ACGME Graduate Medical Education 2035
Initial Comments to Start the
Program Requirement Revision Process
SPECIALTY: INTERNAL MEDICINE
Comment Deadline: July 1, 2018, 11:59 p.m. Central

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Title	President and CEO
Organization	Alliance for Academic Internal Medicine

Select [X] only one	
Organization (consensus opinion of membership)*	X
Organization (compilation of individual comments) *	
ACGME Review Committee or Council	
Designated Institutional Official	
Program Director in the Specialty	
Resident/Fellow	
Other (specify):	

*An organization submitting comments should indicate whether the comments represent a consensus opinion of its membership or if they are a compilation of individual comments.

Consent

As part of the ongoing effort to encourage the participation of the graduate medical education community in the process of revising requirements, the ACGME may publish some or all of the comments it receives on the ACGME website. By submitting your comments, the ACGME will consider your consent granted. If you or your organization do not consent to the publication of any comments, please indicate such by checking the box below.

I do not give the ACGME consent to publish my comments ☐

Instructions

Use this form to provide the Review Committee for Internal Medicine input on changes it should consider to the Program Requirements for Graduate Medical Education in Internal Medicine. The comments gathered will inform the Committee as it drafts a revised set of requirements.

Note: This *is not* the formal review and comment process that takes place *after* the Review Committee drafts its proposed revision of the Program Requirements.

Special Instructions for Internal Medicine 2035 (IM2035)

The Committee invites the community to review and provide comment on the Executive Summary from the two scenario-planning workshops that took place in 2017 called IM2035. It also asks for comment on the current Program Requirements for Internal Medicine. Please note that the current Program

Requirements for Internal Medicine have been folded into the proposed Common Program Requirements, which have not yet been approved by the ACGME Board and therefore are not yet final. Comment only on the specialty-specific requirements and the categorizations associated with these requirements ("core," "detail," or "outcome"), not on the proposed Common Program Requirements (indicated in bold text).

Comments on IM2035 Executive Summary	
Topic/Line Number(s)	**Comment/Rationale**

Reference the requirement or line numbers in the "Executive Summary and Draft Program Requirements – Internal Medicine" document. Note that numbering may differ from the currently-in-effect version, as this new document puts the requirements in the context of the proposed revision to the CPRs. Comment only on the specialty-specific language.

Comments on Requirements	
Topic/Line Number(s)	**Comment/Rationale**
Int C.	Proposed Revision: An accredited residency program in internal medicine must generally provide 36 months of supervised graduate medical education, but may vary if competency based advancement is permitted. Comment: Competency-based education is an inevitability for at least some learners within ten years. The 36-month requirement will need to be loosened for training that results in shortened or lengthened training based on learner progression.
I.D.1.f)	Proposed addition: Point-of-care ultrasound (POCUS) is encouraged. Comment: As stated on the Stanford 25 website which promotes the use of bedside exam skills, "We believe that teaching bedside ultrasound to the next generation of internists has the potential to standardize its use while bringing the internist back to the bedside." Emergency Medicine long ago integrated diagnostic and procedural ultrasound training into their curricula, and now includes ultrasound competency as one of their required milestones. The growing importance of POCUS has led a number of organizations to develop advocacy positions. The Society of Hospital Medicine, one of the largest internal medicine societies, formally recommends the use of ultrasound guidance for common bedside procedures, and is soon

	going to endorse diagnostic POCUS use. At the same time, non-internal medicine societies such as the American Academy of Family Practitioners, are formally supporting POCUS education during family medicine training. Medical schools clearly recognize the value of this technology. POCUS training is flourishing in the undergraduate medical education world. The most recently published survey indicates that over half of all medical schools have, or will be implementing, some form of ultrasound training for their students.
I.D.1.h)	Proposed Revision: The program director must directly supervise or oversee a designee to supervise internal medical subspecialty training programs sponsored by the institution and linked to their core program to ensure compliance with ACGME accreditation standards. Comment: It is important for the core residency director to maintain a close relationship with the subspecialty fellowships to maintain educational consistency across the department and to ensure all are aligned in their priorities. However, some departments of medicine have additional educational administrators such as a vice chair for education who can serve this role as well, contingent that this person stays in close connection to all educational leaders in the department.
I.D.1.j).(2)	Proposed Revision: There must be patients of all genders, with a broad age range, from young adults to geriatric patients. Comment: Pediatrics training does not provide adequate training for patients in young adulthood. As a result of internal medicine's focus and priority being on middle and older adulthood, patients in this age range are often lost to medical care and fall out of the system during this time. As a result, they are the 2nd highest utilizing age group of emergency room services, most often for low level complaints. In addition, women of child-bearing age and women's health issues are part of this age group and need services beyond those provided by Ob/Gyn.
I.D.1.k)	Proposed Revision: There must be services available from other health care professionals such as nurses, social workers, case managers, language interpreters, dieticians, data managers/IT specialists, and other frontline clinicians, etc. to assist with patient care. There must be training on effective interprofessional team building and functioning. Comment: IM2035 and SI2025 both agree that the concept of

