

A New Model for Accreditation of Residency Programs in Internal Medicine

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A renewed emphasis on clinical competence and its assessment has grown out of public concerns about the safety, efficacy, and accountability of health care in the United States. Medical schools and residency training programs are paying increased attention to teaching and evaluating basic clinical skills, stimulated in part by these concerns and the responding initiatives of accrediting, certifying, and licensing bodies. This paper, from the Residency Review Committee for Internal Medicine of the Accreditation Council for Graduate Medical Education, proposes a new outcomes-based

accreditation strategy for residency training programs in internal medicine. It shifts residency program accreditation from external audit of educational process to continuous assessment and improvement of trainee clinical competence.

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Medical education is experiencing a back-to-basics movement, with increased emphasis on mastery of core clinical competencies (1-3). Debates over curricular time, clinical rotations, and conferences are being replaced by discussions about clinical competence and its assessment (4-8). The change is driven largely by evolving societal mandates for quality, safety, and accountability in health care (9-11) and is resulting in re-examinations of priorities and programs not only by medical schools and residency training programs but also by certifying, licensing, and accrediting bodies (12, 13).

As the accrediting body for the nation's medical residency programs, the Accreditation Council for Graduate Medical Education (ACGME) bears responsibility for the quality of graduate medical education (14). Through its accrediting authority, the ACGME has the potential to serve as a constructive force for reform of graduate medical education by better aligning accreditation standards with desired medical education outcomes (5, 6). This paper describes a new outcomes-based model for residency program accreditation in internal medicine initiated by the ACGME's Residency Review Committee for Internal Medicine (RRC-IM).

The RRC-IM's Long-Range Planning Committee (LRPC) was asked to perform a "blue sky" examination of residency program accreditation in internal medicine, taking up the ACGME charge to make the system more outcomes based (that is, focused on trainee clinical competence) (5). In response, the LRPC developed a new accreditation model that is designed to serve as a long-range plan and template for advancing graduate medical education in internal medicine through reform of the accreditation process. Related goals included 1) enhancing the validity, reliability, and efficiency of the accreditation system; 2) encouraging continuous program improvement; and 3) stimulating educational innovation.

CURRENT APPROACH TO ACCREDITATION IN INTERNAL MEDICINE AND ITS SHORTCOMINGS

The current approach relies on documentation of compliance with an extensive list of requirements in such areas as facilities, faculty, teaching program, and methods of evaluation. There are nearly 400 specific requirements listed (15), and educational processes account for the vast majority. The only objective outcome measure is the 3-year rolling-average aggregate pass rate of program graduates on the American Board of Internal Medicine (ABIM) certification examination.

While substantive improvements have been made to this accreditation system (for example, use of standardized computer-based resident questionnaires and constant updating and revision of program requirements in close consultation with stakeholders), the system remains a largely passive process for the training programs, relying on periodic external audit. Shortcomings include extensive documentation that must be prepared by training program directors, hundreds of hours of review required annually by RRC members, little incentive for program directors to monitor key educational outcomes or to continuously improve educational programs between audits, and absence of comprehensive objective measurements of program effectiveness.

These limitations leave some program directors and reviewers questioning the value of the current accreditation process and others concerned about the accountability and societal responsiveness of our training system in internal medicine (12, 13).

TOWARD A NEW ACCREDITATION SYSTEM: BASING PROGRAM ACCREDITATION ON AGGREGATE CLINICAL COMPETENCE AND ESSENTIAL EDUCATIONAL AND CLINICAL INFRASTRUCTURES

The LRPC accreditation model shifts the focus of accreditation from intermittent external audit of educational

process to continuous internal monitoring and improvement of trainee clinical competence. In addition, the model specifies essential resident and patient care protections that foster a safe and effective training environment.

Rationale

The main reason for changing to a competency-based accreditation system is to better align the accreditation process with desired educational outcomes. By making clinical competence the principal basis for residency program accreditation—a high-stakes determination—the model redirects attention to and reinforces the primary educational mission. The existing accreditation system's concentration on educational process prompts the question of whether a program's compliance with current requirements ensures the graduation of skilled internists and enables differentiation between good-quality training programs and substandard ones (12, 13). An accreditation system that makes aggregate trainee clinical competence the prime basis for accreditation should enhance program accountability and provide a powerful stimulus to improve training. In addition, by emphasizing outcomes over process, the new model gives program directors considerably more freedom to innovate.

