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

Participants (type and name): STFM Board of Directors

1. **What does society need from family physicians in the future?**
    - Relationally based comprehensivists at the individual, community, and population levels.
2. **What should we teach?**
    - How to engage with health systems leadership and navigate the healthcare system. How to be an advocate and activist for family medicine within their system.
    - Anti-racism and the complexities that intertwine racism and medicine
    - Advocacy and activism competencies with specific training related to health disparities in communities.
    - Practice management.
    - Disaster and crisis management.
    - How to cultivate longitudinal relationships with patients, populations, and the communities they serve.
    - How to make good decisions about care that is "off the algorithm" for patients who have failed the typical diag/treatment steps, or who have complex/multiple diseases, or who are difficult to diagnose. NPs and PAs follow the algorithms and do it well. In residency, we do a whole lot of teaching people the algorithms. Need to graduate residents to be able to move beyond typical diagnoses and treatments to planning what's next.
    - How to teach. Every resident should graduate with the skills to be a teacher and an understanding of the expectation to educate the next generation.
    - How to have rigor around scholarship.
    - Ways to communicate with sub-specialist colleagues through age of telehealth when face-to-face appointments are less common
    - The care experience needs more focus, especially considering what we are experiencing currently and how FM residents have had to expand their roles.
    - It's important not to drop OB and Peds. FM treats patients of all ages. Scope and continuity of care are important to keep in view.
    - We need opportunities for fellowships, including hospital medicine.
    - There is value in in-hospital medicine training. With limited training time, we need to keep this in balance and provide contact in different settings.
3. **How should we teach?**
    - Provide in a 3-year residency duration:
        - Year One, a mix of rotations to include inpatient experiences in general internal medicine, pediatrics, surgery and OB/Gyn and the outpatient experience to include the resident's own continuity clinic plus time spent in a faculty member's clinic to "learn from our own" as they do from those of other specialties throughout their intern year. Additionally, a significant focus on the social determinants of health and population health should begin.
        - Year Two, the transition to more senior resident continues with increasing

exposure to continuity practice and ongoing work in a faculty member's clinic to continue "learning from our own". Emphasis on community engagement and formal advocacy training.
    - Year Three, concentration in tracks that may relate to the resident's particular area of interest could be organized. Tracks could include home-based care, urgent care, hospitalist care, maternal-child care, public health, etc. Work on community engagement and advocacy could continue and lead to a capstone project.
- The key to resident success is "supervised resident autonomy", the faculty are only the safety net, the residents need to be the doctor, the team lead, the partner in patient care. We must give them tools and get out of the way.
- Rethink rotation-based learning. Team-based learning makes continuity measurements very complex. What is the definition of continuity? How do we capture quality? Challenge RC to go beyond counting visits. If we value teaching around teaming, then continuity goes beyond just points of contact. Teams are the right thing to do but they don't capture relationship continuity.
- Consider ROI with emphasis on specific rotations. Ambulatory surgery and outpatient peds are more beneficial to family medicine residents than inpatient.
- Encourage flexibility in allowing for both 3 and 4-year programs, which both have value.
- Define competence. Numbers are a measure of competence in the current requirements.
- Create examples of adequate support for residents and faculty.

4. **How can we prepare residents for flexibility in scope and population over their whole careers?**
    - Help residents engage with programs as we improve our communities in real time CQI.
    - Set an example by saying yes when it is uncomfortable. Get our programs to act when there's a need and let residents engage in the work. Real time examples are family medicine's responsiveness to the opioid epidemic, or the pandemic.
    - The word "comprehensive" needs to be used a lot more in the requirements. We have let regulatory agencies and systems define what that is. That should belong to us.

5. **What is the right balance between innovation and standardization in residency training?**
    - Some navigate flexibility and ambiguity well and others do well with concrete. Lean toward innovation, but pay attention to ambiguity in the requirements, it is the undoing of many programs and directors.
    - Need flexibility across communities to make training requirements work for more remote environments. Family docs are and should be more than physicians that see patients in the ambulatory setting in urban and suburban large group multispecialty practices.

6. **How can we improve the social accountability of residency training, both at the local level and at the national level?**
    - A long conversation but it starts with GME reform and ends with a functional health system.