



AAIM Response to the ACGME IM2035 Paradigm Shifts

Approved by the AAIM Board of Directors on August 29, 2019

On June 20, 2019, the ACGME Review Committee for Internal Medicine (RC-IM) invited stakeholders to comment on three proposed paradigm shifts that were developed as part of the ACGME IM2035 scenario planning exercise.

The Alliance for Academic Internal Medicine (AAIM) – which includes 11,000 faculty and staff in departments of internal medicine at medical schools and teaching hospitals – is uniquely positioned to comment on the impact of these paradigm shifts on UME, GME, and administration of the largest residency programs in most institutions. AAIM is pleased to share its feedback on the strengths, weaknesses, opportunities, and limitations of the three paradigm shifts as well as the *Preamble*.

AAIM Response to Preamble

Summary

Overall, the statement is aspirational, stretching internists beyond what most currently feel prepared to deliver. Although AAIM does not advocate for lengthening of residency training, we conclude that 36 months may not suffice to train for all the listed competencies. Of the statement’s two paragraphs, the first paragraph is more easily embraced, while there are more discussion-generating statements in the second. There is duplicative content about expert communication and an internist’s educator roles between the two paragraphs.

Vision of the internist

The statement does not address a considerable advantage to the internal medicine career path—that it offers a wide range of options and the opportunity to develop specialized expertise, whether as a primary care provider, hospitalist, clinical subspecialist, physician-scientist, or in other roles. This diversity of opportunity is supported in the original IM2035 document that envisions a future in which trainees can pursue diverse pathways during their residencies, with opportunities to focus on hospital or ambulatory settings, early subspecialization, the development of research proficiencies, or even crossing into traditional “non-clinical/non-medical areas” such as public policy, research, quality improvement, law, and business administration.

While ACGME *IM2035* indicated that some internists will need to be master diagnosticians, the *Preamble* indicates all internists are master diagnosticians. AAIM agrees that most internists should be prepared to function as master diagnosticians, but in the context of their clinical work. We suggest that the *Preamble* be amended to recognize the value of pathway differentiation as well as to include patient safety, quality, and the advancement of research skills.

Some trainees may develop into “master clinicians” who focus on undifferentiated illnesses as described in *IM2035*; others may become master diagnosticians in a subspecialty area; and others not be

diagnosticians at all, but may develop procedural skills for therapeutics or become managers of health systems, public policy advocates, etc. Such an amendment would be more consistent with the paradigm shifts proposed, particularly the innovations described in *Paradigm Shift 2: From AIRE to There*.

Further, it will be important to recognize the potential that shortened “dwell times” in internal medicine residency training and earlier differentiation toward specialized training pathways could impact the effectiveness of developing master clinicians.

Value-Based Care

The *Preamble* states that internists “understand and manage the business of medicine to optimize cost-conscious care...”. This phrasing suggests that cost is the primary focus of business management in health care. The Alliance recommends that this text be revised to state “high value, cost-conscious care” since “value” implies incorporation of measures of quality and cost as well as better captures the priorities of internists.

Expertise in the Business of Medicine and Data Management Science

The magnitude of emphasis on some competencies should be considered so that expectations of future internists is right-sized. Placing competencies in data management and the business of medicine in the core expectations of internists could result in less training time for the development of direct patient-care knowledge and skills. The *Preamble* articulates, “...expert(ly) apply(ing) data management science,” which goes beyond what the Alliance considers reasonable expectations for internal medicine physicians now and in 2035. Instead, it may be more appropriate to consider expertise in data management science, the business of medicine, and population health as subspecialty domains, rather than an expectation of all internists.

AAIM Response to Paradigm Shift 1: Competency-Based Medical Education by 2035

Summary

Theoretically, competency-based medical education (CBME) customizes learning and training to suit that particular learner, therefore enhancing the learner’s experience. However, proficiency is not necessarily the product of the competency-based process. There is potential value to “dwell time,” since it enhances a student’s clinical acumen and further develops inter- and intrapersonal skills. Further, condensed training impacts staff, rotations, and resident well-being.

Strengths

CBME may allow more individualization of training opportunities and experiences, which may ensure that each trainee will experience an enriched learning environment that optimizes his or her skills.

Some trainees may advance quickly toward broad competency while others require the flexibility of additional time to develop proficiency.

Trainees who have settled on a career path may begin honing competencies necessary to those careers earlier and be better positioned to become high achievers in their fields.

Program-wide data on CBME performance has the potential to provide feedback to individual residency programs on areas of curricular strength as well as those areas in which improvement is needed.

Weaknesses

Trainee competence does not necessarily indicate proficiency. There is potential value to “dwell time” since it may increase a trainee’s opportunity for exposure to a broader range of both common and uncommon disorders, thus enhancing clinical acumen.

