INTRODUCTION AND OVERVIEW

GOALS:

Provide the educational and academic environment, formal and informal instruction, and clinical material necessary to train physicians for the practice of internal medicine or for subspecialty fellowship training.

OBJECTIVES:

I. Overview of Objectives for All Rotations

1. Develop and refine skills and knowledge.
   a. Clinical skills
   b. Procedural skills
   c. Medical knowledge

2. Develop and formulate individual professional code.
   a. Humanistic qualities and professional attitude
   b. Professional development and scholarly habits

3. Integrate skills and professional behavior.
   a. Clinical judgment
   b. Overall medical care

4. Obtain competency in 6 areas identified by ACGME
   a. Patient care
   b. Medical knowledge
   c. Practice-based learning and improvement
   d. Interpersonal skills and communication
   e. Professionalism
   f. System-based practice

II. Common Objectives for All PGY Years and All Rotations

1. Understand the effects of cultural diversity and socioeconomic differences on the delivery of health care.
2. Understand the interactions among medical problems, behavior, environment, and occupational exposures when providing health care.

3. Use all clinical activities for patient education and health promotion.

4. Emphasize professionalism, clinical ethics, and humanism during all patient care activities.

III. Overview of Objectives for Each Postgraduate Year

1. PGY-1
   a. Develop clinical skills and clinical judgment through intensive and repeated exposure to hospitalized patients.
   b. Learn communication essentials through the development and maintenance of medical records and interaction with consultant physicians, hospital personnel, and ancillary hospital services.
   c. Begin training in intensive care units.
   d. Establish and expand individual continuity of care clinic.
   e. Learn and use basic procedures necessary for general internists.

2. PGY-2
   a. Build knowledge base in core areas of internal medicine through subspecialty elective rotations and self-directed reading.
   b. Test and refine clinical judgment through greater responsibility on ward services, night float rotations, and general medicine consult services.
   c. Expand continuity of care clinic and develop an appreciation for the natural history of common diseases, for the benefits and hazards of medical therapy, and for the cost and intricacies of chronic health care.

3. PGY-3
   a. Expand knowledge base into more esoteric areas of internal medicine and solidify understanding of clinical-pathological-physiological correlations.
   b. Increase clinical skills in intensive care units.
   c. Increase leadership and educator role on ward services by directing team activities and supervising students and PGY-1 residents.
   d. Start intensive self-directed study for ABIM certifying examination and use
this experience to develop habits which allow continued professional development and learning.

IV. Specific Objectives (see following sections)

PRINCIPAL TEACHING METHODS:

I. Structured clinical activities with faculty supervision using rotations through inpatient and outpatient clinical services at University Medical Center, Texas Tech University Health Sciences Center Ambulatory Clinics, and VA Outpatient Clinic.

II. Increased responsibility as clinical skills develops.

MOST IMPORTANT EDUCATIONAL RESOURCES:

Knowledge and skills essential for the practice of Internal Medicine developed through:

a. Clinical experience with a heterogeneous adult patient population, including ambulatory care and hospital based care.

b. Bedside faculty teaching.

c. Peer interaction.

d. Departmental conferences.

e. Reading based on Harrison’s Principles of Internal Medicine, MKSAP series, and the current literature.

ANCILLARY EDUCATIONAL RESOURCES:

I. Consultants and faculty from other departments in the School of Medicine.

II. Health Sciences Library with journals, texts, videos, and information retrieval system.

III. Outside speakers sponsored by the Department of Internal Medicine and the School of Medicine.

PROGRAM STANDARDS AND EVALUATION:

Program Standards

1. Residents must develop clinical skills, must obtain and organize medical knowledge, must develop and formulate a professional code, and must integrate skills, knowledge and professional behavior to produce sound clinical judgment and
superior overall medical care.

a. Clinical skills include the ability to perform a thorough, directed history and physical examination and to perform basic procedures safely and competently.

b. Medical knowledge includes the essential information known about adult diseases and the necessary clinical-pathological-physiological correlations.

c. Professional code or standards include the efficient organization of clinical care, record keeping, and communication and compassionate attention to the patients’ needs decisions and quality of life.

d. Clinical judgment arises from integration of clinical data and medical knowledge into efficient, safe diagnostic plans and treatment programs.

e. Overall medical care reflects clinical judgment and professional standards.

2. Residents must progress satisfactorily during training, identify deficiencies, and formulate plans for improvement. Residents must increase clinical leadership and educational contributions during training.

