

1 **ACGME Program Requirements for Graduate Medical Education**
2 **in Family Medicine**

3
4 **Common Program Requirements are in BOLD**

5
6 Effective: July 1, 2007

7
8 **Introduction**

9
10 **Int.A. Residency is an essential dimension of the transformation of the medical**
11 **student to the independent practitioner along the continuum of medical**
12 **education. It is physically, emotionally, and intellectually demanding, and**
13 **requires longitudinally-concentrated effort on the part of the resident.**

14
15 **The specialty education of physicians to practice independently is**
16 **experiential, and necessarily occurs within the context of the health care**
17 **delivery system. Developing the skills, knowledge, and attitudes leading to**
18 **proficiency in all the domains of clinical competency requires the resident**
19 **physician to assume personal responsibility for the care of individual**
20 **patients. For the resident, the essential learning activity is interaction with**
21 **patients under the guidance and supervision of faculty members who give**
22 **value, context, and meaning to those interactions. As residents gain**
23 **experience and demonstrate growth in their ability to care for patients, they**
24 **assume roles that permit them to exercise those skills with greater**
25 **independence. This concept—graded and progressive responsibility—is**
26 **one of the core tenets of American graduate medical education.**
27 **Supervision in the setting of graduate medical education has the goals of**
28 **assuring the provision of safe and effective care to the individual patient;**
29 **assuring each resident’s development of the skills, knowledge, and**
30 **attitudes required to enter the unsupervised practice of medicine; and**
31 **establishing a foundation for continued professional growth.**

32
33 **Int.B. Duration of Training**

34
35 Residencies in family medicine must offer three years of training after graduation
36 from medical school. Residencies must be structured so that a coherent,
37 integrated, and progressive educational program with progressive resident
38 responsibility is ensured.

39
40 **Int.C. Scope of Training**

41
42 **Int.C.1. The goal of the family medicine program is to produce fully competent**
43 **physicians capable of providing high quality care to their patients.**

44
45 **Int.C.2. Family medicine residency programs should provide opportunity for the**
46 **residents to learn in multiple settings (e.g., hospital, ambulatory settings,**
47 **emergency rooms, home and long-term care facilities), those skills and**
48 **procedures that are within the scope of family medicine. Residencies**
49 **should prepare residents for lifelong learning.**

50
51 **Int.C.3. Programs using multiple sites and/or tracks must describe a core**

52 curriculum of at least 20 months in which all residents participate. If the
53 remaining months are offered at more than one site, they may differ but
54 each must comply with the requirements.
55

56 **I. Institutions**

57
58 **I.A. Sponsoring Institution**

59
60 **One sponsoring institution must assume ultimate responsibility for the**
61 **program, as described in the Institutional Requirements, and this**
62 **responsibility extends to resident assignments at all participating sites.**
63

64 **The sponsoring institution and the program must ensure that the program**
65 **director has sufficient protected time and financial support for his or her**
66 **educational and administrative responsibilities to the program.**
67

68 I.A.1. Since family medicine programs are dependent in part on other
69 specialties for the training of residents, the ability and commitment of the
70 institution to fulfill these requirements must be documented. Instruction in
71 the other specialties must be conducted by faculty with appropriate
72 expertise. There must be agreement with specialists in other
73 areas/services regarding the requirement that residents maintain
74 concurrent commitment to their patients in the Family Medicine Center
75 (FMC) during these rotations.
76

77 **I.B. Participating Sites**

78
79 **I.B.1. There must be a program letter of agreement (PLA) between the**
80 **program and each participating site providing a required**
81 **assignment. The PLA must be renewed at least every five years.**
82

83 **The PLA should:**

84
85 **I.B.1.a) identify the faculty who will assume both educational and**
86 **supervisory responsibilities for residents;**

87
88 **I.B.1.b) specify their responsibilities for teaching, supervision, and**
89 **formal evaluation of residents, as specified later in this**
90 **document;**

91
92 **I.B.1.c) specify the duration and content of the educational**
93 **experience; and,**

94
95 **I.B.1.d) state the policies and procedures that will govern resident**
96 **education during the assignment.**
97

98 **I.B.2. The program director must submit any additions or deletions of**
99 **participating sites routinely providing an educational experience,**
100 **required for all residents, of one month full time equivalent (FTE) or**
101 **more through the Accreditation Council for Graduate Medical**
102 **Education (ACGME) Accreditation Data System (ADS).**

- 103
104 I.B.3. Participating hospitals may not be at such a distance from the primary
105 teaching sites that they require excessive travel time or otherwise
106 fragment the educational experience.
107
- 108 I.B.4. Participation by a participating site that provides six months or more of
109 the 36 months of training in the program must be approved by the Review
110 Committee.
111
- 112 I.B.5. A program must provide all of the facilities required for the education of
113 residents in sufficient proximity to the primary hospital, particularly the
114 Family Medicine Center(s), to allow for the efficient functioning of the
115 educational program.
116
- 117 I.B.6. Programs may propose using a non-rotational format for providing
118 resident education in areas usually taught in block rotations. Such
119 proposals must demonstrate that residents will have all of the required
120 experiences during their training, including experience with an adequate
121 volume and mix of patients, the required continuity of care experiences,
122 and appropriate faculty supervision.
123
- 124 **II Program Personnel and Resources**
125
- 126 **II.A. Program Director**
127
- 128 **II.A.1. There must be a single program director with authority and**
129 **accountability for the operation of the program. The sponsoring**
130 **institution's GMEC must approve a change in program director.**
131 **After approval, the program director must submit this change to the**
132 **ACGME via the ADS.**
133
- 134 **II.A.2. The program director should continue in his or her position for a**
135 **length of time adequate to maintain continuity of leadership and**
136 **program stability.**
137
- 138 **II.A.3. Qualifications of the program director must include:**
139
- 140 **II.A.3.a) requisite specialty expertise and documented educational**
141 **and administrative experience acceptable to the Review**
142 **Committee;**
143
- 144 **II.A.3.b) current certification in the specialty by the American Board of**
145 **Family Medicine, or specialty qualifications that are**
146 **acceptable to the Review Committee;**
147
- 148 **II.A.3.c) current medical licensure and appropriate medical staff**
149 **appointment; and,**
150
- 151 **II.A.3.d) active involvement in the care of patients and, prior to assuming**
152 **this position, a minimum of two years full-time professional activity**
153 **in family medicine as well as teaching experience in a family**

- 154 medicine residency.
- 155
- 156 **II.A.4. The program director must administer and maintain an educational**
- 157 **environment conducive to educating the residents in each of the**
- 158 **ACGME competency areas. The program director must:**
- 159
- 160 **II.A.4.a) oversee and ensure the quality of didactic and clinical**
- 161 **education in all sites that participate in the program;**
- 162
- 163 **II.A.4.b) approve a local director at each participating site who is**
- 164 **accountable for resident education;**
- 165
- 166 **II.A.4.c) approve the selection of program faculty as appropriate;**
- 167
- 168 **II.A.4.d) evaluate program faculty and approve the continued**
- 169 **participation of program faculty based on evaluation;**
- 170
- 171 **II.A.4.e) monitor resident supervision at all participating sites;**
- 172
- 173 **II.A.4.f) prepare and submit all information required and requested by**
- 174 **the ACGME, including but not limited to the program**
- 175 **information forms and annual program resident updates to**
- 176 **the ADS, and ensure that the information submitted is**
- 177 **accurate and complete;**
- 178
- 179 **II.A.4.g) provide each resident with documented semiannual**
- 180 **evaluation of performance with feedback;**
- 181
- 182 **II.A.4.h) ensure compliance with grievance and due process**
- 183 **procedures as set forth in the Institutional Requirements and**
- 184 **implemented by the sponsoring institution;**
- 185
- 186 **II.A.4.i) provide verification of residency education for all residents,**
- 187 **including those who leave the program prior to completion;**
- 188
- 189 **II.A.4.j) implement policies and procedures consistent with the**
- 190 **institutional and program requirements for resident duty**
- 191 **hours and the working environment, including moonlighting,**
- 192 **and, to that end, must:**
- 193
- 194 **II.A.4.j).(1) distribute these policies and procedures to the**
- 195 **residents and faculty;**
- 196
- 197 **II.A.4.j).(2) monitor resident duty hours, according to sponsoring**
- 198 **institutional policies, with a frequency sufficient to**
- 199 **ensure compliance with ACGME requirements;**
- 200
- 201 **II.A.4.j).(3) adjust schedules as necessary to mitigate excessive**
- 202 **service demands and/or fatigue; and,**
- 203
- 204 **II.A.4.j).(4) if applicable, monitor the demands of at-home call and**

205		adjust schedules as necessary to mitigate excessive
206		service demands and/or fatigue.
207		
208	II.A.4.k)	monitor the need for and ensure the provision of back up
209		support systems when patient care responsibilities are
210		unusually difficult or prolonged;
211		
212	II.A.4.k).(1)	Programs must have formal mechanisms specifically
213		designed for promotion of physician well-being and
214		prevention of impairment. There also should be a
215		structured and facilitated group designed for resident
216		support that meets on a regular basis.
217		
218	II.A.4.l)	comply with the sponsoring institution’s written policies and
219		procedures, including those specified in the Institutional
220		Requirements, for selection, evaluation and promotion of
221		residents, disciplinary action, and supervision of residents;
222		
223	II.A.4.m)	be familiar with and comply with ACGME and Review
224		Committee policies and procedures as outlined in the ACGME
225		Manual of Policies and Procedures;
226		
227	II.A.4.n)	obtain review and approval of the sponsoring institution’s
228		GMEC/DIO before submitting to the ACGME information or
229		requests for the following:
230		
231	II.A.4.n).(1)	all applications for ACGME accreditation of new
232		programs;
233		
234	II.A.4.n).(2)	changes in resident complement;
235		
236	II.A.4.n).(3)	major changes in program structure or length of
237		training;
238		
239	II.A.4.n).(4)	progress reports requested by the Review Committee;
240		
241	II.A.4.n).(5)	responses to all proposed adverse actions;
242		
243	II.A.4.n).(6)	requests for increases or any change to resident duty
244		hours;
245		
246	II.A.4.n).(7)	voluntary withdrawals of ACGME-accredited
247		programs;
248		
249	II.A.4.n).(8)	requests for appeal of an adverse action;
250		
251	II.A.4.n).(9)	appeal presentations to a Board of Appeal or the
252		ACGME;
253		
254	II.A.4.n).(10)	proposals to ACGME for approval of innovative
255		educational approaches; and,

