



**Accreditation Council for
Graduate Medical Education**

**ACGME Program Requirements for
Graduate Medical Education
in Internal Medicine-Pediatrics**

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Addendum to the ACGME Program Requirements for Graduate Medical Education
in Internal Medicine and Pediatrics

**ACGME Program Requirements for Graduate Medical Education
in Internal Medicine-Pediatrics**

I. Introduction

I.A. The four-year combined training in internal medicine and pediatrics must be provided by core programs in these specialties that are accredited by ACGME. (Core)*

I.B. The curriculum must comply with the ACGME requirements for the two specialties, with the modifications to accommodate overlapping experiences in both disciplines, as noted below. (Core)

II. Relation to Core Residencies

II.A. A combined program must function as an integral part of one accredited core program in each specialty, while preserving the integrity of these core programs. (Core)

II.B. Core programs must participate in only one internal medicine-pediatrics program. (Core)

II.B.1. The residents in the core and combined programs must interact at all levels of training. (Core)

II.C. A combined program will not be approved if there is evidence that its presence will have a negative impact on either of the core residency programs. (Detail)

II.D. The two participating core residency programs must be accredited by the Accreditation Council for Graduate Medical Education (ACGME), be sponsored by the same ACGME Sponsoring Institution, and must be in 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 the Designated Institutional Official of the institution that sponsors the internal medicine residency program will have responsibility for oversight of the combined program. (Core)

II.E. Participating sites that are used for training by the combined program must be approved for simultaneous use by the core programs, and must be covered by the inter-institutional agreements of the sponsoring institution. (Core)

II.F. With the exception of a combined internal medicine-pediatrics continuity clinic, 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 core internal medicine program by the Residency Review Committee for Internal Medicine and the core pediatrics program by the Residency Review Committee for Pediatrics. (Core)

- II.F.1. For subspecialty rotations, the resident may combine experiences from each of the core disciplines to allow for an integrated internal medicine-pediatrics experience (i.e., one month of rheumatology may involve inpatient and outpatient experiences that are utilized by the categorical residents in each discipline). ^(Detail)
- III. Residents
- III.A. Residents should be appointed to the combined program and reported as such in the ACGME Accreditation Data System. ^(Core)
- III.B. Residents must not enter combined residency training beyond the beginning of the PGY-2 level. ^(Core)
- III.B.1. Residents should enter combined training at the PGY-1 level. ^(Detail)
- IV. Program Director
- IV.A. The sponsoring institution must ensure that adequate salary support is provided to the program director for the administrative activities of the combined training program. ^(Core)
- IV.A.1. The program director must not be required to generate clinical or other income to provide this administrative support. ^(Core)
- IV.A.1.a) It is suggested that this support be 25-50% of the program director's salary, depending on the size of the program. ^(Detail)
- IV.B. The program director of the internal 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 pediatrics education. ^(Core)
- IV.C. The program director should have the sufficient authority and resources to enact any changes required to the combined program. ^(Core)
- IV.D. There should be one person appointed as the program director of the internal 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. ^(Core)
- IV.D.1. This program director must be certified by both the American Board of Internal Medicine and the American Board of Pediatrics, or possess qualifications that are judged to be acceptable by the Review Committees. ^(Core)
- IV.E. When a program director with dual certification is not available, there must 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. ^(Detail)

- IV.E.1. As an attestation of the requisite collaboration, all official communication should include the signature of the program director of the combined program, or of the co-directors where appropriate, and the signatures of the respective core program directors. ^(Detail)
- IV.F. In either leadership model, the program directors of the related core programs and the program director(s) of the combined program must demonstrate collaboration and coordination of curriculum and rotations. ^(Core)
- IV.F.1. There must be shared accountability among them to ensure integration of the combined residents into the core residencies. ^(Detail)
- IV.G. To achieve appropriate coordination of the combined program, including integration of the training and supervision in each discipline, the program directors of the core programs and the program director(s) of the combined program must hold at least quarterly meetings that involve consultation with faculty and residents from both departments. ^(Detail)
- IV.H. The program director or administrative co-director must also document meetings for educational activities with internal medicine-pediatrics residents. ^(Detail)
- IV.H.1. This must occur at least monthly, such as jointly sponsored journal clubs, clinic conferences, occasional combined grand rounds, conferences on medical ethics program administration and research. ^(Detail)
- IV.I. The program director of the combined program, in collaboration with the program directors of the related core programs, must be 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 specialty assignments. ^(Core)
- V. Shared Curricular Requirements for Internal Medicine and Pediatrics
- V.A. The Program Requirements for Graduate Medical Education in Internal Medicine and for Graduate Medical Education in Pediatrics regarding faculty qualifications, research and scholarly activity, duty hours, and evaluation apply to combined programs.
- V.B. 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. ^(Core)
- V.C. Although combined inpatient internal medicine-pediatrics experiences should not be developed, some joint internal medicine-pediatrics experiences should be encouraged and might include continuity clinics, acute illness/emergency department experiences for situations where there are not separate emergency departments, and subspecialty experiences (e.g., in endocrinology, infectious diseases, and rheumatology). ^(Detail)
- V.D. The curriculum must provide a cohesive planned educational experience, and may

