Characteristics of Combined Family Practice-Psychiatry Residency Programs

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Objective: *To evaluate how family practice-psychiatry residency programs meet the challenges of rigorous accreditation demands, clinical supervision, and boundaries of practice.*

Method: *A 54-question survey of program directors of family practice-psychiatry residency programs outlining program demographic data, curricula, coordination, resident characteristics, integration, and overall satisfaction was mailed to 11 combined family practice psychiatry-residency programs.*

Results: *Programs surveyed were meeting residency review committee (RRC) requirements, and a majority of the program directors believe that the training is as good as or better than categorical programs, and categorical residents benefited from training alongside combined residents.*

Conclusions: *Training programs are growing in size and producing quality physicians.*

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Combined family practice-psychiatry training is a relatively recent innovation, with 11 family practice-psychiatry residency programs in the U.S. Training is 5 years, with equal time spent in both specialties. Requirements were set forth in a 1995 "white paper," which was published jointly by the American Board of Family Physicians (ABFP) and the American Board of Psychiatry and Neurology (ABPN). Combined programs are reviewed by both the ABFP and ABPN but are not independently accredited. Combined residents train in conjunction with approved programs in each specialty. Upon completion, graduates are eligible for board certification in both specialties (1–4).

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Rationale for Combined Training

Primary care physicians play an increasing role in the diagnosis and management of mental illness (5–10). Unfortunately, primary care physicians do not always effectively diagnose or treat mental illness (9, 11–19). Primary care patients often receive minimal or no care for their mental illness and are not usually referred to as subspecialists (5, 7, 10). Compounding this problem, patients with untreated mental illness utilize more medical services than the general population (6–11).

Both family practice and psychiatry are grounded in the bio-psycho-social approach to patient care. However, there is a notable difference in how they conduct the doctor-patient relationship. Family practice physicians may care for several generations of a family and for a single patient from birth to death. Family physicians have more fluid boundaries, reveal more about their personal lives, and use touch as a component of care. Family Physicians oversee and coordinate care for all aspects of a person's health and illness, whereas psychiatrists focus on one aspect of a patient's care.

Physicians trained in both family medicine and psychiatry are uniquely equipped to care for a multitude of medically and psychiatrically complex patients. Throughout training, combined family practice-psychiatry residents care for difficult patients that have both medical and psychiatric problems. In addition to delivering care, combined trained physicians are an educational and consulting re-

source for primary care and psychiatry colleagues dealing with complex patients.

Challenges to Combined Training

Combined family practice-psychiatry training programs face many challenges, including recruiting medical students, retaining residents, and a lack of established role models. Additionally, combined residents face difficulties that are different from their categorical colleagues, including simultaneously learning and integrating two skill sets in a shortened time frame, meeting the sometimes conflicting goals of two distinct programs, establishing a professional identity, and developing appropriate boundaries. Presently, there are no established guidelines for addressing these issues.

Purpose of the Study

The objective of this study was to evaluate the characteristics of combined family practice-psychiatry residency programs in the following areas: curricula, quality and interest of applicants, demographics, program quality, resident performance, integration of skill sets, program difficulties, and boundary formation.

Method

Program directors of all 11 combined family practice-psychiatry residency programs were mailed a copy of our survey. If all data were not obtained by the initial survey, a brief follow-up phone interview was attempted.

The survey consisted of 54 questions divided into six parts: program demographic data, curricula, department coordination, resident characteristics, integration, and overall satisfaction. The survey questions were of three varieties:

- Request for specific data;
- Perception of program characteristics, ranked on a 3-point Likert scale; and
- Satisfaction with program performance, ranked on a 5-point Likert scale.

Results

Ten of the 11 program directors participated in our survey. Four of the surveys were completed by program directors board-certified in family practice, five by program directors board certified in psychiatry, and one by a program director board certified in both specialties. Program directors are generally satisfied with the quality of their applicants (average Likert 3.8), clinic scheduling (average Likert 4.0), ability to meet RRC requirements (average Likert 4.5), and cooperation between departments (average Likert 4.2). Perceived program strengths and weaknesses are outlined in Figure 1. Integration of skill sets was cited as the only weakness.

