

PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION IN FAMILY PRACTICE
(Effective July 1, 2001)

I. Introduction

A. Duration of Training

Residencies in family practice must be 3 years in duration after graduation from medical school and must be planned so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.

B. Scope of Training

The programs must be specifically designed to meet the educational needs of medical school graduates intending to become family physicians and must provide experience and responsibility for the residents in those areas of medicine that will be of importance to their future practice. The goal of the family practice training program is to produce fully competent physicians capable of providing care of high quality to their patients.

Toward this end the residents must learn to gather essential and accurate information about the patient and use it together with up-to-date scientific evidence to make decisions about diagnostic and therapeutic intervention. They must learn to develop and carry out patient management plans.

Family practice residency programs should provide opportunity for the residents to learn, in both the hospital and ambulatory settings, those procedural skills that are within the scope of family practice.

The residency program must ensure that its residents, by the time they graduate, provide appropriate, effective, and compassionate clinical care. Residents are expected to gather essential and accurate information about the patient and use it together with up-to-date scientific evidence to make decisions about diagnostic and therapeutic interventions, develop and carry out patient management plans, provide health care services aimed at preventing health problems or maintaining health.

Residents must locate, appraise, and assimilate "best practices" related to their patients' health problems.

C. Clinical Care

The residency program must ensure that its residents, by the time they graduate, possess knowledge in established and evolving psycho-social biomedical and clinical science domains and apply it to clinical care. Residents are expected to demonstrate rigor in their thinking about clinical situations and to know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

Use of the computer to manage information, access on-line medical information, and support clinical care and patient education is required.

The residency program must ensure that its residents, by the time they graduate, demonstrate the fundamental qualities of professionalism. Residents are expected to

demonstrate respect, regard, and integrity and a responsiveness to the needs of patients and society that supercedes self-interest. They must assume responsibility and act responsibly, and demonstrate a commitment to excellence.

Residents must learn to apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

The residency program must ensure that its residents are aware that health care is provided in the context of a larger system and can effectively call on system resources to support the care of patients. Residents are expected to understand how their patient-care practices and related actions impact component units of the health care delivery system and the total delivery system, and how delivery systems impact provision of health care. They must be taught systems-based approaches for controlling health care costs and allocating resources and must learn to practice cost-effective health care and resource allocation that does not compromise quality of care.

Residents must learn how to advocate for quality patient care and assist patients in dealing with system complexities. They must be taught how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can impact system performance.

The presence of other programs sponsored by the residency, eg, geriatric medicine and/or sports medicine, must not result in significant dilution of the experience available to the family practice residents.

II. Institutional Organization

A. Sponsoring Institution

There must be one sponsoring institution for each residency, as mandated by the Institutional Requirements. This entity must be identified at the time of each review of the residency.

The sponsoring institution must ensure the existence and availability of those basic educational and patient care resources necessary to provide the family practice resident with meaningful involvement and responsibility in the required clinical specialties.

Since family practice programs are dependent in part on other specialties for the training of residents, the ability and commitment of the institution to fulfill these requirements must be documented. Instruction in the other specialties must be conducted by faculty with appropriate expertise. There must be agreement with specialists in other areas/services regarding the requirement that residents maintain concurrent commitment to their patients in the Family Practice Center (FPC) during these rotations.

B. Participating Institutions

When a residency relies on multiple institutions to provide curricular components, the arrangements between the program/primary site and each affiliated facility must be described in a written document that is signed by the appropriate administrators of the respective institutions. These arrangements must be specific to the family practice residency and must address the scope of the affiliation, the content and duration of the rotations involved, the duties and patient care responsibilities of the residents during these rotations and the details

of the supervision and resident evaluation that will be provided. These documents should be appended to the program information forms each time there is a site visit and review of the program.

Participation by an institution that provides more than 6 of the 36 months of training in the program must be approved by the Residency Review Committee (RRC).

A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director.

