

The Requirements for Combined Programs in Medicine-Pediatrics

At its meeting in June 2004, ACGME approved the proposal that the RRC for Internal Medicine and the RRC for Pediatrics review the administrative arrangements and the training that is provided in combined programs in Internal Medicine-Pediatrics and declare the training accredited. The first step in the process was the development of the requirements for these programs by representatives from the two certifying boards, the two accrediting RRC's, and ACGME. Input was received from the Medicine Pediatrics Program Directors' Association (MPPDA). Attached are the requirements for these combined programs.

The two specialty boards are in the process of verifying whether the programs they have approved in the past are in compliance with the format specified in these requirements. The information will be sent to the RRC's, after which the process of designating the training as accredited will begin.

By mid-2005, a letter will be sent from ACGME to the directors of the programs on this list stating that the program has been "grandfathered" into the ACGME process. After July 1, 2005, these programs will be scheduled for a formal review in conjunction with the next review of each of the two related categorical programs. Details regarding these reviews will be publicized at that time.

12/04

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I. INTRODUCTION

The American Board of Internal Medicine (ABIM) and the American Board of Pediatrics (ABP) have developed requirements for 48 months of integrated coherent combined training that fulfills the requirements for certification by each board. The combined training must be provided by categorical programs that are accredited by ACGME and the curriculum must comply with the ACGME requirements for the two specialties, with the exceptions allowed by the certifying boards, as noted below. A graduate would be eligible for certification after satisfactory completion of accredited training.

Combined programs that seek to have their training designated as accredited by ACGME must first have received approval of the educational plan by the ABIM and the ABP.

Once the specialty boards have approved the arrangements for a new combined program, residents may begin training, but they should be informed that ACGME designation of the training as accredited is pending.

II. RELATION TO CATEGORICAL RESIDENCIES

A combined program must function as an integral part of one accredited categorical program in each specialty, while preserving the integrity of these categorical programs. One categorical program may not participate in more than one medicine-pediatrics program. The residents in the categorical and combined programs must interact at all levels of training. A combined program will not be approved if there is evidence that its presence will have a negative impact on either of the categorical residency programs.

The two participating categorical residency programs must be ACGME-accredited, be sponsored by the same ACGME Sponsoring Institution, and must be in close geographic proximity within the same academic health system. The one exception is when the pediatrics program is sponsored by a Children's Hospital, in which case that hospital must be formally related to the institution that sponsors the Internal Medicine Program. The Designated Institutional Official of the institution that sponsors the Internal Medicine residency program will have responsibility for oversight of the combined program.

Affiliated institutions that are used by the combined program must be approved for simultaneous use by the categorical programs and must be covered by the inter-institutional agreements of the sponsoring institution. That is, institutions may not be used for the combined program that have not been approved for use by the categorical program.

The components of training in internal medicine and pediatrics that constitute the curriculum in a combined residency program must be derived from the training that has been accredited as part of the categorical internal medicine program by the Residency Review Committee for Internal Medicine and the categorical program in pediatrics by the Residency Review Committee for Pediatrics.

Documentation of hospital and faculty commitment to the combined residency must be available in signed agreements. Such agreements must include institutional goals for the combined training.

If one of the categorical programs loses its ACGME accreditation, the specialty boards will withdraw their approval of the combined program and it will be removed from the ACGME's list of combined programs.

III. THE RESIDENT

Residents should be appointed to the combined program and reported as such in the ACGME Web Accreditation Data System (WebADS). They should enter combined training at the year-1 level. A resident may enter combined training after completion of year-1 only if that year was served in a categorical residency in either internal medicine or pediatrics in the same academic health system as the combined training. Residents may not enter combined residency training beyond the year-2 level.

IV. PROGRAM DIRECTOR

The director of the Medicine-Pediatrics program must have demonstrated ability as a clinician, medical educator, and administrator, and have an understanding of, and commitment to, internal medicine and pediatric education. The director should have the sufficient authority and resources to enact any required changes to the combined program.

There should be one person appointed as the director of the medicine-pediatrics program who is responsible for ensuring the program's compliance with all pertinent requirements and who is responsible for all communication with the specialty boards, the ACGME, and the respective Residency Review Committees. This director should be certified by both the American Board of Internal Medicine and the American Board of Pediatrics. When someone with dual certification is not available, there may be two co-directors, one certified in Internal Medicine and the other certified in Pediatrics, one of whom must be identified as the administrative director who must assume these responsibilities. As an attestation of the requisite collaboration, all official communication should include the signature of the director or of the co-directors, where appropriate, and the signatures of the respective categorical program directors.

In either leadership model, the program directors of the related categorical programs and the director(s) of the combined program must demonstrate collaboration and coordination of curriculum and rotations. There must be shared accountability among them to ensure integration of the combined residents into the categorical residencies. To achieve appropriate coordination of the combined program, including integration of the training and supervision in each discipline, the program directors of the categorical programs and the director(s) of the combined program must hold at least quarterly meetings that involve consultation with faculty and residents from both departments.

The director or administrative co-director must also document meetings for educational activities with all medicine-pediatrics residents at least monthly, such as jointly sponsored journal clubs, clinic conferences, occasional combined grand rounds, medical ethics conferences, and research conferences.

V. SHARED CURRICULAR REQUIREMENTS FOR MEDICINE AND PEDIATRICS

The Program Requirements for Internal Medicine and for Pediatrics regarding faculty qualifications, research and scholarly activity, duty hours, and evaluation apply to combined programs. When residents rotate on a service in either specialty, they are subject to the minimum numbers, the caps on patient numbers, and all other conditions that are specified in the Program Requirements for that specialty. Although combined inpatient medicine-pediatrics experiences should not be developed, some joint medicine-pediatrics experiences should be encouraged and might include continuity clinics, acute illness/emergency department experiences in situations where there are not separate emergency departments, and subspecialty experiences, e.g., in endocrinology, infectious diseases, and rheumatology. Credit for these joint experiences should be divided equally between the two disciplines.

