

Curriculum Goals and Objectives
Expectation of Residents
Internal Medicine Residency Program
Medical College of Georgia

Synopsis—2008/2009

1 June 2008

I. Mission:

The mission of the Department of Medicine Residency Training Program is to train and produce outstanding clinicians able to accept their choice of sub-specialty fellowship or one of the broad range of practice opportunities afforded a general internist. This is accomplished through rigorous learner-centered education based on outstanding patient care experience, leadership development, and scholastic achievement.

II. The Educational Goals of the Program:

The overall education goal of the program is that by the completion of training, a graduate of this program will have all requisite competencies of a general internist to provide outstanding care for his or her patients over the next 40-50 years. Key to this is to develop in the graduate self-sustaining and disciplined skills, attitudes, and behaviors to acquire and use new knowledge under whatever form of medical care is practiced. Internists and subspecialists will be problem solvers, change agents, and seekers of improved health for patients, populations, and nations. By its nature, internal medicine is both broad and deep in focus, and includes biophysical aspects of normal and abnormal human physiology from the molecular to multi-organ systems. It is no less concerned with psychosocial, economic, ethical and humanistic/spiritual aspects of the health and function of the individual patient from the asymptomatic adolescent to the end-of-life issues of the dying patient. It is the intent of this program to produce excellent internists and future subspecialists practicing with such breadth and depth of competency to be recognized by their peers and patients as truly excellent in the 6 Core Competencies of Practice, as outlined by the ACGME:

A. Patient Care: Residents are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and palliation of symptoms. Patient care competency consists of appropriate and high quality diagnosis (history, physical examination, lab/radiology, procedures), therapy (pharmacology, procedures, patient education, discharge planning, followup), prognosis, and documentation (quality of clinical notes).

B. Medical Knowledge: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and psychosocial sciences, and demonstrate the application of their knowledge to the provision of patient care and to the education of others.

C. Practice Based Learning/Improvement: Residents are expected to constantly evaluate their own performance, incorporate feedback and external evaluation into their behavior to effect self-improvement, use appropriate knowledge and outcome-information sources to manage their patients, track improvements inefficiency and cost of care, and maximize quality of life of patients.

D. Interpersonal and Communication Skills: Residents are expected to establish a highly effective and personalized therapeutic relationship with patients and families through developing and maintaining excellent listening, narrative, and nonverbal skill. They are expected to provide patients and families culturally and personally appropriate counseling and education; and to educate colleagues and the public effectively on health and disease related matters.

E. Professionalism: Residents are expected to demonstrate values that are exemplary of altruism, accountability, excellence, duty, honor, integrity, and respect for others. They are expected to be fully honest, accept responsibility, acknowledge failures, and seek continual improvement for the betterment of patients and colleagues.

F. Systems-Based Learning: Residents are expected to demonstrate an understanding of the contexts and systems in which health care is provided, and demonstrate the ability to apply this knowledge to improve and optimize health care.

At the same time, residents are expected to demonstrate attitudes, skills, and behaviors consistent with the following Institute of Medicine Quality Aims:

- G. Safety: Avoiding injuries to patients from the care that is intended to help them.
- H. Timely: Reducing waits and potentially harmful delays for both those who receive and who give care.
- I. Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- J. Efficient: Avoiding waste, including waste of equipment, supplies, ideas and energy
- K. Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio-economic status.
- L. Patient centered: Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.

Every clinical rotation will incorporate the 6 competencies and 6 IOM Quality Aims contextually for the specific patients seen on that rotation. Residents are evaluated on their learning and subsequent performance of the attitudes, skills, and behaviors comprising these general competencies as specifically seen on the rotations conducted.

III. Specific Objectives of the Program: The program is based on the competency based Report of the Federated Council of the Internal Medicine Task Force on the Internal Medicine Residency Curriculum, 1997, and is organized into the following elaborated competency areas, all of which are explicit in our curriculum:

The Integrative Disciplines: By the completion of training, the graduate will be disciplined and fully competent in the following: Humanism, Professionalism, Medical Ethics, Lifelong Learning, The Clinical Method, Continuity of Care, The Medical Interview or History, Physical Diagnosis, Clinical Epidemiology and Quantitative Clinical Reasoning, Clinical Pharmacology, Scientific Literacy, Legal Medicine, The Management of the Quality of Health Care, Nutrition, Preventive Medicine, Home Care, Nursing Home Care, Occupational and Environmental Medicine, Physical Medicine and Rehabilitation, Care of the Dying Patient, The Management of Medical Practice, and Medical Informatics.

The Clinical Competencies: By the completion of training, the graduates will have in-depth knowledge of principles of management and indications for referral for common clinical conditions in the following organs and systems:

Allergy/Immunology, Cardiovascular Illness, Dermatology, Endocrinology, Diabetes, and Metabolism, Gastroenterology and Hepatology, Hematology, Infectious Diseases, HIV infection, Nephrology, Neurology, Oncology, Ophthalmology, Otolaryngology, Psychiatry, Pulmonary Medicine and Rheumatology. They will also have broad competency in principles of Genetics and competency in the following site-specific and population specific areas of Medicine: Ambulatory and Primary Care, Consultative Medicine, Hospitalist care, Critical Care Medicine, Emergency Medicine, Adolescent Medicine, Geriatrics, Substance Abuse, Women's Health, Palliative Care, and Discharge Planning.

All of the elaborated competencies are subsumed under the 6 core competencies noted above in **II. The Educational Goals of the Program.**

IV. Progressive Patient Care Responsibility of Residents

For each year of the program, residents will have increasing patient care, leadership, teaching, and administration responsibility. They demonstrate their competency within the context of the patient care and educational responsibilities expected of them.

