Perceptions and Practices of Graduates of Combined Family Medicine-Psychiatry Residency Programs: A Nationwide Survey

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Objective: *The authors evaluate the current practices and perceptions of graduates of combined family medicine-psychiatry residency programs in the following areas: preparation for practice, boundary formation, and integration of skills sets.*

Method: *The authors conducted an electronic cross-sectional survey of all nationwide combined family medicine-psychiatry training graduates in the spring of 2005.*

Results: *Twenty-seven (62.8%) graduates participated. Nearly 30% worked in positions designed specifically for combined trained physicians, though only 11.1% participated in fully integrated practice. The mean time spent practicing psychiatry and family medicine is 70% and 16%, respectively.*

Conclusions: *Combined trained graduates felt well prepared for practice in both specialties but somewhat less comfortable providing integrated care. Most are in positions that underutilize their ability to integrate family medicine and psychiatry in one practice. Contributing factors may include limited preparation for integration during residency training and lack of integrated job opportunities. Enhancing combined residents' training in the provision of integrated services may optimize their utilization.*

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Combined family medicine-psychiatry residency training lasts 5 years and follows the guidelines set forth in 1995 by the American Board of Family Medicine and the American Board of Psychiatry and Neurology. The combined programs are not independently accredited but rather rely on the accreditation of the two participating categorical programs. Combined programs are currently available at 10 locations nationwide where residents train in conjunction with categorical programs. The first residency class graduated in 2001. Upon completion, graduates are eligible for board certification in both specialties (1–4).

Family medicine physicians play an increasing role in the diagnosis and management of mental illness but do not always effectively diagnose or treat mental illness (5–19). Family medicine patients often receive minimal or no care for their mental illnesses and are not usually referred to specialists (5, 7, 10). Compounding this problem, patients with untreated mental illnesses utilize more medical services than the general population (6–11). Family medicine-psychiatry residency programs may partially address these issues by projecting mental health resources forward into the primary care setting and developing a synergistic bridge between the two specialties.

Throughout training, combined family medicine-psychiatry residents care for patients who have both medical and psychiatric problems. This uniquely prepares them to care for complex medical and psychiatric patients. In addition to delivering care, combined trained physicians often serve as a valuable educational and consulting resource for both family medicine and psychiatry colleagues.

Several manuscripts have analyzed combined program design and implementation (2, 4, 20, 21). Three areas of concern have been noted in these studies, including boundary limits, identity development, and specialty inte-

gration. We have found no studies examining the practices of graduates and their attributes concerning these issues.

The objective of this study was to evaluate the current practices and perceptions of graduates of combined family medicine-psychiatry residency programs in the following areas: preparation for practice, boundary formation, and integration of skills sets.

Method

We obtained Institutional Review Board approval, and no sources of funding were used. We asked all family medicine-psychiatry residency programs to forward surveys to their graduates. Each graduate was e-mailed a copy of the anonymous electronic survey to which respondents replied via e-mail or hard copy. For those replying via e-mail, the response was printed and the e-mail deleted prior to data entry and analysis. All graduates were ensured that no program-specific data would be included. The survey was sent out on two occasions with one additional message requesting participation sent via e-mail to all of the graduates and current program directors. The survey consisted of demographic information including the location of training, current setting, and level of training. Graduates were asked questions about preparedness for practice, scope of practice, integration of specialties, and boundaries of care. Responses were formatted as "yes/no" or rated on a 5-point Likert scale. Questions delineated whether patients were seen exclusively for psychiatry, family medicine care, or for both. For the purpose of this study, we call such combined treatment "integrated care," and patients who receive combined treatment "integrated-care patients." We also asked respondents about whether they saw integrated-care patients in separate settings or in one integrated care setting (such as a primary care clinic) and about the personal and professional behaviors/procedures they conducted with integrated-care patients.

