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An Interactive Ambulatory Nephrology Curriculum for Internal Medicine Interns: Design, Implementation, and Participant Feedback

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Abstract

While diminishing nephrology fellow recruitment is a known issue, more work is needed to evaluate possible interventions to reverse this trend. We designed and implemented a curriculum to increase exposure to ambulatory nephrology among internal medicine interns. The curriculum focused on key aspects of outpatient nephrology practice including supervised clinic visits, formal themed didactic content, and an online interactive forum with assigned evidence-based readings and small-group responses to relevant cases. We obtained post-course surveys from all participating interns. Of the 43 interns who took part in the first year of the ambulatory nephrology curriculum, 100% of interns reported a positive didactic experience and 91% reported a positive interactive online experience. 77% reported an improvement in their familiarity with clinical nephrology practice (median 2 point increase in familiarity score on a 7-point scale, $p < 0.001$ by signed-rank testing). Qualitative feedback included praise for the high yield topics covered by the lectures and energizing teachers. In conclusion, we successfully implemented an ambulatory nephrology curriculum using a framework that integrated formal didactics, interactive online learning, and key clinical components of outpatient nephrology care. Future investigation will evaluate if early implementation of this curriculum is associated with increased pursuit of nephrology as a career.

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Index words

Nephrology fellow recruitment; nephrology curriculum; nephrology teaching; medical teaching; ambulatory nephrology; outpatient nephrology practice; formal didactics; interactive online learning; internal medicine residency; renal medicine; medical education

There has been a declining interest in nephrology among United States medical graduates since 2002 (1–3). Over half of fellowship programs and over one third of total positions were unfilled in the academic year beginning in 2016 (2). Simultaneously, the total number of nephrology programs has remained relatively stable over the past five academic years (2,4). This waning appeal of nephrology as a career choice may be particularly problematic because data suggest that the demand for nephrologists will increase in coming decades (3) due to a growing prevalence of chronic kidney disease (CKD) (5,6), a larger number of patients requiring dialysis (5), and a concomitant decline in the mortality rate of dialysis patients (5). Further work is needed in the academic nephrology community to engage students and residents early in their clinical rotations and, in particular, to improve internal medicine residents' perceptions of clinical nephrology.

Dissatisfaction with nephrology teaching among medical students and residents likely plays an important role in waning interest in nephrology as a career. Medical students surveyed about pre-clinical renal pathophysiology courses often indicate that they perceive the material to be uninteresting, irrelevant, or overly complicated (7,8). Specifically, medical students criticize that courses are often taught by non-clinicians, using overly confusing approaches to the subject area in the absence of clear clinical correlations (9). This perception of an exceptional level of complexity continues into residency. When asked about reasons for choosing alternative fields, graduating residents cited anxiety related to electrolyte management as well as negative perceptions surrounding dialysis (10). Among fellows in other specialties, almost one third stated that nephrology was the most difficult physiology course in medical school, and almost a quarter stated they would have considered nephrology fellowship if they felt they had been better taught during either medical school or residency (10).

Additionally, resident exposure to nephrology is typically skewed towards inpatient care, where the majority of teaching takes place at the bedside by nonnephrologist internists. Most residents primarily care for highly morbid patients with acute kidney injury and patients on dialysis who become acutely ill (11). Thus, residents' clinical nephrology experience tends to represent a subset of patients with greater medical and social complexity who endure graver outcomes than the broader scope of patients under nephrologists' care. Residents have limited exposure to more common issues such as evaluation of proteinuria, management of diseases of bone and mineral metabolism, and management of complex hypertension (11). Typically, internal medicine residents' exposure to ambulatory nephrologic issues takes place in their primary care clinics, in the absence of formal teaching by a nephrologist. As a result, the perceived complexity of nephrology persists not only into, but throughout residency.

Since a significant part of the perceived difficulty of nephrology seems to be due to excessively complex or irrelevant didactics and skewed clinical experiences, we aimed to design and implement a required nephrology experience for interns early during their residency that would more directly address these issues. We implemented a multifaceted ambulatory nephrology module that aimed to provide residents with exposure to ambulatory topics in nephrology often underrepresented in inpatient medicine and to increase overall comfort with nephrology through organized exposure to these topics. Additionally, we systematically evaluated intern feedback to assess the impact of the module on perceived familiarity with nephrology and satisfaction with the quality and relevance of the didactics, and to facilitate ongoing improvements to the curriculum. Our overarching goal was to create a reproducible nephrology curriculum that would help to elucidate the utility, approachability, and appeal of ambulatory nephrology to internal medicine interns, and to ultimately attenuate the nationwide trend of declining nephrology fellow recruitment.