As important as aggregate clinical competence is for judging the educational effectiveness of a residency program, it is insufficient to ensure fundamental patient and trainee protections. Consequently, the proposed model specifies the inclusion of a limited set of patient care and educational infrastructure requirements that foster safe, well-functioning systems of care and training.

If this reform is to achieve the goal of continuous program improvement, the audit process associated with accreditation needs to become more continuous and internal to the program rather than infrequent and predominantly external. For this reason, the current review process of extensive documentation and periodic external audits for compliance with process requirements is largely replaced by regular ongoing internal (faculty) assessment of trainee clinical performance. Continuous program self-monitoring provides the opportunity for real-time feedback that can be applied both to improving an individual trainee's clinical performance and to strengthening the overall educational program. The alternative, a periodic external evaluation of trainee competence, while appealing for its potential objectivity and uniformity, cannot deliver the necessary information in timely fashion and would be very expensive and difficult to carry out without disrupting training and patient care.

Despite the emphasis on local assessment of trainee competence as the principal basis for accreditation, the model proposes a balanced approach to program evaluation that recognizes the need to have complementary external oversights and national performance standards. Included in the external oversight would be certification and audit of the local evaluation process. In addition, some

measures of clinical competence, such as assessment of medical knowledge and reasoning, will continue to be performed by external testing (for example, through the secured ABIM examination). Moreover, external peer review is retained in this model, relying on the RRC to examine all data and use its judgment to render the final accreditation decision.

An outcomes-based system will require time and much developmental work before it can be universally implemented; however, the LRPC views immediate pilot implementation as a desirable first step. On the basis of the model's potential to stimulate continuous program improvement, the LRPC has recommended that programs with a strong accreditation history be able to opt out of the current accreditation system in return for 1) achieving a higher minimum ABIM pass rate, 2) meeting a strengthened set of infrastructure standards, and 3) implementing a comprehensive (possibly home-grown) competency assessment program that includes critical review of evaluation methods and use of clinical performance data to continuously improve the teaching program.

Developing and implementing assessment methods and setting performance standards represent major undertakings that will require years of shared work and pooled resources. Although the RRC-IM has ultimate responsibility for setting aggregate trainee competency standards for program accreditation, its goal of fundamentally changing the accreditation system will need to be a collaborative process that solicits detailed input from all stakeholders (including the public). Working with stakeholders and using its accrediting authority, the RRC-IM can stimulate development and testing of clinical competency measures and help bring about a sound, acceptable, publically responsive outcomes-based accreditation system.

The Outcome Requirements: Mastery of Core Competencies

The proposed outcome measures are the clinical competencies that all residents should master by the end of their training. A set of such competencies has been identified through an ACGME initiative (5) and refined by stakeholders in internal medicine into a set of working definitions expressed in behavioral terms (Table 1) (16). The ABIM incorporated these 6 competencies into its resident evaluation forms (17), and the ACGME has asked all of its RRCs to begin making reference to the competencies in their program requirements (18). Performance standards for the competencies will need to be specified and might be stated in terms of outcome statements that define safe, patient-centered, efficient, effective, and appropriate care (similar to the Institute of Medicine's "Aims" [19]).

The Infrastructure Requirements: Essential Trainee and Patient Protections

Complementing the competency standards in this model would be requirements for institutional and program infrastructures essential to safe and effective educa-

