Family Practice Forum

Requirements for Residency Training in Family Practice

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The Residency Review Committee (RRC) for Family Practice has recently circulated a draft proposal[1] for the revision of the *Special Requirements for Residency Training in Family Practice*.[2] The proposal has aroused a great deal of concern among the faculty of many family practice residency programs. This concern focuses mainly on the increasing structure and inflexibility of the proposed revisions, which do not permit programmatic adaptations designed to meet the needs of individual residents and different regions and communities. It seems appropriate that the Residency Review Committee should concern itself with broad guidelines and minimal criteria for accreditation, but it should not create a straitjacket of requirements that will stifle attempts to individualize the educational process.

Certain parts of the proposed document are most appropriate and improve on the current *Special Requirements*. The preamble and general outline of the characteristics of a family practice residency program, the parent institution, the model family practice center, and the teaching faculty are well described and provide a realistic framework applicable to most program settings. It is the detailed description of curriculum structure and time allocation that gives rise to the concern of many teaching faculty.

The need for a continuity of care experience during the residency training is clearly necessary. How best to achieve it in a residency setting is unclear. The proposal requires that a resident must spend a designated minimum amount of time per week in the family practice center at each year level, that is, 4 hours in the first year, 8 to 12 hours in the second year, and 16 hours in the third year.

No one knows the optimum time residents should spend in the family practice center with

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their ambulatory based practice. Various residencies have structured their programs to include more than one half-day a week in the family practice center in the first year. Block rotations in the family practice center for up to two months, integrating family medicine inpatient and outpatient responsibilities and teaching, have also proven to be successful. The new requirements would restrict such programmatic innovations on rather shaky pedagogical evidence. It would make more sense to specify an overall minimum time to be spent in continuity of care in the family practice center. This minimum time requirement should be allocated in such a way as to support continuity of care and include an increasing amount of practice time at each year level. The freedom to allocate time, however, would allow programs to be flexible in accommodating certain specialty rotations (eg, coronary care unit) where it is often difficult to free residents for the family practice center and ambulatory practice.

The curriculum requirements in the traditional clinical disciplines of internal medicine (8 months), pediatrics (4 months), obstetrics and gynecology (3 months), and general surgery (2 months) are acceptable as minimum criteria. The emphasis on an integrated behavioral science curriculum and the delineation of a biopsychosocial approach to medical care are important and necessary. It is the detailed time allotments to the various medical and surgical subspecialties and designated block rotations that lead to inflexibility and seriously hamper opportunities for creative curriculum planning. Some skills and topics (eg, dermatology) can be learned as well, if not better, in a longitudinal program when compared with a block rotation. The suggestion that radiology be taught in a block rotation is clearly inappropriate, since radiology is an area of knowledge that is applied in most clinical rotations. There may well be a need for some additional structured teaching, but the requirement of 100 hours is too restrictive. This structured approach will lead to uniformity but will also diminish opportunities to tailor programs to meet individual educational needs. The present requirements for a "useful" experience in selected subspecialties is much more acceptable and permits each program to design such experiences in a number of different ways. The Residency Review Committee should be in a position to judge whether those curricula meet minimum criteria.

Surely the best guide to the success of a given program has to be the performance of its graduates. This can be measured in several ways, including Board examinations and graduate surveys aimed at assessing how well prepared residents felt for their future practice.[3] In the author's experience this kind of feedback does have an impact on curriculum design and content. There needs to be sufficient flexibility to allow family medicine faculties to respond to their own identified needs in creative ways.

The Residency Review Committee proposal downplays the place of research in residency training. Those residents who wish to pursue research interests, particularly if they are contemplating a future career in academic family medicine, should be allowed to do so as a part of their curriculum time and not "in addition to rather than in lieu of clinical instruction." Since the academic and research base of family medicine is in its infancy at the present time, one cannot afford to dismiss the need to encourage suitably motivated residents with appropriate support of resources and time.

The proposal that has been distributed contains many statements which appear to have been taken from the Residency Assistance Program (RAP) guidelines.[4] These guidelines were intended as measures of excellence and were never expected to become minimal criteria for accreditation. The Residency Review Committee would be well advised to pay careful attention to the need for maintaining flexibility in family medicine teaching programs while delineating the basic framework and institutional commitment necessary to support successful family practice residency programs.

References

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4. Family Practice Residency Assistance Program Criteria. Kansas City, Mo, Residency Assistance Program Project Board, 1979