Re-Envisioning Family Medicine Residency Education: From Theory to Practice

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(J Am Board Fam Med 2021;34:1268–1271.)

In 2022, the Accreditation Council for Graduate Medical Education (ACGME) will announce the first major revision of requirements for family medicine residency education in more than a decade. The new requirements will be of critical importance, coming as they do at a time of enormous change in health and health care, and because they will determine skills and knowledge of a generation of family physicians. It is not hyperbole to say they will determine the future of our discipline and thereby will shape the future of health care well into the middle of the 21st century.

Over the past 18 months, the community of family medicine has engaged in an unprecedented conversation to recommend content for the new requirements: over 3500 Diplomates, residency faculty, residents, and members of the public have participated in focus groups, surveys, and a national summit held in December 2020.[1] Thirty-five peer-reviewed articles from this process were published in *Family Medicine*[2] in July. Six weeks out, these articles already have had more than 18,000 page views: 30 times the second-most widely read issue of *Family Medicine*. Clearly, our community is engaged!

So where are we now? The spotlight has shifted to the ACGME writing group, which will publish draft standards later this fall. It is time for the community to focus our thinking: of the many ideas floated over the last year, which are most important? The purpose of this editorial is to describe, in a spirit of dialog with the community, ABFM's initial priorities for the new residency requirements.

The premise of all this work is that we as a specialty must respond to the needs of society. We believe that American health care is in crisis: despite the Affordable Care Act, despite promising innovations in technology and practice, US life expectancy[3] and population outcomes are worsening compared with other industrialized countries[4] even as cost of care continues to increase dramatically. And this was the case even before COVID shone a spotlight on shameful disparities and on the failure of our nation to recognize the essential foundation of primary care.[5] The American Board of Family Medicine (ABFM) believes that well-trained comprehensive personal physicians are part of the solution.

ABFM believes that our residency model needs updating. In the 1970s, family medicine brought residency education out of hospitals and implemented curricular objectives to prepare residents for their future practices, including training in comprehensive primary care, behavioral health, and practice management. Since then, however, our patients have changed, health care has changed, and society has changed: we need to adapt. To be sure, the core functions of primary care illuminated by Barbara Starfield remain foundational, but how we achieve them and what we emphasize must be fundamentally different.[6]

A first step is reinvigorating a key innovation from when our residency programs first started: recognizing that the residency practice is itself a major part of the curriculum. Residents learn by doing, and what they learn in residency they do over many years. Unfortunately, surveys of residents and faculty conducted in advance of the summit suggested that most family medicine residents

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Conflict of interest: The authors are employees of the American Board of Family Medicine.

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do not have patient panels and do not receive feedback on access, quality of care, referrals, or cost of care.[1] ABFM believes that panels are foundational for managing population health, and they provide the denominator for ongoing measurement of access, quality, and cost of care. In particular, *access to care* (including recent developments such as widespread use of telehealth) is critical to practice value and viability. Access measured by time to third open appointment should be maintained at less than 10 days for a physical examination. *Continuity of care* is also vital, and when measured from the patient perspective as usual provider continuity should be greater than 50% for individual residents and higher for clinical teams. Of course, developing office systems for empanelment, access, and continuity is challenging and often hindered by suboptimal electronic health records. Even so, the I^3 Collaborative has demonstrated that a modified advanced access approach can create substantial improvement in both access and continuity in family medicine residencies.[7]

Another priority of family medicine residencies should be training for *comprehensiveness*: taking care of the whole person. Traditionally, this means both *breadth* of scope, across the continuum of care, and also *depth* of expertise so that most questions related to common diseases can be answered by a family physician and not referred out. The residency summit reaffirmed the specialty's commitment to training for breadth of scope. The question for ABFM becomes how much experience is necessary to achieve not only competence but also confidence.[8] ABFM believes that it must be more than "exposure": family physicians should be unafraid of sick patients, able to recognize and to treat them. But comprehensiveness also means depth of knowledge. Here again the residency practice is the curriculum. The survey of residents and faculty suggest that there is currently little organized review of referrals and referral rate, and the I^3 Collaborative documented dramatic variation in the rate of referrals.[7] ABFM believes that family physicians should not be trained as "referralists," and the new residency guidelines should set a standard for review of appropriateness and rate of referrals to other doctors.