Excessive focus on specialty aspirations may undermine the development of a broad foundation of medical knowledge. It might also undermine professionalism behaviors if a trainee perceives a particular learning opportunity as not interesting.

Time in training fosters development of trusting relationships within a clinical setting, to include colleagues, attendings, and the multi-disciplinary team. Shortened training periods may reduce relationship-building and optimization of the work done by inter-disciplinary teams.

As their training progresses, residents acquire more leadership responsibilities. These experiences provide opportunities to enhance important skills, including interpersonal and communication skills, emotional intelligence, supervision, teaching, and feedback to junior trainees. The opportunity this provides to become a role model for professionalism and clinical care should not be underestimated. Truncated training may undermine opportunities to develop meaningful relationships between a resident and his or her continuity patient panel.

The potential for early advancement and truncated training periods would have a major impact on the resident workforce, including coverage of high-intensity rotations such as ICUs and night/weekend coverage of hospitals by housestaff.

Opportunities

Flexibility in required training time may promote resident health and well-being and provide opportunities to address personal needs, such as parental leave.

Trainees may benefit from earlier advancement along chosen career paths in several ways, including financial.

The competencies required of some specialties may overlap sufficiently with general internal medicine training to allow novel combined training tracks.

Eliminating an artificial length to training or combined training tracks might create opportunities to more quickly address societal needs in specialty physician and physician-scientist shortages.

More fully implemented CBME will necessitate the refinement of evaluation systems and clinical competency committee (CCC) processes to recognize and track fast-paced learners.

Limitations

The concept of CBME has been an important focus for years, yet we still struggle to identify reliable and reproducible performance metrics in some competency areas.

Standardization of evaluation processes to minimize bias and achieve valid competency assessment is essential but remains difficult to achieve. Further, the ability of faculty to provide valid assessments,

particularly with short periods of exposure to trainees or in varied clinical settings can magnify this challenge.

Competency-based early advancement will make optimization of faculty assessment skills even more important. However, faculty development in competency assessment is undermined by our current working environment, which prioritizes faculty revenue generation and achievement of RVU thresholds over time spent in trainee education and assessment.

The amount of overlap between residency and fellowship training – in terms of potential time saved by earlier, competency-based advancement – is questioned, particularly in the context of the new competencies anticipated by *IM2035* that will limit time for earlier exposure to specialty experiences.

Unintended consequences

The loss of senior residents to provide in-house supervision of other trainees may require programs and institutions to identify new sources of supervision. The impact on available resident staffing could undermine efforts by programs to balance the sequence and intensity of resident rotation schedules and undermine resident well-being. These additional demands on already-stressed faculty and other personnel may aggravate existing burnout rates. Further, some residents may experience increased stress and anxiety from having to make career decisions earlier, with less experiences or time to explore options.

Programs are already challenged to provide a curriculum that covers all ACGME common program requirements. It may be even more difficult if residents advance to fellowship early. Adding additional competencies advocated by *IM2035* that involve non-traditional areas (such as data management science, business of medicine, etc.), may further undermine the quality and quantity of trainee knowledge in core internal medicine patient care content.

If “master clinicians” are needed as envisioned by *IM2035* to solve complex cases, broader and more lengthy internal medicine training may be required to achieve that expertise.

AAIM Response to Paradigm Shift 2: From AIRE to There

Summary

This system’s methodology would, hypothetically, be supported by program directors due to its practicality. However, stakeholder participation will be varied. As such, the findings may not be thoroughly accurate.

Background Perspective

It is AAIM’s understanding the ACGME AIRE mechanism for program innovation has not led to large numbers of innovations to date, and ACGME is not publicly reporting all projects. Similar in nature to an AIRE project have been the pilots of three-year combined fellowship training in gastroenterology and hepatology. There was also evidence online of pediatric residency programs exploring X+Y clinic scheduling models with the use of AIRE.

Strengths

The stated approach has the potential to be nimbler in testing a variety of training innovations on a broader scale by utilizing the resources and expertise of certifying bodies and specialty boards. Resulting evidence-based conclusions could guide next generation innovations and studies.

Participating in an AIRE innovation, which involves systematic changes for groups of trainees, may offer more manageable logistics for participating programs, compared to delivering individualized competency-based training as considered in *Paradigm Shift #1*. It appears that this approach would be more manageable for program directors and provide predictable impact on the programs (for example, shifts in resident work force within an institution could be more easily foreseen). In addition, if AIRE is an elective, programs can choose AIRE pilots that would fit with their needs. It may permit more predictable plans regarding work force and clinical team composition if a pre-determined strategy has been developed for a group of residents, rather than an adjustable approach for each individual program.

Advantages can arise both from combined training (residency plus fellowship) and shortening of this training. The Alliance advocates for keeping the 36 months of general internal medicine, but loosening “core requirements” so that there would be more flexibility within the system for trainees to start to explore their special interests, such as subspecialties or data management.

