

**PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION
IN FAMILY MEDICINE**

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PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION IN FAMILY MEDICINE

I. Introduction

A. Duration of Training

Residencies in family medicine must offer 3 years of training after graduation from medical school which must be structured so that a coherent, integrated, and progressive educational program with progressive resident responsibility is ensured.

B. Scope of Training

The goal of the family medicine program is to produce fully competent physicians capable of providing high quality care to their patients.

Family medicine residency programs should provide opportunity for the residents to learn in multiple settings (e.g., hospital, ambulatory settings, emergency rooms, home and long-term care facilities), those skills and procedures that are within the scope of family medicine. Residencies should prepare residents for lifelong learning.

II. Institutions

A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.

Since family medicine 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 Medicine Center (FMC) during these rotations.

B. Participating Institutions

1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are

used, there should be assurance of the continuity of the educational experience. 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.

- a) Participation by an institution that provides 6 months or more of the 36 months of training in the program must be approved by the Residency Review Committee (RRC).
- b) A program must provide all of the facilities required for the education of residents in sufficient proximity to the primary hospital, particularly the Family Medicine Center(s), to allow for the efficient functioning of the educational program.

2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:

- a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;**
- b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
- c) **specify the duration and content of the educational experience; and**
- d) **state the policies and procedures that will govern resident education during the assignment.**

These documents should be available for review by the site visitor each time there is a site visit and review of the program.

III. Program Personnel and Resources

A. Program Director

- 1. There must be a single Program Director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either Program Director or department chair, the Program Director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).**

2. **The Program Director, together with the faculty, is responsible for the general administration of the program, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the Program Director and faculty are essential to maintaining such an appropriate continuity of leadership.**

- a) The Program Director must devote sufficient time to the residency program (i.e., at least 1400 hours per year spent in resident administration, resident teaching, resident precepting and attending duties, and exclusive of time spent in direct patient care without the presence of residents).
- b) The Program Director must have a specific time commitment to patient care to maintain his or her clinical skills.
- c) In a program that operates in the 1-2 format with year one in a related three year program, there must be a separate site director at the remote site unless that is where the Program Director is based.

3. **Qualifications of the Program Director are as follows:**

- a) **The Program Director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.** The director should be actively involved in the care of patients and, prior to assuming this position, must have had a minimum of 2 years full-time professional activity in family medicine as well as teaching experience in a family medicine residency.
- b) **The Program Director must be currently certified in the specialty by the American Board of Family Medicine, or possess qualifications judged to be acceptable by the RRC.**
- c) **The Program Director must be appointed in good standing and based at the primary teaching site.**
- d) An acting or interim director should be similarly qualified.

4. **Responsibilities of the Program Director are as follows:**

- a) **The Program Director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, appointing a local site director, and monitoring appropriate resident supervision at all participating**

institutions.

- b) The director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System (WebADS).**
- c) The Program Director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**
- d) The Program Director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents. Such changes, for example, include:**
 - (1) the addition or deletion of a participating institution;**
 - (2) a change in the format of the educational program;**
 - (3) a change in the approved resident complement for those specialties that approve resident complement;**
 - (4) a major curricular change; and**
 - (5) the use of a new or significantly remodeled FMC.**

On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.

With the exception of changes in the FMC, proposed changes should be initially submitted electronically through the WebADS, with follow-up correspondence sent to the Executive Director of the RRC. A special packet of information must be submitted in support of proposals for use of a new FMC.

B. Faculty

- 1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program, including family physician faculty with admitting privileges in the hospital(s) where the FMC patients are hospitalized. The faculty must comprise teachers with the diversified interests and expertise necessary to meet the various training**

responsibilities of the program.

2. **The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.**

- a) Faculty/resident ratio

There must be a sufficient number of hours contributed by a critical mass of family physician faculty to prevent fragmentation of the learning experience. In addition to the Program Director, there must be at least one full-time equivalent (FTE) family physician faculty for each 6 residents in the program. Any program in operation must have at least 2 family physician faculty members, including the director, regardless of resident complement. By the time a program offers all three years of training with the required minimum number of resident positions (i.e., 4-4-4) at least one of the additional family physician faculty must be full time. A full-time commitment is at least 1400 hours per year devoted to the residency spent in resident administration, resident teaching, resident precepting and attending duties, exclusive of time spent in direct patient care without the presence of residents. As the resident complement increases beyond the minimally acceptable size, additional full-time family physician faculty will be needed to provide a core group of family physician faculty. Where part-time faculty members are utilized, there must be evidence of sufficient continuity of teaching and supervision.

- b) Faculty Role Modeling

As is expected of the Program Director, the family physician faculty should have a specific time commitment to patient care in order to enable them to maintain their clinical skills. Some family physician teaching staff must see patients in each of the FMC's that are used in the program to serve as role models for the residents.

- c) Faculty Development

There must be a structured program of faculty development that involves regularly scheduled faculty development activities. Since family medicine faculty should demonstrate the same skills, knowledge and attitudes that are expected of the residents, faculty skill development and update are an important part of faculty

development. The program is expected to address clinical, educational, administrative, leadership, research and behavioral components of faculty performance. It should involve at least annual departmental, residency and individual faculty needs assessments, and may include structured group and individual activities.

Although clinical update is important, faculty development should provide experience to improve teaching in all settings. This should be measurable and documented in evaluations by residents.

d) Other Specialists

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

3. **Qualifications of the physician faculty are as follows:**

- a) **The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.**

Programs should assess the skills and credentials of individual faculty to perform procedures and care for the types of problems they will be teaching the residents. The professional skills of the teacher should always be documented as up to date and meeting the criteria for credentials and privileges of the primary hospital.