	interprofessional teaming and workplace learning are part of the future of health care in the United States.
I.D.1.l)	Proposed Revision: Consultations from other clinical services must be available in a timely manner in all care settings where the residents work. All consultations should be performed by or under the supervision of a qualified health professional. Comment: With the move toward the "master clinician" role, more front line and routine care will be provided by advance practice providers (NPs, PAs), so a more collaborative approach to educating internal medicine trainees is warranted.
I.D.2.e).(1)	Comment: Authors would like for ACGME to reconsider deleting this requirement, as it had enabled program leadership to secure resources to ensure secure placement of residents' personal belongings.
II.A.1.a)	Comment: This passage requires specifics such as development of a succession plan. Stable core faculty leadership is another measure of program stability. Stability within a leadership group includes the contributions of Associate Program Directors. Further, as the program director's role evolves in response to accreditation and health system changes, institutional support of program directors should continue to support continuity and professional development for the PD role through the provision of adequate time and resources.
II.A.2.a)	Proposed Revision: The program director must dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the administrative and educational activities of the internal medicine educational program and receive institutional support for this time. Time allocation and salary support should be increased further based upon the program's size and complexity. Comment: Institutions should be encouraged to consider the optimal, rather than the minimum, for PD salary support
II.A.4.a).(16)	Comment: Specify that generally the deleted comments have been moved to VI.C.
II.B.2.f)	Comment: It is sometimes appropriate for non-faculty (NP, PhD) to provide guidance in areas of educational goal-setting, career planning, patient care, and scholarship.
II.B.4.e) through II.B.4.e).(5)	Comment: While we agree with the liberation of the definition of core faculty based purely on the number of hours per week dedicated to the program, the 15-hour threshold has been valuable to secure salary support for the core faculty in their educational roles and development. The deletion of this objective measure of support compromises faculty's ability to provide adequate time for feedback

	and evaluation, faculty development, and other important goals of the programs, including career development support. Requirements should specify support in these terms, meaning core faculty's efforts for support to provide wide-ranging core activities of program administration, including: teaching, evaluation, scholarly activity support, and faculty development. We recommend adding phrasing that all core faculty appointed by the program director should have at least 15 hours per week on average dedicated to the program and be supported through time and faculty development in this amount.
Following II.B.2.g)	Proposed Addition: Provide educational teaching beyond traditional clinical medicine, of which health system science, data informatics, and population health management may be considered. Comment: The internist of 2035 will have increased responsibility and oversight of populations, as well as individual patients. Each residency program needs faculty with these skills and capabilities to both teach and role model population data and health management for the trainees and other faculty in the program.
II.C.2.	Proposed Revision: At a minimum, the program coordinator must be supported at 50% FTE (at least 20 hours per week) for administrative time, and should be increased further, based upon size and configuration. Further, programs should undertake efforts to assess and address task-shifting to the program coordinator(s), particularly where fundamental program responsibilities involving accreditation, recruitment, human resources, licensing, and onboarding reside in a small number of individual(s). Proposed Requirement: At least annually, Program Coordinator must be provided with formal professional development designed to enhance their program management skills.
II.D.2.d.(1)	Proposed Revision: Currently certified in the subspecialty by the ABIM or osteopathic subspecialty board. Comment: The omission of osteopathic subspecialty board is likely an oversight.
II.D.2.d) (2)	Proposed Addition: "….accountable to the program director *with sufficient time and support to coordinate* the residents' subspecialty educational experiences..." Comment: This phrasing ensures that this position is appropriately valued and supported for its success.
III.C.1.	Proposed Revision: A resident who has satisfactorily completed an internal medicine preliminary training year should not be appointed

