

ACADEMIC INTERNAL MEDICINE INSIGHT

EDUCATION REDESIGN

President's Update: Change Is Imminent

AAIM President Craig Brater, MD, discusses two of the most pressing and interrelated changes facing academic internal medicine: duty hours and education redesign. As internal medicine residency programs prepare to meet the myriad challenges of implementing the new resource-intensive requirements in less than a year, education redesign will be required to train better physicians in less time.

CURRICULUM DEVELOPMENT

Health Care Disparities: A Bimodal Approach to Curriculum

Academic medicine can play an important role in the reduction of health care disparities by addressing the subject in medical education curriculum. The majority of medical schools and teaching hospitals are located in diverse cultural, racial, and ethnic communities that enable students and residents to learn how patients' beliefs, language, and other cultural factors can create obstacles to receiving high-quality health care.

MILESTONES

Incorporating Milestones into Your Program: Capturing What You Already Do

As residency program directors continue to struggle with competency-based educational framework, much work has been done to articulate the milestones of competency development. The internal medicine residency program at Henry Ford Hospital has begun incorporating the milestones into existing structures and routines to better capture educational activities and evaluation decisions.

ASSESSMENT

Developing Standardized and Acceptable Oral Exams

Faced with a clinical assessment grading system that was perceived as less than accurate and too subjective, the third year medicine clerkship at University of Chicago developed an oral examination. The examination uses a 16 point scale to assess clinical evaluation, differential diagnosis, data evaluation, and management in 20 standardized cases and has resulted in better student choices of study materials and improved student and faculty satisfaction with the assessment.

The Hidden Patient: A Novel Way to Evaluate Resident Competency in Professionalism and Interpersonal and Communication Skills

To augment commonly used methods to evaluate ICS and professionalism, University of Iowa Carver College of Medicine added a three-year pilot program using a "hidden patient" experience to its residency program. This assessment provided a snapshot of a resident's skills during the second year of training, allowing for any deficiencies to be identified and addressed prior to graduation.

2

4

8

10

12

By the Numbers

10+5

Number of movers and staff present to manage the AAIM office move

5,500

Pounds of AAIM furniture, boxes, and other materials moved

priceless

A new AAIM office in Alexandria, VA

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President's Update: Change Is Imminent

Much has happened since my last letter. As everyone knows, the Accreditation Council for Graduate Medical Education (ACGME) announced new requirements related to duty hours and supervision. AAIM advocated for some modification in a thoughtful response to the draft that was released last summer. To be perfectly honest, our expectations were not high given that the pressures on ACGME and all of us are considerable in this arena. The most tangible manifestation of that pressure is the recent appeal by several groups for the federal Occupational Safety and Health Administration (OSHA) to step in and monitor duty hours. The appeal has not been ruled upon and AAIM as well as other organizations have argued against it, but in the face of such pressure, it was impossible for ACGME to do anything that appeared to be "soft." Our biggest hope was a delay in implementation until 2012 but even that got no traction. So now everyone is scrambling to meet the new regulations by July 2011.

Let us make no mistake about what is happening. One privilege of the medical profession is that society awards us the right to regulate ourselves. But if we do not regulate in a fashion the public expects, that privilege can be removed and others will regulate us. Whether we agree or disagree with the assessment, society is telling us they are not happy with the status quo in medical education. If we are not responsive, then we are at substantial risk—just ask colleagues in New York how it feels to have state government looking over your shoulder as you try to train your residents.

One privilege of the medical profession is that society awards us the right to regulate ourselves. But if we do not regulate in a fashion the public expects, that privilege can be removed and others will regulate us.

We all know filling the gap of patient care created by the new duty hours will incur substantial costs, mainly the need for more clinicians, hospitalists or others. Our sponsoring health systems will balk, squawk, and whine (perhaps they have learned this from us!). The reality, as ACGME President and Chief Executive Officer Thomas G. Nasca, MD, points out, is residents have been used to provide substantial clinical service. As we are forced to move away from that model, it calls the question of the health systems with which we partner as to whether they are really committed to medical education.

If they waver in that regard, I would argue that the most compelling reason for a health system to invest in medical education is as a strategy to ensure they have the physician workforce they need in the future. What better way to recruit a physician to your staff than to host learners in a fashion that says the system truly values their education and well being? From our perspective as educators, we have no choice but to comply. It seems to me that we should use this external pressure from society through ACGME to truly diminish the service load and enrich the educational experience. Yes, I am a pathological optimist!

Critics are also saying that they think we are slow to adapt to new approaches to medical education, whether for students or residents. The Carnegie reports are ample evidence of this dissatisfaction as is the Medicare Payment Advisory Commission (MedPAC) discussion about assigning graduate medical education funding based on training outcomes rather than head count. The signals are myriad that we need to do things differently and that change must come quickly.

Our efforts through the education redesign task force (that has now morphed to an AAIM standing committee) is one way the alliance is trying to address these issues. That committee is building on the efforts of two preceding task forces. This third committee with is focused on three efforts, the first being milestones in training, a core component of applying competency-based educational approaches to medical education. This group will also be exploring how to implement resident-centered pathways during training. The second effort is centered on assessment of progress against milestones and preparing evaluation tools for this use. The third effort is in faculty development to both disseminate messages about redesign efforts and to prepare faculty to teach as well as learn in this new era.

Additional discussions and projects with the American Board of Internal Medicine (ABIM) and the American College of Physicians (ACP) are also part of this theme of change. Our goal is to push this agenda and be part of the innovation as opposed to having it inflicted on us. The best evidence is that the AAIM Board of Directors recently decided these educational issues are so important that we will focus our resources here for the foreseeable future.

In the spirit of communication and collaboration, we have had a series of meetings and follow up discussions with ACP to identify areas of commonality. For example, we are cross-populating education committees and are considering doing the same in advocacy. Moreover, ACP formally added ASP as a member of their Council of Subspecialty Societies. We thank the new ACP President Steven Weinberger, MD, for taking the lead on these collaborations.

Moving forward, AAIM needs to have two foci. The first is an inward focus to help the members of each organization in their day-to-day responsibilities. Academic Internal Medicine

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AAIM is a consortium of five academically focused specialty organizations representing departments of internal medicine at medical schools and teaching hospitals in the United States and Canada. AAIM consists of the Association of Professors of Medicine (APM), the Association of Program Directors in Internal Medicine (APDIM), the Association of Specialty Professors (ASP), the Clerkship Directors in Internal Medicine (CDIM), and the Administrators of Internal Medicine (AIM). Through these organizations, AAIM represents department chairs and chiefs; clerkship, residency, and fellowship program directors; division chiefs; and academic and business administrators as well as other faculty and staff in departments of internal medicine.

