Combined Internal Medicine–Psychiatry and Family Medicine–Psychiatry Training Programs, 1999–2000: Program Directors' Perspectives

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ABSTRACT

Purpose. Despite tremendous growth in the number of combined-training residency programs, little is known about their directorships, financing, recruitment, curricula, and attrition rates, and the practice patterns of graduates. The authors surveyed residency program directors from combined internal medicine–psychiatry (IM/PSY) and family medicine–psychiatry (FP/PSY) programs to provide initial descriptive information.

Method. Programs' directors were determined from the American Medical Association's *Graduate Medical Education Directory* and FREIDA online database. Three mailings of a pretested questionnaire were sent to the 40 identified combined IM/PSY and FP/PSY residency programs.

Results. A total of 32 directors from 29 programs responded. Most programs were under the dual directorship of representatives from both the psychiatry department and either the internal medicine or the family medicine program. Although most directors responded that the residency program was based in psychiatry, both departments shared in administrative, recruiting, and financial responsibilities. Curricula varied widely, with limited focus on combined training experiences. Graduates (n = 41) tended to practice in academic settings (37%), where both aspects of training could be used. Others practiced in either community mental health centers or traditional private practice settings. The estimated attrition rate from combined residencies was 11%.

Conclusions. Combined-training programs are directed by a diverse group of individuals, including dual-boarded physicians. Curricula vary widely, but most programs are within recommended guidelines. Further prospective studies are warranted to determine predictors of attrition and future practice plans.

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In the last ten years, the number of combined internal medicine–psychiatry (IM/PSY) and family medicine–psychiatry (FP/PSY) programs has grown rapidly. This growth may suggest an increasing interest among graduating medical students in pursuing two fields of study, an interest possibly fueled by a greater need for physicians who are articulate in managing people with combined illnesses. For instance, the growth of managed care has placed an expanded responsibility for the total care of patients in the hands of primary care providers. Persons who have dual training are well qualified to manage primary medical and psychiatric problems. Previously, residents who desired training in two fields had to pursue consecutive residencies. The advent of dual training has allowed residents to complete an IM/PSY or FP/PSY residency in five years. Unfortunately, little is currently known about the structure or function of IM/PSY and FP/PSY residencies in the United States. We surveyed directors of these training programs to better understand the roles of their directors, dual-training curricula, and positions graduates attain once they have com-

pleted IM/PSY and FP/PSY nonsequential training. Results from our survey documenting resident physicians' perspectives are reported elsewhere.[1]

Method

The institutional review board at the principal investigator's (CCD's) institution approved the study design and questionnaires.

The program directors for the 40 IM/PSY or FP/PSY programs listed in the American Medical Association's 1999–2000 *Graduate Medical Education Directory* were contacted and asked to complete a written survey.[2] (Not all programs were active at the time of the study.) In cases where the program director's information was outdated, we either contacted programs directly or obtained the updated director's information from the American Medical Association's FREIDA online directory.[3] The questionnaire was based on discussions held at the Association of Medicine and Psychiatry's annual meeting as well as the personal observations of the authors (CCD, RM, WR), and it was pretested by one FP/PSY program director and one IM/PSY director. The questionnaire assessed basic demographic factors, program curricula, and information about graduates of their dual-training programs. We performed three separate mailings of the questionnaire between September 1999 and May 2000. When curriculum-related questions were not answered by program directors, information was gathered from individual programs' Web pages or from FREIDA documentation.

Results

We received responses from 32 program directors representing 29 programs (14 IM/PSY, 15 FP/PSY; see Table 1). In several cases, the psychiatry program director served as the co-director for the IM/PSY and FP/PSY programs, where both existed at the same center. Seventeen program directors were associate professors, nine were assistant professors, and five were professors. One respondent did not provide rank. Eleven program directors were board certified in both psychiatry and either IM or FP. On average, the directors had served for 3.6 years (range 0–11 years; SD = 2.6) in their positions. Nine (28%) served as the sole director for the combined program.

Table 1

Demographic Information for 32 Directors of Combined Internal Medicine–Psychiatry and Family Medicine–Psychiatry Training Programs Who Responded to a National Survey, 1999–2000

Characteristic	No. (%)*
Gender	
Men	25 (78)
Women	7 (22)
Title	
Assistant professor	9 (29)
Associate professor	17 (55)
Professor	5 (16)
Directorship	
Sole director	9 (28)
Shared	23 (72)
Primary department	
Psychiatry	17 (26)
Internal medicine	25 (38)
Family practice	19 (29)
Dual	5 (7)
Board certification	
Psychiatry	22
Internal medicine	11
Family practice	8
Dual	11

*Some numbers do not total 32 because some directors are board certified in both programs (either internal medicine and psychiatry or family practice and psychiatry).

