# GUIDELINES FOR COMBINED TRAINING IN INTERNAL MEDICINE AND PREVENTIVE MEDICINE

The American Boards of Internal Medicine and Preventive Medicine have agreed to offer dual certification for candidates completing four years of combined accredited training acceptable to both Boards in internal medicine and in of the three specialty areas of preventive medicine: (1) public health and general preventive medicine (PH/GPM); (2) occupational medicine; or 3) aerospace medicine. Combined training will be reviewed by each Board to allow prospective approval for trainees entering training beginning July 1993.

## OBJECTIVES

Traditionally, the practice of internal medicine has been focused on the care of individual patients, while preventive medicine has assumed the perspective of the population as a whole. Both specialties share a concern about the impact of adverse exposures in the production of illness and disease, as well as positive impacts of health promoting behaviors. The overlap in disciplines is evident in areas of shared interest, such as occupational health and environmental medicine, clinical epidemiology and decision sciences, health services research, and disease prevention and health promotion.

The objective of combined resident training in internal medicine and preventive medicine is to produce physicians with broad-based training in both specialties. Such graduates would be trained to provide preventive, clinical, and rehabilitative care in ambulatory and hospital settings, to apply the skills required to study the effect of the environment, including the occupational environment, on the health of individuals, families and communities, and to advance the health of the public by promoting health enhancing behaviors.

The strengths of the residencies in internal medicine and preventive medicine should complement each other to provide an optimal educational experience to trainees.

Combined training includes the components of independent internal medicine and preventive medicine residencies which are accredited respectively by the Residency Review Committee for Internal Medicine and by the Residency Review Committee for Preventive Medicine, both of which function under the auspices of the Accreditation Council for Graduate Medical Education. While combined training will not be independently accredited, the accreditation status of the parent internal medicine and preventive medicine programs shall influence a combined training resident's admission to the certifying examinations of each Board. Residents for combined training should not be recruited if either program has probationary or provisional status. Proposals for combined residencies must be submitted to the ABIM and ABPM for approval before a candidate can be accepted into joint training.

## GENERAL REQUIREMENTS

Combined training in internal medicine and preventive medicine must include at least four years of coherent training integral to residencies in the two disciplines which meet the Program Requirements for accreditation by the RRC-IM and the RRC-Preventive Medicine, respectively. It is strongly recommended that combined training be in the same institution and geographic area; other arrangements may be considered on a case-by-case basis agreeable to both Boards. Documentation of hospital and faculty commitment to and institutional goals of the combined training must be available in signed agreements. For internal medicine training, affiliated institutions must be located close enough to facilitate cohesion among the housestaff, attendance at weekly continuity clinics and integrated conferences, and faculty exchanges of curriculum, evaluation, administration, and

related matters. Preventive medicine rotations at industrial or equivalent affiliated organizations need not be in the immediate geographic area; however, the respective affiliation agreements must reflect the integration of institutional objectives.

Ideally, at least one resident should be enrolled in combined training each year and at least two residents should be present in combined training at any one time. A combined training program with no trainees for a period of three years cannot continue to be approved.

At the conclusion of 48 months of training in internal medicine and preventive medicine, the residents should have had instruction and experience in the detection and treatment of acute and chronic illness, 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 residents should have had the opportunity to study and intervene in health and disease processes as they occur in communities, in defined population groups as well as in individuals, and in the stimulation of clinical practices that promote health enhancing behaviors, prevent disease and injury, and foster habilitation and rehabilitation of persons with disabilities. In occupational medicine, the resident should have had training and experience in the appraisal and control of work environments and the arrangements of work, insofar as they may be determinations of health. In aerospace medicine, the resident should have training and experience in the aerospace environment, and the clinical experience with personnel operating in that environment.

The training of residents while on internal medicine rotations is the responsibility of the internal medicine faculty and while on preventive medicine rotations, the responsibility of the preventive medicine faculty. Vacations, leave and meeting time will be shared equally by both training programs. Absences from training (vacation and/or leave) exceeding four months of the 48 months must be made up.

Except for the following provisions, combined residencies must conform to the Program Requirements for accreditation of residencies in internal medicine and preventive medicine. Funding of trainees will be the responsibility of the residencies and the training directors.