C. Appointment of Residents¹

Programs should appoint only those candidates who intend to complete the full program. As a general rule, programs should appoint residents to the first year of training and those accepted into the first year of training should be assured of a position for the full 3 years, barring the development of grounds for dismissal. A family practice program should endeavor not to function as a transitional year program.

To provide adequate peer interaction a program should offer at least 4 positions at each level and should retain, on average, a minimum complement of 12 residents. Except for periods of transition, the program should offer the same number of positions for each of the 3 years.

In certain cases, for urban or rural areas serving underserved communities, tracks may be approved that have a smaller resident complement but with at least one resident at the second and third levels or two residents at one of the levels to ensure peer interaction. In such cases, programs are encouraged to arrange opportunities for the residents to interact with other residents, eg, through didactic sessions at the parent program.

The degree of resident attrition and the presence of a critical mass of residents are factors that will be considered by the RRC in the evaluation of a program.

III. Faculty Qualifications and Responsibilities

The program director and teaching staff are responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation and advancement of residents and the maintenance of records related to program accreditation.

All members of the teaching staff must demonstrate a strong interest in the education of residents, sound clinical and teaching abilities, support of the goals and objectives of the program, a commitment to their own continuing medical education, and participation in scholarly activities.

A. Program Director

There must be a single program director responsible for the residency.

Continuity of leadership over a period of years is important to the stability of a residency program. Frequent changes in leadership or long periods of temporary leadership usually

¹Applicants who have had previous graduate training may be considered for admission to family practice residencies. Credit for this other training may be given only in the amount that is compatible with the Program Requirements for Residency Education in Family Practice. Directors should consult with the American Board of Family Practice on each case prior to making a determination regarding the equivalence of such training.

have an adverse effect on an educational program and will be cause for serious concern. The RRC must be notified promptly in writing of any change in the leadership of the program.

In order to provide continuity of leadership and to fulfill the administrative and teaching responsibilities inherent in achieving the educational goals of the program, the director must devote sufficient time to the residency program, ie, at least 1400 hours per year exclusive of time spent in direct patient care without the presence of residents. Where a program in the 1-2 format operates in conjunction with a three year program, there must be a separate rural site director.

1. Qualifications of the Program Director

The following are the requirements for the program director. An acting or interim director should be similarly qualified.

- a. Academic and professional qualifications: The director must have demonstrated ability as a teacher, clinician, and administrator; must be capable of administering the program in an effective manner; and must be actively involved in the care of patients. Prior to assuming this position, the program director must have had a minimum of 2 years full-time professional activity in family practice and should have had teaching experience in a family practice residency.
- b. Licensure: The director must be licensed to practice medicine in the state where the institution that sponsors the program is located. (Certain federal programs are exempted.)
- c. Certification requirements: The director must be currently certified by the American Board of Family Practice or have appropriate educational qualifications, as so judged by the RRC.
- d. Medical staff appointment: The director must hold an appointment in good standing to the medical staff of an institution participating in the program.

2. Responsibilities of the Program Director

The program director is responsible for the following:

- a. Written educational goals: The director must have responsibility for a written statement outlining the educational goals of the program. These must be provided in a document that outlines the specific knowledge, skills, and other attitudes expected of residents at each level of training and for each major rotation or other program assignment. The goals must be distributed to residents and teaching staff and should be available for review by the site visitor.
- b. Selection of residents: Residents for appointment to the program must be selected in accordance with institutional and departmental policies and procedures.
- c. Teaching staff and other program personnel: The director must have responsibility for selection and supervision of these staff members at each institution participating in the program.
- d. Supervision of residents: Institutional and program policies and procedures must ensure that all residents are adequately supervised in carrying out their patient care responsibilities. It is the responsibility of the program director and faculty to ensure that residents are appropriately supervised. Supervising policies of the residency should be consistent with those of the institution. They must be in writing and be

distributed to all members of the program staff.

Faculty schedules including their time on-call, must be structured to ensure that supervision is readily available to residents on duty.

