



GUIDELINES FOR COMBINED FAMILY MEDICINE/PSYCHIATRY RESIDENCY TRAINING PROGRAMS

Family physicians and psychiatrists have traditionally been trained in the physical and emotional aspects of patient care. Psychiatrists have been expected to be familiar with organic illnesses presented as psychiatric disorders, while family physicians have been trained to recognize physical manifestations of psychiatric disease. Acknowledging the larger overlap in the domains of these two specialties and the increasing need for specialists trained to treat the broad spectrum of adult illness shared by family medicine and psychiatry, the two specialties have agreed to offer combined training in preparation for dual certification.

Objectives

The objective of combined training in family medicine and psychiatry is to produce physicians with broad-based training in both specialties and specific expertise in such areas common to both specialties. Graduates of combined training may be expected to develop practices which take advantage of the joint training experience, serve as consultants in liaison psychiatry or consultative medicine, or be actively involved in research or administration in family medicine and psychiatry.

The strengths of the residencies in family medicine and psychiatry should complement each other to provide an optimal educational experience to trainees.

Combined training includes the components of categorical family medicine and psychiatry residencies which are accredited respectively by the Residency Review Committee for Family Medicine and by the Residency Review Committee for Psychiatry both of which function under the auspices of the Accreditation Council for Graduate Medical Education. While combined training programs are not independently accredited, the accreditation status of the core psychiatry and family medicine programs shall influence a trainee's admission to the certifying examinations of each Board. Residents for combined training must not be recruited if either program has probationary or provisional status. A proposal for a new combined residency program must be approved by the ABFM and ABPN before a candidate can be accepted into that new combined training program.

General Requirements

A combined residency in family medicine and psychiatry must include at least five (5) years of coherent training integral to residencies in the two disciplines which meet the Program Requirements for accreditation by the RRC-Family Medicine and the RRC-Psychiatry, respectively.

It is strongly recommended that combined training be under the aegis of the same academic institution. Documentation of hospital and faculty commitment and institutional goals for the combined program must be available in signed agreements. Affiliated institutions must be located close enough to facilitate cohesion among the program's housestaff, attendance at

continuity clinics and integrated conferences, and faculty exchanges of curriculum, evaluation, administration, and related matters.

Ideally, at least two residents should be enrolled in the combined program each year. If no trainees are in a combined program for a period of three (3) years, the program will not be listed as approved.

At the conclusion of sixty (60) months of training in family medicine and psychiatry residents should have had experience and instruction in the prevention, detection, and treatment of acute and chronic medical and psychiatric illnesses presented in both inpatient and ambulatory settings. Trainees should be exposed to patients with psychiatric and/or medical problems representing all age groups. Trainees should receive training in the socioeconomics of illness, the ethical care of patients, and the team approach to providing patient care.

The training of residents while on family medicine rotations is the responsibility of the family medicine faculty, while on psychiatry rotations, training is the responsibility of the psychiatry faculty. Vacation, leave, and meeting time will be shared equally by both training programs.

Except for the following provisions, combined residencies must conform to the Program Requirements for accreditation of residencies in family medicine and psychiatry.

The Resident

Residents should enter a combined program at the R-1 level, but may enter as late as the beginning of the R-2 level only if the R-1 year meets the advanced placement requirements of one of the two specialties. Residents may not enter a combined training program beyond the R-2 level. Transfer between combined programs must have prospective approval of both Boards, and is allowed only once during the five-year training period. The continuity requirement of the family medicine Board must be met. In a transfer between combined programs, residents must be offered and also complete a fully-integrated curriculum. A resident transferring from a combined program to a categorical family medicine or psychiatry program must have the prospective approval of the receiving Board.

Training in each discipline must incorporate progressive responsibility for patient care, as well as supervision and teaching of medical students and junior residents throughout the training period.

The Program Director(s)

Combined residencies must be coordinated by a designated full-time director or co-directors who can devote substantial time and effort to the educational program. An overall program director may be appointed from either specialty, or co-directors from both specialties. If a single program director is appointed, an associate director from the other specialty must be named to insure both integration in the program and supervision of the discipline. The program director(s) must be certified by the ABFM or ABPN. An exception to the above requirements would be a single director who is certified and/or residency trained in both specialties and has an academic

appointment in each department. The two directors must embrace similar values and goals for their program. The supervising directors from both specialties must document meetings with one another at least quarterly to monitor the progress of each resident and the overall success of the program.

Duration of Training

Training requirements for credentialing related to the certifying examination of each Board will be fulfilled by sixty (60) months of training in an approved combined program. A reduction of twelve (12) months of training compared to that required for two separate residencies is possible due to overlap of curricular and training requirements. The requirement of thirty-six (36) months family medicine training is met by thirty (30) months family medicine training with six (6) months credit for training appropriate to family medicine obtained during the thirty (30) months psychiatry training. Likewise, the thirty-six (36) months psychiatry training requirement is met by thirty (30) months psychiatry training with six (6) months credit for training appropriate to psychiatry obtained during the thirty (30) months family medicine training.