256		
257	II.A.4.n).(11)	use of a new or significantly remodeled FMC. The Review
258		Committee will review and approve all proposals prior to
259		use.
260		
261	II.A.4.o)	obtain DIO review and co-signature on all program
262		information forms, as well as any correspondence or
263		document submitted to the ACGME that addresses:
264		
265	II.A.4.o).(1)	program citations, and/or
266		
267	II.A.4.o).(2)	request for changes in the program that would have
268		significant impact, including financial, on the program
269		or institution.
270		
271	II.A.4.p)	devote sufficient time to the residency program (i.e., at least 1400
272		hours per year spent in resident administration, resident teaching,
273		resident precepting and attending duties, and exclusive of time
274		spent in direct patient care without the presence of residents);
275		
276	II.A.4.q)	have a specific time commitment to patient care to maintain his or
277		her clinical skills;
278		
279	II.A.4.r)	devise a method by which all procedures are supervised and
280		evaluated. The program director and faculty must also devise a
281		credentialing process to establish whether or not a resident is
282		competent to perform specific procedures. The resident's
283		documentation of procedural learning should include procedure,
284		age and gender of patient, level of performance (e.g., progressing
285		toward independent performance), and number of procedures
286		performed before independent status is granted. Procedural
287		teaching should include didactic presentations, indications and
288		contra-indications, risks and benefits, informed consent,
289		appropriate coding and charging, management of aftercare and
290		complications, and acquisition and maintenance of skills; and,
291		
292	II.A.4.s)	must ensure that educational experiences are provided in either
293		block format or longitudinally. If in block format, no more than five
294		half-days a week may be used for anything other than the focused
295		experience. This includes time in the FMC, nursing home, and
296		lectures. For each month that is accomplished longitudinally, the
297		program must document 100 hours of structured experience.
298		
299	II.A.5.	In a program that operates in the 1-2 format with year one in a related
300		three year program, there must be a separate site director at the remote
301		site unless that is where the program director is based.
302		
303	II.A.6.	An acting or interim director must possess the qualifications listed in
304		Section II.A.3.a-d.
305		
306	II.B.	Faculty

- 307
308 **II.B.1.** **At each participating site, there must be a sufficient number of**
309 **faculty with documented qualifications to instruct and supervise all**
310 **residents at that location.**
311
312 **The faculty must:**
313
314 **II.B.1.a)** **devote sufficient time to the educational program to fulfill**
315 **their supervisory and teaching responsibilities; and to**
316 **demonstrate a strong interest in the education of residents,**
317 **and**
318
319 **II.B.1.b)** **administer and maintain an educational environment**
320 **conducive to educating residents in each of the ACGME**
321 **competency areas.**
322
323 **II.B.1.c)** **The faculty must comprise teachers with the diversified interests**
324 **and expertise necessary to meet the various training**
325 **responsibilities of the program.**
326
327 **II.B.1.c).(1)** All programs with residents in an advanced level of
328 education in maternity care should have at least one family
329 physician delivering and teaching maternity care.
330
331 **II.B.2.** **The physician faculty must have current certification in the specialty**
332 **by the American Board of Family Medicine, or possess**
333 **qualifications acceptable to the Review Committee.**
334
335 **II.B.3.** **The physician faculty must possess current medical licensure and**
336 **appropriate medical staff appointment.**
337
338 **II.B.3.a)** **Family physician faculty must have admitting privileges in the**
339 **hospital(s) where the FMC patients are hospitalized. Programs**
340 **should assess the skills and credentials of individual faculty to**
341 **perform procedures and care for the types of problems they will be**
342 **teaching the residents. The professional skills of the teacher**
343 **should always be documented as up to date and meeting the**
344 **criteria for credentials and privileges of the primary hospital.**
345
346 **II.B.4.** **The nonphysician faculty must have appropriate qualifications in**
347 **their field and hold appropriate institutional appointments.**
348
349 **II.B.5.** **The faculty must establish and maintain an environment of inquiry**
350 **and scholarship with an active research component.**
351
352 **II.B.5.a)** **The faculty must regularly participate in organized clinical**
353 **discussions, rounds, journal clubs, and conferences.**
354
355 **II.B.5.b)** **Some members of the faculty should also demonstrate**
356 **scholarship by one or more of the following:**
357

- 358 **II.B.5.b).(1)** **peer-reviewed funding;**
359
360 **II.B.5.b).(2)** **publication of original research or review articles in**
361 **peer-reviewed journals, or chapters in textbooks;**
362
363 **II.B.5.b).(3)** **publication or presentation of case reports or clinical**
364 **series at local, regional, or national professional and**
365 **scientific society meetings; or,**
366
367 **II.B.5.b).(4)** **participation in national committees or educational**
368 **organizations.**
369
370 **II.B.5.c)** **Faculty should encourage and support residents in scholarly**
371 **activities.**
372
373 II.B.6. The curricula and plans for all rotations and experiences must be
374 developed by the family medicine faculty, and family physicians must be
375 utilized to the fullest extent as teachers consistent with their experience,
376 training, and current competence. Other specialty faculty may be
377 consulted for assistance as needed.
378
379 II.B.7. Faculty/Resident Ratio
380
381 There must be a sufficient number of hours contributed by a critical mass
382 of family physician faculty to prevent fragmentation of the learning
383 experience. In addition to the program director, there must be at least one
384 full-time equivalent (FTE) family physician faculty for each six residents in
385 the program. Any program in operation must have at least two family
386 physician faculty members, including the director, regardless of resident
387 complement. By the time a program offers all three years of training with
388 the required minimum number of resident positions (i.e., 4-4-4) at least
389 one of the additional family physician faculty must be full time. A full-time
390 commitment is at least 1400 hours per year devoted to the residency
391 spent in resident administration, resident teaching, resident precepting
392 and attending duties, exclusive of time spent in direct patient care without
393 the presence of residents. As the resident complement increases beyond
394 the minimally acceptable size, additional full-time family physician faculty
395 will be needed to provide a core group of family physician faculty. Where
396 part-time faculty members are utilized, there must be evidence of
397 sufficient continuity of teaching and supervision.
398
399 II.B.8. Faculty Role Modeling
400
401 As is expected of the program director, the family physician faculty should
402 have a specific time commitment to patient care in order to enable them
403 to maintain their clinical skills. Some family physician teaching staff must
404 see patients in each of the FMC's that are used in the program to serve
405 as role models for the residents.
406
407 II.B.9. Faculty Development
408

409 There must be a structured program of faculty development that involves
410 regularly scheduled faculty development activities. Since family medicine
411 faculty should demonstrate the same skills, knowledge and attitudes that
412 are expected of the residents, faculty skill development and update are an
413 important part of faculty development. The program is expected to
414 address clinical, educational, administrative, leadership, research and
415 behavioral components of faculty performance. It should involve at least
416 annual departmental, residency and individual faculty needs
417 assessments, and may include structured group and individual activities.
418 Although clinical update is important, faculty development should provide
419 experience to improve teaching in all settings. This should be measurable
420 and documented in evaluations by residents.

421
422 II.B.10. Other Specialists

423
424 Physicians in the other specialties must devote sufficient time to teaching
425 and supervising, and to providing consultation to the family medicine
426 residents in order to ensure that the program's goals for their specialty
427 areas are accomplished.

428
429 II.C. Other Program Personnel

430
431 **The institution and the program must jointly ensure the availability of all**
432 **necessary professional, technical, and clerical personnel for the effective**
433 **administration of the program.**

434
435 II.C.1. Additional teaching staff will be needed to provide training in areas such
436 as behavioral science, nutrition, and the use of drugs and their
437 interaction. Mid-level practitioners may teach family medicine residents in
438 conjunction with other faculty in required curricular areas. Their
439 qualifications should be provided.

440
441 II.D. Resources

442
443 **The institution and the program must jointly ensure the availability of**
444 **adequate resources for resident education, as defined in the specialty**
445 **program requirements.**

446
447 II.D.1. Patient Population

448
449 Each residency must document that a patient population of adequate
450 size, representing a broad spectrum of problems, with sufficient age and
451 gender distribution is cared for in the hospital, in the FMC, and in
452 institutions for long-term care or rehabilitation, as appropriate. A sufficient
453 number of inpatients must be available to provide a broad spectrum of
454 problems in any area listed in these requirements that involves inpatient
455 care. The disease spectrum available for resident education must be that
456 which is common to the general community. These experiences must
457 include the opportunity to attain expertise in emergency initial care of
458 unusual or life-threatening problems.

459

460	II.D.2.	Family Medicine Center	
461			
462	II.D.2.a)	Introduction	
463			
464	II.D.2.a).(1)		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.
465			
466			
467			
468			
469			
470			
471			
472	II.D.2.a).(2)		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.
473			
474			
475			
476			
477			
478			
479			
480	II.D.2.a).(3)		An 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 Review Committee 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.
481			
482			
483			
484			
485			
486			
487			
488			
489			
490	II.D.2.a).(4)		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 Review Committee.
491			
492			
493			
494			
495			
496			
497	II.D.2.b)	Administration and Staffing	
498			
499	II.D.2.b).(1)		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.
500			
501			
502			
503			
504	II.D.2.b).(2)		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.
505			
506			
507			
508			
509			
510	II.D.2.c)	Location and Access	

511		
512	II.D.2.c).(1)	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.
513		
514		
515		
516		
517	II.D.2.c).(2)	When an 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.
518		
519		
520		
521		
522		
523		
524		
525		
526	II.D.2.c).(3)	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.
527		
528		
529		
530		
531	II.D.2.d)	Required Areas
532		
533	II.D.2.d).(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.
534		
535		
536		
537	II.D.2.d).(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.
538		
539		
540		
541		
542		
543	II.D.2.d).(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.
544		
545		
546		
547		
548		
549		
550	II.D.2.d).(4)	Faculty offices, if not in the FMC, must be immediately adjacent to the Center.
551		
552		
553	II.D.2.d).(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.
554		
555		
556		
557		
558		
559		
560		
561	II.D.2.e)	Equipment

562		
563		There must be the following:
564		
565	II.D.2.e).(1)	appropriate diagnostic and therapeutic equipment in the
566		FMC to meet the basic needs of an efficient and up-to-date
567		family medicine office, and an acceptable educational
568		program for residents in family medicine;
569		
570	II.D.2.e).(2)	diagnostic laboratory and imaging services in the FMC or
571		nearby to afford prompt and convenient access by patients
572		and residents for patient care and education; tests
573		commonly included as waived or point-of-service (e.g.,
574		urine analysis and wet mounts) and which may require
575		efficiency of physician interpretation should be available
576		within the FMC.
577		
578	II.D.2.f)	Patient Access to the Family Medicine Center
579		
580	II.D.2.f).(1)	The FMC must be available for patient services at times
581		commensurate with community medical standards and
582		practice. When the Center is not open, there must be a
583		well-organized plan that ensures continuing access to the
584		patient's personal physician or a designated family
585		physician from the FMC.
586		
587	II.D.2.f).(2)	Patients of the FMC must receive education and direction
588		as to how they may obtain access to their physician or a
589		substitute family physician for continuity of care during the
590		hours the Center is closed. Patients should have access to
591		printed policies and procedures of the Center.
592		
593	II.D.2.g)	Record System
594		
595	II.D.2.g).(1)	The FMC patients' records should be maintained in the
596		FMC. However, if a centralized record system is used,
597		easy and prompt accessibility of the records of the FMC
598		patients must be ensured at all times, i.e., during and after
599		hours. The record system should be designed to provide
600		information on patient care and the residents' experience.
601		These records must be well maintained, legible, and up-to-
602		date, and should identify the patient's primary physician.
603		
604	II.D.2.g).(2)	The record system must provide the data needed for
605		patient care audit and chart review of all facets of family
606		care, including care rendered in the FMC, in the hospital,
607		at home, by telephone, through consultations, and at other
608		sites.
609		
610	II.D.2.g).(3)	The resident must be taught patterns of record keeping
611		that incorporate a comprehensive information base,
612		retrievable documentation of all aspects of care, and