Week is a great example of the education, networking, and resources available for members by members. The second focus is external as we address the impending changes to medical education and health care in the United States. AAIM is doing both, which means the rationale for forming the alliance in the first place is being realized. Our successes so far are a function of the talent and commitment of our staff, leaders, and members.

Sincerely,



D. Craig Brater, MD

President
Alliance for Academic Internal Medicine

Correction

In "EVP Update: ASP, Partners Helping Williams Scholars Improve Geriatric Medicine," published in Volume 8, Issue 3, the John A. Hartford Foundation is listed as the funder of the T. Franklin Williams Scholars Program. While the foundation provided \$750,000 for the start-up of the Williams Scholars Program, the Atlantic Philanthropies (USA) Inc. has awarded ASP \$8.5 million for the Williams Scholars Program and the GEMSSTAR + TFWS Program. The editorial staff of *Academic Internal Medicine Insight* apologizes for the error.

Health Care Disparities: A Bimodal Approach to Curriculum

Disparities in health care, cultural competency, and cross-cultural education have been addressed in the medical profession, medical education, and public health literature (1-3). The Association of American Medical Colleges (AAMC), the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Institute of Medicine (IOM) have addressed the issue with a wide range of requirements and recommendations (4-7). Academic medicine can play an important role in the reduction of health care disparities by formally addressing the subject in the medical education curriculum. The majority of medical schools and teaching hospitals are located in diverse cultural, racial, and ethnic urban communities that enable students and residents to learn directly how their patients' beliefs, language, and other cultural factors create obstacles with the health care system. The academic medicine-community partnership model with cross-cultural encounters, using the principles of community assessment and community-based participatory research, can offer a rich learning experience in health care disparities.

Unequal Treatment Defined

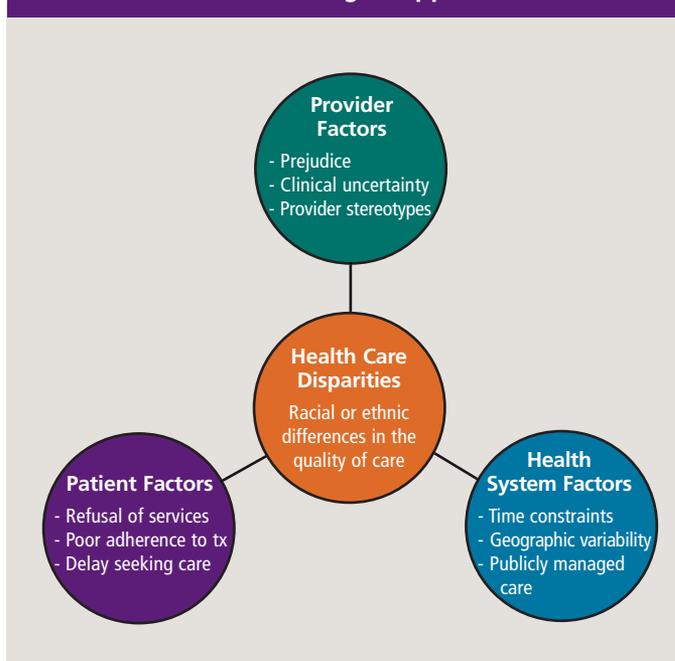
A disparity is something that is fundamentally different or something that is made up of incongruous elements (8). IOM defines health care disparities as "racial or ethnic differences in the quality of health care that are not due to access related factors, or clinical needs, preferences and appropriateness of intervention" (7). Healthy People 2010 attributes disparities in health status to elements such as biology, behavior, culture, and physical and social determinants due to the fact that humans and their environments are complex (9). The causes of disparities in health status are not limited to poverty, race, and ethnicity but are further linked to social determinants. The term social determinant has been defined as "a proposed or established causal factor in the social environment that affects health outcomes" (10).

The complexities of health care disparities can be taught effectively with an integrated approach among all health care professionals. It makes sense for medical education to utilize established models, tools, and evaluation measures to achieve the goal of acknowledging, understanding, and taking action to reduce health care disparities. IOM has outlined recommendations for educating health professionals about health care disparities. A curriculum that integrates the IOM recommendations into the ACGME core competency-based model is proposed for both medical students and residents.

Review of ACGME and IOM

IOM has taken a three-pronged approach by identifying a continuum of the broad sectors of patient-level factors, provider-level factors, and system-level factors that contribute to racial and ethnic health care disparities. (Figure 1) The

FIGURE 1: IOM Three-Pronged Approach



IOM report states that the goal of a cross cultural curriculum entails learning what is taught, using what is taught, and understanding the impact on patient care (7). In an early article about the ACGME core competencies, David Leach pointed out that knowing the rules is not sufficient, it is the application of the rules in diverse and complex clinical situations that demonstrate competency (11). The common paradigm of knowledge, skills, and attitudes (KSA) is the basis for both the IOM recommendations and the ACGME competencies. The IOM report discusses cross cultural education using the framework of KSA, while the ACGME core competencies utilize the three concepts as an evaluation tool. Each competency must be demonstrated by defining specific knowledge, attitudes, and skills. Incorporating the IOM recommendations for cross cultural education into the framework of the six core competencies provides an opportunity to fully integrate disparities education into the medical education curriculum. Mapping the ACGME core competencies with the three-pronged approach to disparities outlined by IOM has the potential to enlighten, educate, and train physicians about the breadth and depth of the impact of disparities in health care.

