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

Participants (type and name): Physician faculty who are not program directors

	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?	We've discovered that learning has been enhanced through virtual didactics. We're getting better participation, have been able to bring in more speakers, and can start on time. Residents don't have to travel. We do still need protected time for residents for this. Will need some in-person didactics in the future, especially for interns who don't know the community. We need to pay more attention to teaching residents to write notes. Medical decision-making documentation is becoming a lost art. Notes are how we communicate to ourselves and other clinicians what our plan is for continuity of care. Residents are viewing the note as a billing tool. Residents are in a hurry. The Boards and certification are too focused on memorizing. It's unacceptable in 2020 to expect people to memorize obscure answers. Learning is about thinking.	Virtual didactics are effective. Residents need to document medical decision making. Teach residents to think, not to memorize.
2	What is the right balance between experience/time—for example, counting weeks of curriculum or numbers of visits and specific clinical competencies?	Requirements are so stringent; residents don't always get enough deliveries/continuities for OB. Milestones evaluation is a good idea. Some could be better defined. Not everyone understands what they truly mean and how to measure them. Meeting numbers requirements is not always useful. What residents	Meeting numbers requirements is not always useful, and residents are traveling in order to meet minimums for things they're not likely to do in practice. Make the requirements broad, with an opportunity for programs to tailor 2nd and 3rd years to accomplish residents' goals.

		need is a good experience in a given subject. Meeting OB requirements is difficult for community programs. And residents are not getting much true experiential learning. They're traveling to places where they're minimally involved and there aren't many patients. Most FPs do not deliver babies. Small programs have a difficult time training in some specialties. Is it worth residents driving a couple hours away to learn, for example, ENT, ophthalmology, and urology? This is disruptive and not totally useful. Don't completely get rid of that training, but the requirements may be too much. Maybe the surgery requirement could be updated. Make the requirements broad, with an opportunity for the program to tailor 2nd and 3rd years to accomplish residents' goals.	
3	How should competencies be assessed systematically?	Assess by direct observation. Counseling can only be assessed through direct observation. Other things can be assessed through role play. Some places using OSCEs and standardized patients. Or simulation. It's important to assess how residents communicate with patients during a procedure. Need to discuss resident progress on a regular basis. Milestone evaluations have helped, but in some categories it's difficult to understand what is being strived for. Most programs have aligned rotation evaluations with milestones. Direct timely feedback is important.	Direct observation and timely feedback are important. Milestones are helpful, but could use some refinement.

4	Should family medicine residencies more fully implement competency-based education?	Competency should be the thing we strive for. We are graduating doctors who are not competent. There's too much emphasis on numbers. Performing procedures is important to learning, but we cannot presume that people are competent based on numbers. Competency is a developmental process. Start observing very early in the process and give ongoing feedback.	We cannot presume that people are competent based on numbers.
5	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?	You can train people to admit what they don't know and to find missing knowledge, and to build networks of people to call with questions. We need to produce well-rounded physicians who understand their limits. If you know you want to practice in a rural setting, you should look for a residency in a rural setting. You can't teach everything in residency. Medicine is a continuum of learning. Good physicians will keep learning.	Train residents to admit what they don't know and to find missing knowledge, and to build networks of people to call with questions. Residents should train in a setting similar to where they intend to practice.