Family medicine organization convening focus group: Society of Teachers of Family Medicine

Participants (type and name): Behavioral Science Faculty

	What questions did your focus group address and discuss?	**What themes were developed in the discussion?**	**Any foundational or critical components in the themes?**
1	How should we teach?	A lot of what we've been doing still works. Residents should learn from being with real physicians who are providing care for real patients. Teaching should be relationship-based. Not just physician and patient, but attending and residents. Relationships between residents and mentors are important, too. Need more reflection embedded in the teaching process. The experiences are half the job. Residents need the opportunity to reflect on what they've seen and done. Reflections could be written or verbal. Individual or with others. Structed or not. Critical to change structure to make time for this kind of learning. Right now, residents are in a hamster will. Residents need to feel okay about taking time for this. Need a way for residents to spend time with community physicians who are family physicians so they can see what it is really like to see continuity of care. Many are not getting the experience of a full ambulatory practice. Residents are working so fast and so hard there's little to no learning going on. That probably had a purpose at some point, but we need to revisit that. There ae so many requirements. Consider the quadruple aim when	Residents learn from observing and working with family physicians in clinical practices. Time for and a structure for reflection needs to be built into the educational process.

		looking at requirements. Need more time for self awareness.	
2	How should residents learn and be assessed?	Direct observation is important. Need time for direct feedback, which is much more meaningful than written evaluation with checked boxes. Video-taped observation is important so learner can reflect first. CCC process is generally a good framework, however it's too easy to go through that process without ever giving residents any type of qualitative feedback. That's not required. Need to broaden scope of who completes assessments. Need to give nurses and others who deal with residents on a regular basis an opportunity to assess residents. Requirements need to address this. Commit to broader 360 evaluation.	Requirements should more explicitly state that there should be multidisciplinary assessment by faculty and providers who work with residents regularly
3	What is the right balance between experience/time—for example, counting weeks of curriculum or numbers of visits and specific clinical competencies?	Flexibility in current requirements is helpful – in some instances allows for time vs number of visits. Counting patients is a challenge due to how EHRs work/count. The right balance varies, depending on location. How do you meet number requirements when you're training in an a rural area with low patient volume? Can Peds ED requirement go away? There's no way to count this. We spend a lot of time counting and collecting. This is not necessarily a good reflection of learning. The time residents spend counting and logging could be spent reflecting on learning. How long does it take to have an "ah-ha" experience? There's no right number. It varies by resident. People	It's not a one-size-fits all. Residents learn differently and the ability to meet #s requirements can be a challenge in rural settings. There are current requirements (e.g. Peds ED and surgery) that are taking up time that could be spent on customizing learning based on need and interest. Faculty need to be better trained (spelled out in requirements) to customize teaching.

		learn differently. Would be ideal to try to customize learning experiences. The requirements could include more robust expectations for faculty development, so they know how to customize teaching/learning. FD requirements are pretty thin right now. There are things suggested in the requirements that could be more explicit. Need some flexibility. There are requirements that become a barrier to learning (like number of weeks on surgery). This is not critical to FPs going into practice. Limits other opportunities for electives. Doesn't allow time to shift if someone needs more training in something. In practice, doctors will do different things. Learning through teaching could be bumped up in the requirements.	
4	How do we prepare physicians to respond to their communities' emerging needs as well as for changing locations, populations and scope of practice over their careers?	The importance of self-reflection and self-evaluation is critical. If a learner knows how to learn and teach themselves, they can be adaptable and learn what they need to learn when they need to. Create life-long learners. Need to get out in the community more. Residents learn through home visits and alcohol/rehab centers, etc. Residents sometimes don't think about the bigger picture. Would like to see requirements about this. Too little is invested in mezzo and macro level. Have residents do an environmental scan and needs assessment so they'll know how to do it on their own in the future. Need time-based requirements for population health. There used to be	Need to train residents to learn and to teach themselves, so they can be adaptable and learn what they need to learn when they need to learn it. Need more explicit requirements about community involvement. Make sure behavioral health continues to be stressed in the requirements.

		a community medicine requirement. This went away a while ago. Need to make sure behavioral health continues to be stressed in requirements. It has been watered down. Must be explicit. Medical knowledge has a life of 5 years. Behavioral health knowledge is ongoing. Behavioral health needs to be taught by behavioral health faculty. Look at the ACGME survey – what are people doing in their practices? Teach to that to identify priorities. Find ways to strengthen the sense of what it means to be holistic.	