3. Quantitative standards for program evaluation will include:

a. Eighty percent or more of Internal Medicine positions will be filled through the Match.

b. Ninety percent or more of Internal Medicine residents will complete the program.

c. Residents will score at or above the median on the In-Training Examination developed for 2nd year residents.

d. Eighty percent or more of residents will take the ABIM certifying examination and at least 70% will pass.

e. Eighty percent of residents will enter the practice of general Internal Medicine, take subspecialty fellowships, or take academic positions.

f. The education environment will include an adequate patient load, complete and timely library resources, and a comprehensive conference schedule.

4. Resident Evaluation

a. Residents will have monthly evaluations by the attending physicians
responsible for their current clinical services. This evaluation will be reviewed with the resident by the attending faculty member and will be reviewed by the Program Director.

b. Resident progress will be reviewed quarterly by the Internal Medicine Faculty and periodically by the Post-Graduate Medical Education Committee. Residents will meet twice yearly with the Program Director for a performance review.

c. All residents will be evaluated direct observations of clinical performance and a review of medical records by Internal Medicine Faculty.

c. All residents will have a yearly summary with their performance evaluations sent to the ABIM.

NUMERICAL GOALS:

The Department of Internal Medicine will adhere to the following guidelines:

1. Teaching Ratios
   a. On inpatient services and subspecialty rotations, the teaching ratio must not exceed eight residents and/or students per one faculty member.
   b. In the ambulatory care setting, teaching ratio must not exceed five residents and/or students per one faculty member.

2. Workload
   a. When averaged over any four week rotation, residents must not spend more than 80 hours per week in patient care duties. Residents must not work more than 30 consecutive hours.
   b. When averaged over any four week rotation, residents must have at least 1 day of 7 free of patient care duties and other responsibilities.
   c. Residents must not be assigned to on-call in-house duty more often than every third night.
   d. During emergency medicine rotations, continuous duty must not exceed 12 hours.
   e. When on an inpatient rotation, a first year resident must not be responsible for more than 5 new patients per admitting day or 8 new patients over any 48 hour period.
   f. When on an inpatient rotation, a first year resident must not be responsible for the ongoing care of more than 12 patients.
   g. When on an inpatient service, a second or third year resident must not be responsible for admitting more than a total of 10 new patients (which includes the supervision of first year residents’ patients) per admitting day.
   h. When on an inpatient rotation, a PGY II or III resident must not be responsible for the ongoing care of more than 16 patients (including the supervision of PGY I residents’ patients).
i. In the continuity of care clinic, a first year resident’s patient load must not be less than three or more than five patients. Upper level patient load must not be less than four patients per ½ day session. Residents must have 108 continuity of care clinics during a three year program.

j. The department must have 210 admissions per PGY 1 resident per year.

3. Rotational Assignments
   a. The total emergency medicine experience must not exceed three months in three years.
   b. The total critical care experience must not exceed six months in three years (elective experience may increase this total to eight months in three years).
   c. During the PGY I year the resident should have a minimum of six months of internal medicine teaching service assignments providing experience with hospitalized patients.
   d. During the PGY II and III year residents, the combined inpatient experience must equal or exceed six months.
   e. During the three year training program, the resident must have at least 24 months of meaningful patient care responsibility defined by rotations in which the resident has primary responsibility for patient care. In this program these rotations include: MICU, CICU, MICU Night float, General Medicine inpatient services, Hematology/Oncology service, ER medicine rotation, VA outpatient clinic rotation, Urgent Care rotation, and a consultation 1 night float rotation.
   f. With each training year, the resident should have increasing responsibility in patient care, leadership, teaching, and administration.

STRENGTHS OF CURRICULUM:

I. Adequate and diverse patient base which provides excellent clinical experience.

II. Well run clinical facilities which provide excellent patient care, superior technical services, and other ancillary services necessary to support educational programs.

III. An experienced faculty with a high level of interest in patient care and in teaching.

LIMITATIONS:

I. The School of Medicine and the Department of Internal Medicine are relatively small. Consequently, no clinical section has a large number of faculty members involved in research and clinical work.

II. The Internal Medicine knowledge base is so broad and deep that supplementary conferences and other educational experiences with non-Internal Medicine core material are difficult to fit into the curriculum.

III. The clinical workload varies and at times it is difficult to use an organized curriculum.

RESPONSIBILITIES:

I. The Program Director is responsible for developing and managing the curriculum.

II. Faculty members in the Department of Internal Medicine are responsible for supporting the curriculum and developing it in areas where their expertise can make important contributions.

III. Internal Medicine residents are responsible for using the curriculum and providing feedback on its
strengths and limitations.