The term "boundaries" refers to the ability of the physician to set both personal and professional boundaries of behavior (e.g., the scope of patient interaction inside and out of the office) as well as boundaries of clinical practice (e.g., whom to conduct pelvic and breast exams on). The term "liaison" in this article refers to providing teaching and communication assistance between members of two specialties.

We entered all responses into an SPSS database and calculated basic descriptive statistics. The number of respondents was low, preventing extensive statistical analysis. Nevertheless, the relationship between preparedness for setting boundaries and integration of the two specialties with personal and professional boundaries was assessed for correlations using Pearson's correlation coefficients.

Results

By the spring of 2005, 42 physicians had graduated from combined family medicine-psychiatry programs nationwide (Table 1). Twenty-seven (64%) of the graduates participated in this survey. Figure 1 highlights some the key characteristics about the practices of the graduates. Of note, only three of the respondents (11%) have a fully integrated practice.

Twenty-five (96.2%) of the 26 who took their American Board of Family Medicine (ABFM) certification passed on their first attempt and obtained certification. For the American Board of Psychiatry and Neurology exam, 21 of the graduates completed both the written and the oral portions with 17 (81%) obtaining certification, 15 (71.4%) passing both portions on their first attempt.

Figure 2 outlines the results of the 5-point Likert scale response for preparation for practice. Respondents reported feeling comfortable providing individual specialty care for psychiatry (4.74, range = 4 to 5 [SD = 0.447], mode 5) and family medicine (4.48, range = 3 to 5 [SD = 0.580], mode 5). Graduates were more ambivalent about and felt relatively less well prepared to integrate the two specialties 3.26 (range = 1 to 5 [SD = 1.130], mode 4). In fact, 40% of the respondents agreed that they were well prepared for integration and 11% strongly agreed, whereas 33% percent disagreed and 3% strongly disagreed with this statement. Only 14% were neutral on the subject.

TABLE 1. Graduates of Family Medicine-Psychiatry Programs (as of Spring 2005)

Institution	Number of Graduates
Case Western Reserve University*	0
Medical College of Wisconsin	2
National Capital Consortium	8
Tripler Army Medical Center	2
University of California, Davis	5
University of California, San Diego	4
University of Cincinnati	9
University of Iowa	2
University of Minnesota**	4
University of Oklahoma-Tulsa	2
West Virginia University	4

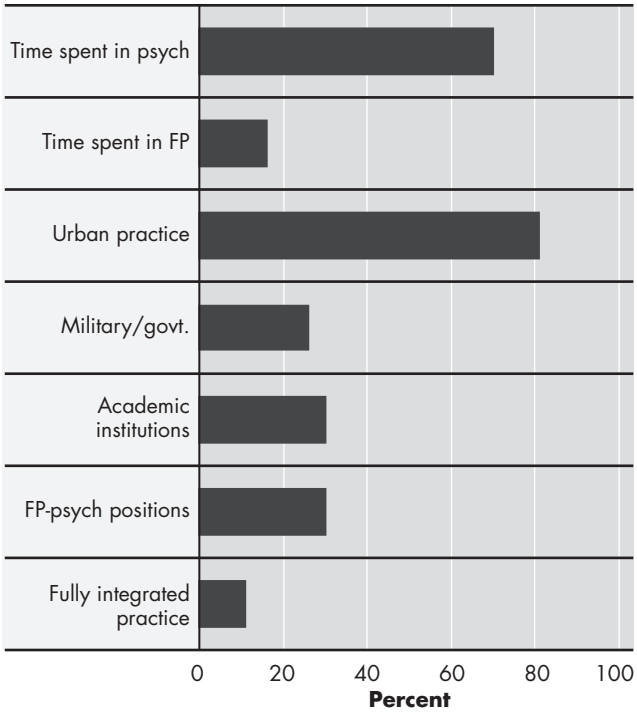
*First graduate was in summer 2005
**Program has closed

Graduates reported that they felt very well prepared to set boundaries (4.19, range = 2 to 5 [SD = 0.74], mode 4) and to be a liaison between the two specialties (4.74, range = 3 to 5 [SD = 0.53], mode 5). We analyzed results to determine whether graduates from particular training programs or in current practice settings were more likely to feel comfortable in setting boundaries and integrating care but there was no significant difference.