PGY-1 (Categorical and Preliminary) PGY-1 residents (interns) will attain competency in the following areas: Humanism, Professionalism, Medical Ethics, Clinical Method, Continuity of Care, Medical Interview, Physical Diagnosis, Clinical Pharmacology, Medical Informatics. They will attain in-depth knowledge of clinical conditions found in inpatients, most of whom are severely ill, with complex medical problems. They will learn the basic “rules” of medical care and apply them to their patients in an increasingly personalized manner. They will engage in supervised, meaningful care of limited numbers of patients to achieve these competencies. They will learn and be tested on key competencies of data gathering and physical examination in non-patient care settings.

Categorical interns are responsible for continuity care of 75 patients.

Interns are responsible to provide pertinent and timely education to students working with them.

PGY-2 residents will further develop and expand those competencies acquired as interns, and begin to acquire remaining competencies listed above (**III Specific Objectives**). They will engage in supervised, meaningful care of increased numbers of patients who have increasing complexity and ambiguity. Care will be increasingly personalized and individualized to meet patient needs.

PGY-2 residents are responsible for leading their inpatient ward team, teaching interns and students, participating in journal club, subspecialty conference and morning report teaching. They will learn the competencies of practice-based learning and systems based practice through participation in seminars in medical economics and scholarly activities such as evidence-based resident report and journal club.

PGY-3 residents continue to expand and refine competencies to qualitative and quantitative standards of excellence before graduation, enabling them to meet criteria to sit for the examination of the American Board of Internal Medicine and achieve passing score. They will see more patients in ambulatory and consultative settings, demonstrate refinement of the 6 core competencies and 6 quality competencies to all areas of internal medicine practice, and increasingly foster improvements in their own care and the care provided by the health care system.

PGY-3 residents are responsible for leading their inpatient ward teams, participating in hospital quality assurance activities, teaching subordinates and peers to include a noon conference and increased numbers of other conferences. PGY-3 residents are expected to engage in scholarly activity, to include noon conferences, journal club, written case reports, published research, and/or paper presentations, and reports and essays pertinent to clinical rotations as outlined below.

V. Methods Used to Achieve Program Mission, Goals, and Objectives

In all the methods used and enumerated below, feedback by program directors and faculty is critical to development and growth of the resident. Just as important is resident self-awareness and self-improvement. Both are absolutely fundamental to the development of life-long habits of excellence in patient care, leadership, and scholarship. Self-awareness and feedback are continuous, spontaneous, and pertinent to the behavior and outcomes observed. Faculty will be encouraged by the program directors to be outstanding role models for residents.

A. Supervised care of limited numbers of hospitalized patients and concurrent educational activities

All patient care will be supervised by a designated attending physician who is responsible not only for the outcome of the patient, but along with the resident, attainment of the educational competencies associated with that patient or type of care. In general, the attending physician of record and teaching attending will be the same individual. Except where designated, such experiences will be one calendar month in length, repeated throughout the curriculum at different years. Each rotation has specific detailed curriculum located on the MCG Internal Medicine Website, to include recommended and/or required readings and scholastic requirements. Residents are expected to know and complete specific requirements of each rotation listed therein. They will provide equal emphasis on patient care and education during the time available.

Location: MCG and VA.

Teaching methods: Attending Rounds minimum 4.5 hours per week, with daily feedback and biweekly evaluation of patient care by attending (mid-term is informal, end of term uses standardized subjective competency evaluation form). The resident is expected to elicit both constructive criticism and feedback.

Self-assessment, pre- and post-rotation assessment and tests independent: Each resident will review the published goals and objectives of the rotation prior to its initiation, and complete the One45 pre-rotation assessment of personal goals for the rotation. Additionally, by the second day of the rotation they will have completed Internal Medicine Testing Online Testing Service Sample test pertinent for that rotation, along with self-scoring. This will be submitted to their evaluation file. Results of this test should guide goals of self-study and patient evaluation during the rotation.

At the end of each rotation, the resident will complete the post-rotation evaluation of self-directed goal accomplishment as well as a critique of the attending performance and peer performance during the rotation. The resident will complete the scored test pertinent to the rotation and record will be kept online and in the resident portfolio. Rotations will not have been satisfactorily completed until testing and evaluations are complete.

Assigned readings, core reading

Textbooks: *Harrison's Principles of Internal Medicine*, *Cecil Textbook of Medicine*, *Washington Manual*, *Parkland Manual of Inpatient Medicine*, *Up-to-Date*

pertinent to patient's needs and educational objectives of specific rotations. Residents should expect to read a major textbook of medicine such as *Harrison* or *Cecil* cover to cover and be completely familiar with its content by the middle of the PGY-3 year.

Electronic and Library resources: As pertinent to fulfill core competencies above.

Assigned writing of essays and reports:

On inpatient and ambulatory services, residents develop and maintain an appropriate patient database using a standardized admission and clinic note form. These are also assigned oral and written reports for specified rotations. These are included in the resident portfolio after appropriate critique. These are listed below under **Scholastic Requirements**.

Scope: Teaching and patient care integrate medical problems, health promotion, cultural, socioeconomic, ethical, occupational, environmental, and behavioral issues.

1. General Medicine Wards

Patients with moderate to severe acute and chronic medical problems requiring hospitalization. Competencies primarily relate to management of complex, very ill patients with infectious, pulmonary, gastrointestinal, metabolic, rheumatologic, and neurologic diseases within the hospital, and planning for discharge for continuity of care and maximal well being, incorporating palliative care principles and practice.

