Ambulatory Training to Lead Residency Reforms

Task force on reform discusses the core curriculum, evaluation of residents, and hospital staffing issues.

BY JOHN R. BELL
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Leaders of academic internal medicine are developing plans to reform residency training so residents can spend more time in ambulatory settings and so 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 during the first 6 months 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.)

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DR. SCHUSTER

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 according to time spent in residency, 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 or because they're worried about their patient in the ICU."

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 way too much time in the hospital," said Dr. Craig R. Keenan, director of the primary care residency program in the internal medicine department. 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 uninsured and underinsured patients, said Dr. Mark C. Henderson, who is 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."

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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. "We have to somehow protect their education and design their education based on what they need to learn, rather than how many patients the hospital has and the fact that they're overwhelmed and need bodies to provide that service."

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," he noted. "So the question becomes, why do you promote people within the 3 years simply based on the amount of time they've spent? 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.

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. The coming paucity of internists will most acutely affect geriatrics, an area of increasing need, he noted.

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 residency.

Today's residents "have seen their parents grow up being workaholics, but they want a balance in their lives," Dr. Keenan said. "Internal medicine demands a lot of hours, after-hours phone calls, and weekend call, yet you don't get reimbursed very well for these activities." This contrasts with the pager-free shift work of emergency physicians, he said. Yet heavy patient loads make hospitals loath to reduce the 80-hour weeks that IM residents must endure.

The changes discussed by the task force are similar to those recommended by the American College of Physicians in a position paper published in the June 2006 issue of the Annals of Internal Medicine (2006;144:927-32).

The next AAIM meeting will be in 2008 and is open to all practicing internists, as well as academic staff in departments of internal medicine. For more information, visit www.im.org. ■