

# Physicians Who Are Certified in Family Practice and Psychiatry: Who Are They and How Do They Use Their Combined Skills?

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**Background:** The American Board of Family Practice (ABFP) and the American Board of Psychiatry and Neurology (ABPN) have jointly established their guidelines for a combined residency training program in family practice-psychiatry. As the new combined programs develop, it is of interest to learn about those physicians who are already board certified in both family practice and psychiatry.

**Methods:** The ABFP provided a list of the 39 physicians in the United States who in 1995 held certification by both the ABFP and the ABPN. A questionnaire eliciting demographic data, information on practice patterns, and comments was mailed to each of them.

**Results:** Ninety percent of the physicians responded. Sixty percent reported that they practice both family medicine and psychiatry, 20 percent practice in communities with a population of 30,000 or less, and the great majority were very satisfied with their choice of specialties.

**Conclusion:** The responding family physician-psychiatrists chose their specialties one at a time, in sequence. Although their practice patterns are interesting, we believe residents who select a combined residency will have different practice patterns, choosing to practice both specialties from the outset. After graduates of these newly emerging combined residencies have entered practice, it will be useful to study how they make use of their combined skills. (J Am Board Fam Pract 1997;10:111-6.)

In October 1994 the American Board of Family Practice (ABFP) and the American Board of Psychiatry and Neurology (ABPN) jointly established their guidelines for a combined residency training program in family practice and psychiatry. Those guidelines were published in a letter to all family practice residency directors in the United States in February 1995, advising those who were interested in developing the combined residency to submit proposals to the two specialty boards. In 1996 the University of California, San Diego, received joint approval from the ABFP and the ABPN to offer an accredited, combined residency training program in family medicine and psychiatry, and several other universities are at various stages of application for accreditation. Upon completion of an accredited, 5-year combined residency, the graduate would be eligible to sit for the

specialty examinations in family practice and psychiatry. As these combined residencies in family practice-psychiatry become established, it is helpful to observe the status of other combined programs and to examine the practice patterns of those physicians in the United States who are currently certified in family practice and psychiatry.

The *Graduate Medical Education Directory 1995-96*<sup>1</sup> lists the accredited internal medicine-psychiatry and pediatrics-child psychiatry combined residency training programs in the United States. The first of these combined programs started in 1972, and their number has gradually increased, with the number of internal medicine-psychiatry programs increasing from 13 to 17 during the 1994-1995 to the 1995-1996 academic years, and the number of pediatrics-child psychiatry programs increasing from 6 to 8 in the same time span. Until 1995 there were no accredited family practice-psychiatry combined residency training programs, although West Virginia University has graduated several residents from a combined program since the mid-1970s (personal communication, James Arbogast, MD, West Virginia University, October 1995.)

Family practice is a primary care specialty that already has defined core curriculum requirements

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**Table 1. Physicians Board Certified in Both Family Practice and Psychiatry with Certifications of Additional Qualifications or Masters or Other Doctoral Degrees.**

Additional Training	Number
Physicians grandfathered into family practice (n = 13)	
Certificates of added qualification (CAQ)	3
Masters of science (MS)	2
Doctor of jurisprudence (JD)	1
Board certification in pediatrics	1
Physicians completing two residencies (n = 21)	
Certificates of added qualification (CAQ)	6
Masters of public health (MPH)	1
Doctor of philosophy (PhD)	1

in psychiatry and the behavioral sciences. Because family medicine, as an essential element of its specialty definition, provides primary care for patients in the context of their family, occupation, culture, and community, without exclusion by age or organ system, the combination of family medicine and psychiatry would seem particularly natural. Indeed, a few physicians in the United States have trained in family medicine and psychiatry, and a questionnaire was distributed to learn more about them. This information was sought to provide some background information that might contribute to the process of developing a combined family practice-psychiatry residency training program.

## Methods

The ABFP provided a list of the 39 physicians in the United States who in April 1995 held certification by both the ABFP and the ABPN. A four-page questionnaire was mailed to each physician, and 35 questionnaires (90 percent) were returned. One respondent was a family physician-neurologist, and her responses were not compiled with the others. The following data pertain to the 34 respondents who were family physician-psychiatrists.

The questionnaire sent to the 39 physicians elicited basic demographic information, the site and timing of residencies completed, whether the respondent had other postgraduate training in addition to those residencies, the size of community in which the respondent grew up and the size of community in which the respondent currently practiced, the type of hospital in which the respondent practiced, the type of office practice, and how much time was devoted to family medi-

cine or psychiatry or other work. Inquiry was also made about how the respondent felt about having chosen family medicine and psychiatry, and what the respondent expected to be doing in 5 years. A large space for comments was generously filled by most of those responding.