There has been a steady rise in both the number of available and filled positions (Figure 2). The combination of graduates and current residents is predominantly male (2:1). The annual attrition rate was approximately 1 resident every other year per program or approximately 25% nationwide annual attrition. Of the 17 residents who dropped out of combined training by 2002, 10 switched to categorical psychiatry; four switched to categorical family practice; one switched to an entirely different specialty; and two left medicine entirely.

Resident practices, integration of care, and the effects of combined family practice-psychiatry residencies are outlined in Table 1. In ours survey, most program directors stated that providing supervision is problematic and that combined residents experience more stress than their categorical colleagues. Five of the programs said they "integrate care" between the two specialties, meaning that they allow residents to see the same patients in both specialties. Six of the programs said they allow residents to practice psychotherapy in the family practice clinic. This revealed some perceived ambiguity regarding the terms "integration" and "psychotherapy" that we did not anticipate. A majority of the programs reported that integration creates problems with boundary formation and one-half noted that it creates difficulty with developing a professional identity.

Many program directors (70%) felt that combined residents performed better than their categorical colleagues in family practice at all levels. However, many abstained from answering similar questions about comparisons with their Psychiatry colleagues (70%). Sixty percent of the program directors reported their residents performed better than categorical family practice residents on the in-service exam, while 50% reported better performance on the Family Practice Board Examination. In contrast, 70% of programs abstained from commenting on performance on psychiatry in-service exam and psychiatry board exams.

Discussion

Overall, program directors were satisfied with their ability to meet both sets of residency review committee (RRC) requirements. They all had family practice clinic schedules that appeared to meet the rigorous RRC requirement of having increasing clinic responsibilities in three consecu-

tive years and at least three half-day clinics per week in the third year. This requirement can be difficult to meet since many psychiatry rotations require the resident to be on the ward full time. Arranging the resident rotation schedule so that all requirements are met is one of the biggest challenges in running a combined program. Most of the program directors were satisfied with both their family practice and psychiatry clinic schedules (Table 2).

Our data suggests that combined training in family practice-psychiatry is growing in size and developing quality physicians. The size of programs and interest from future applicants is increasing yearly. Furthermore, our data suggests that the overall training and skill level of combined graduates is as good or better than their categorical colleagues. Interestingly, many programs do not require a scholarly project, which is a recommendation of both RRCs. The RRC requires that psychiatry residents attend at least 70% of didactic experiences. Most programs noted that their residents were required to attend didactics. However, the same number of programs reported that attendance was a problem for their combined residents. These findings suggest that many of the combined programs may not be meeting the standard for didactic attendance. Didactic attendance is a constant problem for all training programs but may be especially difficult for combined programs due to residents' difficult schedules.

Directors noted that medical student interest was "increasing somewhat" and that residents were "average" to

FIGURE 1. Program Director's Perceived Strengths and Weaknesses of Family Practice and Psychiatry Programs

