Combined Internal Medicine/Psychiatry and Family Practice/Psychiatry Training Programs 1999-2000

Residents' Perspectives

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Residents enrolled in internal medicine/psychiatry (IM/PSY) and family practice/psychiatry (FP/PSY) programs were surveyed to assess their views concerning training experiences and future plans. The FREIDA online directory was used to supplement missing information. Responses were received from 60% of residents (N = 111), representing all active IM/PSY (n = 20) and FP/PSY (n = 9) programs. Variability existed in call, clinical, and didactic experiences. Residents generally were very pleased with training. Following graduation, most plan to practice a combination of skills, primarily in community or academic settings. Levels of recruitment were felt to be equal to or higher than those for colleagues in individual training specialties. Training in IM/PSY and FP/PSY programs is variable. Residents report high levels of satisfaction and plan to practice both specialties. (Academic Psychiatry 2002; 26:110–116)

A tremendous growth in combined internal medicine/psychiatry (IM/PSY) and family practice/psychiatry (FP/PSY) residency training programs has occurred during the last five years. In 1994, 22 positions were offered in IM/PSY through the National Resident Match Program (NRMP). For the 2000 match (NRMP 2000) (1), the number of positions increased to 38. Although no FP/PSY positions were offered through the NRMP in 1994, 15 positions were offered in the 2000 match. Despite the tremendous growth in these programs, little is known about the experience and outcomes of combined training in internal medicine/psychiatry and family practice/ psychiatry programs.

At present, the American Board of Internal Medicine (ABIM), the American Board of Psychiatry and Neurology (ABPN), and the American Board of Family Practice (ABFP) provide certification for combined programs based on submission of a proposed curriculum and on current Accreditation Council for Graduate Medical Education (ACGME) accreditation by the participating departments. These board organizations issue program guidelines to the combined residencies. However, formal individual accreditation of combined residencies is not currently performed, and therefore the structure of curriculums and resident experiences may be quite variable. The guidelines for combined training state that "the curriculum must assure a cohesive, planned educational experience and not simply comprise a series of rotations between the two specialties" (2). However, it is currently unknown how programs provide an inte-

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grated curriculum or provide educational experiences directed at the overlap between medicine and psychiatry.

In order to better understand the experience of combined training, we surveyed combined program residency training directors and a nationwide sample of residents enrolled in combined programs in internal medicine/psychiatry or family practice/psychiatry. The results of the training directors' surveys have been reported in a separate article (3).

METHODS

The Institutional Review Board at the principal investigator's institution approved the study design and questionnaires. The questionnaire was pilot tested and revised on the basis of comments provided by resident physicians at the principal investigator's program. Respondents were provided the option to include their names or answer anonymously. Combined residency programs training directors listed in the 1999-2000 *Graduate Medical Education Directory* were contacted and asked to provide a list of residents currently enrolled in their programs. In the case of outdated program director information, we either contacted programs directly or obtained current information from the American Medical Association's online FREIDA directory (4). Residents were directly mailed the questionnaires, which assessed basic demographic factors and training opportunities and which also included a qualitative section requesting comments about the experience of combined training. Three separate mailings were performed between September 1999 and May 2000.

RESULTS

Characteristics of Respondents

At least 1 resident physician from each of the 20 active internal medicine/psychiatry programs and 9 active family practice/psychiatry programs responded. Seven IM/PSY programs listed in the *Graduate Medical Education Directory* either had closed or were accepting applicants for the first time during the 1999-2000 match. One FP/PSY program had closed at the time of the mailings.

Overall, 111 responses were received from an estimated pool of 184 residents (60% response rate). Sixty-eight residents (61%) were graduates of American medical schools. The majority were male, white, and in the first three years of training. Demographic characteristics of the residents who responded are shown in Table 1. Five residents had previously been enrolled in general psychiatry programs, 3 in general internal medicine programs, 2 in combined FP/PSY, and 1 each in family practice, emergency medicine, and dermatology residency programs prior to matriculation in a combined program.

