



ACGME International

**Advanced Specialty Program Requirements for
Graduate Medical Education
in Family Medicine**

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ACGME-International Advanced Specialty Program Requirements for Graduate Medical Education in Family Medicine

I. Introduction

I.A. Definition and Scope of the Specialty

Family medicine is a primary care specialty that demonstrates high quality care within the context of a personal doctor-patient relationship and with an appreciation for the individual, family, and community connections. Continuity of comprehensive care for the diverse patient population family physicians serve is foundational to the specialty. Access, accountability, effectiveness, and efficiency are essential elements of the discipline. The coordination of patient care and leadership of advanced primary care practices and evolving health care systems are additional vital roles for family physicians.

I.B. Duration of Education

The educational program in family medicine must be 36 or 48 months in length.

II. Institutions

II.A. Sponsoring Institution

II.A.1. Since family medicine programs are dependent in part on other specialties for the education of residents, the ability and commitment of the institution to fulfill these requirements must be documented.

II.A.2. Instruction in the other specialties must be conducted by faculty members with appropriate expertise.

II.B. Participating Sites

II.B.1. Participating sites should not be at such a distance from the primary clinical site that they require excessive travel time or otherwise fragment the educational experience for residents.

III. Program Personnel and Resources

III.A. Program Director

III.A.1. Qualifications of the program director must include:

III.A.1.a) a minimum of five years of clinical experience in family medicine; and,

III.A.1.b) if the length of the program's accreditation allows, at least two years as a core faculty member in an ACGME International-accredited family medicine residency program.

III.A.2. The program director must maintain clinical skills by providing direct

patient care.

III.B. Faculty

- III.B.1. All family medicine physician faculty members must maintain clinical skills by providing direct patient care.
 - III.B.1.a) Family medicine physician faculty members should have a specific time commitment to patient care.
 - III.B.1.b) Some family medicine physician members must see patients in each of the FMPs used by the program.
- III.B.2. All programs must have family medicine physicians or other qualified physicians as faculty members providing or teaching care for each of the following:
 - III.B.2.a) maternity patients,
 - III.B.2.b) inpatient adults; and,
 - III.B.2.c) inpatient children.
- III.B.3. There must be faculty members dedicated to the integration of behavioral health into the educational program.
- III.B.4. There must be a structured program of faculty development that involves regularly scheduled activities designed to enhance the effectiveness of teaching, administration, leadership, scholarship, clinical, and behavioral components of faculty members' performance.

III.C. Other Program Personnel

- III.C.1. The program must have a program coordinator.

III.D. Resources

- III.D.1. Family Medicine Practice (FMP) Sites
 - III.D.1.a) There must be at least one FMP site to serve as the foundation for educating residents and to provide family medicine physician role models.
 - III.D.1.b) FMP site(s) must support continuous, comprehensive, convenient, accessible, and coordinated care to a panel of patient families.

- III.D.1.b).(1) There must be agreement with specialists in other areas/services regarding the requirement that residents maintain concurrent commitment to their patients in the FMP site during these rotations.
- III.D.1.c) If multiple FMP sites are used for resident education, each must meet the criteria for the primary practice and be approved by the Review Committee-International prior to use.
- III.D.1.d) Each FMP site must have a mission statement describing its dedication to education and to the care of patients within the practice as relates to the greater community served by the program.
- III.D.1.e) The resident-to-faculty preceptor ratio in the FMP must not exceed four-to-one.
- III.D.1.f) The FMP site must be sufficiently staffed to ensure efficiency of operations, adequate support for patient care, and fulfillment of educational requirements.
- III.D.1.f).(1) The staff should include nurses, technicians, clerks, administrative personnel, and other health professionals.
- III.D.1.g) Other physician specialists should not see patients in the FMP site unless their presence enhances the experiences and learning of the residents.
- III.D.1.h) Each FMP site must involve all members of the practice in ongoing performance improvement, and demonstrate use of outcomes in improving clinical quality, patient satisfaction, patient safety, and financial performance.
- III.D.1.i) The FMP site must have adequate space and resources to effectively conduct the educational program, including:
 - III.D.1.i).(1) contiguous space for residents' clinical work and education;
 - III.D.1.i).(2) readily available computer access to electronic resources;
 - III.D.1.i).(3) adequate space to conduct private resident precepting sessions, teaching conferences, group meetings, and small group counseling; and,
 - III.D.1.i).(4) faculty members' offices, either in the FMP site or immediately adjacent to the FMP site.
- III.D.1.j) The FMP site must be available for patient services at times commensurate with community medical standards and practice.
- III.D.1.j).(1) When the FMP site is not open, there must be a well-organized plan that ensures continuing access to each

