Sarah McIntire, M.D., always wanted to be a pediatrician, but in her third year of medical school, she began to have doubts about limiting herself to pediatrics. “I was driving to Idaho talking on the phone to a friend about doing a pediatrics rotation, and I said that I didn’t know if I could wrap my head around just doing peds,” she says.

McIntire found out she didn’t have to. By doing an internal medicine-pediatrics (med-peds) residency, she could become board-eligible in both specialties. But finding a program wasn’t easy. Only 367 slots exist in 79 programs in the United States. McIntire, who’s from Washington State, discovered there were no med-peds residency programs in her home state and only a handful on the West Coast.

Although McIntire considered family medicine, which also involves caring for both adults and children and has many more training options (3,109 positions in 480 programs), she ultimately chose med-peds. She is now completing her third year in the University of Minnesota’s residency program. “I wanted a more in-depth pediatrics experience than you get in family medicine,” she says. “I didn’t only want to be prepared for well-child visits but also to be able to treat the unusual conditions, make the uncommon diagnoses in peds.”

**Med-peds vs. family medicine**
What sets med-peds apart is its emphasis on caring for sicker patients. “Family medicine is more focused on preventive medicine, and treating 80 to 90 percent of the cases that come before them—the most common complaints. Med-peds physicians do that as well, but we also enjoy the detective work that goes along with diagnosing and managing a medically and psychologically complex patient,” says Michael Aylward, M.D., who directs the University of Minnesota’s residency program—one of the country’s largest with about 40 residents.

Aylward explains that medical students who are interested in hospital medicine, acute medicine and challenging diagnostics tend to choose med-peds over family medicine. “There’s the opportunity to care for adult survivors of childhood diseases...
such as asthma and those with cystic fibrosis and congenital heart disease who are living to adulthood,” he says.

During their four years of training, med-peds residents spend 24 months in internal medicine and another 24 months in pediatrics. Med-peds programs provide about 19 more months of both internal medicine and pediatric medicine training than family medicine residency programs do. And unlike family medicine, they don’t provide training in obstetrics or general surgery.

The med-peds curriculum includes not only general internal medicine and pediatrics but also normal newborn care; neonatal, pediatric and adult intensive care; emergency care; behavioral pediatrics; adolescent medicine and geriatrics. In addition, residents may do subspecialty rotations in allergy/immunology, gastroenterology, cardiology, endocrinology/metabolism, hematology/oncology, immunology, Infectious disease, nephrology, neurology, pulmonology, rheumatology and sports medicine.

Residents work in both ambulatory and hospital settings including the neonatal ICU and pediatric emergency department. “The requirement is that each med-peds residency include one-third of its rotations in outpatient clinics,” Aylward says.

Diverse training, diverse careers

Such diverse training leads to a variety of career options. Med-peds graduates go into primary care and hospital medicine in approximately equal numbers, with a smaller percentage going on to fellowships, Aylward says. According to the National Medicine-Pediatrics Residents’ Association (NMPRA), 26 types of fellowship programs accept med-peds graduates. They include generalist fellowships only open to med-peds residents, combined adult-pediatrics fellowships in areas such as cardiology and neurology, and fellowships such as adolescent medicine and global health that are open to a wide variety of residents.

Aylward says dual board certification makes med-peds residents attractive to employers. “Internal medicine is reimbursed [by insurance] at a higher rate

Med-peds as a specialty

Med-peds had its beginnings in 1949, when a two-year rotating internship in internal medicine and pediatrics was first established. But after losing both faculty and resident support, the two-year internships were replaced with a one-year post-graduate training option in medicine-pediatrics. In 1967, the American Board of Pediatrics and the American Board of Internal Medicine approved the current four-year med-peds residency model that leads to dual board eligibility.

By the 1980s, med-peds began coming into its own. Internal medicine and pediatrics departments began to receive more government funding for residency programs. At the same time, advancements in medicine were allowing children with diseases such as cystic fibrosis and sickle cell anemia to live well into adulthood, and adult-onset diseases such as type 2 diabetes were starting to appear in children. Thus, these young patients needed specialists who could treat them over their entire lifespan.