Residents report that they are able to integrate training experiences in a variety of settings, including substance abuse rotations, geriatric rotations, and combined treatment venues. Twenty-three percent ($n = 25$) reported that they have the opportunity to rotate through an inpatient IM/PSY unit during training. On average, for those residents who have this option, 3.7 months (SD = 2; range 1–9) are spent in this venue. Slightly more (31%; $n = 34$) rotate through a combined outpatient IM/PSY or FP/PSY clinic. Only 12 programs (40%) of the 30 reporting have a lecture series devoted to the combined training residents. Training dedicated to psychotherapy may be limited

TABLE 1. Demographic information of residents in combined IM/PSY and FP/PSY training programs ($N = 111$)

Characteristic	*n*	%
Gender (1 missing response)		
Male	61	56
Female	49	44
Program type		
IM/PSY	86	
FP/PSY	25	
Race		
White	75	71
Asian	16	15
Hispanic	7	7
Black	3	3
Other	3	3
American Indian	1	1
N/A	6	
Training year		
PGY-1	24	22
PGY-2	28	25
PGY-3	31	28
PGY-4	15	14
PGY-5	13	12
Age, years, mean ± SD (range)	31.0 ± 4 (24–43)	

Note: IM = internal medicine; FP = family practice; PSY = psychiatry; N/A = no answer.

in combined programs: the percentage of residents in PGY-2 or higher who reported receiving one or fewer hours of supervision per week ranged from 42% to 79% (Table 2).

Call schedules between programs are quite variable, as shown in Table 3. In-house call responsibilities range widely among programs, with residents reporting a range of 0 to 97 (mean = 21) in-house internal medicine calls during the first year and 0 to 35 (mean = 1) during the fifth year. During the family practice components of training, call varies from 0 to 94 (mean = 39) during the first year, and 0 to 60 (mean = 11) during the final year. Importantly, residents who had not yet completed a given year of training often left survey answers blank, limiting the sample sizes of numbers reporting call schedules in latter years of training. In cases of partial responses to the call schedules within a year, blank spaces were considered to be zero.

In order to determine what future positions residents planned to pursue at the completion of training, we asked them the type of practice setting in which they were planning to work (Table 4). Forty-three percent reported that they anticipated their future practices to be mostly outpatient work, and 38% anticipated a balance between inpatient and outpatient work. The majority (>70%) of residents reported that they believed their future practices would involve a combination of psychiatry and IM or FP work. The combined program residents reported that the level of recruitment for job positions was about the same as or greater than the level for their resident colleagues in general psychiatry programs (combined program residents: "much more," 7%; "more," 32%; "about the same," 45%). Only 24% of IM/PSY and 28% of FP/PSY combined residents reported that they received "more" or "much more" recruitment than their respective primary care colleagues. Only 20% or fewer dual-program residents reported that their level of recruitment was "less" or "much less" than general psychiatry, family practice, or internal medicine residents.

Qualitative Responses

Respondents were asked to offer opinions concerning their experiences in combined training. The responses varied widely in comments related to current training conditions and future employment opportunities. However, most residents reported satisfaction with combined training, as noted by this respondent:

> I love med/psych . . . I couldn't have picked anything better or that I could be more proud of!

TABLE 2. Psychotherapy training experience in combined residency training

	PGY-1		PGY-2		PGY-3		PGY-4		PGY-5	
Element	**Mean hr/wk**	**% ≤1 hr/wk**	**Mean hr/wk**	**% ≤1 hr/wk**	**Mean hr/wk**	**% ≤1 hr/wk**	**Mean hr/wk**	**% ≤1 hr/wk**	**Mean hr/wk**	**% ≤1 hr/wk**
Experience conducting psychotherapy	0.3	93	1.2	67	6.7	36	8.0	12	6.6	13
Psychotherapy supervision received	0.3	94	0.9	79	1.5	62	2.0	42	1.7	50

TABLE 3. Estimates of total numbers of overnight calls in combined training programs per year