patient's personal physician, substitute family physician, or care from a physician with access to the patient's health records.

III.D.1.j).(2)

Patients of the FMP site must receive education and direction as to how to obtain access to their physician, a substitute family physician, or another physician for continuity of care during hours the FMP site is closed.

III.D.2. Inpatient Facilities

III.D.2.a) Inpatient facilities must have occupied teaching beds to ensure a patient load and variety of problems sufficient to support the education of the number of residents and other learners on the services.

III.D.2.b) Inpatient facilities must also provide physical, human, and other resources for education in family medicine.

IV. Resident Appointment

IV.A. Eligibility Criteria

See International Foundational Requirements, Section III.A.

IV.B. Number of Residents

IV.B.1. The program must have at least four residents at each educational level.

IV.B.2. The program should have at least 12 on-duty residents.

V. Specialty-Specific Educational Program

V.A. Regularly Scheduled Didactic Sessions

V.A.1. The program must provide a regularly scheduled forum for residents to explore and analyze evidence pertinent to the practice of family medicine.

V.B. Clinical Experiences

Background and Intent: Clinical practice in family medicine differs throughout the world based, in part, on differences in medical practice, population demographics, and disease patterns. The goal of the clinical experience requirements in family medicine are to provide flexibility and to maintain quality so that the program educates physicians:

- *for current as well as future practice;*
- *to care for families in a comprehensive and caring manner; and,*
- *to care for families throughout the continuum of care.*

V.B.1. Each resident must be assigned to a primary FMP site.

- V.B.1.a) Residents must receive regular reports of individual and practice productivity, and clinical quality, as well as the training needed to analyze these reports.
- V.B.1.b) Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality.
- V.B.2. Residents must be scheduled to see patients in the FMP site for a minimum of 40 weeks during each year of the program.
- V.B.2.a) Residents' other assignments must not interrupt continuity for more than eight weeks at any given time or in any one year.
- V.B.2.b) The periods between interruptions in continuity must be at least four weeks in length.
- V.B.3. Experiences in the FMP site must include acute care, chronic care, and wellness care for patients of all ages.
- V.B.3.a) FMP site patient encounters should include care for patients younger than 10 years of age.
- V.B.3.b) FMP site patient encounters should include care for patients 60 years of age or older
- V.B.4. Residents, including individual residents or a team of residents, must be primarily responsible for a panel of continuity patients.
- V.B.4.a) The responsibilities must include integrating each patient's care across all settings, including the home, long-term care facilities, the FMP site, specialty care facilities, and inpatient care facilities.
- V.B.4. Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients.
- V.B.5. Residents must provide care for a minimum of 1,650 in-person patient encounters at the FMP site, with at least 150 visits occurring in the first year.
- V.B.5.a) The majority of these visits must occur in the resident's primary FMP site.

Background and Intent: Patient encounters at the FMP site may include telephone visits, electronic visits, telemedicine visits, group visits, and patient- peer education sessions.

- V.B.7. The program must ensure that every resident has exposure to a variety of medical and surgical subspecialties throughout the educational program.