Table 1. The Core Clinical Competencies for Internal Medicine*

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| <p>I. Patient care Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:</p> <ul style="list-style-type: none"> Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families Gather essential and accurate information about their patients Make informed decisions about diagnostic and therapeutic interventions on the basis of patient information and preferences, up-to-date scientific evidence, and clinical judgment Develop and carry out patient management plans Counsel and educate patients and their families Use information technology to support patient care decisions and patient education Perform competently all medical and invasive procedures considered essential for the area of practice Provide health care services aimed at preventing health problems or maintaining health Work with health care professionals, including those from other disciplines, to provide patient-focused care <p>II. Medical knowledge Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiologic and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:</p> <ul style="list-style-type: none"> Demonstrate an investigatory and analytic thinking approach to clinical situations Know and apply the basic and clinically supportive sciences that are appropriate to their discipline <p>III. Practice-based learning and improvement Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:</p> <ul style="list-style-type: none"> Analyze practice experience and perform practice-based improvement activities using a systematic methodology Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems Obtain and use information about their own population of patients and the larger population from which their patients are drawn Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness Use information technology to manage information, access online medical information, and support their own education Facilitate the learning of students and other health care professionals <p>IV. Interpersonal and communication skills Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families, and professional associates. Residents are expected to:</p> <ul style="list-style-type: none"> Create and sustain a therapeutic and ethically sound relationship with patients Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills Work effectively with others as a member or leader of a health care team or other professional group <p>V. Professionalism Residents must demonstrate a commitment to carrying out professional responsibilities, adhering to ethical principles, and being sensitive to a diverse patient population. Residents are expected to demonstrate:</p> <ul style="list-style-type: none"> Respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development A commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices Sensitivity and responsiveness to patients' culture, age, sex, and disabilities <p>VI. Systems-based practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:</p> <ul style="list-style-type: none"> Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources Practice cost-effective health care and resource allocation that does not compromise quality of care Advocate for quality patient care and assist patients in dealing with system complexities Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance |
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* As defined by internal medicine stakeholders (16).

tion and patient care. Examples of educational infrastructure requirements might include workload standards, duty-hour limits, faculty qualifications, and procedures ensuring regular evaluation and timely feedback. Requirements to ensure patient safety might encompass electronic medical records, order-entry and tracking systems, and well-organized and adequately staffed patient care teams.

Developing Measures of Clinical Competence and Setting Performance Standards

To successfully implement a competency-based model of program accreditation, it will be necessary to develop a

comprehensive set of clinical performance measures and establish minimum aggregate performance standards. Competency measures that can be aggregated and used to assess educational outcomes will be essential. Although internal medicine has a long history of assessment of clinical competence through the ABIM program (20), the newly expanded competency agenda will require additional methods of assessment and new national performance standards to encompass the wide range of requisite knowledge, skills, and behaviors. A variety of methods are currently used in internal medicine, some well validated and others not so

(21). A suggested “toolbox” of methods has been identified (Table 2) (22).

Several principles of performance measurement have emerged in recent years and can be suggested as guidelines to selection of assessment methods.

1. Medical knowledge and some forms of clinical judgment can be formally assessed through written and oral examinations.

2. Systematic evaluation of practice performance (through the measurement of medical outcomes, patient observations, and processes of care) can provide the basis for assessing practice-based performance and improvement.

3. The assessment of professionalism can be facilitated by use of “360-degree” evaluations and commentary by patients.

4. Clinical skills can be evaluated by direct expert observation or, in some instances (for example, communication), by use of specially trained laypersons.

Proposed assessment measures will need to be tested for reliability and validity and then vetted for practicality before they can be deemed appropriate for use in accreditation. The vetting process for competency measures should include a review of the supporting scientific evidence and an assessment by stakeholders of the practicality and cost-effectiveness of implementation across the full spectrum of internal medicine training programs. To this end, it might be useful to convene an annual forum that brings together all relevant parties for review of work in progress and for discussion of the best ways to pool and leverage available resources for future work.

Setting aggregate trainee competency standards for program accreditation will require and benefit from detailed input from stakeholders. The basis for a minimum standard of clinical competence should be a combination of professional expectation and public protection, and the minimum standard at the completion of residency training should be the same as the standard for competency of an internist in practice.

Setting and Assessing the Infrastructure Requirements

These tasks can be accomplished through consensus development followed by documentation and verification by site visit. As with competency standards, specifying the infrastructure requirements will require considerable input from the stakeholder community, which should include representation from trainees and the public as well as from sponsoring institutions and program directors. The incorporation of emerging patient safety standards and methods will need to be an important component of these infrastructure requirements, as will key elements of systems-based practice. Compliance will probably require documentation confirmed by site visit. Collaborating with other accrediting bodies, particularly the Joint Commission on Accreditation of Healthcare Organizations, in setting standards and monitoring for compliance should help save documentation time and site visit expenses.

