

Goals and General Objectives – Internal Medicine Training Program

Goals:

1. Train internal medicine residents to competently practice general internal medicine in preparation for ambulatory and hospital practice, further subspecialty training, or an academic career.
2. Train preliminary medicine residents in the basics of internal medicine practice to become fully prepared for careers in a variety of medical disciplines.

General Objectives:

1. Provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health in adults.
2. Demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
3. Investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
4. Demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, patient families, and professional associates.
5. Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
6. Demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

All internal medicine training is based on the six competencies – patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. These competencies are reflected in the goals and general objectives listed above.

In addition there has been a shift from process-based evaluation to outcomes-based evaluation. Accordingly the curriculum has changed formats to include rotation name, goals, and objectives, (often listed by competency), learning venues, competency evaluation designed to verify achievement of objectives, and outcome assessment designed to see if the curriculum has been successful. Under the old curriculum, residents were evaluated exclusively by the monthly ABIM global evaluation form along with the mini-clinical evaluation exercise. The ABIM form still remains the mainstay for resident evaluations. However, the form now reflects the six competencies and has an additional category called “chart audit.” In addition, this training program will be using new evaluation methods. A summary of these evaluation methods is also included as part of the curriculum introduction. (See Attachment 1 - Tool Table)

This curriculum document reflects a high level of faculty and resident participation. Specifically a curriculum committee consisting of subspecialty representatives, associate program directors, and chiefs residents assembled the curriculum over several months.

The completed product was reviewed by the Resident Executive Committee. While the Federated Council of Internal Medicine Guide to Curriculum Development has served as a rough template, numerous other curricula were reviewed. This document is also a work in progress. In the future the curriculum will be revised at least annually by the Subspecialty Program Directors and Curriculum Committee.

Residents and teaching faculty must review the curriculum for an upcoming rotation on a monthly basis. This review should clarify learning objectives and competency assessment methods. In accordance with RRC guidelines, faculty must also provide the resident evaluation feedback at the end of each rotation.

Supervision Policy

Patient care delivered by residents must be supervised closely by faculty. The levels of supervision may vary depending upon the resident's level of training and overall clinical competence. In general PG1 housestaff have every encounter with patients supervised on a daily basis by an advanced level resident and usually also by the faculty. Faculty are expected to see a new patient admission or consultation within 24 hours and verify the resident's evaluation in writing (general supervision). In the continuity clinics faculty are expected to see every patient evaluated by a PG1 resident for a six month period. After this time, faculty are expected to supervise every clinical encounter but do not necessarily see every patient (direct supervision). Faculty must be available at all times to respond to resident questions and are expected to personally supervise residents at the bedside if called upon.

Progressive Responsibility

The following curriculum at times specifies different expectations for PG1, PG2, and PG3 residents. If not specified, the following expectations are appropriate for each level of training:

PG1 - perform a thorough clinical evaluation pertinent to the field, list a basic differential diagnosis and plan, write orders with close supervision required, teach M3 students effectively, and score appropriately for level on an MCQ examination.

PG2 – perform a thorough clinical evaluation pertinent to the field, list a more comprehensive diagnosis and plan, write orders with less supervision required, teach M4 students, and score appropriately for level on an MCQ examination.

PG3 – perform a through clinical evaluation pertinent to the field, last a comprehensive diagnosis and plan, write orders with minimal supervision required, teach M4 students effectively, and score appropriately for level on an MCQ examination. The PG3 resident should function at or near the level of a general internist.