

Internal Medicine Residency Redesign: Time to Take Stock

During the past few years, the internal medicine community has engaged in a serious discussion about the need to redesign internal medicine residency training to ensure that residents are prepared to provide high-quality care to the patients whom they are likely to encounter when they enter practice. In 2005, persons within the internal medicine community published several articles (1–3) noting the need to reform certain aspects of internal medicine training. That same year, the Society of General Internal Medicine issued a report (4) calling for the redesign of residency training. In 2006, the American College of Physicians (ACP) (5) and the Association of Program Directors in Internal Medicine (6) acknowledged that redesign of internal medicine residency training was urgently needed and offered recommendations for the kinds of changes that should be adopted.

Commenting on the 2006 ACP and Association of Program Directors in Internal Medicine reports, Schroeder and Sox (7) expressed concern that because “internal medicine is ambivalent about what it stands for and what it should become,” agreeing on the kinds of changes that should be adopted would be difficult. Because of a lack of agreement in the internal medicine community about the future of internal medicine and the absence of a clear strategy for going forward, Schroeder and Sox warned that residency redesign might be doomed to “the default pathway of halfway measures.” Given that almost 5 years have passed since the publication of these reports, it seems appropriate to examine the status of the residency redesign effort.

The Alliance for Academic Internal Medicine (AAIM) has been directing these efforts and established the Education Redesign Task Force in 2005 to develop recommendations for how to redesign internal medicine training for residents. The task force included representatives of the AAIM’s member organizations as well as representatives of the ACP and the American Board of Internal Medicine. In 2007, each member organization approved the task force’s recommendations for residency redesign (8). Among the many recommendations, the call for internal medicine training to adopt and implement competency-based education was the most important. Therefore, the AAIM established a second task force to examine the concept of competency-based education more deeply and to suggest how this concept might be applied to the redesign of residency training. In this issue, Weinberger and colleagues (9) report on the second task force’s deliberations.

The AAIM Education Redesign Task Force II links the residency redesign effort with the competency-based approach for accreditation in the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project. In this regard, the task force’s position is completely consistent with the position that the Residency Review Com-

mittee for Internal Medicine (10) adopted in 2004 for accrediting programs. However, considering the task force’s position, it is important to recognize that the ACGME Outcome Project’s approach infers that residents are prepared to enter practice only if, during the course of their training, they successfully meet performance standards linked with 6 practice-related domains. The ACGME calls these domains “competencies” and defines them as medical knowledge, patient care, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice.

The internal medicine community now seems to be following the default pathway against which Schroeder and Sox warned readers. The collective results of the assessment process that the ACGME has adopted for accreditation purposes simply cannot indicate whether residents are actually competent clinicians when they complete residency training. The only way to determine whether residents completing a training program have become clinically competent is to have skilled clinicians repeatedly observe the resident providing care in appropriate practice settings for the kinds of patients whom they will encounter when they enter practice (11, 12). The first AAIM Education Redesign Task Force clearly stated these points in its 2007 report.

There is nothing inherently wrong with using various assessment methods to demonstrate that residents have achieved a predetermined level of performance in numerous arbitrarily defined practice-related domains during their training. Yet, the internal medicine community must not interpret demonstration of this performance as evidence that a resident is a competent clinician. Clinical competence is not defined by the knowledge, skills, and attitudes that physicians acquire during training but rather by how they incorporate those attributes into actual patient care. Huddle and Heudebert (13) argued persuasively that focusing on whether residents acquire certain knowledge and skills during their training rather than whether they are truly capable of providing high-quality care threatens the future quality of internal medicine residency training. The AAIM needs to heed this warning.

The fundamental purpose of redesigning residency training in internal medicine should be to develop programs fully capable of training residents who can provide high-quality care upon entering practice. The internal medicine community has acknowledged that the current approach for training residents needs to be changed. The report of the AAIM’s task force clearly states that because substantial challenges are involved in incorporating the competency-based approach into the redesign of internal medicine training, the training of internal medicine residents is unlikely to change in substantive ways for many years.

Key internal medicine organizations must provide the leadership to design and implement real changes that will ensure that residents completing internal medicine training programs are fully competent to meet the challenges involved in providing high-quality care. Most important, the internal medicine community must develop a structured approach to ensure that program faculty repeatedly observe residents as they care for patients in various clinical settings.

Such observation will require substantial resources. These resources should not be diverted to the development of competency-based accreditation mechanisms that do not ensure that programs are training competent internists. By requiring the clinical encounter to be deconstructed into vaguely defined domains for accreditation purposes, the ACGME Outcome Project inadvertently distracts from efforts to redesign residency training in ways that can ensure that residents completing training are clinically competent. Unless this issue is addressed, accredited programs will continue to provide suboptimal training and patients will continue to encounter inadequately trained internists.

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