Behavioral Science Residency Education Priorities: The Perspective of Practicing Family Physicians

Richard L. Brandt-Kreutz, MA, MSW; Kyle Ferguson, PHD; Devin Sawyer, MD • St. Peter Family Medicine Residency Program, Olympia WA

BACKGROUND

Behavioral science residency education should be prioritized to be relevant to primary care.

25-40%
of primary care patients have behavioral and mental health problems[1-2]

Up to 70%
of visits involve some degree of psychosocial impact[3]

The specific context of primary care differs from mental health settings including shorter visits[4-6]

Behavioral science education is valued by primary care physicians.

82.5%
of residents/faculty reported referring to or using behavioral interventions[7]

90%
thought that behavioral interventions were "very important" or "important"[7]

Others have studied the opinions of practicing Family Physicians regarding behavioral science priorities in residency education.

Studies in Colorado (1999)[13] and Mississippi (2003)[14] identified similar topic prioritization including:
#1 depression, #2 anxiety and #5 interviewing

Limitations with these studies include:
- Important topics were not included[10-12]
- The effect of rural versus urban was not assessed[13]
- Physician competence was not assessed[14-15]

OBJECTIVES

Replicate these prior studies in order to:

Inform residency education efforts by identifying the behavioral science priorities of practicing Family Medicine physicians so that curriculum can be better aligned with the needs of practicing physicians

Building on prior research in Colorado and Mississippi, assess regional differences between Washington State physicians and physicians in these 2 states

Assess the effect of size of community on prioritization

Based on updated curriculum guidelines, expand the priorities list to include additional content areas not included in the original survey

Assess the impact of physician perceived competence on prioritization

METHODS

Participants

2170 practicing family physicians in Washington State identified as "active members" of the Washington Academy of Family Physicians (WAFP) were sent the survey via e-mail

Procedure

The study was determined "exempt" by the Spokane, WA IRB

An initial e-mail request from the WAFP President and two additional reminders were sent out 2 weeks apart

Instrument

On a 4-point scale (1=Lo, 4=Hi) respondents rated behavioral science topics according to the priority to be given in residency education and the respondent's competence in each topic

Original survey was modified to include:
- 27 of the original 28 behavioral science topics
- 8 additional topics were added for a total of 35 topics

In addition to the original demographic and practice data:
- Two additional options (psychologist and PharmD) regarding behaviorist in the practice were included
- Size of the physician's community was included

Data Analysis

Data were analyzed using both descriptive and inferential methods using SPSS statistical software

RESULTS

14% RESPONSE RATE 2270 surveys e-mailed • 370 replied • 326 completed both scales

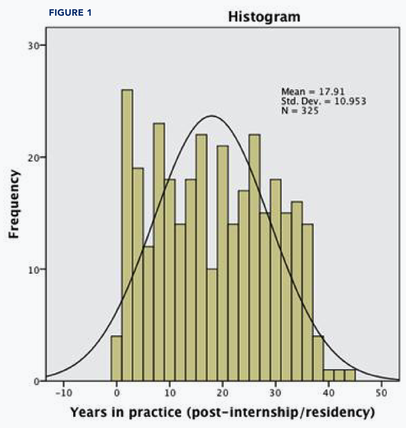
TABLE 1
Respondent demographics and practice information (N=326)

	Mean
Gender	54% male
Years in practice (post-internship/residency)	17.91 years (SD = 10.95)
Average number of pts seen per ½ day of clinic	9.94 (SD = 3.96)
Behaviorist/Pharmacist present in your practice	
Health/Patient Educator	26.71%
Mental Health Therapist	37.26%
Social Worker	34.18%
Psychologist	21.38%
PharmD	35.58%
Patient payment type	
Fee-for-service (indemnity plans)	30.07% (SD = 24.88)
Managed care (HMOs, PPOs, capitated contracts)	30.54% (SD = 26.94)
Other (Medicaid, Medicare, self-pay, indigent)	43.99% (SD = 26.55)
Size of Community	
Less than 30,000	22%
30,000 to 75,000	16%
75,000 to 150,000	21%
150,000 to 500,000	21%
500,000 to 1 million	12%
More than 1 million	8%

