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Benchmarks for Support of Internal Medicine-Pediatrics Programs

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BENCHMARKS FOR SUPPORT OF INTERNAL MEDICINE-PEDIATRICS PROGRAMS

The responsibilities of residency program directors and the level of support they receive vary by specialty and by institution. "Benchmarks of Support in Internal Medicine Residency Training Programs" by Susan D. Wolfsthal, MD, and colleagues details the current level of support for internal medicine residency program directors.¹ However, little information exists about the level of support for combined internal medicine and pediatrics (med-peds) programs, which represent the largest group of combined programs—84 med-peds residency programs participated in the 2006 National Resident Matching Program (NRMP) and those programs represent 82% of all combined residents.² Combined residency program directors are in the unique position of working with multiple departments with separate and often different financial and reporting arrangements. As a result, the support and logistics of individual combined residency program directors is likely to vary widely among programs. Although several studies of med-peds residency program directors have been published, none of the studies address the level of support provided for the combined program director duties.³⁻⁸

The Accreditation Council of Graduate Medical Education (ACGME) recently instituted accreditation requirements for med-peds residency programs. The new requirements suggest that program directors should be certified in both internal medicine and pediatrics with an allowance for co-directorship by an internist and a pediatrician. Although the requirements from both the Residency Review Committee (RRC) for Internal Medicine and RRC for Pediatrics specify that the program director must dedicate at least 50% of his or her time to the educational program, the med-peds requirements specify that the combined program director must dedicate only 25% to 50% of his or her time to the program.⁹ With the implementation of new requirements for med-peds residency programs, it becomes increasingly important to understand the current level of support for med-peds program directors, as well as the association between the level of support for med-peds residencies and outcomes, including the ability to recruit new residents and board certification rates for graduates. We conducted a national survey of med-peds residency program directors participating in both the 2004 and 2005 NRMP in order to answer these questions. An invitation and three reminders were sent via e-mail with directions to complete the survey online or in paper format.

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PROGRAM DIRECTOR CHARACTERISTICS

Of the 89 eligible med-peds residency programs, 71 program directors representing 71 different programs responded for a response rate of 80%. Of the 71 re-

Table Internal Medicine-Pediatrics Program Demographic Information from 71 Programs

Program Factor	Variable	Mean/Frequency % SD
Region	Midwest	23 (32.9)
	Northeast	18 (25.7)
	Southeast	15 (21.4)
	South Central	7 (10.0)
	West	7 (10.0)
Program type	University	58 (94.4)
	Community	13 (18.3)
Year program started	Year	1988 (\pm 8)
Residents	Interns	4.4 (\pm 2.2)
	Total residents	415.9 (\pm 8.6)
Dually trained program director demographics (n = 63)	Age	39.4 (\pm 5.6)
	Sex (male/female)	40/23 (63%/37%)
	Salary (\$)	134000 (\pm 28000)
	Year residency completed	1996 (\pm 5)
	Year appointed	2000 (\pm 4)
NRMP (n = 58)	Number of applicants/position	11.9 (\pm 18.4)
	Number of interviews/position	3.7 (\pm 4.0)
	Programs filled in match	29 (49.2)
Combined curricular programs	Grand rounds	22 (36.7)
	Journal club	34 (54.8)
	Noon conference	31 (51.7)

spondents, 88% (n = 63) were trained in both internal medicine and pediatrics, whereas 6% (n = 4) were trained in internal medicine and 6% (n = 4) were trained in pediatrics. All respondents answered the curricular, support, and outcome portions of the survey. However, the categorically trained program directors did not answer questions regarding their personal salary and support. The Table summarizes the demographic variables of the programs represented by the respondents. Program directors trained in both internal medicine and pediatrics were predominantly male (63%), and their average age was 39 years. Program directors achieved their positions an average of 4 years after graduating from residency and had been in their current positions for an average of 5 years at the time of the survey.

The average salary for 81% of dually trained program directors surveyed was \$134,000. Dually trained program directors received higher salaries at community programs than university programs (\$156,000 vs \$129,000, $P = .007$). Although male and female program directors had been in their current position for the same length of time (5 years vs 5.1 years), male program directors earned slightly higher salaries than female program directors (\$139,000 vs \$126,000), but the difference was not statistically significant ($P = .836$).