Residency programs began to proliferate. According to the National Med-Peds Residents’ Association, the number of programs in the United States grew from nine in 1980 to 79 in 2013. In 2014, 374 med-peds positions were offered during the Match; 362 were filled.—M.S.

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than pediatrics, and employers know that med-peds residents can do both,” he says. He’s seen recent graduates go on to work in community clinics, primary care clinics and in palliative care and hospital settings. Nationally, more than 50 percent of med-peds physicians hold an academic position in addition to practicing, according to the NMPRA. Aylward says many graduates of the University of Minnesota’s program stay in the Twin Cities and mentor med-peds residents; a number of them also hold faculty appointments.

Like McIntire, Lauren Haveman, M.D., a fourth-year med-peds resident at the University of Minnesota, chose med-peds because she wanted to care for both adults and children. Initially, she thought she wanted to work as a hospitalist, but instead she decided to go into primary care. Like many who choose med-peds, Haveman is interested in working with patients with serious conditions. “I truly want to handle more complex pediatric patients, those who need specialty care—critical care, pulmonology, cardiology,” she says. But that’s not Haveman’s only reason for selecting the specialty. While in medical school at Ohio State University, she spent five weeks at a hospital in Durban, South Africa, caring for patients with HIV/AIDS and tuberculosis. That experience sparked an interest in working overseas, something both Haveman and her husband, a pediatrician who is completing a fellowship, eventually plan to do. “When it comes to global health, I don’t want to just be trained in one specialty, such as pediatrics, and then treating adults, too,” she says. One reason Haveman chose Minnesota’s program was because of its strength in global health. As a second-year resident, she spent five weeks working in Tanzania.

**Professional flexibility**

McIntire finds herself torn between hospital medicine and primary care. “Hospital medicine is fast-paced, fascinating,” she says. “But I like the idea of having the option to do outpatient medicine; it’s more family-friendly, more conducive to working part-time.” With one more year of training to go, she’s still keeping her options open.

Michele St. Martin is a St. Paul freelance writer.

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**Another combined specialty**

Hennepin County Medical Center (HCMC) in Minneapolis is home to one of a dozen combined emergency medicine (EM)/internal medicine (IM) residency programs. It was started in 2006 in response to requests from University of Minnesota medical students who had heard about such programs elsewhere and wanted an option in the state.

Residents in the program spend their time alternating between three-month EM and IM rotations, some of which are in the clinic. EM/IM residents see their primary care patients in HCMC’s internal medicine clinic. They are instructed by both EM and IM faculty and gradually assume more responsibility in the hospital. By year three, they begin taking a leadership role in the emergency department. By year five, they serve as chief residents of the program. They leave prepared to practice either emergency or internal medicine or do a fellowship in an area such as critical care.

Anne Pereira, M.D., M.P.H., who co-directs the EM/IM program with Richard O. Gray, M.D., says trainees tend to go on to work in one of three settings: rural hospitals, where they can provide both emergency and general medical care in the hospital; international settings, where they might be involved in disaster response or program leadership; or academia. She points out that the five-year program allows residents time to do research and identify an academic interest. They have six months during which they can explore specialties in depth, undertake a clinical research project, explore pathways programs in global health or primary care, or improve their procedural proficiency. She notes many times residents’ interests lie between the two specialties. They might focus on observational care (which is provided to patients who don’t meet Medicare standards for hospital admission) or transitions between the ED and ICU. Or they might take on a larger issue such as finding ways to get heavy ED users into primary care.

Pereira says having physicians with the ability to see things through the lens of two specialties can benefit a hospital. For example, the fifth-year residents at HCMC have organized a quarterly conference, during which a clinical scenario is presented and faculty, residents and students from both the EM and IM departments discuss it. “It’s not only their clinical training but the appreciation they have across boundaries,” she says explaining why EM/IM physicians are valuable. “They’re living half in one world and half in another, and that enhances communication between departments.”—Carmen Peota

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**HCMC’s EM/IM program at a glance**

**CURRENT RESIDENTS:** 9

**GRADUATES:** 8

**APPLICANTS EACH YEAR:** 100

**RESIDENCY SLOTS:** 2