2. MICU

Patients with severe complex acute and chronic medical problems requiring hospitalization in the intensive care unit. Competencies relate primarily to care of severely ill patients with altered physiology and include procedure required to diagnosis and appropriate manage such patients.

3. Cardiology and CCU

Patients with complex cardiac problems requiring care by cardiologists. Competencies relate primarily to the management of cardiovascular diseases and their impact on patients with additional morbid conditions.

4. Hematology/Oncology (MCG)

Patients with sickle cell disease malignancy undergoing chemotherapy and other special therapy requiring expertise of an Oncologist. (This rotation includes ambulatory oncologic care). Competencies relate primarily to management of acute and chronic pain, altered physiology and sepsis

5. Nephrology (MCG)

Patients on dialysis and status post renal transplant. Competencies relate primarily to metabolic and infectious complications of renal disease and psychologic, economic, and cultural impact of renal disease.

6. Infectious Disease Consults

Patients with HIV, osteomyelitis, cellulitis, endocarditis, pneumonia and other acute, suspected, or chronic infectious diseases. Competencies relate clinical epidemiology, infection control, anti-microbial use, discharge planning (including hospice and palliative care), and public health issues. Residents are expected to be familiar with and appropriately implement IDSA and other guidelines in the management of patients.

7. Gastroenterology Consults

Patients with gastrointestinal bleeding, cirrhosis, inflammatory bowel disease, cholecystitis and cholangitis, as well as other hepatic and gastrointestinal problems. Competencies are similar to those in general internal medicine.

8. Night Float

Patients necessitating admission at night or weekend due to acute problems. Inpatients with after hours medical problems. Competencies relate primarily to timely decision making and management of acute problems in multiple patients at one time.

9. Consultation

Patients, mostly on surgical services or emergency room, necessitating general internal medicine consultation.

Time Management: Residents on all rotations will abide with RRC work hour rules and balance service to education. The primary role of the resident is to be educated and trained in the provision of service. This requires time for reflection, self-study, personal and family development, recreation, physical exercise and spiritual growth. Residents will report difficulties in limitation of work hours, and honestly and accurately report duty hours performed. It is the responsibility of the attending to proportion and facilitate service requirements to balance and promote educational and personal time. The following template will be standard for all teams:

Medicine Ward Services

0630- earliest arrival at hospital
0630-0730 Independent “pre-rounding” and review of labs, discussion with nurses
0730-0800 Hand off conference
0800-0830 Morning Teaching Conference (Wed Grand Rounds 0800-0900)
0830-0900 Discharge Planning Meeting (M, Tues, Thur, Fri)
0900-1000 Resident Team Work Rounds
1000-1130 Teaching Rounds with Attendings (thrice weekly)
1130-1200 Orders, consultations called in, final discharge instructions
1200-1300 Noon Conference
1300-1830 Admissions, work rounds, order writing, self-study, f/u consultations, re-examination and counseling of patients (if work completed, team members may leave at 1630 save one member for hand off conference)
1900-1915 Hand off conference to NF and Night MICU/Card (one member of team)
1915 Departure if no late admissions
2000 Departure if admissions after 1800.

Teams on overnight call

0630 Teaching rounds (new cases)(finish by 0900)
0730 Hand off conference (one member)-not official on weekends, but need to sign out to your colleague what happened with their patients overnight
0900-1100 Charting
1100 Departure all residents

MICU/CCU

0630-earliest arrival to hospital (on most days)
0700 Residents need to be in-house by 0700 in the units; call in the MICU/CCU is from 0700 to 0700
0700 Unit-Unit or Card-Card handoffs (one member); hand off the code pager
0630-0900 Pre-round/Resident/Fellow Team work rounds
0900-1100 Teaching rounds with attending
1100-1200 Charting, personal time
1200 Post call resident **must be clocked out and on way home or at home**
1200-1300 Noon Conference
1300-1700 Admissions, work rounds, order writing, self-study, f/u consultations, reexamination and counseling of patients; family meetings; may not leave units earlier

than 1700, except on the weekends (assuming all the work for the day has been completed)

Residents will conduct their continuity clinics at times scheduled and will be excused from the above schedule when in their clinics. Attending clinic schedules may require movement of teaching rounds to the afternoon 1400-1530. Post call day does not count as a “day off.” Teams will distribute work and coverage to allow each member one day off in 7.

B. Supervised care of limited numbers of ambulatory patients

All patient care will be supervised by a designated attending physician who is responsible not only for the outcome of the patient, but along with the resident, attainment of the educational competencies associated with that patient or type of care. Except where designated such experiences will be one calendar month in length, not repeated throughout the curriculum.

Location: MCG or VA unless designated

Teaching methods: Seminars in clinic (and ambulatory morning report) minimum 4.5 hours per week, daily feedback and semimonthly evaluation of patient care. Assigned readings.

Scope: Teaching and patient care integrate medical problems, health promotion, cultural, socioeconomic, ethical, occupational, environmental, behavioral issues, practice based learning and health systems improvement issues. .

1. Continuity Care Clinic: All years

Residents care for patients with continuing health care needs, often previously hospitalized. Competencies relate primarily to continuity of care and preventive care, integrative disciplines, and specific organ/system based competencies of general internal medicine primary care practice.

2. Subspecialty Continuity Clinic: PGY 3 in subspecialty track

Residents care for patients with continuing health care needs in a subspecialty of interest. Competences as above, with special development of knowledge and skills related to the subspecialty.