## Results

### Demographics

Of the 34 physicians board certified in family practice and psychiatry who responded, 29 were men (85 percent), 28 were white (82 percent), and 31 were native born (91 percent). Nineteen of the 34 respondents (56 percent) grew up in urban-suburban areas; 8 (24 percent) grew up in small towns, and 6 (18 percent) in rural areas. The majority (25, or 74 percent) practiced in urban-suburban areas.

### Training Order and Patterns

Of the 34 respondents, 13 were grandfathered into family practice, having taken the specialty board examination after some years of general practice, and then maintained their family practice board certification by meeting the board's education requirements and taking the recertification examination every 7 years. Of those grandfathered into family practice (all were men), 4 were certified in psychiatry before they were certified in family practice. Two of those grandfathered into family practice have taken the certifying examination twice, 7 have taken the examination three times, and 4 have taken the family practice

**Table 2. Practice Patterns of Physicians Board Certified in Both Family Practice and Psychiatry (n = 34).**

Type	Practice Pattern	Number
Grandfathered into family practice (n = 13)	Psychiatry	10
	Family medicine	7
	Practice both specialties	6
	Psychiatry only	4
	Family practice only	1
	Full-time administration	1
	Medical leave	1
Completed two residencies (n = 21)	Psychiatry	20
	Family medicine	12
	Practice both specialties	12
	Psychiatry only	8
	Other (eg, addiction medicine)	2
	Majority of work in research	2
	Emergency medicine only	1

**Table 3. Combined Practice Patterns of Physicians Board Certified in Both Family Practice and Psychiatry (n = 34).**

Practice Pattern	Number
Primary care medicine	19
Both specialties	18
Psychiatry only	12
Family practice only	1
Full-time emergency medicine	1
Medical leave	1
Full-time administration	1

certifying examination four times—including 1 charter diplomate who was first certified in 1970.

Twenty-one physicians completed two separate residencies in family medicine and psychiatry. Three completed their psychiatry residency before their family medicine residency, and the rest completed their family medicine residency first. Certification of additional qualifications (CAQs) held by 9 (27 percent) of the 34 physicians included addiction medicine, geriatrics, geropsychiatry, administrative psychiatry, tropical medicine, and forensic psychiatry. Of the 34 respondents, 14 (41 percent) had an additional master's degree, doctoral degree, CAQ, or specialty board certification (pediatrics) (Table 1). Some physicians had more than one advanced degree or certification; for example, the physician who had a doctor of jurisprudence degree also had two CAQs.

### **Practice Patterns of Respondents**

Table 2 and Table 3 display the practice patterns of the physicians who responded. One physician was on medical leave, 1 worked full-time in administration, and 1 worked full-time in emergency medicine. Of the remaining 31 physicians, 1 practiced family practice exclusively; 18 practiced both specialties, and 12 practiced psychiatry only. Most physicians who were certified by the ABFP and the ABPN (20) practiced primary care medicine. All of those who responded to the questionnaire believed that theirs was an excellent combination of skills, and those who practiced only psychiatry commented that their family practice expertise enhanced their clinical ability substantially.

This group of physicians did not focus their practice in private psychiatric hospitals. Eight were working in federal hospitals (Veterans Administration, military, Public Health Service, In-

**Table 4. Type of Hospital Practice of Physicians Board Certified in Both Family Practice and Psychiatry (n = 34).**

Hospital Type and Practice	Number
Academic	13
Veterans Administration	4
Military	3
Public Health Service, Indian Health Service	1
Tertiary care	3
Urban	6
Rural	3
None	5
Private psychiatric hospital	1
Obstetrics	0

dian Health Service), and 13 were working in university and academic hospitals (Table 4). Seven physicians were working in small communities of 10,000 to 30,000 population. In the office setting 5 of the 13 physicians grandfathered into family practice practiced in a solo office, whereas 8 of the 21 physicians who completed two residencies practiced in a university or other teaching office practice (Table 5). The respondents were asked about their satisfaction with their professional choice, and those who responded expressed very high satisfaction (Table 6).

