

GUIDELINES FOR COMBINED TRAINING IN EMERGENCY MEDICINE AND INTERNAL MEDICINE

INTRODUCTION

In June 1989, the American Board of Emergency Medicine (ABEM) and American Board of Internal Medicine (ABIM) announced that they will offer dual certification for candidates (eligible for certification by each Board) who have completed at least two-and-one-half years of suitable accredited training in *each* specialty. These guidelines are applicable to residents entering training after July 1989.

OBJECTIVES

The objectives of the combined training in Emergency Medicine-Internal Medicine (EM/IM) include the training of physicians for practice or academic careers, which address the spectrum of illness and injury from the emergent through the chronic. Graduates of the combined training may function as generalists, practice either discipline, enter subspecialty training, or undertake research. Within an institution, their perspective spanning two specialties has the potential to increase communications and understanding.

Combined programs include components of categorical Emergency Medicine and Internal Medicine residencies, which are accredited respectively by the Residency Review Committee for Emergency Medicine (RRC-EM) and by the Residency Review Committee for Internal Medicine (RRC-IM), both of which function under the auspices of the Accreditation Council for Graduate Medical Education (ACGME). While combined programs will not be independently accredited, their accreditation status is determined by that of the parent residencies.

Every program that wishes to offer this combined training must be approved by both ABEM and ABIM before residents are recruited. In addition, both Boards, and RRCs when applicable, will review these training requirements periodically. Both Boards must adhere to these Guidelines in administering combined programs and may not alter the Guidelines without the written consent of both Boards.

To be eligible for dual certification, the resident must satisfactorily complete 60 months of combined education, which must be verified by the Program Director, and Associate Program Director, if applicable, of both programs. Proposals for combined residency training programs must be submitted to, and approved by, ABEM and ABIM before a candidate can be accepted into this joint training.

GENERAL REQUIREMENTS

A combined EM/IM residency consists of five years of balanced training in the two disciplines, which meet the Program Requirements for accreditation by the RRC-EM and the RRC-IM, respectively. The EM and IM residencies must be ACGME accredited and in good standing when the application for a combined residency program is submitted.

It is strongly recommended that the participating residencies be in the same academic health center, and documentation of hospital and university commitment, where applicable, to the

program must be available in signed agreements. Such agreements must include institutional goals for the combined program. Participating institutions must be located close enough to facilitate cohesion among the program's house staff, attendance at weekly continuity clinics and integrated conferences, and faculty exchanges over curriculum, evaluations, administration, and related matters. At the conclusion of 60 months of training in Emergency Medicine and Internal Medicine, the residents must have had experience and instruction in the prevention, detection, and treatment of illness and injury, and in the rehabilitation of patients, as well as in the socioeconomics of illness, the ethical care of patients, and in the team approach to the provision of medical care.

The training of residents while on Emergency Medicine rotations is the responsibility of the faculty of Emergency Medicine. Likewise, the training of residents while on Internal Medicine rotations is the responsibility of the Internal Medicine faculty. Prior to the completion of training, each resident must demonstrate some form of acceptable scholarly activity. Scholarly activity may include original research, comprehensive case reports, or review of assigned clinical and research topics.

Vacations, sick leave, and leave for meetings must be shared equally by both training programs. Absences from the training program (vacation, maternity/paternity leave, sick leave) exceeding five months in the 60 months must be made up.

Combined residencies must conform to the Program Requirements for accreditation of residencies in Emergency Medicine and Internal Medicine. If the residency in either discipline receives probationary accreditation after initiation of the combined training, new residents should not be appointed to the combined training program. And, for training that occurs during a period of probationary accreditation, the eligibility criteria that ABEM and ABIM have in place for residents in categorical residency training will likewise apply to residents in the combined program.

THE RESIDENT

Residents should enter a combined program at the R-1 level. A resident may enter a combined program at the R-2 level *only* if the first residency year was served in an accredited, categorical residency in either Emergency Medicine or Internal Medicine. Residents *may not* enter combined training beyond the R-1 level or transfer between combined training programs in different institutions unless prospectively approved by both Boards. If they transfer between combined training programs, residents must be offered, and complete a fully-integrated curriculum. A transitional year of training will provide *no credit* toward the requirements of either Board.

A resident transferring from a combined training program to a categorical Emergency Medicine or Internal Medicine program must have prior approval from the specialty Board whose categorical training program would accept the resident.

Training in each discipline must incorporate graded responsibility throughout the training period. Each resident must have supervisory responsibility for at least six months during each discipline's 30 months of training.

THE TRAINING DIRECTOR(S)

The combined training must be coordinated by a designated director or co-directors who can devote substantial time and effort to the educational program. An overall Program Director may be appointed from either specialty, or co-directors may be appointed from both specialties. If a single Program Director is appointed, an Associate Program Director from the other specialty must be named to ensure both integration of the program and supervision of each discipline. An exception to the above requirements would be a single director who is board certified in each discipline and has an academic appointment in each department. The two directors should embrace similar values and goals for their program.

TRAINING

The training requirements for credentialing for the certifying examination of each Board will be fulfilled in 60 months of the combined program. A shortening of 12 months training from that required for two separate residencies is possible due to appropriate overlap of training requirements.

CURRICULAR REQUIREMENTS

A clearly described, written curriculum must be available for residents, faculty, ABEM, ABIM, and both Residency Review Committees. There must be 30 months of training in each specialty. The curriculum must assure a cohesive, planned, educational experience, and not simply comprise a series of rotations between the two specialties. Duplication of clinical experiences between the two specialties should be avoided. The curricular components must conform to the program requirements for accreditation in Emergency Medicine and Internal Medicine. This should include both the common and specialty-specific program requirements, addressing the six ACGME general competencies, incorporation of the ACGME Milestones for each specialty, and the duty hour and supervision standards. Periodic review of the program curriculum must be performed. This review must include the Program Directors from both departments, as well as faculty and residents.