613		mechanisms for promotion of health maintenance and
614		quality assessment of care. This should include experience
615		with electronic medical records.
616		
617	II.D.2.g).(4)	Programs not currently using an electronic medical record
618		system should document their plans for conversion to one
619		in the near future.
620		
621	II.D.2.h)	Source of Income
622		
623		The fiscal operation of the FMC must reflect an appropriate
624		balance between education and service. Service demands must
625		not adversely affect educational objectives. A plan should be in
626		place to ensure fiscal stability of the program.
627		
628	II.D.3.	Inpatient Facilities
629		
630	II.D.3.a)	The inpatient facilities must be of sufficient size and have an
631		adequate number of occupied teaching beds to ensure an
632		appropriate patient load and variety of problems for the education
633		of the number of residents and other learners on the services.
634		Inpatient facilities must also provide sufficient physical, human,
635		and educational resources for training in family medicine. In
636		determining the adequacy of the number of occupied beds in the
637		primary and hospitals, the patient census, the types of patients
638		and their availability for residency education, and the range of
639		support services will be considered.
640		
641	II.D.3.b)	The medical staff should be organized so that family physician
642		members may participate in appropriate hospital governance
643		activities on a basis equivalent to that of physicians in other
644		specialties.
645		
646	II.D.3.c)	Where a hospital is departmentalized, there must be a clinical
647		department of family medicine.
648		
649	II.E.	Medical Information Access
650		
651		Residents must have ready access to specialty-specific and other
652		appropriate reference material in print or electronic format. Electronic
653		medical literature databases with search capabilities should be available.
654		
655	III	Resident Appointments
656		
657	III.A.	Eligibility Criteria
658		
659		The program director must comply with the criteria for resident eligibility
660		as specified in the Institutional Requirements.
661		
662	III.B.	Number of Residents
663		

664 **The program director may not appoint more residents than approved by the**
665 **Review Committee, unless otherwise stated in the specialty-specific**
666 **requirements. The program's educational resources must be adequate to**
667 **support the number of residents appointed to the program.**
668

669 III.B.1. Review Committee Approval

670
671 The letters of notification from the Review Committee for Family Medicine
672 do not specify the number of approved positions. Each time a program
673 undergoes review by the Review Committee, the Committee will evaluate
674 the program's resources in relation to the number of resident positions
675 reported by the program.
676

677 III.B.2. Minimum size

678
679 III.B.2.a) To provide adequate peer interaction, a program should offer at
680 least four positions at each level and should retain, on average, a
681 minimum complement of 12 residents.
682

683 III.B.2.b) Except for periods of transition, the program should offer the same
684 number of positions for each of the three levels of training.
685

686 III.B.2.c) A family medicine program should endeavor not to function as a
687 transitional year program. Those who are appointed to the
688 program should intend to complete the three years of training in
689 the program.
690

691 III.B.2.d) Those accepted into the first year of training should be ensured of
692 a position for the full three years, barring the development of
693 grounds for dismissal.
694

695 III.B.2.e) The degree of resident attrition and the presence of a critical mass
696 of residents are factors that will be considered by the Review
697 Committee in the evaluation of a program.
698

699 III.B.3. Special Tracks

700
701 III.B.3.a) In certain cases, such as programs that operate in the 1-2 format,
702 the Review Committee may approve a smaller resident
703 complement, but this should include at least one resident at each
704 of the second and third levels or two residents at one of these
705 levels to ensure peer interaction.
706

707 III.B.3.b) Such programs are encouraged to arrange opportunities for the
708 residents to interact with other residents (e.g., through didactic
709 sessions at the parent program).
710

711 III.B.4. Change in Complement

712
713 The Review Committee allows programs to implement a modest change
714 in complement without formal Review Committee review. Those desiring

715 to change the resident complement between full program reviews should
716 enter the information regarding the proposed change electronically into
717 ADS for administrative review. If it is determined that Review Committee
718 review is required, additional information may be requested.
719

720 **III.C. Resident Transfers**

721
722 **III.C.1. Before accepting a resident who is transferring from another**
723 **program, the program director must obtain written or electronic**
724 **verification of previous educational experiences and a summative**
725 **competency-based performance evaluation of the transferring**
726 **resident.**

727
728 **III.C.2. A program director must provide timely verification of residency**
729 **education and summative performance evaluations for residents**
730 **who leave the program prior to completion.**

731
732 **III.D. Appointment of Fellows and Other Learners**

733
734 **The presence of other learners (including, but not limited to, residents from**
735 **other specialties, subspecialty fellows, PhD students, and nurse**
736 **practitioners) in the program must not interfere with the appointed**
737 **residents' education. The program director must report the presence of**
738 **other learners to the DIO and GMEC in accordance with sponsoring**
739 **institution guidelines.**

740
741 **IV Educational Program**

742
743 **IV.A. The curriculum must contain the following educational components:**

744
745 **IV.A.1. Overall educational goals for the program, which the program must**
746 **distribute to residents and faculty annually;**

747
748 **IV.A.2. Competency-based goals and objectives for each assignment at**
749 **each educational level, which the program must distribute to**
750 **residents and faculty annually, in either written or electronic form.**
751 **These should be reviewed by the resident at the start of each**
752 **rotation;**

753
754 **IV.A.3. Regularly scheduled didactic sessions;**

755
756 **IV.A.3.a) A variety of teaching methods may be used for residents to**
757 **achieve the cognitive knowledge, psychomotor skills,**
758 **interpersonal skills, professional attitudes, and practical**
759 **experiences and competence required of physicians in the care of**
760 **patients and families.**

761
762 **IV.A.3.b) Didactic as well as clinical learning opportunities must be provided**
763 **as part of the curriculum, but the majority of time for any required**
764 **experience should be clinical. Although lectures and workshops**
765 **are helpful and may be required to supplement learning, residency**

766		experiences should include direct practice experience to enable
767		residents to learn how to implement principles learned in the
768		didactic curriculum.
769		
770	IV.A.3.c)	Conferences
771		
772	IV.A.3.c).(1)	Conferences should reflect the needs of the program and
773		the residents. At least one faculty should attend each
774		conference given by residents, and residents must not be
775		the majority of presenters.
776		
777		Each program must have the following:
778		
779	IV.A.3.c).(1).(a)	an educational rationale for use of conferences for
780		the program;
781		
782	IV.A.3.c).(1).(b)	a statement on how conferences are evaluated and
783		how the resultant data are used by the program;
784		and,
785		
786	IV.A.3.c).(1).(c)	an explanation of resident involvement in
787		conference design and presentations.
788		
789	IV.A.4.	Delineation of resident responsibilities for patient care, progressive
790		responsibility for patient management, and supervision of residents
791		over the continuum of the program; and,
792		
793	IV.A.5.	ACGME Competencies
794		
795		The program must integrate the following ACGME competencies into
796		the curriculum:
797		
798	IV.A.5.a)	Patient Care
799		
800		Residents must be able to provide patient care that is
801		compassionate, appropriate, and effective for the treatment of
802		health problems and the promotion of health. Residents:
803		
804	IV.A.5.a).(1)	must receive training to perform those clinical procedures
805		required for their future practices in the ambulatory and
806		hospital environments;
807		
808	IV.A.5.a).(1).(a)	The residency director and family medicine faculty
809		should develop a list of procedural competencies
810		required for completion by all residents in the
811		program prior to their graduation.
812		
813	IV.A.5.a).(1).(b)	This list must be based on the anticipated practice
814		needs of all family medicine residents. In creating
815		this list, the faculty should consider the current
816		practices of program graduates, national data

817		regarding procedural care in family medicine, and
818		the needs of the community to be served.
819		
820	IV.A.5.a).(2)	must receive training that focuses on the core principles of
821		Family Medicine;
822		
823	IV.A.5.a).(2).(a)	Continuity of Care
824		
825		Continuity of care is a recognized core value of the
826		specialty of family medicine and must be a priority
827		in each program. Continuity may pertain to
828		individuals or to the practice in its entirety.
829		
830	IV.A.5.a).(2).(a).(i)	Resident panels must include continuity
831		patients requiring home care and care in
832		long-term care facilities to provide each
833		resident with continuity experience in those
834		settings.
835		
836	IV.A.5.a).(2).(a).(ii)	Nursing home experience must consist of at
837		least two patients as a continuity experience
838		over a minimum of 24 consecutive months,
839		in addition to that which residents might
840		experience as part of a rotation.
841		
842	IV.A.5.a).(2).(a).(iii)	Additionally, each resident must perform at
843		least two home visits with at least one being
844		for an older adult continuity patient. Faculty
845		must supervise all home and nursing home
846		care either on site or by prompt chart review
847		as is appropriate based on a resident's level
848		of expertise and competence.
849		
850	IV.A.5.a).(2).(a).(iv)	In order to coordinate and integrate each
851		patient's care and to optimize each
852		resident's continuity training, the program
853		must require that each resident maintain
854		continuity of responsibility for some of his or
855		her patients in all settings when such
856		patients require urgent or emergent care,
857		home care, long-term care, hospitalization
858		or consultation with other providers.
859		Continuity of responsibility should include
860		active involvement in management and
861		treatment decisions, and interactive
862		communications about management and
863		treatment decisions. In the second and third
864		years of residency, when other curricular
865		responsibilities temporarily prevent a
866		resident from providing continuity of
867		responsibility in any of these settings, that

868		continuity must be provided by another
869		resident or faculty from the program (i.e.,
870		the inpatient team or the physician on-call
871		for the practice). When a substitute
872		physician, such as a member of a family
873		medicine team, is involved in continuity of
874		care, there must be a mechanism to transfer
875		information clearly and expeditiously to the
876		primary continuity physician.
877		
878	IV.A.5.a).(2).(b)	Family-Oriented Comprehensive Care Experience;
879		
880	IV.A.5.a).(2).(b).(i)	Comprehensive care is important for the
881		welfare of the patients as they function in
882		the family, the community, and in the health
883		care system. Principles of comprehensive
884		care for patients include physician
885		availability, accessibility, efficiency, and
886		continuity.
887		
888	IV.A.5.a).(2).(b).(ii)	The family physician assumes responsibility
889		for the total health care of the individual and
890		family, taking into account social,
891		behavioral, economic, cultural, and biologic
892		dimensions. Therefore, residents must learn
893		to demonstrate cultural competence in
894		caring for patients from varied ethnic and
895		cultural backgrounds.
896		
897	IV.A.5.a).(2).(b).(iii)	Residents must be given the opportunity to
898		achieve high levels of competence in health
899		maintenance and in disease and problem
900		management, and to develop attitudes that
901		reflect expertise in comprehensive patient
902		management and education.
903		
904	IV.A.5.a).(2).(b).(iv)	The program must provide the opportunity
905		for residents to acquire knowledge and
906		experience in the provision of longitudinal
907		health care to families, including assisting
908		them in coping with serious illness and loss,
909		and in promoting family mechanisms to
910		maintain wellness of its members.
911		
912	IV.A.5.a).(2).(b).(v)	Essential elements to be integrated into the
913		teaching of family care to residents include
914		for the individual patient: health
915		assessment, health maintenance,
916		preventive care, acute and chronic illness
917		and injury, rehabilitation, behavioral
918		counseling, health education, and human