At the time of the survey, 27 program directors reported that they had received accreditation for combined training by the respective boards. Of the remaining five, two directors reported their programs had no current accreditation, and three did not respond to the question. A wide range (0–20 years) was seen in the numbers of years the programs had been operating, with a mean of 5.0 years (SD = 3.8). The majority of programs (n = 17) were primarily based in departments of psychiatry; the remainder were based in departments of either internal medicine (n = 8) or family medicine (n = 6). One program director did not respond to this question. Despite this, over half of the program directors stated that funding streams for recruitment, book and travel funds, and clerical support were provided equally by both departments of the program. While 69% of the combined programs that responded had a residency coordinator, only 38% named a chief resident. In the majority of cases, the responsibility for making annual residents' schedules was also shared equally by the departments.

Only 12 (40%) of the program directors reported they had a lecture series specifically devoted to residents in combined training (18 reported no lecture series and two did not answer). Nearly half of the program directors (47%) reported that residents rotated in an outpatient IM/PSY or FP/PSY clinic. Staffing patterns in the clinics included mixtures of faculty, including double-boarded staff (n = 8), internists (n = 5), family practitioners (n = 5), and psychiatrists (n = 10). Six program directors reported that their institutions had inpatient settings devoted to medical psychiatry units. Staffing patterns on these inpatient units include combinations of internists (n = 3), family practitioners (n = 1), psychiatrists (n = 5), or dual-boarded (n = 4) faculty members.

Figures 1 and 2 show typical residents' schedules over the five years of training. Neurology months were counted as either internal medicine or family medicine months unless otherwise noted as psychiatry months by the

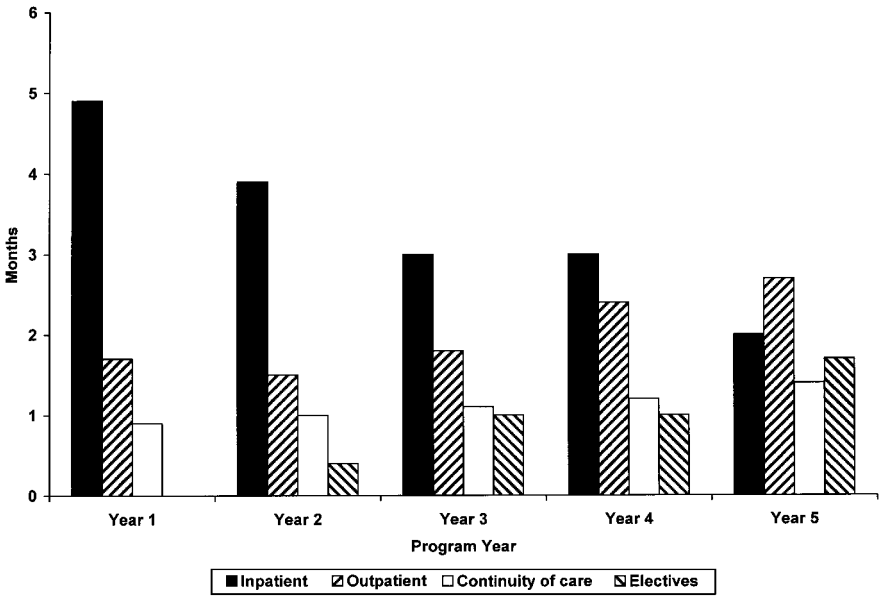

Figure 1. Typical internal medicine or family medicine residency schedule. Rotation is shown by months during the year of residency.