## THE RESIDENT

Residents should enter combined training at the R-1 level, but may enter as late as the beginning of the R-2 level only if the R-1 year was served in a categorical (or preliminary) residency in internal medicine in the same academic health center. Residents may not enter combined training beyond the R-2 level. Transfer between combined residencies must have prospective approval of both Boards, and is allowed only once during the four-year training period. In a transfer between combined residencies, residents must be offered and complete a fully integrated curriculum. A resident transferring from combined training to a straight internal medicine or preventive medicine program should have prospective approval of the receiving Board.

Transitional Year training shall receive no credit toward the requirements of internal medicine unless eight months or more have been completed under the direction of a program director of an ACGME-accredited sponsoring residency in internal medicine.

Training must incorporate graded responsibility throughout the training period, and supervisory responsibility must be provided to the resident for at least six months during the 24 months of internal medicine training.

Training in the three specialty areas of preventive medicine shall provide sufficient continuity of clinically supervised service in practicum activities to foster the authentic assumption of clinical and administrative responsibility.

## THE TRAINING DIRECTOR(S)

Combined training must be coordinated by a designated full-time director or co-directors who can devote time and effort to the educational program. An overall training director may be appointed from either specialty, or co-directors from both specialties. If a single training director is appointed, an associate director from the other specialty must be named to ensure both integration of the training and supervision in the discipline. The training director(s) should be certified by the ABIM or ABPM. An exception to the above requirements would be a single director who is certified and/or residency trained in both specialties and has an academic appointment in each department. The two directors must embrace similar values and goals for their training. The supervising directors from both specialties must document meetings with one another at least quarterly to monitor the progress of each resident and the overall success of the training.

## LENGTH OF TRAINING

Training requirements for credentialing for the certifying examination(s) will be fulfilled after 48 months of approved training in a combined internal medicine-preventive medicine program. A total credit of 12 months over that required for two separate residencies is possible due to overlap of curriculum and training requirements. The requirement of 36 months internal medicine training is met by a total of 30 months internal medicine training with six months credit for training appropriate to internal medicine obtained during 18 months preventive medicine training. Likewise, 36 months of preventive medicine training requirements are met by 18 months of preventive medicine training and 18 months credit for training appropriate to preventive medicine obtained during the 30 months of internal medicine training. PGY-1 and PGY-2 training should be completed in sequence. PGY-3 and PGY-4 training may be completed in a sequence deemed most appropriate for the program and trainee; however, the preference of preventive medicine is to have the academic year precede or be concurrent with the practicum year(s).

The 24 months of training in the PGY-1 and PGY-2 years will be spent in R-1 and R-2 level training in internal medicine. During the next two years, trainees will complete the academic requirements leading to the MPH degree (or equivalent) and complete integrated clinical training which meets the requirements of the practicum experience and includes six months of clinical training in internal medicine under the direction of an internal medicine program director. The integrated training for each resident should be developed jointly by the training directors to meet each trainee's career goals. Close coordination between training directors and geographic proximity are mandatory during the year of integrated clinical training.

## CORE CURRICULAR REQUIREMENTS

A clearly described written curriculum must be available for residents, faculty and both Residency Review Committees and must assure a cohesive, planned educational experience. Duplication of clinical experiences between the two specialties should be avoided and periodic review of the training curriculum must be performed. This review must include the training directors from both departments, with consultation with faculty and residents from both departments.

## REQUIREMENTS FOR INTERNAL MEDICINE

Among the 30 months of internal medicine, each resident must obtain a minimum of 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 one-month experience during 2 years 1 or 2 in the emergency department with first-contact responsibility for the diagnosis and management of adults. The resident's responsibility must include direct participation in reaching decisions about admissions.

Each resident will be assigned to the care of patients with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units) for 3-4 weeks during years 1 or 2 and again during years 3 or 4 during the 30 months of internal medicine training.

At least 33% of the 30 months in internal medicine 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 a block experience in ambulatory medicine for at least 2 months. These experiences may include subspecialty clinics, walk-in clinics, and brief rotations for appropriate interdisciplinary experience in areas such as dermatology and office gynecology. Health maintenance, prevention and rehabilitation should be emphasized. Residents will be encouraged to follow their clinic patients during the course of the patients' hospitalizations. Health maintenance, prevention and rehabilitation should be emphasized. Residents should work with other professionals such as social workers, nurse practitioners, physician assistants, behavioral scientists, and dietitians in the clinics.