	Mean (Range)				
Service	**PGY-1**	**PGY-2**	**PGY-3**	**PGY-4**	**PGY-5**
Psychiatry					
In-house	21 (0–97)	20 (0–72)	10 (0–72)	4 (0–48)	1 (0–35)
Home call	7 (0–104)	12 (0–104)	14 (0–104)	11 (0–60)	6 (0–24)
Night float	2 (0–43)	4 (0–30)	3 (0–30)	0 (0–15)	0 (0–15)
IM/FP					
In-house	39 (0–94)	27 (0–60)	23 (0–72)	17 (0–60)	11 (0–60)
Home call	4 (0–100)	6 (0–100)	6 (0–100)	2 (0–35)	3 (0–30)
Night float	5 (0–30)	3 (0–30)	3 (0–40)	4 (0–30)	3 (0–40)

Note: IM = internal medicine; FP = family practice.

Two residents voiced discontent with the psychiatry training in their programs, calling it "unbelievably pathetic" and "woefully inadequate." Three reported that they had chosen to leave combined training at the end of the 1999-2000 academic year to pursue general psychiatry training. Residents reported an interest in formal conferences devoted to the combined training programs.

Respondents noted that although they were assigned to primary care clinics, the bulk of their patient care was dedicated to patients with comorbid medical and psychiatric issues, as reflected in the following (all noted comments are verbatim):

> Aren't all outpatient clinics med-psych? Seriously—my continuity medical clinic has approximately 40% patients with psychiatric issues.

> Although my medicine clinic is not a "med-psych" clinic, I do see a preponderance of patients with issues medically and also psychiatrically.

A breadth of responses was seen regarding future employment opportunities. Most respondents envisioned practices in which they could continue to practice both specialties either directly or in consultative or geriatric psychiatry settings. For instance, three residents responded that

> Goal/dream = small town serving as community GP as well as psychiatrist.

> Will do 60/40% psych/FM in a rural area in the West.

> Intend on establishing a small practice in a small town as an IM clinic, but will be able to provide psych care also.

In terms of searching for jobs, two offered the following advice:

> A hint for the job search: recruiters seem to be stymied by my combined qualifications. I would suggest searching by contacting practices directly.

> Mostly both psychiatrists and internists are curious about how they can use my services for their patients. They have complicated (HIV, EDO, mentally ill, diabetes, etc.) patients they would like help with.

Military or community-health obligations influenced some future practice choices. Several commented that it was too early in the training process to think about issues concerning recruitment.

DISCUSSION

In this article, we have provided training perspectives from residents involved in combined IM/PSY and FP/PSY programs. Generally, there is wide variability among combined training programs. Many programs are less than five years old, and several have possible marginal compliance to Board requirements and recommendations in terms of numbers of enrollees, curriculum, and integration of the two specialties.

Combined residency training has been in existence for approximately 20 years. Prior to integrated training, dual certification had to be attained by training consecutively in each specialty. The philosophies and benefits behind dual training in primary care specialties such as internal medicine and family practice with psychiatry were voiced in 1995 by leaders in internal medicine and family practice, who stated that the goals of combined specialty training should be 1) to provide residents with enhanced training as generalist physicians for the optimal care of adult patients; 2) to allow residents added opportunities to select specific training experiences needed by the communities in which they intend to practice (e.g.,

TABLE 4. Anticipated future practice patterns of residents enrolled in combined training programs

	n (%)				
Type	**Definitely Yes**	**Probably Yes**	**Unsure**	**Probably No**	**Definitely No**
Private practice	17 (16)	38 (36)	29 (27)	17 (16)	5 (5)
Academic practice	12 (11)	48 (44)	28 (26)	19 (18)	1 (1)
Psychiatry practice	46 (42)	39 (36)	21 (19)	3 (3)	0 (0)
IM/FP practice	34 (33)	43 (41)	14 (13)	7 (7)	6 (6)
Formal psychotherapy	10 (10)	31 (30)	33 (31)	24 (23)	7 (7)

Note: Total number of respondents to each question; percentages rounded to nearest significant digit. IM = internal medicine; FP = family practice.

rural or inner-city settings); 3) to improve the overall efficiency of the educational process; 4) to increase the attractiveness of generalist careers; 5) to improve communication between family physicians and internists about their relative roles as generalist physicians; and 6) to increase the number of generalist faculty who can function as effective role models for students and residents (5). Combined primary care and psychiatry residency programs tend to promote at least two further goals of training, including the need to train physicians in the understanding of "psychosomatic" and brain–body medical presentations and to train physicians to provide medical care to the chronically mentally ill population, a group of persons whose health care needs are largely unmet.

