

psychiatrist. The authors point out that major modifications to Accreditation Council for Graduate Medical Education requirements and the American Board of Psychiatry and Neurology board-certification process would need to be implemented for their proposal to launch, but an alternative (and likely equally complicated initiative) would be to lobby government agencies and funders to better compensate dual-certified neurologists-psychiatrists for their clinical work. If successful, the demand by medical students to pursue combined neurology-psychiatry training would grow.

Second, the option of completing a BNNP fellowship after finishing a residency in either neurology or psychiatry should be considered. It is important to state at the outset that although combined neurology-psychiatry training and fellowship training in BNNP have different strengths and weaknesses, I do not believe one path is better or produces greater expertise at the interface of neurology and psychiatry than the other. There may be, however, certain niches where one route offers advantages (e.g., FND is the quintessential example where neurological expertise is critical for diagnosis, whereas longitudinal care is aided by proficiency in neuropsychiatric management principles). The field of BNNP has an established curriculum (4), has a high-impact tradition dating back to the origins of modern-day neurology and psychiatry, has accredited fellowships by the United Council for Medical Subspecialties, has a formal certification process, and has a practical approach to the maintenance of certification. Furthermore, there are national and international professional organizations that are instrumental in advancing the field of BNNP (e.g., the American Neuropsychiatric Association and the British Neuropsychiatric Association).

That said, I believe that one of the most important takeaways from the article by Brown et al. is that the field of BNNP must innovate continuously to remain at the forefront of integrated clinical neuroscience. The tradition of BNNP in the area of neurodegenerative disorders is well established, however, the field of BNNP must show the added patient-care, institutional, financial, and research benefits of being a subspecialist in BNNP across a range of patient populations (e.g., traumatic brain injury, other acquired neurological conditions, treatment-refractory major depression, and neurodevelopmental disorders). Furthermore, the fields of therapeutic neuromodulation, chronic pain, long COVID, FND, and brain health are rapidly growing, and clinician-scientists trained in BNNP should be leaders in these content areas (8–10). Additionally, individuals trained in BNNP need to demonstrate a stronger presence in working with funding agencies, ensuring that the many gaps in scientific knowledge within BNNP are identified as funding priorities.

In closing, I applaud Brown et al. in advocating for increased cross-training between neurology and psychiatry. Rather than starting an alternative brain medicine residency pathway, however, I believe that we should reinvest

in clinical, research, educational, and programmatic innovations within combined neurology-psychiatry residency programs and BNNP fellowship training programs to advance the field of integrated clinical neuroscience.

REFERENCES

1. Brown JC, Dainton-Howard H, Woodward J, et al: Time for brain medicine. *J Neuropsychiatry Clin Neurosci* 2023; 35:333–340
2. Juul D, Gutmann L, Adams HP, Jr., et al: Training in neurology: feedback from graduates about the psychiatry component of residency training. *Neurology* 2021; 96:233–236
3. Benjamin S, Travis MJ, Cooper JJ, et al: Neuropsychiatry and neuroscience education of psychiatry trainees: attitudes and barriers. *Acad Psychiatry* 2014; 38:135–140
4. Arciniegas DB, Kaufer DI, Joint Advisory Committee on Subspecialty Certification of the American Neuropsychiatric Association, et al: Core curriculum for training in behavioral neurology and neuropsychiatry. *J Neuropsychiatry Clin Neurosci* 2006; 18:6–13
5. LaFaver K, Maurer CW, Nicholson TR, et al: Choosing a career in functional movement disorder; in *Functional Movement Disorder: An Interdisciplinary Case-Based Approach*. Edited by LaFaver K, Maurer CW, Nicholson TR, et al. Cham, Switzerland, Springer Nature, 2022, pp 451–457
6. Perez DL, Aybek S, Popkirov S, et al: A review and expert opinion on the neuropsychiatric assessment of motor functional neurological disorders. *J Neuropsychiatry Clin Neurosci* 2021; 33:14–26
7. Saxena A, Paredes-Echeverri S, Michaelis R, et al: Using the biopsychosocial model to guide patient-centered neurological treatments. *Semin Neurol* 2022; 42:80–87
8. Siddiqi SH, Taylor JJ, Horn A, et al: Bringing human brain connectomics to clinical practice in psychiatry. *Biol Psychiatry* 2023; 93:386–387
9. Baslet G, Aybek S, Ducharme S, et al: Neuropsychiatry's role in the postacute sequelae of COVID-19: report from the American Neuropsychiatric Association Committee on Research. *J Neuropsychiatry Clin Neurosci* 2022; 34:341–350
10. Bateman JR, Hurley RA, Taber KH: Neurodegenerative dementias: improving brain health to decrease risk. *J Neuropsychiatry Clin Neurosci* 2019; 31:A4–A5

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Doubling Down on Combined Neurology-Psychiatry Residency Training and Behavioral Neurology & Neuropsychiatry Fellowship Training: Reply to Perez

TO THE EDITOR: As authors of “Time for Brain Medicine” (1), my colleagues and I appreciated the comments of

Dr. Perez in his letter “Doubling Down on Combined Neurology-Psychiatry Residency Training and Behavioral Neurology & Neuropsychiatry Fellowship Training.” As his title denotes, the logical counterargument to creating a new training program is to improve existing programs. We are pleased to engage in dialogue that will ultimately bring us closer to the optimal path forward. However, after a close reading of the letter, it appears we may be talking about different things.

