August 31st, 2018

Dr. Jeffrey Wiese and Dr. Asher Tulsky
Chair and Chair-Elect
American Board of Internal Medicine
510 Walnut Street, Suite 1700
Philadelphia, PA 19106-3699

Dear Drs. Wiese and Tulsky,

Thank you for allowing us the opportunity to respond to your questions regarding current American Board of Internal Medicine (ABIM) procedure requirements. As stakeholders, we feel this is an important and helpful dialogue. The Society of General Internal Medicine (SGIM) leadership asked our Education Committee to spearhead our discussion. Please find our responses below.

(1) Should competency in procedures be required of all residency graduates for initial certification in Internal Medicine regardless of their career plans?

While we do believe that residents should have specific knowledge regarding core procedures (see next section for details), the ABIM should not require competency to safely perform these procedures. As practice patterns have changed, an increasing number of procedures once considered core for Internists are being performed by ancillary or specialty services resulting in improvements in patient safety (excepting ACLS). For example, in many hospitals, peripherally inserted central catheters can quickly be placed by advanced practice provider teams on the medical floors and intra-osseous catheters are available in emergent situations obviating the need for the higher-risk, central venous lines.

Today, most procedures are largely specialty-driven leading to lower competency rates of faculty members (this is compounded by the fact that and ABIM does not require procedure competency for physician recertification). As a result, the same system that does not actually expect credentialed faculty to maintain competency in procedures, requires resident trainees perform and gain competence in them. Residents then not only perform procedures they will not perform later in their careers, but also often burdened with doing the majority of teaching and supervision of other residents. This further complicates measuring “competency” which is not achieved with any given minimum number. Finally, the issue of competency with procedures may really best be addressed by the Accreditation Council for Graduate Medical Education (ACGME) which governs specific programmatic requirements for residency training.

If so, which procedures should be included? If not, please share your reasoning.

As noted above, while we do not believe competency to safely perform procedures should be an ABIM requirement, graduating residents should be required to have a working knowledge of

the indications for, techniques involved, and risks and benefits, interpretation, and/or potential complications of the following procedures:

- Abdominal Paracentesis
- Arthrocentesis
- Central Venous Line Placement
- Drawing Arterial Blood
- Drawing Venous Blood
- EKG
- Incision/Drainage of Abscess
- Lumbar Puncture
- Nasogastric Intubation
- Pap Smear / Endocervical Culture
- Placing Peripheral IV
- Thoracentesis

While the following procedures may be helpful in management or therapy of a patient, they are non-emergent specialty-based procedures:

- Arterial Line Placement
- Pulmonary Artery Catheter Placement

Lastly, we do not believe that ABIM need comment on ACLS as it is required of all resident trainees by hospital systems.

(2) The current procedure requirements include those that the graduate must "perform competently" and some that they must "Know, Understand, and Explain." See the above link for an explanation of each category. Is that a useful framing? Should this categorization be retained, modified, or eliminated? Please share the reasons for your recommendation.

"Know, understand, and explain" is not measureable and is, therefore, confusing so should be modified. It would be far clearer to be specific about what, for each procedure, competence should be achieved in as noted in part 2 of the question above. For example, it is more clear to require residents have the ability to list the indications for, techniques involved, and risks and benefits, and/or potential complications of a central venous catheter, or to interpret an EKG.

(3) In order to successfully transition to fellowship training in your discipline, are there any procedures that should be added to, or eliminated from, the procedural requirements?

N/A

(4) Please feel free to share your thoughts about how the procedural requirements for Internal Medicine certification are communicated on ABIM's website (https://www.abim.org/certification/policies/internal-medicine-subspecialty-

policies/internal-medicine.aspx), especially if there are specific things you find confusing or complex.

As the ABIM website states, it does not specify a minimum number of procedures to demonstrate competency (since the number would vary by trainee) so it seems arbitrary to then suggest each resident "be an active participant for each procedure five times or more" as this similarly does necessarily not "assure adequate knowledge and understanding." If ABIM modifies the "Know, understand, and explain" language as recommended above, programs could determine the method by which they test "adequate knowledge and understanding of the common procedures."

Once again, thank you for your requesting our suggestions and feedback. Please contact us if you require any further clarification or have additional questions.

Regards,

Danielle Jones, MD, FACP and Becky Mazurkiewicz, MD, MPH
SGIM Education Committee

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