Despite the longevity of combined training, most of the programs listed in Appendix A have been established in the last five years, resulting in a marked increase in the number of training options available to graduating medical students. However, these programs may lack experience in integrated training. Simultaneously, a decline in the number of U.S. medical graduates entering general psychiatry programs has occurred. A 1998 graduate medical education survey published in *JAMA* showed that 120 residents were enrolled in 27 combined IM/PSY and 39 residents were enrolled in 13 different FP/PSY programs. However, in the same year, only 5 persons completed IM/PSY training and no one completed FP/PSY training (6). These latter numbers reinforce the relative newness of most programs and may also speak to attrition that occurs over the five years of rigorous training.

Citing his personal communications based on graduates of triple board programs (pediatrics, adult psychiatry, child psychiatry), who tended to practice only psychiatry, Shore (7) recently published concerns that graduates of dual IM/PSY and FP/PSY programs may do likewise, thereby failing to address the goal for provision of nonpsychiatric medical care to the chronically mentally ill. The qualitative responses from this survey, however, suggest that residents currently enrolled in combined programs plan on practicing both specialties, especially in areas where needs exist for comprehensive care of the mentally ill. Unfortunately, at this point, the published data on postresidency practice patterns are sparse and mainly reflect persons who have completed consecutive training in two specialties. Two surveys evaluating IM/pediatrics program graduates and FP/PSY practices suggest that nearly two-thirds of graduates continue to practice in both specialties (8,9). The companion piece to this article sheds further light on emerging practice patterns of dual-trained IM/PSY and FP/PSY residents (3). Most continue to seek positions in academic medicine, which allow for continued practice of both sets of skills.

Responses from the resident physicians in this survey and review of program curriculums through FREIDA and program web pages suggest a wide variability among programs. For instance, fewer than half of the programs have a lecture series devoted to residents in combined training. Despite the Boards' recommendation that programs should have a minimum of two residents per training year, many fall short of this recommendation.

Although some programs meet the American Board of Psychiatry and Neurology's recommendation that 12 consecutive months of outpatient clinical experience be scheduled, only a few currently provide dedicated time over 2 years to ensure an uninterrupted 12-month experience or provide for a part-time psychiatry continuity clinic that would ensure the 12-month full-time equivalency. Certain local program requirements may prohibit the 12-month full-time equivalency, an issue that may need future modification in combined program guidelines.

Residents report a wide variability in the amount of psychotherapy training received and the amount of supervision provided by the programs. The American Board of Psychiatry and Neurology states that residents "must have at least two hours of supervision weekly in addition to teaching conferences and rounds, in the PG-2 through PG-4 years of training." However, as noted above, the majority of residents in combined programs receive one or fewer hours of supervision during the PGY-2 to PGY-4 years of training. This likely reflects the difficulty in meeting the scheduling demands of combined training in which residents must maintain continuity clinics, supervision, and rotation activities.

Limited dual-training practice venues and limited conferences directed at integrated practice are shortcomings of many of the dual-training programs. As hospital systems and institutional residency training programs become more familiar with dual programs, further development of unique training opportunities may become available. Further-

more, dually trained physicians who enter academic medicine may be instrumental in providing mentorship and developing training venues for residents.

This is a descriptive study meant to provide pilot data for further work in assessment of training and outcomes of dual-residency programs in IM/PSY and FP/PSY. Limitations of the study include the relatively low response rate. Although all active programs were represented, in some cases only one respondent from a program provided comments about the training experience. The disproportionate number of IM/PSY residents responding might have influenced the responses. In this initial survey, questions directly addressing satisfaction could have been included. Further, the responses were self-reported and data such as those provided on level of recruitment are based solely on the residents' opinions, not on documentation about what types of service delivery systems are recruiting the residents.