- b) **The physician faculty must be certified in the specialty by the American Board of Family Medicine, or possess qualifications judged to be acceptable by the RRC.**

- c) **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**

4. **The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. *Scholarship* is defined as the following:**

- a) **The scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**

- b) **The scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**
- c) **The scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.

5. Qualifications of the nonphysician faculty are as follows:

- a) **Nonphysician faculty must be appropriately qualified in their field.**
- b) **Nonphysician faculty must possess appropriate institutional appointments.**

C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

Additional teaching staff will be needed to provide training in areas such as behavioral science, nutrition, and the use of drugs and their interaction. Mid-level practitioners may teach family medicine residents in conjunction with other faculty in required curricular areas. Their qualifications should be provided.

D. Resources

The program must ensure that adequate resources (e.g., sufficient laboratory space and equipment, computer and statistical consultation services) are available.

1. Patient Population

Each residency must document that a patient population of adequate size, representing a broad spectrum of problems, with sufficient age and gender distribution is cared for in the hospital, in the FMC, and in institutions for

long-term care or rehabilitation, as appropriate. 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 which is common to the general community. These experiences must include the opportunity to attain expertise in emergency initial care of unusual or life-threatening problems.

2. Family Medicine Center

a) Introduction

The primary setting for training in the knowledge, skills, and attitudes of family medicine is the model office or FMC, where each resident must provide continuing, comprehensive care to a panel of patient families. The facility must be clearly and significantly identified as a *Family Medicine Center* and must be for the exclusive use of the residency program.

When other learners (e.g., fellows, residents from other specialties, medical students, nurses and other medical professionals) are being trained by family physicians in the FMC, additional personnel and space may be required. Efficiency and education of the family medicine residents must not be compromised by the training of other health care professionals.

A FMC must be in operation on the date the program begins. If a temporary center is used, it must meet these same criteria. If multiple centers are used for training, each must be approved by the RRC and must meet the same criteria as the primary center. Although all of the FMCs used in a program need not provide the same experiences, the experiences at each must comply with the requirements. That is, the experiences may differ in various tracks within a program.

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

b) Administration and Staffing

The Program Director must have control of the educational activities that occur in the FMC, and of the activities of the support personnel. The Program Director must participate in and provide

leadership for decisions affecting the FMC.

The FMC must be appropriately staffed with nurses, technicians, clerks, administrative personnel and other health professionals to ensure efficiency of operation and adequate support for patient care and educational requirements.

c) Location and Access

The FMC 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 residents' educational opportunities, efficiency, or patient care responsibility.

When a FMC 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 patients at one hospital while having their required rotations at another; the extent to which residents are able to participate in the program's educational activities, such as required conferences must also be demonstrated.

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.

d) Required Areas

- (1) There must be a reception area, waiting room and business office that are consistent with the patient care and educational needs of the residency.
- (2) A suitable resident work space and a separate private area for resident precepting, as well as an office library resource must be included. Computer access to electronic resources must be readily available for all of the physicians practicing in the Center.
- (3) Two examining rooms that are large enough to accommodate the teaching and patient care activities of the program must be available for each physician faculty member and resident when they are providing patient care. Additional space for individual and small group counseling must be included.
- (4) Faculty offices, if not in the FMC, must be immediately

adjacent to the Center.

- (5) The program must have a conference room that is conveniently accessible and readily available, as needed, and that is large enough to accommodate the full program. In programs using multiple FMCs, there must be a meeting room within or immediately adjacent to each FMC that is large enough for smaller meetings of all faculty, residents, and staff who work at that site.

e) Equipment

There must be the following:

- (1) appropriate diagnostic and therapeutic equipment in the FMC to meet the basic needs of an efficient and up-to-date family medicine office, and an acceptable educational program for residents in family medicine;
- (2) diagnostic laboratory and imaging services in the FMC or nearby to afford prompt and convenient access by patients and residents for patient care and education; tests commonly included as waived or point-of-service (e.g., urine analysis and wet mounts) and which may require efficiency of physician interpretation should be available within the FMC.

f) Patient Access to the Family Medicine Center

The FMC 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 FMC.

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

g) Record System

The FMC patients' records should be maintained in the FMC. However, if a centralized record system is used, easy and prompt accessibility of the records of the FMC patients must be ensured at

all times, i.e., 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 identify 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 FMC, in the hospital, at home, by telephone, through consultations, and by other institutions.

The resident must be taught patterns of record keeping that incorporate a comprehensive information base, retrievable documentation of all aspects of care, and mechanisms for promotion of health maintenance and quality assessment of care. This should include experience with electronic medical records.

Programs not currently using an electronic medical record system should document their plans for conversion to one in the near future.

h) Source of Income

The fiscal operation of the FMC must reflect an appropriate 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.

3. Inpatient Facilities

The inpatient facilities must be of sufficient size and have an adequate number of occupied teaching beds to ensure an appropriate 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 sufficient physical, human, and educational resources for training in family medicine. 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, and the range of support services will be considered.

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 physicians in other specialties. Where a hospital is departmentalized, there must be a clinical department of family medicine.

4. Library Services

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, so that a collection of appropriate texts and journals is accessible in each institution participating in a residency program. These must be readily available during nights and weekends. Library services must include the electronic retrieval of information from medical databases.

