Re-Envisioning Family Medicine Residency Education
Interim Comments/Themes from Residency Summit
1/15/21

What follows is an initial distillation of notes taken during and right after the meeting, the reflections of the summit planning group immediately after the meeting and on January 11, and feedback from participants collected by email immediately after the summit. Participants and the residency summit planning group have reviewed and commented on this list.

Please refer to the website RE-ENVISIONING FAMILY MEDICINE RESIDENCY EDUCATION (starfieldsummit.com) which documents all of the backgrounders, organizational surveys and other information related to the Summit. It will be kept up to date. We will post new information (including accepted papers) as we finalize them.

Key results and themes:

1. **There were new voices**. The national nomination process yielded 170+ nominations; 49 were selected on the basis of planned diversity of experience and skills, including under-represented minorities, gender, career phase (including many residents/students), region, osteopathy, professions other than medicine, rurality and institutional background. There were also 5 patient and public members. This was different than past tribal gatherings.

2. **The family of family medicine organizations leaned in**. All organizations contributed materially, starting with participation in the summit planning committee, to giving the Starfield name, to surveys and focus groups and support of paper writing. We encourage reviewing the focus group findings on the websites. They are thoughtful and bring the perspectives of many different groups. The surveys by AFMRD and ABFM are very relevant to our community wide discussion.

3. **The papers (n=31, with 5 others being finished) make excellent contributions**. Having them in advance was very important. Peer review in process for a dedicated issue of *Family Medicine*.

4. **Participants were engaged**. Virtually all participants reported reading all or almost all of papers in advance, and it showed in the discussion, which was crisp and to the point. We used a variety of meeting formats from large group to small group discussions and actively used the chat function to capture additional comments. We used Zoom polls to both drive and to reflect conversation; consider these representative of an informed and representative group, as the participants had read the articles in advance and heard the discussion. There were also groups meeting on the basis of career phase and region to give their perspective. Evaluations were very positive.

5. **There was consensus that family medicine education should reflect the current and future needs of society**. The polls reflect remarkable consensus on the importance of the 4Cs (first contact, continuity, comprehensiveness and coordination) to the health of public, and were supportive of the explicit addition of community to this criterion. There was agreement on the importance of maintaining training for the full scope of practice in residency, and remarkable consensus on the new clinical problems family physicians will need to be trained. Papers, presentations and small groups addressed the what and how of requirements for hospital care, maternity care, integrated behavioral health, community and public health, osteopathy and many other related topics. Other papers and small groups emphasized "enabling" drivers such as diversity and inclusion, team-based care.

6. **The practice is the curriculum**. There was strong consensus that residency practices need to lead practice redesign and population health, and a lot of discussion of what to include in that package of changes, including defined panels of patients, attention to access, quality, cost and equity, and putting in place patient advisory panels for residencies.

7. **There was consensus that we move forward with more competency-based assessment as quickly as possible.** The group recognized that the specialty needs to define the important competencies, something very challenging for a generalist discipline, and invest heavily in faculty development in assessment. It will need an incremental approach that includes both the ACGME Milestones and family medicine Entrustable Professional Activities (EPAs). Duration of residency is an important but controversial topic, and a point counterpoint discussion brought out the salient issues. Not all can or needs to be taught in residency, but students are coming to residency seem less prepared than before and there is much to teach. At the end of the discussion, 30% of attendees wanted 4 years of training and there was interest in new models of training.

8. **The concept of development of training family physicians to be master adaptive learners took the meeting by storm**—it seems to fit our concepts of ourselves like a glove, and the COVID pandemic has further demonstrated this. The concept embraces adapting to changes in the family physician's community and career path over time. Now the focus must on what and how (and how to measure) to assess adaptive learning.

9. **As we re-envision a national system of residency education, we must create the conditions for both major innovation—to meet the needs of society—and for better standardization—to keep our promise to society**. Well targeted competency-based assessment is an important tool; the ACGME milestones are an invaluable national benchmark. The specialty needs to be proactive in leading its own development.

10. **Replacing core faculty time dedicated to education is critical to competency based assessment, innovation and standardization**. Responding to what society needs will

take faculty to lead, develop and maintain changes in both practice and education—and time for the faculty development to develop new skills. Recent changes in ACGME policy have had a major and adverse impact on family medicine residencies; we await the final decision of the ACGME Board of Directors.

11. **Residencies must be more socially accountable.** At the local level this means a more robust continuous quality improvement process that addresses both education and clinical care, and must be more than a checkbox exercise. At the national level, there must be more social accountability for GME funding, with significant attention to the outcomes of the whole GME system. A vast amount of funding is going into our national GME system: is society getting its money's worth?

12. **We must invest in the future of the specialty**. This means committing to diversity, recruiting future teachers and researchers and preparing family physicians to lead at the highest levels of health and health care.