NEPHROLOGY CURRICULUM DESIGN

The module took place over an eight week period, consisting of four consecutive two-week blocks. The curriculum consisted of three major components, including 1) inperson themed didactic content, 2) subspecialty clinic experiences, and 3) an interactive online forum (Fig 1). The didactic content was comprised of a series of core lectures on topics relevant to ambulatory nephrology. These topics included CKD management in the primary care setting, introduction to chronic dialysis patient care, case-based approach to electrolyte and acid-base disorders, management of difficult-to-control hypertension, initial evaluation of nephrotic and nephritic syndromes, and fundamentals of posttransplant care. Each of the lectures were provided by nephrologists in the Renal- Electrolyte and Hypertension Division at the University of Pennsylvania, with a focus on recruiting lecturers who had previously received accolades for their teaching abilities. The lectures were provided to the entire cohort of interns during three dedicated half-day didactic periods throughout the ambulatory block, with lecture time dispersed between nephrology and primary care (see Item S1, provided as online supplementary material, for an example of an intern schedule during the ambulatory block). Twelve nephrology faculty members rotated in delivering the nephrology lectures based on availability, each dedicating approximately two to six hours of lecture time over the course of the eight weeks, with the course director delivering a greater proportion of lectures. Four renal fellows also expressed a desire to take part in order to gain experience in medical education. They were each mentored by a faculty member and delivered a lecture during the latter half of the eight-week course. All lecturers were encouraged to perform casebased “chalk-talks” in preference to slide-based presentations in order to promote intern participation, avoid monotony, as well as limit excessive faculty preparation time.

The subspecialty clinics were intended to expose interns to varied experiences in general and subspecialized outpatient nephrology. Participants were assigned to a combination of CKD clinic, in-center hemodialysis rounds, home hemodialysis and peritoneal dialysis clinic, pre-transplant evaluation and post-transplant clinics, complex hypertension clinic, glomerular disease clinic, and stone clinic. Each intern took part in four to eight half-day nephrology clinics during the two week period, interspersed with their continuity clinics (with variation in the number of clinics occurring due to inpatient emergency coverage, licensing exams,

residency program requirements such as simulation center training, and making up rescheduled continuity clinics due to similar prior conflicts). Available nephrology faculty members provided their clinic schedules to the course director. Scheduling was performed in close coordination with the Department of Medicine, with the intention to provide interns with a variety of exposures as well as some attending continuity. Depending on the clinic workflow and individual comfort level, interns either shadowed or worked closely under a nephrologist's supervision. Whenever possible, interns were assigned to work with the same attending two weeks in a row to help foster potential mentorship relationships. In certain cases, interns were also assigned to fellows' clinics, where a dedicated teaching attending supervised 2–3 fellows. This environment provided a wide variety of patients and exposed the intern to both fellow and attending teaching.

The interactive online forum provided an opportunity for reviewing challenging cases and exchanging questions and ideas regarding an area of controversy in outpatient nephrology (Fig 2). Interns were divided into small groups, each consisting of 3–4 members. Each intern within a small group was assigned a different journal article related to the management of hypertension (eg. SPRINT (12), the 2014 Report from the Panel Members Appointed to the Eighth Joint National Committee (13), and the countering Minority View (14)). Online bulletin boards were created for each small group that were moderated a faculty member with expertise in clinical nephrology and epidemiology. Each intern was asked to post responses to two questions related to his/her reading assignment, which provided important information on the content of each article for the other members of the small group (see Item S2 for examples of the questions). Within the small groups, interns were then asked to discuss how they would approach the management of two relevant cases, using an adapted decision making tool for multimorbid patients (see Item S2 for the cases; the cases were developed and the tool was adapted in collaboration with the Geriatrics Division) (15). Interns were encouraged to try to come to a consensus as a small group, drawing from the information they had gained from the readings. At the end of each module, all of the small groups met together (along with the renal course director, the forum moderator, and a geriatrics faculty member) for an hour-long debate about the management of the cases and discussion of important points related to the readings.

NEPHROLOGY CURRICULUM IMPLEMENTATION

With the introduction of duty hour restrictions and emphasis on improved ambulatory training (16), many internal medicine residency programs have undertaken substantial scheduling changes (17–19), resulting in increased resident exposure to multispecialty outpatient care (18). The University of Pennsylvania internal medicine residency program recently adopted a 6+2 scheduling model. Interns' schedules are now templated such that they have 6 weeks of inpatient time, followed by two weeks of ambulatory time. The ambulatory time has been organized into themed blocks. As nephrology is relatively underrepresented in the clinical and didactic portions of the internal medicine training experience (i.e. prior to implementation of this module, <10% of internal medicine residents took part in the nephrology elective, while there were multiple mandatory rotations in cardiology, oncology, and pulmonology/critical care), we were able to work with the Department of Medicine to incorporate a two-week renal module into the intern curricular

framework. Other specialties that received similar dedicated two-week modules included rheumatology and endocrinology. All categorical interns participated in the renal module, which was repeated four times in succession to allow for standardized curriculum delivery to all four cohorts of interns.

