# Special Communication

## Success Strategies For Departments Of Family Medicine

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***Abstract:*** **Strong departments of family medicine in academic medical centers help assure the future scope and quality of family practice patient care, the ongoing evolution of family medicine as a scholarly discipline, and a continued flow of qualified medical school graduates into family practice residency programs and eventually into practice. This report presents key strategies of six successful departments of family medicine and describes the methods and skills considered important by the leaders of these departments. Common themes that emerge are (1) recruit and mentor the best faculty, (2) build a reputation for clinical excellence of faculty and residents, (3) become part of schoolwide curriculum activities, (4) establish a scholarly presence, and (5) develop networks of support. (J Am Board Fam Pract 1991; 4:427-36.)**

The long-term success of family practice as a specialty will depend upon a steady supply of well-trained new practitioners to replace retirees and to meet the growing needs of the American public. There are currently 389 accredited graduate family practice training programs in the United States that provide broad-based training for family physicians.[1] These residency training programs require more than 2400 medical school graduates yearly to maintain the flow of family physicians into the community. The first-year residents come largely from medical schools accredited by the Liaison Committee for Medical Education (LCME), and the faculty and curriculum have a profound influence on student specialty choice.

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Medical schools are well known to be a subspecializing influence, with departments of family medicine running counter to this tendency. Schools in which there are no departments of family medicine have a much lower percentage of students entering family medicine than schools at which our specialty has a strong presence. In fact, if departments and divisions of family medicine were to disappear tomorrow from US medical schools, the supply of medical school graduates entering the specialty of family practice would almost certainly fall and might approach the levels found in the early 1960s. Thus, our specialty's future rests upon a foundation of strong departments of family medicine in LCME-accredited medical schools.

How do we measure the success of a department of family medicine? Figure 1 presents one model. A new department of family medicine must fight for survival during its early years and battle for initial acceptance, both of which are usually based upon competent patient care, including skillful consultation and referral. The next step involves accomplishments of the department that represent contributions to the school, often through clinical service or predoctoral teaching. Integration into the medical school comes when the department of family medicine is represented on or leads important decision-mak-



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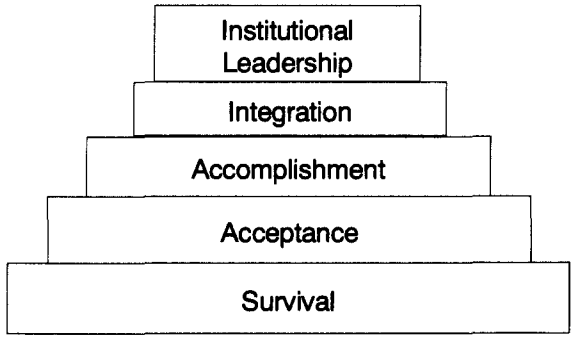


**Figure 1. Some measures of departmental success.**

ing bodies, such as task forces, committees, and faculty councils. Some departments are reaching the point of institutional leadership, with senior faculty moving into deanships and with productive patient care services, research programs, and predoctoral clerkships firmly in place.

Specific measures of departmental success (which contribute to the above) might be the number and quality of students selecting careers in family practice, the presence of family medicine in the predoctoral curriculum, the extent of the family practice service in the university hospital, the number of publications in peer-reviewed literature, and the promotion and tenure of departmental faculty.

Today, as if a (relatively) new specialty serving an academic counterculture role did not face enough challenges, a new problem is emerging. More than one-half of all chairs of family medicine departments plan to vacate their positions within 5 years.[2] New leaders must be identified, and the involved university departments will undergo the metamorphosis that generally accompanies the arrival of a new chair. This urgent need for new leadership in academic medical centers—in the face of budget constraints and declining student interest in family practice (and other primary care) careers—makes the study of successful departments both pertinent and timely. This report is intended to identify strategies of strong departments of family medicine and the skills that are needed to make these strategies successful.

## Methods

In preparation for a presentation at the 1991 meeting of the Association of Departments of Family Medicine, the first author (Robert Taylor) selected six departments that have exhibited success in one or more of the six strategies listed in Table 1.

These departments were not selected by consensus, nor are they necessarily the "six best" in the nation; they are intended to serve as exemplars of useful strategies.

The chairs of these departments were asked to discuss briefly their accomplishments in these areas and describe the methods used to achieve success. These six separate contributions were edited to minimize differences in style.