IV. Resident Appointments

A. Eligibility Criteria

The Program Director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

B. Number of Residents

The RRC may approve the number of residents based upon established written criteria that include the adequacy of the resources for resident education (e.g., the quality and volume of patients and related clinical material available for education), faculty-resident ratio, institutional funding, and the quality of faculty teaching.

1. RRC Approval

The letters of notification from the RRC for Family Medicine do not specify the number of approved positions. Each time a program undergoes review by the RRC, the Committee will evaluate the program's resources in relation to the number of resident positions reported by the program.

2. Minimum size

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 levels of training. A family medicine program should endeavor not to function as a transitional year program. Those who are appointed to the program should be those who intend to complete the 3 years of training in the program. 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. 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.

3. Special Tracks

In certain cases, such as programs that operate in the 1-2 format, the RRC may approve a smaller resident complement, but this should include at least one resident at each of the second and third levels or two residents at one of these levels to ensure peer interaction. Such programs are encouraged to arrange opportunities for the residents to interact with other residents (e.g., through didactic sessions at the parent program).

4. Change in Complement

The RRC allows programs to implement a modest change in complement without formal RRC review. Those desiring to change the resident complement between full program reviews should enter the information regarding the proposed change electronically into the ACGME Web Accreditation Data System (WebADS) for administrative review. If it is determined that RRC review is required, additional information may be requested.

C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the Program Director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A Program Director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

D. Fellows and Other Students

The appointment of fellows and other specialty residents or students, must not dilute or detract from the educational opportunities available to regularly appointed residents.

V. Program Curriculum

A. Program Design

1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process. Programs in family medicine may propose using a non-rotational format for providing resident education in areas usually taught in block rotations. Such proposals must demonstrate 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.

Programs using multiple sites and/or tracks must describe a core curriculum of at least 20 months in which all residents participate. If the remaining months are offered at more than one site, they may differ but each must comply with the requirements.

2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments. This should include specific methodologies for teaching and competency-based evaluation.

B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both academic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

The curricula and plans for all rotations and experiences must be developed by the family medicine faculty, and family physicians must be utilized to the fullest extent as teachers consistent with their experience, training, and current competence. Other specialty faculty may be consulted for assistance, as needed.

A variety of teaching methods may be used for residents to achieve the cognitive knowledge, psychomotor skills, interpersonal skills, professional attitudes, and practical experiences and competence required of physicians in the care of patients and families. Didactic as well as clinical learning opportunities must be provided as part of the curriculum, but the majority of time for any required experience should be clinical. Although lectures and workshops are helpful and may be required to supplement learning, residency experiences should include direct practice experience to enable residents to learn how to implement principles learned in the didactic curriculum.

Residents must receive training to perform those clinical procedures required for their future practices in the ambulatory and hospital environments. The residency director and family medicine faculty should develop a list of procedural competencies required for completion by all residents in the program prior to their graduation. This list must be based on the anticipated practice needs of all family medicine residents. In creating this list, the faculty should consider the current

practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served.

The program must clearly document that each curricular area is addressed in a defined experience with measurable outcomes. If the curriculum involves longitudinal arrangements for some curricular elements, the program must clearly document how each resident is assured of the required educational experience.

1. Principles of Family Medicine

- a) Continuity of Care

Continuity of care is a recognized core value of the specialty of family medicine and must be a priority in each program.

Continuity may pertain to individuals or to the practice in its entirety.

Resident panels must also include continuity patients requiring home care and care in long-term care facilities to provide each resident with continuity experience in those settings. Nursing home experience must consist of at least 2 patients as a continuity experience over a minimum of 24 consecutive months, in addition to that which residents might experience as part of a rotation.

Additionally, each resident must perform at least 2 home visits with at least one being for an older adult continuity patient. Faculty must supervise all home and nursing home care either on site or by prompt chart review as is appropriate based on a resident's level of expertise and competence.

In order to coordinate and integrate each patient's care and to optimize each resident's continuity training, the program must require that each resident maintain continuity of responsibility for some of his or her patients in all settings when such patients require urgent or emergent care, home care, long-term care, hospitalization or consultation with other providers. Continuity of responsibility should include active involvement in management and treatment decisions, and interactive communications about management and treatment decisions. In the second and third years of residency, when other curricular responsibilities temporarily prevent a resident from providing continuity of responsibility in any of these settings, that continuity must be provided by another resident or faculty from the program (i.e., the inpatient team or the physician on-call for the practice). When a substitute physician, such as a member of a family medicine team, is involved in continuity of care, there must be a mechanism to

transfer information clearly and expeditiously to the primary continuity physician.

b) Family-Oriented Comprehensive Care

Comprehensive care is important for the welfare of the patients as they function in the family, the community, and in the health care system. Principles of comprehensive care for patients include physician availability, accessibility, efficiency, and continuity.

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, residents must learn to demonstrate cultural competence in caring for patients from varied ethnic and cultural backgrounds.

Residents must be given the opportunity to achieve high levels of competence in health maintenance and in disease and problem management, and to develop attitudes that reflect expertise in comprehensive patient management and education.

The program must provide the opportunity for residents to acquire knowledge and experience in the provision of longitudinal health care to families, including assisting them in coping with serious illness and loss, and in promoting family mechanisms to maintain wellness of its members.

Essential elements to be integrated into the teaching of family care to residents include for the individual patient:

health assessment, health maintenance, preventive care, acute and chronic illness and injury, rehabilitation, behavioral counseling, health education, and human sexuality.

Elements for the family include:

family structure and dynamics, genetic counseling, family development, family planning, child rearing and education, aging, end of life issues, epidemiology of illness in families, the role of family in illness care, family counseling and education, nutrition, and safety.

