Family Medicine Curriculum Resource Project: Overview

Ardis K. Davis, MSW; Jeffrey A. Stearns, MD; Alexander W. Chessman, MD; Paul M. Paulman, MD; David J. Steele, PhD; Roger A. Sherwood, CAE

In 2000, the Health Resources and Services Administration, in the interest of fostering curriculum reform in medical schools, awarded a 4-year contract to the Society of Teachers of Family Medicine to develop a curricular resource. The contract directed development of a multi-part resource aimed at (1) preclerkship prerequisites for third-year clerkships in collaboration with internal medicine and pediatrics, (2) the family medicine clerkship, (3) post-clerkship preparation for residency training, and (4) specific special topic areas of importance to the government. The Family Medicine Curriculum Resource (FMCR) was produced by primary care educators, with day-to-day direction from an executive committee and overall oversight by an advisory committee. The FMCR was built around a theoretical framework to link medical student competencies with the Accreditation Council for Graduate Medical Education (ACGME) competencies for residency training. Considerable energy throughout development of the FMCR was devoted to obtaining input from potential end-user audiences through an active dissemination effort.

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In 2000, the Division of Medicine and Dentistry (DOMD) of the Health Resources and Services Administration (HRSA), in the interest of fostering curricular reform in medical schools, awarded a 4-year federal contract to the Society of Teachers of Family Medicine (STFM) to develop a set of curricular resources for use by medical educators. Numerous studies have addressed the need for medical education reform, and the DOMD in recent years has supported reform efforts focusing on specific components of medical school education. With the issuance of Healthy People 2010,¹ the rapid advances emanating from the Human Genome Project, and the graying of America, a sense of urgency prompted the government to be more proactive with the medical education community. As a result, the DOMD created a contract to produce a resource document, the Family Medicine Curriculum Resource (FMCR), that would assist medical school faculty in improving curricula while addressing important national health and societal issues.

The contract (HRSA Contract 240-00-0107) under C.1 “Description/Background” states that HRSA selected the discipline of family medicine to lead this effort for several reasons: (1) family medicine education focuses on the common problems in the care of persons from birth to death, (2) faculty from family medicine departments play a critical role in the education of virtually all medical students, and (3) family medicine faculty members are in strong positions to influence the direction of medical school curricula. A previous HRSA-funded survey of departments of family medicine was cited in the contract as the reference in support of the second and third reasons listed above.²

Purpose

The contract’s scope of work directed a critical examination of current curricula that address (1) prerequisites for third-year clerkships, (2) family medicine clerkship competencies, (3) post-third-year competencies intended to prepare students for residency training, specifically in family medicine but potentially relating to other specialties, and (4) competencies in special top-
ic areas of importance to the federal government. The topics of interest to the government that were specified in the contract were substance abuse, including mental health; genetics; geriatrics, including end-of-life and palliative care; informatics; oral health; and the national health objectives as detailed in *Healthy People 2010*. This examination process would lay the groundwork for the development of a multi-part resource. While addressing special topic areas of national interest, the resource would define competencies to be attained prior to all clerkships and during and after the family medicine clerkship.

**Organization of This Overview of the FMCR Project**

This overview describes the history of the project, the process of the project, and the people involved in planning and development. The overview is divided into three sections. The first is “people” and addresses who were the people involved, how they came together, and who provided input along the way. The second section is “product,” which addresses what was produced. The third is “process,” which reviews how the work of the contract was completed and how an external evaluation team assessed the process. Finally, to conclude this overview, direction is given to the reader about what other details of the project process and outcomes can be found in this issue of *Family Medicine*.

**People: Who Was Involved?**

The contract specified that an executive committee be formed to conduct the day-to-day work of the project and that it be directed by a family physician with leadership skills and high-level responsibilities in a medical school. It also specified that two additional members of the executive committee be actively involved in education of family physicians and stakeholder organizations.

An advisory committee, as specified in the contract, was to be comprised of up to 20 members and was to include representatives from the following organizations: American Academy of Family Physicians, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, STFM, Predoctoral Education Group of STFM, Association of American Medical Colleges (AAMC), Society of General Internal Medicine, and Ambulatory Pediatric Association. In consultation with the HRSA project officer, the executive committee added the American Association of Colleges of Osteopathic Medicine, the American College of Osteopathic Family Physicians, the American Medical Student Association, and the Clerkship Directors of Internal Medicine to the list of organizations to be represented on the advisory committee. The advisory committee membership was also to include representatives who had expertise in the areas of special interest to the government.