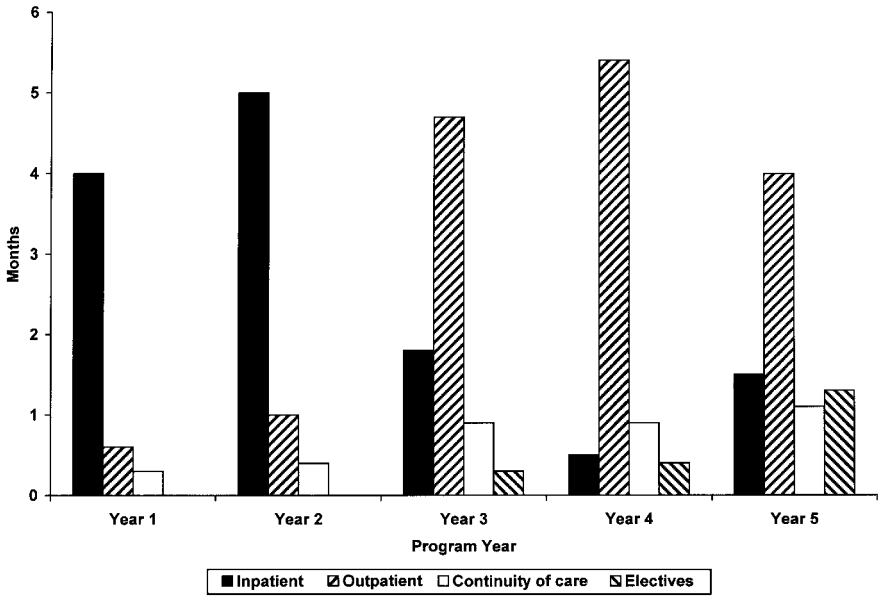

Figure 2. Typical psychiatry residency schedule. Rotation is shown by months during the year of residency.

respondents. Child psychiatry months are included in either the inpatient or the outpatient psychiatry experiences according to how they were reported. Continuity clinics are reported as numbers of half-days per week spent in the clinic. In some cases, we were unable to determine whether a given month in either field was considered required or elective. The scheduling of inpatient and outpatient clinical experiences varied widely among departments and programs. Overall, during the first postgraduate year (PGY-1), residents averaged seven months (range 4–10) on IM or FP services and five months (range 1–8) on psychiatry services. During the next four years, however, the times residents spent in the two departments were divided nearly equally. Residents spent an average of five and a half months (SD = 2) in internal medicine and an average of six months (SD = 2) in psychiatry. Notably inpatient responsibilities tended to decrease annually over the five years, and elective time was minimal. Generally, elective months in either specialty are not allowed during the first two years. For PGYs 3–5, an average of one elective

Table 2

Numbers of Graduates from Combined Internal Medicine–Psychiatry Programs and Their Positions as of May 2000, Based on a Survey of Program Directors, 1999–2000

Program	Academic Medicine and Psychiatry	Academic Consultation Liaison or Geriatric Psychiatry	Community Mental Health Center Psychiatry	Private Practice Medicine and Psychiatry	Private Practice Psychiatry	Private Practice Medicine	Substance Abuse	Military	Unknown/ Other
West Virginia University School of Medicine (Charleston)	3	2	3	—	8	—	—	—	—
University of Iowa College of Medicine	3	1	—	1	—	—	—	1	1
Southern Illinois University School of Medicine	4	—	—	—	—	—	—	—	—
Brody School of Medicine at East Carolina University	—	—	—	—	1	1	2	—	1
Tulane University School of Medicine	1	—	—	—	—	—	—	—	—
University of Virginia School of Medicine	1	1	—	—	—	—	—	—	—
University of Rochester School of Medicine and Dentistry	2	—	—	—	—	—	—	—	1
Duke University School of Medicine	1	—	—	—	—	—	—	—	1
Michigan State University College of Human Medicine	—	—	—	1	—	—	—	—	—
Total	15 (37%)	4 (10%)	3 (7%)	2 (5%)	9 (22%)	1 (2%)	2 (5%)	1 (2%)	4 (10%)

month in each specialty was allowed by the majority of programs, for an average total of six elective months during the five years. It is important to note that the ranges reported by individual programs were extremely variable. For instance, one program reported that residents spent 12 months in inpatient psychiatry during PGY 2, and other programs reported that residents took the 12 consecutive months of outpatient psychiatry entirely during PGY 3 or PGY 4.

The program directors reported that the number of residents who practiced in both specialties following graduation from a combined residency may be growing when compared with suggestions in previous literature.[4] Table 2 shows the practice patterns of graduates of the nine IM/PSY programs responding to the questions about graduates. At the time of the final mailing (May 2000), 15 graduates were practicing internal medicine and psychiatry in academic health centers. Four graduates were focussed on academic geriatrics or consultation-liaison psychiatry. In the community sector, three served at community mental health centers, while nine were in other private practice settings. Only one graduate was reported to be practicing only internal medicine. Of the FP/PSY program directors responding, none reported that their residents had yet finished training.

From the programs that responded, a total of 29 residents had left prior to completing their dual training. An average of 2.3 residents (SD = 2.5) had left dual-training programs prior to completion (range from individual programs 0–9). An estimate of attrition based on three factors the directors reported (numbers of residents who had left programs, 41 reported graduates, and an estimated 184 residents currently enrolled) suggests the attrition rate was 11.4%. Those programs reporting higher rates of attrition were the same programs that had been in operation for longer periods of time.

