**Combined Pediatric Programs**

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Introduction

Combined pediatric training programs provide many opportunities for collaboration across core programs. These programs promote synergy in training to develop residents and future leaders with unique skills. Graduates have both strong general foundations in each core as well as specialized skillsets to serve pediatric patients with complex needs. Combined programs can promote collaboration among programs, creating opportunities for efficient use of resources and expansion of services. These benefits accrue to the categorical residents, faculty and institution.

Other sections of the APPD Handbook serve as reference for common requirements. In this guide, we have highlighted some unique aspects of combined training for those considering starting a new program, taking on new leadership roles, or seeking to refine existing programs.

Overview of Combined Training Programs

There are eight different combined programs approved by the American Board of Pediatrics ([www.abp.org/content/combined-programs](http://www.abp.org/content/combined-programs)). Programs range from 4-6 years in total, with a minimum core of 24-months equivalent in pediatrics (see Table 1). Some programs alternate blocks in pediatrics with varying patterns of switching throughout training. Other programs have an early focus on pediatrics, and others are separated with an initial 2 years in Pediatrics, followed sequentially by training in Child Neurology or Neurodevelopmental Disabilities ([www.abp.org/content/non-standard-pathways-and-combined-programs](http://www.abp.org/content/non-standard-pathways-and-combined-programs)) training.

Table 1. Overview of Combined Pediatrics Training

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| --- | --- | --- | --- |
| **Combined Program type** | **Duration**  **(years)** | **# Programs**  **(2024 Match)** | **# positions**  **(2024 Match)** |
| Emergency Medicine-Pediatrics (EM-Peds) | 5 | 4 | 8 |
| Internal Medicine-Pediatrics (Med-Peds) | 4 | 77 | 390 |
| Pediatrics-Anesthesia | 5 | 5 | 8 |
| Pediatrics-Medical Genetics | 4 | 22 | 31 |
| Pediatrics-Physical Medicine & Rehabilitation (Peds-PM&R) | 5 | 3 | 4 |
| Pediatrics-Psychiatry-Child & Adol Psychiatry (Triple Board) | 5 | 11 | 28 |
| **Non-standard pathways** | | | |
| Pediatrics-Child Neurology | 5 | 79 | 184 |
| Pediatrics-Neurodevelopmental Disabilities (NDD) | 6 | 4 | 6 |
| Pediatrics (Categorical)— *for comparison* | 3 | 251 | 3078 |

Most programs have accreditation through their core program categorical components. Medicine-Pediatrics is distinct in being independently accredited by the ACGME. All other combined training includes components that are independently accredited by the ACGME Review Committees in their respective field, and some programs have additional ABMS Board oversight to ensure combined program graduates meet training requirements. In 2025, combined programs will have some expanded opportunities for separate combined accreditation as a new application option within the ACGME.

Combined programs are a partnership of two or three “core” programs. Note that we use the term ‘core’ programs vs. ‘parent’ programs, or vernacular of ‘sides’, or other terms such as ‘off service’ that can undermine the combined program residents’ sense of belonging in the core programs.

Key points for programs and prospective residents are available on the ABP website. There are important specifications for institutional oversight, certifying Board exams, and curricular requirements to note for each program [Appendix A]. It is vital to have collaboration and equal input into these programs to develop clear full rights, expectations, and responsibilities equal to peers in categorical residency programs. Combined residents should not feel separated nor have lesser expectations. Although they may have different schedules or PGY-level responsibilities, combined residents are expected to meet full competencies upon graduation with verification to practice independently in all facets of pediatrics and the paired specialty (not just in the overlapping content). Notably, combined residents’ eligibility for ABP certification is contingent on their board eligibility in their paired specialty.

Organization and Leadership Structure

Whether starting a new combined program, or reviewing an established program, it is key to have a clear leadership organizational chart. Many combined programs have a relatively small number of residents; however, it is still vital to ensure thoughtful delineation of shared leadership and organizational structure to administer these programs. This should include clear descriptions of representation from all core programs and include program directors, coordinators, and key faculty. Most organizations require one single designated Program Director (PD) for communications with GME, Board verification, ERAS/NRMP, and accreditation bodies. However, it is vital that major decisions have input from all stakeholders. It is a common pitfall to have one program be more dominant in focus— this can undermine important decisions. Finally, GME and departmental funding of FTE/salaries, benefits, and program support can threaten balance and shared responsibility if not properly outlined and discussed at the highest level of core program and Departmental support.

