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COMMITTEE UPDATE

SGIM EDUCATION COMMITTEE RESPONSE TO ACGME IM2035

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On behalf of the SGIM Education Committee.

The ACGME asked SGIM to provide our organization's perspective of the Review Committee for Internal Medicine's (RC-IM) revision and redesign for the Program Requirements. In the ACGME's process, they participated in an Alternative-Futures Scenario Planning exercise to help the committee proactively and creatively anticipate future practices of the specialty, the internist, and the patients. SGIM's Education Committee drafted the response to the ACGME about their three proposed paradigm shifts of the future, IM2035. Please see our following response:

Dear Drs. Desai, Cable, Lieh-Lai, and Vasilias:

Thank you for the opportunity to comment on the ACGME's three proposed paradigm shifts produced by the Review Committee for Internal Medicine through Alternative Futures Scenario Planning.

The preamble describing the internist of the future who is a patient-centered master diagnostician committed to providing cost-conscious, interdisciplinary team-based care resonates with us. We are excited to see that the internist will be the team leaders of interprofessional members who are practicing at the top of their licenses. Internists will also possess skills such as data management science, excellent communication skills, high integrity and ethical standards, and high levels of emotional intelligence used to promote wellness in their patients, their teams, and their communities. This is an aspirational person to be. In thinking about the future internist, we propose that she should also be adept at health systems science and be change agents when necessary. Furthermore, as internists master data management science, we would like internists to continue practicing evidence-based medicine to ensure our patients are constantly receiving data driven care. In the proposed vision of the internist, she is clearly the team leader. However, in a future where all interdisciplinary team members are high performing, there may be times when it is more appropriate for another team member to take the lead. Therefore, internists must collaboratively engage with team members for the best interests of our patients.

This aspirational vision has influenced the following three paradigms that will be assessed for strengths, weaknesses, opportunities, limitations, and unintended consequences:

Paradigm Shift #1: Competency-based Medical Education: This paradigm allows residents to individualize their careers early in training. For example, if a resident chooses to pursue Primary Care, she can prioritize rotations more relevant to her career and allocate more time to the ambulatory setting. This will allow for efficient education for each resident, streamlined pathways to underrepresented fields of medicine, and accelerated tracks to geographically underrepresented areas in medicine. Furthermore, it can allow trainees to move at their own pace through training, either through earlier specialization or a longer time needed to train. An unintended consequence might be loss of generalism as trainees forego broad exposure to a more focused approach. As residents go through training, they often change initial career plans based on clinical exposures

continued on page 2

COMMITTEE UPDATE *(continued from page 1)*

they receive during residency. Would that flexibility still exist if there is early differentiation? We would also need reliable evaluation methods to assess if residents are ready for the next step. This paradigm can lead to many opportunities like the creation of hybrid programs, for example: IM-palliative care, IM-geriatrics, IM-addiction medicine, and others. It could allow integrating advanced degrees like MBA or MPH into training to better teach skills in leadership, population health, data management science, and quality improvement. Furthermore, competency-based medical education can lead to incentivizing fields that need further representation, benefiting primary care and ambulatory-based fields. However, individualized scheduling for an entire residency program will be extraordinarily challenging. For heavily selected specialty fields, rotations might have too many learners. For less popular rotations, faculty may not have access to learners for evaluations needed for promotions. Academic institutions might reduce teaching faculty or push them towards clinical duties. Since training would be so individualized, the standard Internal Medicine residency program would cease to exist, making accreditation difficult.

Paradigm Shift #2: From AIRE to There: In this paradigm, collaboration across programs would reduce workload on individual programs and individual program directors in developing ideas from professional societies or accrediting bodies. This model would allow for centralization of data and provide outcomes data for novel curricular innovations over multiple institutions. Through AIRE to There, residents could potentially enter the workforce earlier through shortened pathways with earlier access to increased pay. For example, an IM-geriatrics combined program could graduate geriatricians in a shorter timeframe than traditional IM residency followed by geriatrics fellowship. One of the limitations of program is that students would not know the rigor of a program until completion. Furthermore, if residents in a program are enrolled in a national study, who would be responsible for evaluating that resident and assessing advancement? Who would decide when the resident had achieved competency and then feed that information back to an accrediting body? Comparable to the prior paradigm, residents might lose the flexibility of changing their careers either during residency or afterwards.. Again, if residents are participating in experimental experiences for training, this could push the borders of what we currently conceptualize as the standard of training. Residency curricular changes would be driven by larger scale data that is multi-institutional. However, if a certain training is studied and found to be flawed, would the participants who completed that pathway have to repeat training? Would their training become invalid? Also, novel programs could be difficult to imbed into existing residency programs. An unintended consequence could be if some residents enroll in certain experimental programs, this might affect their peers' schedules and the rotational staffing of the hospital. It is unclear who would be creating the curricula, who would be responsible for enrolling, monitoring, and studying the impact of these programs. We are concerned that many programs would not be able to support these ideas. If criteria to enroll exist and a program decides to opt out, would that program be less attractive to students and be another comparator between residency programs?