To begin with a recap, our proposed training paradigm is intended to provide a broad training foundation across all aspects of brain medicine, covering both neurology and psychiatry. It is not a modification of existing neuropsychiatric-oriented training, limited to combined programs and fellowships, but is intended for *all* residents who practice medicine related to the brain. Indeed, the proposed paradigm is intended to replace existing psychiatry and neurology residency programs where possible. In addition to increasing breadth of training for all residents, the other central component of this paradigm is the capacity for increased depth of training in the latter half of the program. Residents would have the flexibility to individualize the curriculum toward subspecialization or to remain generalized. Because existing combined neurology-psychiatry residency programs are quite rare and behavioral neurology & neuropsychiatry (BNNP) subspecialization focuses on the interface between neurology and psychiatry, it is unclear how “doubling down” would meet the existing need to increase the breadth of training necessary for current and future practice, as we previously outlined.

First, could the need for training all residents in the practice of brain medicine be met through existing combined programs (of which I and my coauthors are grateful beneficiaries)? The content of these programs certainly meets this need. The problem is accessibility and feasibility. At present, there are only four individual positions available annually for prospective combined program trainees. Our intended audience, by contrast, is more than 2,000 psychiatry and 1,000 neurology residency candidates, annually. Could these four spots grow to meet this need? The number of combined programs has decreased in the past two decades, not increased. Stagnant trends in financial support for residency positions also suggest that a 50% increase in the duration of training would be unlikely. Regarding feasibility, we emphasized that training years are precious. Longer residency programs without financial remuneration would deter some candidates. While increasing pay for combined program trainees or attending physicians would help make sense of the upfront investment, changing pay structures would involve an entire restructuring of payor systems, which is not in our control. Moreover, and most important, although value could be gained by training for decades, we contend that 4 years is sufficient to gain the level of competency required by the relevant administrative bodies (see list of similarities between programs and the implementation section in the article [pages 336 and 339, respectively]).

Second, consider BNNP fellowships. At its core, the proposed brain medicine program is meant to increase training breadth, whereas a fellowship denotes a narrowed focus and greater depth. In this sense, brain medicine is both complementary and opposite to BNNP fellowships, which focus specifically on conditions at the interface of neurology and psychiatry. The fellowship is not designed to encompass the breadth of both neurology and psychiatry nor is it intended for all physicians of the brain. Brain medicine graduates would be excellent candidates for BNNP fellowships and would likely strengthen these programs with increased interest and relevant background training. The distinction between a brain medicine program and a BNNP fellowship emphasizes the confusion that could arise by calling our proposed training program something similar to “neuropsychiatry.” A new name, brain medicine, will be helpful in disambiguating overlapping conceptual areas of training.

The letter poses several additional questions that we are pleased to address directly. First, what would be the credentials of a brain medicine graduate? Our article points out that the program is designed to credential a graduate in both neurology and psychiatry. As pointed out in the subsection on page 336 (“What is similar between the existing and proposed residency programs?”), brain medicine would fulfill the existing rotation requirements of both neurology and psychiatry, would meet the goals and competencies of both, and would lead to board eligibility in both. In other words, from a credential standpoint, brain medicine graduates would be indistinguishable from combined program graduates; they would not lack credentials but would have more credentials. Confusion about this point may have originated from our sentence “Board eligibility and board certification in brain medicine would encompass psychiatry and neurology.” The sentence may be better understood as “Board eligibility and board certification in brain medicine would include both psychiatry and neurology, rather than one or the other” (1).

Second, could brain medicine lead to a “growing multiplicity” of departments? Although we explicitly noted that departmental structure need not change, it is conceivable that brain medicine departments could emerge. We expect the most likely context for this to occur would be in settings where neither department already exists, such as in a new center, and the new department would be established in lieu of separate neurology and psychiatry departments. We acknowledge that although the question is currently unanswerable, we think that a brain medicine department would more likely be a unifying rather than a dividing (or multiplying) enterprise.

Third, which department would a brain medicine physician be hired into or receive their appointment? As we illustrate in the implementation section of the discussion (page 339), a brain medicine physician who goes on to train in movement disorders would follow the same course as in our existing paradigm; in this case, the physician would go

into a neurology department (1). Similarly, an epileptologist, vascular neurologist, behavioral neurologist, or other neurology subspecialist would be hired by a neurology department, whereas a general psychiatrist, addiction psychiatrist, geriatric psychiatrist, or other psychiatric subspecialist would be hired by a psychiatry department. As occurs today, physicians who have clinical or research activities in both specialties would have appointments in both departments. Of note, we expect that as the trend toward subspecialization increases, relatively few physicians will generalize in brain medicine, but those who do would likely work in rural or community settings or perhaps pursue BNNP fellowship training. In this case, they would have flexibility to choose departments, just as combined graduates who practice at the interface have now.

In summary, we applaud Dr. Perez and *JNCN* for facilitating this important discussion. Here, we aimed to clarify

certain points and address outstanding questions. Importantly, the only way to know if the brain medicine training program reaches its stated goals and improves training outcomes is to test it. Next steps include implementation as a pilot program, recording and reporting outcomes, and replication. Until then, the arguments are theoretical.

REFERENCE

1. Brown JC, Dainton-Howard H, Woodward J, et al: Time for brain medicine. *J Neuropsychiatry Clin Neurosci* 2023; 35:333–340

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