GUIDELINES FOR COMBINED INTERNAL MEDICINE/PSYCHIATRY RESIDENCY TRAINING PROGRAMS

Internists and psychiatrists have traditionally been trained in the physical and emotional aspects of patient care. Psychiatrists have been expected to be familiar with organic illnesses presenting as psychiatric disorders, while internists have been trained to recognize physical manifestations of psychiatric disease. Acknowledging the large overlap in the domains of these two specialties, and the increasing need for specialists trained to treat the broad spectrum of adult illness shared by internal medicine and psychiatry, the two specialties have agreed to offer combined training leading to dual certification.

OBJECTIVES

The objective of combined training in internal medicine and psychiatry is to produce physicians with broad-based training in both specialties and specific expertise in areas common to both specialties. Graduates of combined training may be expected to develop practices which take advantage of the joint training experience, serve as consultants in liaison psychiatry or consultative medicine, or be actively involved in research or administration in internal medicine and psychiatry.

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

Combined training includes the components of categorical internal medicine and psychiatry residencies which are accredited respectively by the Residency Review Committee for Internal Medicine and by the Residency Review Committee for Psychiatry both of which function under the auspices of the Accreditation Council for Graduate Medical Education. While combined training programs are not be independently accredited, the accreditation status of the core psychiatry and internal medicine programs shall influence a trainee's admission to the certifying examinations of each Board. Residents for combined training must not be recruited if either program has probationary or provisional status. Proposals for combined residencies must be approved by the ABIM and ABPN before a candidate can be accepted into combined training.

GENERAL REQUIREMENTS

A combined residency in internal medicine and psychiatry must include at least five 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-Psychiatry, respectively. It is strongly recommended that combined training be in the same institution. Documentation of hospital and faculty commitment to and institutional goals of the combined training must be available in signed agreements. Affiliated institutions must be located close enough to facilitate cohesion among the program's housestaff, attendance at weekly continuity clinics and integrated conferences, and faculty exchanges of curriculum, evaluation, administration, and related matters.

Ideally, at least two residents should be enrolled in combined training each year. If no trainees are in a combined program for a period of three years, the program will not be listed as approved.

At the conclusion of 60 months of training in internal medicine and psychiatry, residents should have had experience and instruction in the prevention, detection, and treatment of acute and chronic medical and psychiatric illness presenting in both inpatient and ambulatory settings. Trainees should be exposed to the psychiatric and medical problems and patients from adolescence to old age and receive training in socioeconomics of illness, the ethical care of patients, and in the team approach to the provision of patient care.

The training of residents while on internal medicine rotations is the responsibility of the internal medicine faculty, and while on psychiatry rotations, the responsibility of the psychiatry faculty. Vacations, leave, and meeting time will be shared equally by both training programs.

Except for the following provisions, combined residencies must conform to the Program Requirements for accreditation of residencies in internal medicine and psychiatry.

The Committee will take into consideration the information provided by the ABPN regarding resident performance on the certifying examinations during the most recent five years. The expectation is that 70% of those who complete the program will take the certifying examination; and the rate of those passing the psychiatry examination on their first attempt is 50%.

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. Under unusual circumstances and with the permission of both Boards, the Boards will consider accepting individuals who have trained in other accredited programs. Entry after completion of an R-1 year in psychiatry which involved less than eight months of internal medicine training requires prospective approval of each Board.

Residents may not enter combined training beyond the R-2 level. Transfer between combined programs must have prospective approval of both Boards, and is allowed only once during the five-year training period. In a transfer between combined programs, residents must be offered and complete a fully integrated curriculum. A resident transferring from combined training to categorical internal medicine or psychiatry training must have prospective approval of the receiving Board.

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

Training in each discipline must incorporate progressive responsibility for patient care, as well as supervision and teaching of medical students and junior residents throughout the training period.

THE PROGRAM DIRECTOR(S)

Combined residencies 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 must be appointed from either specialty, or co-directors from both specialties. If a single program director is appointed, an associate director from the other specialty must be named to ensure both integration of the training and supervision in each discipline. 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 program. 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 program.

DURATION OF TRAINING

Training requirements for credentialing for the certifying examination of each Board will be fulfilled by 60 months of training in an approved combined program. A reduction of 12 months of training compared to 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 30 months internal medicine training with six months credit for training appropriate to internal medicine obtained during the 30 months psychiatry training. Likewise, the 36 months psychiatry training requirement is met by 30 months psychiatry training with six months credit for training appropriate to psychiatry obtained during the 30 months internal medicine training.

CORE CURRICULAR REQUIREMENTS

A clearly described written curriculum must be available for residents, faculty, and both Residency Review Committees. 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 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.

Each year of the residency should include both internal medicine rotations and psychiatry residency rotations. Except where stated in the Program Requirements for each specialty, specific rotations must be at least four weeks long. Care must be exercised to avoid unnecessary duplication of educational experiences, in order to provide as many clinical/ educational opportunities as possible. In each of the five years, no less than two months FTE should be spent in each specialty.

Joint educational conferences involving residents from internal medicine and psychiatry are recommended and should specifically include the participation of all residents in the combined

training program. Availability of faculty from both specialties for consultation during clinical rotations, and especially during continuity clinic, is encouraged.

REQUIREMENTS FOR INTERNAL MEDICINE

Among the 30 months of internal medicine, 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 one-month experience during years 1 or 2 in the emergency room with first contact responsibility for the diagnosis and management for 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 R-1 or R-2 and again during years R-3, R-4 or R-5 during the 30 months of internal medicine training.