## Strategies

### *Area of Excellence*

The Department of Family and Community Medicine at the University of Missouri–Columbia School of Medicine has developed an area of excellence in research. Currently the department has research projects in several important areas, has more than $3 million in research and training grant funding, and ranks second only to the Department of Medicine in grant activities. A review of factors leading to these achievements includes the following:

#### *Development of Commitment*

The departmental commitment to research evolved during the 1970s as a result of numerous faculty retreats that were designed to develop long-term goals for the department. These goals included placing a balanced emphasis on each of the legs of the three-legged "academic stool" of education, research, and patient care. The research goal was not easily accepted because of faculty fear that research might dilute efforts in education and patient care.

#### *Recruitment of Faculty with Methodological Expertise*

A strong academic program in family medicine is dependent upon having faculty with methodological expertise in the basic sciences of the

**Table 1. Strategies for Departments of Family Medicine.**

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| 1. Develop an area of excellence |
| 2. Seek a leading role in patient care |
| 3. Participate in school-wide curriculum development |
| 4. Build strategic alliances |
| 5. Institutionalize the department |
| 6. Plan for the future of the department |



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discipline, i.e., the behavioral sciences and clinical epidemiology. The department was initiated by integrating a strong academic behavioral sciences group who had expertise in medical sociology with a group in family practice. These faculty were later complemented by additional faculty who had expertise in clinical epidemiology and in health services research. Thus, almost serendipitously the department had methodological expertise upon which to expand subsequent programs.

*Creation of an Intellectual Milieu to Stimulate Research*

Significant research programs are most likely to develop in a milieu in which many persons are committed to research activities. At the University of Missouri, the intellectual milieu was fostered first through the Robert Wood Johnson Faculty Fellowship Program and more recently through a faculty fellowship program supported by the National Research Service Award (NRSA) and the Health Resources and Services Administration (HRSA). The presence of trainees created a priority within the department to address scholarly issues, which was complemented by weekly research seminars that were begun in the mid-1970s and have continued to the present time. These seminars provide a forum to discuss research ideas, to offer research designs for critique, to present finished research, and to review presentations to be made at national meetings.

*Commitment by the Chairman to Provide Adequate Faculty Time for Research*

Faculty members with 10 to 20 percent research time frequently complete small research projects but rarely are able to compete successfully for funded research. The department found that a faculty member provided with a time-limited 40 to 60 percent commitment to research was successful in obtaining necessary research funding. Similar opportunities for other faculty have now been created. Persons for whom such commitments are made must be carefully selected, must have a true research commitment, and must be able to identify important and researchable problems.

*Strategic Funding Opportunities*

The department must recognize strategic funding opportunities to implement the program. What are national priorities? What unique databases or research opportunities are available?

Administratively, a basic principle used by the chairman has been that programmatic dollars be utilized to fund education and to catalyze development of funded research. Time spent in patient care and in research should ultimately fund itself.

Despite its success, departmental efforts in research still do not equal those in education and patient care. The goal is only partly achieved. The department's research record at the University of Missouri–Columbia is paralleled in other institutions. In each case, many of the above steps are likely to have occurred. Frequently, as occurred at Missouri, a planned program is facilitated by serendipitous opportunities, such as unexpectedly available faculty candidates who have specific expertise, available fellowship program funding, and funding opportunities in areas of faculty interest.

***Patient Care***

The University of California at Los Angeles (UCLA) Division of Family Medicine has developed a financially successful patient care organization within the environment of a tertiary care academic medical center. The Family Health Center, the ambulatory care facility of the Division of Family Medicine, has undergone tremendous growth in the last decade. In 1979, the center, situated adjacent to the university, was a small storefront operation that provided care for approximately 8000 patients. In the past academic year, the center has become an integral part of the new UCLA Medical Plaza on the medical campus and will generate 32,000 patient visits and more than $2 million in revenue. It has become the busiest ambulatory facility on campus, accounting for 1 out of every 12 patients who come to the UCLA Medical Center. The success of this enterprise has been a direct result of the changing environment in which health care is delivered at UCLA.

*Changing Trends in Health Care Delivery*

The current trend toward managed health care and health care contracting has posed significant problems for academic medical centers. Steeped in the tradition of scholarly endeavor, these institutions have found it difficult to respond to a system that places a premium on high-quality, cost-effective medical care. In fact, the issues of



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service, availability, and responsiveness to patient needs—fundamental values of family physicians—are difficult for most faculty who are committed to laboratory research and to the instruction of medical students. Academic medical centers are unable to provide competitive health care under these circumstances, and a clinical vacuum has been created in which administrators struggle to maintain the competitiveness of their institutions in the medical marketplace.