Figure 3 details the respondents' perceptions of their abilities to set personal and professional boundaries after graduation. We asked graduates about their comfort in setting time boundaries with their patients, their comfort in liaising between their two specialties, and whether they perceived pressure from colleagues to perform care in places that they deemed inappropriate. Of note, there is little consistency about the graduates' comfort in setting time boundaries, but they do express comfort in acting as liaisons.

Table 2 reviews the specific activities implemented by the graduates when treating integrated care patients. Fourteen (52%) indicated that they felt comfortable (a Likert score of 4 or 5) in their preparedness to both set boundaries and integrate the two specialties (Figure 2). These respondents, who see integrated-care patients, did not conduct home visits, see patients socially, self-disclose emotional responses, nor perform male or female genital exams. However, they differed widely in their implementation of other various clinical practices. The respondents were assessed for potential correlations between their comfort with integrated practice and the specific activities or exams that they performed in their integrated practice. We inferred that a positive correlation reflected a level of comfort performing that activity based on being well prepared to integrate the skill sets in a boundaried fashion. Likewise, a negative correlation reflected a certain degree of discomfort or lack of confidence in preparation to such an extent that the respondent avoided the activity in integrated practice.

FIGURE 1. Practice Characteristics of Family Medicine-Psychiatry Graduates



FP = family practice

Conclusions

Overall, the graduates who responded to our survey were satisfied with their individual specialty training. They are performing at the same level or above that of their categorical family medicine and psychiatry graduates in their ability to achieve board certification, with 96% passing their family practice boards on their first attempt (national average is 91%) and 71% passing both portions of their psychiatry boards on their first attempt (national average is 62%) (22, 23). In addition, graduates are predominantly practicing psychiatry, although all but three continue to practice some family medicine. Notably, nearly 30% are practicing in positions specifically designed for combined trained graduates, yet are not practicing fully integrated care. Further investigation is required to delineate the specifics of these practices as many may be teaching positions in training programs, research positions, or consultation-liaison positions.

Preparation for Practice

Our study indicates that the graduates feel comfortable in their ability to practice each specialty individually. This finding is consistent with prior reports from family medicine-psychiatry program directors who felt that these individuals performed as well as, if not better than, their categorical colleagues during residency training (20).

Prior studies have shown that family medicine-psychiatry program directors lack a clear and consistent approach towards teaching the integration of care (20). This lack of clarity appears to carry over to the practices of the graduates. Some have suggested that residents should become

proficient in both skill sets (including not only content knowledge but also the skill of setting boundaries appropriate to each specialty) before they are allowed to integrate the two. The hope is that they would then integrate the two with a greater degree of confidence (21). Unfortunately, our data suggest that most graduates of this young specialty have yet to develop comfort in integrating their family medicine and psychiatry skill sets and practices. Perhaps the absence of a standard approach to teaching the integration of skill sets in a way that also facilitates boundary formation contributes to their uncertainty.

A primary goal in establishing combined programs was to develop graduates that bridge the gap between family medicine and psychiatry. Along these lines, graduates are comfortable acting as liaisons between the two specialties. In addition, with over half of the graduates either serving in academic institutions or in military service roles, they act as force multipliers in developing more psychiatrically minded family physicians. Although our study did not measure the effect of such force multiplication, we suspect that it increases the efficiency and decreases the cost of medical care.