919		sexuality.
920		
921	IV.A.5.a).(2).(b).(vi)	Essential elements to be integrated into the teaching of family care to residents include for the family: 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.
922		
923		
924		
925		
926		
927		
928		
929		
930		
931	IV.A.5.a).(2).(c)	Family Medicine Center Experience;
932		
933	IV.A.5.a).(2).(c).(i)	Orientation
934		
935		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.
936		
937		
938		
939		
940		
941		
942		
943	IV.A.5.a).(2).(c).(ii)	Faculty Supervision
944		
945		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 four 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.
946		
947		
948		
949		
950		
951		
952		
953		
954		
955		
956		
957		
958		
959		
960		
961		
962		
963		
964		
965		
966		
967		
968		
969	IV.A.5.a).(2).(c).(iii)	Patient Care Experience

970		
971	IV.A.5.a).(2).(c).(iii).(a)	
972		
973		
974		
975		
976		
977		
978		
979		
980		
981		
982		
983		
984		
985		
986		
987		
988		
989		
990	IV.A.5.a).(2).(c).(iii).(b)	
991		
992		
993		
994		
995		
996	IV.A.5.a).(2).(c).(iii).(c)	
997		
998		
999		
1000		
1001		
1002		
1003		
1004		
1005		
1006		
1007		
1008		
1009		
1010		
1011	IV.A.5.a).(2).(c).(iii).(d)	
1012		
1013		
1014		
1015		
1016		
1017		
1018		
1019		
1020	IV.A.5.a).(2).(c).(iii).(e)	

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 three years of training must include progressive responsibility for increased patient visit volume and visit efficiency.

The three-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

1021		number of patient encounters noted
1022		above, the program must document
1023		that by the end of the third year,
1024		each resident has achieved the
1025		essential skills/competencies of both
1026		productivity and efficiency necessary
1027		to meet the expectations of
1028		independent clinical practice. This
1029		documentation must provide
1030		evidence of a variety of patient
1031		demographics and diseases, as well
1032		as a commitment to continuity.
1033		
1034	IV.A.5.a).(2).(c).(iv)	FMC Continuity and Accessibility
1035		
1036	IV.A.5.a).(2).(c).(iv).(a)	The learning of continuity of care
1037		requires stable, protected physician-
1038		patient relationships that are
1039		structured to enhance both resident
1040		learning and patient care. Therefore,
1041		assignment of patients to a personal
1042		physician in the FMC is required.
1043		Whenever possible, residents should
1044		see their own patients to develop the
1045		doctor-patient relationship. In
1046		addition, there should be a team
1047		structure to ensure appropriate
1048		back-up for the patients to
1049		experience continuity of care.
1050		
1051	IV.A.5.a).(2).(c).(iv).(b)	A resident must be assigned to one
1052		FMC, preferably for all three years,
1053		but at least throughout the last two
1054		years of training.
1055		
1056	IV.A.5.a).(2).(c).(iv).(c)	Residents must be scheduled to see
1057		patients in the FMC for a minimum
1058		of 40 weeks during each year of
1059		training. Their other assignments
1060		must not interrupt continuity for more
1061		than eight weeks at any given time
1062		or in any one year. The periods
1063		between interruptions in continuity
1064		must be at least four weeks in
1065		length.
1066		
1067	IV.A.5.a).(2).(c).(iv).(d)	The FMC should provide a continuity
1068		experience for the residents, and
1069		ensure continuity of care and access
1070		for the patient. The FMC staffing,
1071		scheduling system, and hours of

1072		operation must ensure FMC patients
1073		access to healthcare by their primary
1074		provider or the FMC health care
1075		team as backup if the primary
1076		resident is unavailable. The program
1077		must document that each resident
1078		has provided continuity of care in the
1079		FMC. This may be accomplished in
1080		a number of ways, and may include
1081		monitoring the number or
1082		percentage of visits by continuity
1083		patients to their continuity physician.
1084		The practice must also ensure 24
1085		hour accessibility to care for their
1086		patients.
1087		
1088	IV.A.5.a).(2).(d)	Medical/Surgical Experiences
1089		
1090	IV.A.5.a).(2).(d).(i)	The program should implement a plan to
1091		ensure that residents retain their identity
1092		and commitment to the principles and
1093		philosophic attitudes of family medicine
1094		throughout the training program, particularly
1095		while they rotate on other specialty services.
1096		
1097	IV.A.5.a).(2).(d).(ii)	Residents must have on-site supervision by
1098		an appropriately-qualified member of the
1099		program's faculty when the services or
1100		procedures needed exceed the capability of
1101		the most senior supervising resident, or
1102		when qualified senior residents are
1103		unavailable for supervision of more junior
1104		residents.
1105		
1106	IV.A.5.a).(2).(d).(iii)	While the content of a rotation is more
1107		important than the time assigned to it, it is
1108		necessary to establish guidelines for the
1109		allocation of time segments to provide an
1110		objective measure of the opportunity
1111		provided for residents to achieve the
1112		cognitive knowledge, psychomotor skills,
1113		attitudinal orientation, and practical
1114		experience required of a family physician in
1115		each of the curricular elements. Time spent
1116		in the FMC seeing continuity patients may
1117		not be included when calculating the
1118		duration of the specialty rotations for which
1119		a duration is specified. It is understood,
1120		however, that FMC time is included in the
1121		required rotations that are specified in
1122		months. A program that uses a longitudinal

1123		format instead of a block rotation must
1124		document 100 hours of structured
1125		experience in lieu of a block month.
1126		
1127	IV.A.5.a).(2).(e)	Inpatient Experiences
1128		
1129	IV.A.5.a).(2).(e).(i)	The resident must develop the skills
1130		required to treat male and female patients of
1131		all ages and those having various levels of
1132		severity of illness who are hospitalized. In-
1133		patient care must include the continuity of
1134		care of adults and children from the
1135		residency patient panel. This inpatient
1136		experience should occur primarily on a
1137		family medicine or an internal medicine
1138		service, and must involve teaching and role-
1139		modeling by family physician faculty. Daily
1140		faculty rounds must occur to ensure
1141		appropriate supervision and teaching. Each
1142		resident must also receive clinical
1143		experience caring for hospitalized patients
1144		in special care units including medical
1145		intensive care, coronary care, and newborn
1146		nursery. Additional experience will occur on
1147		other inpatient services.
1148		
1149	IV.A.5.a).(2).(e).(ii)	The length, breadth, and intensity of the
1150		experience must ensure that every resident
1151		becomes competent diagnosing and
1152		managing common inpatient problems of
1153		adults and children as seen by the family
1154		physician. Residents must demonstrate
1155		direct management of patients to include
1156		initial evaluation, admission of patients,
1157		repeat evaluations, development of a plan
1158		of care, ongoing management, performance
1159		of basic procedures of medicine,
1160		appropriate consultation and discharge
1161		planning and continuing care. Residents
1162		must demonstrate the ability to write
1163		appropriate admitting orders and to modify
1164		them daily according to changes in the
1165		patient's condition.
1166		
1167	IV.A.5.a).(2).(e).(iii)	Residents are expected to maintain
1168		involvement in the care of their hospitalized
1169		patients whenever possible, even if the
1170		program uses the services of hospitalists.
1171		The residency must foster a team system
1172		that ensures continuity of care from the
1173		patient's perspective when the primary

1174		resident is unable to be present in both
1175		inpatient and outpatient settings. The
1176		continuity resident is expected to
1177		communicate daily with the hospital
1178		resident, and to provide long-term continuity
1179		care after discharge.
1180		
1181	IV.A.5.a).(2).(e).(iv)	The residency must define and monitor the
1182		most common medical problems cared for
1183		by family physicians in the hospital where
1184		inpatient experience takes place. Residents
1185		must receive ample clinical experience in
1186		caring for these problems. There must also
1187		be a didactic curriculum that covers these
1188		common medical problems. This list of
1189		common diagnoses should be generally
1190		consistent with national data that are
1191		published about family medicine. The
1192		program must document how the residents'
1193		skills are progressing from care that is
1194		dependent on supervision by faculty toward
1195		unsupervised, independent care at the time
1196		of graduation. The program must also
1197		document the residents' competency in
1198		providing supervision to others in a learning
1199		environment.
1200		
1201	IV.A.5.a).(2).(e).(v)	Upon completion of training, residents must
1202		be competent to provide hospital care.
1203		Assessment of resident hospital practice
1204		must be included in the required semiannual
1205		resident evaluation.
1206		
1207	IV.A.5.a).(2).(e).(vi)	By the conclusion of the residency,
1208		residents should have developed
1209		competence in knowledge, attitudes, and
1210		skills to care independently for hospitalized
1211		patients without supervision, and to utilize
1212		appropriate consultation by other
1213		specialists. Procedural skill documentation
1214		should indicate when the resident is capable
1215		of independent performance of the
1216		procedure.
1217		
1218	IV.A.5.b)	Medical Knowledge
1219		
1220		Residents must demonstrate knowledge of established and
1221		evolving biomedical, clinical, epidemiological and social-
1222		behavioral sciences, as well as the application of this
1223		knowledge to patient care. Residents:
1224		

1225	IV.A.5.b).(1)	Adult Medicine
1226		
1227		must receive eight months of adult medicine experience, of
1228		which six are inpatient;
1229		
1230	IV.A.5.b).(1).(a)	Residents must have the following curricular areas
1231		in either longitudinal or block format:
1232		cardiovascular, neurologic, endocrinologic,
1233		pulmonary, gastrointestinal, rheumatologic,
1234		infectious, nephrologic, and hematologic diseases;
1235		
1236	IV.A.5.b).(1).(b)	Residents must receive instruction and clinical
1237		experience in the prevention, counseling, detection,
1238		diagnosis and treatment of gender-specific
1239		diseases in women and men:
1240		
1241	IV.A.5.b).(1).(b).(i)	Women's Health
1242		
1243		This must include structured experience in
1244		non-obstetrical, non-gynecologic care of
1245		women that deals with the study of gender
1246		differences and the diversity of women's
1247		health needs throughout the life cycle.
1248		Woman's health conditions are those that
1249		are unique or more common to women,
1250		including disorders that differ in presentation
1251		or treatment of women.
1252		
1253	IV.A.5.b).(1).(b).(ii)	Inpatient
1254		
1255		While caring for adults on the inpatient
1256		service, each resident is expected to
1257		manage the care of at least five patients, on
1258		average, at any one time. Senior residents
1259		who are functioning in a supervisory role
1260		may have direct responsibility for a smaller
1261		number of patients.
1262		
1263	IV.A.5.b).(1).(b).(iii)	Intensive Care
1264		
1265		All residents must be taught skills in the
1266		care of critically ill patients. The program
1267		must document that during the three years
1268		of training, each resident has managed a
1269		substantial portion of the care for at least 15
1270		critically ill patients.
1271		
1272	IV.A.5.b).(1).(b).(iv)	The Older Patient
1273		
1274		Educational experiences must be in both
1275		common and complex clinical problems of