Integrated Model

There are inherent challenges in developing a fully integrated curriculum that includes teaching about health care disparities. IOM acknowledges the challenge of integrating

TABLE 1: Mapping of ACGME Core Competencies and IOM Recommendations

ACGME Competency	IOM Recommendation
Patient Care	
<ul style="list-style-type: none"> Compassionate Appropriate Effective for health problems and health promotion 	<ul style="list-style-type: none"> Humility, empathy, curiosity, respect, sensitivity, awareness of outside influence (attitudes central to professionalism) Differences (IOM) – patients’ preferences, needs, racial/ethnic differences in the clinical appropriateness of care may contribute to differences Expression of pain symptoms differs among cultural and racial groups
Medical Knowledge of Established and Evolving	
<ul style="list-style-type: none"> Biomedical sciences, clinical, epidemiological, and social-behavioral sciences Cultural and Spiritual practices that might interfere with prescribed therapies Application of this knowledge to patient care 	<ul style="list-style-type: none"> Community oriented primary care and community assessment of the surrounding community in which they train or practice (social and historic context of the population) Ethnopharmacology, disease incidence, prevalence, outcomes among distinct populations Not just unifying facts or cultural norms but also multiple influences such as acculturation and SES
Practice Based Learning and Improvement	
<ul style="list-style-type: none"> Investigate and evaluate their care of patients Appraise and assimilate scientific evidence Continuously improve patient care based on constant self-evaluation and life-long learning 	<ul style="list-style-type: none"> Continual provider awareness of impact of socio-cultural factors on patients’ health values, beliefs, behaviors and ultimately quality of care and outcomes (and minimizing reliance on generalizations)
Interpersonal and Communication Skills/Provider-Patient Communications	
<ul style="list-style-type: none"> Result in effective exchange of information and collaboration with patients, families and health professionals 	<ul style="list-style-type: none"> Communication- patient satisfaction- adherence- health outcomes Medical interviewing + ethnographic tools of medical anthropology Inductive approach focuses on the patient, rather than theory, as starting point for discovery Individual patient as teacher, providers adjust practice style accordingly to meet their patients’ specific needs Preferences: patients’ choices regarding health care that are based on a full and accurate understanding of treatment options
Professionalism	
<ul style="list-style-type: none"> Commitment to carrying out professional duties Adherence to ethical principles 	<ul style="list-style-type: none"> Humility, empathy, curiosity, respect, sensitivity, awareness of outside influence (attitudes central to professionalism)
Systems Based Practice	
<ul style="list-style-type: none"> Awareness of and responsiveness to larger context and system of health care Effectively call on other resources in system to provide optimal health care Knowledge of government programs for low income patients 	<ul style="list-style-type: none"> Disparities in care emerge from a range of sources such as characteristics of health care systems and the legal and regulatory context of health care delivery How SES, culture, race, ethnicity, possible mistrust shape an individual’s interaction with health care system System level variables: language barriers, availability and access to services Maneuvering through clinical bureaucracy Referral patterns and access to specialty care Fragmentation of health care systems

what is considered a “soft curricula” on health care disparities into medical education in which the students and residents are accustomed to fact-based, practical learning. The institute also recognizes that it takes an investment of time to explore these complex social and cultural issues.

Each of the ACGME core competencies can be expanded to include the IOM recommendations. A good example of this expansion is the ACGME competency of medical knowledge, which must include both established and evolving knowledge of biomedical, clinical, epidemiological, and social-behavioral sciences. In addressing the provider factors contributing to unequal treatment, IOM supports the use of a knowledge-based approach in cross cultural education. IOM decrees that a knowledge-based approach is acceptable when practitioners use the approach to learn about the immediate, surrounding community in which they train. This learning about and understanding social determinants in a community include common occupations and patterns of housing as well as immigration experiences and nutritional habits. The goal is to go beyond the surface learning of facts or cultural norms to understand multiple influences, such as acculturation and socioeconomic status. The use of the knowledge-based approach using the evidence of ethnopharmacology, disease incidence, prevalence, and outcomes in distinct populations is also effective (7). Methods to incorporate this level of disparities education into the curriculum include community assessment and also offer opportunities for community-based

participatory research. Expanding the medical knowledge competency with this knowledge-based approach to cross-cultural education also serves to highlight the academic-community partnership. **Table 2** provides a full mapping of the IOM recommendations with the ACGME core competencies

Case Study

Following the belief that “learning is doing,” the University of Medicine and Dentistry of New Jersey Robert Wood Johnson Medical School, Camden Campus uses community immersion combined with a companion curriculum to teach about health care disparities. The health disparities curriculum involves three components: a student-run clinic, “Continuity of Care” seminars, and journaling.

In the clinic, students learn about health care from a disadvantaged patient’s perspective, while maximizing health care for the patient. Students must coordinate a patient’s application for charity care, schedule specialty visits, procedures, and screenings; and accompany the patient to all appointments, including waiting for the appointment and helping to resolve issues related to insurance. In this immersion experience, students learn first-hand about the health care disparities experienced in a diverse cultural, racial, and ethnic urban community. This community immersion experience is enriched by a Continuity of Care seminar series that is delivered by community members, faculty, and the student body. Finally, students are required to journal their experiences weekly, allowing them to reflect on

TABLE 2: Teaching Methods and Opportunities

Methods	Opportunities
Focused Didactics	Orientation
Self Reflection/Journaling	Electives
Vignettes	Workshops
Problem Based Learning Cases	Rounds
Medical Encounter Videos (Review/Feedback)	Conferences
Individual Case-Based Discussion	Service Learning Project
Workshops	Retreats
Community Immersion/Expedition	Community-Based Participatory Research Projects
Faculty Role Models/Mentors	Student-Run Clinics
Role Playing	Dedicated/Stand-Alone Course (Highlights Importance of Disparities Education)
Student/Resident Produced Poster/Slide Presentation/Research Paper	Dedicated Research Time

Sources: IOM, SGIM, Cavanaugh

their experiences first hand, while providing a mechanism to monitor their work outside of the clinic.

A number of teaching methods and opportunities for health care disparities education have been suggested (Table 3). This integrated model addresses some of the challenges of incorporating education on health care disparities into the medical education curriculum. It makes use of a variety of methods and teaching opportunities; it can also be adapted for use with residents in ambulatory care experiences, provided the challenges of duty hours and competing responsibilities are addressed. 