Combined programs will often have a core PD included in leadership, while others (especially larger programs, like Med-Peds) will develop separate Program Director. In this case, it is essential to discuss how the Combined PD, Associate PD, and Coordinator relate to their core counterparts. Some communications may occur within existing core program educational leadership meetings, but separate meetings with a focus on combined programs should be considered. (Example: ACGME mandates collaboration and coordination of curriculum and rotations across core programs and combined programs as a core requirement, specifying at least quarterly meetings as a detail requirement.) Some educational leaders will have different core and combined roles and responsibilities/FTE effort. This this should be made clear in accounting and expectations to ensure appropriate dedication to each role. We discourage simply expanding core administrator categorical roles, and new ACGME accreditation requirements seek to ensure each program has dedicated support.

*Administration and Communication*

Early in-training physicians have many competing demands that may be exacerbated via combined program structure if not properly organized. Thus, it is important to have clear delineation of administrative professional expectations and oversight at every level— including post-match communications, onboarding and credentialing, scheduling, and compliance with GME and program administrative requirements. Combined residents can be confused if categorical residents or core programs have differing policies. We recommend mirroring policies to the extent possible. It is essential to communicate clearly and consistently on areas of difference and how they apply to the combined residents.

Some programs will simply have combined residents function under core Pediatrics leadership while on pediatric rotations and use the other core program administrative support while on non-peds rotations. This can be problematic, as there are often overarching administrative items in onboarding, credentialing, etc. that are not neatly separated.

Combined leaders should communicate about residents who are not meeting clinical expectations or administrative professional requirements so that each separate program is aware of any concerns. Leaders (including coordinators) should collaborate to provide feedback and corrective action. CCC notes, involvement of knowledgeable combined core faculty on categorical CCCs, and other educational handoff methods can share information for residents rotating to the other core program. Promotion and remediation decisions are discussed in a separate section below, but explicit combined policies must be in place to ensure a clear process in how decisions are administered as well as rights to review disputes.

Particular attention should be given to administrative details on vacation, FMLA/leave, and other unique issues as categorical and combined ABMS Board policies often differ for rotation requirements, ABP allowable time away from training, and other nuances. Other areas benefiting from explicit agreements include financing and guidelines for use of CME/travel funds, participation in program retreats, scholarly activity expectations, and resident committees. This is also important for budgetary and logistical considerations.

Scheduling and Oversight for Accreditation and Board Training Requirements

Scheduling must be well-planned and intentional to ensure combined residents meet all requirements. There is less flexibility to meet the 24-month explicit combined training requirements vs. 3-year curricula for categorical training in pediatrics alone. Many programs rely on scheduling by Chief Residents who change positions annually, or core coordinators who may not fully understand the complexity of combined training. Thus, it is critical to have combined leadership oversight of scheduling templates with details to ensure requirements at each PGY-level are met. Combined trainees should not have ‘leftovers’ in scheduling decisions, and often they will need to be slated early (especially as seniors) to ensure completion of the detailed requirements found in ABP and ACGME documents. Note that these combined training requirements include several common requirements (Newborn Nursery, Adolescent Medicine, etc.), yet the number of ICU rotations, specialty blocks, and other features can vary by combined program per ABP and ACGME details. Supervisory requirements are also important to note for scheduling on pediatrics during senior block rotations.

Switches and transitions are a major part of combined training, and leaders should thoughtfully plan the right blend to balance enough time in each core block to gain experience, while ensuring smooth transitions to the other core program rotations. Transitions are less frequent in some programs with longer blocks or may even encompass full years in pediatrics (CN, NDD, et. al.). Timing of matriculation from pediatrics to other core program experiences demands coordinated efforts to reorient and ensure logistics are in place. Scheduling with a broader view to examine how switches align (example coming off an adult ICU back-to-back with PICU or being post call off a switch) requires oversight from Chiefs, Coordinators, and others to review changes across rotations and programs. Uniform change dates or calendars that align across multiple GME programs can help support transitions for combined residents alongside categorical residents. Other calendar issues of 12-months vs. 13 blocks of 4-weeks, or shorter/longer blocks (2-week, 4-week, 8-week, etc.), and any dissimilarities in holiday scheduling can also add complexity.

