail later in this section. It is anticipated that the existing fellowship curriculum will form the foundation for a training curriculum for fellows in PM. The proposed subspecialty certificate in PM would be awarded after the completion of an accredited fellowship, similar to the one described in this section. The final guidelines for fellowship training in PM will be developed by the ACGME in collaboration with the APM and the AMP. After the grandfathering period,

graduates of combined residencies will be eligible to sit for the PM subspecialty certificate examination **only if they also complete a PM Fellowship** accredited by the ACGME.

Guidelines for accreditation of fellowship programs with the capacity to award PM board eligibility status will be determined by the ACGME with the assistance of the APM and AMP.

a. Training during psychiatric residency

The Accreditation Council for Graduate Medical Education (ACGME) mandates training in consultation-liaison psychiatry (PM) as part of residency training in general psychiatry.

Supervised consultation-liaison experience is listed among the essentials of accredited residencies. At the present time, psychiatric consultation or PM services exist at most university hospitals throughout the country. Services in academic centers and many major hospitals are involved in the education of psychiatric residents and medical students. However, because the PM field has expanded, only limited exposure can be provided during general psychiatry residency. Historically, fellowships have been developed so that the field can be covered in sufficient depth for residents who wish to focus on this area.

The program requirements for residency training in psychiatry have recently been revised. Recommended changes became mandatory January 1, 2001. In the new curriculum guidelines, two months full-time (or its equivalent) must be spent on C-L (PM) services (detailed in Appendix 6). One month of pediatric consultation-liaison psychiatry may be credited toward one month of the 2-month requirement.

b. Advanced training in consultation-liaison psychiatry, the existing name for PM

Standards for consultation-liaison fellowship training were developed by the Academy of Psychosomatic Medicine, which established a committee to review programs for compliance with these standards. (See Appendix 2 for these Guidelines for Consultation-Liaison Fellowship Training). Programs desiring committee approval are encouraged to make application for review to the Academy. To date, twelve programs have been reviewed and have met the standards for fellowship training. Once a subspecialty recognition of PM is established, the Accreditation Council for Graduate Medical Education will accredit these programs, and the Academy will discontinue its review program.

c. Curriculum of existing fellowship training programs in consultation-liaison psychiatry which will form the basis of fellowship training in Psychosomatic Medicine (also Appendix 2)

A competency-based curriculum has existed in consultation-liaison psychiatry for over 15 years. This framework forms the basis for the fellowship programs that currently exist in the United States. Trainees who complete approved fellowships are expected to demonstrate the following core competencies:

- Advanced knowledge of abnormal behavior and psychiatric illnesses that occur among medical, neurological, obstetrics-gynecology and surgical patients;
- Knowledge of the biological, psychological and social factors that influence the development, course and outcome of medical/surgical diseases;
- Expertise in the diagnosis and treatment of psychiatric disturbances that occur among the physically ill, including the administration of psychotropic medication to seriously ill patients;

- Advanced skills in providing consultation in medical and surgical settings;
- Ability to facilitate and enhance the care of psychiatric disturbances among the physically ill through cooperative interaction with medical and allied health colleagues;
- Ability to effectively supervise medical students and residents performing consultations and to teach medical and surgical colleagues about psychiatric complications of physical illness; and
- Ability to critically evaluate knowledge and new research in the field.

Fellows in consultation-liaison psychiatry are usually assigned to a consultation service where they have clinical responsibility throughout their training. They function under the direct supervision of psychiatrists who have special training and experience in consultation-liaison psychiatry. During a portion of their time, fellows rotate on a variety of medical services or units (e.g. organ transplant unit, medical psychiatry unit, oncology service, HIV/AIDS) for more concentrated exposure to the psychiatric aspects of one illness or group of illnesses.

There they are expected to engage in the evaluation and treatment of psychiatric disturbances and to advise the medical team concerning the psychosocial aspects of physical illnesses and treatments. As part of their training, they assume responsibility for teaching medical students and residents. Fellows are also expected to participate in a didactic program, including regular conferences (e.g. work rounds, grand rounds, case conferences), courses, and seminars on various topics in consultation-liaison psychiatry, and to receive regularly scheduled supervision (e.g. caseload supervision, individual supervision). In addition, they are expected to undertake individual study, library research (e.g. individual reading, literature reviews, preparation of manuscripts for submission), or data-based research projects. (See Appendix 2).

