

## **GUIDELINES FOR COMBINED TRAINING IN INTERNAL MEDICINE AND ANESTHESIOLOGY**

Effective January 1, 2012

### **INTRODUCTION**

The American Board of Internal Medicine (ABIM) and the American Board of Anesthesiology (ABA) offer dual certification in internal medicine and anesthesiology. A combined residency consists of 5 years of balanced education in the two disciplines; not six years as would be necessary if these two residency programs were completed separately/sequentially.

Combined training includes the components of independent internal medicine and anesthesiology residencies which are accredited respectively by the Residency Review Committee (RRC) for Internal Medicine and by the RRC for Anesthesiology, both of which function under the auspices of the Accreditation Council for Graduate Medical Education (ACGME).

Every program that wishes to offer this combined training must be approved by both the ABIM and the ABA before residents are recruited. In addition, both Boards (and RRCs, when applicable) will review these training requirements periodically.

To be eligible for dual certification, the resident must satisfactorily complete 60 months of combined education, which must be verified by the director and associate director if applicable of both programs. The final certifying examinations cannot be taken until all 5 years are completed.

### **OBJECTIVES**

Combined training in Internal Medicine and Anesthesiology should allow the development of physicians who are fully qualified in both specialties. Physicians completing this training should be competent internists and anesthesiologists capable of professional activity in either discipline. The strengths of the residencies in internal medicine and anesthesiology should complement each other to provide an optimal educational experience to trainees.

Combined training includes the components of independent internal medicine and anesthesiology residency programs that are accredited respectively by the RRC for Internal Medicine and by the RRC for Anesthesiology, both of which function under the auspices of the ACGME. While combined training will not be independently accredited by the RRCs and the ACGME, the continued approved accreditation status of the parent internal medicine and anesthesiology programs is essential for the stability and continued approval of the combined training program in internal medicine and anesthesiology. Thus, residents for combined training must not be recruited if the accreditation status of either program is probationary or provisional. Proposals for combined residency training programs must be submitted to and approved by the ABIM and ABA before a candidate can be accepted into this joint training.

### **GENERAL REQUIREMENTS**

Combined training in anesthesiology and internal medicine must include at least five years of coherent training integral to residencies in the two disciplines that meets the program requirements for accreditation by the RRC for Internal Medicine and the RRC for Anesthesiology.

Combined training must be conducted under the auspices of the Committee on Graduate Medical Education within a single institution and its affiliated hospitals. Documentation of hospital, university and faculty commitment to the program must be available in signed agreements. Affiliated institutions must be located close enough to facilitate cohesion among the housestaff, attendance at continuity clinics and integrated conferences, and faculty exchanges of curriculum, evaluation, administration and related matters.

Ideally, at least one resident should be enrolled in combined training each year. A combined training program with no trainees for a period of five years cannot continue to be approved. The ABA and the ABIM will only approve a combined training program intended to be offered to residents annually and not a training track for a single resident.

Both Boards encourage residents to extend their training for an additional sixth year or more in subspecialty training in critical care medicine, pain medicine, other subspecialties of internal medicine or anesthesiology and/or investigative, administrative or academic pursuits in order to prepare graduates of this combined training program for careers in research, teaching, or departmental administration and to become leaders in their fields.

### Characteristics of Eligible Combined Residencies

The two participating core residency programs must be accredited by the ACGME, be in good standing and be within the same academic medical center. They must be located close enough to facilitate cohesion among the residents, attendance at conferences when scheduled, and faculty exchanges of curriculum, evaluation, administration and related matters. The same ACGME Sponsoring Institution should sponsor them both.

### **THE RESIDENT**

Residents should enter a combined program at the PGY-1 level. A resident may enter a combined program at the PGY-2 level only if the first residency year was served in an accredited categorical residency in Internal Medicine in the same institution. Residents may not enter combined training beyond the PGY-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 full-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 Anesthesiology or Internal Medicine program must have prior approval from the receiving Board.

### **THE TRAINING DIRECTOR(S)**

The combined residency must have one designated director who will be responsible for all administrative aspects of the program and who can devote substantial time and effort to the educational program. This individual can be the director of either the categorical residency program in internal medicine or anesthesiology; the director of the other categorical residency program will be designated the associate director of this combined program. An exception to this requirement would be a single director who is certified in both specialties and has an academic appointment in each department.

The program director is responsible for assuring all aspects of the program requirements are met. This individual, along with the associate program director, should submit the application for the program to both the ABIM and ABA and notify both Boards should any significant changes occur in either of the associated categorical residency programs. The program director and associate program director are responsible for completing evaluation forms for all trainees in the combined program as required by their respective Boards, and both must verify satisfactory completion of the training program on the resident's final evaluation form.