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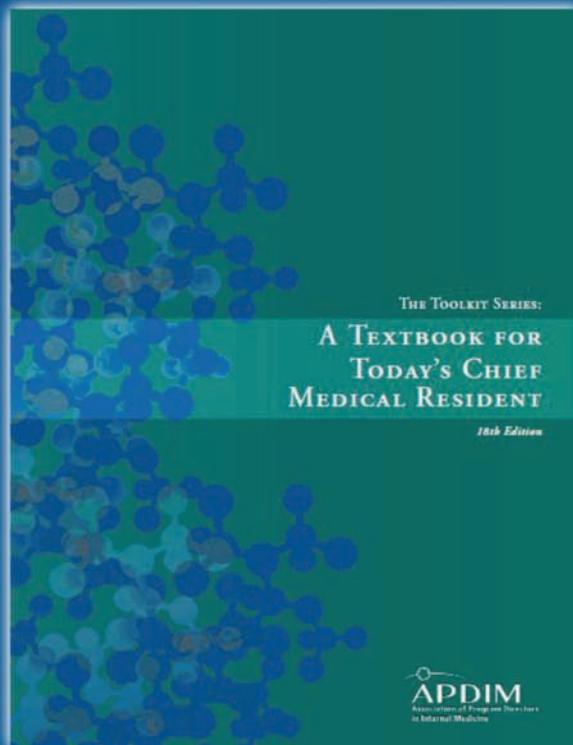
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Incorporating Milestones into Your Program: Capturing What You Already Do

The Accreditation Council for Graduate Medical Education (ACGME) Outcomes Project was designed to move graduate medical education from a process-based to an outcomes-based system in which programs and residents are expected to demonstrate competence in six separate core competencies (1). Despite extensive work and energy, program directors continue to struggle with integrating this competency-based framework into their training programs, in part because of the unclear and complex nature of the core competencies and the inherent difficulties in their assessment. To further facilitate this transition, ACGME engaged all disciplines to “articulate milestones of competency development” (2). In response, a multi-stakeholder internal medicine task force developed and published a comprehensive set of behaviorally based developmental milestones that were rooted in the ACGME core competencies (3). Initial feedback regarding the

attitudes, residents are expected to have before moving on to the next phase of their training. For example, program leadership had historically made decisions such as assigning our “strong” postgraduate year (PGY)-3 residents to be ward team supervisors early in the academic year. This decision was primarily based upon global assessments, personal experiences, and overall gestalt. Using the milestones as a template, we aimed to objectify this decision by defining milestones-based focused curricular objectives that PGY-2 residents must demonstrate before being assigned as a PGY-3 ward team supervisor. It was first necessary to identify the relevant milestones most important to residents working in this role. Using key core faculty, we asked ourselves: “What behaviors should a resident demonstrate before being entrusted to be a ward team supervisor?” Through an iterative process, we identified specific milestones from all six competencies that were used to develop the rotational objectives for our PGY-2

Feedback provided to residents based upon the milestones tends to be more formative, meaningful, and specific, especially for the interpersonal and communications skills, SBP, and PBLI competencies.

milestones from program directors and residents has generally been positive; however, little has been published regarding the early application of these milestones to residency training.

The internal medicine residency program at Henry Ford Hospital has begun incorporating the milestones into existing structures and routines to better capture our educational activities and evaluation decisions. Our ultimate goal is to develop a comprehensive, milestones-based curriculum and evaluation system that tracks resident progression towards competence throughout the course of training. To get started on this goal, we have begun integrating the milestones into our program in unique ways that help to capture what we already do.

Curricular and Evaluation Redesign

The first step at incorporating milestones into our program began through a redesign of the night float rotation curriculum to focus learning on the knowledge, skills, and

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night float curriculum. Whereas our prior curriculum tended to focus on generic skills expected of a resident in the PGY-2 year, the new curriculum focused on behaviors that residents must demonstrate before being entrusted with increased autonomy and responsibility as a ward team supervisor. As a result of this curricular change, both residents and faculty now have a clear understanding of the behaviors expected of a resident at this point in their training. It also has set the stage for the redesign of our evaluation system through an increased role of the clinical competency committee.

Competency Committee

As part of ongoing program improvement activities, we re-engineered our clinical competency committee to improve its efficiency, transparency, and impact. Specifically, we have incorporated sets of pre-defined milestones into the resident review process, a formal procedure where the committee periodically tracks individual residents' progress over time. When the committee performs its review of a resident, it will compare that resident's performance against the expected level of performance as defined by the selected milestones. For example, the committee will utilize the expectations of PGY-3 ward team supervisors during its periodic review of PGY-2 residents to monitor and track a resident's progress. Over time, this information will be used to provide recommendations to the program director for use in periodic summative assessments and high-stakes evaluations. In this process, we are explicitly linking curriculum (i.e. the night float curriculum described) with assessment and evaluation in a transparent fashion for faculty. Additionally, residents are provided a clear path of expected competence over the course of training. This process has also provided an opportunity for the clinical competency committee and program leadership to give valuable formative feedback to learners, especially residents who are struggling.

Improving Feedback

Feedback refers to information describing a learners' performance in a given activity that is intended to guide their future performance in the same or related activity (4). It is a key step in the acquisition of clinical skills and for learning. Providing feedback, however, can be difficult for faculty to adequately perform. Too often, feedback focuses on a learner's personal characteristics as opposed to observable behaviors. To help improve this process, particularly with residents who are struggling, we have begun referring to the milestones while providing formative feedback. Using the fact that the milestones were specifically written as behaviors, we have found that the feedback provided to residents based upon the milestones tends to be more formative, meaningful, and specific than before, especially for the interpersonal and communication skills, systems-based practice, and practice-

based learning and improvement competencies. We have also found that if we link multiple milestones together across several core competencies, the feedback becomes rooted in the context of the specific deficiency. In a similar fashion, other institutions have begun incorporating the milestones into resident self-assessment and semi-annual evaluations with positive results.

The internal medicine milestones can be incorporated into existing residency program structures and routines. In our program, we have been able to promote early faculty and resident understanding of and comfort with the concept of developmental milestones and competency-based education. Future work will focus on further integration of the milestones into our current activities. 

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10 Tunes

Ten Tunes That Make You Think...
Office Move

If you would like to suggest a theme or a list for 10 Tunes, please email *Insight* Editor Sheila T. Costa at scosta@im.org.

Meet Virginia: Train

A Change Would Do You Good: Sheryl Crow

Keep On Moving: Soul II Soul

Movin' On Up: Janet Du'Bois (theme song from "The Jeffersons")

Make Me Better: Fabulous

Dare You to Move: Switchfoot

Bust a Move: Young MC

Space Between: Dave Matthews Band

I Like to Move It: Reel 2 Reel

Upgrade U: Beyonce

Developing Standardized and Acceptable Oral Exams

Ask any clinical clerkship director what the most challenging aspect of the position is and evaluation of medical students is likely to lead the list.

In the medicine clerkship at University of Chicago, we evaluated students in a traditional way. Students' grades came from a weighted average of clinical assessments, for which we use the reporter-interpreter-manager-educator (RIME) framework, evaluations from preceptors, who meet with small groups of students for four hours each week, and a score on the US Medical Licensure Examination subject exam. Although the grading system was generally considered fair and reliably differentiated the strongest from the weakest students, both course directors and students were not satisfied with how it worked.

