

EDITORIAL

New ACGME Duty Hours: Is it Time to Change the Internal Medicine Residency Interview Process?

Douglas P. Olson, MD

Dr. Olson is a member of the Forum Editorial Board and can be reached at OlsonD@chc1.com.

As my internal medicine residency program redesigned the floor and admitting structure to comply with the new Accreditation Council for Graduate Medical Education (ACGME) guidelines last year, the main thing that kept coming up as a “barrier” was time: This one thing was a central theme of every proposal. Even in the 30-hour system, there never seemed to be enough time. For much of the year, interns had trouble connecting with seven new admissions, writing thoughtful and comprehensive admit notes, looking up clinical questions, participating fully in ward and bedside rounds, attending multidisciplinary rounds, participating in attending rounds, and actually discharging some patients by 11 am the next day in order to prevent a backlog in the ER for new admissions.

When I used to admit patients as an intern, I would hate getting paged out of the initial history and physical. Still, I knew that if I wanted (or needed) to spend 10 or 15 extra minutes with a patient, I could have it. I would admit six or seven patients, cross cover an extra 20 or 30, and be able to catch up on everything “sometime after 1 am” when the admitting cycle ended. Now, things for interns are different. Admission numbers may have decreased slightly, but other responsibilities have not changed—we’ve only thrown in an extra hand-off or two and required that everything be done in less than 16 hours. There’s no “catch-up” time. This may not be the best model for maximizing safe and error-free care, especially given the lack of guidance from the ACGME on “best handoff practices.” This is not a hallmark of patient-centered care, either.

I’m not complaining—this is the state of medicine, and it is not going to become easier. Efficiency and

brevity are quickly becoming (or maybe already are) a foundation of good clinical practice. Like communication skills, these things are often secondarily appreciated or taught in residency. Many times, they are picked up by working with a good resident or faculty member. But it’s tough to “teach” these intangible qualities. They just don’t fit on 50 PowerPoint slides over lunch the way learning about endocarditis or a pulmonary embolus does.

So, here’s the dilemma: Health care is changing and demanding that physicians become better more efficient communicators and also deliver the same (or better) quality health care in less time—while still providing patient-centered health-care for sick patients and their families. How are trainees going to learn this? Can it even be taught?

Here’s a proposal that might help. Maybe we should select residents who already have some of these skills and work on improving them during residency. We already know it works for establishing relationships (i.e. speed-dating). It has even been instituted for medical school interviews. So why not residency?

The “speed interview,” more formally called the MMI or the “Multiple Mini Interview,” is already used by at least 21 medical schools in the United States and Canada, according to an article published on July 11, 2011, in the *New York Times*. Its essence is this: rather than a typical 20- to 30-minute one-on-one or group interview, candidates are given a “situation” common to the field to show how they would act in a specific ethical dilemma, or work with a new nurse, or react when an outpatient shows up 20 minutes late for a 30-minute appointment, or cooperate with a resident who they do not get along well with. These are skills that

do not rely on medical knowledge (which is reflected in United States Medical Licensing Examination (USMLE) step 1 and 2 scores) but that rely on good communication.

Because interviewers rarely change their score of an interviewee after the *first five minutes of an interview*, situational interviews remove bias better and reveal character strengths and flaws. The results: six or seven 8-minute interviews instead of two 30-minute interviews. The risk: that faculty members themselves might have trouble adapting to this change in the interview process. But for academics married to evidence-based medicine, it is more evidence based than what most people do now.

It can be difficult to teach communication skills to *anyone*, and as we all know, many successful managers and leaders are often successful not because they are the smartest or work the most but because they communicate well. This is true for both medical and non-medical professions.

Is it impossible to teach communication to residents? No, but at some point, it may well be time to “swim upstream” to solve problems or improve them. The MMI interview method can help select the residents who already think and reason quickly, communicate well, connect with people in five to eight minutes, and do it “convincingly” with more than two interviewers. Couple that with USMLE scores and a personal statement and you have top candidates!

Will the interview process change across the country? Not likely. But the MMI is at least evidence based, thought provoking, and responsive to the changing culture of medicine.