- V.B.8. Residents must have at least 600 hours (or six months) of clinical experience dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions.
- V.B.9. Residents must have exposure to the care of critically-ill patients.
- Background and Intent: Experiences caring for hospitalized and critically-ill adults can provide residents with an opportunity to deliver continuity of care to their panel of patients. These experiences also provide residents with opportunities to develop clinical skills, including initial evaluation, development of a plan of care, ongoing evaluation and management, performance of basic procedures of medicine, appropriate consultation, and planning for discharge and continuing care. Additionally, the experience provides opportunities to learn how families deal with critical illness and loss and how to deliver bad news.*
- V.B.10. Residents must have emergency department experience that includes care of acutely ill or injured adults.
- V.B.10.a) Residents must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting.
- V.B.11. Residents should have clinical experiences dedicated to the care of the older patient across a continuum of sites.
- V.B.11.a) The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases.
- V.B.12. Residents must have at least 200 hours (or two months) of clinical experience dedicated to the care of ill child patients in the hospital and/or emergency setting.
- V.B.13. Residents must have at least 200 hours (or two months) of clinical experience dedicated to the care of children and adolescents in an ambulatory setting, including:
- V.B.13.a) well-child care;
- V.B.13.b) acute care;
- V.B.13.c) chronic care; and,
- V.B.13.d) newborn patient encounters, to include well and ill newborns.
- V.B.14. Residents must have at least 100 hours (or one month) of clinical experience dedicated to the care of surgical patients, including hospitalized surgical patients.
- V.B.15. Residents must have at least 200 hours (or two months) of clinical

experience dedicated to the care of patients with a breadth of musculoskeletal problems.

- V.B.15.a) This experience must include a structured sports medicine experience.
- V.B.16. Residents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy.
- V.B.17. Residents must document at least 200 hours (or two months) dedicated to obstetrics, including prenatal care, labor management, delivery management, and post-partum care.
- Background and Intent: Experiences in obstetric care can provide residents with an opportunity to deliver continuity of care to their panel of patients. These experiences are also intended to provide residents with opportunities to learn to recognize common problems associated with pregnancy and delivery and provide opportunities for residents to develop competence in making referrals for obstetric care. The requirement can be met through participation in deliveries, providing pre- and post-natal care, and through simulation.*
- V.B.18. Residents must have clinical experiences in diagnosing and managing common dermatologic conditions.
- V.B.19. The curriculum must be structured so behavioral health is integrated into the residents' total educational experience.
- V.B.20. There must be a structured curriculum in which residents are educated in the diagnosis and management of common mental illnesses.
- V.B.21. There must be a structured curriculum in which residents address population health, including the evaluation of health problems of the community.
- V.B.22. The curriculum should include diagnostic imaging and nuclear medicine therapy pertinent to family medicine.
- V.B.23. Residents must receive training to perform clinical procedures required for their future practices in ambulatory and other health care environments.
- V.B.23.a) The program director and family medicine faculty must develop a list of procedural competencies required for completion by all residents in the program prior to graduation.
- V.B.23.a).(1) This list must be based on the anticipated practice needs of all family medicine residents.
- V.B.23.a).(2) In creating this list, the members of the faculty should consider the current practices of program graduates,

national data regarding procedural care in family medicine, and the needs of the community to be served.

- V.B.24. Residents must have experiences dedicated to health system management.
- V.B.25. Residents must have elective experiences.
- V.B.26. The curriculum should prepare residents to be active participants and leaders in their practices, their communities, and the profession of medicine.

V.C. Residents' Scholarly Activities

- V.C.1. Residents should complete two scholarly activities, at least one of which should be a quality improvement project.

V.D. Duty Hour and Work Limitations

- V.E. See International Foundational Requirements, Section VI.