From the perspective of the course directors, the primary concern was the ability to accurately assess student clinical reasoning skills. Although acquisition of clinical reasoning skills is one of the primary objectives of the clerkship, the grading system was not terribly good at assessing this skill. Clinical assessments were often influenced more by a student's "polish," effort, and the attentiveness of her resident than her clinical skill. The subject exam, although certainly geared more toward reasoning skill than in the past, still seemed to weight knowledge over process. Preceptor groups, which should have been a perfect setting in which to evaluate reasoning skill, were hampered by variable attention to this task by the 25 preceptors who participate each year. Because clinical reasoning was not adequately assessed, students did not put a priority on the acquisition of this skill.

From the perspective of the students, the grading system was too subjective. On the one hand, this criticism was accurate. Despite using the RIME system, faculty evaluation continued to be influenced by individual faculty expectations and student personality. On the other hand, this criticism arose from the novelty of a clinical grading system for students. Most of our students come directly from undergraduate education and are far more comfortable with grading that comes from test scores and essays than from a multifaceted assessment of their ability to function as a member of a clinical team.

Recognizing these issues, we considered possible remedies and decided that an oral examination had potential. The concerns about instituting an oral exam were that it would be subjective (a problem that were trying to remedy), poorly standardized, and anxiety provoking for students. We therefore identified four primary goals for the exam.

1. Have a positive influence on students' studying, focusing their efforts on mastering clinical reasoning skills (a stated goal of the medicine clerkship).
2. Be standardized, reproducible, and objective in its evaluation of student performance.
3. Be acceptable to students.

TABLE 1: Oral Exam Topics

Abdominal Pain
Acid Base Disorders
Acute Renal Failure
Anemia
Back Pain
Chest Pain
Cough, Fever, and Respiratory Complaints
Delirium & Dementia
Diarrhea
Dizziness
Dyspnea
Edema
Fatigue
GI Bleeding
Headache
Hypo/Hyponatremia
Jaundice
Joint Pain
Syncope
Wheezing and Stridor

4. Provide information about the strengths and weaknesses of students' clinical reasoning skills that could be used for future curricular development.

Fulfilling the first goal seemed the easiest to achieve. Although mastering clinical reasoning skills had been formally endorsed by the clerkship directors for years and was well represented in the curriculum, its importance was marginalized as it was underrepresented in our evaluation scheme. We expected that designing an oral exam that specifically evaluates clinical reasoning would influence students to focus on the material available to learn this skill. To counter the tendency for oral exams to be non-standard and subjective, we wrote 20 structured cases and established a protocol for delivery; two examiners are in the room, one delivering the test from a written script and one evaluating the student. The case topics are shown in **Table 1**. All cases were scored on a 16-point scale with specific values being given to clinical evaluation, differential diagnosis, data evaluation, and management (**Table 2**). We also limited the number of evaluators to four, allowing us the ability to analyze scoring behaviors. To limit the possibility that students underperform because they are asked about a single topic for which they are unprepared, we designed a strategy where students are

TABLE 2: Case Scoring

Category	Sub-Category	Answers	Points
Data Gathering			_____ out of 2
Differential Diagnosis	Functionally identify pivotal points		
	Included correct diagnosis		
	Included appropriate can't miss diagnosis		_____ out of 6
Evaluation	Appropriate test for ruling in disease		
	Made correct diagnosis		_____ out of 4
Management	Basics of management of specific patient		_____ out of 2
Overall Performance			_____ out of 2
Totals			_____ out of 16

Our effort thus far has been quite successful. When we compared the reading material the students ranked most useful during the clerkship before and after institution of the exam, we saw a shift in students' choice of reading material from board exam practice type texts to texts that focused more on clinical reasoning. Analysis of exam performance demonstrated that the exam is both standardized and accurate. The mean difference in scoring between the two examiners was only 0.55 (+/- 0.72) on the 16-point scale. The exam was predictive of both clinical performance and exam performance. The sensitivity and specificity of the exam in predicting a failing score on the final subject exam was 66% and 88%, respectively. The test characteristics for predicting performance in the lower quartile of clinical performance were: sensitivity 75%, specificity 90%. Students generally like the exam. When asked whether the oral exams tested material covered in the clerkship, the students rated the written and oral exams as 3.7 and 4.8 respectively on a five-point Likert Scale (p=0.0001). When asked if the exam was fairly administered and scored, students rated the exam at a 4.5 ± 1.10.

From the point of view of a clerkship director, the oral exam has been a positive addition to the clerkship. In addition to the factors discussed, the oral exam provides an opportunity for course directors to interact with every student in concentrated evaluation of their medical knowledge and clinical reasoning skill. The requirement of faculty time is moderate given a class size of about 100 students but might be excessive for clerkship directors at schools with much larger classes. 🔄

AUTHOR

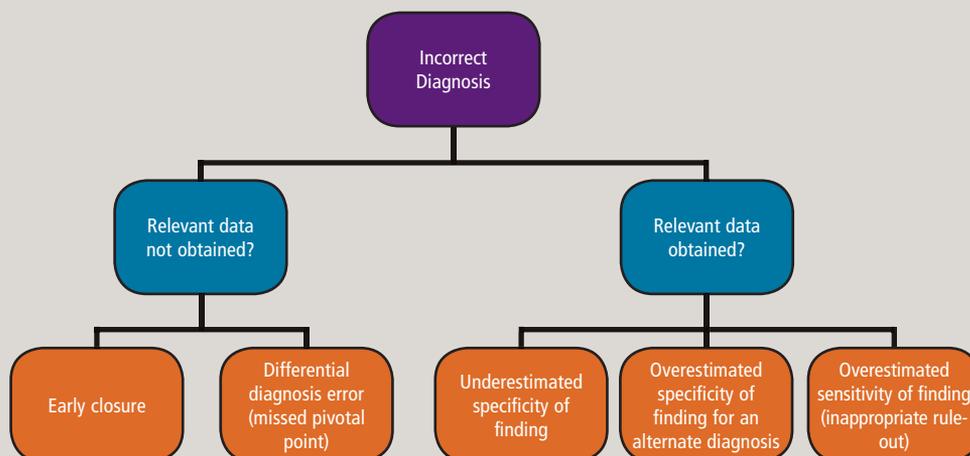
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randomly presented with three of 20 pre-assigned topics from which they choose one. There is the option to be given a second case if more information is needed.