Table 2. Competency Evaluation Methods for Residency Training: The “Toolbox”*

Medical knowledge

- ABIM Certification Examination (outcome measure)
- ACP In-Training Examination
- NBME Subject Examination
- Chart Stimulated Recall Oral Examination
- Standardized oral examination

Professionalism

- Faculty global assessment
- Patient survey
- Peer evaluations
- Nurse evaluations
- 360-degree evaluations
- Electronic professionalism challenge simulation
- Portfolio of personal challenges to professionalism
- Attitude evaluation and values clarification assessment

Interpersonal skills and communication

- Faculty global assessment
- Patient survey
- Peer evaluations
- Nurse evaluations
- 360-degree evaluations
- Electronic “patient” simulations
- Observed structured clinical examinations
- Standardized patient examination

Patient care

- Faculty global assessment
- Peer evaluations
- Nurse evaluations
- Patient survey
- 360-degree evaluations
- “One-minute observations”
- Mini-CEX
- Observed structured clinical examinations
- Electronic “patient” simulations
- Chart Stimulated Recall Oral Examinations
- Patient care log (patient registry)
- Record review
- Practice improvement modules

Practice-based learning and improvement

- Faculty global evaluations
- Patient improvement modules
- Health system or professional society “physician report cards”
- Portfolios
- Record review
- Outcome of quality improvement projects
- Electronic log of clinical questions searches
- Satisfaction survey of microsystem members
- Practice improvement module

Systems-based practice

- Faculty global assessment
- Nurse evaluations
- Peer evaluations
- Patient survey
- 360-degree evaluation
- Portfolios
- Record review
- Quality improvement exercise

* ABIM = American Board of Internal Medicine; ACP = American College of Physicians; CEX = clinical evaluation exercise; NBME = National Board of Medical Examiners.

Transitioning to the New System

The transition to an outcomes-based system need not wait until a full set of clinical competency measures and standards is developed and validated. The ACGME has already asked all RRCs to include elementary competency

assessment requirements in new updates of program requirements (18), and the LRPC is recommending that the RRC-IM invite programs with an exceptional accreditation record to pilot the new system during the developmental phase. Programs invited to participate would be judged largely on their ability to implement a competency-based evaluation system and use it to improve training rather than to demonstrate a particular level of aggregate clinical performance. During this transitional period, the criteria for “substantial compliance” for accreditation might include 1) use of surveys of patients, nurses, and other health care team professionals for evaluation of professionalism, systems-based practice, communications, and interpersonal skills; 2) use of peer assessments and measurements of outcomes of care for evaluation of professionalism and patient care; 3) development of clearly stated performance expectations for each level of training and regular use of formative evaluations based on these expectations; and 4) use of such assessments in a standardized, uniformly applied, and regularly appraised manner to improve the educational program and the performance of individual residents.

Later, as performance measures mature and performance standards are established, accreditation judgments would increasingly involve consideration of aggregate trainee clinical competence and performance. Benchmarking with other institutions or professional societies would be expected of participating programs, as would incremental adoption of evolving evaluation methods.

Universal Implementation of the Model

Once aggregate measures and standards of trainee clinical competence are developed, validated, and deemed appropriate for widespread implementation, the outcomes-based accreditation system would replace the old one for all internal medicine residency training programs. The infrastructure requirements identified in the transition phase would supplant the old “process” requirements, and most might be incorporated into the ACGME’s institutional requirements for all training programs at a participating training institution, eliminating the need for each individual training program to address them in its accreditation application. The performance standards that proved valid and practical during the transitional phase would initially be used, but over time, it is expected that the RRC-IM would raise the standards as educational methods improve. Benchmarking and comparing evaluation data between programs would continue to ensure that standards for medical competence are free from significant local and regional variations.

To ensure the validity and integrity of the local clinical performance and competency assessment, the LRPC model proposes that each program designate an evaluation coordinator accountable to the sponsoring institution’s graduate medical education committee and to the RRC-IM of the ACGME. The ACGME (perhaps in conjunction with certifying or licensing authorities) would be responsible for

training each local evaluator and providing periodic performance evaluation as well as opportunities for professional education and interaction with other local evaluators regionally and nationally. As part of this process, the ACGME would specify and promote best practices for competency evaluation. Qualifications for the evaluation coordinator would be set by the RRC-IM of the ACGME and should include clinical expertise and knowledge of clinical performance measurement. If also interested in performing individual competency assessment for certification or licensure, the evaluator will need to meet accountability standards that extend to the ABIM, American Board of Medical Specialties, and state licensing board. Collectively, such individuals might form a national assessment cadre with responsibility for the development and uniform local application of standardized, reliable, and valid methods for evaluation of clinical performance and competence.