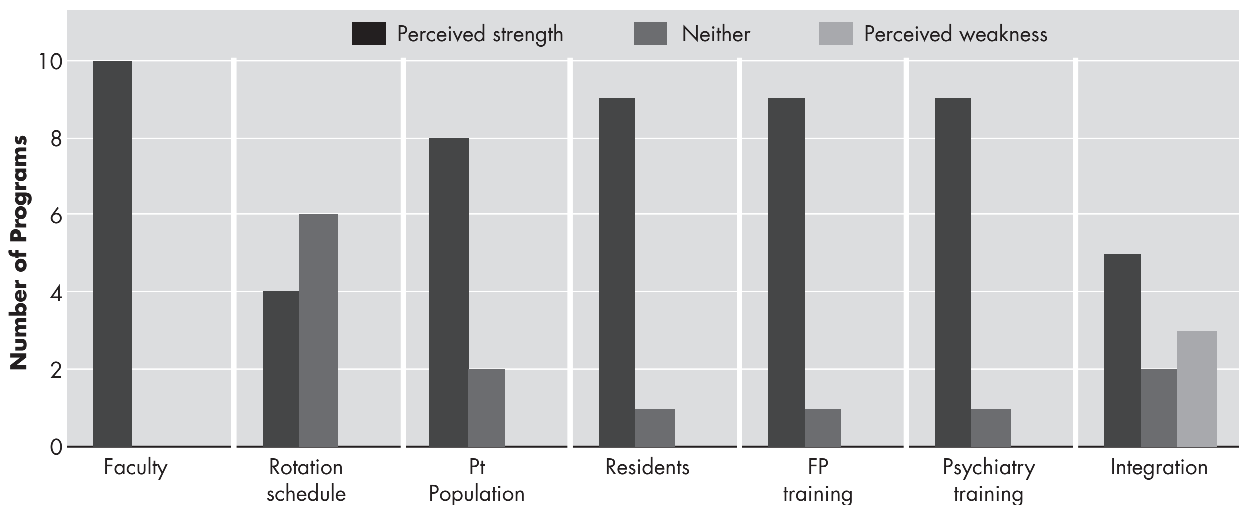
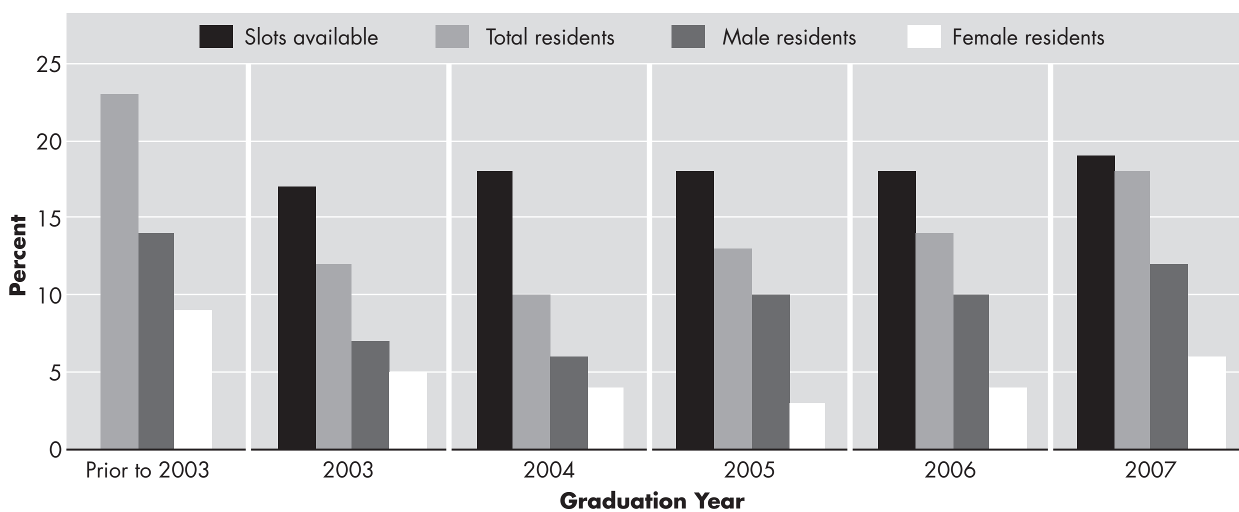


FIGURE 2. Breakdowns of Residents and Graduates by Year Group at the Beginning of Training



"above average." Recruiting quality students is always a challenge, and recruiting for a new and challenging specialty is even more problematic. Many medical students are unaware that combined training is an option for them.

Attrition

One of the major concerns with any demanding residency is the attrition rate. In our experience, residents may leave the program for any number of reasons. A given resident may simply decide that one of the specialties interests him or her more than the other and elect to switch to that categorical residency. On the other hand, a resident may find that mastering two completely separate skill sets and knowledge bases is too difficult and decide to switch to a categorical residency. Undoubtedly, the increased level of resident stress also plays a role. We have observed that it is common for residents to find it impossible to balance work and home life while pursuing the hectic and chaotic combined training experience.