We thought that this structure, combined with the use of experienced educators as the examiners, would make the exam acceptable to the students as it would seem fair and hold the potential to be an educational experience. We developed a tool to assess the clinical reasoning errors that students made during the exam that could be used to refine our curriculum (Figure 1).

FIGURE 1: Clinical Reasoning Error Assessment



The Hidden Patient: A Novel Way to Evaluate Resident Competency in Professionalism and Interpersonal and Communication Skills

To measure internal medicine resident competence in the Accreditation Committee for Graduate Medical Education (ACGME) core competencies, many tools have been developed, including the use of standardized patients. Our initial experience using standardized patients was directed towards evaluation of interns' clinical skills (all six competencies) as a way of developing individualized learning plans based on unique strengths and weaknesses. Based on our experience, we believed interpersonal and communication skills (ICS) and professionalism could best be evaluated using a single, standardized patient encounter. As a way to augment commonly used methods to evaluate ICS and professionalism, a three-year pilot program using a "hidden patient" experience was added to our residency program. This assessment would

The hidden patient encounter may provide an additional assessment tool of a resident's ability to interact effectively with patients.

provide a snapshot of a resident's skills during the second year of training, allowing for any deficiencies to be identified and addressed prior to graduation. Our institution's institutional review board approved this pilot study. Unannounced (standardized) patient encounters have been used to evaluate physician ICS and professionalism in the United States as well as in Europe (1-4).

Initiative

In this three-year pilot program at University of Iowa, 12 postgraduate year (PGY)-2 internal medicine residents were randomly selected each year for an unannounced hidden patient encounter to occur during their outpatient continuity of care clinic. The hidden patients were actors trained using validated case scenarios for common outpatient complaints. Following the encounter, the hidden patients used a 29-item, standardized checklist to evaluate history-taking, physical examination skills, communication, and professionalism. To fully blind the evaluation and prevent bias, neither the resident nor the responsible faculty members were informed of the hidden patient encounter. Following the encounter, the electronic medical record entry created for the hidden patient

actor was deleted. The hidden patient checklist was compared with patient satisfaction surveys, faculty global evaluations, and mini-clinical evaluation exercise (CEX) scores for professionalism and ICS for each of the participating residents.

Results

The 34 residents included in the analysis were visited by a hidden patient and had patient satisfaction surveys, faculty evaluations, and mini-CEX evaluations completed by faculty members. Two other residents had been selected for hidden patient encounters but due to scheduling difficulties, these visits did not occur and the residents were excluded from the analysis. Each of the 34 participating residents had a single hidden patient encounter, an average of 10.3 (mean) patient satisfaction surveys, 3.1 (mean) mini-CEX evaluations, and 13.2 (mean) faculty evaluations. Two of the 34 hidden patient encounters were discovered by the residents or faculty supervisors.

Reliability of the evaluation methods was assessed using generalizability theory (G coefficients). The patient satisfaction surveys had a G coefficient of 0.61 for ICS and 0.54 for professionalism; G coefficients for faculty evaluations were 0.75 and 0.44, respectively. Statistically significant correlations were found for ICS between faculty evaluations and patient satisfaction. The Pearson's correlation coefficient was 0.39 ($p=0.02$) for faculty evaluation of ICS and patient evaluation of ICS. The correlation coefficient was 0.31 ($p=0.075$) for faculty evaluation of professionalism and patient evaluation of professionalism. The estimated reliability from the literature of a single hidden patient encounter is low and estimated to be approximately $G=0.20$ for one case (1). This low reliability predicted that the correlation coefficient of hidden patient scores with other measures (faculty evaluations, patient satisfaction and mini-CEX scores) would also be low. The mini-CEX evaluations had a G coefficient of 0.45. However, they were not significantly correlated with any of the other evaluation methods, which may have been due to the attenuating influence of the low hidden patient reliability.

Discussion

In medical education, evaluations of ICS and professionalism are routinely done by faculty supervisors but have been criticized because they may reflect the "best" performance of the learner (i.e. the learner knows they are being evaluated). Hidden or unannounced patients have the theoretical advantage of evaluating a learner's "usual" performance. Ozuah found that residents received lower professionalism scores for unannounced standardized patient

visits than for announced standardized patient visits (2). The hidden patient encounter also has the advantage of fitting into the “does” level on Miller’s Pyramid (5).

Our pilot study showed that patient satisfaction surveys and faculty global evaluations, when averaged over a number of observations, yield acceptably reliable evaluations of resident professionalism and ICS. However, it appears that a single hidden patient encounter does not provide enough information to make a reliable evaluation of these skills if used alone. Gorter found similar results, showing that six to eight unannounced cases were needed to obtain a generalizability coefficient of 0.8 (1).

The hidden patient encounter may provide an additional assessment tool (when used in combination with faculty and patient evaluations) of a resident’s ability to interact effectively with patients. Such an adjunct to assessment could offer an unbiased evaluation provided by the hidden patient during a time without faculty supervisors to observe performance directly, which allows for a more usual interaction between resident and patient rather than a “best” interaction as occurs with most faculty member observed evaluations. Using a weighted approach with several evaluation components has been described previously (6).

The question arises whether the use of a hidden patient will be a cost effective means of providing further evaluation of a resident’s professionalism and ICS competency. The cost of this program needs to be assessed and compared with the cost of faculty time. It is suspected that the initial cost associated with training of the hidden patient actors and development of the standardized cases may be high. However, as the program progresses, costs should diminish. This program may also be more beneficial if the faculty supervisor is not blinded to the hidden patient encounter allowing them to observe resident clinical skills.

Conclusions

Faculty and patient evaluations of resident ICS and professionalism are acceptably reliable. A single hidden patient encounter, however, does not provide a sufficiently reliable score for assessing a resident’s professionalism and ICS. It is possible, however, that it could effectively augment current evaluation methods. It provides a means of an unbiased evaluation in an environment similar to solitary clinical practice without immediate direct faculty monitoring. A cost-benefit analysis of the program needs to be assessed, although it is likely that following the initial development costs, the program may be sustainable with minimal support. ☺

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The AAIM Office Has Moved!

The AAIM office moved to Alexandria, VA, in November. Please be sure to change the address, fax number, and phone number for AAIM, APM, APDIM, CDIM, ASP, and AIM in your records. Please note that email addresses, website addresses, and check payment addresses have not changed.