Measures to ensure the independence and integrity of the internal competency assessment would need to be considered and might include external salary support and certification from the ACGME (as well as from any participating certifying and licensing boards) and periodic external auditing of the evaluation process and its results. The effort could be modeled after or be an extension of the ABIM Clinical Competence Evaluation program that systematically collects, monitors, and visits programs to determine the adequacy of their evaluation process (20).

Compliance with infrastructure requirements would be determined by documentation and confirmed by site visit, optimally integrated with other institutional accreditation activities to minimize the administrative burden on the training program.

DISCUSSION

Our model makes aggregate trainee clinical competence the principal basis for residency program accreditation in internal medicine. Program accountability and stimulus for continuous improvement derive from ongoing assay of clinical performance, complemented by attention to essential trainee and patient care protections. The model attempts to make accreditation less irksome by eliminating the vast majority of existing program requirements that specify clinical rotations, learning experiences, and curriculum content—areas viewed by some as overly burdensome, lacking validation, and discouraging of innovation—but retaining and emphasizing the importance of those infrastructures that define safe, well-functioning systems of education and patient care.

A major decision in designing this model was to keep most of the clinical competence evaluation local and internal to the residency program, rather than dependent on an external assessment mechanism. This is consistent with the principal goal of stimulating continuous program improvement through ongoing faculty monitoring of trainee performance. Nonetheless, to ensure the independence and

integrity of this high-stakes assessment, national performance standards will be required, as will an oversight system that includes certification of a local evaluation coordinator and periodic auditing of the clinical performance assessment. In addition, the final accreditation decision will still rest with the RRC-IM through its peer review of assessment data and site-visit findings.

Another important feature of our accreditation model is its emphasis on critical trainee and patient protections. An outcomes-only system of accreditation might overlook such protections and the infrastructures needed to support them. Our model is designed to ensure that training takes place in settings that are respectful of residents' needs and capable of delivering patient care efficiently, effectively, and safely.

A major barrier to implementation of this model is the relatively primitive state of clinical performance–clinical competence evaluation. The need to develop and validate evaluation methods is great, especially in the less traditional areas such as practice-based learning and systems-based practice. This will require collaboration among the RRC-IM of the ACGME; stakeholders; and other accrediting, certifying, and licensing bodies. The substantial resources necessary to develop and implement a competency-based system mandate the pooling of resources, both financial and technical. The synergies realized should help offset the associated costs and facilitate the transition to an outcomes-based system. For example, use of the ABIM competency evaluations for individual trainees, currently performed by faculty for board certification, could be aggregated to provide an initial assessment of program effectiveness.

The funding for development, testing, and implementation of the requisite competency assessment methods should be viewed as a shared responsibility of the profession and the public, with participation by all relevant parties, including health care institutions, payers (both public and private), liability insurers, and professional organizations, especially those responsible for accrediting, certifying, or licensing physicians. Assessment and enhancement of clinical competence is a shared interest of all these groups. The expenses related to developing and implementing a competency assessment program are a legitimate cost of doing business in health care, since the intended outcome is a safer, more effective medical care system.

Although this initiative is ambitious and likely to take years to be fully consummated, it need not wait for competency assessment methods to be perfected, especially in programs with a strong accreditation history and expertise in evaluating clinical competence. Enabling such programs to pilot an outcomes-based model of accreditation is essential to identifying best practices and to stimulating innovation and improvement of training programs. A cornerstone of this accreditation reform is the continuous improvement of training and educational outcomes through ongoing monitoring of aggregate trainee competence; it need not

wait for final validation and full vetting of competency measures.

Possible Effects on Residency Education

Freed of requirements for specific rotations and tightly prescribed divisions of curricular time, program directors are likely to design a host of newly configured training programs. New methods of teaching and evaluation should emerge from research into strategies that produce the greatest improvements in clinical competence and performance measurement. Data-driven evaluation systems that can provide meaningful assessments of clinical competence will be greatly valued, as will collective efforts to identify and disseminate “best practices.” Over time, it is expected that these efforts will lead to a rise in accreditation standards, improvements in training and clinical performance, and better identification of qualified training programs.

Several possible unintended consequences deserve mention. Demands on faculty time are likely to increase in parallel with requirements for enhanced teaching and assessment of clinical competence. These demands will probably trigger renewed tensions within training institutions as to how Medicare dollars for direct and indirect medical education are distributed. Programs that cannot marshal the necessary resources might have a difficult time implementing the proposed model and qualifying for accreditation. The RRC-IM may need to develop a suggested budget for competency-based training in internal medicine to empower program directors in their negotiations with training institutions, similar to a previous budgetary guideline initiative from the RRC-IM (23).