3. Emergency Medicine: One month as PGY-3 (VA and MCG ED)

Residents will care for patients with acute medical problems and needs requiring immediate attention or felt by the patient to require such attention. Competencies relate primarily to integrative disciplines, cardiac, pulmonary, drug abuse, psychiatric, and metabolic diseases listed above.

Residents will develop competencies in decision making, triage and rapid evaluation and management of acutely ill patients. They will all serve as consultants in internal medicine to the emergency department during this rotation.

4. Patient Centered Care and Value Based Medicine (VA Educational Innovation Project, at Uptown VA, all three years, didactic and experiential components) Part of the PGY-2 Didactic Experience will be at the Atlanta HQ of BlueCross BlueShield.

Vision, Goals, Objectives, and Hypothesis/AIMS of the Augusta VA/MCG EIP

- a. Vision: To develop leaders who will implement a chronic care model that is patient-centered and value-based and results in enhanced health for the population.
- b. Goals:
 - 1) To provide effective didactic and experiential education in patient-centered and palliative care
 - 2) To improve patient biological, psychological, and social outcomes in a population with chronic illness in a cost-efficient manner.
 - 3) To develop leadership skills, attitudes, and behaviors to the extent that resident graduates of this program will demonstrate competency in patient-centered and value-based care during the remainder of their residency.
 - 4) To develop leadership skills, attitudes, and behaviors to the extent that resident graduates will make scholarly and leadership contributions in patient-centered and value-based care in near and long-term practice.
- c. Objectives
 - 1) PGY-1: By the end of the PGY-1 didactic and experiential rotations, residents will be able to accomplish the following within the competency level of *proficient*:
 - a) Explore both disease and illness while conducting patient interviews
 - b) Explore understanding of the whole person, including military, occupational, social support, psychological, sexual, and spiritual issues
 - c) Use interviewing techniques to find common ground with the patient
 - d) Incorporate prevention and health promotion in management planning
 - e) Enhance the patient-physician relationship through communication and management skills
 - f) Conduct comprehensive multi-disciplinary evaluations using a variety of tools
 - g) Assess, manage, and alleviate common symptoms, including pain.
 - h) Prognosticate anticipated morbidity, adverse drug reactions, and mortality to assist patients in goal setting and health care planning.
 - i) Conduct outcomes evaluation of provided patient-centered care.
 - 2) PGY-2: By the end of the PGY-2 didactic and experiential rotations, residents will be able to accomplish the following within the competency level of *proficient*:
 - a) Evaluate and apply current methods of quality of life measurement
 - b) Apply patient values and preferences in health care with respect to their chronic illness or disability
 - c) Apply concepts of value-based medicine to the longitudinal care of two patients with chronic, disabling or progressive illness.
 - d) Conduct cost-utility analyses of health care utilization from the patient and payer perspective.
 - e) Describe the current systems of health care financing and their impact on efficacy, efficiency, safety, and patient satisfaction with health care provided.
 - 3) PGY-3: By the end of the PGY-3 didactic and experiential rotations, residents will be able to accomplish the following within the competency level of *competent*:
 - a) Teach in PGY-1 and PGY-2 didactic sessions on patient-centered and value-based care.

- b) Conduct case discussions on patient-centered and value-based care with medical residents and students.
- c) Complete a publishable paper on or within the scope of patient-centered and/or value-based care.
- d) Assist the OEF/OIF Program Director in managing the weekly patient review meeting, and fostering team development.
- e) Participate in the OEF/OIF Program semi-annual outcomes report.

5. Women's Health /Adolescent Medicine (Richmond County Health Department)

PGY-3: 2 weeks required or may elect 4 weeks

Residents will care for patients with sexually transmitted diseases, women's health screening, adolescent evaluation and health care pertinent to women's health issues. Residents will develop competencies in women's health and adolescent medicine

6. Geriatrics (MCG Center for Senior Health): PGY-3 2 weeks required or may elect 4 weeks.

Residents will manage geriatric patients in conjunction with faculty at the Center. Competencies include Geriatrics, Clinical Method, Continuity of Care, Home Care, Nursing Home Care, and the Dying Patient.

7. Community Health: To provide residents a supervised opportunity to manage and educate patients and the public in an inner city community context, thereby enhancing competencies of systems based practice, professionalism and communication to foster the health of the future communities in which they practice.

Specific Objectives:

- 1) To increase knowledge and understanding of social/economic and spiritual determinants of health.
- 2) To increase communication skills and cultural knowledge by caring for diverse patients as well as providing health education to patients and the public
- 3) To develop competency in practice based learning and knowledge of methods of community health assessment
- 4) To foster professionalism in caring for a diverse patient population

Location: Christ Community Health Services, Augusta, Georgia

Duration: 2 weeks, 4 weeks, or second continuity clinic.

8. Neurology PGY-3 One half-month, required

Residents manage patients with neurologic diseases and symptoms (one half clinic, one half consultative). Primary competencies are in Neurology, to include physical diagnosis and management of acute and chronic neurological disease expected of a general internal medicine practice.

9. MTW Foreign Ambulatory Internal Medicine (Dr. Ted Kuhn and other faculty). 2 week supervised elective experience in ambulatory and community medicine in a developing country under supervision of Dr. Ted Kuhn and other faculty, designed to develop appreciation of systems-based practice and physical exam skills in resource-poor environments. Requires 3 month prior approval.

10. Albany Georgia Internal Medicine (Dr. Joseph Stubbs). 2 week opportunity for exposure to a premier internal medicine practice to develop skills in communication, patient care, practice-based learning and systems-based practice.

