Residency to Shift Out of the Ward

BY JOHN R. BELL
Associate Editor

Leaders of academic internal medicine are developing plans to reform training so residents can spend more time in ambulatory settings and programs can promote residents on the basis of their mastery of certain skills.

The recently convened Education Redesign Task Force of the Alliance for Academic Internal Medicine (AAIM) is expected to issue its final report in the first half of 2007.

The task force recommendations are likely to guide those of the Residency Review Committee for Internal Medicine of the Accreditation Council for Graduate Medical Education, which updates its requirements every 3 years, according to Dr. Barbara Schuster, president of the Association of Professors of Medicine, one of the component organizations of the AAIM. (The other four AAIM organizations are the Association of Program Directors in Internal Medicine, the Association of Specialty Professors, the Clerkship Directors in Internal Medicine, and the Administrators of Internal Medicine.)

The task force, which met in October in New Orleans during an AAIM meeting that was closed to the press, focused its efforts on defining the core curriculum of internal medicine residency, identifying resources needed in residency programs, and assessing ways to evaluate residents, Dr. Schuster said in an interview.

The committee also discussed basing training and progress within residency on demonstration of the specific ACGME competencies, rather than gauging progress by the clock, she said. Those competencies are patient care, medical knowledge, practice-based learning and improvement, systems-based practice, professionalism, and interpersonal and communication skills.

Giving residents more training in ambulatory care was of great interest, Dr. Schuster said. One option discussed by the task force, she said, was having residents spend 3 months in ambulatory care and then rotate back to the hospital, instead of spending a half day in ambulatory care every week. Educators are concerned that having residents spend a half day each week is not effective, and that residents sometimes can't come into the ambulatory clinic "because they've been on call the night before."

That sentiment was shared by two internists from the University of California–Davis Medical Center in Sacramento who attended the meeting.

"One criticism is that we have residents spend too much time in the hospital," said Dr. Craig R. Keenan, director of the primary care residency program. But a change would require reforms in funding of residency programs, he said, given that teaching hospitals and university medical schools are funded in large part based on the number of patients who receive treatment from residents in the hospital.

Another potential obstacle is the integral role that teaching hospitals—and by extension, their residents—play in caring for the uninsured and underinsured, said Dr. Mark C. Henderson, vice chair for education in the internal medicine department. "Teaching hospitals bear the largest share of uncompensated care," he said. "So most of the underinsured are taken care of by residents in the large urban centers. To take residents away to offices, where they can get better training, could worsen the crisis of care for the uninsured and underinsured."

Thus "the stewards of the teaching programs … have to advocate to disentangle our residents from the financial and service needs of their teaching hospitals," he said.

Promotion within residency is an area that many IM educators consider to be in need of change, Dr. Henderson said. "People are promoted from the first year to the second year to the third year based on how much time they've spent in the program," he said.

"The problem is that in that 1 year, two residents may have a very different actual clinical experience. One resident may see twice as many patients as another resident. So the question becomes, why do you promote people within the 3 years simply based on the amount of time they've spent?

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DR. SCHUSTER

Wouldn't it be better to promote them based on the acquisition of certain required skills or competencies?"

But such an approach would require more intense supervision of each resident, he noted.

Residency reform is needed to address the dearth of IM residents, Dr. Henderson added. "Fewer students are choosing internal medicine as a career—and this has implications not only for the quality of individuals who go into internal medicine but also for the workforce."

Given the aging U.S. population, this shortage could lead to a national crisis in primary care.

Recruitment to internal medicine, particularly general internal medicine, may be stymied by value differences between two generations—physicians in current practice and those now going into resident training. ■

Software to Idle Patient: Examine Thyself

BY BRUCE K. DIXON
Chicago Bureau

A Maine internist has distinguished himself by turning his exam room computers into time-saving patient education tools.

Dr. Mukesh Bhargava has developed a "show and tell" that helps patients learn how to examine themselves for skin, breast, and testicular cancers—and he used nothing more elaborate than commonly available software and a $20 microphone.

"We've created a short multimedia presentation that patients can view in the privacy of one of our three examination rooms," said Dr. Bhargava, an internist in Sanford.

After each exam, Dr. Bhargava leaves the patient alone in the exam room to view the 2-minute presentation on a secure desktop computer. The half-dozen PowerPoint slides, which he narrates, walk the patient through the process of examining the skin for suspicious moles, or performing a breast or testicular self-exam.

Patients appreciate the presentation, Dr. Bhargava said, noting that it "reinforces the importance of proper self-care and saves me time in the process. They say this is more helpful than a handout, and they appreciate the fact that it is their own doctor doing the narration," he said in an interview.

"All the literature says that medical advice carries more weight when it's your own doctor that's giving it," he added.

There's no danger that a patient will access electronic medical records or other sensitive data, which are securely locked and password protected, he explained.

Dr. Bhargava welcomes inquiries about his multimedia project. You can reach Dr. Bhargava at mbhargava@gmail.com. ■