1276		older patients.
1277		
1278	IV.A.5.b).(1).(b).(iv).(a)	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.
1279		
1280		
1281		
1282		
1283		
1284		
1285		
1286		
1287		
1288		
1289		
1290		
1291		
1292		
1293		
1294		
1295	IV.A.5.b).(1).(b).(iv).(b)	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.
1296		
1297		
1298		
1299		
1300		
1301		
1302		
1303		
1304		
1305		
1306		
1307		
1308	IV.A.5.b).(2)	Care of Neonates, Infants, Children, and Adolescents
1309		
1310		must complete four months of structured experience in the care of infants, children and adolescents.
1311		
1312		
1313	IV.A.5.b).(2).(a)	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.
1314		
1315		
1316		
1317		
1318		
1319		
1320		
1321		
1322		
1323		
1324		
1325	IV.A.5.b).(2).(b)	This experience must involve teaching and role modeling by family medicine faculty in the care of
1326		

newborns and sick children. Residents and faculty must provide continuity of responsibility for hospitalized infants and children from their Family Medicine Center patient panel.

1327
1328
1329
1330
1331
1332
1333
1334
1335
1336
1337
1338
1339
1340
1341
1342
1343
1344
1345
1346
1347
1348
1349
1350
1351
1352
1353
1354
1355
1356
1357
1358
1359
1360
1361
1362
1363
1364
1365
1366
1367
1368
1369
1370
1371
1372
1373
1374
1375
1376
1377

IV.A.5.b).(3)

Maternity Care of the Pregnant Patient

~~must receive a minimum of two months of experience in maternity care, including the principles and techniques of prenatal care, management of labor and delivery, and postpartum care; must have experience in maternity care that includes a structured curriculum in prenatal, intra-partum and post-partum care.~~

IV.A.5.b).(3).(a)

~~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:~~

IV.A.5.b).(3).(a).(i).(a)

recognize abnormal from normal pregnancy;

IV.A.5.b).(3).(a).(i).(b)

care for common medical problems arising from or coexisting with pregnancy, and assist a patient experiencing a spontaneous precipitous birth;

IV.A.5.b).(3).(a).(i).(c)

demonstrate basic skills in managing obstetrical emergencies;

IV.A.5.b).(3).(a).(i).(d)

complete a minimum of 20 deliveries; and,

IV.A.5.b).(3).(a).(i).(e)

complete 200 hours of labor and delivery experience, or two blocks/months dedicated to participating in deliveries, prenatal care, and post-partum care.

IV.A.5.b).(3).(b)

~~Each resident must be trained in the recognition and initial management of the high-risk prenatal patient, including consultation and referral. Additionally, the resident 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. Residents who pursue an~~

1378		<u>advanced level of education in maternity care must:</u>
1379		
1380	IV.A.5.b).(3).(b).(i).(a)	<u>complete a total of 400 hours of labor and delivery experience or four blocks/months dedicated to resident performance of maternity care over the course of the educational program;</u>
1381		
1382		
1383		
1384		
1385		
1386	IV.A.5.b).(3).(b).(i).(b)	<u>perform prenatal care;</u>
1387		
1388	IV.A.5.b).(3).(b).(i).(c)	<u>independently manage labor and delivery patients, including:</u>
1389		
1390		
1391	IV.A.5.b).(3).(b).(i).(c).(i)	<u>those who require assisted deliveries (vacuum and forceps);</u>
1392		
1393		
1394	IV.A.5.b).(3).(b).(i).(c).(ii)	<u>those who require intra-partum care that includes conduction of a spontaneous vaginal delivery and management of common intra-partum complications and emergencies;</u>
1395		
1396		
1397		
1398		
1399		
1400		
1401	IV.A.5.b).(3).(b).(i).(c).(iii)	<u>those who have obstetrical emergencies; and,</u>
1402		
1403		
1404	IV.A.5.b).(3).(b).(i).(c).(iv)	<u>serving in the first-assist role at Caesarean section or vaginal operative deliveries.</u>
1405		
1406		
1407		
1408	IV.A.5.b).(3).(b).(i).(d)	<u>perform a total of 80 documented vaginal deliveries in a designated labor and delivery area, including a total of 10 continuity deliveries, over the course of the educational program; and,</u>
1409		
1410		
1411		
1412		
1413		
1414	IV.A.5.b).(3).(b).(i).(e)	<u>perform post-partum care, including management of post-partum complications.</u>
1415		
1416		
1417	IV.A.5.b).(3).(c)	Each resident must perform a minimum of 40 deliveries over the three-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.
1418		
1419		
1420		
1421		
1422		
1423		
1424		
1425		
1426	IV.A.5.b).(3).(d)	For the minimum of ten continuity patient deliveries, each resident must assume responsibility for provision of antenatal, natal, and postnatal care
1427		
1428		

1429 during their three years of training. Whenever
1430 possible, these patients should be derived from the
1431 residents' panels of patients in the FMC. Where this
1432 is not possible, the continuity experiences may be
1433 met at other clinical sites with appropriate
1434 supervision. A list of these patients must be
1435 available in the resident's file.
1436

IV.A.5.b).(3).(e)

1437 The program must have at least one family
1438 physician faculty who is engaged in providing these
1439 services and who can participate in supervising the
1440 residents and serving as a role model for them.
1441 Supervision of labor and delivery care must be
1442 immediately available. For deliveries, and for labor
1443 when risk factors are present, there must be on-site
1444 supervision in the delivery suite/labor deck by a
1445 family physician, an obstetrician, a senior resident
1446 in an ACGME obstetrics residency, a certified nurse
1447 midwife, or a third year family medicine resident
1448 who has had sufficient delivery experience. If
1449 supervision is provided by anyone other than a
1450 faculty member, it must be documented that this
1451 supervisor has had sufficient maternity care
1452 experience to function competently in this capacity,
1453 and this documentation should include the criteria
1454 used to make this determination. When the
1455 supervisor of the resident is reliant on others for c-
1456 section or emergency procedures outside the
1457 scope of his or her practice, procedures for
1458 emergency consultative relationships and back-up
1459 must be documented. Specific details must be
1460 available on the service at all times. In judging the
1461 adequacy of the supervision provided by a resident,
1462 the program director must consider the year of
1463 training and previous obstetrical experience, and
1464 documented competency of the supervising
1465 resident. When a resident provides the direct
1466 supervision, there must be on-site physician faculty
1467 supervision immediately available in the hospital.
1468

IV.A.5.b).(3).(f)

1469 The program must make available additional
1470 training in maternity care as an elective within the
1471 36-month curriculum. This elective experience must
1472 include high-risk maternity care, including the
1473 opportunity for residents to develop technical
1474 proficiency in appropriate operative procedures that
1475 may form a part of their future practice. Programs
1476 should provide training in ALSO, or similar
1477 advanced obstetrical training, for those residents
1478 interested in providing maternity care in their future
1479 practices.

1480		
1481	IV.A.5.b).(4)	Gynecology
1482		
1483		must receive one month of structured curriculum in
1484		gynecology;
1485		
1486	IV.A.5.b).(4).(a)	All residents must be trained to competency in
1487		normal gynecological examinations, gynecological
1488		cancer screening, preventive health care in women,
1489		common STD's and infections, reproductive and
1490		hormonal physiology including fertility, family
1491		planning, contraception, options counseling for
1492		unintended pregnancy, pelvic floor dysfunction, and
1493		disorders of menstruation, perimenopause, and
1494		postmenopause, including osteoporosis. In
1495		addition, the program should provide adequate
1496		instruction and clinical experience in issues of
1497		sexual health, management of breast disorders,
1498		management of cervical disease. Residents should
1499		become competent in the performance of
1500		appropriate procedures.
1501		
1502	IV.A.5.b).(4).(b)	This structured experience must be in addition to
1503		the routine gynecologic care of continuity patients
1504		in the FMC and the gynecological experience
1505		gained during family medicine call.
1506		
1507	IV.A.5.b).(4).(c)	Special sessions dedicated to gynecological care
1508		may be arranged in the FMC, provided that the
1509		residency can document that these sessions are
1510		used for gynecology care above and beyond the
1511		routine care provided by the continuity physicians.
1512		
1513	IV.A.5.b).(5)	Care of the Surgical Patient
1514		
1515		must receive instruction with special emphasis on the
1516		diagnosis and management of surgical disorders and
1517		emergencies and the appropriate and timely referral of
1518		surgical cases for specialized care;
1519		
1520	IV.A.5.b).(5).(a)	Residents must be taught to appreciate the
1521		varieties of surgical treatments and the potential
1522		risks associated with them to enable them to give
1523		proper advice, explanation, and emotional support
1524		to patients and their families. The residents should
1525		also be taught to recognize conditions that are
1526		preferably managed on an elective basis.
1527		
1528	IV.A.5.b).(5).(b)	The program must provide all residents with
1529		training in preoperative and postoperative care,
1530		basic surgical principles, asepsis, handling of

1531		tissue, and technical skills to assist the surgeon in
1532		the operating room. The residents should develop
1533		technical proficiency in those specific surgical
1534		procedures that family physicians may be called on
1535		to perform.
1536		
1537	IV.A.5.b).(5).(c)	Residents must be required to participate in a
1538		structured experience in general surgery of at least
1539		two months, including ambulatory care (non-
1540		inpatient care: e.g., surgical centers, emergency
1541		room and physician offices), operating room
1542		experience, and post-operative experience.
1543		
1544	IV.A.5.b).(5).(c).(i)	Experiences in general surgery must be
1545		designed to provide opportunity for
1546		residents to achieve competency in the
1547		diagnosis and management of a wide
1548		variety of common surgical problems
1549		typically cared for by family physicians.
1550		Experiences are usually expected to be with
1551		general surgeons. If non-generalist
1552		surgeons are used for this experience, the
1553		program director must explain how this
1554		experience exposes residents to common
1555		surgical problems.
1556		
1557	IV.A.5.b).(5).(c).(ii)	If surgical experience occurs in conjunction
1558		with a family medicine or internal medicine
1559		service, the program must document how
1560		each resident meets the required surgical
1561		experience.
1562		
1563	IV.A.5.b).(5).(d)	Surgical Subspecialties: In addition to the general
1564		surgery experience, residents must have
1565		adequately structured, hands-on educational
1566		experiences in the following subspecialty areas:
1567		otorhinolaryngology, to include oral health, urology,
1568		and ophthalmology. This must be in addition to
1569		resident experience with continuity patients during
1570		routine care in FMC and must involve disorders that
1571		are commonly seen in a family physician's office.
1572		
1573	IV.A.5.b).(6)	Musculoskeletal and Sports Medicine
1574		
1575		must have two months experience in the care of patients
1576		with orthopedic and musculoskeletal problems, including
1577		experience in sports medicine.
1578		
1579	IV.A.5.b).(6).(a)	The curriculum should include non-articular
1580		rheumatic disorders, infectious, suppurative and
1581		degenerative arthritic conditions, acquired and