For example, a combined trained physician working in a psychiatric setting may take care of routine medical problems for their patients and thus avoid referral for many medical problems. This will decrease the cost of duplicate appointments, increase access to care, and decrease the delay in receiving care. Along the same lines, a combined trained physician working as a family practitioner will be able to provide high quality psychiatric care for most of his or her medical patients. An example of this comes from the first graduate from the National Capital Consortium's program. This physician served as a public health officer and worked as a psychiatrist at St. Elizabeth's Hospital in

FIGURE 2. Preparation for Practice

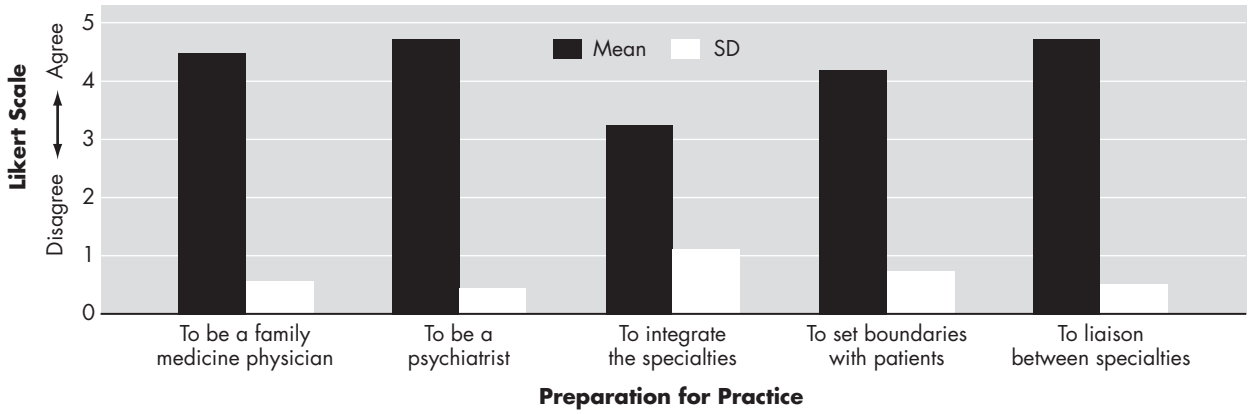
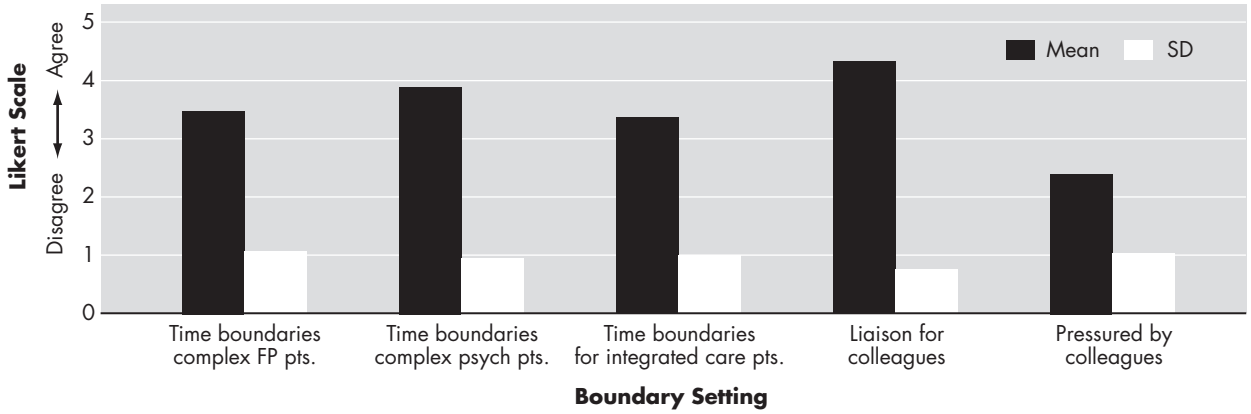


FIGURE 3. Ability to Set Boundaries of Practice



Likert scale, 1 = strongly disagree and 5 = strongly agree

Washington, D.C. In discussions with him, we discovered that it was a matter of routine practice for him to manage hypertension, diabetes, thyroid medication, and other medical issues for his patients. These patients, from an underserved population, received quality primary care from their psychiatrist. This is an asset that the patients were unlikely to receive had he only been trained in psychiatry. There are many such examples like this reported anecdotally by almost every combined graduate. However, the full economic impact of combined training and practice and the intricacies of coding and billing these encounters have not yet been analyzed and constitute an area for future investigation. Careful studies of these impacts may do more to promote combined training than any other single factor.