- e. Resident evaluation: There must be regular and formal evaluation of residents with participation of the teaching staff.
- f. Discipline: The director has responsibility for the implementation of fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances.
- g. Resident well-being: The director must monitor resident stress, including mental or emotional conditions that inhibit performance or learning, and dysfunction related to drugs or alcohol. The director and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support service to residents. To promote physician well-being and prevent impairment, residents should be trained to balance personal and professional responsibilities in a way that can be reflected throughout their careers. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.
- h. Provision of accurate information: The director must submit accurate and complete information as requested by the RRC on the program information forms or in special communication as directed by the committee.
- i. Notification of change: The director must notify the RRC regarding major programmatic changes and obtain approval prior to their implementation.

B. Family Physician Faculty

The faculty must contain teachers with the diversified interests and expertise necessary to meet the training responsibilities of the program. There must be a sufficient number of hours contributed by a critical mass of family physician faculty to prevent fragmentation of the learning experience. Where part-time faculty are utilized, there must be evidence of sufficient continuity of teaching and supervision.

In addition to the program director, there must be at least one full-time equivalent (FTE) family physician faculty for each six residents in the program. By the time a program offers all three years of training with the required minimum number of resident positions, ie, 4-4-4, at least one of the additional Family Physician faculty should be full time. A full-time commitment is at least 1400 hours per year devoted to the residency, exclusive of time spent in direct patient care without the presence of residents. Any program in operation must have at least two family physician faculty members, including the director, regardless of resident complement.

The family physician faculty should have a specific time commitment to patient care to enable them to maintain their clinical skills. Some of the family physician teaching staff must see patients in the FPC to serve as role models for the residents. In addition, the program must have family physician faculty with admitting privileges in the hospital(s) where the FPC patients are hospitalized.

The family physician faculty must be currently certified by the American Board of Family Practice or must demonstrate appropriate educational qualifications, as so judged by the RRC. The RRC will determine the acceptability of alternate qualifications.

C. Other Faculty

Physicians in the other specialties must devote sufficient time to teaching and supervising the family practice residents and providing consultation to ensure that the program's goals for their specialty areas are accomplished.

Additional teaching staff will be needed to provide training in areas such as behavioral science, nutrition, and the use of drugs and their interaction.

D. Qualifications and Development of Faculty

All of the key members of the teaching staff in the program must demonstrate appropriate qualifications for their specialty areas, eg, certification by a member board of the American Board of Medical Specialties (ABMS) or appropriate educational qualifications for physician faculty, and appropriate credentials for the non-physician faculty. The RRC will determine the acceptability of alternate qualifications.

There must be an explicit system to develop and maintain academic and clinical skills of the faculty and to foster their continual professional growth and development.

IV. Facilities

A program must provide the facilities required for the education of residents in sufficient proximity to the primary hospital to allow for the efficient functioning of the educational program.

A. Primary and Affiliated Hospitals

1. Multiple Hospitals

If the primary facility is unable to provide all of the required experiences, additional facilities may be used. Such arrangements will be considered acceptable only if there is no compromise in the quality of the educational program and no significant reduction in attendance of residents at teaching sessions or of camaraderie and exchange of information among residents and with the faculty. These affiliated hospitals may not be at such a distance from the primary teaching sites that they require excessive travel time or otherwise fragment the educational experience.

2. Number of Beds

It is essential that the participating hospitals, primary and affiliated, be of sufficient size and have an adequate number of occupied teaching beds to ensure a sufficient patient load and variety of problems for the education of the number of residents and other learners on the services. Inpatient facilities must also provide adequate physical, human, and educational resources for training in family practice. In determining the adequacy of the number of occupied beds in the primary and affiliated hospitals, the patient census, the types of patients, and their availability for residency education will be considered.

3. Medical Staff

The medical staff should be organized so that family physician members may participate in appropriate hospital governance activities on a basis equivalent to that of members in other specialties. Where a hospital is departmentalized, there must be a clinical department of family practice.