Philosophically, combined training must incorporate the breadth of core pediatrics. It is a disservice to the intent of comprehensive training if rotation assignments overly weigh experiences that will be part of their paired core content (e.g. Neurology electives while on Pediatrics for Child Neurology residents). Electives, selectives, and individualized curriculum should be purposeful as these experiences are often more limited in combined schedules. The ABP explicitly disallows duplication in electives for some combined trainings. Faculty and residents should be aware of their own biases, which can contribute to combined residents being directed to specific clinical situations or patients based on future goals (e.g. a Peds-EM resident given preference for procedures). Continuity clinics should similarly ensure strong general pediatric primary care experiences.

Holidays, night call, and jeopardy can be contentious issues in schedules and must be equitably pro-rated to ensure combined residents are not over (or under) scheduled. Ensuring an understanding across core leadership and schedulers of the commitments on each side often reassures that the combined residents are pulling equal weight.

Programs should also discuss any special pathways in research, global health, advocacy, etc. with a goal of inclusion when possible, or accommodations in pathways which may span programs. Residents should be made aware of instances where requirements may not allow participation in some features offered to categorical residents.

Vacations should be scheduled with equity across combined programs. FMLA/Leave can create complex situations which should be reviewed individually, specific to ABP and the other relevant ABMS specialty guidance. Typically, there is less allowed leave, and distribution across specialties may be specified. Program directors should be aware of ABP requirements for leave, promotion and graduation.

Evaluation, Clinical Competency Committees and Remediation

Setting expectations, providing feedback, and providing summative evaluations are cornerstones for training programs and resident development. A particular challenge of combined programs is incorporating variable evaluation formats, scoring systems, and expectations. Thus, combined programs must have clear policies in place for educators and residents, and a system of regular feedback, evaluation, and reviews to ensure combined residents are on track. Often, a resident may have similar areas of strength and needed growth across the milestones and EPAs of the core programs. Coordination can identify and build on competencies and strengthen improvement plans. On the other hand, if a resident is falling behind in a single core program, the resident and PD may need to reflect on relative strengths, weaknesses, and develop more directed improvement plans with the core program. Ultimately, the combined program process requires residents to meet graduation competencies in each of the core specialties to be eligible for recognition of training in any of them.

CCCs should be developed in alignment with accreditation policies. Some combined program requirements allow separate core entities which review combined residents alongside comparable level categorical residents, while others encourage a separate combined CCC with joint core input. Evaluators must understand the expected progress of combined residents, including awareness of extension of intern-level rotations for those alternating time across core programs and acknowledging a varied trajectory, and the expectation that the residents ultimately must reach full and comparable competency in each.

Coordinated advisors, mentors, and semi-annual reviews will help combined residents reflect on how their level of training progress may vary versus categorical peers. Combined trainees commonly express heightened concerns for progress relative to categorical peers at times of transition between core program blocks and as their core-program peers progress across post-graduate years. Combined residents who are noted by the CCC to be delayed in progression require a coordinated improvement plan. Improvement and remediation plans should include all programs to ensure shared awareness, input and accountability. If a resident is not able to progress to the next PGY level or meet graduation requirements, combined leaders must work together to document and communicate deficiencies and to support remediation and probation designations. Delayed progression will affect all involved programs.

Although uncommon, combined programs may receive trainee requests to join from or transfer to a categorical program. PDs should clarify the impetus for the request and review relevant ACGME and board guidance. Resident performance to-date and the resources and goals of the individual and the core and combined programs should be considered in determining options for transfer. Combined program advisors and leaders should be prepared to review ABMS and ACGME restrictions and have open discussions on the pros/cons, local GME funding issues, FTE slots, training requirements and other issues. As perspective, the most recent edition available of the ACGME Data Resource Book notes residency-wide transfers to represent 2.3% of the graduating residents for 2022-23, including 1.4% of IM residents, 1.8% of Pediatric residents and 2.1% of Med-Peds residents.