C. Ambulatory and Consultative Rotations: Required and Elective

Ambulatory and Consultative Care experiences are extremely important in preparing residents for the bulk of their future practice. Residents will select these “non-ward” months after declaring their track and discussing their desires with their advisor. In general patients are seen both in the clinic and in consultation. Depending on the rotation percentage of ambulatory time, zero, 50 or 100% month credit will be given for “Meaningful Patient Responsibility” for rotations listed.

Patients seen typify patients with acute and chronic illnesses in the named specialties. Unless specified, rotations are at the VA or both VA and MCG. Application for specific non-ward rotations will be approved by the Program Director contingent upon track of resident, performance on inservice exam subspecialty components, and availability of teaching space on the rotation for the month desired. Residents should plan their non-ward rotations early in the academic year and must have their request submitted by the 5th of the previous month.

Core Rotations (see curriculae on web)

1. Gastroenterology Consults/Clinics
2. Cardiology Consults/Clinics
3. Rheumatology Consults/Clinics
4. Pulmonary Consults/Clinics
5. Endocrine Consults/Clinics
6. Nephrology Consults/Clinics
7. Infectious Disease Consults/HIV Clinic

Other Electives-Track specific

9. General Medicine Practice (Albany Medical Clinic, Albany Georgia): 2 or 4 weeks, PGY-2/3 required for generalist track.
10. Women’s Health (Athens, Georgia, VA or as special arrangement)
11. Sports Med/Orthopedics/Rheum (Musculoskeletal)
12. Allergy-Immunology
13. Rehabilitation-(VA Spinal Cord Unit)
14. WIC (walk-in clinic) VA or MCG
15. Inpatient Hospitalist (MCG)
16. Advanced Procedural Skills (Echo, Sigmoidoscopy, Treadmill Stress Testing, EKG, others as individually arranged) PGY-3
17. Dermatology Clinic/Consults
18. Ophthalmology/ENT
19. Research Month (needs defined and approved research protocol and mentor, completion of Clinical Trials Competency 4 module training prior)

20. Off Campus Elective (maximum one month at US ACGME approved program, see policy for approval)
21. Community Medicine
22. MTW Short Term Foreign Ambulatory Care (needs 3 month prior approval)
23. Albany Georgia Ambulatory Internal Medicine

Non-ward rotations will be approved according to the following track distribution requirements over 2 years of PGY2-3:

Primary Care Track

3 months Core Rotations

4 months required: Select from: Sports Medicine/Ortho, WIC, Geriatrics

Women's Health, Allergy-Immunology, Dermatology, MTW, Community Medicine, Albany Georgia Ambulatory Medicine

3 Electives

Hospitalist Track

4 months Core Rotations

3 months required: Hospitalist rotation plus 2 others: Radiology, Rehabilitation, VA Spinal Cord, Doctor's Burn Unit,

3 Electives

Sub-Specialty Track

4 months Core Rotations

3 months required: month of consult in chosen subspecialty area, month of clinic/procedures/ancillary studies in subspecialty area, month research in subspecialty area

3 Electives

Note: Core requirement is for total time; must be done in at least 2 week blocks

Vacation can be only taken in elective rotations

Non-ward rotations taken in PGY1 count toward requirements

Changes in track choice will be handled individually through the advisor system.

D. Procedures

Residents are expected to learn the indications for, complications of, and demonstrate the skills of the following ABIM recommended internal medicine procedures:

Abdominal paracentesis (3)
Arterial puncture for blood gas analysis (5)
Arthrocentesis of knee joint (3)
Central Venous line placement (5)
Lumbar Puncture (5)
Nasogastric Intubation (3)
Thoracentesis (5)
Breast examination (5)
Rectal Examination (5)
Pelvic examination with PAP smear including wet mount (5)
Venapuncture (10)
Peripheral IV insertion (10)

Residents must have documented successful performance of their procedures in their One45 portfolio and log book with annotation by an attending that the procedure was appropriately considered and accomplished. In order to complete the PGY-1 year at least 2 of each procedure listed above except arthrocentesis should be documented. In order to complete the PGY-2 year, the complete number of procedures must be successfully completed and documented.

Advanced procedural skills may be acquired during the special procedures elective noted above.

E. Didactic Curriculum

Didactics are designed to integrate, supplement, and broaden experience and knowledge in the rapidly developing fields encompassed by internal medicine. Students learn from their mentors and peers, through literature review, and by study and analysis in preparing timely topics. The didactic curriculum does not replace patient care. The didactic curriculum is designed as a three year educational experience, with educational repetition of approximately one-fourth of the topics. Topics include information from the basic medical sciences, psychosocial, economic, and cultural aspects of health and illness, as well as population dynamics, health care quality and management, and personal, family, community, and national/international aspects of health and disease.

Residents are expected to attend 60% of scheduled didactic conferences. Attendance is taken at all conferences. It is the responsibility of the resident to make certain attendance is tabulated. Failure to achieve attendance goals will result in failure to graduate from the PGY year unless the RPEC accepts hour-per-hour alternative education such as Hopkin Modules, assigned self-study, or tested video/computer study.