2. Family Medicine Center Experience

a) Orientation

First-year residents must have an orientation period in the FMC to introduce the comprehensive approach to health care and to promote resident identity as a family physician. They must also have a regular patient care experience in the FMC throughout this first year.

b) Faculty Supervision

Whenever residents are performing clinical duties in the FMC, there must be an appropriate number of family physician faculty who, without other obligations, are engaged in active teaching and supervision of the residents. The appropriate number of faculty must be determined in relation to the level of training of the residents, the number of patients being seen in a clinic session, and the competency of the residents. In general, there should be at least one supervising family physician faculty member who is freed of all other activities for every 4 residents working in the clinic at any given time. If only one resident is seeing patients in the FMC, a single faculty member may be engaged in other activities to a maximum of 50%, but the teaching and supervision of the resident must take priority. Faculty time involved with medical students and other learners under the faculty's clinical supervision should not dilute the supervision of residents.

c) Patient Care Experience

It must be the goal of the program that residents be scheduled to see their own patients (i.e., those with whom they have developed an on-going doctor-patient relationship). The program must document the availability of a stable patient population in the FMC of sufficient number and variety to provide all residents with an adequate experience in the comprehensiveness of the specialty. It should be documented that each resident has experience with all age groups having adequate gender distribution, in volumes sufficient to achieve competency in all aspects of family medicine.

Residents' FMC assignments over the course of 3 years of training must include progressive responsibility for increased patient visit volume and visit efficiency. The 3-year FMC experience for each resident must include a documented total of at least 1650 patient visits, with at least 150 visits occurring in the first year. The number of patient visits from resident participation at a second FMC and/or from other longitudinal clinics may be counted toward the total number of patient visits if these visits are supervised by family physician faculty and if it can be documented that these

patients are seen in continuity by the residents.

Since continuity requires following patients to other settings, the continuity visit numbers may also include patients from the residents' panels who are seen at home, at long-term care sites, and patients seen in an OB continuity care setting.

In addition to meeting the minimum number of patient encounters noted above, the program must document that by the end of the third year, each resident has achieved the essential skills/competencies of both productivity and efficiency necessary to meet the expectations of independent clinical practice. This documentation must provide evidence of a variety of patient demographics and diseases, as well as a commitment to continuity.

d) FMC Continuity and Accessibility

The learning of continuity of care requires stable, protected physician-patient relationships that are structured to enhance both resident learning and patient care. Therefore, assignment of patients to a personal physician in the FMC is required. Whenever possible, residents should see their own patients to develop the doctor-patient relationship. In addition, there should be a team structure to ensure appropriate back-up for the patients to experience continuity of care.

A resident must be assigned to one FMC, preferably for all 3 years, but at least throughout the last 2 years of training. Residents must be scheduled to see patients in the FMC for a minimum of 40 weeks during each year of training. Their other assignments must not interrupt continuity for more than 8 weeks at any given time or in any one year. The periods between interruptions in continuity must be at least 4 weeks in length.

The FMC should provide a continuity experience for the residents, and ensure continuity of care and access for the patient. The FMC staffing, scheduling system, and hours of operation must assure FMC patients access to healthcare by their primary provider or the FMC health care team as backup if the primary resident is unavailable. The program must document that each resident has provided continuity of care in the FMC. This may be accomplished in a number of ways, and may include monitoring the number or percentage of visits by continuity patients to their continuity physician. The practice must also ensure 24 hour accessibility to care for their patients.

3. Medical/ Surgical Experiences

The program should implement a plan to ensure that residents retain their identity and commitment to the principles and philosophic attitudes of family medicine throughout the training program, particularly while they rotate on other specialty services.

Residents must have on-site supervision by an appropriately-qualified member of the program's faculty when the services or procedures needed exceed the capability of the most senior supervising resident, or when qualified senior residents are unavailable for supervision of more junior residents.

While the content of a rotation is more important than the time assigned to it, it is necessary to establish guidelines for the allocation of time segments to provide an objective measure of the opportunity provided for residents to achieve the cognitive knowledge, psychomotor skills, attitudinal orientation, and practical experience required of a family physician in each of the curricular elements. Time spent in the FMC seeing continuity patients may not be included when calculating the duration of the specialty rotations for which a duration is specified. It is understood, however, that FMC time is included in the required rotations that are specified in months. A program that uses a longitudinal format instead of a block rotation must document 100 hours of structured experience in lieu of a block month.

4. Inpatient Experiences for Family Medicine Residents

The resident must develop the skills required to treat male and female patients of all ages and those having various levels of severity of illness who are hospitalized. In-patient care must include the continuity of care of adults and children from the residency patient panel. This inpatient experience should occur primarily on a family medicine or an internal medicine service, and must involve teaching and role-modeling by family physician faculty. Daily faculty rounds must occur to assure appropriate supervision and teaching. Each resident must also receive clinical experience caring for hospitalized patients in special care units including medical intensive care, coronary care, and newborn nursery. Additional experience will occur on other inpatient services.

The length, breadth, and intensity of the experience must assure that every resident becomes competent diagnosing and managing common inpatient problems of adults and children as seen by the family physician. Residents must demonstrate direct management of patients to include initial evaluation, admission of patients, repeat evaluations, development of a plan of care, ongoing management, performance of basic procedures

of medicine, appropriate consultation and discharge planning and continuing care. Residents must demonstrate the ability to write appropriate admitting orders and to modify them daily according to changes in the patient's condition.