Mentorship and Career Guidance

Combined residents have a commensurately expanded range of career interests and opportunities. They will benefit from exposure to the diversity of professional paths available to someone with their full skillset. If a resident has identified a specific career goal, focused mentoring regarding additional training, job searching, and negotiations may be beneficial. We recommend a single primary mentor who can provide semi-annual reviews and identify additional mentoring relationships or a formal mentoring committee. Advanced mentorship is helpful for residents who wish to pursue additional training or fellowship opportunities.

It is the responsibility of the combined program PD to ensure the curriculum and individual residents meet all requirements for board-eligibility in each field. A PD should not assume core program faculty will know the nuances of combined requirements. Encourage residents to join the national professional societies for each of their fields of study. Enrolling residents program-wide, with dues carried by program budget, is a strategy to ensure early engagement. In addition, there are many combined training national organizations and networking opportunities within combined training communities. Such national networking may be especially important to combined trainees, given the smaller numbers of residents and graduates overall. Graduates of these programs have also experienced this challenge and are generally highly motivated to engage trainees seeking advice.

Programs should provide on-going In-Training Exam opportunities in each specialty, individualized feedback on resident ITE performance, and program-level responses to ITE trends that could guide improvement. Timing of American Board of Medical Specialty certification is another area to review and strategize with mentors. Combined training expects residents to board-certify in each specialty. This requires planning for costs and timing, and awareness of windows of eligibility for initial exams and requirements for maintenance of certification. Open discussion of the pros/cons of deferring or not undertaking a certifying exam is important.

Recruitment

Residents in combined programs must be capable of effectively completing the requirements of multiple programs simultaneously, often at an accelerated pace. Moreover, core programs may prioritize different qualities in applicants. A high level of involvement in the recruitment process helps to ensure residents entering a combined program will thrive in all settings. The degree of participation may take different forms, such as creating a list of minimum requirements, core program contributions to online materials for applicants, core program faculty directly interviewing candidates, and/or participating in the combined selection committee.

We recommend programs collaboratively devise a recruitment strategy that accounts for constraints of the NRMP Match season timeline. Program directors should work together on approaches to online program promotion, outreach to visiting students, and pre-recruitment activities. Potential applicants should be aware of unique requirements for combined programs at your institution; program directors should work to identify these (e.g. away rotation expectations, standardized or chair’s letters of recommendation, numbers of letters of recommendation from each specialty, etc.) and publicize them on their website. PDs should be familiar with the specialty-specific Program Director Association Guides for Residency Applicants published through CMSS OPDA (<https://cmss.org/opda/>).

Institutional approaches to screening ERAS applications may differ, but communication and identification of responsibilities should be clear to each program prior to the start of screening. Some combined programs allow the smaller program to first screen applications, then present a list of potential interviewees to the larger program for approval. Others may take a reverse approach, or the combined program may select interviewees independently but be informed by guidance about the requirements of the other core program. A clear outline of the reviewing algorithm can help avoid confusion or conflict.

On interview days, combined programs may wish to feature aspects of each program, including information from chief residents and categorical program leadership. Categorical program representatives (leadership or core faculty) may wish to have a direct role in interviewing, especially if the categorical program influences ranking. Prior to a rank meeting, program leadership should determine how ranking will be determined (such as a numerical scoring based on applications and interviews). During rank meetings, it is advisable to include representatives from all programs to ensure that all ranked applicants are acceptable to all programs.

*Dual Applicants*

Some applicants to combined programs may simultaneously apply to one or both core specialties. This can reflect on-going decision-making on specialty choice, or a strategic response to the limited number of combined positions. Programs should be clear if dual application is required, recommended, discouraged or not considered in determining interview offers. In instances of applicants applying to combined and categorical programs at the same institution, programs may be asked if multiple interviews are required or if the interview for the combined program would also allow the applicant to also be assessed for the categorical program’s rank list. The structure of interviews should be explained to applicants, preferably on the website before they apply, especially if interviews will be an entire day, multiple days, or include social opportunities in the evenings. Applicants should not be pressed to indicate a primary interest or disclose which programs are ‘back-ups’. For many programs with only a handful of national slots, it is expected that applicants will apply to categorical programs as well as combined options.