Variability in the training experience is not surprising given the relative newness of most programs. The many challenges to dual training include the difficulty in integrating both clinical and didactic training experiences, the task of establishing an identity for residents and future graduates, and the need to gain acceptance of combined programs by peer residencies, as well as the problems of resident stress and fatigue and a lack of faculty role models (10). We propose that in order to face these challenges, directors of combined residency programs should meet annually to discuss and share curriculums devoted to integrating experiences. An "ideal graduate" model could be developed, to ensure that during and at completion of dual training, residents have a developed identity that will ensure that their practice capabilities are greater than the sum of their training parts. Given the increase in the numbers of residents enrolled in combined training, an influx of new role models will soon exist for medical students and residents in dual programs. Issues related to resident stress will need to be dealt with on both local and national levels in terms of setting up experiences for residents to share training experiences, curriculum flexibility, and development of mentorship programs to connect dual-trained faculty and practitioners with residents.

As a nationwide and global phenomenon, the societal and financial impact of psychiatric disorders in community and primary care settings is substantial. Whether entering community practice settings or academic positions in teaching and research, physicians with dual training will provide an unparalleled breadth of expertise to the medical community. Physicians with integrated training will serve as models for both psychiatrists and primary care providers. As educators, we will need to follow the trajectory of these physicians for years to come.

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APPENDIX A. 1999–2000 active U.S. programs in combined internal medicine/psychiatry and family practice/psychiatry

Program Type and Institution	Location	Positions Available Per Year[#]
Internal Medicine/Psychiatry		
Good Samaritan Regional Medical Center	Phoenix, AZ	1
*University of Connecticut	Farmington, CT	2
Tripler Army Medical Center	Honolulu, HI	2
University of Iowa	Iowa City, IA	2
Rush-Presbyterian-St. Luke's	Chicago, IL	4
Southern Illinois University	Springfield, IL	2
University of Kansas	Kansas City, KS	2
Tulane University	New Orleans, LA	2
**University of Massachusetts	Worcester, MA	—
National Capital Consortium	Bethesda, MD	3
Duke University	Durham, NC	4
East Carolina University	Greenville, NC	2
Dartmouth-Hitchcock Medical Center	Lebanon, NH	2
UMDNJ-Robert Wood Johnson	New Brunswick, NJ	2
**Albert Einstein	Bronx, NY	—
**Bronx-Lebanon Hospital Center	Bronx, NY	—
**SUNY Health Science Center	Brooklyn, NY	—
University of Rochester	Rochester, NY	2
Medical University of South Carolina	Charleston, SC	2
**East Tennessee State University	Johnson City, TN	2
University of Texas Health Sciences Center	San Antonio, TX	2
University of Virginia	Charlottesville, VA	4
University of Virginia	Roanoke/Salem, VA	2
West Virginia University	Charleston, WV	2
West Virginia University	Morgantown, WV	2
Family Practice/Psychiatry		
University of California-Davis	Sacramento, CA	2
University of California-San Diego	San Diego, CA	2
*Dwight David Eisenhower Army Medical Center	Fort Gordon, GA	—
Tripler Army Medical Center	Honolulu, HI	2
University of Iowa	Iowa City, IA	2
National Capital Consortium	Bethesda, MD	2
**Michigan State University	East Lansing, MI	—
University of Minnesota	Minneapolis, MN	3
University of Cincinnati	Cincinnati, OH	2
Case Western Reserve/University of Cleveland	Cleveland, OH	2
University of Oklahoma-Tulsa	Tulsa, OK	2
West Virginia University	Morgantown, WV	1
Medical College of Wisconsin	Milwaukee, WI	2

#Based on information from the *Graduate Medical Education Directory* and FREIDA.
*Program not yet opened at time of original survey.
**Program closed at time of original survey.