Residents are expected to maintain involvement in the care of their hospitalized patients whenever possible, even if the program uses the services of hospitalists. The residency must foster a team system that ensures continuity of care from the patient's perspective when the primary resident is unable to be present in both inpatient and outpatient settings. The continuity resident is expected to communicate daily with the hospital resident, and to provide long-term continuity care after discharge.

The residency must define and monitor the most common medical problems cared for by family physicians in the hospital where inpatient experience takes place. Residents must receive ample clinical experience in caring for these problems. There must also be a didactic curriculum that covers these common medical problems. This list of common diagnoses should be generally consistent with national data that are published about family medicine. The program must document how the residents' skills are progressing from care that is dependent on supervision by faculty toward unsupervised, independent care at the time of graduation. The program must also document the residents' competency in providing supervision to others in a learning environment.

Upon completion of training, residents must be competent to provide hospital care. Assessment of resident hospital practice must be included in the required semiannual resident evaluation.

By the conclusion of the residency, residents should have developed competence in knowledge, attitudes, and skills to care independently for hospitalized patients without supervision, and to utilize appropriate consultation by other specialists. Procedural skill documentation should indicate when the resident is capable of independent performance of the procedure.

5. Specific Curricular Areas:

Experiences may be accomplished in block format or longitudinally. If in block format, no more than 5 half-days a week may be used for anything other than the focused experience. This includes time in the FMC, nursing home, and lectures. For each month that is accomplished longitudinally, the program must document 100 hours of structured experience.

a) Adult Medicine

The adult medicine experience must total 8 months, of which 6 are inpatient. The following curricular areas must be included in either longitudinal or block format:

cardiovascular, neurologic, endocrinologic, pulmonary, gastrointestinal, rheumatologic, infectious, nephrologic, and hematologic diseases.

Residents must receive instruction and clinical experience in the prevention, counseling, detection, diagnosis and treatment of gender-specific diseases in women and men

(1) Women's Health

This must include structured experience in non-obstetrical, non-gynecologic care of women that deals with the study of gender differences and the diversity of women's health needs throughout the life cycle. Woman's health conditions are those that are unique or more common to women, including disorders that differ in presentation or treatment of women.

(2) Inpatient

While caring for adults on the inpatient service, each resident is expected to manage the care of at least 5 patients, on average, at any one time. Senior residents who are functioning in a supervisory role may have direct responsibility for a smaller number of patients.

(3) Intensive Care

All residents must be taught skills in the care of critically ill patients. The program must document that during the 3 years of training, each resident has managed a substantial portion of the care for at least 15 critically ill patients.

(4) The Older Patient

Educational experiences must be in both common and complex clinical problems of older patients. The training must include the appropriate preventive modalities, functional assessment, the physiologic and psychologic aspects of senescence, as well as the socio-cultural

parameters of the patients and their greater community. The residents must have supervised clinical experiences dealing with common acute and chronic diseases of aging. The resident must learn about, and practically apply, a multidisciplinary approach to the care of older patients in the hospital, the FMC, the long-term care facility, and the home.

This experience must result in the competence of residents in preventive healthcare, promotion of independent living, and maximizing function and quality of life. Residents must develop competency in assessing and meeting the healthcare needs of declining elders, episodic, illness-related care, delivery of healthcare in the home, FMC, hospital, and long-term facility, and end-of-life care.

b) Care of Neonates, Infants, Children, and Adolescents

Residents must complete 4 months of structured experience in the care of infants, children and adolescents. The time must include experience in the following areas: neonates, infant care (both well-baby and ill), hospitalized children, ambulatory pediatrics, emergency care of children and adolescent medicine. This may include experience gained on the Family Medicine Inpatient Service, in the emergency department, in the pediatric hospital and clinic, and experience in nursery care associated with OB experience, provided that appropriate documentation of such experience is maintained for each resident.

This experience must involve teaching and role modeling by family medicine faculty in the care of newborns and sick children. Residents and faculty must provide continuity of responsibility for hospitalized infants and children from their Family Medicine Center patient panel.

c) Maternity and Gynecologic Care

(1) Maternity Care

(a) Duration & Scope

There must be a minimum of 2 months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care. Each resident must become capable of

managing a normal pregnancy and delivery. Residents must be provided instruction in the biological and psychosocial impacts on a woman and her family of pregnancy, delivery, and care of the newborn. All programs must demonstrate that each resident acquires competency in the common problems of prenatal and postnatal care.

Residents must be trained in the recognition and initial management of the high-risk prenatal patient, including consultation and referral. Additionally, the residents must be taught to recognize and manage complications and emergencies in pregnancy, labor, and delivery. Residents also must receive training in genetic counseling. When appropriate for the resident's future practice and patient care, the resident must be trained in the management of the high-risk prenatal patient.

(b) Total Deliveries

Each resident must perform a minimum of 40 deliveries over the 3-year program, of which a minimum of ten must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries. Two residents may be given credit for the same delivery if one of those residents is supervising. The experience of each resident must be documented as to the role played in the delivery.

(c) Continuity Deliveries

For the minimum of ten continuity patient deliveries, each resident must assume responsibility for provision of antenatal, natal, and postnatal care during their three years of training. Whenever possible, these patients should be derived from the residents' panels of patients in the FMC. Where this is not possible, the continuity experiences may be met at other clinical sites with appropriate supervision. A list of these patients must be available in the resident's file.