B. Family Practice Center

1. Introduction

The primary setting for training in the knowledge, skills, and attitudes of family practice is the model office or FPC, where each resident must provide continuing, comprehensive care to a panel of patient families. The FPC must be for the exclusive use of the residency, i.e., all activities in the FPC must be residency-related and under the direction of the program director. The center must be clearly and significantly identified as a Family Practice Center.

An FPC must be in operation on the date the program begins. If a temporary center is used, it must meet the criteria specified below. If multiple centers are used for training, each must be approved by the RRC and must meet the same criteria as the primary center. All of the FPC's used in a program must provide comparable experiences.

Programs that involve training in Community or Migrant Health Centers (C/MHCs)² must provide assurance that these facilities meet the criteria for an FPC, as outlined below, unless an exception is approved by the RRC.

2. Administration and Staffing

The program director must have administrative responsibility for and control of the FPC and its staff. The director of the FPC must report to the program director. In cases where the facility is not owned by the program, its primary hospital, or its sponsoring institution, eg, a Community Health Center, a letter of agreement must be provided that guarantees the program director's authority over and responsibility for the educational activities that take place in the facility.

The FPC must be appropriately staffed with nurses, technicians, clerks, and administrative and other health professional personnel to ensure efficiency and adequate support for patient care and educational needs.

3. Location and Access

The FPC must be close enough to the hospital to require minimal travel time. It may not be at such a distance as to require travel that interferes with the educational opportunities, efficiency, or patient care responsibility.

When a FPC is at such a distance from the primary hospital that the patients are hospitalized elsewhere, the program director must demonstrate how the residents will efficiently maintain continuity for their hospitalized patients at one hospital while having their required rotations at another and the extent to which they are able to participate in the program's educational activities, such as attendance at required conferences.

The facility must be designed to ensure adequate accessibility and efficient patient flow, be environmentally sensitive to patient care needs, and provide appropriate access and accommodations for the handicapped.

4. Required Areas

Each FPC must have

- a. a reception area and waiting room that is consistent with the patient care and

² See Section 330 of the Public Health Service Act.

- educational needs of the residency;
- b. suitable resident work space and space for individual and small group counseling;
 - c. an office library resource, office laboratory, and a business office
 - d. two examining rooms that are large enough to accommodate the teaching and patient care activities of the program for each physician faculty member and resident when they are providing patient care
 - e. faculty offices, if not in the FPC, then immediately adjacent to the center
 - f. a conference room that is conveniently accessible and readily available, as needed, and is large enough to accommodate the full program. Where multiple FPC's are used in a program, there must be a meeting room within or immediately adjacent to each FPC that is large enough for smaller meetings of all faculty, residents, and staff at that site.

When other learners, eg, fellows, residents from other specialties, medical students, and nurses, are being trained by family physicians in the FPC, additional space may be required. Efficiency and education of the family practice residents must not be compromised by the training of other health care professionals.

5. Equipment

There must be

- a. appropriate diagnostic and therapeutic equipment in the FPC to meet the basic needs of an efficient and up-to-date family practice office and an acceptable educational program for residents in family practice and
- b. provision for diagnostic laboratory and imaging services so that there is prompt and convenient access by patients and residents for patient care and education.

6. Patient Access to the Family Practice Center

The FPC must be available for patient services at times commensurate with community medical standards and practice. When the center is not open, there must be a well-organized plan that ensures continuing access to the patient's personal physician or a designated family physician from the FPC.

Patients of the FPC must receive education and direction as to how they may obtain access to their physician or a substitute physician for continuity of care during the hours the center is closed. Patients should have access to printed policies and procedures of the Center.

7. Record System

The FPC patients' records should be maintained in the FPC. However, if a centralized record system is used, easy and prompt accessibility of the records of the FPC patients must be ensured at all times, ie, during and after hours. The record system should be designed to provide information on patient care and the residents' experience. These records must be well maintained, legible, and up-to-date, and should document the patient's primary physician.

The record system must provide the data needed for patient care audit and chart review

of all facets of family care, including care rendered in the FPC, in the hospital, at home, by telephone, through consultations, and by other institutions.

