

# FAMILY MEDICINE SUB-INTERNSHIP CURRICULUM

Created by the Family Medicine Sub-I Task Force, 2022  
(Based on the Kemp Model of Curriculum Design)

*This curriculum has been endorsed by STFM and the Association of Family Medicine Residency Directors (AFMRD) and is supported by the American Academy of Family Physicians (AAFP).*

## GOALS AND OBJECTIVES

### Definition and goals

The Family Medicine sub-Internship (Acting Internship, sub-I) is an advanced clinical rotation offered in the final phase of medical school. It aims to provide students with advanced training in the knowledge, skills, and attitudes that are foundational to family medicine. By the end of the sub-I, students should be ready to assume the role of a family medicine intern. Therefore, emphasis is placed on the learner's experience of: "the provision of *integrated, accessible health care services* by clinicians who are accountable for **addressing a large majority of personal health care needs**, developing a sustained **partnership with patients**, and practicing in the **context of family and community.**" (*definition of primary care adopted by the Institute of Medicine [IOM] Committee on the Future of Primary Care*)

**The Family Medicine sub-Internship curriculum will emphasize the following primary care concepts experienced across various family medicine practice settings:**

- BIOPSYCHOSOCIAL MODEL
- COMPREHENSIVE CARE
- CONTEXTUAL CARE
- CONTINUITY of CARE
- COORDINATION OF CARE

**7 Core Entrustable Professional Activities (EPAs) are recommended as areas of focus and growth:**

- EPA 2: Prioritize a differential diagnosis following a clinical encounter
- EPA 3: Recommend and interpret common diagnostic and screening tests
- EPA 4: Enter and discuss orders and prescriptions
- EPA 7: Form clinical questions and retrieve evidence to advance patient care
- EPA 8: Give or receive a patient handover to transition care responsibility
- EPA 9: Collaborate as a member of an interprofessional team
- EPA 10: Recognize a patient requiring urgent or emergent care and initiate evaluation and management

## PRE-ASSESSMENT

There are multiple stakeholders in the Family Medicine sub-Internship: students, residency programs, and medical schools. In adapting this sub-I curriculum for your institution, it is important to fulfill the needs of each stakeholder.

### Student needs

- Get to know family medicine as a discipline
- Assess residency program fit
- Strengthen application to residency (evaluations, letters of recommendation)
- Seek professional development opportunities for building networks and finding role models/mentors
- Increase responsibility and autonomy for residency preparedness
- Advance clinical skills

### Resident program needs

- Recruit future residents
- Evaluate potential future applicants
- Evaluate student's progression from observer to intern

### Medical school needs

- Provide required sub-I rotations for graduation
- Assess competency of student and readiness for graduation/residency
- Align with LCME and medical school educational program objectives

## LEARNER CHARACTERISTICS

### Learner level

- Students who have successfully completed a third-year family medicine or primary care clerkship, typically in their last year of medical school

### Characteristics

- Considering family medicine as specialty choice
- Choosing a Family Medicine sub-I in the case where sub-Is are a graduation requirement and other specialty sub-Is are unavailable

## STRUCTURE

### Course Director

- A family medicine faculty member should be designated as course director with **protected time based on FTE**. There should be **administrative staff specifically assigned** to assist the sub-Internship course director.
- Responsibilities include orienting students, coordinating schedules, midpoint feedback, providing faculty development, addressing student concerns, conveying concerns regarding student performance/professionalism, collecting evaluations, and submitting a final grade.

### Curriculum structure

- The program will consist of a **4-week rotation**.
- Orientation should occur on the first day of the rotation. This session should review rotation goals, objectives and expectations, structure, clinical setting, and evaluation/assessment methods. A course syllabus containing this information should be provided.
- Students should complete a self-assessment of EPAs using the evaluation form ([see Rotation Evaluation Forms](#)) and review with a faculty member at the beginning, middle, and end of rotation for bi-directional feedback sessions.

### Assignments/reading

- Students should actively engage in forming clinical questions and reading/learning that relates to patient care.
- Students should **reflect on and describe the role of the family physician** within the greater health care system and interprofessional/intraprofessional specialty team.

### Setting and learning environment

- **Two or more settings** should be incorporated (e.g: inpatient, outpatient, labor & delivery, home, care facility, telehealth etc) to experience comprehensive care and continuity of care.
- Students should **autonomously** with an appropriate level of oversight. The learning environment must be supportive with feedback given in real-time. Minimal time should be spent shadowing or observing. If it occurs, the goal of that time should be explicit.

## TOPICS

Students should have completed basic learning at the family medicine clerkship level prior to their sub-Internship experience ([refer to STFM National Clerkship Curriculum](#)). Learning should focus on student performance of the tasks and activities an intern would perform across settings, through the lens and within the culture of family medicine.