*Filling the Vacuum*

This dilemma created a leadership opportunity for the Division of Family Medicine to develop a clinical service that would expand the primary care base and increase the competitiveness of the UCLA Medical Center. The hospital director was enlisted to support financially the growth of the Family Health Center by convincing him that the expansion of the primary care base would enhance the financial status of the institution owing to the multiplier effect of primary care health dollars.[3,4]

With financial support guaranteed, short- and long-range strategies were developed. These strategies included delegation of practice management to a faculty member with management expertise, development of referral personnel who hold similar philosophies about patient care, attraction of a major managed care contract, and development of a management team that could respond in an efficient fashion to opportunities in the medical marketplace. The most important element was the commitment of faculty to treat patients, to provide empathic care, and to be available to see patients on an immediate basis.

*Integration of Educational Activities*

Equally important, however, was the development of mechanisms that would incorporate medical student and resident education into a busy clinical practice without affecting profitability of the clinic. This integration has been accomplished by distributing resident practice hours equally throughout the week, creating unique faculty-resident-nursing teams, and assigning students to faculty practices. The integration of residents and students into contractual and managed care arrangements has given them an excellent opportunity to experience the delivery of cost-effective care within a framework that they will encounter in the future as they move into community practice.

***Curriculum Development***

At the University of New Mexico, the Department of Family Medicine has been integral in developing a series of curricular changes over nearly 15 years. The first step was departmental community-oriented teaching of family medicine at sites outside the medical school; these sites included a rescue mission, congregate living centers for the elderly, and even a revitalized ghost town that had been sold by a mining company. Students identified health problems in the community and were involved in tutorial sessions using group process to seek solutions.

The next step in curricular change was a school-wide experience in medical education: the primary care curriculum.[5] This curriculum is a separate track in which tutorial teaching methods and patient cases are used to teach basic and clinical sciences in an integrated fashion rather than in a series of longitudinal block courses with a lecture format. The initial primary care curriculum experiment was offered during the first 2 years of medical school.[6]

The third step in curriculum change was a series of clinical experiences using the same learning concepts experienced during the clinical years. Longitudinal experiences in primary care settings used tutorial teaching and identification of learning issues in both the basic and clinical sciences during the 3rd and 4th years of medical school. A current departmental self-study review of the curriculum for both the traditional and nontraditional tracks is underway, and efforts are being made to integrate the types of learning between the two current tracks. There will also be a greater emphasis on teaching in the ambulatory care setting.

The following paragraphs describe how change has been achieved at New Mexico:

*Interdisciplinary Cooperation*

New programs housed in a department can be perceived as development of a further power base. Involving many disciplines in the planning and operation of a curricular element provides each department with ownership and greatly facilitates cooperative interactions. The Department of



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Family Medicine is heavily involved in the primary care curriculum at the University of New Mexico, but this curriculum is technically administered through the Dean's office. In this manner, support from all basic science and appropriate clinical departments has been enlisted. Family medicine has received appropriate recognition for its high level of activity and energy in the development of this program.

*Involving the Skeptics*

A curricular change is likely to make medical school faculty uncomfortable, and it certainly disrupts the status quo. Consequently, the first proposal of the primary care curriculum drew opposition from many traditional faculty. Inviting these persons to participate in planning often serves to change attitudes. Such an approach was taken, and several of the faculty who were originally most skeptical have made significant contributions and even career-changing decisions to participate in this experimental program. Some have become the most dynamic spokespersons on behalf of the primary care curriculum.

*Development of "How To" Books and Manuals*

An essential part of the program was a series of books, manuals, workshops, and individual consultations developed to facilitate new teaching methods. The primary care curriculum required extensive retraining of faculty members to make them familiar with the tutorial process.

*Infiltrating the Infrastructure*

At New Mexico, the infiltration of the curriculum committees has been so complete that currently almost all members of the established curriculum committee participate in the various new types of curriculum activities.

*Networking*

The primary care curriculum has been widely described in the literature and at medical meetings.[7,8] Linkages with other medical educators in more than 30 countries have led to the formation of an international consortium of schools with interests in this type of curriculum.

***Strategic Alliances***

Building strategic alliances that can advance the department has been a key strategy in the evolution of the Department of Family Medicine at the Medical College of Virginia. Close ongoing relationships with the Virginia Farm Bureau Federation and legislative members interested in health care issues have been extremely helpful to this department in focusing attention on continued public health care needs in Virginia.