PERCENTAGE OF MALES (46%) SIGNIFICANTLY DIFFERENT from the population (53.4% males) [χ2 (df = 1) = 7.248, 0.0071]
- However, no significant difference found between male/female priority ratings t(318) = -1.402, p = .162)

YEARS OF EXPERIENCE RANGED WIDELY FROM <1 YEAR TO 44 YEARS (M = 17.91, SD = 10.95) and was positively skewed (Figure 1 below)

FIGURE 1



MEDIUM TO LARGE SIGNIFICANT CORRELATION BETWEEN PRIORITY RATINGS AND COMPETENCE ratings (r = .432, n = 325, p = .000) (Figure 2 below)

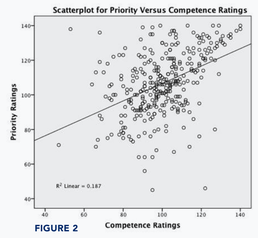


FIGURE 2

SMALL RELATIONSHIP BETWEEN YEARS OF PRACTICE AND PERCEIVED COMPETENCE RATINGS (r = .117, n =324, p = .035)

NO OTHER SIGNIFICANT DIFFERENCES between mean ratings and other demographic and practice variables

AVERAGE PRIORITY RATINGS of the present study ranged between 3.65 (DEPRESSION) TO 2.31 (ENURESIS/ENCOPRESIS)

5 OUT OF 8 TOPICS that were added to the present study WERE RANKED IN THE TOP HALF (1-16 out of 35) including Well Child Skills, Psychopharmacology, Chronic Mental Illness, Mood Disorders and Cognitive Disorders

SPIRITUALITY AND MEDICINE RANKED AT THE BOTTOM (34/35)

COMMON PSYCHIATRIC PROBLEMS RANKED HIGH (e.g., depression (1/35) and anxiety 3/35)
- However, OVER 60% OF PSYCHIATRIC TOPICS were rated in the BOTTOM HALF in the present and prior studies

TOP 13 TOPICS ARE IDENTICAL between the studies (table 2 below)

TABLE 2
Priority Ranking Top 13 out of 27 Topics

	1999 Rank Order	2003 Rank Order	Present Rank Order
1. Depression	1	1	1
2. Anxiety	2	2	3
3. Lifestyle Counseling	3	6	4
4. Headaches	4	4	13
5. Difficult Patients	5	7	10
6. Interviewing	5	5	2
7. Stress-related Disorders	5	9	11
8. Geriatrics	8	3	6
9. Physician Well-Being	9	12	12
10. Patient Education	10	13	5
11. Chronic Pain	11	7	6
12. Substance Abuse	12	10	9
13. Death and Dying	13	10	8

DISCUSSION

Family Medicine physicians in Washington State rated topic priority similar to Colorado[8] and Mississippi[9]

Patient-centered care is important with 6 topics consistently ranking in the top 13: Interviewing, Lifestyle Counseling, Difficult Patients, Physician Well-Being, Patient Education and Death and Dying

Important topics were added to the present study
- Well Child Skills ranked #5/35.

This is not surprising given that Family physicians provide 16-26% of visits with children[19]

Physicians with higher perceived competence in behavioral medicine are likely to value behavioral science and give it greater priority in residency curriculum[14-15]

Spirituality and medicine may be less important despite gaining interest in recent years[16]

Curriculum should give higher priority to common psychiatric topics including, depression, anxiety and substance abuse[17-18] and worry less about teaching less common topics such as, enuresis/encopresis, eating disorders and psychotic disorders

LIMITATIONS

Response rate was low (14%) and not representative when compared to the total population male/female numbers

Comparability with the two prior studies is reduced by differences including:
- Paper versus e-mail survey
- One original survey question not included in the present instrument
- Greater number of years between surveys with the present study (11 versus 4 years between 2 prior studies)

PROVIDENCE St. Peter Family Medicine

REFERENCES: See Handout