not simply involve a series of rotations between the two specialties. ^(Core)

V.E. Residents must have graded responsibility for patient care and teaching. ^(Core)

V.F. There must be 24 months of training in each specialty. ^(Core)

V.F.1. Twenty-two months of training must be in clinical rotations and other educational experiences. ^(Detail)

V.F.2. In each specialty, up to two months per specialty off-site is allowed for outside elective experiences. ^(Detail)

V.F.3. For the first two years of training, continuous assignments to one specialty or the other should be for periods of not less than three or more than six months. ^(Core)

V.F.3.a) For subsequent training, these continuous assignments should be for periods of no more than six months. ^(Detail)

V.F.4. In order to provide as many opportunities as possible, unnecessary duplication of educational experiences should be avoided. ^(Detail)

V.G. Continuity Clinics

V.G.1. Weekly continuity clinic experience must begin at the onset of residency and be maintained throughout the four years of combined training. ^(Core)

V.G.2. Residents must have a minimum of 36 half-day sessions per year. ^(Core)

V.G.3. Continuity clinic experience must be obtained either by a weekly combined internal medicine-pediatrics continuity clinic or by alternating every other week between an internal medicine and a pediatrics continuity clinic. ^(Detail)

V.G.3.a) The sessions must be scheduled over a minimum of 26 weeks per year. ^(Detail)

V.G.4. Residents must see the following number of patient visits per year: ^(Detail)

V.G.4.a) 54 adult and 54 pediatric patient visits in the PGY-1; ^(Detail)

V.G.4.b) 72 adult and 72 pediatric patient visits in the PGY-2; ^(Detail)

V.G.4.c) 90 adult and 90 pediatric patient visits in the PGY-3; and, ^(Detail)

V.G.4.d) 90 adult and 90 pediatric patient visits in the PGY-4. ^(Detail)

V.G.5. It is suggested that residents follow their continuity patients during the course of a hospitalization. ^(Detail)

V.H. Intensive Care

V.H.1. 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. ^(Detail)

V.H.2. The total required critical care experience must not exceed eight months, and must include three months in pediatrics and at least two months in internal medicine. ^(Detail)

VI. Specialty-Specific Curricula

Except for the following provisions, combined residencies must conform to the ACGME Program Requirements for Graduate Medical Education in Internal Medicine and the Program Requirements for Graduate Medical Education in Pediatrics. ^(Core)

VI.A. Internal Medicine Component

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

VI.A.1. 20 months of direct patient care or supervision of more junior residents in direct patient care; ^(Core)

VI.A.1.a) Including at least six months of supervision of the care provided by more junior residents. ^(Detail)

VI.A.2. a maximum of two months of night float, with no more than one month in any year; ^(Core)

VI.A.3. experience in the emergency department; ^(Core)

VI.A.3.a) This should include at least a one-month experience in the emergency department during the first or second year. ^(Detail)

VI.A.4. clinical experiences with hospitalized patients; ^(Core)

VI.A.4.a) This experience should be at least eight months in duration. ^(Detail)

VI.A.5. care of adults with various illnesses in critical care units (e.g., intensive care units, cardiac care units, respiratory care units) ^(Core)

VI.A.5.a) Patient care experiences in the critical care units should be for three to four weeks during the first or second year and once again in subsequent years. ^(Detail)

VI.A.6. clinical experience involving ambulatory care; ^(Core)