Advanced training in consultation-liaison psychiatry is currently provided by fellowships that are one or two years in length. A one-year fellowship provides supervised exposure to and intensive study of several areas, such as psycho-oncology, psychiatric manifestations of AIDS, psycho-nephrology, psychiatric care of trauma patients, and organ transplant psychiatry. It permits the development of liaison activities on specific services. One year of training also makes possible review of the epidemiology, neurosciences, neuropharmacology and other topics as they relate to the PM field. In addition, it provides the PM psychiatrist with teaching and administrative skills, as well as an appreciation of research methods in PM. An optional second year may include research and further concentration on a particular area.

Residency training prepares general psychiatrists to provide routine care to uncomplicated medically ill patients. However, mastery of specific area of knowledge within consultation-liaison psychiatry (e.g. psychonephrology, psychooncology, AIDS, psychiatric aspects of neurologic disease, psychiatry of high risk pregnancies etc.) requires fellowship training.

Likewise, the psychiatric skill and knowledge needed for subspecialists who assume responsibility for the cooperative management of acutely and severely ill medical and surgical patients is extensive and ever increasing. Considerable work in intensive care units with trauma victims, brain injured patients, transplant recipients, etc. is necessary for proficiency in this area. Academic psychiatrists who assume responsibility for the teaching of psychiatric residents and students also require fellowship training in order that their trainees may receive high quality, up-to-date instruction.

6. THE NUMBER AND TYPE OF EDUCATIONAL PROGRAMS THAT CAN BE DEVELOPED FOR THE PSYCHOSOMATIC MEDICINE (PM)

As of July 2000, there are 32 Fellowship Training Programs in Consultation/Liaison Psychiatry. In addition, 23 Fellowships in C-L Psychiatry closed between 1991 and 2000. The APM has been in touch with these programs, many of which closed due to the lack of subspecialty recognition for the PM field. Several of these 23, perhaps half, are likely to reinstitute their programs should Subspecialty Certification be forthcoming (see letters in Appendix 1 from former training directors in these programs).

The Task Force developing this application has also been in contact with academic departments of psychiatry nationwide that have never before had fellowship training in C-L but that have strong programs in PM or Neuropsychiatry (see Appendix 1). It is anticipated that 5-10 additional fellowship programs might be developed if Subspecialty Certification in PM is forthcoming (examples include Johns Hopkins, Grady Memorial/Emory in Atlanta, Western Psychiatric Institute and Clinic [University of Pittsburgh], and the University of Pennsylvania). Thus, in total, it is anticipated conservatively that there would be at a minimum: 32 existing fellowships; reinstitution of an additional 12 fellowships of the C-L Fellowships that closed; and 5 completely new fellowships.

7. THE COST OF THE REQUIRED TRAINING IN PSYCHOSOMATIC MEDICINE (PM)

The costs of current fellowship programs consist primarily of the salaries of the fellows. Eighty percent are currently paid for directly by teaching hospitals, with more than two-thirds of those paying 100% of the salary costs. Training grants, other government or foundation support, and/or clinical revenues support the remainder. While there are costs associated with faculty

time, at most programs the services provided by fellows offset faculty costs, as fellows assist faculty in providing clinical care, teaching, research, and service, while learning these skills at an advanced level. ***Approval of subspecialty status for PM would not increase costs at any of the existing programs.*** At some it might reduce costs to Psychiatry departments by making fellowships eligible for Medicare training dollars. For example, in many states, an ACGME accredited fellowship at the PGY-5 level brings substantial Medicare funds into the training institution, above and beyond the cost of the fellow's salary. New fellowships (including restarting previously existing fellowships) would require new salary support for the additional fellows, but the same mix of support sources used by current programs can be expected.

8. THE QUALIFICATIONS OF APPLICANTS FOR SUBSPECIALIZATION IN PSYCHOSOMATIC MEDICINE (PM)

Applicants must be certified in psychiatry by the American Board of Psychiatry and Neurology (ABPN). During a “grandfathering” period of five years, psychiatrists who have completed fellowship training in consultation-liaison psychiatry, psychiatrists who consider themselves PM psychiatrists by virtue of the time and effort they have devoted to practice at the interface of psychiatry and medicine, and graduates of an approved Psychiatry Residency Combined with Internal Medicine, Family Practice, Pediatrics, or Neurology may sit for the PM board examination. After the “grandfathering” period, candidates must have satisfactorily completed an approved fellowship in Psychosomatic Medicine. The Review Committee in Psychiatry of the American Council on Graduate Medical Education will become the accrediting body for PM Fellowships and Combined Residencies, in collaboration with the appropriate medical boards involved in certification of the Combined Residencies. A Credentials Committee

will be appointed by the ABPN/ABMS/ACGME and this committee will review the credentials of applicants for certification.