## TEACHING AND LEARNING ACTIVITIES

### Suggested integration of Core [Entrustable Professional Activities \(EPAs\)](#) into Sub-I

|   |                                  |
|---|----------------------------------|
| Students should have developed competency in these EPAs prior to sub-I                | EPAs 1, 5, 6                     |
| <b>Students should focus on these EPAs during sub-I (Core EPAs for sub-I)</b>         | <b>EPAs 2, 3, 4, 7, 8, 9, 10</b> |
| Students should participate in these EPAs during the sub-I if there is an opportunity | EPAs 11, 12, 13                  |

### Mapping of Core EPAs to [ACGME Competencies](#) and RIME model

| Core EPAs for Sub-I  | Prerequisite/<br>enabling or related<br>core EPAs | ACGME<br>Compe-<br>tencies | RIME   |
|--|---|----------------------------|--|
| EPA 2: Prioritize a differential diagnosis following a clinical encounter                            | EPA-1   | PC, MK                     | Consistent Reporter,<br>Some Interpreter                                       |
| EPA 3: Recommend and interpret common diagnostic and screening tests                                 | EPA-1, EPA-2                                      | PC, MK                     | Consistent Reporter, Consistent Interpreter, Some Manager                      |
| EPA 4: Enter and discuss orders and prescriptions  | EPA-1, EPA-2, EPA-3, EPA-6                        | PC, MK, PBLI, ICS          | Consistent Reporter, Consistent Interpreter, Initial Manager                   |
| EPA 7: Form clinical questions and retrieve evidence to advance patient care                         | EPA-1, EPA-2, EPA-3                               | PC, MK                     | Consistent Reporter, Consistent Interpreter, Initial Manager                   |
| EPA 8: Give or receive a patient handover to transition care responsibility                          | EPA-1, EPA-2, EPA-3, EPA-4, EPA-5, EPA-6, EPA-9   | PC, MK, SBP, P, ICSt       | Consistent Reporter, Consistent Interpreter, Initial Manager, Initial Educator |
| EPA 9: Collaborate as a member of an interprofessional team  | EPA-5, EPA-6, EPA-8                               | ICS, SBP, P, PC            | Consistent Reporter, Consistent Interpreter, Initial Manager, Initial Educator |
| EPA 10: Recognize a patient requiring urgent or emergent care and initiate evaluation and management | EPA-1, EPA-2, EPA-3, EPA-5, EPA-6, EPA-7, EPA-9   | PC, MK, ICS, P             | Consistent Reporter,<br>Some Interpreter                                       |

#### AAMC 13 Core EPAs for entering residency

1. Gather a history and perform a physical exam
2. Prioritize a differential diagnosis following a clinical encounter
3. Recommend and interpret common diagnostic and screening tests
4. Enter and discuss orders and prescriptions
5. Document a clinical encounter in the patient record
6. Provide an oral presentation of a clinical encounter
7. Form clinical questions and retrieve evidence to advance patient care
8. Give or receive a patient handover to transition care responsibility
9. Collaborate as a member of an interprofessional team
10. Recognize a patient requiring urgent or emergent care and initiate evaluation and management
11. Obtain informed consent for tests and/or procedures
12. Perform general procedures of a physician
13. Identify system failures and contribute to a culture of safety and improvement

#### ACGME Competency Framework

PC = Patient Care  
 MK = Medical Knowledge  
 ICS = Interpersonal and Communication Skills  
 SBP = Systems-Based Practice  
 PBLI = Practice-Based Learning and Improvement  
 P = Professionalism

#### RIME Framework

**(Levels: Initial, Some, Consistent demonstration of skills)**

Reporter  
 Interpreter  
 Manager  
 Educator

## EVALUATION

### Evaluation of students

- Students will be evaluated on their use of EPAs from the above list. EPA critical functions can be added if needed by the medical school.
- EPA assessment is based on direct observation across the clinical settings. Multiple observations should be made over the course of the rotation by residents and faculty.
- Evaluations should be conducted by those who worked with the student and compiled by the sub-I director or proxy. Context and amount of time together should be noted. Evaluations should be quick and easy to complete/compile. ([See sample Rotation Evaluation Forms](#))
- Provide 1:1 mid-rotation and end-of-rotation meetings with a student for bi-directional formative feedback.

### Curriculum and rotation site evaluation by the student

- Students should evaluate their sub-I experience. Areas for students to assess: patient variety, level of autonomy, appropriate oversight, adequacy of feedback, opportunity for growth. A student's evaluation should be available to the program only after the student's grade and evaluation is submitted. Ideally, these evaluations should be compiled bi-annually to protect student anonymity. ([See sample Rotation Evaluation Forms](#))

## SUPPORT SERVICES

### Faculty (leader, supporting)

Primary teachers should be family physicians and/or residency faculty: both attendings and residents. Interactions with interdisciplinary teams (nursing, medical assistants, physical/occupational therapists, consultants, etc) should be integrated into the experience.

## OTHER

### Potential barriers to implementation of curriculum and strategies to overcome

- Limited resources (faculty and administrative support)
- Desire for programs to have autonomy over their sub-I curriculum
- Wide variety of current Family Medicine sub-Is

### Use this curriculum and modify to fit each sub-I site's strengths and goals

### Family Medicine Milestones Work Group

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