Evaluation of Behavioral Medicine Curriculum

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Background

The residency has 24 residents with 2 Clinical Psychologists on faculty with part-time teaching responsibilities.

Behavioral Medicine teaching is delivered by:

•Didactic lectures 2x/month
•Brief wellness activities 1x/week
•Block of "Essentials" 1x/year per class
•4-week Family Stress Clinic rotation iPGY-2
•Intern Lunch 1x/week
•Practice Inquiry (addresses cases of clinical uncertainty) every-other-week
•Collaborative care consultation and support at point of care.

The curriculum had been growing and changing incrementally over the past 5 years, but in a piecemeal fashion. We felt it was time to step back, look at the overall curriculum, and evaluate whether it was meeting the educational needs of the residents.

Objective

Evaluate the current curriculum for teaching Behavioral Medicine knowledge, attitudes, and skills. Identify what the faculty and residents see as the most valuable aspects of our curriculum, which aspects should be eliminated, and what areas are being missed or inadequately addressed.

Methods

- Reviewed ACGME requirements and the new Milestones.
- Prepared list of all current Behavioral Medicine educational activities. Organized into four aspects for evaluation purposes:
  - Family Stress Clinic PGY-2 rotation
  - Didactics
  - Exposure to Integrated Care
  - Professionalism, Self-care and Resiliency
- During a retreat of the Family Medicine faculty and residents, divided participants into four groups to evaluate the four aspects of the curriculum by answering:
  - What elements should we keep as is?
  - What elements should we adjust? How so?
  - What element should we eliminate?
  - What elements should we add? (What is missing?)

Results

- Overall, the curriculum was judged to be effective and well organized.
- The faculty appreciated learning about the curriculum as a whole.
- Residents appreciated being consulted on the curriculum.
- No consensus on eliminating any components. Several specific and useful suggestions for improvements:

"We need a talk on eating disorders."

"Psychopharmacology lectures have not been helpful; too much nitty-gritty about meds we will not use."

"It would be nice to have a repository of talks on video."

"Family Stress rotation should be 6 weeks instead of 4."

"Catherine Casey has a great lecture on talking to patients at different ages."

"We need training in conflict resolution."

"Faculty need to learn more about Motivational Interviewing so they can support the residents better."

"Can we learn a CBT intervention for rumination? "I just worry all the time" is a very common complaint."

"Some wellness activities seem silly."

"Joint resident-behaviorist intervention is nice idea, but not feasible."

"Don't waste time teaching what can easily be looked up."

"We need to know how to find appropriate community referrals quickly."

Future Plans

➢Experiment with presenting more disorder-based teaching: combining in one lecture the basics of the disorder, screening tools, medical treatment, and when to refer out.

➢Ask Family Medicine faculty (rather than specialists) to present psychopharmacology lectures. Or give specialists more direction about learning needs of FM residents.

➢Establish weekly inpatient psychosocial rounds.

➢Invite physician faculty to see patients in front of Family Stress Clinic mirror for consultation on behavior change or other psychosocial intervention, observed by resident on rotation.

➢In the coming year, review the curriculum again from the perspective of the Milestones. Are we providing sufficient educational support for residents to achieve each milestone? What opportunities do we have for observation and evaluation in our current activities?

References

ACGME Program Requirements for Graduate Medical Education in Family Medicine (July 2007).

The Family Medicine Milestone Project (September 2013)