At least 33% of the 30 months in internal medicine must involve ambulatory experiences. Continuity clinic should occur during the entire 30 months of internal medicine training. Continuity clinic may be in internal medicine every week (10% ambulatory time), every other week if alternating with a psychiatry continuity clinic (5% ambulatory time), or every week as a combined medicine/psychiatry clinic (5% ambulatory time). Each resident should have at least two months of block ambulatory experience (7%), which might include additional continuity clinic, walk-in-clinics, subspecialty clinics, or brief experiences in appropriate interdisciplinary areas such as dermatology, office gynecology, orthopedics, otorhinolaryngology, or ophthalmology. The remaining ambulatory time can be obtained through additional continuity clinics, subspecialty clinics, emergency department rotations and other ambulatory experiences scheduled as partial or full months rotations. A month of ambulatory experience counts as 3.5%; one-half day a week during a month-long rotation counts as 0.4%. Some arrangement should be made to allow residents to follow their patients while on psychiatry rotations. 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 four months. Some of this must include experience as a consultant. Significant exposure to inpatient 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 PSYCHIATRY

Among the 30 months of psychiatry, the following experiences are required Neurology: two FTE months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions. At least one month should occur in the first or second year of the program.

Inpatient Psychiatry: at least six months, but no more than 16 months FTE of inpatient psychiatry of which there must be a minimum of six months of significant responsibility for the assessment, diagnosis, and treatment of general psychiatric patients who are admitted to traditional psychiatry units, day hospital programs, research units, residential treatment programs, and other settings where:

the patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender; and

patient services are comprehensive and continuous and allied medical and ancillary staff are available for backup support at all times.

Outpatient Psychiatry: 12 months FTE of organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients. Each resident must have significant experience treating outpatients longitudinally for at least one year. This longitudinal experience should include:

evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision;

exposure to multiple treatment modalities that emphasize developmental, biological, psychological, and social approaches to outpatient treatment;

opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically-ill patient population; and, no more than 20 percent of child and adolescent patients.

This portion of education may be used to fulfill the two-month child and adolescent psychiatry requirements, so long as this component meets the requirements for child and adolescent psychiatry below.

Child and Adolescent Psychiatry: two months FTE of organized clinical experience in which the residents are:

supervised by child and adolescent psychiatrists who are certified by the ABPN or who are judged by the Review Committee to have equivalent qualifications; and

provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents and their families, using a variety of interventional modalities.

Consultation/Liaison: two months FTE in which residents consult under supervision on other medical and surgical services.

Geriatric Psychiatry: one month FTE of organized experience focused on the specific competencies in areas that are unique to the care of the elderly. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, and understanding of neuropsychological testing as it relates to cognitive functioning in the elderly, and the unique pharmacokinetic and pharmacodynamic considerations encountered in the elderly, including drug interactions.

Addiction Psychiatry: one month FTE of organized experience focused on the evaluation and clinical management of patients with substance abuse/dependency problems, including dual diagnosis;

Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of self-help groups.

Forensic Psychiatry: This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competency to stand train, criminal responsibility, commitment, and an assessment of their potential to harm themselves or others. This experience should include writing a forensic report. Where feasible, giving testimony in court is highly desirable.

Emergency Psychiatry: This experience must be conducted in an organized 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings, but not as part of the 12-month outpatient requirement. Residents must be provided experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients;

On-call experiences may be part of this experience, but no more than 50 percent

Community Psychiatry: This experience must expose residents to persistently and chronically-ill patient in the public sector, (e.g., community mental health centers, public hospitals and agencies, and other community-based settings). The program should provide residents the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals.

Addiction, community, forensic, and geriatric psychiatry requirements can be met as part of the inpatient requirements above the minimum six months, and/or as part of the outpatient requirement.

EVALUATION

There must be adequate, ongoing evaluation of the knowledge, skills, and performance of the residents. Such evaluations must be in accordance with the IM and Psychiatry Program Requirements and include documentation of milestones achieved in each parent discipline. There must be a method of documenting the procedures that are performed by the residents. Such documentation must be maintained by the program, be available for review by the RRCs, ABPN, and ABIM.

The program must formally conduct clinical skills examinations that conform to the requirements set forth in the document "Requirements for Clinical Skills Evaluation in Psychiatry." In at least three evaluations with any patient type, in any clinical setting, and at any time during the program residents must demonstrate satisfactory competence in establishing an appropriate doctor/patient relationship, psychiatric interviewing, performing the mental status examination, and in case presentation. Each of the three required evaluations must be conducted by an ABPN-certified psychiatrist, and at least two of the evaluations must be conducted by different ABPN-certified psychiatrists. Satisfactory demonstration of the competencies during the three required evaluations is required prior to completing the program.

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 must maintain a permanent record of evaluation for each resident and have it accessible to the resident and other authorized personnel. The program director and faculty are responsible for documenting a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during training and should verify that the resident has performed in a professional manner and is able to practice competently and independently in all relevant components of the Combined Program. This final evaluation should be part of the resident's permanent record maintained by the institution.

CERTIFICATION

To meet requirements for dual certification the resident must satisfactorily complete 60 months of combined training and this must be verified by both training directors. The written certifying examinations may not be taken until all required years of training in both specialties are satisfactorily completed.

November 1996
Revised February 1999
Revised February 2002
Revised April 2015
Revised June 2016