The process for selection of organizational representatives to the advisory committee involved two steps. First, the current president of each organization was asked to submit the names of two nominees (with their curriculum vitae). Second, the executive committee selected one representative from among the nominees, taking into consideration expertise in areas of interest to the government. In the few cases where only one name was submitted by the president of an organization, the executive committee chose that individual. In no case did an organizational representative asked by the executive committee decline to participate. Other members-at-large named to the advisory committee were selected by the executive committee to round out expertise on the committee with regard to special areas of interest to the government. The final list of advisory committee members selected by the executive committee was approved by the federal project officer. Individuals who comprised the executive and advisory committees are listed in Table 1.

Other structural specifications within the contract included the use of (1) a panel of consultants from the broader medical education community, to include expertise in areas of interest to the federal government, (2) an independent consultant with expertise in evaluation of the process of curriculum development, and (3) two subcontracts to engage members of the Society of General Internal Medicine (working with members of the Clerkship Directors in Internal Medicine) and the Ambulatory Pediatric Association to work independently and in conjunction with family medicine representatives in discussion of pre-clerkship competency requirements. Executive staff of the Society of General Internal Medicine, the Clerkship Directors in Internal Medicine, and the Ambulatory Pediatric Association named individuals from their own organizations to commit to the work of these subcontracts.

Throughout the entire contract process, continuous feedback and comments were solicited. Various stakeholder groups provided advice through numerous peer-reviewed presentations/exhibits at national and regional meetings of the AAMC and family medicine, internal medicine, and pediatrics organizations. Table 2 provides a tabulation of the 51 dissemination events concerning the FMCR Project outcomes between February 2001 and May 2005. In addition, the advisory committee provided significant input during eight meetings held between July 2001 and April 2004.

The Future of Family Medicine (FFM) Project took place concurrent with the FMCR Project, and both projects supported and informed each other’s work. The advisory committee recommended that the FMCR Project seek input from the FFM Project, in particular as it related to development of the family medicine clerkship component. The contract was modified to subcontract with the American Academy of Family Medicine.
Table 1
Family Medicine Curriculum Resource (FMCR) Project Members, Consultants, and Project Officers
HRSA Contract # 240-00-0107
Contractor: Society of Teachers of Family Medicine
2000–2004

Executive Committee Members

PROJECT DIRECTOR
Jeffrey Stearns, MD
University of Wisconsin, Milwaukee Clinical Campus

PROJECT CO-DIRECTOR
Alexander Chessman, MD
Medical University of South Carolina

PROJECT CO-DIRECTOR
Paul Paulman, MD
University of Nebraska

PROJECT MANAGER
Ardis Davis, MSW
AKD Consulting

PROJECT ADMINISTRATOR
Roger Sherwood, CAE
Society of Teachers of Family Medicine

Advisory Committee Members

ORGANIZATIONAL REPRESENTATIVES
American Academy of Family Physicians
Deborah McPherson, MD
American Academy of Family Physicians

American Association of Colleges of Osteopathic Medicine
Harry Morris, DO
Philadelphia College of Osteopathic Medicine

American College of Osteopathic Family Physicians
Joseph McNerney, DO
Touro University

Association of American Medical Colleges
Thomas Schwenk, MD
University of Michigan

Association of Departments of Family Medicine
Joseph Hobbs, MD
Medical College of Georgia

Association of Family Medicine Residency Directors
Janice Nevin, MD, MPH
Christiana Care Health Services, Wilmington, Del

American Medical Student Association
Lauren Oshman, MD
Baylor Medical College

Ambulatory Pediatric Association
David Turkewitz, MD
York Hospital, York, Penn

Clerkship Directors in Internal Medicine
Alison Jean Whelan, MD
Washington University

Society of General Internal Medicine
Ruth-Marie Fincher, MD
Medical College of Georgia

Society of Teachers of Family Medicine
Stephen Bogdewic, PhD
Indiana University

STFM Group on Predoctoral Education
Richard Usatine, MD
University of Texas Health Science Center at San Antonio

MEMBERS AT-LARGE
Ann O’Brien-Gonzales, PhD
University of Colorado

Linda Headrick, MD, MS
University of Missouri-Columbia

Caryl Heaton, DO
UMDNJ-New Jersey Medical School

Christine Matson, MD
Eastern Virginia Medical School

Elizabeth Morrison, MD, MSEd
University of California, Irvine

David Schneider, MD, MSPH
University of Texas Health Science Center at San Antonio

Susan Skochelak, MD, MPH
University of Wisconsin

Kathleen Woo-Rippe, MD
University of Minnesota

Government Project Officers
Ruth Kahn, DNSc (2000–2002)

Division of Medicine and Dentistry
Bureau of Health Professions
Health Resource and Services Administration

Collaborative Curriculum Project (CCP)
Preclerkship Collaborative Workgroup Members

CHAIR
Christine Matson, MD
Eastern Virginia Medical School

EXECUTIVE COMMITTEE LIAISON
Jeffrey Stearns, MD
University of Wisconsin, Milwaukee Clinical Campus