VI. ACGME-I Competencies

VI.A. Patient Care

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must demonstrate proficiency in:

- VI.A.1. the essential skills/competencies of both productivity and efficiency necessary to meet the expectations of independent clinical practice, including:
 - VI.A.1.a) ability to collect a complete initial data base and examination;
 - VI.A.1.b) ability to define and expand the differential diagnoses list;
 - VI.A.1.c) identification of the most likely diagnoses and the establishing of a plan for diagnostic and treatment modalities;
 - VI.A.1.d) ability to educate the patient and family about the diagnoses, evaluation and treatment of the disease, to obtain informed consent, and perform appropriate procedures;
 - VI.A.1.e) ability to practice in a team and with a systems-based approach;
 - VI.A.1.f) ability to present data to other members of the team and consultants;
 - VI.A.1.g) cost-conscious ordering of diagnostic tests and therapeutics;
 - VI.A.1.h) construction of a medical record summary with accuracy and in

- compliance with expected format and in compliance with the hospital's medical records policies;
- VI.A.1.i) formulating short- and long-term goals; and,
- VI.A.1.j) providing guidance to patients regarding advanced directives, end-of-life issues, and unexpected diagnoses/outcomes.
- VI.A.2. preventive health care, promotion of independent living, and maximizing function and quality of life in the geriatric patient;
- VI.A.3. provision of longitudinal health care to families, including assisting them in coping with serious illness and loss, and in promoting family mechanisms to maintain wellness of its members;
- VI.A.4. assessing and meeting the health care needs of declining geriatric patients; episodic, illness-related care; delivery of health care in the home, family medicine center, hospital, and long-term care facility; and end-of-life care;
- VI.A.5. managing a normal pregnancy and delivery;
- VI.A.6. managing common problems related to prenatal and postnatal care;
- VI.A.7. performing appropriate gynecological procedures;
- VI.A.8. giving proper advice, explanation, and emotional support during the care of surgical patients and their families, and recognizing surgical conditions that are preferably managed on an elective basis;
- VI.A.9. diagnosing and managing of a wide variety of common general surgical problems typically cared for by family physicians;
- VI.A.10. diagnosing and managing common inpatient problems of adults and children as seen by the family physician;
- VI.A.11. caring for hospitalized male and female patients with various levels of severity of illness and utilizing appropriate consultation by other specialists; and,
- VI.A.12. providing supervision to others in the learning environment.

VI.B. Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents must demonstrate proficiency in knowledge of:

- VI.B.1. the broad spectrum of clinical disorders seen in the practice of family medicine; and,

VI.B.2. the ability to evaluate evolving medical knowledge and incorporate it into meaningful clinical practice.

VI.C. Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on continuous self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:

- VI.C.1. identify strengths, deficiencies, and limits in one's knowledge and expertise;
- VI.C.2. set learning and improvement goals;
- VI.C.3. identify and perform appropriate learning activities;
- VI.C.4. systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- VI.C.5. incorporate formative evaluation feedback into daily practice;
- VI.C.6. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- VI.C.7. use information technology to optimize learning; and,
- VI.C.8. participate in the education of patients, families, students, residents, and other health professionals.

VI.D. Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- VI.D.1. communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- VI.D.2. communicate effectively with physicians, other health professionals, and health-related agencies;
- VI.D.3. work effectively as a member or leader of a health care team or other professional group;
- VI.D.4. act in a consultative role to other physicians and health professionals; and,
- VI.D.5. maintain comprehensive, timely, and legible medical records, if applicable.

VI.E. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

- VI.E.1. compassion, integrity, and respect for others;
- VI.E.2. responsiveness to patient needs that supersedes self-interest;
- VI.E.3. respect for patient privacy and autonomy;
- VI.E.4. accountability to patients, society, and the profession;
- VI.E.5. sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and,
- VI.E.6. adherence to the Sponsoring Institution's professionalism standards and code of conduct, to citizenship, and to other responsibilities.

VI.F. Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

- VI.F.1. work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- VI.F.2. coordinate patient care within the health care system relevant to their clinical specialty;
- VI.F.3. incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
- VI.F.4. advocate for quality patient care and optimal patient care systems;
- VI.F.5. work in interprofessional teams to enhance patient safety and improve patient care quality; and,
- VI.F.6. participate in identifying system errors and implementing potential systems solutions.