Time-limited certificates of PM subspecialty qualification will be issued. Re-certification will be required after ten years and diplomate status in psychiatry with the ABPN will always remain a requisite for re-certification.

9. PROPOSED SCOPE AND METHOD OF EVALUATION OF CANDIDATES FOR SUBSPECIALIZATION IN PSYCHOSOMATIC MEDICINE (PM)

The directors of ACGME accredited PM Fellowships will evaluate the knowledge and skills of candidates for a subspecialization in Psychosomatic Medicine to certify satisfactory completion of a program. Satisfactory completion of an ACGME accredited PM fellowship will be required. These skills and qualities will be evaluated in conformity with the Residency Review Committee in Psychiatry guidelines.

Candidates will then be required to successfully complete a one-day multiple choice examination that is administered in a secure and proctored manner. This examination will be developed by the ABPN and will cover the entire field of Psychosomatic Medicine.

Several of the Academy of Psychosomatic Medicine senior members already have developed a very large bank of questions. Theodore Stern, MD has published a widely respected and cited book (Psychiatry: Boards Preparation and Update) with questions geared to the field and annotated answers. As well, there are study guides with questions for the Rundell and Wise Textbook of Consultation-Liaison Psychiatry. Many members and Fellows of APM also have considerable test-writing experience for USMLE, ABPN, and PRITE and will volunteer for writing questions for the proposed examination. The certificates will indicate that the diplomate

has met the requirements of the ABPN and will be designated as having Subspecialty Certification in the Psychosomatic Medicine.

10. COPY OF THE PROPOSED APPLICATION FORM TO BE USED BY CANDIDATES FOR SUBSPECIALIZATION IN PSYCHOSOMATIC MEDICINE

Appendix 8 contains a copy of the proposed application.

11. OBJECTIONS TO THE PROPOSED SUBSPECIALIZATION IN PSYCHOSOMATIC MEDICINE BY PRIMARY AND CONJOINT BOARDS HAVING EXPRESSED RELATED INTERESTS IN CERTIFYING THE SAME FIELD

The Academy of Psychosomatic Medicine is aware of no effort by other Boards to develop certification in the field of Psychosomatic Medicine or in a closely related field. Therefore, at this time, there are no objections to address.

12. PROJECTED NEEDS AND EFFECTS OF THE NEW SUBSPECIALTY FIELD OF PSYCHOSOMATIC MEDICINE ON THE EXISTING PATTERNS OF GENERAL PSYCHIATRIC PRACTICE

a. Needs projection

The needs projections presented here are based on estimates of the population of patients with complex medical conditions on a nationwide basis. The healthcare field is rapidly expanding its ability to detect, evaluate, and treat patients with a wide range of medical conditions. There is an increasing number of individuals with chronic and severe medical diseases. Estimates from the National Center for Health Statistics, the Centers for Disease Control, and the National Institutes of Health indicate the following numbers of living patients with individual conditions:

- Heart disease 33 million
- Renal disease 6.4 million
- HIV/AIDS 900,000, with 50,000 new cases per year
- Cerebrovascular disease 21 million,
- Brain injury 5-7 million, with 500,000/year new head injuries requiring hospitalization
- Hypertension 96 million
- Cancer 10.7 million new cases per year

These individuals now live longer and must follow more complex medical regimens. The prevalence and impact of psychiatric disorders on these rapidly increasing numbers of patients is substantial. Thus, the patient population of PM psychiatry is growing, and is likely to expand further. These patients will be faced with substantial stress related to their medical condition and to their efforts to live normal lives despite their condition. The literature (Appendix 4) suggests that 25-30% of the above patients *who come to medical attention* may meet the definition of complex medically ill psychiatric patients put forth in this application. This means that as many as 8-10 million complex medically ill psychiatric patients are alive today. This number may be much larger. If a PM psychiatrist can care for 2,500 (conservatively) patients with complex medically ill patients, this would suggest that 3,200 PM psychiatrists are needed. This is a very conservative estimate.