POST-MODULE PARTICIPANT SURVEY

Survey Design

Surveys were distributed to all participants at the end of the module to obtain anonymous, detailed feedback regarding the different components of the curriculum and improvement in perceived nephrology knowledge (see Item S3 for the survey). The surveys used an ascending ordinal Likert scale (ranging from 1 to 7, indicating that “Not at all”=1, “Somewhat”=4, and “Very”=7) for numerical grading of each survey question, and allocated space for open-ended comments. A score of four or greater on the survey questions was determined to be positive or favorable (20). Questions specifically asked participants to indicate the degree to which each component of the module was an effective learning tool and would alter their future clinical practice. Participants were also asked to indicate their degree of familiarity with practicing clinical nephrology prior to and after taking part in the module. Descriptive statistics (median and proportions) were used to describe the results of the surveys (20).

Survey Results

All 43 categorical and primary care interns in the internal medicine residency program at the University of Pennsylvania participated in the ambulatory renal module and submitted a post-course survey. Eight of the interns noted on the surveys that they missed a portion of the module. Reasons for interrupted participation in the module included urgent inpatient service coverage, absence to take a licensing examination, and assignment to extra resident continuity clinics based on predetermined scheduling requirements.

The overall median score for the course was 6 (on a 7-point scale; interquartile range [IQR] 5–6.5), with a median score of 6 for the didactic and online components, and 5 for the clinical components (Table 1). 100% of interns reported a positive didactic experience (score 4), 88% reported a positive clinic experience, and 91% reported a positive interactive online experience. When asked about their familiarity with clinical nephrology prior to and after partaking in the module, 77% reported an improvement in their familiarity with clinical nephrology practice (median 2 point increase in familiarity score across the entire group, $p<0.001$ by Wilcoxon signed-rank testing of within-individual differences (21); analysis performed using STATA version 13.0). Median self-reported post-module familiarity with clinical nephrology among individuals who did *not* report an improvement in familiarity was 5 (IQR 5-6), compared to 6 (IQR 5-6) among individuals who did report an improvement in familiarity.

Qualitative feedback included substantially more positive comments ($n=11$) than negative comments ($n=4$; see Table 2 for specific comments). General positive comments included praise for way the module was organized, the energetic nature of the teaching, and the

quality of the content. The didactic component was lauded for the high yield topics, individual attendings were singled out for their contributions to teaching in the clinics, and the readings and online discussion were remarked upon favorably. Constructive comments included that the material was not relevant to one of the participants' interests, that one of the clinics was composed of "looking at creatinines without much discussion/explanation," and that the required reading and online discussion were too "burdensome."

STRENGTHS AND LIMITATIONS OF THE CURRICULUM

Our ambulatory nephrology curriculum integrated formal didactics, outpatient clinic experiences, and an online interactive forum in an attempt to improve internal medicine residents' perceptions of nephrology and to enhance their proficiency in the clinical care of renal patients. Analyses of post-course surveys demonstrated that 77% of participants felt more familiar with clinical nephrology at the conclusion of the module. Qualitative feedback was largely positive, including appreciation for the organization of the course and the enthusiasm of the teachers in the didactic sessions and outpatient clinics. While there were some criticisms identifying didactic material as irrelevant, clinic as monotonous, and the assignment load as excessive (i.e. one article as assigned reading, two questions, and an online discussion), these negative comments were limited in number. The critiques will be used to identify areas for improvement. Specifically, we plan to add more wide-ranging outpatient experiences (to achieve this, we will introduce a small-group primer in home hemodialysis clinic for all participants during a scheduled clinic block). We also plan to expand the time allotted for in-person discussion of the interactive online forum to 90 minutes. These sessions generally resulted in a lively discussion that was cut short by lack of time. In addition, by shifting some of the synthesis and application of knowledge to this session, we hope to make the assignment less onerous for interns who are taking licensing exams or diverted to cover inpatient services.

We anticipate that this intervention will be an important contribution to ongoing efforts to increase interest in nephrology. Recognizing the crisis of declining interest in nephrology against a backdrop of expanding need, the American Society of Nephrology created a task force in 2010 dedicated to increasing interest in nephrology careers. Among their recommendations were directives to develop educational rotations focusing on overlooked areas in nephrology such as hypertension, and to develop strategies to increase interest in nephrology (3). These directives have resulted in significant efforts to improve nephrology electives and mentorship for medical students and residents. For example, the Hofstra North-Shore Long Island Jewish School of Medicine expanded its nephrology elective to include broader exposure to both inpatient and outpatient services. The Hofstra program found that residents participating in the new elective were more likely to indicate interest in pursuing nephrology as a career (22). Nonetheless, programs based on optional electives are often limited in their scope to participants who already have some underlying interest in nephrology. Institutional implementation of innovative outpatient curricula that are integrated into residents' schedules can help to disseminate important and relevant knowledge of topics in nephrology to a broader audience. Among programs where a structured, mandatory ambulatory curriculum is not an option, interventions that may similarly foster resident interest in nephrology include integration of primary care-focused

renal didactics into the primary care continuity clinics and greater emphasis on ambulatory exposure during nephrology electives (23).