The following are the key didactic and patient care conferences:

1. Morning Hand Office Conference: Night Float or Night call team transfers care (using PAMPER Handoff form) to receiving physicians through discussion of cases, and bedside rounds as appropriate (0745-0800, daily).
2. Morning Report Conference and bedside rounds as appropriate (0800-0845 Tues and Thurs). This is also a required conference for Night Float/Unit Float residents. Scheduled presentation by residents of case management issues, graded by protocol format with attending and resident discussion.
3. Night Float Follow Up Conference: Mondays 0800-0830 Hospitalist and teams give feedback to Night Float Team on outcome of cases admitted to various teams during previous week
4. Clinical Pharmacology/Adverse Drug Reaction Conference (every other Tuesday) 0800-0830). PGY2/3 ward residents at MCG to report and discuss adverse outcomes with representative of department QI, Allergy Program, and PharmD/Clinical Pharmacology Programs. Mini-lecture on ADE topic.
5. Medicine Grand Rounds: Wednesday 0800-0900 Small Auditorium. Topics of current general interest to internists.
6. Hematology Case Unknown and Review, Dr. Paul Dainer, every other Thurs 0800-0830
7. Resident Problem/Didactic Conference (PGY 2 and 3). (Friday 0800-0830 August-April). Evidence-based discussion of current medical topic by resident. Must use evidence-based format outlined by program director to achieve competency scores in practice-based learning, medical knowledge and communication. (See attached)
8. Acute Care Lecture Series (Noon T,W,Th,F) July-August : Acute Medical Problems
9. Physical Diagnosis Course and Simulator Training/Testing (Noon last week July, first week August, PGY -1)
10. Noon Conference (Noon Tues, Thur, Fri): Key management topics pertinent to the practice of general and subspecialty internal medicine and preparation for the ABIM. The schedule of lectures and discussions (with pre and post MKSAP questions) is based on 120 top topics and repeated every 18 months. Some conferences will be given by residents.
11. Research Conference (Noon First Mondays) Departmental and Resident Research Presentations
12. Interdisciplinary Conference: (Wed Noon): Medical Ethics, Practice Management, Health Care Evaluation, Information Mastery, Interdisciplinary Medicine)
13. Basic Science and Medicine Series (Noon Second Mondays)
14. Clinical Pathologic Conference (Third Monday Noon)
15. Housestaff Administrative Meeting and Periodic Examinations (Last Fridays, noon)
16. Morbidity/Mortality/TQI Conference (Fourth Monday Noon)
17. Medicine-Surgery Interdisciplinary Conference: as scheduled
18. Medicine-Emergency Medicine Interdisciplinary Conference: Third Thursday 0800 monthly.
19. PGY-2 Leadership Seminar (Before beginning PGY-2 year): Discussion and role play of major issues of leadership, teaching, time management, feedback and evaluation.

20. X-ray rounds (as scheduled by Radiology). Review and teaching on current cases managed by ward teams at MCG and VA.
21. Board Review Course: Based on MKSAP, for PGY 2 and PGY 3 residents, Fridays March-June, time varies.
22. Journal Club: Wednesday Evenings at selected restaurants: Required for PGY3, partial attendance expected for PGY 1 and 2.
23. Subspecialty conferences: Residents electing a specific subspecialty track are encouraged and expected to attend subspecialty conferences held outside of core conferences noted above.

F. Special Educational Experiences

Special educational experiences further supplement and broaden the competencies of the resident by providing a frame of reference and view of the practice of medicine. These include required and optional/encouraged experiences listed below:

Required:

1. Journal Club: Monthly evidenced based medicine review of key journal article and current article answering a clinical question. (Required for PGY3 to present, partial attendance requirement for other years).
2. Clinical Evaluation Exercise (CEX): Bedside evaluation of diagnostic and decision making skills of the resident. Four of these mini-CEX are to be performed in the PGY-1 year.
3. Annual ACP Inservice Examination held for each categorical resident each October.
4. Procedure accreditation-residents are expected to log the successful performance of all procedures in One45. Every effort should be made to complete all procedures by the end of the PGY-1 year.
5. Resident Research: All residents are required to have completed a scholarly paper or abstract in publishable format by the end of the PGY-3 year. Guidelines, expectations, and timelines for this requirement are listed in the document: "Resident and Fellow Research Program" dated 16 October 2001.
6. Hopkins Ambulatory Care Web-based Curriculum: All residents are expected to fully complete at least 6 of ambulatory care modules each year. This activity is found at www.hopkinsilc.org
7. IM Test: Prior to each rotation, residents will complete the appropriate Pre-Test and prior to the completion of each rotation, residents will complete the appropriate Post-Test for that rotation on www.imtests.com

G. Scholastic Requirements

Residents are expected to complete the following scholastic requirements for the rotations noted below:

1. All residents, all rotations: All residents are encouraged to submit reports of adverse drug reactions, quality improvement initiatives, near miss reports and other QI events promptly to the program director on the “near miss form.” Residents will be measured and achieve competency in Practice based learning and Systems Based Practice based on reports submitted and activities accomplished. In addition, all residents will participate on subcommittees of the Residency Program Patient Care Quality Improvement Committee, as well as selected residents (designated future Chief Residents) on the Residency Program Improvement Committee.
2. Resident Reflection and Self-Evaluation: Each resident will complete the One45 pre and post rotation self-evaluations before and after each rotation. This includes setting goals and objectives for the rotation with the attending and monitoring whether goals have been achieved.
3. Walton Rehabilitation Hospital: Residents will write a 2 page paper on a topic of rehabilitation pertinent to a patient seen there.
4. Practice Profile: Residents will participate in performance monitoring of their continuity clinic patients with semi-annual report on the following performance measures: Number of patients followed, number of visits, % patients with controlled hypertension, diabetes, completion of preventive care tasks, and assessment of individual patient and system interventions to improve performance.
5. Outside and Special Rotations: Each resident will complete assigned essays by the completion of the rotation in order to achieve credit for the month. These rotations will be incorporated into the resident’s portfolio.

The residents each have the following scholastic requirements for use in the didactic curriculum: Copies of these products must be submitted to the resident personal file for credit to be annotated.

