

How Combined Internal Medicine–Dermatology Residency Programs Can Improve Patient and Population Health

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The volume of knowledge and skills that medical students and residents must learn is increasing. With the focus of medical education shifting toward competencies and outcomes, greater emphasis is being placed on objective measurements of competency in different areas of medicine, including recognition of common skin disorders and dermatologic procedural skills. In addition, physicians today are being trained in an era of mounting health care costs, decreased funding for medical education, rising medical–legal expenses, and increasing levels of complexity in treatment regimens.

There is also a growing need for dermatologic care. Patients in urban areas are experiencing longer waits for appointments, and those in rural areas are disproportionately underserved because of the geographical distribution of dermatologists. Dermatologic complaints are thus common in primary care. It is concerning, therefore, that one study¹ found that medical residents' dermatologic diagnoses were correct in only 43% of patients and that those of internal medicine (IM) faculty were correct in only 52%. That study also found a much higher rate of biopsies and treatments ordered incorrectly by internists than by dermatologists.¹ The clear need for improved dermatologic care in the primary care setting can be addressed in part by combined IM–dermatology

(med-derm) residency training programs and their future graduates.

Med-derm residencies are five-year programs, consisting of 30 months of training each for IM and dermatology. Their goal is to train physicians to become board certified in both specialties. These programs focus on medical dermatology and on systemic diseases that span these two fields of medicine. Historically, a large number of medical dermatologists have been double boarded in these specialties after completing consecutive, not combined, residencies in IM and dermatology. Double board certification made them ideal candidates to manage complex, cutaneous illness.

As treatments advance and gain complexity, training a new generation of physicians in both IM and dermatology is becoming increasingly important to ensure patient safety. Dermatologists should feel comfortable using toxic, systemic medications, and they must thoroughly understand and be able to manage the risks and complications of these therapies.

The professional practice of graduates from med-derm programs continues to evolve and is often tailored to physicians' specific areas of expertise or interest. Many graduates are using their training to focus on hospital consults, integrating both specialties in the management of complex inpatients. Others are focusing on dermatologic disease on a global scale by working to improve the health of immigrants and international patients in impoverished areas. In rural communities, med-derm-trained physicians can provide primary care to patients while also functioning as consulting dermatologists. Other physicians are focusing on clinical practice that integrates the dermatologic manifestations of systemic disease through rheumatologic dermatology, cutaneous oncology, or HIV. In all of these circumstances, med-derm physicians' complementary training improves care provided to patients and patient access to these important specialties.

Combined training programs also provide an economic advantage over sequential training in both specialties. Over time, the U.S. government has discontinued financial

support for second residencies, which has left individual institutions to bear the costs of additional training. Between 2000 and 2007, U.S. residency training costs were estimated at \$75,000 to \$106,000 per resident per year.² In our program training 10 med-derm residents, this equates to a savings of \$750,000 to \$1,060,000 compared with training these physicians in sequential, three-year programs. In 2011, there are 38 residents training in seven combined med-derm programs in the United States, resulting in a calculated national savings of \$2,850,000 to \$4,028,000 compared with training the same number of physicians in sequential residencies. These cost savings could translate to more health care dollars for patients in need.

Med-derm residents in our program have become instrumental in educating the categorical residents of both IM and dermatology programs. These efforts have involved formal education offerings (e.g., dermatologic procedure courses,³ didactic lectures), informal discussions, and case presentations. Providing additional educational opportunities for our categorical counterparts will lead to improved health care and patient outcomes.

The enhanced and innovative education of physicians trained in med-derm residencies may lead to improved and more accessible care for individual patients and underserved populations. Combined training is more cost-effective than sequential training in both specialties. With advances in patient-centered medicine, interdisciplinary preparation of dermatologists and internists in convergent areas of these specialties through such combined training may become critical for the safety and health outcomes of patients.

References

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