Paradigm Shift #3: from NAS to LAS: In this paradigm, an ongoing iterative approach promotes the use of continuous data to initiate change. Similar to paradigm #2, it allows for sharing outcomes data on a larger scale to promote process improvement for residency programs. However, we are concerned that data that is continuously collected from our learners might be overwhelming. Residents and programs may need some reprieve from continuous data collection and reporting in order to maintain their wellness. Furthermore, the logistics of this level of data collection seem overwhelming. Will this data be locally mined or will it be reported to the ACGME? Who would collect it? Who would analyze it and inform programs on what to do with it? Would more data be useful data? Because programs would be responsible for obtaining real time data on all their residents on Common Program Requirements while also participating in pilot programs from AIRE to There, it would be powerful to have this breadth of data informing the success of innovations. This could ensure that common program requirements can meet the needs of all residents and programs throughout the country, enhancing ACGME's ability to grant accreditations. They would have more data points from programs and could possibly intervene earlier if early warning signs indicate that programs having difficulty. Like paradigm #2, we cannot predict the impact on enrollees to such pilot programs. If pilot programs through continuous data analysis are deemed ineffective, that may call negate residents' training in such programs. This livestream approach could then negatively impact residents' learning environment. It would be difficult for learners to learn in a constantly changing environment and conversely adapt to new requirements. There would be no predictability

continued on page 3

COMMITTEE UPDATE *(continued from page 2)*

for them, the program leaders, or the faculty. We worry that the program director would become responsible for managing this level of data and become overwhelmed by the volume of it, leaving less time for other essential elements of the job. Also, what would be the threshold to trigger change? Should programs only change based on major and significant differences, or should they change based on minor differences as well? Due to these concerns, programs and program directors may not honestly report their findings due to consequences from accrediting agencies.

Finally, in reflecting on this 30,000-foot view, the future seems bleak. We seem to be preparing for a time when AI and advanced practice providers (APPs) will spend more face time with patients, and the internist will be more specialized and function as consultant. Would algorithmic care through APPs and AI lead to better care? Secondly, the future seems to put more onus on individual patients and their role in maintaining health, but social barriers like poverty and access to care are not expected to change. As advocates for our patients, we do not believe that patients experiencing social barriers to care be held responsible for healthcare disparities. An IM-advocacy pathway would need to exist so that we could promote change within systems that make and keep people sick. Furthermore, in being tasked to see the most complicated and challenging patients, physicians might suffer higher levels of burnout. There would be fewer opportunities to celebrate small wins with patients and relish in the individualized coaching that is so incredibly rewarding in primary care. Instead, algorithms and non-physicians would be doing that very rewarding work. Even though we might be preparing for this future, we have strong concerns about it and are motivated to change it. We have a responsibility to deliberately influence a future we believe to be just, in line with our values, and one in which we uphold the promise we make through the Hippocratic Oath.

Thank you again for this opportunity to reflect and comment on three potential paradigms in medical education. We accept the challenge to be dynamic, compassionate, and just as we move forward in the changes to training and the practice of medicine in the upcoming future.

Sincerely,

SGIM

Following this response, SGIM was invited to attend a day-long summit to facilitate open dialogue with stakeholder leaders in the internal medicine community including members of the IM2035 Writing Group, members of RC-IM and the ACGME Board of Directors, representatives from AAIM, ABIM, ACP, SGIM, the American College of Osteopathic Internists, the ABOIM, and four current residents. The purpose of the summit was to engage in a shared vision of what needs to be done to better prepare our residents for the future practice of medicine. Participants answered two vital questions:

1. What can we do now to offer residents individualized educational experiences after they complete two years of foundational training in their internal medicine residency programs?
2. How can we promote innovation and participation in pilot programs that will offer residents individualized educational experiences?

From the conversation, it became apparent and essential that our professional societies should collaborate to work on the components we believe to be vital for the physician of the future, so that we can start teaching it now. We are on the cusp of designing residency. Let us not wait for change, but be the forces that change it to what it should be. SGIM