At the time of this study, the nationwide attrition rate was approximately 25%, and most of the programs lost approximately one resident every other year. There were no reports available in the recent medical literature outlining attrition rates in psychiatry training. One study of family practice programs noted a 7.8% attrition rate for U.S. graduates and a slightly higher rate for international graduates (20). In contrast, general surgery, a field viewed to have a high attrition rate, reported a mean attrition rate of 20.2% in 2000 (21).

The high attrition rate for family practice-psychiatry residency programs is especially concerning because starting residency class sizes are small, ranging from one to four residents. The number of residents needed to form a critical mass for an adequate training environment is unclear. The size of the class will affect morale, cohesion, camaraderie, group learning, influence in residency politics, and formation of the combined resident's professional identity.

Cooperation Between Programs

In this study, cooperation between departments and between residents was reportedly good. In order to conduct an effective combined family practice-psychiatry residency program there must be active support for the residents and for the program, from both departments. Each department has goals for the categorical residents, which also apply to combined residents. These goals periodically create conflict between departments. The conflicts require innovative solutions by residents and program directors to meet the goals of training and maintain the health of the program.

Program directors overwhelmingly stated that having

TABLE 1. Practices, Integration of Care, and Effects of Combined Family Practice-Psychiatry Programs (N = 10)[a]

Characteristic	Yes (%)
Combined program practices	
Have rotations in which combined residents are excused from Family Practice duties	60
Have rotations in which combined residents are excused from Psychiatry duties	60
Combined residents must attend didactic education sessions.	60
Combined resident didactic attendance is a problem.	60
Require an academic project	50
Scheduling supervision is a problem	70
Combined residents experience more stress than their categorical residents	80
Integration of care	
Integrate care	50
Allow residents to see the same patients in both Family Practice and Psychiatry	50
Perform psychotherapy in the Family Practice Clinic	60
Integration causes difficulty with boundary formation	60
Integration causes difficulty with development of professional identity	50
Medical care given in Psychiatry Clinic must meet Family Practice Standard of Care	70
Psychiatric care given in Family Practice Clinic must meet Psychiatry Standard of Care	50
Effects of the combined programs	
Combined training enhances the experience of categorical Family Practice residents	100
Combined training enhances the experience of categorical Psychiatric residents	90
Given your experience, would you start your own combined program again?	70

[a]Data gathered from the following Family Practice-Psychiatry Programs: Case Western Reserve University Hospital, National Capital Consortium, Tripler Army Medical Center, University of California-Davis, University of California-San Diego, University of Cincinnati, University of Iowa, University of Minnesota, University of Oklahoma, West Virginia University.

combined training benefited the categorical residencies. In the program at our medical center, the combined residents act as a resource for the categorical programs in several ways. They provide weekly neurology and psychiatry didactics for the categorical family practice residents. They also answer informal "curbside" consultation questions about difficult psychiatric patients for family practice residents and faculty, often saving the patient a formal consult and providing an educational experience for the physician. On the psychiatry wards, they are often asked to help with difficult medical patients. The combined residents also function as a resource for the psychiatric consult liaison service.

Supervision, Integration of Skills, and Boundaries

Many of the programs in our study noted that scheduling supervision for one or both of the specialties was difficult. This is not surprising since approach to supervision is very different in family practice and psychiatry residencies. In general, family practice supervision is very intense during internship and residents are rapidly given substantial autonomy. Conversely, in psychiatry, supervision remains intense for the entire residency, especially for psychotherapy cases. Additionally, combined residents' schedules are more intense than those of categorical residents, making it difficult to find time for supervision.

It appears that integrating care between the two specialties is challenging for combined residents. While many respondents noted that their residents learned each individual skill set well, they were ambivalent about how to teach the residents the appropriate integration of the two specialties. Part of the difficulty of teaching and practicing integrated care is that there is no clear model for accomplishing this goal in training. From our data, it is unclear whether residents in the programs were able to integrate care during residency under faculty guidance or maintain clear limits between the fields during their training. Additionally, there are no guidelines for program directors regarding integration and boundaries. Some of the programs allow their residents to practice "psychotherapy" in the family practice clinic, although our survey did not adequately elicit which type of psychotherapy is allowed. Furthermore, some of the programs that reported allowing psychotherapy were ones that also reported not allowing integration. This finding is conflicting and leaves us uncertain about exactly how the various programs defined "integration" and what rules they set forth for their residents. These were new programs and it would be natural for the rules to evolve over time, leading to some ambiguity.