Discussion

We believe that ours is the first study to survey directors of combined residency training programs in IM/PSY and FP/PSY. The tremendous growth of interest among medical students in combined residency programs in the last five years has placed many institutions in the position of creating dual residencies in IM/PSY and FP/PSY. Our finding that most program directors are assistant or associate professors suggests that these combined programs are being led by younger faculty. At the time of our study, only nine persons functioned as the sole director, possibly reflecting the low number of graduates to date and the number of those graduates who have pursued academic careers. Although, in general, the programs were primarily based in one department, both departments involved tended to share the financial and scheduling demands of the combined programs.

There are many challenges to designing a curriculum that meets the individual needs of participating departments, residents' requests for elective time in curricular selections, and guidelines issued by the American Boards of Internal Medicine, Family Practice, and Psychiatry and Neurology. Although the programs generally split the years evenly between the two departments, the rotation schedules shown in Figure 2 reveal a fair amount of scheduling variability. It is difficult at this point to interpret whether this scheduling variability translates into any deficits in the residents' overall training experiences.

Mentorship is important for the development of resident physicians, and it may follow that mentorship is also an important component of the development of combined residency programs. For instance, communication between directors of long-standing programs and those of newer programs might help to prevent or solve problems that may arise during curriculum development. Also, the experiences of faculty members who have completed dual-training programs may inform newer programs. In cases where a single IM/PSY or FP/PSY program director exists, we would encourage that director to maintain close contact with the program directors of the parent programs to optimize schedules and flexibility, but still maintain requirements of the Residency Review Committees. Members from the Association of Medicine and Psychiatry, a national organization devoted to physicians practicing at the interface of internal medicine, family medicine, and psychiatry, may provide a valuable resource to both residents and faculty working in a dual-training environment. Information about the organization is available at ⟨http://www.amedpsych.com⟩.

Several of the programs surveyed had not graduated a single resident because they had not been in operation for five years, a trend that will certainly change in the next three to five years. Importantly, the data in our study do not reflect the number of residents who were expected to complete their dual training on June 30, 2000, or June 30, 2001. Based on the number of residents reported to be in PGYs 3, 4, and 5 at the time of the survey, we expect that the number of graduates completing combined training may nearly double in the next three years. Although attrition from combined-residency programs such as pediatrics/adult psychiatry/child psychiatry has previously been reported to be problematic,[5,6] attrition rates from the combined residencies we surveyed (11%) do not appear as alarming. We propose that reasons for attrition include (1) medical students' selecting combined programs based on indecision about selecting a single residency; (2) residents' developing preferences for one field after exposure to training, (3) undisclosed personal reasons, and (4) residents' choosing not to undergo the rigors and length of combined training. The latter may be a hazard more commonplace at the completion of PGY 3, when colleagues in internal medicine or family medicine programs complete their training. Further data evaluating the peak times for risk of attrition will be beneficial in learning how to counsel medical students entering combined programs and residents who are considering leaving combined training.

Additional challenges associated with combined training, including lack of role models, poorly established joint-training venues, establishing identities for graduates, and curriculum-related stresses as outlined by Chapman and Nuovo, may become less problematic as centers gain experience in dual training and more graduates are able to provide a dual-training identity.[7] Data we report elsewhere show that the majority of graduates of dual programs have selected or plan to take positions in which they may continue to use both sets of skills gained during training.[1] It is greatly encouraging to learn that the majority of graduates to date have chosen to stay in academic programs, either in medicine or psychiatry, consultation–liaison psychiatry, or geriatric psychiatry. In roles such as these, dual-trained physicians are in ideal positions to serve as mentors for medical students and residents. Of added benefit, these physicians may provide mentorship not only to residents in dual tracks, but also to residents from general psychiatry, family practice, or general internal medicine programs. Little is currently known about the actual practice patterns of graduates with dual training who are working in community and private-practice settings. For instance, do these physicians typically care for general psychiatry patients, or do they serve as consultants to primary care group practices, or do they provide care for persons with complex interactions of psychiatric and medical disorders?

This study has limitations, including the failure to achieve a response from every program program's director and the small overall pool of programs active at the time of the survey. However, responses were received from 29 of the 30 active programs. We might have

been able to better categorize the current practice patterns among prior graduates of combined programs if we had directly contacted the graduates.

We recommend that long-term follow-up studies of dual-trained program graduates by conducted at five-year intervals in order to better understand the opportunities, successes, and failures of combined-practice residency programs. Information such as this will be integral in further designing dual programs and in developing the "products" of combined training.

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