VI.A.6.a) At least one-third of the internal medicine clinical experiences must occur in an ambulatory setting. ^(Detail)

VI.A.7. subspecialty experience that is inpatient, outpatient, or a combination of

the two; ^(Core)

VI.A.7.a) subspecialty experiences should be for at least four months; ^(Detail)

VI.A.7.b) should include experience as a consultant; and, ^(Detail)

VI.A.7.c) significant exposure to cardiology. ^(Core)

VI.A.8. clinical experience in geriatrics; and, ^(Core)

VI.A.9. regular attendance at morning report, medical grand rounds, residents' work rounds, and mortality and morbidity conferences when on internal medicine rotations. ^(Detail)

VI.B. Pediatrics Component

VI.B.1. An educational unit should be a block (four weeks or one month) or longitudinal experience. ^(Core)

VI.B.1.a) A longitudinal outpatient educational unit should be a minimum of 32 half-day sessions. A longitudinal inpatient educational unit should be a minimum of 200 hours. ^(Detail)

VI.B.2. The pediatrics curriculum must include: ^(Core)

VI.B.2.a) a minimum of nine educational units of inpatient care experiences, including: ^(Core)

VI.B.2.a).(1) pediatric critical care; ^(Core)

VI.B.2.a).(1).(a) There must be one educational unit. ^(Detail)

VI.B.2.a).(2) neonatal intensive care; ^(Core)

VI.B.2.a).(2).(a) There must be two educational units. ^(Detail)

VI.B.2.a).(3) inpatient pediatrics; and, ^(Core)

VI.B.2.a).(3).(a) There must be five educational units. ^(Detail)

VI.B.2.a).(4) term newborn care. ^(Core)

VI.B.2.a).(4).(a) There must be one educational unit. ^(Detail)

VI.B.2.b) a minimum of six educational units of additional subspecialty experiences, including: ^(Core)

VI.B.2.b).(1) developmental-behavioral pediatrics; ^(Core)

VI.B.2.b).(1).(a) There must be one educational unit. ^(Detail)

- VI.B.2.b).(2) adolescent health; and, ^(Core)
- VI.B.2.b).(2).(a) There must be one educational unit. ^(Detail)
- VI.B.2.b).(3) four educational units of four of the following subspecialties: ^(Core)
- VI.B.2.b).(3).(a) child abuse; ^(Core)
- VI.B.2.b).(3).(b) medical genetics; ^(Core)
- VI.B.2.b).(3).(c) pediatric allergy and immunology; ^(Core)
- VI.B.2.b).(3).(d) pediatric cardiology; ^(Core)
- VI.B.2.b).(3).(e) pediatric dermatology; ^(Core)
- VI.B.2.b).(3).(f) pediatric endocrinology; ^(Core)
- VI.B.2.b).(3).(g) pediatric gastroenterology; ^(Core)
- VI.B.2.b).(3).(h) pediatric hematology-oncology; ^(Core)
- VI.B.2.b).(3).(i) pediatric infectious diseases; ^(Core)
- VI.B.2.b).(3).(j) pediatric nephrology; ^(Core)
- VI.B.2.b).(3).(k) pediatric neurology; pediatric pulmonology; or, ^(Core)
- VI.B.2.b).(3).(l) pediatric rheumatology. ^(Core)
- VI.B.2.c) a minimum of four educational units of ambulatory experiences, including: ^(Core)
- VI.B.2.c).(1) two educational units of emergency medicine (one educational unit of emergency medicine is equivalent to 160 hours); and, ^(Detail)
- VI.B.2.c).(1).(a) Residents must have first-contact evaluation of pediatric patients in the emergency department. ^(Detail)
- VI.B.2.c).(2) two educational units of ambulatory experiences, to include elements of community pediatrics and child advocacy. ^(Detail)
- VI.B.2.d) two educational units as an individualized curriculum; and, ^(Core)
- VI.B.2.d).(1) The individualized curriculum must be determined by the learning needs and career plans of the resident and must be developed through the guidance of a faculty mentor.

(Detail)

VI.B.2.e) serving in a supervisory role. ^(Core)

VI.B.2.e).(1) This should be for a minimum of four months. ^(Detail)

***Core Requirements:** Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process for achieving compliance with a Core Requirement. Programs in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.