Re-Envisioning Family Medicine Residencies: The End in Mind

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Over the last year, Family Medicine has engaged in a robust dialog about what society needs from the family physicians of the future, and what the implications are for Family Medicine residency education.[1] A national summit to give recommendations for the major revision of Family Medicine residency requirements was held on December 6 to 7, 2020 and the articles are being revised for publication in a dedicated issue of *Family Medicine*. As this article comes out, the Accreditation Council of Graduate Medical Education (ACGME) Family Medicine writing group is beginning to draft new standards for residencies. The process will take a year or more, with iterative review at many levels by the ACGME, the specialty and the public.

In any curricular change, it is important to start with the end in mind. What does the American Board of Family Medicine (ABFM), as one of the stakeholders, want to get out of the major revision of the residency requirements major revision process? As most understand, the ACGME accredits residencies, whereas the ABFM certifies individuals. The 2 organizations are independent but work closely together. ABFM generally accepts as Board eligible those who have completed a Family Medicine residency. As a result, the ABFM is keenly interested in improving residency education, having supported 2 national trials in residency innovation[2,3] and worked closely with the ACGME Family Medicine Review Committee to reduce disparities in knowledge assessment.[4]

ABFM believes that American health and health care are at a critical junction. Despite 15 years of "innovation and transformation" and health care reform, life expectancy is now dropping,[5] and there are major emerging clinical and health care problems.[1,6] Family physicians represent the most numerous and widespread of personal physicians[7]: ABFM's major emphasis is thus assuring that family physicians leave residencies equipped to address these problems and lead the changes society needs in health and health care.

Innovation and Standardization

We take the long view. Reform in health care and health education will not be overnight: we must construct a system of Family Medicine residency education across the country that will more successfully and continually adapt to the needs of society and improve outcomes of care and education while preserving the enduring core of knowledge, skills, and attitudes essential to practice of Family Medicine. To that end, a major question residency redesign faces is the balance of innovation and standardization. Over the past 20 years, our specialty has put a great deal of emphasis on innovation, with at least 5 substantial regional or national trials of innovation in curriculum and in practice—in chronological order, the I^3 Collaborative,[8–11] the P4 Collaborative,[2] Residency Performance Index,[12] the Length of Training trial,[3] the Colorado Patient Centered Medical Home (PCMH) Initiative[13,14]

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and now the ongoing Clinic First/Family Medicine Innovation in Continuity Clinical Experience (FM NICCE) ongoing trial.[15] These experiments have yielded many articles and many national presentations. They reveal a specialty passionately interested in education and in new ways of educating and taking care of patients.

On the other side of the balance is standardization. We make a promise to society that our graduates can do what we say they can do—and what society needs. To this end, ABFM has heard occasional anecdotal reports of employers of new graduates who say, for example, I've just hired one of "your" graduates and he/she cannot manage adults with Attention Deficit and Hyperactivity Disorder (ADHD) (or any number of other conditions). More systematically, the ACGME milestones[16,17] suggest that large numbers of Family Medicine residents may not be reaching proficiency by the end of residency in many milestones.

So, at this point in time, do we emphasize innovation or standardization? ABFM believes that this is a "both/and" issue. Our specialty and health care itself need both innovation and improved standardization. Innovation will come from Program Directors and institutions if we give them enough flexibility and support evaluation and dissemination. Standardization can be helped by thoughtful implementation of competency-based evaluation and further definition and elaboration of Entrustable Professional Activities for Family Medicine.[18] Our program directors and residency faculty are key to our future: we need to develop them, unleash their skills—and trust them.

How should the specialty and the ACGME drive both innovation and standardization? One important tool is the ACGME milestones, which debuted in 2015 and were revised in 2020. Milestones represent a tremendous advance, both in framing a developmental approach to residency education and providing a national standard for the natural history of that development. Our specialty has done a good job at implementing them—avoiding the temptation to "straight line" evaluations—but rather truly stating where residents are in their progress toward proficiency. National aggregate results are now available online.[19] These national data are a gift to the specialty and should spark discussion about how we should move forward. It is on us to ask the questions, learn the lessons, and spread change.

Another key tool is residencies' required ongoing efforts to improve their educational and clinical programs. As Carek[20] has articulated, the current Family Medicine Standards have this expectation, but there may be variability in how well this is done. In addition, over the last decade, the ACGME has developed a new, integrated process for monitoring residencies, monitoring key parameters from annual data submissions, and combining this with surveys of residents and faculty, with relatively fewer site visits. How effective is this relatively new oversight system? We look for the ACGME to evaluate the new system and report publicly. More broadly, we must improve the overall social accountability of the Graduate Medical Education (GME) training system. As Kaufmann and many others have argued,[21,22] the Medicare GME system began more than 50 years ago and has supported remarkable growth and development in the system of training physicians. Now, however, as improvement of health falters and cost continues to increase, we must ask whether the overall system is meeting the changing needs of society. ABFM believes that both which residencies are offered by sponsoring institutions, and the content of the residency education itself must better respond to the needs of communities and society, while continuing to insist on clinical and educational excellence.

Little progress can come without better outcome measures. The milestones, for all their potential, focus on outcomes during residency as do many studies of residency curriculum. As with clinical care, however, ongoing improvements of residency education need to consider longer term outcomes, such as where residents practice, clinical performance in initial jobs, and patient evaluations. One important tool is the ABFM graduate survey[23] administered to family physicians 3 years after residency. The survey has a good response rate and provides excellent data on what graduates are doing 3 years after graduation. We look forward to working with AFMRD and others to better identify high performing residencies and to begin to use longer term outcomes to drive curricular change.

In summary, ABFM supports new residency standards which will catalyze both innovation and better standardization in Family Medicine residency education. We will work with all the clinical and educational organizations of the family—the American Academy of Family Physicians (AAFP), American Board of Family Medicine (AFMRD), Association of Departments of Family Medicine (ADFM), Society of Teachers of Family Medicine (STFM), North American Primary Care Research Organization

(NAPCRG), and the American College of Osteopathic Family Physicians (ACOFP)—to promote excellence in residency education. We stand ready to use our standard setting role to support clinical excellence and responsiveness to the needs of society. And, finally, ABFM and its Foundation also commit to support a new national trial of innovation and dissemination of best practices under the new residency standards.

To see this article online, please go to: http://jabfm.org/content/34/1/246.full.

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