Forming and maintaining boundaries with patients is one of the most difficult aspects of medicine. Like all residents, combined residents must establish appropriate personal and professional boundaries with their patients. But unlike other residents, the fields they are training in have two different rules for boundaries and practice. The respondents suggest that the integration of skills during training leads to difficulty with boundary formation. In our

TABLE 2. Family Practice and Psychiatry Clinic Schedules

	Program[a]									
Clinic Type	**WVU**	**OU**	**IU**	**UCSD**	**UC**	**NCC**	**MN**	**CWU**	**UCD**	**TAMC**
Family practice clinics										
PGY-1	1	1	2	1	1	1	1	1	1	1
PGY-2	2	2	3	1	1	1	1	1–4	1.5	1
PGY-3	2	3	5	2	1	1	2	1–4	2	1
PGY-4	3	1[b]	1	3	2	2	3	2	2.5	2
PGY-5	3	1[b]	1	1–2	3	3	1	2	3	3
Psychiatry clinics										
PGY-1	0	1	0	0	0	0	0	0	1	0
PGY-2	0	2	0	0	0	0	0	0	1	0
PGY-3	0	3	0	6 or 8	0	7	0	1	1	0
PGY-4	1	1[b]	9	0	9	1	1	9	1	8
PGY-5	1	1[b]	1 or 2	0	1	1	9	0	1	1

[a]WVU-West Virginia University, OU-Oklahoma University, IU-University of Iowa, UCSD-University of California San Diego, UC-University of Cincinnati, NCC-National Capital Consortium, MN-University of Minnesota, CWU-Case Western Reserve University Hospital, UCD-University of California Davis, TAMC-Tripler Army Medical Center
[b]Optional.

study, it is unclear from the responses whether residents had difficulty setting personal boundaries with patients, setting boundaries of care, or both.

Professional Identity

Program directors generally note that combined residents have difficulty forming professional identity. Residents are immersed in two different medical cultures with two different philosophies for teaching. There is a natural tension between the two styles of care created by: differences in practice boundaries, the role of touch as an intervention, the amount of self-disclosure by the practitioner, and formulation of patient disease processes. In the program at our medical center, residents appear unsure about professional roles and identity during the first 3 years of training. Due to the staggered structure of the curricula, combined residents are always 6 months behind their categorical counterparts. Furthermore, categorical residents are building their skills and fund of knowledge more rapidly. Combined residents often feel like "outsiders" from their categorical colleagues. However, many program directors note that combined residents develop a separate, stronger professional identity by the fourth and fifth year. We suspect this may be due to several factors including: 1) catching up with their categorical counterparts in knowledge base and skill sets in the respective specialties, 2) growing comfort with integrating the two specialties, 3) increased professional confidence, and 4) identifying and cohesive development with the group of residents in the combined program. To help aid in this identity development, our program has strong initiatives to increase cohesion as a group, develop and maintain an individual identity as a combined program and to emphasize the unique roles of combined residents emphasizing leadership and development as educators and translators between the fields.

Conclusion

Family practice-psychiatry residency programs are growing in size and training quality physicians. Programs are successfully meeting RRC requirements, and most program directors believe that the training is as good as or better than categorical training. Categorical residents apparently benefit from the presence of combined residents.

Several areas require further investigation due to limitations in this study. Our questionnaire was limited to the program director's subjective perceptions and self-report data. It did not assess resident or graduate perceptions, and, in some cases, it did not adequately define such terminology as integration of care, boundary formation, and psychotherapy. Therefore, we were unable to ascertain how many programs teach residents how to integrate care during residency or to what extent they do so.

Studies to evaluate the parameters and practices of graduates of family practice-psychiatry training programs and to determine how they are dealing with issues of identity, boundaries, mentorship, and role diffusion are underway. It is our objective to continue to clarify these important questions.

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