1. PGY-2:
 - Completion of at least one Friday Morning Evidence-based Medicine Conference according to prescribed format with grading and entry into portfolio.
2. PGY-3:
 - a. Preparation of at least 1 noon conference on assigned topics for PGY1 or PGY2/3 curricula with grading according to written criteria and entry into portfolio.
 - b. Preparation of at least one journal club presentation according to CAT methodology with grading and entry into portfolio.
 - c. Completion of at least one Friday Morning Evidence-based Medicine Conference presentation according to prescribed format with grading and entry into portfolio.

3. All years: Each resident will prepare a case vignette each year for submission to the annual ACP state competition.

H. Optional Activities

1. Resident paper/poster competition for ACP state meeting.
2. Hospital and MCG committees (especially Risk Management, GME, Drug Reaction)
3. Community service
4. Resident organization
5. Moonlighting-Moonlighting is limited to PGY2/3 only, must be prior approved according to department policy, and must be reported monthly to the Program Director.
6. Social Activities-Department parties and activities
7. Christian Medical and Dental Society
8. Religious Organizations (Churches, etc.)
9. Personal recreation and fitness

I. Resident Program Tracks

The program will offers 3 tracks to categorical medicine residents. This allows residents opportunity to pursue their personal academic goals while satisfying the requirements of the American Board of Internal Medicine. PGY-1 residents will declare their chosen track by 31 December.

1.Subspecialty Track

The subspecialty track allows participation in desired subspecialty inpatient, outpatient, and consultative subspecialty experiences in the first 2 years of residency to prepare the resident for application to a competitive fellowship program. Residents will initiate and participate in subspecialty related scholastic and research activities in their desired subspecialty.

2. Hospitalist Track

The hospitalist track allows enhanced participation in inpatient care on general medicine. This is coupled with training in managed care administration, quality improvement, hospital epidemiology, drug utilization review, medical error prevention, and medical outcomes research.

3. General Medicine Track

The general medicine track prepare resident for a career as a general internist working primarily in an outpatient primary care or multi-specialty setting. Residents receive special training in practice organization, psycho-social aspects of primary care, communication skills, and small group leadership.

VI. Administrative Requirements

- A. Performance of Duty: Residents are expected to be prompt and dutiful in assumption of all patient care and administrative duties. Residents are expected to know,

understand and abide by the Department Policy on Professionalism. Residents on wards are expected to arrive in time to conduct personal “pre-rounds” on their patients (PGY-1 on all patients, PGY2/3 on selected ill patients), to be completed by 0730. At 0830 each team is expected to begin work rounds as a team, visiting each patient expeditiously, and discharging all appropriate patients in order to clear beds by 1000.

- B. Dictation of Charts: Interns/Residents are expected to dictate charts of patients prior to or at the time of discharge. Death charts are the responsibility of the intern/resident who was primarily taking care of the patient. However, it is the intern’s responsibility to fill out the death paperwork at the time of the patient death. MICU and Cardiology-CCU patients will be dictated only by PGY2 or PGY3 residents during July and August to ensure quality of the dictation.
- C. Incomplete and Delinquent Records: Residents are expected to check their inboxes weekly to verify they have no dictations or signatures to complete. Delinquent records will result in withholding of paycheck.
- D. Attendance: 60% attendance is required for each conference, as measured on a quarterly basis. This percentage takes into account leave and off-site rotations.
- E. MSLE 3 Examination: Residents will successfully complete MSLE 3 within 6 months of date of eligibility.
- F. Evaluation Forms Completion: It is the responsibility of the resident that all scholastic requirements be accomplished and that all evaluation methods be completed and annotated in his or her personal record no later than June 10.

VII. Resident Evaluation, Promotion, Probation, and Dismissal

A. Resident competency will be evaluated and documented according to the methods outlined in the policy paper “Resident Competency Program” dated 6 June 2002. Residents are expected to be familiar with this policy and program, key components of which are outlined below:

B. Advisor Program: Each resident is assigned a faculty advisor who will be his or her primary mentor and advisor for the length of the residency. Advisors will meet the resident at least 3 times per year and assist the resident in completing all requirements including rotations, procedures, completion of required scholastic papers, research paper and administrative and professional requirements. The advisor will also complete chart reviews and assist in preparation and supervision of learning agreements.

C. Competency Evaluation Tools

1. Monthly One 45 Summary Evaluation: Residents are expected to discuss their evaluation with their attending physician at mid-month informally and at the end

of the rotation before leaving the service. The attending should discuss and show the completed evaluation to the resident who should sign it. It is the responsibility of the resident as well as the attending that this be accomplished. (All competences)

