Like the first author of the article, Dr. Vanderlip, I am also a double-boarded psychiatrist-family physician (actively working in both disciplines), and I engage in the treatment of psychiatric and general medical conditions during the same visit. Furthermore, in coordination with a social worker trained in supportive therapy, I teach family medicine residents to evaluate and treat these "combined" patients in a primary care setting.

The best person to treat both psychiatric and comorbid medical conditions is someone practicing both. Absent that, rigorous psychiatric training for family physicians and general internists built into residency training allows for some cross-treatment. The management of general medical conditions in non-primary-care subspecialty settings should be viewed with caution to avoid undue risk to the patients in question.

REFERENCE

1. Vanderlip ER, Raney LE, Druss BG: A framework for extending psychiatrists' roles in treating general health conditions. Am J Psychiatry 2016; 173:658–663

Paul Rosen, M.D.

From the Icahn School of Medicine at Mount Sinai and the Family Medicine Center, Brooklyn Hospital Center, New York.

The author reports no financial relationships with commercial interests.

This letter was accepted for publication in August 2016.

Am J Psychiatry 2016; 173:1243–1244; doi: 10.1176/appi.ajp.2016.16070807

Harnessing Medical Training for Psychiatrists to Expand Access to Care

TO THE EDITOR: The article by Vanderlip and colleagues (1), published in the July 2016 issue of the *Journal*, makes the case for extending psychiatrists' role to include management of general health conditions. Patients with mental illness are at increased risk for mortality from comorbid medical issues, and poor health hygiene and limited access to high-quality health care are likely contributory (2). Addressing primary care issues in behavioral health care settings may reduce such disparities. While the authors highlight the potential use of evidence-based medical algorithms and primary care consultations to assist the psychiatrist in this role, there is limited discussion of current gaps in medical education and of the need to reform training in psychiatry.

According to the American Board of Psychiatry and Neurology (ABPN) and the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee for Psychiatry, psychiatry residents must have a minimum of 4 months of training in a "primary care specialty setting" within their first year (3). Goals and objectives for this experience are not delineated. While the ABPN and the ACGME have outlined developmental milestones for achieving competency within psychiatry, there are no specific competency expectations for general medical practice (4). Within this vacuum, decisions about residency training in medicine are often driven by economic factors and service needs instead of educational goals. In turn, it is not uncommon for psychiatry residents to rotate through specialized inpatient services and critical care units.

While these may be useful learning experiences, they are not necessarily aligned with the type of outpatient medicine practice psychiatrists could provide in treating general health conditions. Furthermore, because of time-limited experiences within the first year, it is unlikely that psychiatrists will retain significant medical knowledge or skills by the time they graduate. Providing integrated, longitudinal outpatient medical training with corresponding milestones could help prepare psychiatrists to assume the practice scope described by Vanderlip et al. While some models for integrated medicine and psychiatry training exist (5), widespread dissemination of such models is unlikely without specific calls for change from the ABPN and the ACGME Residency Review Committee for Psychiatry.

REFERENCES

1. Vanderlip ER, Raney LE, Druss BG: A framework for extending psychiatrists' roles in treating general health conditions. Am J Psychiatry 2016; 173:658–663
2. Druss BG, Zhao L, Von Esenwein S, et al: Understanding excess mortality in persons with mental illness: 17-year follow-up of a nationally representative U.S. survey. Med Care 2011; 49:599–604
3. Accreditation Council for Graduate Medical Education: ACGME Program Requirements for Graduate Medical Education in Psychiatry. Effective July 1, 2016. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2016.pdf
4. Accreditation Council for Graduate Medical Education, American Board of Psychiatry and Neurology: The Psychiatry Milestone Project: A Joint Initiative of the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology. July 2015. https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf
5. McCarron RM, Bourgeois JA, Chwastiak LA, et al: Integrated medicine and psychiatry curriculum for psychiatry residency training: a model designed to meet growing mental health workforce needs. Acad Psychiatry 2015; 39:461–465

Melissa R. Arbuckle, M.D., Ph.D.

Form the Department of Psychiatry, Columbia University Medical Center, and the New York State Psychiatric Institute, New York.

Dr. Arbuckle receives grant support from NIMH and the ABPN.

This letter was accepted for publication in August 2016.

Am J Psychiatry 2016; 173:1244; doi: 10.1176/appi.ajp.2016.16070834

In Support of a Call for Enhancing General Medical Training of Psychiatrists: Response to Rosen and Arbuckle

TO THE EDITOR: We appreciate the opportunity to respond to the letters to the editor sent to the *Journal* regarding our article, "A Framework for Extending Psychiatrists' Roles in Treating General Health Conditions," that was published in the July 2016 issue. In particular, we are happy to clarify some of the rationale for the framework provided and to address concerns that psychiatrists and primary care physicians alike may have with an expansion of the traditional scope of psychiatric practice.