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Table 1
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MEMBERS
Eric Bass, MD
Johns Hopkins University

Thomas Defer, MD
Washington University

Scott A. Fields, MD
Oregon Health and Science University

Allan Goroll, MD
Harvard University

Larrie Greenberg, MD
George Washington University

Mary Ann Kuzma, MD
Drexel University

Steve Miller, MD
Columbia University

William Raszka, MD
University of Vermont

Rick E. Ricer, MD
University of Cincinnati

John C. Rogers, MD, MPH
Baylor Medical College

William Wilson, MD
University of Virginia

Executive Staff to Collaborative Curriculum Project
Marge Degnon
Ambulatory Pediatric Association

Todd Dickinson
Clerkship Directors in Internal Medicine

Bradley Houseton
Society of General Internal Medicine

Roger Sherwood, CAE
Society of Teachers of Family Medicine

Family Medicine Clerkship/Post-clerkship Workgroup Members

CHAIR
Ann O’Brien-Gonzales, PhD
University of Colorado

EXECUTIVE COMMITTEE LIAISON
Alexander Chessman, MD
Medical University of South Carolina

MEMBERS
Caryl Heaton, DO
UNDNJ-New Jersey Medical School

Janice Nevin, MD, MPH
Christian Care Health Services, Wilmington, Del

Lauren Oshman, MD
Baylor Medical College

Deborah McPherson, MD
American Academy of Family Physicians

Mark Quirk, EdD
University of Massachusetts

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University of Texas Health Science Center at San Antonio

William Shore, MD
University of California, San Francisco

Richard Usatine, MD
University of Texas Health Science Center at San Antonio

Consultants

Curriculum Consultant to the Executive Committee
Kent Sheets, PhD
University of Michigan

Primary Evaluation Consultant to the Executive Committee
David Steele, PhD
Florida State University

Secondary Evaluation Consultants
Rebecca Henry, PhD
Michigan State University

Marina Hewson, PhD
Health Professions Education Consultant

John Ullian, PhD
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Special Topic Consultants
Alan Douglass, MD (End-of-life and Palliative Care; Oral Health)
Middlesex Hospital Family Practice Residency Program, Middletown, Conn

Jeanna Douglass, DDS, BDS (Oral Health)
University of Connecticut

Paul Gates, DDS (Oral Health)
Bronx-Lebanon Hospital Medical Center, Bronx, NY

Jeffrey Samet, MD (Substance Abuse)
Boston University

Harry Strothers, MD, MMM (Geriatrics)
Morehouse School of Medicine

Marian Stuart, PhD (Mental Health)
UMDNJ-Robert Wood Johnson Medical School

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Physicians to support the work of FFM Task Force #2, which addressed training of future family physicians. The report of this task force can be viewed at www.annfammed.org/cgi/content/full/2/suppl_1s51.

After the final FFM Project report was released in March 2004, members of the FMCR Project leadership and an advisory committee member who also represented the leadership of the FFM Project incorporated language derived through the FFM into revisions of the principles of family medicine as defined by the FMC Project for the family medicine clerkship.

As resource development neared completion, nine consultants (five representing family medicine, one representing internal medicine, and one representing pediatrics, one student, and one resident) reviewed the entire FMCR product. Additionally, selected experts reviewed several of the special topic resources.

Product: What Was Produced?

Figure 1 is a graphic depiction of the FMCR Project’s resource illustrating the continuum over 4 years of medical school education into residency training within the larger framework of the Accreditation Council for Graduate Medical Education (ACGME) competencies for residency training. The six competencies defined by the ACGME for residency training are (1) patient care, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism, and (6) systems-based practice.

The executive and advisory committees chose the ACGME competency framework as the foundation on which to build the resource because of the connection with residency training and the inherent strength of this framework. The FMCR Project leadership also judged the ACGME competency structure to be simple and powerful, well suited to organize the reformation of medical education. A detailed description of the structure and content of the resources, including the accompanying User’s Guide, are currently available at www.stfm.org/curricular/index.htm.

The government contract specified the creation of a resource, not a prescriptive curriculum. The context and curricula for all of the then 125 allopathic and 20 osteopathic medical schools are diverse. Given this diversity, the FMCR was designed so that end users can extract parts of the resources to fit specific curricular needs. Each of the four components (pre-clerkship, family medicine clerkship, post-clerkship, special topics) is cross-referenced by ACGME competencies, specific goals and objectives, recommended resources, implementation strategies, evaluation strategies, faculty development recommendations, and comments on resource challenges. Certainly, a given institution could use the FMCR as the basis for a defined curriculum, but the government’s expressed intent was not to create curricular requirements.

Process: How Was the Work of the Project Completed?