In addition, meaningful involvement in a systematic approach to behavioral health[9] and medication-assisted treatment must be closely integrated into the residency practice, and the practice and its faculty should model meaningful quality improvement, with robust processes leading to meaningful improvements. More broadly, the innovative areas of concentration highlighted by 4 year residencies suggest that residents can achieve mastery in focused areas such as primary care HIV, emergency department care, or maternity care that will be helpful to communities the residents will serve in the future.[10]

We must also train Diplomates to be responsive to and competent in *addressing community needs*. As argued by Wheat,[11] this is more than an occasional experience in a health department sexually transmitted infection clinic! Of course, what is possible and appropriate will vary from community to community. ABFM believes that what is needed is breadth of experience along with involvement with a sustained project. Perhaps most important is learning the right attitude: the willingness to "lean in" along with both commitment and humility to work with partners to solve problems that matter. This will require faculty modeling and mentoring by community partners.

Where does *formal competency assessment* fit in? This is a big deal, and it represents much more than the Clinical Competency Committee (CCC) discussing informally whether or not a resident is competent on a specific milestone. As Holmboe points out,[12] competency-based medical education has been around since the 1970s, but how to systematically assess competency of family medicine residents is unclear. Given the breadth of our clinical practice, a first step will be to systematically sample across what we do to identify a manageable set of competencies. Then, we will need to develop and implement specific assessments and track competency over the residency. This will, in turn, need a functional data system. Importantly, we must not make it so complex as to cause the process to collapse under its own weight.

Implementing competency-based residency education will also require dedicated faculty time for education.[13] Developing our capacity for competency-based education will need systematic attention and creativity by our community of educators in the Society of Teachers of Family Medicine, Association of Departments of Family Medicine (ADFM), and Association of Family Medicine Residency Directors (AFMRD). The critical constraint is the need for faculty development and skills so the specialty can begin to pilot assessments, share findings, and develop

consensus about how the specialty will routinely assess competence across the continuum of care. Skill building in this area should be in addition to routine development of faculty skills such as giving feedback and planning curricula and evaluation. Fortunately, we already have made a start toward this in that our specialty has already developed assessments in a variety of areas, such as AV reviews, chart reviews, and pharmacy audits, that can be repurposed to support competency-based assessment.

ABFM also believes that the national system of residency education needs catalysts for both major *innovation* and better *standardization*.[14] Given the dramatic changes in health and health care, the case for major innovation in both clinical care and education is clear. At the same time, with the rapid increase in number of new family medicine residencies, it is critical that we keep our commitment to the American people that graduates are able to do what we promise. ABFM believes that a robust system of competency-based graduate medical educations will support standardization, while emphasizing the practice as the curriculum and engaging with communities will push innovation, including further experimentation with robust areas of concentration and extended duration of residency training.

While meeting the needs of society must be our priority, it is also important to consider the future of the specialty. The enormous expansion of family medicine residencies taking place now requires talented faculty who lead clinical practices that are broad in scope, cutting edge, and competitive, and who are also willing to nurture others.[15,16] Similarly, family medicine residencies should plant the seeds for the researchers we desperately need by engendering clinical curiosity, requiring training critical appraisal of evidence, and supporting scholarly experiences.[17] Finally, family medicine needs to support development of the future leaders of communities, health care systems, and medical schools.[18] Being intentional about how we accomplish these goals is important: residencies can provide foundational experience for future leaders across all missions.

Going from theory to practice is hard but exhilarating. ABFM is confident in the clinical and educational creativity of our specialty, and we along with the ABFM Foundation are committed to working with our sister organizations—the American Academy of Family Physicians, American College of Osteopathic Family Physicians, ADFM, AFMRD, North American Primary Care Research Group, and their members to shape the future of family medicine residency education. The future of our residencies is the future of the specialty.

To see this article online, please go to: http://jabfm.org/content/34/6/1268.full.

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