1582		congenital abnormalities of bones and joints,
1583		musculoskeletal and connective tissue disorders,
1584		evaluation and management of common sprains,
1585		fractures and dislocations, preventive care,
1586		rehabilitation and restorative function. Clinical
1587		experience should include acute evaluation of
1588		musculoskeletal trauma and acute pain syndromes.
1589		
1590	IV.A.5.b).(6).(b)	Sports medicine must be a clear and separate
1591		curriculum within the two-month/200 hours of
1592		experience and must include non-orthopedic
1593		aspects of sports medicine with emphasis on care
1594		of athletes of all ages, both genders, and persons
1595		active or anticipating exercise activities. The care of
1596		the athlete includes performance of pre-
1597		participation sports physicals, assessment of
1598		common injuries, knowledge of treatment and
1599		rehabilitation. Both curricula must include
1600		performance of procedures common in the
1601		evaluation and care of orthopedic and sports
1602		medicine patients and participation in the
1603		rehabilitation required for these patients. These
1604		include interpretation of radiographs, aspiration and
1605		injection of joints, splinting and casting.
1606		
1607	IV.A.5.b).(7)	Emergency Care
1608		
1609		must have a structured educational experience that trains
1610		them to deliver emergency care that includes didactic
1611		teaching, skills training, and clinical experience in caring
1612		for patients of all ages with acute illnesses and injuries in
1613		an emergency care setting.
1614		
1615	IV.A.5.b).(7).(a)	Residents should receive structured skills training
1616		in all standard current life support skills (e.g. ACLS
1617		and PALS), and should learn procedures for both
1618		trauma and medical emergencies in patients of all
1619		ages.
1620		
1621	IV.A.5.b).(7).(b)	This clinical experience should encompass 200
1622		hours of emergency medicine training.
1623		
1624	IV.A.5.b).(7).(c)	The setting used for this training must offer the full
1625		spectrum of emergency services, and on-site
1626		faculty supervision must be available at all times.
1627		Suitable facilities and adequate support personnel
1628		must be present for resident training. The patients
1629		seen by family medicine residents should be
1630		representative of the patient population served by
1631		the emergency care facility overall.
1632		

1633	IV.A.5.b).(8)	Human Behavior and Mental Health
1634		
1635		should acquire knowledge and skills in this area through a
1636		program in which behavioral science and psychiatry are
1637		integrated with all disciplines throughout the residents' total
1638		educational experience.
1639		
1640	IV.A.5.b).(8).(a)	Training should be accomplished primarily in an
1641		outpatient setting through a combination of
1642		longitudinal experiences and didactic sessions.
1643		Intensive short-term experiences in facilities
1644		devoted to the care of chronically ill patients should
1645		be limited.
1646		
1647	IV.A.5.b).(8).(b)	There must be faculty who are specifically
1648		designated for this curricular component who have
1649		the training and experience necessary to apply
1650		modern behavioral and psychiatric principles to the
1651		care of the undifferentiated patient. Family
1652		physicians, psychiatrists, and behavioral scientists
1653		should be involved in teaching this curricular
1654		component.
1655		
1656	IV.A.5.b).(8).(c)	There must be instruction and development of skills
1657		in the diagnosis and management of psychiatric
1658		disorders in children and adults, emotional aspects
1659		of non-psychiatric disorders, psychopharmacology,
1660		alcoholism and other substance abuse, the
1661		physician/patient relationship, patient interviewing
1662		skills, and counseling skills. This should include
1663		videotaping of resident/patient encounters or direct
1664		faculty observation for assessment of each
1665		resident's competency in interpersonal skills. This
1666		will require sufficient faculty who participate on an
1667		on-going basis in the program, and in the FMC, in
1668		particular.
1669		
1670	IV.A.5.b).(9)	Community Medicine
1671		
1672		must receive a structured curriculum in community
1673		medicine, including didactic and some experiential
1674		components. The curriculum should include:
1675		
1676	IV.A.5.b).(9).(a)	assessment of risks for abuse, neglect, and family
1677		and community violence;
1678		
1679	IV.A.5.b).(9).(b)	reportable communicable disease;
1680		
1681	IV.A.5.b).(9).(c)	population epidemiology, and the interpretation of
1682		public health statistical information;
1683		

1684	IV.A.5.b).(9).(d)	environmental illness and injury;
1685		
1686	IV.A.5.b).(9).(e)	school health;
1687		
1688	IV.A.5.b).(9).(f)	disease prevention through immunization
1689		strategies;
1690		
1691	IV.A.5.b).(9).(g)	disaster responsiveness;
1692		
1693	IV.A.5.b).(9).(h)	community-based disease screening, prevention,
1694		health promotion; and,
1695		
1696	IV.A.5.b).(9).(i)	factors associated with differential health status
1697		among sub-populations, including racial,
1698		geographic, or socioeconomic health disparities,
1699		and the role of family physicians in reducing such
1700		gaps.
1701		
1702		The program should also require that each resident
1703		participate in clinical experiences in community medicine
1704		including:
1705		
1706	IV.A.5.b).(9).(j)	experience in using community resources
1707		appropriately for individual patients who have
1708		unmet medical or social support needs;
1709		
1710	IV.A.5.b).(9).(k)	structured interaction with the public health system;
1711		
1712	IV.A.5.b).(9).(l)	occupational medicine including disability
1713		determination, employee health and job-related
1714		illness and injury;
1715		
1716	IV.A.5.b).(9).(m)	experience in community health assessment;
1717		
1718	IV.A.5.b).(9).(n)	experience in developing programs to address
1719		community health priorities; and,
1720		
1721	IV.A.5.b).(9).(o)	community-based health education of children and
1722		adults.
1723		
1724	IV.A.5.b).(10)	Care of the Skin
1725		
1726		must be exposed to diagnosis and management of
1727		common dermatologic conditions;
1728		
1729	IV.A.5.b).(10).(a)	These must include, but not be limited to, viral,
1730		bacterial, allergic and fungal infections, ulcers,
1731		rashes, malignant and pre-malignant skin lesions,
1732		and dermatologic manifestations of system
1733		disease. This training should include experience in
1734		the surgical excision of skin lesions and

1735		performance of other dermatologic procedures with
1736		supervision by a physician with documented
1737		competence in this area. This may include
1738		experience gained in the FMC, provided that
1739		appropriate documentation is maintained for each
1740		resident.
1741		
1742	IV.A.5.b).(11)	Diagnostic Imaging and Nuclear Medicine
1743		
1744		must receive a structured opportunity to learn the
1745		appropriate application of techniques and specialty
1746		consultations in the diagnostic imaging and nuclear
1747		medicine therapy of organs and body systems. Instruction
1748		should include the limitations and risks attendant to these
1749		techniques.
1750		
1751	IV.A.5.b).(11).(a)	The format of the instruction should be adapted to
1752		the resources available, but must include
1753		radiographic film/diagnostic imaging interpretation
1754		and nuclear medicine therapy pertinent to family
1755		medicine.
1756		
1757	IV.A.5.b).(12)	Management of Health Systems
1758		
1759		must receive at least 100 hours of management and
1760		leadership instruction to include both the didactic and the
1761		practical settings.
1762		
1763	IV.A.5.b).(12).(a)	This curriculum should prepare residents to
1764		assume leadership roles in their practices, their
1765		communities, and the profession of medicine. The
1766		residency must have specific strategies to
1767		demonstrate that residents have mastered these
1768		skills.
1769		
1770	IV.A.5.b).(12).(b)	The FMC must be considered the primary site for
1771		teaching management and leadership skills, and
1772		should serve as an example on which residents
1773		may model their future practices.
1774		
1775	IV.A.5.b).(12).(c)	Each resident must receive reports of individual
1776		and practice productivity, financial performance,
1777		patient satisfaction and clinical quality, at least
1778		quarterly, as well as the training needed to analyze
1779		these reports. Residents must attend regular
1780		monthly FMC business meetings with staff and
1781		faculty to discuss practice-related policies and
1782		procedures, business and service goals, and
1783		practice efficiency and quality.
1784		
1785	IV.A.5.b).(12).(d)	They must participate in projects to improve the

1786		quality of care and service delivered to the FMC
1787		patient population.
1788		
1789	IV.A.5.b).(12).(e)	The management curriculum should include current
1790		billing practices, designing and managing a budget,
1791		assessing practice staffing needs, the impact of
1792		new technologies on practice, determining value in
1793		the marketplace, assessing customer satisfaction,
1794		measurement of clinical quality, tort liability and risk
1795		management, office scheduling systems,
1796		computers in practice, alternative practice models,
1797		and employment law and procedures. Residents
1798		should also learn principles of public relations,
1799		media training, and personnel management.
1800		
1801	IV.A.5.b).(12).(f)	The leadership curriculum should include training to
1802		provide leadership for a clinical practice, a hospital
1803		medical staff, professional organizations, and
1804		community leadership skills to advocate for the
1805		public health.
1806		
1807	IV.A.5.b).(13)	Electives
1808		
1809		must have a minimum of three and a maximum of six
1810		months of appropriately supervised electives. Electives are
1811		intended primarily to enrich the residents' training with
1812		experiences relevant to their plans for future practice or
1813		their interests as family physicians. The choice of electives
1814		by the resident, including those for remedial purposes,
1815		must be made with the approval of the program director.
1816		
1817	IV.A.5.c)	Practice-based Learning and Improvement
1818		
1819		Residents must demonstrate the ability to investigate and
1820		evaluate their care of patients, to appraise and assimilate
1821		scientific evidence, and to continuously improve patient care
1822		based on constant self-evaluation and life-long learning.
1823		Residents are expected to develop skills and habits to be able
1824		to meet the following goals:
1825		
1826	IV.A.5.c).(1)	identify strengths, deficiencies, and limits in one's
1827		knowledge and expertise;
1828		
1829	IV.A.5.c).(2)	set learning and improvement goals;
1830		
1831	IV.A.5.c).(3)	identify and perform appropriate learning activities;
1832		
1833	IV.A.5.c).(4)	systematically analyze practice using quality
1834		improvement methods, and implement changes with
1835		the goal of practice improvement;
1836		