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Meeting the Milestones: Restructuring Resident Assessment and Evaluation

Assessment and evaluation of resident performance has been a challenge in graduate medical education for many years. During phase two of the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project, programs restructured their curricula and evaluations based on the six ACGME competencies. To help program directors operationalize outcomes and assist in evaluating residents, ACGME and the American Board of Internal Medicine (ABIM) have recommended that programs revise their curricula and evaluations to incorporate the concept of milestones. The draft document released last year by an ACGME/ABIM task force is a comprehensive list of milestones that can be used to track the progress of residents in the six competencies (1). The internal medicine residency program sought to restructure assessment and evaluation of residents by developing a milestones-based system. We presented our process, milestones document, and

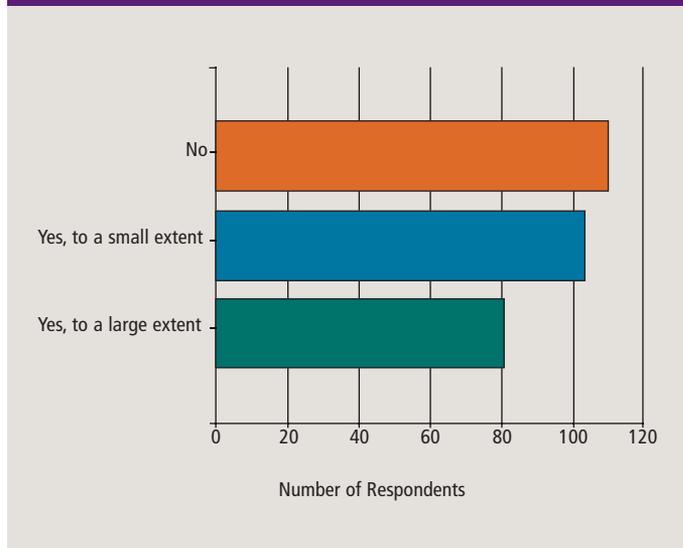
The global evaluations and self evaluations essentially mirrored the milestones, while the peer and nursing/ ancillary staff evaluations reflected specific milestones that the evaluator was asked to assess.

global inpatient evaluations in a workshop at the 2010 APDIM Spring Meeting (2).

In January and February 2010, we conducted a survey of the program directors to determine if and how programs were using the milestones (personal communication). The vast majority of respondents had not yet incorporated milestones into their evaluation process or had done so to a small extent (Figure 1). However, a large percentage of respondents reported dissatisfaction with their current methods of assessment and evaluation (Figure 2). Reasons include their subjectivity and unreliability. In particular, program directors reported a tendency of faculty to inflate residents' ratings on the global evaluations, resulting in a "Lake Woebegone" phenomenon. Our program had similar difficulties with its evaluation process.

A plan-do-study-act (PDSA) scheme was initiated in the middle of the 2008-2009 to improve the evaluation system, prior to the publication of the draft milestones (1).

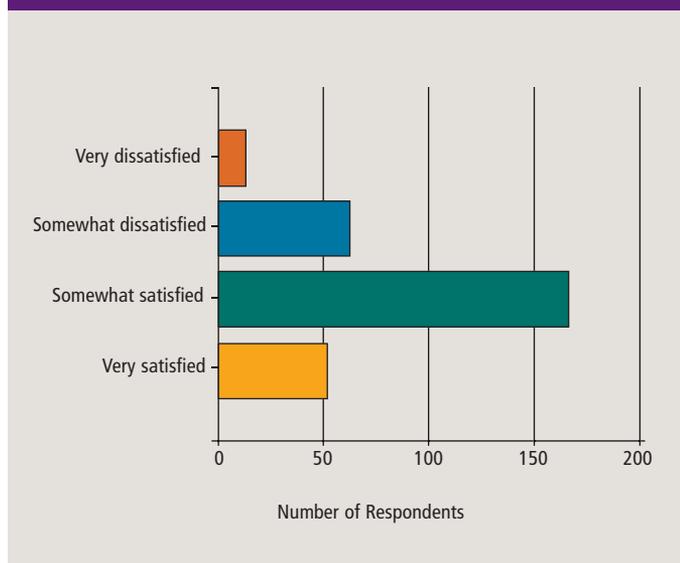
FIGURE 1: Have You Incorporated the ABIM Milestones into Your Evaluation System?



The first step was to reexamine the goals and objectives for each rotation as well as for the overall program. We also reviewed the promotion criteria that we had established for advancement at each level of training to provide the framework for the milestones document. Any objectives that were vague, too subjective, or difficult to demonstrate were translated into "milestones language," i.e., specific behaviors that could be observed or measured. The minimum set of behaviors or skills that residents were required to demonstrate at each level of training became the milestones. The milestones were organized by competency for each postgraduate year; however, the milestones and attached timelines were constructed to reflect increasing skill level and responsibility over a three-year continuum that would lead to competence in the Dreyfus model of skill acquisition (3). The Dreyfus model describes the learner's progression from novice to expert. To achieve competence in a particular skill, the learner has to demonstrate the ability to sort through and prioritize relevant information, discard the over-reliance on rules characteristic of earlier stages, and assume personal responsibility for decision-making and outcomes. The resulting milestones document was distributed to key clinical faculty for their discussion and input, then distributed to the residents.

The next steps were to design new evaluation forms based on these milestones and to select the assessment tools

FIGURE 2: How Satisfied Are You with Your Current Evaluation System?



that would be used. In this case, the global evaluations and self evaluations essentially mirrored the milestones, while the peer and nursing/ancillary staff evaluations reflected specific milestones that the evaluator was asked to assess. The new assessment and evaluation process was implemented at the start of the 2009-2010 academic year, so outcomes data are unavailable at this time. However, the response from residents and faculty has been favorable. The new evaluations have provided useful information for formative feedback as well as individualized, self-directed learning and improvement.

There are several additional advantages of this new process. First, it will solidify the requirement that residents demonstrate competence in specific skills before they can be promoted to the next level; prior to this change, these decisions were perceived to be subjective and arbitrary. Second, they enable faculty to provide focused feedback to residents about specific skills in which they need to improve. Third, they clearly articulate and standardize the faculty's expectations at each level of training and guide residents to the ultimate goal of residency training: the ability to practice medicine independent of direct supervision. On a larger scale, they may help assure the public about residency programs' rigorous standards for graduating "competent" residents.