(d) Supervision of Labor and Delivery

The program must have at least one family

physician faculty who is engaged in providing these services and who can participate in supervising the residents and serving as a role model for them. Supervision of labor and delivery care must be immediately available. For deliveries, and for labor when risk factors are present, there must be on-site supervision in the delivery suite/labor deck by a family physician, an obstetrician, a senior resident in an ACGME obstetrics residency, a certified nurse midwife, or a third year family medicine resident who has had sufficient delivery experience. If supervision is provided by anyone other than a faculty member, it must be documented that this supervisor has had sufficient maternity care experience to function competently in this capacity, and this documentation should include the criteria used to make this determination. When the supervisor of the resident is reliant on others for c-section or emergency procedures outside the scope of his or her practice, procedures for emergency consultative relationships and back-up must be documented. Specific details must be available on the service at all times. In judging the adequacy of the supervision provided by a resident, the Program Director must consider the year of training and previous obstetrical experience, and documented competency of the supervising resident. When a resident provides the direct supervision, there must be on-site physician faculty supervision immediately available in the hospital.

(e) Advanced OB Elective

The program must make available additional training in maternity care as an elective within the 36-month curriculum. This elective experience must include high-risk maternity care, including the opportunity for residents to develop technical proficiency in appropriate operative procedures that may form a part of their future practice. Programs should provide training in ALSO, or similar advanced obstetrical training, for those residents interested in providing maternity care in their future practices.

(2) Gynecology

There must be one month of structured curriculum in gynecology. All residents must be trained to competency in normal gynecological examinations, gynecological cancer screening, preventive health care in women, common STD's and infections, reproductive and hormonal physiology including fertility, family planning, contraception, options counseling for unintended pregnancy, pelvic floor dysfunction, and disorders of menstruation, perimenopause, and postmenopause, including osteoporosis. In addition, the program should provide adequate instruction and clinical experience in issues of sexual health, management of breast disorders, management of cervical disease. Residents should become competent in the performance of appropriate procedures.

This structured experience must be in addition to the routine gynecologic care of continuity patients in the FMC and the gynecological experience gained during family medicine call. However, special sessions dedicated to gynecological care may be arranged in the FMC, provided that the residency can document that these sessions are used for gynecology care above and beyond the routine care provided by the continuity physicians.

d) Care of the Surgical Patient

The program must provide instruction with special emphasis on the diagnosis and management of surgical disorders and emergencies and the appropriate and timely referral of surgical cases for specialized care.

Residents must be taught to appreciate the varieties of surgical treatments and the potential risks associated with them to enable them to give proper advice, explanation, and emotional support to patients and their families. The residents should also be taught to recognize conditions that are preferably managed on an elective basis.

The program must provide all residents with training in preoperative and postoperative care, basic surgical principles, asepsis, handling of tissue, and technical skills to assist the surgeon in the operating room. The residents should develop technical proficiency in those specific surgical procedures that family physicians may be called on to perform.

(1) General Surgery

The residents must be required to participate in a structured experience in general surgery of at least 2 months, including ambulatory care (non-inpatient care: e.g., surgical centers, emergency room and physician offices), operating room experience, and post-operative experience.

Experiences in general surgery must be designed to provide opportunity for residents to achieve competency in the diagnosis and management of a wide variety of common surgical problems typically cared for by family physicians. Experiences are usually expected to be with general surgeons. If non-generalist surgeons are used for this experience, the Program Director must explain how this experience exposes residents to common surgical problems.

If surgical experience occurs in conjunction with a family medicine or internal medicine service, the program must document how each resident meets the required surgical experience.

(2) Surgical Subspecialties

In addition to the general surgery experience, residents must have adequately structured, hands-on educational experiences in the following subspecialty areas: otorhinolaryngology, to include oral health, urology, and ophthalmology. This must be in addition to resident experience with continuity patients during routine care in FMC and must involve disorders that are commonly seen in a family physician's office.

e) Musculoskeletal and Sports Medicine

All residents must have 2 months experience in the care of patients with orthopedic and musculoskeletal problems, including experience in sports medicine. The curriculum should include non-articular rheumatic disorders, infectious, suppurative and degenerative arthritic conditions, acquired and congenital abnormalities of bones and joints, musculoskeletal and connective tissue disorders, evaluation and management of common sprains, fractures and dislocations, preventive care, rehabilitation and restorative function. Clinical experience should include acute evaluation of musculoskeletal trauma and acute pain syndromes. Sports medicine must be a clear and separate curriculum within the

2-month/200 hours of experience and must include non-orthopedic aspects of sports medicine with emphasis on care of athletes of all ages, both genders, and persons active or anticipating exercise activities. The care of the athlete includes performance of pre-participation sports physicals, assessment of common injuries, knowledge of treatment and rehabilitation. Both curricula must include performance of procedures common in the evaluation and care of orthopedic and sports medicine patients and participation in the rehabilitation required for these patients. These include interpretation of radiographs, aspiration and injection of joints, splinting and casting.

f) Emergency Care

There must be a structured educational experience to train the resident to deliver emergency care that includes didactic teaching, skills training, and clinical experience in caring for patients of all ages with acute illnesses and injuries in an emergency care setting. Residents should receive structured skills training in all standard current life support skills (e.g. ACLS and PALS), and should learn procedures for both trauma and medical emergencies in patients of all ages.

This clinical experience should encompass 200 hours of emergency medicine training.

The setting used for this training must offer the full spectrum of emergency services, and on-site faculty supervision must be available at all times. Suitable facilities and adequate support personnel must be present for resident training. The patients seen by family medicine residents should be representative of the patient population served by the emergency care facility overall.

g) Human Behavior and Mental Health

Knowledge and skills in this area should be acquired through a program in which behavioral science and psychiatry are integrated with all disciplines throughout the residents' total educational experience. Training should be accomplished primarily in an outpatient setting through a combination of longitudinal experiences and didactic sessions. Intensive short-term experiences in facilities devoted to the care of chronically ill patients should be limited. There must be faculty who are specifically designated for this curricular component who have the training and experience necessary to apply modern behavioral and psychiatric principles to the care of the undifferentiated patient.