Subspecialty experiences must be provided to every resident for at least 4 months. Some of this must include experience as a consultant. Significant exposure to in-patient cardiology exclusive of coronary care unit assignments is necessary. Subspecialty experience may be inpatient, outpatient or a combination thereof.

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

## REQUIREMENTS FOR PREVENTIVE MEDICINE

The basic components of preventive medicine are common in all fields of practice. These components are:

1. Biostatistical principles and methodology

2. Epidemiological principles and methodology

3. Planning, administration, and evaluation of health and medical programs and outcomes of medical care

4. Principles of the recognition, assessment and control of environmental hazards to health including those of the occupational environment

5. Social, cultural and behavioral factors in medicine

6. Applications of primary, secondary, and tertiary prevention principles and measures in assessing population and individual needs, as well as medical administrative practice

7. Study the effect of work and the work setting on the health of workers, their families, and communities, including behavioral, environmental, and toxicological considerations

The academic (PGY-3) year phase consists of a course of study leading to the degree of masters of public health or equivalent degree. This requires a minimum of one full academic year or its equivalent as determined by the residency review committee. The content will reflect the basic components of preventive medicine training. Emphasis will be on the particular field of the resident=s choice for elective course work. In certain instances, individuals may come to the training program with a MPH degree. If the degree meets the requirements of the RRC, the resident may move directly to the PGY-4 year at the discretion of the program directors.

The practicum (PGY-4) year is a year of continued learning and supervised application of knowledge, skills, and attitudes of preventive medicine in the field of special study. The total practicum will be a minimum of 12 months full time, 6 months of which must meet clinical requirements for internal medicine. It is desirable that academic work proceed or at least be concurrent with activities of the practicum year which apply the principles in the body of the academic program.

The practicum year shall offer both didactic and applied components. It should be provided in settings where there are well-organized programs appropriate to the particular field of preventive medicine and the resident shall be provided with graduated responsibility during the course of study.

If the field is PH/GPM, the residency is encouraged to make rotations in occupational medicine available to the residents and the practicum shall consist of both practice and didactic components. The training must also provide an experience in an operating health agency, generally of one month's duration. Placements in all outside agencies should be accompanied by appropriately signed and current affiliation agreements as required by the general and special requirements.

In occupational medicine, there are required didactic components which are listed in the special requirements for occupational medicine which must be met either in course work or through didactic components in the practicum year of training. It should be noted that the practicum year requires that the residents shall engage for at least 4 months, full-time or the equivalent in supervised practice within an organized comprehensive program in the real world of work, including clinical service to employed individuals. This does not require block rotations but can be integrated on a longitudinal basis throughout the educational process to achieve the four month requirement.

An administrative component is also required to provide the resident with some administrative responsibilities the specifics of which can be found in the special requirements for occupational medicine.

Specialty training for the physician in aerospace medicine must provide for the attainment of competencies relevant to the diagnosis, prevention, and treatment of disorders associated with the unique aerospace environments and with the adaptive systems designed to enhance performance and support life under such conditions.

## EVALUATION

There must be adequate, ongoing evaluation of the knowledge, skills and performance of the residents. Entry evaluation assessment, interim testing and periodic reassessment, as well as other modalities for evaluation, should be utilized. There must be a method of documenting the procedures that are performed by the residents. Such documentation must be maintained by the residency, be available for review by the RRCs, ABPM, ABIM, and site visitor, and be used to provide documentation for future hospital privileges.

The faculty must provide a written evaluation of each resident after each rotation, and these must be available for review by the resident a site visitor. Written evaluation of each resident's knowledge, skills, professional growth, and performance, using appropriate criteria and procedures, must be accomplished at least semiannually and must be communicated to and discussed with the resident in a timely manner.

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

The residency must maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel. The training 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 and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be part of the resident's permanent record maintained by the institution.

## CERTIFICATION

To meet eligibility for dual certification, the resident must satisfactorily complete 48 months of combined training (or equivalent total clinical experience in the case of residents who enter combined training while already in possession of the MPH degree). Satisfactory completion must satisfactorily meet the published eligibility requirements of *each* specialty. The certifying examination in internal medicine may be taken following satisfactory completion of the PGY-4. Failure to certify in internal medicine does not preclude admission to the certifying examination in preventive medicine and vice versa.

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