Core Curricular Requirements

A clearly described written curriculum must be available for residents, faculty and both Residency Review Committees. The curriculum must assure a cohesive, planned educational experience and not simply comprise a series of rotations between the two specialties. Duplication of clinical experiences between the two specialties should be avoided and periodic review of the program curriculum must be performed. This review must include the program directors from both departments and consultation with faculty and residents from both departments.

Each year of the residency should include both family medicine residency rotations and psychiatry residency rotations. Care must be exercised to avoid unnecessary duplication of educational experiences in order to provide as many clinical/educational opportunities as possible.

During the final 48 months, continuous assignment to one specialty or the other should not be less than three months nor more than six months in duration with allowance for the required twelve months FTE of continuous outpatient psychiatry scheduled at the program's discretion.

Joint educational conferences involving residents from family medicine and psychiatry are recommended and should specifically include the participation of all residents in the combined training program. Availability of faculty from both specialties for consultation during clinical rotations, especially during continuity clinic, is encouraged.

Requirements for Family Medicine

Thirty (30) months of training in family medicine must be devoted to the fulfillment of all required longitudinal and intense short duration experiences defined in the Program Requirements. The remaining six (6) months will be fulfilled by utilizing psychiatric training as electives.

The continuity requirement for attending a panel of patients and families in the Family Medicine Center for thirty-six (36) months must be met. At least twenty-four (24) months of continuous care must be sequential, irrespective of the concurrent training requirement in either family medicine or psychiatry. A minimum of one half day a week in the R-1 year must be spent in the Family Medicine Center. During R-2 through R-5 any two consecutive years may be utilized for continuity experience, so long as the first of these years requires at least two (2) half days per week and the second year requires at least three (3) half days per week in the Family Medicine Center. Residents must follow their own panel of patients, including obstetric patients, in the hospital or other residential facility. All other elements of the Program Requirements for Family Medicine must be met.

Requirements for Psychiatry

Among the 30 months of psychiatry, the following experiences are required: Neurology: two FTE months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program.

Inpatient Psychiatry: at least six months, but no more than 16 months FTE of inpatient psychiatry of which there must be a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units, day hospital programs, research units, residential treatment programs, and other settings where:

- the patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender; and

- patient services are comprehensive and continuous and allied medical and ancillary staff are available for backup support at all times.

Outpatient Psychiatry: 12 months FTE of organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients. Each resident must have significant experience treating outpatients longitudinally for at least one year. This longitudinal experience should include:

- evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;

exposure to multiple treatment modalities that emphasize developmental, biological, psychological, and social approaches to outpatient treatment;

opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically-ill patient population; and,

no more than 20 percent of child and adolescent patients. This portion of education may be used to fulfill the two-month child and adolescent psychiatry requirements, so long as this component meets the requirements for child and adolescent psychiatry below.

Child and Adolescent Psychiatry: two months FTE of organized clinical experience in which the residents are:

supervised by child and adolescent psychiatrists who are certified by the ABPN or who are judged by the Review Committee to have equivalent qualifications; and

provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities.

Consultation/Liaison: two months FTE in which residents consult under supervision on other medical and surgical services.

Geriatric Psychiatry: one month FTE of organized experience focused on the specific competencies in areas that are unique to the care of the elderly. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, and understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including drug interactions.

Addiction Psychiatry: one month FTE of organized experience focused on the evaluation and clinical management of patients with substance abuse/dependency problems, including dual diagnosis;

Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of self-help groups.

Forensic Psychiatry: This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand trial, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable.

Emergency Psychiatry: This experience must be conducted in an organized 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients;

On-call experiences may be part of this experience, but no more than 50 percent

Community Psychiatry: This experience must expose residents to persistently and chronically-ill patient in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community-based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals.

Addiction, community, forensic, and geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement.

Evaluation

There must be adequate, ongoing evaluation of the knowledge, skills and performance of the residents. Such evaluations must be in accordance with the Family Medicine, and Psychiatry Program Requirements. There must be a method of documenting the procedures that are performed by the residents. Such documentation must be maintained by the program and be available for review by the RRCs, ABPN, and ABFM.

The program must formally conduct clinical skills examinations that conform to the requirements set forth in the document “Requirements for Clinical Skills Evaluation in Psychiatry.” In at least three evaluations with any patient type, in any clinical setting, and at any time during the program residents must demonstrate satisfactory competence in establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination, and in case presentation. Each of the three required evaluations must be conducted by different ABPN-certified psychiatrists. Satisfactory demonstration of the competencies during the three required evaluations is required prior to completing the program.

Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.

The program must maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel. The program director and faculty are responsible for documenting a final evaluation for each resident who completes the program. This evaluation must include a review of the resident’s performance during training and should verify that the resident has performed in a professional manner and is able to practice competently and independently in all relevant components of the Combined Program. This final evaluation should be part of the resident’s permanent record maintained by the institution.

Certification

To meet requirements for dual certification the resident must satisfactorily complete 60 months of combined training and this must be verified by the training director or both training directors of the parent programs. The written certifying examinations may not be taken until all required years of training in both specialties are satisfactorily completed. Lacking verification of acceptable clinical competence and performance in both specialties in combined training, the resident must satisfactorily complete the training requirements as required by each specialty.

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