1837	IV.A.5.c).(5)	incorporate formative evaluation feedback into daily practice;
1838		
1839		
1840	IV.A.5.c).(6)	locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
1841		
1842		
1843		
1844	IV.A.5.c).(7)	use information technology to optimize learning; and,
1845		
1846	IV.A.5.c).(8)	participate in the education of patients, families, students, residents and other health professionals.
1847		
1848		
1849	IV.A.5.d)	Interpersonal and Communication Skills
1850		
1851		Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:
1852		
1853		
1854		
1855		
1856	IV.A.5.d).(1)	communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
1857		
1858		
1859		
1860	IV.A.5.d).(2)	communicate effectively with physicians, other health professionals, and health related agencies;
1861		
1862		
1863	IV.A.5.d).(3)	work effectively as a member or leader of a health care team or other professional group;
1864		
1865		
1866	IV.A.5.d).(4)	act in a consultative role to other physicians and health professionals; and,
1867		
1868		
1869	IV.A.5.d).(5)	maintain comprehensive, timely, and legible medical records, if applicable.
1870		
1871		
1872	IV.A.5.e)	Professionalism
1873		
1874		Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:
1875		
1876		
1877		
1878	IV.A.5.e).(1)	compassion, integrity, and respect for others;
1879		
1880	IV.A.5.e).(2)	responsiveness to patient needs that supersedes self-interest;
1881		
1882		
1883	IV.A.5.e).(3)	respect for patient privacy and autonomy;
1884		
1885	IV.A.5.e).(4)	accountability to patients, society and the profession; and,
1886		
1887		

1888	IV.A.5.e).(5)	sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.
1889		
1890		
1891		
1892		
1893	IV.A.5.f)	Systems-based Practice
1894		
1895		Residents must 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.
1896		
1897		
1898		
1899		Residents are expected to:
1900		
1901	IV.A.5.f).(1)	work effectively in various health care delivery settings and systems relevant to their clinical specialty;
1902		
1903		
1904		
1905	IV.A.5.f).(2)	coordinate patient care within the health care system relevant to their clinical specialty;
1906		
1907		
1908	IV.A.5.f).(3)	incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
1909		
1910		
1911		
1912	IV.A.5.f).(4)	advocate for quality patient care and optimal patient care systems;
1913		
1914		
1915	IV.A.5.f).(5)	work in interprofessional teams to enhance patient safety and improve patient care quality;
1916		
1917		
1918	IV.A.5.f).(6)	participate in identifying system errors and implementing potential systems solutions; and,
1919		
1920		
1921	IV.A.5.f).(7)	be taught to develop the skills necessary for career-long professional learning sufficient to maintain certification in the specialty. These should include:
1922		
1923		
1924		
1925	IV.A.5.f).(7).(a)	knowledge sufficient to pass the ABFM certification exam;
1926		
1927		
1928	IV.A.5.f).(7).(b)	ability to collect a complete initial data base and examination;
1929		
1930		
1931	IV.A.5.f).(7).(c)	ability to define and expand the differential diagnoses list;
1932		
1933		
1934	IV.A.5.f).(7).(d)	identification of the most likely diagnoses and the establishing of a plan for diagnostic and treatment modalities;
1935		
1936		
1937		
1938	IV.A.5.f).(7).(e)	ability to educate the patient and family about the

1939		diagnoses, evaluation and treatment of the disease,
1940		to obtain informed consent, and perform
1941		appropriate procedures;
1942		
1943	IV.A.5.f).(7).(f)	ability to practice in a team and with a systems-
1944		based approach;
1945		
1946	IV.A.5.f).(7).(g)	ability to present data to other members of the team
1947		and consultants;
1948		
1949	IV.A.5.f).(7).(h)	cost-conscious ordering of diagnostic tests and
1950		therapeutics;
1951		
1952	IV.A.5.f).(7).(i)	construction of a medical record summary with
1953		accuracy and in compliance with expected format
1954		and in compliance with the hospital's medical
1955		records policies;
1956		
1957	IV.A.5.f).(7).(j)	formulate short and long term goals; and,
1958		
1959	IV.A.5.f).(7).(k)	the providing of guidance to patients regarding
1960		advanced directives, end-of-life issues and
1961		unexpected diagnoses/outcomes.
1962		
1963	IV.B.	Residents' Scholarly Activities
1964		
1965	IV.B.1.	The curriculum must advance residents' knowledge of the basic
1966		principles of research, including how research is conducted,
1967		evaluated, explained to patients, and applied to patient care.
1968		
1969	IV.B.2.	Residents should participate in scholarly activity.
1970		
1971	IV.B.2.a)	Each program must provide supervised experiences for all
1972		residents in scholarly activities such as research, presentations at
1973		national, regional, state, or local professional meetings, or
1974		presentation and/or publication of review articles and case
1975		presentations. Formal instruction and practical experience must
1976		ensure that each resident develops and demonstrates skills in
1977		locating sources of scientific data pertinent to the care of patients,
1978		analyzing the appropriateness of research design and statistical
1979		methods, obtaining information about diagnostic and therapeutic
1980		effectiveness, and applying evidence from pertinent clinical
1981		studies to patient care.
1982		
1983	IV.B.2.b)	The program must provide a supervised, ongoing forum in which
1984		residents explore and analyze emerging scientific evidence
1985		pertinent to the practice of family medicine.
1986		
1987	IV.B.2.c)	Additionally, all residents must actively participate in scientific
1988		inquiry, either through direct participation in research, or
1989		undertaking scholarly projects that make use of the scientific

1990		methods noted above.
1991		
1992	IV.B.2.d)	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.
1993		
1994		
1995		
1996		
1997	IV.B.3.	The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.
1998		
1999		
2000		
2001	V	Evaluation
2002		
2003	V.A.	Resident Evaluation
2004		
2005	V.A.1.	Formative Evaluation
2006		
2007	V.A.1.a)	The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.
2008		
2009		
2010		
2011		
2012	V.A.1.b)	The program must:
2013		
2014	V.A.1.b).(1)	provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
2015		
2016		
2017		
2018		
2019		
2020	V.A.1.b).(2)	use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
2021		
2022		
2023	V.A.1.b).(3)	document progressive resident performance improvement appropriate to educational level; and,
2024		
2025		
2026	V.A.1.b).(4)	provide each resident with documented semiannual evaluation of performance with feedback.
2027		
2028		
2029	V.A.1.c)	The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
2030		
2031		
2032		
2033	V.A.1.d)	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.
2034		
2035		
2036		
2037		
2038		
2039	V.A.2.	Summative Evaluation
2040		

2041 **The program director must provide a summative evaluation for each**
2042 **resident upon completion of the program. This evaluation must**
2043 **become part of the resident’s permanent record maintained by the**
2044 **institution, and must be accessible for review by the resident in**
2045 **accordance with institutional policy. This evaluation must:**
2046

2047 **V.A.2.a) document the resident’s performance during the final period**
2048 **of education, and**

2049

2050 **V.A.2.b) verify that the resident has demonstrated sufficient**
2051 **competence to enter practice without direct supervision.**
2052

2053 **V.B. Faculty Evaluation**

2054

2055 **V.B.1. At least annually, the program must evaluate faculty performance as**
2056 **it relates to the educational program.**
2057

2058 **V.B.2. These evaluations should include a review of the faculty’s clinical**
2059 **teaching abilities, commitment to the educational program, clinical**
2060 **knowledge, professionalism, and scholarly activities.**
2061

2062 **V.B.3. This evaluation must include at least annual written confidential**
2063 **evaluations by the residents.**
2064

2065 **V.B.4. This on-going faculty assessment/evaluation system should facilitate**
2066 **faculty development. Additionally, the program should use resident**
2067 **evaluations of the faculty to help determine their areas of special interest**
2068 **and appropriate teaching.**
2069

2070 **V.C. Program Evaluation and Improvement**

2071

2072 **V.C.1. The program must document formal, systematic evaluation of the**
2073 **curriculum at least annually. The program must monitor and track**
2074 **each of the following areas:**
2075

2076 **V.C.1.a) resident performance;**
2077

2078 **V.C.1.b) faculty development;**
2079

2080 **V.C.1.c) graduate performance, including performance of program**
2081 **graduates on the certification examination; and,**
2082

2083 **V.C.1.c).(1) Each program must maintain a system of evaluation of its**
2084 **graduates. The residency should obtain feedback on**
2085 **demographic and practice profiles, licensure and board**
2086 **certification, the graduates' perceptions of the relevancy of**
2087 **training to practice, suggestions for improving the training,**
2088 **ideas for new areas of curriculum, and identification of**
2089 **which procedures are done in practice. The suggested**
2090 **format is a written survey after one year and every five**
2091 **years thereafter.**

2092		
2093	V.C.1.c).(2)	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.
2094		
2095		
2096		
2097	V.C.1.d)	program quality. Specifically:
2098		
2099	V.C.1.d).(1)	Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
2100		
2101		
2102		
2103	V.C.1.d).(2)	The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
2104		
2105		
2106		
2107	V.C.2.	If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.
2108		
2109		
2110		
2111		
2112		
2113	V.C.3.	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 Review Committee will take into consideration the information provided by ABFM regarding resident performance on the certifying examinations over a period of several years.
2114		
2115		
2116		
2117		
2118		
2119		
2120	V.C.4.	The committee will use scores for a minimum of three and a maximum of five 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.
2121		
2122		
2123		
2124		
2125		
2126		
2127	VI. Resident Duty Hours in the Learning and Working Environment	
2128		
2129	VI.A. Professionalism, Personal Responsibility, and Patient Safety	
2130		
2131	VI.A.1.	Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
2132		
2133		
2134		
2135		
2136	VI.A.2.	The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
2137		
2138		
2139		
2140	VI.A.3.	The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
2141		
2142		

- 2143
2144 **VI.A.4.** **The learning objectives of the program must:**
2145
2146 **VI.A.4.a)** **be accomplished through an appropriate blend of supervised**
2147 **patient care responsibilities, clinical teaching, and didactic**
2148 **educational events; and,**
2149
2150 **VI.A.4.b)** **not be compromised by excessive reliance on residents to**
2151 **fulfill non-physician service obligations.**
2152
2153 **VI.A.5.** **The program director and institution must ensure a culture of**
2154 **professionalism that supports patient safety and personal**
2155 **responsibility. Residents and faculty members must demonstrate an**
2156 **understanding and acceptance of their personal role in the**
2157 **following:**
2158
2159 **VI.A.5.a)** **assurance of the safety and welfare of patients entrusted to**
2160 **their care;**
2161
2162 **VI.A.5.b)** **provision of patient- and family-centered care;**
2163
2164 **VI.A.5.c)** **assurance of their fitness for duty;**
2165
2166 **VI.A.5.d)** **management of their time before, during, and after clinical**
2167 **assignments;**
2168
2169 **VI.A.5.e)** **recognition of impairment, including illness and fatigue, in**
2170 **themselves and in their peers;**
2171
2172 **VI.A.5.f)** **attention to lifelong learning;**
2173
2174 **VI.A.5.g)** **the monitoring of their patient care performance improvement**
2175 **indicators; and,**
2176
2177 **VI.A.5.h)** **honest and accurate reporting of duty hours, patient**
2178 **outcomes, and clinical experience data.**
2179
2180 **VI.A.6.** **All residents and faculty members must demonstrate**
2181 **responsiveness to patient needs that supersedes self-interest.**
2182 **Physicians must recognize that under certain circumstances, the**
2183 **best interests of the patient may be served by transitioning that**
2184 **patient’s care to another qualified and rested provider.**
2185
2186 **VI.B.** **Transitions of Care**
2187
2188 **VI.B.1.** **Programs must design clinical assignments to minimize the number**
2189 **of transitions in patient care.**
2190
2191 **VI.B.2.** **Sponsoring institutions and programs must ensure and monitor**
2192 **effective, structured hand-over processes to facilitate both**
2193 **continuity of care and patient safety.**