### **Discussion**

While this study takes an initial look at physicians who are certified by both the ABFP and the ABPN, it has several limitations in its design and

**Table 5. Main Practice Sites of Physicians Board Certified in Both Family Practice and Psychiatry.**

Main Practice Site	Grandfathered Family Physicians	Two Residencies
Solo office	5	3
Family practice group	1	3
Community clinic	1	1
Emergency department full time	1	2
Health maintenance organization	1	0
University or teaching	2	8
Family medicine		2
Psychiatry		5
Both		1
Industry or corporate	1	0
Psychiatry group	1	1
Private psychiatric hospital	0	1
Military, Veterans Administration, Public Health Service, Indian Health Service	1	4

**Table 6. Respondents' Satisfaction With Professional Choice (n = 31).**

Physician Choice	No. (%)
Would choose family practice again	26 (84)
Would choose psychiatry again	28 (90)
No plans to change work situation	20 (65)
Within the next 5 years	
Stop family practice	3 (10)
Retire	2 (6)
Stop psychiatry	1 (3)

implications. Although 35 responses out of 39 questionnaires mailed is an excellent return, the original list of 39 physicians is a very small one. The list was obtained from the ABFP, which asks its diplomates about their certification in an additional specialty only when they register for the recertification examination. It is possible that there

were other physicians who were board certified in psychiatry at the time they registered for their first certification examination in family practice, and these physicians would not have appeared on the list. It is also possible that a physician could have completed two residencies, one in family practice and one in psychiatry, and not have taken one or both certification examinations; they, too, would not appear on the list.

Many directories of medical specialists will not classify a physician in more than one specialty, so those directories are not a reliable source of information regarding those who practice both family medicine and psychiatry. The list obtained from the ABFP is the most reliable one available, but likely does not include all of the physicians practicing both specialties.

The questionnaires left room for comments

**Table 7. Physician Comments on Advantages of Dual Training, Compared With Colleagues Trained in One Specialty (n = 32).**

Great advantage in caring for medically ill patients on the consultation service, geriatric patients, nursing home patients, and those with somatization disorders. Also, I am comfortable with a busy practice—seeing patients back-to-back, reading electrocardiograms, assessing laboratory abnormalities. I manage busy rural and village clinics—I'm trained to make quick assessments.
I think of both family practice and psychiatry as primary care specialties.
I have breadth and depth and can talk with all physicians and practitioners.
I can easily spot the harmful aspects of my colleagues' and patients' blind spots.
Tremendous advantage. Dual training allows me (1) to understand the inseparable interaction of mind and body, (2) to screen patients' psychophysiological problems with greater ease, and (3) to develop and maintain rapport with the patients and colleagues. Family practice in itself is almost 80% psychiatry, and patients with emotional problems feel more comfortable seeing a family physician who is a psychiatrist, rather than seeing just a psychiatrist.
I am able to provide total care in a greater percentage of cases.
My base in primary care helped me in my focus and later practice in an administrative function in geriatric care.
I have a strong awareness of the advantages of integrated primary care and of patient education.
I have a better understanding of what clinical practice is, what it means to be a physician, and the somatic basis of disease.
I'm better able to do really high-quality patient care.
I'm clearly better prepared for the type of work I do (senior health care executive).
My assessment and management skills are much above my peers.
General medical background gives me greater respect among other medical professionals and an increased role as consultant, ie, geriatric psychiatry.
I have much more confidence and skill in a broad spectrum of problems in primary care and psychiatry.
It has been very helpful in diagnosing various medical conditions in the psychiatric patients seen in the psychiatric emergency service. My family practice training has also been very helpful in my role as psychiatric consultant to the emergency department.
I can offer efficient and proper psychiatric care for family practice patients, enlargement of service to community in many ways by combining both.
Advantages from dual training are (1) depth and sophistication in physician-patient relationship, (2) depth and sophistication in self-awareness and self-monitoring, (3) a sense of confidence that comes from mastering in depth at least one of family practice's subspecialties, and (4) expanded professional options.
I am the medical director of a specialized chemical dependency treatment program for pregnant women, which allows me to combine my knowledge of both specialties. I also provide medical care for severely ill eating-disordered patients.
I have special skills in dealing with psychiatric issues in primary care. Dual training has been very helpful in an academic career.
It made me an expert in mental illness in primary care.

Note: Two physicians did not comment on advantages.



**Table 8. Physician Comments on Problems or Disadvantages of Dual Training and Board Certification (n = 16).**

Psychiatry and family medicine—both labor intensive and low tech—get little respect and relatively low pay. Both fields are under attack by midlevel practitioners. Cardiac surgeons, for instance, do not have this problem.

Internists and family physicians are suspicious I will steal their patients.