There are natural alliances between departments of family medicine and citizens' groups, legislators, governmental administrators, and health-related public bodies. These alliances are based upon public need for the reasonably priced services of the family physician in a health care system where costs are rising faster than personal incomes, corporate profits, and government revenues.[9] One such alliance has been formed with the Virginia Academy of Family Physicians (VAFP). Whereas the department faculty have been constrained to live within the academic medical center and not be seen to be at odds with the university, a close alliance with the VAFP has allowed the organization to provide information to the public that has kept the issues of rural physician shortages alive over time.

*Identifying Advocates*

Who are the advocate citizen groups? The question might be phrased: Who needs family physicians? The answer includes rural people, suburban people, medically indigent people, and those living in primary health manpower shortage areas.

Groups that are vitally interested include farm bureau federations, rural legislators (especially those on finance, budget, higher education, and health committees), staff of government bodies concerned with health and budgets, municipal leagues, retail merchants, family practice professional groups, medical societies, and senior administrative leaders in academic health science centers. For example, on one occasion, the continued expenditure of state funds for family practice residency training was called into question by a legislator from a small (population 100,000) city. The Department of Family Medicine immediately contacted the Virginia Farm Bureau Federation, which in turn alerted their members in the three rural counties in that legislator's district, who in turn contacted the legislator. They informed the legislator that family practice residency training funds were essential to ensure an



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ongoing supply of family physicians for those counties. The inquiry was abruptly stopped.

To influence medical education, citizens need to have data pertinent to their needs. These data include the logistics of health care in the community; for example, 96 percent of patients cared for in the community practice setting have their problems managed without consultation, referral, or hospitalization.[10,11] Potential supporters also need to know current data that track the performance of medical schools, the departments of family practice, and other primary care training programs (e.g., general internal medicine and pediatrics) in meeting the public need for primary care physicians.

*Building Relationships*

How can family practice departments form alliances with influential groups to meet public need effectively? Since the inception of the Department of Family Medicine at the Medical College of Virginia 20 years ago, the information described above has been provided annually to Virginia public interest groups. The building of these coalitions is best facilitated by personal contact between family physicians practicing in the community and key members of these public interest groups who receive their health care from these family physicians. Through personal dialogue, these public groups have been able to influence strategic health care policy, planning, and implementation.

Relationships with key legislators on the budget and health committees have been established and are continually nurtured. In addition, before elections, the farm bureau holds regional meetings for legislative candidates; their policies include health issues and support for family practice residency programs. Graduates of these programs attend the meetings and answer questions concerning the family practice educational programs.

This networking has involved much time and personal commitment by the senior leadership within the department, who are convinced that without this effort, public need would not have been met, and the very existence of the department would have been in jeopardy.

***Institutionalization of the Department***

An important long-term strategy of any department of family medicine must be to integrate itself so thoroughly into the fabric of the institution that its absence would be unthinkable. Our specialty can no longer tolerate an academic medical center belief system that, in times of fiscal austerity, considers its department of family medicine to be expendable. Successful integration—attaining a leadership role in the institution—involves skillfully maneuvering the department from its initial survival at the time of establishment through the different hierarchical stages displayed in Figure 1.

The chair at the Department of Family Medicine at Baylor College of Medicine has started three departments of family medicine and has experienced the transition of attitudes from "resistance to the unknown" to the current state of support by administrators who now recognize the need for our discipline and the contributions we can make to teaching in the ambulatory setting. The use of the model office or family practice center for teaching, research, and patient care is one of our greatest strengths. It is our classroom for teaching the essentials of family practice and our laboratory for conducting research. It comes up short, however, as a realistic environment for modeling private practice when compared with a private family physician's office.

Attention to the following areas was essential in guiding these departments through their stages of evolution:

*Alliances*

Alliances with other departments help integrate the new department into the fabric of the medical school. These alliances can be accomplished by shared teaching duties for courses and through cooperative research by faculty. Faculty in other departments are exposed to family practice faculty and concepts, which build familiarity, trust, and respect.

*Committee Appointments*

Placing faculty on such key committees as curriculum, practice plan, and promotions not only gains access to areas of important policy decisions but also increases the contact between family medicine faculty and leaders in other departments. In these forums we can demonstrate that family practice standards are at least as rigorous as those of other departments and show that we plan to work as team players toward achieving ex-



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cellence and maintaining the standards of the institution.