2194		
2195	VI.B.3.	Programs must ensure that residents are competent in communicating with team members in the hand-over process.
2196		
2197		
2198	VI.B.4.	The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.
2199		
2200		
2201		
2202		
2203	VI.C.	Alertness Management/Fatigue Mitigation
2204		
2205	VI.C.1.	The program must:
2206		
2207	VI.C.1.a)	educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
2208		
2209		
2210	VI.C.1.b)	educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
2211		
2212		
2213	VI.C.1.c)	adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.
2214		
2215		
2216		
2217	VI.C.2.	Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
2218		
2219		
2220		
2221	VI.C.3.	The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.
2222		
2223		
2224		
2225	VI.D.	Supervision of Residents
2226		
2227	VI.D.1.	In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.
2228		
2229		
2230		
2231		
2232		
2233	VI.D.1.a)	This information should be available to residents, faculty members, and patients.
2234		
2235		
2236	VI.D.1.b)	Residents and faculty members should inform patients of their respective roles in each patient's care.
2237		
2238		
2239	VI.D.2.	The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.
2240		
2241		
2242		Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising
2243		
2244		

2245 physician may be a more advanced resident or fellow. Other
2246 portions of care provided by the resident can be adequately
2247 supervised by the immediate availability of the supervising faculty
2248 member or resident physician, either in the institution, or by means
2249 of telephonic and/or electronic modalities. In some circumstances,
2250 supervision may include post-hoc review of resident-delivered care
2251 with feedback as to the appropriateness of that care.
2252

2253 **VI.D.3. Levels of Supervision**

2254
2255 To ensure oversight of resident supervision and graded authority
2256 and responsibility, the program must use the following classification
2257 of supervision:
2258

2259 **VI.D.3.a) Direct Supervision – the supervising physician is physically**
2260 **present with the resident and patient.**

2261
2262 **VI.D.3.b) Indirect Supervision:**

2263
2264 **VI.D.3.b).(1) with direct supervision immediately available – the**
2265 **supervising physician is physically within the hospital**
2266 **or other site of patient care, and is immediately**
2267 **available to provide Direct Supervision.**

2268
2269 **VI.D.3.b).(2) with direct supervision available – the supervising**
2270 **physician is not physically present within the hospital**
2271 **or other site of patient care, but is immediately**
2272 **available by means of telephonic and/or electronic**
2273 **modalities, and is available to provide Direct**
2274 **Supervision.**

2275
2276 **VI.D.3.c) Oversight – the supervising physician is available to provide**
2277 **review of procedures/encounters with feedback provided**
2278 **after care is delivered.**

2279
2280 **VI.D.4. The privilege of progressive authority and responsibility, conditional**
2281 **independence, and a supervisory role in patient care delegated to**
2282 **each resident must be assigned by the program director and faculty**
2283 **members.**

2284
2285 **VI.D.4.a) The program director must evaluate each resident’s abilities**
2286 **based on specific criteria. When available, evaluation should**
2287 **be guided by specific national standards-based criteria.**

2288
2289 **VI.D.4.b) Faculty members functioning as supervising physicians**
2290 **should delegate portions of care to residents, based on the**
2291 **needs of the patient and the skills of the residents.**

2292
2293 **VI.D.4.c) Senior residents or fellows should serve in a supervisory role**
2294 **of junior residents in recognition of their progress toward**
2295 **independence, based on the needs of each patient and the**

2296		skills of the individual resident or fellow.
2297		
2298	VI.D.5.	Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.
2299		
2300		
2301		
2302		
2303	VI.D.5.a)	Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
2304		
2305		
2306		
2307	VI.D.5.a).(1)	In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.
2308		
2309		
2310		
2311	VI.D.6.	Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.
2312		
2313		
2314		
2315		
2316	VI.E.	Clinical Responsibilities
2317		
2318		The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
2319		
2320		
2321		
2322		The program director must have the authority and responsibility to set appropriate clinical responsibilities (i.e., patient caps) for each resident.
2323		
2324		
2325	VI.F.	Teamwork
2326		
2327		Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.
2328		
2329		
2330		
2331		
2332	VI.G.	Resident Duty Hours
2333		
2334	VI.G.1.	Maximum Hours of Work per Week
2335		
2336		Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
2337		
2338		
2339		
2340	VI.G.1.a)	Duty Hour Exceptions
2341		
2342		A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.
2343		
2344		
2345		
2346		The Review Committee for Family Medicine will not consider

2347		requests for exceptions to the 80-hour limit to the residents' work
2348		week.
2349		
2350	VI.G.1.a).(1)	In preparing a request for an exception the program
2351		director must follow the duty hour exception policy
2352		from the ACGME Manual on Policies and Procedures.
2353		
2354	VI.G.1.a).(2)	Prior to submitting the request to the Review
2355		Committee, the program director must obtain approval
2356		of the institution's GMEC and DIO.
2357		
2358	VI.G.2.	Moonlighting
2359		
2360	VI.G.2.a)	Moonlighting must not interfere with the ability of the resident
2361		to achieve the goals and objectives of the educational
2362		program.
2363		
2364	VI.G.2.b)	Time spent by residents in Internal and External Moonlighting
2365		(as defined in the ACGME Glossary of Terms) must be
2366		counted towards the 80-hour Maximum Weekly Hour Limit.
2367		
2368	VI.G.2.c)	PGY-1 residents are not permitted to moonlight.
2369		
2370	VI.G.3.	Mandatory Time Free of Duty
2371		
2372		Residents must be scheduled for a minimum of one day free of duty
2373		every week (when averaged over four weeks). At-home call cannot
2374		be assigned on these free days.
2375		
2376	VI.G.4.	Maximum Duty Period Length
2377		
2378	VI.G.4.a)	Duty periods of PGY-1 residents must not exceed 16 hours in
2379		duration.
2380		
2381	VI.G.4.b)	Duty periods of PGY-2 residents and above may be
2382		scheduled to a maximum of 24 hours of continuous duty in
2383		the hospital. Programs must encourage residents to use
2384		alertness management strategies in the context of patient
2385		care responsibilities. Strategic napping, especially after 16
2386		hours of continuous duty and between the hours of 10:00
2387		p.m. and 8:00 a.m., is strongly suggested.
2388		
2389	VI.G.4.b).(1)	It is essential for patient safety and resident education
2390		that effective transitions in care occur. Residents may
2391		be allowed to remain on-site in order to accomplish
2392		these tasks; however, this period of time must be no
2393		longer than an additional four hours.
2394		
2395	VI.G.4.b).(2)	Residents must not be assigned additional clinical
2396		responsibilities after 24 hours of continuous in-house
2397		duty.

2398		
2399	VI.G.4.b).(3)	In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
2400		
2401		
2402		
2403		
2404		
2405		
2406		
2407		
2408	VI.G.4.b).(3).(a)	Under those circumstances, the resident must:
2409		
2410	VI.G.4.b).(3).(a).(i)	appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
2411		
2412		
2413		
2414	VI.G.4.b).(3).(a).(ii)	document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
2415		
2416		
2417		
2418		
2419	VI.G.4.b).(3).(b)	The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
2420		
2421		
2422		
2423		
2424	VI.G.5.	Minimum Time Off between Scheduled Duty Periods
2425		
2426	VI.G.5.a)	PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
2427		
2428		
2429	VI.G.5.b)	Intermediate-level residents should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
2430		
2431		
2432		
2433		
2434		PGY-2 residents are considered to be at the intermediate-level.
2435		
2436	VI.G.5.c)	Residents in the final years of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.
2437		
2438		
2439		
2440		PGY-3 residents are considered to be in the final years of education.
2441		
2442		
2443	VI.G.5.c).(1)	This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents
2444		
2445		
2446		
2447		
2448		

2449 must stay on duty to care for their patients or return to
2450 the hospital with fewer than eight hours free of duty.
2451
2452 **VI.G.5.c).(1).(a)** **Circumstances of return-to-hospital activities**
2453 **with fewer than eight hours away from the**
2454 **hospital by residents in their final years of**
2455 **education must be monitored by the program**
2456 **director.**
2457
2458 **VI.G.5.c).(1).(b)** The Review Committee defines such
2459 circumstances as: required continuity of care for a
2460 severely ill or unstable patient, or a complex patient
2461 with whom the resident has been involved; events
2462 of exceptional educational value; or, humanistic
2463 attention to the needs of a patient or family.
2464
2465 **VI.G.6. Maximum Frequency of In-House Night Float**
2466
2467 **Residents must not be scheduled for more than six consecutive**
2468 **nights of night float.**
2469
2470 **VI.G.6.a)** Night float experiences must not exceed 50 percent of a resident's
2471 inpatient experiences.
2472
2473 **VI.G.7. Maximum In-House On-Call Frequency**
2474
2475 **PGY-2 residents and above must be scheduled for in-house call no**
2476 **more frequently than every-third-night (when averaged over a four-**
2477 **week period).**
2478
2479 **VI.G.8. At-Home Call**
2480
2481 **VI.G.8.a)** **Time spent in the hospital by residents on at-home call must**
2482 **count towards the 80-hour maximum weekly hour limit. The**
2483 **frequency of at-home call is not subject to the every-third-**
2484 **night limitation, but must satisfy the requirement for one-day-**
2485 **in-seven free of duty, when averaged over four weeks.**
2486
2487 **VI.G.8.a).(1)** **At-home call must not be so frequent or taxing as to**
2488 **preclude rest or reasonable personal time for each**
2489 **resident.**
2490
2491 **VI.G.8.b)** **Residents are permitted to return to the hospital while on at-**
2492 **home call to care for new or established patients. Each**
2493 **episode of this type of care, while it must be included in the**
2494 **80-hour weekly maximum, will not initiate a new "off-duty**
2495 **period".**
2496
2497 **VII. Innovative Projects**
2498
2499 **Requests for innovative projects that may deviate from the institutional, common**

2500 **and/or specialty specific program requirements must be approved in advance by**
2501 **the Review Committee. In preparing requests, the program director must follow**
2502 **Procedures for Approving Proposals for Innovative Projects located in the**
2503 **ACGME Manual on Policies and Procedures. Once a Review Committee approves**
2504 **a project, the sponsoring institution and program are jointly responsible for the**
2505 **quality of education offered to residents for the duration of such a project.**

2506

2507

2508

2509 ACGME Approved: September 2005 Effective Date: July 1, 2006

2510 Revised Common Program Requirements Effective: July 1, 2011