As a general principle, the training of residents in internal medicine is the responsibility of the internal medicine faculty and the training of residents in anesthesiology is the responsibility of the anesthesiology faculty.

There should be an adequate number of faculty members who devote sufficient time to provide leadership to the combined residency program and supervision of the residents. It is recommended that some faculty members have completed training in these two specialties. Since each component of the residency must be

accredited by its respective discipline, the faculty must meet the requirements for their specialty.

Internal Medicine faculty must be certified by the ABIM or have equivalent educational qualifications in internal medicine.

Anesthesiology faculty must be certified by the ABA or have equivalent educational qualifications in anesthesiology.

## **TRAINING**

The training requirements for eligibility for the certification process of each Board will be met by the satisfactory completion of 60 months of approved combined training. A reduction of 12 months over that required for the two separate residencies is possible due to the overlap of curriculum and experience inherent in the training of each discipline. The reduction of 6 months of the standard 36 months of internal medicine training is met by 30 months of training in the internal medicine component of the combined residency and 6 months of credit granted for training appropriate to internal medicine obtained during the 30 months of anesthesiology residency. The requirement of 48 months of training in anesthesiology is met by the first year of residency in internal medicine, 30 months of training in the anesthesiology component of the combined residency, and 6 months of credit for training appropriate to anesthesiology obtained during the remaining 18 months of residency in internal medicine. The working relationships developed among categorical and combined residency trainees will facilitate communication between the two specialties and increase the exposure of categorical residents to the other discipline.

Training in the PGY-1 must include 12 months of training in Internal Medicine. During the second year, the resident must have 12 months of training in anesthesiology. In each of the remaining 3 years, the resident shall have 6 months of training in Internal Medicine and 6 months of training in anesthesiology. Rotations of shorter duration, but periods not less than 3 consecutive months should be spent in the respective specialty. During these last 3 years, it is important that program directors make certain that in the PGY-3, -4 and -5 years, each resident will have 18 months of training in each specialty.

Training in each discipline must incorporate graded responsibility throughout the training period.

## **CURRICULAR REQUIREMENTS**

A clearly described written curriculum must be available for residents, faculty, and the RRCs of both Internal Medicine and Anesthesiology. The curricular components must conform to the program requirements for accreditation in internal medicine and anesthesiology including both the common and specialty specific program requirements addressing the six ACGME general competencies and the duty hour and supervision standards. The curriculum must assure a cohesive, planned educational experience and continuum of training rather than providing an uncoordinated series of rotations required by the two RRCs.

Duplication of clinical experiences between the two specialties should be avoided. Periodic review of the residency curriculum must be performed by the program director and associate program director in consultation with residents and faculty from both departments. Combined training must not interfere with or compromise the training of the categorical residents in either field.

Joint educational conferences involving residents from Internal Medicine and Anesthesiology are desirable and should specifically include the participation of all residents in the combined training residency whenever possible.

## **REQUIREMENTS FOR INTERNAL MEDICINE**

The development of the resident's skills in Internal Medicine will be fostered by rotations on general and

subspecialty services, both inpatient and outpatient, with exposure to a wide spectrum of disease.

The training should be the same as described in the Program Requirements of the RRC for Internal Medicine. The 30 months of internal medicine training must include 24 months of experiences as specified below, with the additional 6 months at the discretion of the general Internal Medicine program director but taken from experiences accredited by the RRC. The additional 6 months of credit is recognized through 6 months of anesthesiology training.

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, including geriatric medicine.

Each resident shall have a four week experience during year one in the emergency department with first-contact responsibility for the diagnosis and management of adults.

Each resident will be assigned to the care of patients in a medical or general medical and surgical intensive care. The total required critical care experience must include at least 4 months in MICU or medical-surgical combined ICU)/CCU/RICU with at least one additional month of surgical or surgical subspecialty critical care experience. Over the course of training, critical care experience attributed to Internal Medicine Residency must not exceed six months.