The curriculum must provide a cohesive, planned educational experience and may not simply involve a series of rotations between the two specialties. Residents must have graded responsibility for patient care and teaching. There must be 24 months of training in each specialty, of which 22 months must be in clinical rotations and other educational experiences. In each specialty, up to two months of time away from the program is allowed for elective experiences, such as international rotations and Indian health service.

Continuous assignments to one specialty or the other should be for periods not less than 3 nor more than 6 months. Except where stated in the Program Requirements for each specialty, rotations should be at least 4 weeks in duration. Occasional variations in these assignments in years 3 and/or 4 may be permitted for valid educational reasons. In order to provide as many opportunities as possible, unnecessary duplication of educational experience should be avoided. The director of the combined program, in collaboration with the program directors of the related categorical

programs, is responsible for ensuring that residents in the combined program have schedules that comply with the ACGME duty hours standards, and for carefully monitoring the potential for excessive duty hours that may occur during the transition between specialties.

A. Continuity Clinics

The categorical program requirements for numbers of patient visits per session and interruptions to continuity apply to the continuity clinic experience in the medicine-pediatrics program throughout the four years of training.

At a minimum, a once-weekly continuity clinic experience must begin at the onset of residency and be maintained throughout the four years of combined training. Each resident must participate in a continuity clinic at least one half day per week during at least 36 weeks per year. Continuity clinic experience may be obtained either by a weekly combined medicine-pediatrics continuity clinic or by alternating every other week between an internal medicine and a pediatrics continuity clinic. The patients should be divided equally between pediatrics and internal medicine, whether the experience occurs in combined or alternating separate clinic settings.

Sequential continuity experiences, (e.g., 24 months of internal medicine followed by 24 months of pediatrics) are not acceptable. Residents should be encouraged to follow their continuity patients during the course of a hospitalization.

B. Intensive Care

Because of the truncated training and the transferability of critical care experience between internal medicine and pediatrics, it is important to avoid excessive time in intensive care units. Therefore, while the minimum requirements for intensive care experience in the categorical programs must be met by those in the combined program, the total required critical care experience shall not exceed 8 months and must include at least four months in pediatrics and two months in Internal Medicine. Reference should be made to the program requirements for internal medicine and for pediatrics for more specific criteria.

VI. SPECIALTY- SPECIFIC CURRICULA

Except for the following provisions, combined residencies must conform to the ACGME Program Requirements for Residency Education in Internal Medicine and the Program Requirements for Residency Education in Pediatrics. Reference should be made to the Requirements for Internal Medicine and for Pediatrics for a fuller description of the

content of the specialty experiences listed below. If the program requirements for either of the categorical programs change, there may be a corresponding change in what is required of those in combined programs and these requirements will be revised to reflect this.

A. Internal Medicine Component

The training in Internal Medicine for the combined program must include the following:

- 20 months of direct patient care or supervision of more junior residents in direct patient care
- A maximum of two months of night float, with no more than one month in any year
- At least six months of supervision of the care provided by more junior residents
- 1-month experience in the emergency department during the first or second year
- At least eight months of clinical experience with hospitalized patients
- Care of adults with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units) for 3 to 4 weeks during the first or second year and again during the second, third, or fourth year
- At least one third of internal medicine clinical experience involving ambulatory care
- At least four months of subspecialty experience that is inpatient, outpatient, or a combination of the two, including experience as a consultant, with significant exposure to cardiology
- Clinical experience in geriatrics
- Regular attendance at morning report, medical grand rounds, residents' work rounds, and mortality and morbidity conferences when on internal medicine rotations.

B. Pediatrics Component

The breadth of the required patient population is specified in the Program Requirements for Pediatrics. Care for young adults must be included but may be part

of either the pediatrics or of the internal medicine experience. The training in Pediatrics for the combined program must comply with the following:

- Experience at the 1st year level of pediatrics not to exceed 9 months
- Senior supervisory experience of at least 4 months, including inpatient and outpatient experiences
- Pediatric subspecialty experience of at least 4 block months taken from the first list of subspecialties in the program requirements for categorical programs, each of which must include inpatient and outpatient experience and the opportunity to function as a consultant under appropriate supervision
- 40% of the pediatric experience in ambulatory pediatrics, that may include all assignments in continuity clinic, acute illness/emergency medicine, and community-based experiences, as well as the ambulatory portion of the normal newborn, subspecialty, developmental/behavioral, and adolescent experiences
- Acute Illness Clinic and Emergency Department experience of at least 3 months, one of which must be a block month in the emergency department
- General pediatric inpatient care of at least 5 block months, to include at least 2 months in a supervisory role during the latter part of training
- At least 1 month of normal newborn nursery, which may be a block or longitudinal experience
- Intensive Care Experience, limited to a total of 4 months, of which 3 months are NICU and one month is PICU; one of the 3 months in the NICU may be met by 200 hours of night call
- Developmental/Behavioral Pediatrics of at least 1 block month
- Adolescent Medicine of at least 1 block month, during which an experience in adolescent gynecology should be available
- Basic sciences studied in an integrated manner at the patient's bedside and in conferences.

Note: Using the on-line ACGME WebADS and Case Log System, residents' experiences will be tracked in the combined program to which they have been appointed, and therefore, must be documented separately from those in the related categorical program.