8. Source of Income

The fiscal operation of the FPC must reflect a balance between education and service. Service demands must not adversely affect educational objectives. A plan should be in place to ensure fiscal stability of the program.

Residents, faculty, and staff should be educated periodically on the importance of cost-effective quality health care and the importance of efficiency within the FPC.

C. Library Services

In addition to the office library in the FPC, residents must have ready access to a major medical library, either at the institution where the residents are located or through arrangement with convenient nearby institutions.

Library services should include the electronic retrieval of information from medical databases.

There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in a residency program, and these must be readily available during nights and weekends.

D. Patient Population

A patient population of adequate size and representing a broad spectrum of problems, various ages and both sexes should be attended in the hospital, in the FPC, at home, and in institutions for long-term care or rehabilitation. A sufficient number of inpatients must be available to provide a broad spectrum of problems in any area listed in these requirements that involves inpatient care. The disease spectrum available for resident education must be that common to the general community. These experiences must include the opportunity to attain expertise in emergency initial care of unusual or life-threatening problems.

V. The Educational Program

A. Introduction

The curricula and plans for all rotations and experiences must be developed by the family practice faculty. Other specialty faculty should be consulted for assistance as needed. All major dimensions of the curriculum should be structured educational experiences for which written goals and objectives, specific methodologies for teaching, and methods of evaluation exist.

While every residency program must have the required core curriculum as contained in this document, curriculum components may vary, with approval of the RRC, to reflect current regional practice patterns and patient care needs and may be flexible enough to utilize the strengths of the program.

Family physicians must be utilized to the fullest extent as teachers consistent with their experience, training, and current competence.

1. Program design

The program design and/or structure must be approved by the RRC as part of the regular review process. All components of a residency program should be related to the

program goals. Programs utilizing multiple sites and/or tracks must describe a core curriculum of at least 20 months that is participated in by all of the residents. If the remaining months are offered at more than one site they must be comparable in terms of their content, duration, and intensity.

Innovative and experimental educational designs and formats will be considered. For example, programs in family practice may propose utilization of a nonrotational format for providing resident education in areas usually taught in block rotations. Such proposals must demonstrate that the program provides experience equivalent to that of block rotations for its residents and must include documentation that residents will have all of the required experiences during their training, including experience with an adequate volume and mix of patients, the required continuity of care experiences, and appropriate faculty supervision.

2. Approval of Changes

Prior approval of the RRC is required for major changes in the curriculum, format, or design of the program; the addition or deletion of a major participating hospital; and/or the utilization of a new or additional FPC or the alteration of an existing center in any way that might make the facility less suitable.

On review of a proposal for major change in curriculum, facilities, or design of a program, the RRC may determine that a site visit is necessary before a decision can be made.

B. Principles of Family Practice

Continuity of care and family-oriented comprehensive care must be integral components of all programs. Residents must be taught throughout their training to demonstrate and to articulate clearly the following philosophy and concepts of family practice to patients and colleagues.

1. Continuity of Care

The program must instruct residents in the provision of continuity of care and ensure that each resident has experience with the interrelating roles played by the physician, the patient, the patient's family, the health care system, and the community in optimizing the patient's care.

The learning of continuity of care requires stable, protected physician-patient relationships that are structured to enhance both resident learning and patient care. This must occur primarily with a panel of patients in the FPC. Additional continuity patients, who may not be able to visit the FPC, should be enrolled and assigned as needed to provide residents with continuity experience in home care and long-term care settings.

The program must require that each resident maintain continuity of responsibility for his/her patients when such patients require hospitalization or consultation with other providers, both to integrate each patient's care and to optimize each resident's continuity training. The resident must maintain active involvement in management and treatment decisions.

2. Family-Oriented Comprehensive Care

The family physician assumes responsibility for the total health care of the individual and family, taking into account social, behavioral, economic, cultural, and biologic dimensions. Therefore, a program must emphasize comprehensive, family-oriented care that must be taught in didactic and clinical settings during the entire period of residency training. Residents must have experience in all patient care contexts, including