Most dually trained program directors (71%) led the same med-peds residency program where they trained. One was trained in a combined subspecialty (infectious disease), but all others were generalists. One program director each was also the director of the categorical pediatrics program, the internal medicine clerkship, the pediatrics clerkship, and the adolescent medicine divi-

sion. Thirteen (21%) respondents also served as an associate program director (APD) for one of the categorical programs.

All dually trained program directors responding to the survey were certified by the American Board of Pediatrics (ABP); 62 respondents (98%) were also certified by the American Board of Internal Medicine, (ABIM). Forty-three respondents (68%) had a primary appointment in the Department of Internal Medicine, and 20 respondents (32%) had a primary appointment in the Department of Pediatrics. Sixty-two respondents (98%) had an appointment in both departments.

Compared with internal medicine program directors, med-peds program directors had been in their current positions for less time (5 years vs 7.5 years) and were more likely to be female (37% vs 17%).¹ Whereas the majority of internal medicine program directors were subspecialists,¹ the med-peds program directors responding to the study were trained almost exclusively in general internal medicine and pediatrics. The med-peds program directors are different in this regard from the graduates of their programs, as nearly one-quarter of all med-peds graduates enter subspecialty training. It is not clear why these differences exist. With the main growth of med-peds programs occurring in the 1990s, subspecialty-trained med-peds physicians may not yet have advanced to the level of program director in their careers.

Although med-peds program directors earned less than internal medicine program directors, it would appear that the difference might be entirely explained by subspecialty training and date of graduation. Some of the difference also may be explained by reporting re-

relationships in many institutions where the med-peds program director reports directly to one or both of the categorical program directors. For med-peds residency programs, the institution (university vs community-based) was the only predictor of program director salaries. This factor also predicted internal medicine program director salaries.¹

PROGRAM SUPPORT

Personnel

The programs surveyed had an average of 16 residents (4 per year) and 5 dually trained full-time faculty employed by the sponsoring institution. Full-time faculty in med-peds residency programs had less than 50% (average = 32%) of protected time for the administration of the residency program. Twenty-five of the programs (35%) reported having an associate program director (APD) for the combined program. The APDs had less than 50% (average = 32%) of faculty protected time, averaging out to one full-time APD for every 20 med-peds residents and one full-time program coordinator/administrator for every 25 med-peds residents. Programs had an average of 14 full-time faculty who were dually trained, including those not directly involved with the training program. Results showed one dually trained faculty physician employed by the sponsoring institution for every 2.9 med-peds residents at university programs and one faculty member for every 4.8 med-peds residents at community programs ($P = .10$).

Forty-seven programs (71%) had a med-peds chief resident. Most of these programs ($n = 41$ or 87%) had a chief resident in their 4th post-graduate year (PGY), and 6 programs (13%) had a PGY-5 chief resident. Thirty-seven chief residents received supplemental incomes. Chiefs with supplemental incomes received an average of \$2900 in addition to the amount designated for residents at their level of training.

Compared with internal medicine program directors,¹ med-peds program directors have more APD support per resident. However, only a minority of med-peds residencies surveyed actually have APDs. These data do not allow us to ascertain what level of APD support for med-peds programs is appropriate.

Financial Support

Thirty-three dually trained program directors (52%) reported having separate budgets for the med-peds residency program. All program directors reported they receive support from both the departments of internal medicine and pediatrics. Twenty-three dually trained program directors (36%) reported that internal medicine was more supportive of the med-peds residency; 14 program directors (22%) reported that pediatrics was

more supportive. Twenty-six dually trained program directors (41%) reported that both departments were equally supportive. However, the survey design did not allow for determination of the type of support (financial or administrative).

Twenty-four (34%) of the respondents also indicated that their med-peds programs received an average of \$2715 of annual support from pharmaceutical companies. These funds were mainly used to purchase books, sponsor meetings and social events, and provide food. Twenty-nine of 57 respondents (51%) reported having a recruitment budget separate from either internal medicine or pediatrics. Ninety-five percent of programs provided applicants with meals, three (4%) covered travel, and 48 (68%) covered lodging. Four programs (6%) offered a signing bonus for incoming med-peds residents.