*Curriculum*
The new department should design courses that either fill a void or expand those currently in the curriculum, such as offering courses in interviewing techniques, medical ethics, clinical problem solving, or physical diagnosis. At least one course should be offered in each of the 4 years, with those offered in the 1st and 3rd years being the most valuable.

*Student Interest*
Enlist the help of students by forming a family practice student interest group, such as a family practice club. Other student activities include DOC (Doctors Ought to Care), a student speakers bureau, and athletic activities—anything of interest to students that is not addressed by other departments or the administration.

*Community Involvement*
The department of family medicine needs a cadre of community-based clinical faculty who are respected family physicians. All of these physicians should be given clinical faculty appointments. Community physicians in other specialties who teach in family medicine should be given their primary appointment in the department of their specialty and then a secondary appointment in family medicine. This approach avoids the appointment of faculty in family medicine who are not acceptable to their own specialty colleagues.

*Publications*
There is no question that "publish or perish" is still true in academic medicine; scientific publications are necessary for promotion. Publications are a measure of scholarly activity and demonstrate the acceptance of new ideas by peers. Data collection and research are not always necessary if, in the judgment of peers, the ideas contribute new knowledge. It stands to reason, however, that the ideas should be pursued and validated using the scientific method. Reports of well-controlled research projects receive the greatest credit, whereas editorials and articles in nonpeer-reviewed publications receive the least.

*Funding for Research*
Funding from federal research grants (RO1s) are given the greatest academic credit, followed by other forms of peer-reviewed projects. Pharmaceutical grants rank near the bottom unless the project was designed by the investigator rather than the company. Private foundations, especially if they are local, are an excellent source of funding and are less bureaucratic.

***Planning for the Future***
One measure of a department's success is the legacy of vigor, momentum, and harmony that a retiring chair leaves to his or her successor. The Department of Family Medicine at the University of Washington School of Medicine has recently undergone such a change. In a sense, planning for the change has occurred over many years through careful selection and mentoring of faculty and by careful positioning of the department in the academic medical center. The following are some specific strategies identified by the former chair, who has recently stepped down from the chairmanship after 14 years in that capacity:

*Faculty Development and Recruitment*
A number of methods have helped build the talent and leadership potential of full-time faculty. One method emphasizes academic development within institutional criteria and expectations. The department assures at least 20 percent "academic time" for all faculty and uses sabbaticals for academic development. A faculty mentor system has been established for junior faculty, and there is careful matching of individual faculty strengths and interests to departmental roles, with annual reassessment and renegotiation of roles with the chairman. Specific preparation for the transition in leadership included appointment of a vice chairman to share responsibility with the chairman and a sabbatical leave for the chairman with the vice chairman serving as acting chair.

*Decentralization*
Decision making and governance are decentralized through a strong sectional infrastructure. Grants management and other chairman responsibilities are retained as appropriate central departmental governance. Established sections for



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undergraduate, graduate, and continuing medical education and research have empowered section heads in leadership roles. There is participative, consensus-based faculty decision making. The department encourages entrepreneurial activity of faculty in research and grant development within the scope of departmental missions and priorities.

*Collaborative Links*

Over 20 years the department has built a network of interactive linkages with the Washington State Academy of Family Physicians, the School of Public Health and Community Medicine, the Area Health Education Center (AHEC), the Department of Health, and others. There are also important linkages to other departments in the medical school and to community physicians. Development of these networks is a major time commitment of the chair, but it is considered to be well worth the effort.

*Medical School Mission*

The department has become indispensable to the mission of the medical school, particularly as the classic primary care discipline, in its roles in primary care education, in its interactive role with the community and region, and in its activities in rural health. The department has taken an active role in predoctoral teaching, in HMO (health maintenance organization) contracted patient care, and in collaborative links with the community through research and demonstration projects. It has received the facilitative support of successive deans and has gained institutional acceptance through demonstration of departmental clinical competence, teaching contributions, academic strengths, team player role, and high academic standards.

*Funding Support*

The department has become increasingly self-sufficient and in 1990 received only 37 percent of its support from the state. The balance of support comes through diverse grant sources, renegotiations within the institution for increased reimbursement for primary care services (e.g., HMO services), increased patient care activity, and building a departmental cash reserve to buffer against a temporary decrease in extramural funding.