Boundaries of Practice

Family medicine-psychiatry graduates must establish appropriate personal and professional boundaries with patients in two very different specialties. Respondents reported a moderate level of comfort with implementing boundaries, noting less difficulty in the psychiatric setting than in family medicine or integrated practice settings.

These results were further supported by the level of comfort in setting time boundaries with their patients. Respondents felt more comfortable in setting time boundaries with their psychiatric practice, which would be expected. Psychiatric practice places greater emphasis on boundaries as part of the therapeutic process. However, the lower level of comfort in setting boundaries with the integrated patient may again reflect some of the difficulty graduates might experience in learning to integrate care.

Furthermore, only 52% of the respondents noted that they felt comfortable in both setting boundaries and integrating care. Considerable variance was reported regarding specific boundaries of practice implemented by all respondents. This lack of clear consensus may be accounted for by variance in training programs, variance in the practitioners' scope of care, the unique identity of each of the graduates, or a byproduct of the lack of comfort providing integrated care as previously noted.

Analysis of the correlations in Table 2 supports the theory that natural boundaries will begin to develop. For graduates who are comfortable in setting boundaries and integrating their skills, they are likely to see their integrated patients in the same setting as walk-ins, to care for their families, shake their hands, provide some physical contact, conduct physical exams, share personal history and emotional responses, and share religious views. They are not likely to perform breast and genital exams, perform home visits, or see patients socially.

These evolving boundaries demonstrate the unique nature of care that a combined trained graduate can provide in comparison with their categorical colleagues, but they also outline the limitations. Family medicine is a specialty that emphasizes preventive care, including screening for breast, cervical, and testicular cancer, and the development of long-term doctor-patient relationships with the

TABLE 2. Physician Behaviors With Integrated-Care Patients (N = 14) and Correlations Between Behaviors and Degree of Provider Comfort Performing Integrated Care

Personal or Professional Behavior With Implications for Boundary Limits	N	%	Pearson Correlation Coefficient	Significance
See all patients in the same setting*	6	42.9	0.515	0.006
Provide care for my patients' families*	6	42.9	0.515	0.006
Shake my patients' hands*	10	71.4	0.739	0.000
Give patients a ''pat on the shoulder''*	6	42.9	0.515	0.006
Conduct physical exams on my patients*	8	57.1	0.625	0.000
See patients for walk in visits outside the established appointment times**	4	28.6	0.402	0.038
Self disclose personal information with my patients**	5	35.7	0.459	0.016
Self disclose emotional responses with my patients**	4	28.6	0.402	0.038
Share my religious views and offer to meditate/pray with those who desire**	4	28.6	0.402	0.038
Perform home visits	1	7.1	0.189	0.345
See my patients socially	2	14.3	0.273	0.169
Conduct breast exams on my patients	2	14.3	0.273	0.169
Conduct pelvic exams on my female patients	2	14.3	0.273	0.169
Conduct genital exams on my male patients	2	14.3	0.273	0.169

*Correlation is significant at the 0.01 level
**Correlation is significant at the 0.05 level

entire family. This is in direct contrast to many of the boundaries that are emphasized in psychiatric practice for the importance of the therapeutic relationship. With these limitations, it raises questions about whether a "true fully integrated" practice is possible or whether combined trained graduates will need to work in conjunction with their categorically trained colleagues to provide the full scope of care.