At all programs, residents were provided with educational or professional stipends for conference, travel, books, subscriptions, and software. The stipend increased with each year of training. The average educational stipend by level of training was \$475 for a PGY-1, \$555 for PGY-2, \$585 for PGY-3, and \$685 for PGY-4.

BOARD PASS RATES

Survey results show that the overall ABIM and ABP first-time pass rates for the graduating classes of 2000, 2001, and 2002 were 92.5% and 85.4%, respectively. After bivariate analysis, two factors were significantly associated with higher board pass rates: programs filling in the NRMP match and more med-peds full-time faculty employed by the program.

A program's history of filling all of its positions via NRMP was a predictor for passing the ABIM certification examination, which is not surprising, as filling all positions obviates the need to scramble for less viable candidates. It should not be surprising that factors affecting board certification pass rates for med-peds residency programs were similar to factors affecting internal medicine programs because med-peds programs share educational resources and support with their categorical programs.

Interestingly, the number of full-time med-peds faculty employed by the program was a positive predictor for passing the pediatrics certification examination but not for the internal medicine examination. The small number of pediatric faculty relative to the number of internal medicine faculty at many institutions may allow a handful of combined trained faculty to have a greater impact on pass rates for med-peds residents on the ABP examination. The effect of having the same number of med-peds faculty in a larger department of medicine may be diluted.

In addition, programs receiving financial support from pharmaceutical companies were associated with

lower pass rates. One-third of med-peds programs accept a small amount of pharmaceutical money, primarily for the purpose of purchasing educational materials. This finding is consistent with internal medicine programs.¹ However, this does not demonstrate a causal relationship. Reliance on pharmaceutical company support may be a marker of an under-funded program. Programs with lower board pass rates may be attempting to increase the educational materials available to residents of the same level or above those available in other programs.

NRMP MATCH

Thirty-five (49%) of the responding med-peds residency programs in the study filled all of their positions in the NRMP. The two factors associated with filling available positions in the match were a higher first-time ABIM pass rate and the presence of combined noon conferences as part of the curriculum. Associating a combined med-peds noon conference with filling all positions in the match could simply be spurious, but could also be a marker of a more integrated program for combined residents. Applicants to med-peds programs value this integration between internal medicine and pediatrics highly when creating their rank lists.¹⁰

RECENT TRENDS IN SUPPORT

In 2003, ACGME stated several reasons for moving forward to accredit combined med-peds residency programs independently instead of solely accrediting the core programs. Reasons for this change included difficulty in obtaining credentialing and medical licensure in certain states and the inability of ACGME to directly address resident issues related to integration and duty hours as a result of residents transitioning between two residency programs. Although the ideal standard is not yet known, these data represent the only published study regarding current institutional support for med-peds residencies, their directors, and their residents.

Compared with previously unpublished data from 1999, this study shows that a greater proportion of program directors are now dually trained (88% vs 65%).¹¹ Programs also now employ a greater number of med-peds faculty (5 vs 3.5), are more likely to have a budget independent from the categorical pediatrics and internal medicine budgets (52% vs 36%), and are more likely to have a med-peds chief resident (71% vs 52%). Although med-peds programs remain clinically and educationally integrated into both categorical programs and are intimately linked for ACGME accreditation, the data from this study, in comparison to data as recent as

1999, demonstrate a trend toward greater independent support for combined programs. Although med-peds residency programs are increasingly receiving institutional support to allow program flexibility and develop mentors trained in both specialties, movement toward being an independent specialty or department is not in the best interest of med-peds residents, training programs, or practicing physicians. Combined programs should remain fully integrated into the educational curriculum of the categorical programs. However, some flexibility in time and resources should be afforded to the combined programs to carry out educational needs unique to their residents.

In conclusion, these data summarize the current state of institutional support present for med-peds residencies. Since 1999, there has been a movement toward greater administrative and financial independence for these programs. These data are useful for those making decisions about the accreditation process and requirements for med-peds residencies. These data also should be useful to department chairs as they arrange the structures of their residency programs and directors.

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