37th Forum for Behavioral Science in Family Medicine

“How double-boarded physicians improve behavioral health education for all learners “

1. Dual-Board Training Options
	1. Combined Training Programs in Medicine and Psychiatry for Resident Physicians
		1. First programs emerged in the 1990s
		2. 5 Family Medicine-Psychiatry Programs
		3. 12 Internal Medicine-Psychiatry Programs
		4. 10 “Triple Board” Pediatrics-Psychiatry-Child Psychiatry Programs
	2. Basics of Training
		1. Residencies are 5 years and blend medicine and psychiatry
		2. Accredited separately by individual board (ABFM, ABPN, ABIM, ABP)
		3. Medicine residencies tend to be focused on inpatient medicine and Family Medicine residencies tend to be focused on outpatient medicine
		4. Residencies provide 12 months of continuous, supervised outpatient psychotherapy training.
	3. Career Paths
		1. >75% of graduates practice to some degree in both specialties
		2. Graduates work in multiple arenas including academics, consultation-liaison psychiatrists, hospitalists, outpatient physicians, emergency psychiatrists, and fellowship-trained specialties including forensics, addictions, geriatrics, child psychiatrists
		3. Dual-boarded & Triple-boarded physicians provide unique teaching experiences to medical students and residents seeking integrated care.
2. Mentoring Students Interested in Primary Care and/or Psychiatry
	1. Explore their perceived identity/goal as a ‘Medically Oriented Psychiatrist’ versus ‘Behaviorally Minded Family Physician’. Identifying end goal helps determine most logical/efficient training path.
	2. What is their ‘backup’ plan if not combined training? Why did they pick that one?
	3. Can you take a categorical program scaffolding and build your specific interest or experience into the training?
	4. Obtaining a mentor
		1. Hard to do if school does not have a combined program or a double-boarded faculty member.
		2. Can look to organizations such as Association of Medicine & Psychiatry or one of the consultation liaison psychiatry meetings or this meeting to find like-minded individuals and opportunities to network.
	5. Review of competitiveness given limited programs:
		1. 5 FMP programs with approximately 2 spots each year
		2. 100 applicants (UC’s experience), 20 interviews (UC’s experience)
	6. Need to mention combined training in personal statement, need to have letters from both primary care and psychiatry, although end goal is obviously fluid we expect applicants to have thought about it, membership in organizations from both specialties, clinical experiences on both sides, publications/research are a plus.
	7. Audition electives – can be a huge factor because many schools do not have combined training or access to a double boarded mentor, most FMP programs offer medical student rotations such as AI’s, can be a chance to sample the program as well as present your qualifications to training leadership and residents, can go both ways though (impress beyond your paper credentials or the opposite) so only advise if serious about the program and capable of committing to a strong rotation performance

|  |  |  |  |
| --- | --- | --- | --- |
| **Consideration** | **Psychiatry** | **Family Medicine** | **Internal Medicine** |
| *Pharmacology* | More exposure to lithium, mood stabilizers, depot formulations, pediatrics | More comfort outside of pure psych drugs, exposure in OB settings, ADHD management | Same as family with broad medicine exposure, but NO OB and less ADHD due to no pediatrics |
| *Therapy* | More contact and skill development time over the required 12 month continuous outpatient experience; practical realities of less physician contact time for therapy | Able to do brief interventions or spend some elective time focusing on specific modalities such as motivational interviewing; behavioral science faculty teaching | Same as family in having to spend elective time, need to focus on 15 minute based interventions; no required behavioral health science faculty |
| *Pathology* | Extensive time spent on inpatient with the severely mentally ill and less time with more functional individuals | Primary population is depressed or anxious, may have limited experience with more psychotic presentations | Primary population is depressed or anxious, may have limited experience with more psychotic presentations |
| *Training* | 4 years; includes substance abuse & neurology | 3 years, one required month of behavioral science | 3 years |
| *Fellowship Opportunities* | Many ACGME accredited in forensics, geriatrics, pain management, sleep, psychosomatics etc. | Some CAQs (maternity, geriatrics, palliative care) and some informal (faculty development) but emphasis is on generalist approach | Many ACGME accredited in medical specialties if potential desire for focusing on a single disease process or advanced training  |
| *Lifestyle* | Work day, Salary, practice settings/business model | Work day, salary, practice settings/business model | Work day, salary, practice settings/business model |
| *Licensing Issues* | ECT privileges, Court, emerging standard of care for medical but primarily limited to mental health | Formulary issues, ability to do more with general FP license | Formulary issues, ability to do more with general IM license |

1. How to Partner with Dually-Boarded Physicians to Teach FM Residents
	1. Behavioral Health Rotations
		1. Even if practicing only psychiatry, often have a unique perspective
	2. Behavioral Health Lectures
		1. Often can bridge gap between psychiatry world and primary care world
			1. Collaborative Care: understand that attraction for psychiatrists and frustration for primary care doctors
			2. Provide realistic and useful methods for interacting with primary care patients with behavioral health needs.
	3. Balint Groups
		1. Often have been through Balint in primary care, perhaps individual therapy, perhaps group process
	4. Integrated Behavioral Healthcare Programs
		1. Natural interests in integrating primary care and behavioral healthcare
	5. Your liaison to another department
		1. Collaborative research projects
		2. Bridge to Psychiatry residents, medical students interested in psychiatry