2. Clinical Evaluation Exercise: A mini-CEX is to be accomplished by interns while on each General Medicine, Cardiology, Renal, or Hem-Onc Rotations (Patient care, communication, professionalism competencies).
3. Direct Observation by attendings, program director, chief residents at morning report, conferences, and in working on wards (Patient care, communication, PBL, SBP)
4. VA Educational Innovation Project Tools: Specific tools designed for and used in the various components of the VA EIP will be used for formative and summative evaluation of resident competency in Patient-centered care and Value-based medicine. These will be tracked both in the EIP and by the program for advancement and outcomes.
5. 360 degree evaluation by nurses, students, others performed at least semiannually by nurses, monthly on One 45 by residents (patient care, professionalism, Institute of Medicine quality aims, Practice Based Learning)
6. Formal written examinations: EKG, Palliative Care, Microscopy, ACP Inservice, pre- and post month quizzes on assigned reading, monthly exams on noon conference subject matter and ad hoc exams as determined by the program director (Medical Knowledge)
7. Chart Reviews: Admission notes, progress notes, and dictations are formally reviewed and graded by the program director (inpatient) and three times yearly by advisors (outpatient). Residents review such evaluations and correct deficiencies.(Patient Care, PBL, Communication)
8. Patient satisfaction surveys/Complaints (Professionalism) are performed in continuity clinics and wards and placed in portfolio after review by the program director.
9. Procedure Documentation log (Patient care, PBL). Residents are expected to complete approximately 50% of ABIM recommended internal medicine procedures by the end of PGY-1 and all of recommended procedures by the end of PGY-2 year in order to advance. These procedures will be documented in One45 and the ABIM procedure log book provided each resident.
10. Self-assessment instrument will be completed thrice yearly by residents and discussed with advisors (All competencies and IOM quality aims).
11. Validated reflective thinking on case vignettes (Morning case conferences, Morbidity and Mortality conference) (Medical Knowledge, PBL)
12. Critique of written and oral communication by peers and faculty, particularly of noon conference presentation. (Medical Knowledge, Communication)
13. Semi-annual resident continuity report (Systems-based practice).

Permanent records of evaluations, report cards, and counseling are maintained in a Resident Portfolio in the Residency Program Office. It is the responsibility of the resident to review his or her own record frequently.

D. Criteria for Advancement of Residents

1. Residents are evaluated continuously by advisors, the program directors, and the Resident Evaluation and Promotion Committee (RPEC) according to standards listed in the policy Statement Criteria for Advancement of Residents (Appendix 1, linked)
2. Residents are evaluated biannually by the Residency Evaluation and Promotion Committee with written report from the Program Director with due input from attendings, advisors and others as appropriate, and are promoted and graduated by committee vote.
3. Successful completion of individual rotations is based on the attending evaluation (One45), mid-month counseling, and specific behaviors and activities during the rotation, as judged by the RPEC under due process to include documentation of prior expectations (goals and objectives of performance), resident knowledge of potential deficiencies, and impartial investigation of the facts. Rotations considered to be unsuccessful or failing will be remediated using standardized remediation plans mandated by the RPEC (see below).
4. The Program Director completes an semi-annual Resident Report Card outlining resident progress in completion of scholastic, procedural, and administrative requirements of the program, and summarizing scores in the 6 competencies obtained during rotations, chart review, and scholastic activities.
- 5.. Residents are evaluated annually by the RPEC based on completion of duty and quality of performance as measured using the evaluation tools listed above, as well as meeting of milestones listed in the Criteria for Advancement of Residents. The RPEC vote determines promotion of each resident. The program director completes an annual report on competency and progress to the American Board of Internal Medicine, documenting satisfactory completion of the academic year. After the PGY-3 year, the program director also recommends to the ABIM the suitability of the resident to sit for the ABIM certifying examination.

E. Academic Remediation, Probation, and Dismissal from the Program

These are accomplished according to written policies of the Department and the Medical College of Georgia Graduate Medical Education Committee, in keeping with due process:

Residents will be counseled promptly for perceived deficiency in any of the 6 core competencies. Such counseling will be performed by attending, advisor, chief resident, or program director as appropriate, and documented in the academic record of the resident.

The program director may write specific letters of counseling, censure, or reprimand as he or she deems appropriated. Such letters will be reviewed by the RPEC,

which may vote to remove or sustain such information in the permanent academic record of the resident.

Residents may be placed on academic remediation or probation by the RPEC in order to accomplish specific remediation of weaknesses. Standardized remediation plans and templates are used for this purpose with modification as required by the RPEC. Such action should be viewed as an educational, not punitive action. Periods of remediation or probation are up to 3 months, with one 3 month period of extension if the RPEC agrees that progress has been made. Residents on remediation or probation will be assigned a specific advisor to facilitate remediation and report on progress to the RPEC. All records relating to probation will be a permanent part of the academic record.

Residents will be dismissed for blatant unprofessionalism, or failure to successfully complete remediation during probationary periods. All dismissals are subject to due process according to Department and MCG policies.

VIII. Program Evaluation

The Program is evaluated in the following methods:

- A. Resident written evaluation of attendings and Program as a whole.
- B. Post-graduate written inquiry (letter to graduates 9 months after)
- C. ABIM Pass/Scores
- D. Inservice Training Scores
- E. Yearly Internal Review (by faculty and residents using formal questionnaire)
- F. Biannual External Review
- G. RRC Review
- H. Weekly informal housestaff/Chief Resident/Program Director Meeting
- I. Resident formal and informal input into this curriculum.

IX. Action to Improve the Program

The Program is improved in the following manner, using results of evaluations noted above in VIII.

- A. Curricular change: Modification of rotation content, location, length, scope
Modification of didactic schedule, content, teachers
Modification of available electives
Modification of available research
- B. Personnel change: Modification of ineffective teachers
Faculty Development
- C. Equipment change: Purchase of Literature as needed
Purchase of Computer, AV or other equipment as needed
- D. Systems change: Modification or re-engineering of systems of care, teaching, or research as needed to improve program accomplishment
- E. Reassessment: After modifications are made, the changed are assessed to determine that improvement has been accomplished.

X. Responsibility

The responsibility for the attainment of the mission, goals, and objectives of this program belongs solely to the Program Director. He is assisted by Associate Program Directors, who are designated Key Faculty Members of this Program, working through the Residency Evaluation and Promotion Committee.

The Program Director delegates to the faculty responsibilities and activities of education and mentorship for the daily implementation of this program and holds them responsible for their performance through feedback, persuasion, and counsel to the Chairman, Department of Medicine.