Broader involvement of certifying specialty boards as well as program directors in AIRE, could result in more careful consideration of the range of questions such projects can address, followed by prioritization of projects that will be pursued. ACGME would need to ensure that novel approaches submitted to this pilot platform represents all types of training programs, from large to small scale innovations to academic and community environments.

Weaknesses

The AIRE methodology would limit certain types of innovation for stakeholders interested in pursuits not aligned with the priorities of the majority or the dominant views of the specialty board or societies.

Certain types of innovation could be limited if individual programs were not permitted to pursue the AIRE mechanism for their innovation due to the lack of an existing multicenter study. AAIM encourages ACGME to maintain the AIRE option for individual programs, in addition to being supportive of AIRE projects that are multicenter and completed in collaboration with specialty boards and societies.

Opportunities

AAIM and its institutional members could contribute to and help lead innovations.

Based on the positively-perceived example of combined gastroenterology and hepatology fellowship training, there likely are other similar innovations in internal medicine pathways where the benefits would outweigh drawbacks.

Limitations

It would be easier to engender broad participation by programs if much of the project detail and execution is handled by professional societies or ABIM, compared to the current AIRE model. Pilots would likely have broader buy-in by those “sponsoring” organizations and eventual generalizability to similar programs with this structure.

Some stakeholders will be more interested in an AIRE-like project than others, resulting in variable participation and contribution to learning from initiatives. Heterogeneous representation of programs, trainee and patient composition, geographic location, rural/urban settings, etc. will impact the overall outcomes evinced by this process. Conclusions drawn from participating programs may not be generalizable to all programs. Similar to the results of clinical trials, study results need to be considered in the context of participant characteristics – such as program size, community v. university-based, geographic location, patient population, rural v. urban, etc.

Unintended Consequences

A drawback is that including larger numbers of programs and trainees up front in such pilot work spreads the impact of any unintended outcomes to more programs and trainees. Some types of pilots are controversial and would never be attempted in large scale but might gain traction if started small, with a well-chosen pilot site.

The presence of an innovative AIRE project could be a recruitment advantage for participating programs. However, residency programs that lack fellowship curricula or, for other reasons cannot participate, may be at a disadvantage in terms of intern recruitment and may miss any advantages of being a pilot participant. Combined training opportunities could result in some trainees committing to a subspecialty prematurely. As conveyed previously, the resident workforce would be affected.

The physician workforce could be affected, positively for some fields and negatively for others. Recruitment into primary care career paths could suffer whenever opportunities for earlier subspecialization or shortened training pathways become available. Alternatively, trainees could participate in outpatient longitudinal clinics that could help display the benefit of general internal medicine.

The AIRE program will need to take into consideration how its conclusions will affect primary care. Understanding its magnitude longitudinally and how it would impact the number of trainees choosing to remain in general internal medicine, rather than favoring subspecialty training, is essential.

AAIM anticipates that institutions will shoulder additional administrative costs and support to meet the pilot's requirements.

It is difficult to predict the impact of this paradigm without knowing the intended number of such pilot projects and the number of specialty societies that might participate.

AAIM Response to Paradigm Shift 3: From NAS to LAS

Summary

Compared to the other paradigm shifts, this proposal was vague. The Alliance feels that the Learning Accreditation System (LAS) would be an incumbrance for residency program leadership teams. However, should this approach generate comprehensive data that is circulated at a suitable pace, it would help address trainee gaps and influence individual program improvements.

Strengths

Ideally, data already being collected for other purposes (such as the AIRE pilot study) would automatically feed into the Learning Accreditation System (LAS), therefore reducing some of the reporting onus for a program.

Data could result in evidence-based conclusions to guide improvement in accreditation processes. However, the Alliance is concerned that biases introduced in a pilot program could lead to applying such evidence inappropriately to other settings.

Individual programs may be able to leverage interpretations of their data for local program optimization in a more agile, prompt fashion.

Programs with recognized gaps in their trainee population could utilize data to better understand and address these gaps. ACGME could assistance in providing resources and guidance to address disquieting trends in individual programs.

Weaknesses

There is concern that data reporting burden on individual programs would increase to unreasonable degrees.

The rationale and potential benefits of such data collection is unclear. It is unclear how data collection for NAS has contributed to program innovation. Twice annual milestone score reporting is an example of how data collection and associated administrative burden is a process without an ideal outcome measure.

Opportunities

Theoretically, such data collection processes would facilitate the ability for individual programs to distill meaning from the data and generate action plans for improvement.

Limitations

Despite the promise of computer technology and artificial intelligence, there is concern there will be inadequate resources to manage and interpret a significantly-increased volume of data.

Challenges associated with ACGME providing oversight due to delayed 10-year self-studies and site visits could be worsened.

Unintended Consequences

The establishment of large, continuous data collection may raise concerns about misinterpretation and misapplication of data by entities outside the program.