Alternatively, further establishing the boundaries of care provided by combined trained physicians may result in a reconsideration of the clinical boundaries held as commonplace in psychiatry. A poignant clinical example can illustrate the potential socioeconomic impact. Consider a female patient with a history of sexual trauma who avoids visiting her primary care physician for cervical or breast cancer screenings. Both of these screening modalities, when implemented, have demonstrated a reduction in morbidity and mortality as well as health care costs associated with these conditions (24, 25). It is well documented that primary care physicians routinely fail to obtain trauma history from their patients (26). Conversely, this historical information is a routine element of psychiatric intakes. The combined trained physician is more ideally prepared to elicit a trauma history and address this clinically than categorical family medicine counterparts and has the skill set available to provide annual cervical and breast cancer screenings that would not be routinely performed by a categorical psychiatrist. In this clinical scenario, the combined trained clinician may be ideally suited to identifying and reducing mental health-related barriers to medical care. This may result in an increased access to care and health care cost savings.

Integration of Practice

Though most respondents reported practicing both family medicine and psychiatry, only a small percentage do so in a full-time integrated practice. A variety of factors may contribute to a lack of integrated practice among combined trained graduates. Chief among them is limited preparation for integration during residency training. Most graduates are not in positions specifically designed for integrated care; thus, a lack of integrated job opportunities may play a role. Though not yet elucidated, it is possible that legal or administrative policies affecting the provision of integrated care may play a role in the current provision of services that integrate family medicine and psychiatry. Specifically, barriers may be created by the medicolegal implications of "standard of care" in a given practice setting or region. With so few graduates providing fully integrated care, confusion may exist as to how and by whom decisions regarding a standard of care would be implemented.

Limitations

This pilot study is limited in certain areas. Our questionnaire is restricted to the graduates' subjective perceptions and the results are based on self-report data from 63% of a small number of graduates from combined family medicine-psychiatry residencies, making it difficult to generalize these data to all family medicine-psychiatry trained individuals. The use of a survey standardizes responses and keeps respondents focused on the areas of investigation, but it also limits the ability to gain full comprehension of the graduates' scope and nature of clinical practice. This survey does not assess the perceptions of patients who receive care from these graduates or their colleagues, nor does it assess the effect of combined training on medical business practice, quality of care, or access to care. Additionally, the survey focused on the location and setting of practice but did not look at the type of practice (high volume medication versus integrated psychotherapy/pharmacology). Lastly, because there are so few graduates from each of the individual programs, respondents might have been concerned about being identified even though this was an anonymous survey. This could potentially influence their responses in that they would not want their training programs and experiences to be perceived in a negative light.

Future Applications

Previous studies have noted that integrating the two specialties was difficult during residency training (20, 21). From our data, it appears that this continues to be a dilemma for graduates. The majority are not in a fully integrated practice and there does not appear to be a consensus of practice within the scope of care. Much of this difficulty can be reasonably attributed to the lack of preparation at the residency level. There is no established model for teaching integrated care in combined training; furthermore, a number of the residencies restrict the residents from being able to practice integrated care during their training (20, 21). These practices have resulted in no clear consensus among those in the field. Clearly, a set of training standards and goals specific to the combined training programs is needed. We recommend that a multidisciplinary oversight committee consisting of combined family medicine-psychiatry graduates, as well as current and

former residency program directors, establish standards for teaching integrated care within these programs.

There appear to be few graduates working in positions designed specifically for graduates of combined training, with the majority of those being at academic institutions. Graduates of combined programs should be more effectively utilized. Some potential uses are 1) within integrated inner city or rural practices, 2) integrated care within a group family medicine clinic, 3) integrated care in a deployed military or public health environment, 4) educational positions at residency training programs, or 5) providing integrated care to special needs groups, such as autistic children or schizophrenia patients and their families. Furthermore, it is unclear whether there is any medical or economical benefit to the utilization of combined trained graduates in these populations. Determining whether there is a comparative advantage is also an area for future investigation.

Further studies needed to determine how graduates of family practice-psychiatry training programs are dealing with issues of professional identity, mentorship, and role diffusion, and to assess the full impact of combined training on the practice of medicine in the United States. We hope to continue to clarify these important questions.

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