	to additional years as a preliminary resident. (Detail) [Moved from II.C.3.] Comment: Since preliminary years can be completed in other specialties, it is important to state internal medicine.
IV.A.4.a)	Proposed Revision: Residents must be provided with protected time to participate in core didactic activities, including asynchronous learning. Comment: Although asynchronous learning appears in the background and intent, emphasis within the requirement will reflect what is likely to be greater reliance on digital technologies for teaching and evaluation.
Following IV.B.1.a).(1).(g)	Proposed Revision: Demonstrate competence and adaptability to innovative or emerging technologies. Comment: This proposed requirement reflects a present reality for trainees and an essential skill for future trainees given the likely proliferation of technology in patient care. This addition casts keeping up with technology as a role of the profession, and not optional.
Following IV.B.1.a).(1).(g)	Proposed Revision: Maintain administrative professionalism with regard to record completion and policy adherence. Comment: Administrative professionalism is a basic skillset for 21st century medicine, both in terms of patient care and follow-up, as well as teamwork and collaboration.
IV.B.1.b).(2).(a).(iii)	Comment: ABIM requirements for procedures are currently under review, and changes in the clinical learning environment such as procedure teams will necessitate thoughtful wording of this requirement.
Following IV.B.1.b).(1).(a)(vi)	Proposed Addition: Residents must learn leadership development skills specifically to optimize patient care and advocacy Comment: Across IM2035 scenarios, leadership figured prominently and requires that residents develop leadership skills.
Following IV.B.1.e).(2)	Proposed Addition: Residents must demonstrate patient-centered communication skills and bedside manner Comment: Despite likely emergence of new IM specialties and achievement of early specialization, bedside manner is a core principle that must be a continued part of the profession.
Following IV.B.1.e).(2)	Proposed Addition: Residents must demonstrate competence in communicating with patients and families across different technological platforms (such as email, phone, telehealth)

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	Comment: Telehealth and technological platforms such as email and phone are pervasive in the practice of modern medicine.
IV.C.2.	Comment: There are both pros and cons for the one-third ambulatory requirement. Current requirements ensure that residents, regardless of their career choice, receive a depth of training in both inpatient and outpatient settings. However, more flexibility is needed to increase or decrease ambulatory training based on community and regional needs. This change would also support institutional and program efforts to align educational opportunities with mission and goals. The goal does not seek to provide training exclusively in one environment over another, but rather to permit innovation in curriculum for both program and learner centeredness.
IV.C.2.	Proposed Deletion: Emergency Medicine may count for no more than two weeks toward the required 1/3 ambulatory time. Comment: Emergency medicine experiences with 'first contact duties' should count toward the 1/3 ambulatory time.
IV.C.6.	Proposed Revision: Residents' service responsibilities must be limited to patients for whom the teaching service share diagnostic and therapeutic responsibility. Comment: This is a challenging issue to standardize across all training programs. While it serves to protect residents from becoming 'cross cover' for patients they do not directly care for, it may have the unintended consequence of diminishing inter professional training opportunities. Clarification is needed on whether APP-covered wards can handoff to teaching services for night coverage. Would this be acceptable if a fellow or attending is involved overnight?
IV.C.6.d).(2)	Proposed Revision: A first-year resident must not be assigned more than eight new patients in a 48-hour period, and should be lowered based on acuity, complexity, and severity of patient illness, as well as learner progression and available institutional resources. Comment: Institutions may choose to lower caps based on local conditions considering patient safety and learning environment.
IV.C.6.d).(2).(e)	Comment: We agree with the spirit of this requirement but wonder about unintended consequences of reducing the residents to the role of scribes and diminishing the opportunity for team-based documentation. Perhaps an FAQ is in order to clarify the intent.
IV.C.6.d).(6)	Comment: Securing dermatology sites is increasingly more challenging since internal medicine programs compete with