*Facilitative Role of the Chairman*

The chairman has developed a facilitative leadership style, avoiding excessive chairman control. Hence, there is an emphasis on the diversity of faculty roles and teamwork within the department.[12] The chair has concentrated on moving forward on a small number of major long-range departmental agendas and been careful not to respond to all the stimuli and opportunities presented.

The transition in leadership was achieved in an orderly fashion; with the retiring chair in place, an early notice of the chairman's decision to step down provided for an orderly search process for the next chairman, with acting chairmanship for only 6 weeks. There was a successful transition of leadership to a highly qualified internal candidate. This transition was achieved through the 18-month lead time, timing of the decision based upon stability in the department, readiness of internal candidates, completion of most of the chairman's agenda, and a need for a new chapter of vision and energy in the next chairman.

## Discussion

What are the common themes that emerge?

*Recruit and Mentor the Best Faculty*

Petersdorf and Wilson[13] have written that "the recruitment and development of faculty may be the single most important function of the departmental chairman." Several contributors to this article spoke of the importance of recruitment and subsequent faculty development. Faculty diversity will be needed, and some faculty must be targeted early for leadership roles—receiving faculty development in administrative skills, being empowered to develop alliances and networks, and being prepared for transition into positions of greater responsibilities in the department. One technique is to send faculty applicants and new faculty members to meet with the dean and other key faculty. Another is to rotate chairmanship of departmental meetings.

*Build a Reputation for Clinical Excellence of Faculty and Residents*

Patient management is still the quintessential skill of clinical practice and the unique field of knowledge of family physicians.[14] Family physicians will earn—or lose—respect based upon their skills as



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clinicians. Simply stated, family physicians practicing in the university setting must be as competent in their area of specialization as surgeons or internists are in their areas. Success in many academic medical centers, such as UCLA, demonstrates that this goal can be reached. Patient care offers a particularly attractive opportunity for success for two reasons. The first is the growth of health maintenance organizations and capitated care, which many leaders in family medicine believe will have a salutary effect on family practice.[15] Also, in this time of fiscal austerity and decreasing federal research dollars, academic medical centers are becoming increasingly dependent upon patient care revenues.[16] These two factors are an open invitation for family medicine to build credibility by meeting the primary care patient needs of the academic medical center.

*Become Part of the Academic Curriculum Process*

Earlier we discussed the importance of the continuing flow of students selecting family practice as a career. This in turn depends upon the presence of strong role models and the credibility of family medicine offerings in the academic curriculum. Several of the departments discussed above described the importance and process of integrating medical education with clinical activity in the community and in the model family practice center. There are other opportunities. For example, Relman[17] states, "We don't teach enough of what might be called 'social medicine' to our students. We don't prepare them adequately to practice in the new social climate." Many departments have identified a biopsychosocial curricular need and filled it, leading to ongoing electives and sometimes required courses in family medicine.

*Establish a Scholarly Presence*

Family physicians in academic medical centers must view themselves as academicians; even those physicians on an explicit clinical track should engage in some scholarly activity. Evidence of scholarly activity—research reports published in refereed journals—is a requisite not only for academic credibility in the university setting, but also for eventual promotion. There is no way around this fact, and department chairs must begin early to foster research in their departments.

*Develop Networks of Support*

Building bridges within and outside the academic community allows colleagues to address sensitive issues on a nonconfrontational basis. Useful, but informal approaches involve socializing in the doctors' lunch room and at school functions, participating with spouses in faculty auxiliary events, and attending social events with key department heads and administrators. The success of such networking calls for special effort on the part of top departmental leadership. The responsibility, however, should not fall entirely upon the chair, because building these alliances is an important learning process for emerging leaders. The alliances themselves must be viewed as both facilitative (in achieving current goals) and protective (as insurance against disenfranchisement or encroachment by some other entity).

## Summary

The above discussion—descriptions of six departments, some strategies for which they are known, and the methods their leaders have used—has allowed us to discern a few common themes presented in the discussion. The American Academy of Family Physicians and other family practice organizations have long recognized the importance of strong departments of family medicine in medical schools, and the American Medical Association has recently resolved that all US medical schools should have departments of family medicine. The establishment and support of family medicine departments with vigorous leadership in every medical school in the United States is fundamental to the long-term success of family practice.

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# NOTICE

## *Reminder to Graduating Residents*

All residents applying for the July 10, 1992, American Board of Family Practice Certifying Examination must hold a valid, full and unrestricted license to practice medicine by May 1, 1992. Any resident who does not provide documentation of valid, full and unrestricted licensure by this date will not be eligible for the 1992 Certification Examination.



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