Another possibly adverse consequence might be deterioration in the breadth of clinical experiences and a predominance of service over teaching brought on by the elimination of specific curriculum and teaching program requirements. General internal medicine programs might also be tempted to “specialize,” violating their generalist mission. Clinical performance standards will have to be written very carefully, as will the ABIM examination, to provide programs with strong incentives to maintain a full spectrum of clinical and educational offerings.

Possible Effects on Patient Care

By specifying essential patient protections and effective systems of care as requirements for training program accreditation, the new model should be a stimulus for improvements in patient care. A spur in demand for necessary infrastructure improvements, such as electronic health records and order-entry tracking, is likely in settings where residents will be working. Sites that lack the essential infrastructures will have to consider upgrading to maintain their accreditation for training. Those who previously qualified for accreditation but cannot afford to make the necessary investments in patient and resident protections may try to roll back the reforms or prevent them from occurring, arguing that they are invalid or unfair. A considerable

amount of lead time will be necessary in implementing the new infrastructure standards.

By expanding the accreditation agenda to include measurement of competence in systems-based practice and in practice-based learning, the proposed model should also encourage better integration of the educational program with the sponsoring institution's system of care. Specifically, the requirements should result in greater participation of the program leadership in the strategic and operational planning of the sponsoring institution and in measurement and improvement of its educational and patient care systems. The priority given to development of competence in systems-based practice and in practice-based learning and improvement will require that sites for residency training be models of such activity. Training under this model should produce clinicians who recognize the interdependence of all components of the delivery system and develop the requisite management skills and approaches to systems-based care.

Possible Effects on Board Certification and Licensure

A competency assessment system for program accreditation could be used for board certification and state licensure, enabling trainees and programs to realize considerable savings in time and cost. Operational synergies could be achieved, scarce resources pooled, and duplication minimized. Moreover, the public would benefit from a more robust assessment of clinical competence because the effort is likely to improve training, raise performance standards, and ultimately produce more competent physicians. The heightened importance of competency assessment has already spurred changes in Step 2 of the U.S. Medical Licensing Examination, which now includes independent assessment of interviewing and communication skills (24).

On the downside, the very high-stakes nature of the local competency assessment could bring considerable pressure to bear on the local evaluation coordinator, who might be subjected to charges of favoritism or incompetence if a candidate fails to achieve certification or licensure. Such pressures might discourage the best-qualified persons from assuming this very important role. Indemnification and even immunity from lawsuits will need to be considered.

For maintenance of certification and licensure, the competency-assessment approach to accreditation also provides synergistic opportunities. The American Board of Medical Specialties Maintenance of Certification program now requires that boards base recertification programs on evidence of continuing competence in the 6 core competencies specified by the ACGME (25, 26). Although state boards do not currently have a specified competency focus for relicensure of all physicians, they do have interest in assessment of competence for physicians who are brought to their attention (27). Their interest in competency assessment makes them potentially important future partners. A

unified periodic competency assessment serving multiple purposes could emerge.

The raising of standards runs the risk of unintentionally jeopardizing access to care, especially in areas that are underserved or in practices that are financially tenuous. While loss of licensure or certification has not been a major problem for internists, the time and expense necessary to prepare are potential sources of legitimate concern. Attention to practical, affordable, educationally sound methods of monitoring performance and testing knowledge will be essential.

Possible Effects on Continuing Medical Education

If accreditation, board certification, maintenance of certification, and licensure become competency based, then continuing medical education (CME) activities that rely heavily on passive learning are likely to be replaced by methods that result in demonstrated improvements in competence. Already there is discussion of crediting CME activity for maintenance of certification only if enhanced competence from the CME activity is demonstrated, not simply for participating (28). This change could initially drive up costs and disrupt existing CME programs, but it promises to tighten the link between CME and clinical outcomes. The focus on competencies is also likely to make CME a more continuous process with more emphasis on self-assessment and continuous improvement and less on attending traditional lecture courses.

Conclusion

By proposing a competency-based, outcomes-focused accreditation system for internal medicine residencies, the RRC-IM ultimately seeks to strengthen graduate training in internal medicine and improve patient care. The proposed change should enhance program accountability and stimulate continuous improvement of training. Much work needs to be done. It is time for pilot efforts to begin.

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