	pediatrics and family medicine for such training opportunities.
IV.C.6.d).(6)	Proposed Revision: Must include opportunities for experience in young adult population health. Comment: As a result of internal medicine's focus and priority being on middle and older adulthood, patients in the young adult age range are often lost to medical care and fall out of the system during this time. As a result, they are the 2nd highest utilizing age group of emergency room services, most often for low level complaints. In addition, women of child-bearing age and women's health issues are part of this age group and need services beyond those provided by Ob/Gyn.
IV.C.6.d).(11).(c)	Proposed Revision: Final year residents can complete up to (no more than) 43 distinct half days over twelve months in a single internal medicine specialty continuity clinic to be counted toward the 130 half-day requirement. An emphasis on continuity with the specialty patients should be maintained. Comment: Early specialization is likely for IM 2035. Final year trainees who intend to pursue a fellowship would benefit from outpatient subspecialty clinic opportunities to replace general internal medicine continuity clinic.
V.A.1.b).(2)	Comment: Although this core requirement has been approved, ongoing concerns persist with regard to the frequency of continuity clinic evaluations, as the quality of feedback between shorter intervals is unlikely to vary for some programs. We continue to support continuity clinic evaluations every 6 months, rather than every 3 months.
V.A.1.h).(5)	Proposed Addition: Teamwork and leadership skills Comment: Leadership is a skill that must be taught. Since leadership is inherent within a team-based environment, leadership skills development is befitting here.
V.A.1.h).(6)	Proposed Addition: Ability to maintain appropriate professional relationships with patients, colleagues, non-physician team members and the public. Comment: The continued emergence of social media platforms necessitates a distinct professional boundary for physicians to maintain with the public.
V.A.1.h).(6)	Comment: Medicare rules governing patient evaluations – that the first patient evaluation must be Medicare's – has prevented feedback from patients in the inpatient setting and limited many programs' ability to gather full 360 evaluations as stated in the

	requirements.
V.A.1.h).(7).(b)	Proposed Revision: "..ability to work collaboratively and lead in interdisciplinary teams" Comment: The physician assumes an important leadership position within health care teams. While leadership may be shared with other non-physician providers throughout the continuum of care, physicians must learn leadership and teaming skills as part of their position.

Final Thoughts
Include additional *general* or *overall* comments in the box below.

1. I.D.2.e).(1) – Concerns remain that the deletion of secured space for belongings deprives programs of an important source to advocacy for resident lockers and private spaces.
2. While added flexibility in the requirements to permit opportunities for earlier focus/specialization within internal medicine training may help address workforce and other needs, care should be taken to ensure adequate breadth of training is maintained to support future career adjustments.
3. Although future projections indicate internal medicine physicians may have less direct patient contact in favor of other roles and responsibilities, training requirements should maintain an emphasis on the bedside skills and the fostering of humanism.
4. Given predictions that new specialties within internal medicine are likely to arise (although specifics remain uncertain), and certain subsets of teaching hospitals may more likely support the training of such subspecialists, flexibility should be incorporated in training requirements so that programs can offer at least introductory content in new, relevant fields.
5. The expectations of the core internal medicine program director may be unrealistic even if the PD is provided 100% support, contributing to program director burnout. Greater flexibility in permitting PDs to delegate responsibilities to APDs and other program leaders may improve program leadership continuity.
6. To the extent that early specialization is allowed, care should be taken in how it may negatively impact structural barriers. For example, cardiology-bound residents who have attained competence in echocardiogram interpretation may have interest in sitting for the Echo Board, except eligibility requires an unrestricted medical license.
7. While the importance of training Master Clinicians for the future is predicted, it seems unlikely such individuals will be fully developed immediately after three years of internal medicine residency.
8. Given the recognition that future internists will have added expectations for knowledge and skills, entering internal medicine residents will need to be functioning at a higher level, which suggests a greater immersion in internal medicine knowledge and skills during medical school. It will be important for discussions to occur between the ACGME and other relevant stakeholders, such as LCME, AOA, and ECFMG.
9. The IM RRC should consider whether it is time to introduce branchpoints in certain requirements depending on the program and/or individual trainee desired output (e.g., "Master Clinician", inpatient-focused provider, ambulatory-focused provider, etc.)

10. Program requirements should encourage, but not mandate, residency pathways in health system science (data management, etc.). Such pathways may not be realistic additions for some training programs, including smaller programs. The ACGME should determine the most appropriate place where these requirements should appear.
11. Assessing systems-based practice remains an ongoing challenge for many programs.

Submission

All comments must be submitted via e-mail to internal_medicine2035@acgme.org by 11:59 p.m. Central on July 1, 2018. Specific comments must reference the requirement(s) by number as described above. All comments must be submitted using this form; comments submitted in any other format will not be considered. For more information, see the ACGME Review and Comment web page.