Hospital will recognize only one area of expertise.

The Directory of Medical Specialists will recognize only one area of expertise.

Managed care companies don't know how to classify me and seem to prefer listing one or the other specialty, but not both.

Becoming obsessive-compulsive and buying into the pseudointellectual game of valuing titles and degrees rather than abilities.

In the beginning, after switching from psychiatry to family practice, some colleagues were suspicious of my competence.

*[This physician completed a family practice residency after psychiatry and does 100% family medicine.]*

There are economic disadvantages compared with procedure-oriented specialties.

Colleagues tend to view us differently and sometimes wonder whether we can handle physical and emotional problems alike.

Excessive costs to join both (specialty) organizations.

Schedulers will always book a new psychiatric intake crisis into an overbooked or double-booked 15-minute family practice time slot. We are ethically and legally bound to treat mental illness to the skill level of a psychiatrist, and this takes much more time than our fellow family physicians schedule for depression, etc.

A lot of time is spent attending department meetings of both specialties. It also takes 2 or 3 physicians to cover for me when I'm away.

I am regarded locally as authentic, but I sense that in this small area, I'm not fully a member of either department.

The medical profession is organized so that we each fit in a slot. I don't fit in one slot easily, or I fit in more than one.

It is difficult to maintain continuing medical education requirements in both specialties.

It took 6 years (or 7) of training. A combined residency would be an asset.

Note: Thirteen responded that there were no disadvantages, and five others did not respond.

pertaining to the development of a combined residency training program in family practice-psychiatry. Although these comments cannot be quantified, they are presented in Tables 7 and 8. Overall, the respondents heartily applaud the development of a combined residency, and their comments provide some very helpful insight into the factors involved in the blending of skills in family medicine and psychiatry. Many of the respondents stated that they felt particularly more confident than their peers in either family medicine or psychiatry in the treatment of patients with somatoform disorders.

It must be emphasized that the practice patterns of residents who complete a combined family practice-psychiatry residency cannot be expected to resemble the practice patterns of those who responded to this survey. In fact, the practice patterns are likely to be quite different. The 39 dual-board-certified physicians in the United States studied family medicine and psychiatry (or in one case, neurology) in whatever sequence and for whatever goals moved them to pursue one specialty first and then the other. Residents who enter a combined residency will be deciding to practice both specialties from the outset. It is likely that all will practice primary care medicine; if they did not wish to do so, they would take a traditional psychiatry-only residency. After grad-

uates from combined residencies have entered into practice, additional study of physicians who are certified in both family practice and psychiatry will be needed to assess the practice patterns of dual-certified physicians who choose both specialties simultaneously.

## Reference

1. Graduate Medical Education Directory, 1995-1996. Chicago: American Medical Association, 1995:929-32.

## Commentary

The population of the study reported above was derived from the database of the American Board of Family Practice (ABFP). All physicians who apply for recertification are asked to provide information about themselves. Among the data collected is certification by other American Board of Medical Specialties (ABMS) boards. Thus, the data are self-reported but are considered to be reasonably reliable because the response has no effect on the application.

Of the 42 currently recertified family physicians who also hold a certificate from the American Board of Psychiatry and Neurology (ABPN), 24 were initially certified by ABFP in 1978 or before. Of these 24, 19 did not complete an accredited family practice residency. All those certified after 1978 have completed a residency in family

practice. Of the 42, 9 have recertified 3 times. It is possible that some of these who have recertified 3 times have gaps in their recertification history.

In addition to the 42 physicians studied, there have been 25 double boarded in family practice and psychiatry and neurology who have lost their family practice certificate because of failure to recertify or license problems.

Thirteen of the 42 report that their practice is more than 75 percent psychiatry. Ten of the 42 report less than 25 percent psychiatry in their practice.

Because the ABPN has not in the past required recertification, they would not have similar data unless they were to do a special survey of their diplomates.

Combined residency programs are not accredited by the American College of Graduate Medical Education (ACGME). Certifying boards will accept graduates of the combined programs only

if both residencies independently are fully accredited by the ACGME. The ABFP and the ABPN have agreed to accept applications for approval of combined programs only after the curricula are evaluated by both boards and are found to meet all the requirements of both specialties. Both residencies must be in the same institution and physically near each other. The total time spent can be shortened by utilizing overlapping curriculum requirements and elective time. Because the certification requirements of both boards are being met, no action by the ABMS is required. The candidate may apply to either or both boards, who will independently assess the candidate in the same way they assess all other candidates.

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