*Reversions*

For NRMP Match, some programs use a “reversion” process, where if a combined program does not fill, the combined position reverts to a categorical position to allow that program to take an additional resident. Reversion creates protection for sites offering programs with smaller numbers of participants; unfilled combined program positions can be claimed by next-ranked categorical applicants, ensuring stable numbers of incoming residents. This option should have explicit, early discussion of which core program will be prioritized to add a reverted position, and if there would be a process for alternating in future matches. Some programs may choose not to fill, and consider taking additional applicants in a future cohort, if slots and budgets allow. The SOAP process is available when a program doesn’t fill. Participation in SOAP is indicated at the beginning of the recruitment season and should be a mutual decision of the combined and core programs. If a program participates in SOAP, it is advisable for all leadership members to assist in the flurry of activity during SOAP week and ensure applicants meet the qualifications outlined by each component of a combined program.

Developing Identity and Community with Combined Trainees

Residents in combined programs may experience varying degrees of connection to the core communities. Residents will benefit from having their own combined program identity while also being a part of larger groups. Program directors of the combined and categorical programs should be intentional in encouraging positive, unified community building.

Residents may benefit from a well-formed program identity with regular program-specific communications (such as newsletters and updates), educational and social events with trainees and faculty, and a combined-program website presence highlighting accomplishments. Residents are just learning to navigate the demands of being aware and involved in multiple specialties. Specific combined meetings, or programming for journal club, grand rounds, research programming, or boards preparation can enhance a sense of identity.

For the categorical program director, we encourage a view of the combined resident as bringing an added skillset to the categorical program; avoid regarding combined trainees as part-time or temporary based on their reduced time in pediatrics rotations compared to categorical residents. Make an intentional effort to include combined residents in categorical program communications, orientation, social events, didactics, retreats, and eligibility for program recognition awards. Strongly consider including combined residents in the celebrations and ceremonies with their cohort class. For example, including the rising PGY4 Med/Peds residents in the PGY3 pediatrics graduation events, as they may want to celebrate the achievements of the residents with whom they entered training.

Combined programs can be a point of synergy, creating unique programming opportunities where combined residents and faculty serve as a bridge across specialties, sharing learning and resources, and identifying opportunities for improvement with the categorical program. For example, Pediatrics/Genetics residents can lead didactic sessions about common genetic syndromes with pediatrics residents; Med-Peds residents may use their familiarity with specialists in the pediatric and adult systems to develop transition of care resources for emerging adults; Pedi-EM residents may use their in-depth knowledge of both systems to broaden understanding of care seeking behaviors. Vertical mentoring incorporating PGY4, 5, and 6 residents expands support for combined interns, ensuring role models on their less-typical paths, and reminds the senior residents how much progress they have made in their combined training.

Rotating between programs can be a time when residents feel disconnected from their other core program, so consistent communication and inclusion is important. When major events (orientation, retreats, program-wide meetings, graduation ceremonies) occur, residents may appreciate effort from both programs arranging work schedules to accommodate their ability to attend even when on a rotation with the other program. This requires early communication and cooperation among all program directors for scheduling and planning. Explicit advance discussion of events deemed program requirements versus ‘if available to attend’ is important to avoid unrealistic expectations and perceptions of program activities being under-valued.

Program Evaluation and Final Thoughts

Most combined programs will review core program evaluations, ACGME surveys, and other data to assess strengths and weaknesses in each program. This important for all programs, yet there may also be some unique threats and opportunities within the combined program experience. Thus, best practices include separate review by combined program leaders to integrate ACGME annual survey results, internal reviews, program evaluation committees, and other sources to help improve the combined training experience. This can improve education for individuals, aid in recruitment efforts, and serve as a foundation for program accreditation. Combined program accreditation varies. Currently, Med-Peds programs are independently accredited by the ACGME, while others have oversight and accreditation by each involved ACGME Review Committee and ABMS Board. In 2024-25, combined programs were invited to provide input into developing new accreditation pathways and this may further delineate formal expectations for combined training.

In conclusion, although there are challenges in developing and supporting combined training, the authors and most affiliated with combined training appreciate the unique and rewarding synergy and multifaceted graduates they provide. Many combined trainees enter fields that are underserved by the pediatric workforce and numerous graduates go on to be leaders in patient care, teaching, academics, and the community. Beyond the training program, coordination across core programs and departments creates many other opportunities to collaborate in education, clinical care, research, and advocacy.