The executive and advisory committees struggled with how to incorporate the perspective of internists and pediatricians around the pre-clerkship component of the FMCR over the life of the contract in a meaningful way. Rather than simply subcontracting with each group to work separately, the leadership created
Special content-oriented topics had to bridge all segments of the 4-year continuum in the FMCR. Small teams were created to develop resources around each of the specific topics. To create a product that spanned the pre-clerkship to clerkship to post-clerkship continuum, these teams were comprised of representatives from both of the FMCR workgroups to incorporate input from family medicine, internal medicine, and pediatrics representatives involved in the project.

The contract specified that the executive committee name an external evaluation consultant to help determine an approach to evaluation, focusing on process. The contract was later modified to add three evaluation consultants to work with the primary evaluation consultant. This evaluation team developed and carried out a process evaluation as specified in the contract.

**External Evaluation Team’s Assessment of Process**

The following features of how the project was conducted were highlighted in the final evaluation report submitted by the external evaluation team as contributing to the overall success of the project. First, recruitment of family medicine and, for the pre-clerkship workgroup, other primary care educators, who were knowledgeable, experienced, and willing to donate considerable time to the project was essential. These participants were also willing to debate and compromise.

Second, maximizing opportunities for input from the wider educational community was an important element of the process to ensure interest and buy-in from educators who would eventually use the resource. It was vital to stay abreast of developments in the FFM project so that the resource could be aligned with changes being proposed.

Third, decision making by consensus was manifested at all levels, from the way the executive committee worked to the way the workgroups did their work. The leadership allowed the workgroups considerable flexibility. When the executive committee recognized that gaps were developing (e.g., the fourth-year component and some of the special topics), it moved to fill them.

Finally, the decision to use the ACGME competencies as the theoretical framework for resource development and organization was important. One of the key challenges of this large project was to figure out how

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**Table 2**

**Family Medicine Curriculum Resource Project**

**Dissemination Activity February 2001–May 2005**

The data below reflect 51 dissemination activities that took place between February 2001 and May 2005. The audiences listed represent participants of regional and national organizational meetings of these constituent groups.

<table>
<thead>
<tr>
<th></th>
<th>Interactive Sessions (Seminars, Workshops)</th>
<th>Poster Sessions</th>
<th>Total</th>
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<tr>
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<td>STFM Predoctoral Education Conference</td>
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<tr>
<td>STFM Annual Spring Conference</td>
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<td>University of Wisconsin Department of Family Medicine</td>
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<td><strong>Broader Audiences</strong></td>
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<td>UME-21</td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>CDIM/SGIM</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>APA</td>
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<td>3</td>
</tr>
<tr>
<td>AMSA</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>35</td>
<td>16</td>
<td>51</td>
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STFM—Society of Teachers of Family Medicine
FM—family medicine
AAMC—Association of American Medical Colleges (includes regional Group on Educational Affairs meetings and national AAMC meetings)
UME-21—Undergraduate Medical Education for the 21st Century project
CDIM/SGIM—Clerkship Directors in Internal Medicine/Society of General Internal Medicine
APA—Ambulatory Pediatric Association
AMSA—American Medical Student Association

a collaborative workgroup to create the pre-clerkship segment of the resource. In parallel fashion, a separate workgroup of family medicine consultants was formed to create the family medicine clerkship component of the resource.

Another challenge with two separate workgroups was to create a resource that demonstrated a clear sequence of a curriculum, from matriculation to graduation. The FMCR Project executive committee worked to inform each workgroup of the other’s progress and outcomes along the way. In addition, after both workgroups had completed their competency lists, the post-clerkship component of the resource was built on these two sets of competencies. This post-clerkship segment, which was to include a specific focus on students entering family medicine residency programs, was built on the pre-clerkship competencies, with modifications derived from (1) the clerkship workgroup’s recommendations and (2) outside input received at presentations to individuals involved in family medicine residency training programs.
to “get in control.” The ACGME framework enabled that process and served to link the FMCR with the continuum of medical education.

Conclusions

This overview has described the people (who), product (what), and process (how) of the FMCR Project. The theoretical basis and past work supporting the decision to hang the FMCR around the larger ACGME competency framework for residency training as well as the challenges and issues involved in development of the four main resource components are described in subsequent articles in this issue of *Family Medicine*.

Acknowledgments: The project reported on in this manuscript was supported by a contract from the Health Resources and Services Administration to the Society of Teachers of Family Medicine (contract # 240-00-0107).

The specific content of this manuscript has not been presented elsewhere. Development work on the project was presented at various meetings between 2001–2005.

This issue of *Family Medicine* is dedicated to Dr Steve Miller, a member of the FMCR’s interdisciplinary pre-clerkship Collaborative Curriculum Project, who died tragically toward the conclusion of the project.

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REFERENCES


The FMCR Project Resource is depicted above to illustrate a continuum of competencies and special topics over 4 years of medical student education, which flow into residency training.