An alternative estimate can be derived from the number of acute care beds. Fink and Oken have reported that 1 full-time PM psychiatrist is needed for every 300-350 acute care beds. Assuming approximately 483,000 acute care beds in the USA (source: National Center for Health Statistics), this would *conservatively* estimate a current need for about 1,380-1,610 *full-*

time PM psychiatrists. If to this is added the growing need for PM psychiatrists in primary and specialty care, 3,200 remains a conservative estimate. Existing psychiatrists in the field are far too few to adequately address the needs of this overlooked population.

b. Effects on existing patterns of practice

No negative effects of the new subspecialty field on the existing patterns of general psychiatric practice are anticipated. The support of the APA for the C-L/PM subspecialty field supports this. In fact, on balance the PM subspecialty is likely to have a positive impact on the practice of general psychiatry.

First, PM psychiatrists and general psychiatrists care for different patient populations. While general psychiatrists encounter patients with comorbid medical illnesses on a regular basis, the vast majority of these patients do not have chronic or complex medical conditions. As a rule, general psychiatrists are reluctant to assume responsibility for the continuing follow up care required to treat acute disorders in the general hospital or in primary care. Generalist psychiatrists typically welcome the existence of PM psychiatrists who can assume these responsibilities. Most general psychiatrists, because they do not routinely evaluate and treat patients who are hospitalized or with serious medical illness, welcome the existence of PM subspecialists in general hospitals and in the community. They often also collaborate with them in providing care. In addition in academic settings coverage is provided for psychiatric emergencies in the general hospital by specialists in PM and by psychiatry residents and fellows training in the field. Thus, in situations where their patients do overlap, PM psychiatrists offer welcome additional expertise to general psychiatrists in the care of these generally difficult patients.

Second, PM psychiatrists increase the identification of previously underserved patients who are in need of psychiatric care. While many of these patients are complex and require ongoing care by a PM psychiatrist, many, perhaps as many as one third, are not complex and are referred by PM psychiatrists to general psychiatrists. Thus, in this way, the practice of PM psychiatry serves as a means of getting proper ongoing *general* psychiatric care for otherwise unidentified patients.

Third, subspecialty recognition for Psychosomatic Medicine is likely to improve the quality of training in the PM field overall. This will affect both subspecialists as well as general psychiatrists. Subspecialty status will lead to the further improvement of existing national standards for subspecialty training in this area and for residency training of general psychiatry residents in this subspecialty field. Thus, improvements in the training of both psychiatric and non-psychiatric physicians in the care of the medically ill will result.

Fourth, there is already a substantial minority of general psychiatrists who dedicate large parts of their practices to the Psychosomatic Medicine. Subspecialty recognition for the PM field would offer these psychiatrists the opportunity to have their additional expertise recognized. This in turn is likely to have beneficial effects on patient care, and on the ability of these psychiatrists to compete for resources for their patients and for themselves.

In discussions prior to the submission of this application, concerns were raised by the American Association of Geriatric Psychiatry (AAGP) regarding overlap between geriatric psychiatry and PM. Discussions between AAGP and APM are ongoing about finding ways for subspecialty recognition of PM not to impact adversely on geriatric psychiatry. APM and AAGP both recognize that the two subspecialty fields, while having areas of overlap, are fundamentally

distinct, and that the distinctions can be articulated adequately. AAGP has had substantial positive input into the development of this application, Given current needs and projections, the growth opportunities for both fields are substantial so that recognition of PM as a subspecialty field is in fact likely to lead to growth of both PM and geriatric psychiatric, with a resultant benefit to the patients served by subspecialist psychiatrist sin both fields.

The proposed subspecialty recognition of PM will not have an adverse effect on most other psychiatric subspecialties or subfields .The reasons are similar to the above regarding general psychiatry. The patient populations dealt with by PM psychiatrists have very limited overlap with that of other psychiatric subspecialty areas. Some degree of overlap exists, as already exists between existing recognized subspecialties. However, it is anticipated that the addition to the field of a new coherent, professionally, and scientifically recognized subspecialty area can only enhance the overall practice of psychiatry as already detailed in this application.

IV. APPENDICES

Appendix 1: Letters of endorsement supporting this application

Appendix 2: Current training guidelines for psychiatrists in “Psychosomatic Medicine”, including C-L Psychiatry and Combined Programs

Appendix 3: Listing of existing training programs in C-L Psychiatry and of Combined Psychiatry Residencies with other medical specialties

Appendix 4: Bibliography and key papers reflecting the breadth and extent of specialized knowledge in the Psychosomatic Medicine (PM)

Appendix 5: Scientific program of the most recent annual meeting of the Academy of Psychosomatic Medicine (APM)

Appendix 6: Outline of required training relevant to the Psychosomatic Medicine in accredited psychiatric residencies

Appendix 7: Sample application for certification in the subspecialty field of Psychosomatic Medicine (PM)

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