Resources/References

American Board of Pediatrics Combined Program training [www.abp.org/content/combined-programs](http://www.abp.org/content/combined-programs)

and [www.abp.org/content/non-standard-pathways-and-combined-programs](http://www.abp.org/content/non-standard-pathways-and-combined-programs) Accessed 8.12.2024.

ACGME Program Requirements for Combined Programs Summary and Impact of New Requirements

[www.acgme.org/globalassets/pfassets/reviewandcomment/2024/combined-programs-impact-statementv1.pdf](http://www.acgme.org/globalassets/pfassets/reviewandcomment/2024/combined-programs-impact-statementv1.pdf)

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*Appendix A*

Guidelines on ABP requirements from: [Combined Programs | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/combined-programs); accessed 7.29.2024.]

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| **Combined Program type** |  | **Link** | **Guidelines** |
| Internal Medicine-Pediatrics (Med-Peds)1 |  | [Medicine-Pediatrics Program | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/medicine-pediatrics-program) | Integrated 2 years IM and 2 years Pediatrics |
| Pedi-Anesthesia |  | [Pediatrics-Anesthesiology Program | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-anesthesiology-program) | PGY1: Peds  PGY2: Anes  PGY3-5: 18mos each, no less than 3 mos of each year |
| Pedi-EM |  | [Pediatrics Emergency Medicine Program | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-emergency-medicine-program) | PGY1: 6mo Peds, 6 mos EM  PGY2-5: minimum 3, max 6 consecutive mos under the direction of one specialty |
| Pedi-Medical Genetics |  | [Pediatrics-Medical Genetics Program | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-medical-genetics-program) | PGY1: Peds “in direct patient care experiences”  PGY2-4: continuous assignment to one specialty or the other should be for not less than 3 or more than 6 months’ duration in any given year, with the option for up to 9 months spent in clinical genetics and genomics in the 4th year. |
| Pedi Physical Medicine &Rehabilitation |  | [Pediatrics-Physical Medicine and Rehabilitation | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-physical-medicine-and-rehabilitation) | PGY1: Pediatrics  PGY2-5: except for one consecutive 12-month period that may be spent in physical medicine and rehabilitation, continuous assignment to one specialty or the other should be not less than 3 or more than six months’ duration in any given year. |
| Pedi-Psychiatry-Child & Adol Psychiatry-Psychiatry1  (Triple Board) |  | [Pediatrics-Psychiatry/Child and Adolescent Psychiatry | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-psychiatrychild-and-adolescent-psychiatry) | 24 mos Pediatrics, 18 mos Psychiatry, 18 mos Child and Adolescent Psychiatry |
| **Non-standard pathways** | | | |
| Child Neurology2 |  | [Pediatrics-Neurology | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-neurology) | A special agreement exists between the American Board of Pediatrics (ABP) and the American Board of Psychiatry and Neurology (ABPN) whereby an applicant who completes at least two years of accredited training in general comprehensive pediatrics, in addition to the necessary training to meet the requirements for neurology certification with special qualifications in child neurology, fulfills the training requirements of both the ABP and the ABPN |
| Neurodevelopmental Disabilities2 |  | [Pediatrics-Neurodevelopmental Disabilities Pathway | The American Board of Pediatrics (abp.org)](https://www.abp.org/content/pediatrics-neurodevelopmental-disabilities-pathway) | The American Board of Psychiatry and Neurology (ABPN) offers a subspecialty certificate in neurodevelopmental disabilities whereby an applicant who completes at least 2 years of accredited training in general comprehensive pediatrics, in addition to the necessary training to meet the requirements for neurology certification with special qualifications in child neurology and in neurodevelopmental disabilities fulfills the training requirements of both the ABP and the ABPN. |
| Notable additional requirements | 1. minimum of 36 half-day sessions per year of a longitudinal outpatient experience in a continuity clinic throughout training. The sessions must not be scheduled in a time period fewer than 26 weeks per year. 2. minimum of 36 half-day sessions per year of a longitudinal outpatient experience in a continuity clinic during the pediatric-specific years of training. The sessions must not be scheduled in a time period fewer than 26 weeks per year. | | |