Six months of training in the first year must be spent under the direction of each specialty. During the final 48 months, continuous assignments to one specialty or the other should be not less than three, nor more than six months in duration.

A joint educational conference involving residents from Emergency Medicine and Internal Medicine is desirable. The joint conference should specifically include the participation of all residents in the combined training program.

REQUIREMENTS FOR EMERGENCY MEDICINE

Unless otherwise specified, all program and curricular requirements as described in the ACGME Program Requirements for Graduate Medical Education in Emergency Medicine must be met, including those related to the education and evaluation of residents under the ACGME Milestones for Emergency Medicine. The emergency department experience must provide the

resident the opportunity to manage an adequate number of patients of all ages, and both sexes, with a wide variety of clinical problems.

Training in Emergency Medicine must include the following experiences:

- a) At least three percent of the patient population must present with critical illness or injury. The curriculum must include four months of dedicated critical care experiences, including critical care of infants and children. At least two months of these experiences must be at the PGY-2 level or above.
- b) A pediatric experience, defined as care of patients less than 18 years of age, should be provided, consisting of five full-time equivalent months, or 20 percent of all emergency department encounters. At least 50 percent of the five months should be in an emergency setting. This experience should include the critical care of infants and children.
- c) Experience in performing invasive procedures, monitoring unstable patients, and directing major resuscitations of all types, in all age groups, must be provided. Each resident must maintain, in an accurate and timely manner, a record of all major resuscitations and procedures performed throughout the entire educational program.
- d) Residents must have experience in Emergency Medical Services (EMS), emergency preparedness, and disaster management. EMS experiences must include ground unit runs and direct medical command. This should also include participation in multi-casualty incident drills. Residents should have experience teaching out-of-hospital emergency personnel.

REQUIREMENTS FOR INTERNAL MEDICINE

During the 30 months of Internal Medicine training, each resident must obtain 20 months of experience with direct responsibility for patients with illnesses in the domain of Internal Medicine. These 20 months must include three months in intensive care units, and at least seven months on non-intensive inpatient rotations. The resident should have significant exposure to cardiology. Both general medical and specialized (i.e., oncology) units are acceptable assignments. A maximum of three months of Emergency Medicine experience can be applied to 20 months of meaningful patient responsibility requirements for Internal Medicine.

At least 33 percent of the 30 months of Internal Medicine experience must involve non-hospitalized patients. This must include a continuity experience for each resident in a half-day per week continuity-care clinic during the 30 months of Internal Medicine training, and block experience in ambulatory medicine for at least two months. These experiences may include work in subspecialty clinics and walk-in clinics, and brief rotations for appropriate interdisciplinary experience in areas such as dermatology, office gynecology, and orthopedics. All residents must gain significant exposure to the disciplines of psychiatry and neurology.

Residents are to be encouraged to follow their outpatients during the course of the patient's hospitalizations. The resident need not be scheduled in the continuity-care clinic during emergency department and intensive care unit rotations. Health maintenance, prevention, and rehabilitation should be emphasized. Residents should work in the clinics with other professionals, such as social workers, nurse practitioners, physician assistants, behavioral scientists, and dietitians.

Internal Medicine subspecialty experiences must be provided to every resident for at least four months. Some of this must include experience as a consultant. In addition, all residents must be given experience as a general medical consultant to other services in the institution. Residents must have formal and regular supervised clinical experience in geriatric medicine. This may occur on geriatric inpatient units, geriatric consultation services, long-term facilities, geriatric ambulatory clinics, and/or home care settings.

Residents must regularly attend morning report, medical grand rounds, work rounds, and mortality and morbidity conferences when on Internal Medicine rotations.

EVALUATION

The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. The evaluations must be accessible for review by the resident, as well as the RRC site visitors. Written evaluation of each resident's knowledge, skills, professional growth, and performance, using appropriate criteria and procedures, must be accomplished at least semi-annually, and must be communicated to, and discussed with, the resident in a timely manner. Both ABEM and ABIM require documentation that candidates for certification are competent in (a) patient care and procedural skills, (b) medical knowledge, (c) practice-based learning and improvement, (d) interpersonal and communication skills, (e) professionalism, and (f) systems-based practice.

The Program Director must ensure the reporting of Milestones' evaluations of each resident semi-annually to the ACGME.

There must be a method of documenting the procedures that are performed by the residents. Such documentation must be maintained by the Program Director and/or Associate Program Director, be available for review by the RRCs in Emergency Medicine and Internal Medicine, ABEM, ABIM, and site visitors, and may be used to provide documentation for application for hospital privileges by graduates of these training programs.

Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.

The training program must maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel. The training director of the EM/IM program is responsible for provision of a written, final evaluation for each resident who completes the program. This evaluation must include specialty-specific milestones as one of the tools to ensure that residents are able to practice core professional activities without supervision upon completion of the program, and that they are prepared to apply for the certification processes of both ABEM and ABIM. This final evaluation must be part of the resident's permanent record maintained by the institution.

ELIGIBILITY FOR CERTIFICATION

To meet eligibility for dual certification, the resident must satisfactorily complete the specific requirements of both ABEM and ABIM, and this must be verified by the directors of both

programs. Lacking verification in one or both specialties, the resident must satisfactorily complete 36 months of training in either Emergency Medicine or Internal Medicine to meet the eligibility requirements in either specialty. The certifying examinations cannot be taken until all five years of training in both specialties are satisfactorily completed.

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