Our intervention has a number of limitations. Implementation of the curriculum was restricted to a single residency program that already made largescale changes to residents' schedules, facilitating greater emphasis on ambulatory subspecialty education. Although ambulatory blocks are increasingly common in internal medicine residencies (17–19), introduction of a similar curriculum may not be generalizable to programs that lack outpatient block scheduling. Furthermore, assessment of the success of the curriculum was restricted to cross-sectional surveys from participating interns; our outcomes were limited to assessing interns' self-reported satisfaction with the curriculum and the feasibility of its implementation. Based on limitations of these surveys, we were unable to draw conclusions about changes in intern attitudes towards nephrology as a career following completion of the curriculum or if the interns had an objective improvement in nephrology-associated medical knowledge. Another major limitation is the absence of a control group for comparison (i.e. a group of interns who took part in a structured inpatient curriculum, a combined inpatient and outpatient experience (23), or no nephrology curriculum), which would better elucidate the importance of ambulatory exposure in improving interns' perception of nephrology. The absence of a control group renders our experience as hypothesis-generating, rather than a source from which to draw definitive conclusions about the effectiveness of the ambulatory nephrology curriculum. Future work will include longitudinal follow up to determine if the module improves resident performance on nephrology components of internal medicine in-service examinations. Additionally, we will perform before-and-after assessments of changes in resident perception of nephrology as a career as a result of taking part in the module, and will collect data to assess if taking part in the module increases resident recruitment into nephrology fellowship. We also plan to introduce similar clinically relevant and evidence based medicine themes into the medical student nephrology course, with a goal of improving perceptions of nephrology prior to reaching clinical rotations.

In conclusion, we successfully designed and implemented an ambulatory nephrology curriculum using a framework that combined didactic lectures, an interactive online forum with assigned evidence-based readings and case discussions, and coordinated exposure to nephrology outpatient clinics. Interns reported a high degree of satisfaction with the module, including improvement in familiarity with clinical nephrology. Nationally, residents' perceptions of nephrology seem to be negatively skewed by overly complex medical school physiology courses and unfavorable, poorly representative inpatient experiences. Early exposure to ambulatory nephrology can have an important impact on residents' views and understanding of nephrology, which may enhance residents' perceptions of nephrology as a career choice. As residency programs make changes to address the need for broader outpatient exposures, nephrology programs will benefit from working to formally integrate ambulatory nephrology as a fundamental component of intern education.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1. Intern Ambulatory Nephrology Curriculum: Detailed Components of the Curriculum Design

Figure 2. Implementation of the Interactive Online Forum

Abbreviations: SPRINT, Systolic Blood Pressure Intervention Trial; JNC8, Eighth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Assigned readings comprise SPRINT article,¹² JNC-8,¹³ and the minority view.¹⁴

Table 1

Median survey scores for each component of the intern ambulatory nephrology curriculum

Survey Item	Median Score (IQR)
Didactics effective	6 (6-7)
Didactics likely to alter practice	6 (6-7)
Clinical experience effective	5 (5-6)
Clinical experience likely to alter practice	5 (5-6)
Interactive forum effective	6 (4-6)
Interactive forum likely to alter practice	6 (5-6)
Familiarity with clinical nephrology prior to the module	4 (4-5)
Familiarity with clinical nephrology after the module	6 (5-6)

The survey scale is 1-7, where 7 is the most favorable score. IQR: Interquartile range

Table 2

Qualitative feedback from interns on the components of the intern ambulatory nephrology curriculum and overall experience

	Positive	Negative
General	Really great module - good medical content throughout	Not very (entirely) applicable to my interests
	Better approach than previous ambulatory blocks	
	Best module of the year! Thanks for being such excellent and energizing teachers	
	Very good module - well organized, well thought out, laid back yet extremely educational	
Didactics	Transplant lecture was excellent!	
	I wish the lectures had been recorded	
	Overall good high yield topics	
Clinic	Very much enjoyed clinic w[ith] Dr. [name] and Dr. [name]	Lots of follow up visits looking at creatinines without much discussion/explanation
	Dr. [name] is an incredible teacher	
Online	I really enjoyed the SPRINT/JNC-8 discussions	Burdensome project. Discussions can be without required documentation
	I thought the readings and discussions were great	It was difficult to do homework during this block when many of us were studying for Step 3

Abbreviations: SPRINT, Systolic Blood Pressure Intervention Trial; JNC8, Eighth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure