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Modernizing Psychiatry Training for Neurologists—From Off-Service to In-Service

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Off-service training (clinical experiences in which a trainee is embedded in a service other than their primary specialty) in psychiatry for neurology residents has been a long-standing requirement of the Accreditation Council for Graduate Medical Education (ACGME).¹ The ACGME mandates neurology residents complete 1 month of full-time clinical experience in psychiatry without further specification. Neurology is the only field besides psychiatry with mandated psychiatry training. This requirement is a reflection of the shared history of neurology and psychiatry, the pathophysiologic overlap of brain disease, and the frequency of psychiatric comorbidity among individuals with neurologic disease.^{2,3} However, the current model of psychiatry training does not meet the needs of neurology trainees with the majority of neurology residency graduates underprepared for providing psychiatric care in routine neurologic practice.⁴

The current model of off-service rotations is a common feature of graduate medical education. Internal medicine residents must complete 1 month of emergency medicine, psychiatrists complete 2 months of neurology, and so forth. However, this model has been critiqued. Trainees are often assigned to sites based on workforce needs rather than educational value.² The incongruity between service and trainee needs is worsened by the lack of operationalized learning objectives, rotator-appropriate didactics, and longitudinal continuity of training.²

While there are national milestones in psychiatry for neurology training programs, there is no operationalized guidance regarding the clinical and didactic experiences that align with these objectives. The ACGME Milestones for neurologists emphasize understanding the interplay between neurologic and psychiatric disorders and addressing psychiatric symptomatology.¹ This emphasis, coupled with feedback of neurology residency graduates seeking psychiatric training relevant to their practice setting, suggests the need for a curriculum focused on assessment and management of psychiatric symptoms and conditions

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common in neurologic settings and emphasizing cross-disciplinary collaboration and novel models of care.

Both the format (1-month off-service) and the content (general psychiatry without emphasis on practice-relevant medical knowledge or models of care) of psychiatry training for neurologists need modernization. Neurology residents would benefit from psychiatry training that (1) uses educational best practices emphasizing repetition and applicability, (2) reinforces the interconnections between neurology and psychiatry, and (3) provides exposure to integrated care. Such training is critical to ensure neurologists can meet the clinical needs of patients with neuropsychiatric disorders, function effectively in modern health systems, and strengthen the connection between neuroscience and clinical neurology.

The current 1-month psychiatry model inserts neurologists into a clinical frame oriented around patients with psychiatric conditions that are not the most common in the neurologic setting, often emphasizing consultation-liaison and inpatient psychiatry despite an identified need by trainees for more outpatient psychiatry training with neurology-relevant patients.⁴ In addition, the 1-month rotation does not reflect educational best practices, failing to build on prior training, address educational goals, or allow for longitudinal development of skills.^{2,4} From a pedagogic perspective, strategies suggested^{2,3} to improve off-service training—longitudinal experiences, targeted didactics, and interdisciplinary collaboration—have not been deployed in a systematic way despite a desire for such training. There is as striking incongruity between the goal of equipping neurologists to manage psychiatric manifestations and comorbidities of neurologic disease in a neurologic care setting with 1 month of isolated psychiatric training in a psychiatric setting.

In addition to their pedagogic pitfalls, isolated 1-month psychiatry training experiences reinforce the siloing of neurology and psychiatry. Under the aegis of clinical neurosciences, the adage of neurology as the field of the brain and psychiatry as the field of the mind is outdated. There is an immense need to expand care for disorders at the clinical borderlands of psychiatry and neurology such as dementia and functional neurologic disorders. Furthermore, as the mechanistic understanding of neurologic and psychiatric disease increases, the vestigial disciplinary lines are further dismantled by shared pathophysiologic features. Many diseases traditionally considered purely neurologic or psychiatric such as epilepsy, movement disorders, psychotic disorders, and mood disorders are now understood to have significant neuropsychiatric components. To that end, neuroscience makes little distinction between psychiatric and neurologic pathology and operates in an integrated framework.³

A holistic brain health paradigm requires neurologists have fluency across domains of brain (dys)function, including psychiatric domains. This paradigm shift has inspired calls for neurology and psychiatry residency training to be entirely or partially merged.³ Reconceptualization of the fundamental training pathway for neurologists and psychiatrists may not align with the realities of clinical practices, but reconfiguring “off-service” training offers a solution. Rather than an isolated experience, psychiatry training for neurologists could better match the trajectory of the field by serving as a “minor” area of specialization

that is longitudinal throughout residency and aimed at empowering neurologists to meet the first-line psychiatric needs of patients with neurologic disorders.

Training models in which neurologists provide (neuro) psychiatric care to longitudinal clinic patients with psychiatrist super-vision and collaboration may especially reflect future practice environments. Recently, models of integrated care have become a prominent part of the health care landscape. Such models privilege population-level, measurement-based approaches using alternative payment and accountability structures to promote interdisciplinary care. Models of integrated mental and physical health care such as the collaborative care model have become de rigueur in large care systems. Providing integrated care requires an array of skills not traditionally taught to trainees including measurement-based care using validated instruments, advanced communication and coordination skills, and direct patient care under indirect specialty consultants.⁵ Approaches to integrate medical care have already begun to include neurology in domains such as dementia.⁶ Psychiatry training for the modern neurologist must entail both the ability to triage and treat relevant psychiatric illness and also to practice effectively in novel systems. Implementing models of collaborative neurology-psychiatry service delivery in training settings can prepare learners to operate in future-facing models of care and allow for longitudinal comanagement of and learning about psychiatric disorders.

The inadequacy of current psychiatry training for neurologists represents an opportunity for improving not only this training, but for challenging the off-service rotation paradigm more broadly. The core guidelines we recommend in reconfiguring psychiatry training for neurologists likely apply across disciplines.

Tailoring Training to Appropriate Settings of Care and Patient Populations

Psychiatry training needs to be built around meeting the psychiatric needs of patients encountered in neurologic care settings. Example: Rather than neurologists learning from psychiatrist-specific didactics, nationally disseminated e-learning curricula provide an opportunity for “psychiatry for neurologists” curricula shared between programs, as is being developed for psychiatrists’ neurology training needs.⁷

Ensure Clinical Training Is Situated Within Appropriate Systems of Care

Neurologists should develop core skills to deliver care within integrated care models and psychiatry training should reflect that. Example: Embedded psychiatry residents in neurology clinics serving as peer educators/indirect consultants to guide neurologists in managing the psychiatric comorbidities of their clinic patients. This model leverages the integrated care training needs of psychiatrists.

Make Training Longitudinal

Ongoing learning, use of skills, and supervision is a key component of developing practicable clinical skills. Example: Longitudinal neuropsychiatry clinics staffed by both neurology and psychiatry faculty and trainees with comanagement of cases. This may

be a particularly attractive option for programs with well-developed neuropsychiatry and behavioral neurology programs and existing fellowships.

Conclusions

Perhaps most importantly, guidelines like these and others must be actualized by residency training programs. Neurology residents and graduates recognize the need for improved psychiatry training to optimize patient care and improve neurologists' ability to function in new systems of care; the time has come for educators to follow suit.

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