During our workshop, many program directors expressed significant concerns about incorporating the milestones into their training framework. The overriding concern was the lack of time and resources available for intensive faculty

development, which is a key component of restructuring of the evaluation process. This point is particularly important in the current economic climate, in which budget cuts to graduate medical education have resulted in pressure to increase clinical productivity at the expense of administrative and teaching time. Other program directors voiced that while the milestones system effectively identifies under-achieving residents, it does not address the over-achievers. Another concern was that the milestones may reduce residency training to a checklist of skills that does not reflect the complex and multifaceted nature of being a physician. One answer to these concerns may be the development of entrustable professional activities (EPAs), which describe more fully the activities a competent physician must be able to perform (4). Residents would have to demonstrate competence in a predetermined cluster of applicable milestones to perform an EPA. For example, to be deemed competent to take care of a critically ill patient on a ventilator, the resident must have demonstrated competence in the requisite milestones, such as appropriate management of ventilated patients under direct supervision, understanding of respiratory physiology and modes of ventilation, and the ability to discuss difficult topics with family and counsel them through complex decision making.

Overall, the milestones framework is a jump in the right direction. We anticipate that in the future, programs will be held accountable for residents' performance in the milestones not only by ACGME, but by consumers of health care and the public at large. 

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ASP Honors Walter G. Barr, MD, with Eric G. Neilson, MD, Distinguished Professor

The Association of Specialty Professors (ASP) awarded the late Walter G. Barr, MD, the 2010 ASP Eric G. Neilson, MD, Distinguished Professor Award during the 2010 Annual Scientific Meeting of the American College of Rheumatology (ACR), held November 7-11, 2010, in Atlanta, GA. Before his passing, Dr. Barr was rheumatology fellowship program director at Northwestern University Feinberg School of Medicine.

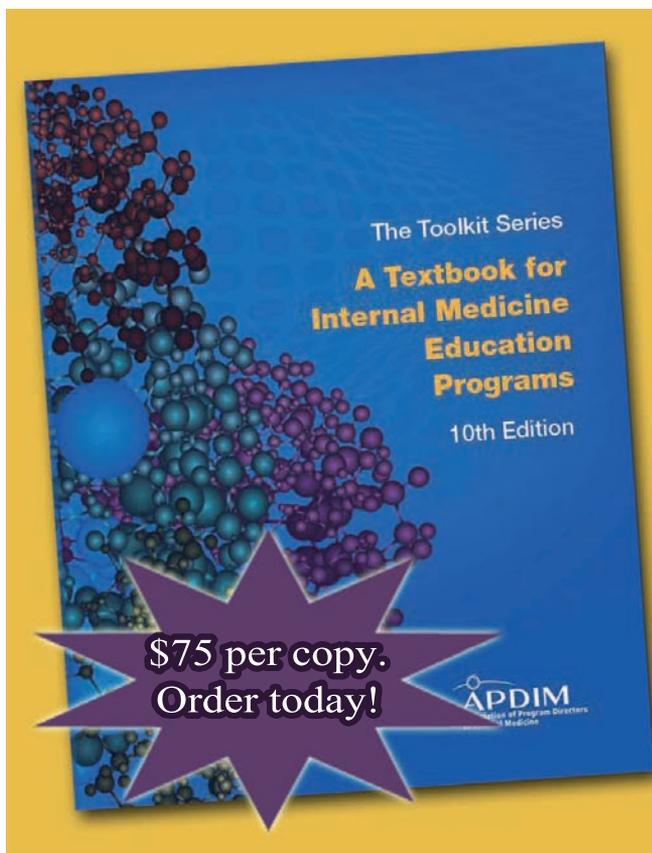
Named for the association's founder, the Neilson Award is presented annually to a leader who has shaped the specialty internal medicine landscape. The award acknowledges and promotes the work of outstanding leaders who bring about change for specialty medicine and the internal medicine community.

David I. Daikh, MD, PhD, presented this year's award, recognizing Dr. Barr for his significant impact on ASP and his lasting contributions to both rheumatology and specialty internal medicine. According to Dr. Barr's nominators, "... through words and deeds, he has provided the highest ethical and professional role model for all of us to emulate."

Dr. Barr served in various leadership roles in ASP, including President in 2008 and Treasurer in 2006. He was also chair of the ASP Task Force on Teaching and Applying Quality Principles, chair of the ASP Member Services Committee, and a member of the Alliance for Academic Internal Medicine Education Redesign Working Group.

Dr. Barr's nominators highlighted his work at ACR and his efforts to develop the first internal medicine subspecialty in-service training examination with the National Board of Medical Examiners as examples of his contribution to subspecialty internal medicine. Dr. Barr's nominators noted that "his leadership and selfless, unending devotion to his work in support of education and training in internal medicine and rheumatology are underscored by the remarkable successes and contributions he has made in these areas."

Before becoming Fellowship Program Director and Clinical Practice Director for the Division of Rheumatology at Northwestern University Feinberg School of Medicine, Dr. Barr was Director of Continuing Medical Education at Loyola



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University of Chicago Stritch School of Medicine, where he also earned his MD, completed his residency, and completed his fellowship in clinical immunology. Dr. Barr also completed a fellowship in rheumatology at Mayo Clinic College of Medicine.

For more information about the ASP Eric G. Neilson, MD, Distinguished Professor Award or previous recipients of this award, please visit the ASP website at www.im.org. 

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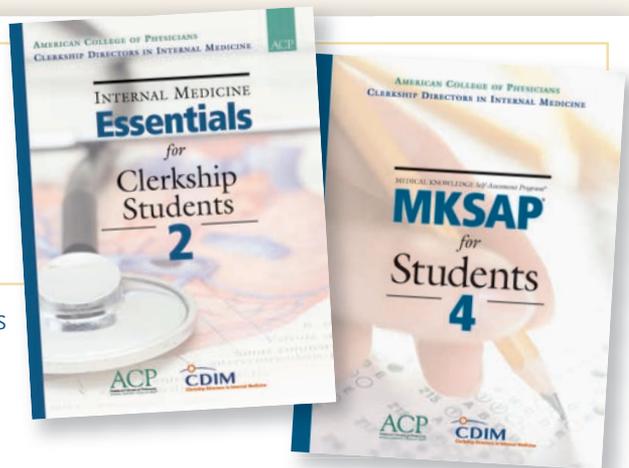
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