At least one third of the 30 months of Internal Medicine experience must occur in the ambulatory setting, and at least one third must be in the inpatient setting. The ambulatory experience must include a longitudinal continuity experience for each resident consisting of a minimum of 130 distinct half-day outpatient sessions and must include evaluation of performance data for each resident's continuity panel of patients relating to both chronic disease management and preventive health care. Residents must receive faculty guidance for developing a data based action plan and evaluate this plan at least twice a year. The ambulatory experience must also include exposure to each of the internal medicine subspecialties, neurology, and geriatrics as well as opportunities to experience patient care in the disciplines of psychiatry, allergy/immunology, dermatology, medical ophthalmology, office gynecology, otorhinolaryngology, non-operative orthopedics, palliative medicine, sleep medicine, and rehabilitation medicine. Outpatient chronic disease management, patient counseling, health maintenance, prevention and rehabilitation should be emphasized. Residents must also participate in the coordination of care across health care settings.

Training must also provide the opportunity to demonstrate competence in the performance of required procedures as listed by the ABIM.

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

Residents must be free one day per month when on anesthesiology rotations to continue to participate in medical continuity clinics. Ideally these days should occur when the resident can attend medical conferences as well.

## **REQUIREMENTS FOR ANESTHESIOLOGY**

The development of the resident's skills in anesthesiology will be fostered by rotations in anesthesiology and its subspecialties caring for adult as well as pediatric patients.

The training should be the same as described in the program requirements of the RRC for Anesthesiology with the exceptions that follow.

Thirty months of training must be in anesthesiology. The additional 6 months of credit is recognized through 6 months of Internal Medicine training.

Training in anesthesiology must include the following experiences:

1. Two identifiable one-month rotations in obstetric anesthesiology, pediatric anesthesiology, neuroanesthesiology, and cardiothoracic anesthesiology with graded levels of responsibility and complexity of the patient populations.
2. A minimum of one month experience in an intensive care unit must occur during each of the last 3 years, in addition to any critical care training occurring in the first (PGY-1) year.
3. Three months of pain medicine; this may include one month in an acute perioperative pain management, one month in the assessment and treatment of inpatients and outpatients with chronic pain problems, and one month of regional analgesia experience.
4. One month in a preoperative evaluation clinic.
5. At least a 2 week rotation in a post anesthesia care unit.
6. Advanced experiences can be in additional focused anesthesia subspecialties, related areas, or research.
7. No single subspecialty, excluding critical care medicine, shall exceed a total of six months.
8. Minimum clinical experiences as defined by the program requirements for anesthesiology must be met.
9. It is expected that anesthesiology experiences continue one day a month during all internal medicine rotations in the last 3 years; attendance at anesthesiology conferences is desirable on these days of anesthesiology practice.

## **EVALUATION**

There must be adequate, ongoing evaluation of the knowledge, skills and performance of residents. Entry evaluation assessment, interim testing and periodic reassessment, utilizing appropriate evaluation modalities, including in-training examinations as currently required by both internal medicine and anesthesiology, should be employed. 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 Internal Medicine and Anesthesiology, the ABIM, the ABA, and site visitors, and may be used to provide documentation for application for hospital privileges by graduates of these training programs.

The faculty must provide a written evaluation of each resident after each rotation and these must be available for review by the site visitors of RRCs. 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 ABIM and ABA require documentation that candidates for certification are competent in: (1) patient care and procedural skills, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism and (6) systems-based practice.

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

The program director and associate program director are responsible for the maintenance of a permanent record of each resident and its accessibility to the resident and other authorized personnel. The program director, associate program director, and faculty are responsible for provision of a written final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of training in each specialty and should verify that the resident has demonstrated sufficient professional ability to practice competently and without supervision and is prepared to apply for the certification processes of both the ABIM and ABA. This final evaluation should be part of the resident's permanent record and should be maintained by the institution.

### **ELIGIBILITY FOR CERTIFICATION**

The residents in a combined training residency must satisfactorily complete the specific requirements of both the ABIM and ABA to be eligible for the examination by each Board. Clinical competence must be verified by both the program director and associate program director of the combined program. Lacking this verification, the resident must satisfactorily complete 3 years of training in Internal Medicine or 3 years training in anesthesiology in addition to the PGY-1 to qualify for the examination in the respective specialty.

Upon successful completion of all requirements of the combined residency, the candidate is qualified to take both the ABIM and ABA certification examinations. Residents may submit an application for the internal medicine certifying examination and the ABA's final part 1 (written) examination during their fifth year of training; however, applicants may not take either of these examinations until all of the combined residency training requirements have been successfully completed. The ABA's part 2 (oral) examination can occur at the earliest the following year. Each Board upon successful completion of its certifying requirements will certify the candidate. Certification in one specialty will not be contingent upon certification in the other. It is the candidate's responsibility to complete the certification process in each specialty.

*Approved August 6, 2011*

*The American Board of Internal Medicine and The American Board of Anesthesiology, Inc.*