Family physicians, psychiatrists, and behavioral scientists should be involved in teaching this curricular component.

There must be instruction and development of skills in the diagnosis and management of psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse, the physician/patient relationship, patient interviewing skills, and counseling skills. This should include videotaping of resident/patient encounters or direct faculty observation for assessment of each resident's competency in interpersonal skills. This will require sufficient faculty who participate on an on-going basis in the program, and in the FMC, in particular.

h) Community Medicine

Each residency must have a structured curriculum in community medicine, including didactic and some experiential components. There must be a process to evaluate this curriculum and to document appropriate resident skill attainment in this area. The curriculum should include:

- (1) assessment of risks for abuse, neglect, and family and community violence
- (2) reportable communicable disease
- (3) population epidemiology, and the interpretation of public health statistical information
- (4) environmental illness and injury
- (5) school health
- (6) disease prevention through immunization strategies
- (7) disaster responsiveness
- (8) community-based disease screening, prevention, health promotion
- (9) factors associated with differential health status among sub-populations, including racial, geographic, or socioeconomic health disparities, and the role of family physicians in reducing such gaps

The program should also require that each resident participate in clinical experiences in community medicine including:

- (10) experience in using community resources appropriately for individual patients who have unmet medical or social support needs
- (11) structured interaction with the public health system
- (12) occupational medicine including disability determination,

- employee health and job-related illness and injury
- (13) experience in community health assessment
- (14) experience in developing programs to address community health priorities
- (15) community-based health education of children and adults

i) Care of the Skin

All residents must be exposed to diagnosis and management of common dermatologic conditions. These must include, but not be limited to, viral, bacterial, allergic and fungal infections, ulcers, rashes, malignant and pre-malignant skin lesions, and dermatologic manifestations of system disease. This training should include experience in the surgical excision of skin lesions and performance of other dermatologic procedures with supervision by a physician with documented competence in this area. This may include experience gained in the FMC, provided that appropriate documentation is maintained for each resident.

j) Diagnostic Imaging and Nuclear Medicine

The program must provide the residents with a structured opportunity to learn the appropriate application of techniques and specialty consultations in the diagnostic imaging and nuclear medicine therapy of organs and body systems. Instruction should include the limitations and risks attendant to these techniques. The format of the instruction should be adapted to the resources available, but must include radiographic film/diagnostic imaging interpretation and nuclear medicine therapy pertinent to family medicine.

k) Conferences

Conferences should reflect the needs of the program and the residents. At least one faculty should attend each conference given by residents, and residents must not be the majority of presenters.

Each program must have the following:

- (1) an educational rationale for use of conferences for the program
- (2) a statement on how conferences are evaluated and how the resultant data are used by the program
- (3) an explanation of resident involvement in conference

design and presentations

l) Management of Health Systems

There must be at least 100 hours of management and leadership instruction to include both the didactic and the practical settings. This curriculum should prepare residents to assume leadership roles in their practices, their communities, and the profession of medicine. The residency must have specific strategies to demonstrate that residents have mastered these skills.

The FMC must be considered the primary site for teaching management and leadership skills, and should serve as an example on which residents may model their future practices. Each resident must receive reports of individual and practice productivity, financial performance, patient satisfaction and clinical quality, at least quarterly, as well as the training needed to analyze these reports. Residents must attend regular monthly FMC business meetings with staff and faculty to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality. They must participate in projects to improve the quality of care and service delivered to the FMC patient population.

The management curriculum should include current billing practices, designing and managing a budget, assessing practice staffing needs, the impact of new technologies on practice, determining value in the marketplace, assessing customer satisfaction, measurement of clinical quality, tort liability and risk management, office scheduling systems, computers in practice, alternative practice models, and employment law and procedures. Residents should also learn principles of public relations, media training, and personnel management.

The leadership curriculum should include training to provide leadership for a clinical practice, a hospital medical staff, professional organizations, and community leadership skills to advocate for the public health.

m) Electives

Electives are intended primarily to enrich the residents' training with experiences relevant to their plans for future practice or their interests as family physicians. There must be a minimum of 3 and a maximum of 6 months of appropriately supervised electives available to all residents. The choice of electives by the resident,

including those for remedial purposes, must be made with the approval of the Program Director.

n) Documentation of Procedures and Diagnoses

The director and family physician faculty should devise a method by which all procedures are supervised and evaluated. They must also devise a credentialing process to establish whether or not a resident is competent to perform specific procedures. The resident's documentation of procedural learning should include procedure, age and gender of patient, level of performance (e.g., progressing toward independent performance), and number of procedures performed before independent status granted. Procedural teaching should include didactic presentations, indications and contra-indications, risks and benefits, informed consent, appropriate coding and charging, management of aftercare and complications, and acquisition and maintenance of skills.

C. Residents Scholarly Activities

Each program must provide an opportunity for residents to participate in research or other scholarly activities, and residents must participate actively in such scholarly activities.

Each program must provide supervised experiences for all residents in scholarly activities such as research, presentations at national, regional, state, or local professional meetings, or presentation and/or publication of review articles and case presentations. Formal instruction and practical experience must assure that each resident develops and demonstrates skills in locating sources of scientific data pertinent to the care of patients, analyzing the appropriateness of research design and statistical methods, obtaining information about diagnostic and therapeutic effectiveness, and applying evidence from pertinent clinical studies to patient care.

