# The Family Medicine Residency as a Clinical Site for the Psychiatry Trainee

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Much confusion exists concerning the role of clinical medicine education in the psychiatry training program. Psychiatric educators have vacillated from full-year internships to four-month clinical rotations, to no clinical training at all. It is generally agreed, however, that experience must be offered to give the future psychiatrist a well-rounded knowledge of medicine.

According to the 1977-1978 *Directory of Medical Specialists*, there are currently two alternatives for physicians entering psychiatric training programs. The first involves a categorical or flexible program in the first year, which includes experience in medicine, family practice, or pediatrics. The second alternative involves a four-year training program in psychiatry, during which at least one year is spent in an approved program that provides direct responsibility for general medical care of children and/or adults.[1]

The American Board of Psychiatry and Neurology has not compared the performances of candidates who had an internship and those who did not.[2] There is great controversy on this subject owing to insufficient information about the internship experience. Among the questions are: what difficulties do interns encounter in caring for their patients, what is the quality and direction of the training experience, and, which model is most appropriate for the psychiatric resident.[3] Sabshin recommends that the psychiatric trainee have direct experience in birth, death, pain, and severe human distress, life threatening crisis, and families in crisis.[4]

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When the psychiatric resident does his/her clinical rotation in internal medicine, he/she feels the same physical and emotional stress as any other intern: more patients than can be efficiently and effectively managed, and the pressure to treat a specific disease in a limited time. This "exploitation . . . depletes the young physician's altruism."[5] Most medical services make no special accommodation for the psychiatric trainee. He is considered an intruder, as one who does not know or care enough to become an internist, or as one who wants to work in a specialty that does not fit the medical model. The largely inpatient experience places little emphasis on common ambulatory complaints. The psychiatry resident begins to think of this clinical rotation in terms of "survival" and spends little time relating the experience to preparation for his own ultimate practice.

## The Program

Since July 1, 1977, the psychiatric resident who wishes to be board eligible is required to spend at least four months of the first year of training in a "primary care" rotation. The definition of a primary care physician has been the subject of considerable discussion, but the general consensus is that he is the "physician of first contact, of initial assessment, and the one who attempts to solve as many of the patient's problems as possible."[6]

During the past year, the family practice department of the Downstate Medical Center of the State University of New York was asked by the director of training in psychiatry to provide clinical training for two psychiatry residents. They each spent four months in the family practice center providing continuous medical care for a group

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of patients. Supervision was provided by the family practice faculty, including physicians, a social worker, and a nurse. The psychiatry trainee spent six half-days in the office of a community based family physician and time with the family practice center manager learning about billing and patient flow.

The initial impetus for this arrangement came from the psychiatry trainees themselves. They were aware of the problems of learning clinical medicine in the university medical service setting and thought that the unique combination of ambulatory and inpatient experience available through a family medicine training program would be more appropriate. These residents were easily accommodated and willingly took full medical responsibility for both their patients and their rotations on night call. The concept of continuing care is best achieved by training in an ambulatory setting where a balanced mixture of physician, scientist, and behaviorist can provide maximal assistance to the patient and act as his advocate when dealing with other specialized areas of the health care system. Educators in psychiatry also recommend that their residents gain experience with appropriate utilization of nonphysicians in a team approach,[7] as is done in many family medicine programs.

## Results

The psychiatry residents who worked with the family practice training program rapidly became vital and participating members of the patient care team and learned both the scientific principles of medicine and the art of communicating with patients. They were found to be equal to the family practice trainees in enthusiasm and ability to absorb information. Both psychiatry residents felt that they acquired an understanding and appreciation of illness in a humanistic experience which will remain with them throughout their professional careers. It is appropriate to encourage this form of exchange and offer training to physicians in other specialties in order to improve their understanding of family practice as well as to enable them to engage in their own specialty in a more comprehensive and humanistic manner.

Besides the learning processes already discussed, the psychiatry resident has an opportunity to follow the thinking of ambulatory care physicians concerning patient management. He can view firsthand the reasons for referral and problems of compliance, and can have an opportunity for direct dialogue with physicians who may be sending him referrals later in his practice.

## Comment

Family medicine education is still in a state of flux, but now, at the close of its tenth birthday as a recognized specialty, it has matured to the point of having concrete guidelines as well as readily available concepts and teaching techniques to prepare its trainees. The experience recommended by Sabshin for the psychiatric resident seems curiously like that of a family medicine training program.

The behavioral sciences are held in high esteem by the family physician who recognizes the frequent effect of the psyche on somatic complaints. The psychiatric trainee is welcome in the family practice center as an associate and often valued consultant. The resident is exposed not only to isolated occurrences of disease but to families with their various health problems. The impact of illness on the family is evaluated and appropriate support is offered. The typical family practice center maintains a patient population of diverse socioeconomic and cultural backgrounds with a wide variety of complaints. A multideterminational model of rehabilitative, therapeutic, and preventive medicine is practiced. Patients are followed through hospitalization and during readaptation to their own environment. This is an ideal location for the psychiatry resident to "observe patients' and families' reaction to the effects of illness or injury."[7]

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