The program must provide a supervised, ongoing forum in which residents explore and analyze emerging scientific evidence pertinent to the practice of family medicine. Additionally, all residents must actively participate in scientific inquiry, either through direct participation in research, or undertaking scholarly projects that make use of the scientific methods noted above.

Residents must also have guided experiences in the application of emerging clinical knowledge applicable to their own patient panels. The training environment must be in compliance with accepted evidence-based practices.

D. ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

- 1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;**
- 2. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;**
- 3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;**
- 4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;**
- 5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;**
- 6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.**

Specifically related to family medicine, residents must be taught to develop the skills necessary for career-long professional learning sufficient to maintain certification in the specialty. These should include:

1. knowledge sufficient to pass the ABFM certification exam;
2. ability to collect a complete initial data base and examination;
3. ability to define and expand the differential diagnoses list;
4. identification of the most likely diagnoses and the establishing of a plan for diagnostic and treatment modalities;

5. ability to educate the patient and family about the diagnoses, evaluation and treatment of the disease, to obtain informed consent, and perform appropriate procedures;
6. ability to practice in a team and with a systems-based approach;
7. ability to present data to other members of the team and consultants;
8. cost-conscious ordering of diagnostic tests and therapeutics;
9. construction of a medical record summary with accuracy and in compliance with expected format and in compliance with the hospital's medical records policies;
10. formulate short and long term goals; and
11. the providing of guidance to patients regarding advanced directives, end-of-life issues and unexpected diagnoses/outcomes.

VI. Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervision of Residents

1. **All patient care must be supervised by qualified faculty. The Program Director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
2. **Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
3. **Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**

B. Duty Hours

1. **Duty hours are defined as all clinical and academic activities related**

to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

- 2. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- 3. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
- 4. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call. The RRC will not consider requests for a rest period of less than 10 hours.**

C. On-call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.

- 1. In-house call must occur no more frequently than every third night, averaged over a 4-week period.**
- 2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.** For family medicine programs, the only outpatient activity allowed is the scheduled continuity office hours in the FMC, and/or self-directed activities. No other clinical duties are permitted. FM residents may not have continuity office hours in the afternoon or evening following an overnight call responsibility. Directors are responsible for anticipatory scheduling to avoid having to cancel patient appointments for afternoon FMC continuity sessions following overnight call.

For programs using a night block rotation, residents may have their continuity office hours in the FMC either before or after the night block hours, as long as there are 10 hours of rest between assigned duties and all

other duty hour rules are addressed.

Residents should also be available for critical events in the lives of their continuity patients such as obstetrical delivery throughout their 3 years of training but with the understanding that their subsequent schedules should be adjusted, as necessary, to comply with the duty hours restrictions.

3. **No new patients may be accepted after 24 hours of continuous duty.** Patients seen post call during a morning continuity session in the FMC are not considered new patients.
4. ***At-home call (or pager call)* is defined as a call taken from outside the assigned institution.**
 - a) **The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.**
 - b) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**
 - c) **The Program Director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.**

D. Moonlighting

1. **Because residency education is a full-time endeavor, the Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
2. **The Program Director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**
3. **Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.**

E. Oversight

- 1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.**
- 2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular basis.**

F. Duty Hours Exceptions

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required. The RRC for Family Medicine will not consider requests for an exception to the limit to 80 hours per week, averaged monthly.

VII. Evaluation

A. Resident

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

- a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.**
- b) Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each**

resident in a timely manner, and maintained in a record that is accessible to each resident.

- c) **Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.**
- d) The faculty must provide a written evaluation of each resident after each rotation, and these evaluations must be available for review by the residents and site visitor. The residency must document the inpatient clinical experiences of the residents and show how this prepares them to care for the patients in their community as defined by the program's written goals. This information should include the patient diagnoses seen and the procedures performed.

2. Final Evaluation

The Program Director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents. This on-going faculty assessment/evaluation system should facilitate faculty development. Additionally, the program should use resident evaluations of the faculty to help determine their areas of special interest and appropriate teaching.

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

- 1. **Representative program personnel (i.e., at least the Program Director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they**

are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

- 2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.**

D. Evaluation of the Graduates

Each program must maintain a system of evaluation of its graduates. The residency should obtain feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, ideas for new areas of curriculum, and identification of which procedures are done in practice. The suggested format is a written survey after 1 year and every 5 years thereafter.

The data from the evaluation of the graduates should be used as part of the program's determination of the degree to which the program's stated goals are being met.

E. Evaluation of the Program by the RRC

The program will be evaluated by the RRC at regular intervals, at which time the RRC will judge the degree of its compliance with the Program Requirements.

One measure of the quality of a residency program is the performance of its graduates on the certifying examination of the American Board of Family Medicine. In its evaluation of residency programs, the RRC will take into consideration the information provided by ABFM regarding resident performance on the certifying examinations over a period of several years.

The committee will use scores for a minimum of 3 and a maximum of 5 years and will take into consideration noticeable improvements or declines during the period considered. Poor performance will be cited if more than 10% of a program's candidates fail on the first examination over a period of consecutive years and/or the program's composite score is consistently at or below the 25th percentile in

the nation.

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

Requests for experimentation that deviate from the program requirements must be limited to innovative ways that the minimum requirements will be met and to how equivalent competency outcomes will be achieved.

IX. Board Certification

Residents who plan to seek certification by the American Board of Family Medicine should communicate with the office of the board regarding the full requirements for certification.

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