Family Medicine Updates

From the Association of Family Practice Residency Directors

INTEGRATING SCHOLARLY ACTIVITY INTO RESIDENCY TRAINING

Research and scholarly activity are important components of family medicine education.[1] Whereas research refers to the process by which knowledge is tested or developed, scholarly activity usually incorporates a thorough, critical collection of knowledge. Many residency program directors are challenged to include a research curriculum into their already busy family medicine programs.

The Accreditation Council for Graduate Medical Education (ACGME), through the Core Competencies, recently introduced additional required goals for residency programs. Several goals involve incorporating scholarly activity into the patient care experience. Of the 6 core competencies, practice-based learning and improvement and systems-based practice address using scientific evidence to improve patient care. Practice-based learning and improvement require residents to investigate and evaluate their own patient care and improve upon it after appraising and assimilating scientific evidence. Systems-based practice requires that residents show an awareness of and responsiveness to the larger context of health care and are able to use system resources to provide optimal patient care.

James Gill, MD, MPH, research director for the Department of Family and Community Medicine at Christiana Care Health System, offers recommendations consistent with the core competencies. "[W]e should not try to teach all residents how to do research or get them all involved in research projects." To become "good consumers of research," Dr. Gill believes residents should be taught skills that allow them to appraise the literature and evidence-based guidelines critically while understanding the basic application of clinical epidemiology. To accomplish these objectives, residents could write evidence-based reviews or undertake "quality-of-care" research by measuring their care against evidence-based practice guidelines.

Scholarship, broadly defined, includes such areas as qualitative/quantitative research, quality improvement, and community-oriented primary care. The AFPRD believes that resident scholarship should be required and endorses the ACGME incorporation of quality improvement as a form of scholarly activity into family medicine residency training.

Used in industry for decades, quality improvement has yet to be fully implemented into the family medicine curriculum. Ogrinc et al[2] provide a framework of objectives to assist educational leaders when integrating practice-based learning and improvement into a curriculum. Efforts to teach improvement to residents have ranged from including residents on hospital quality improvement committees[3] to resident membership on teams to improve the residency itself[4] to projects without formal quality improvement instruction.[5] One residency-based, ambulatory family medicine center developed a continuous improvement program that used indicators of diabetes management as measures of quality of care.[6]

As an example of implementing scholarly activity, the Trident Family Medicine Residency Program established the Clinical Scholars Program to foster critical thinking skills for primary care clinicians, specifically in areas of primary care research, evidence-based medicine reviews, and continuous quality improvement initiatives.

After an orientation program in July, second- and third-year residents attend weekly 2-hour sessions to develop and conduct projects. Working in teams, residents choose a project, and each team is required to do a literature evaluation, write a concept paper, present their ideas to the larger group, and submit their work to the internal review board for approval. The program conducts large-group meetings every 6 to 8 weeks for monitoring project progress and for group-learning activities.

In June the residency program hosts a Clinical Scholars Program Research Day, with a 10-minute podium presentation and a 5-minute question-and-answer period for each project. Projects are judged by a 3-member panel, and the best project is recognized. Several projects have been presented at national meetings or published in the primary care literature.

Although this program provides experience in a wide range of scholarly activities for residents, not all residents would benefit from additional instruction in basic research. Dr. Gill believes "[other types of research] should be viewed as an 'extra' skill, where residents who are interested get involved, usually by working with a faculty already doing that research." Dr. Gill notes that the considerable commitment of time to conduct research is no different from the time required to master procedural skills. "Research should not be

viewed as a basic skill, but as an extra skill that can be acquired and developed for residents with a particular interest."

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References

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From the American Academy of Family Physicians

HEEDING INFORMATION TECHNOLOGY'S CALL

The AAFP boldly established itself as a leader in the arena of health care information technology (IT) during the past few months.

The first step came in September, when the Academy's Board of Directors voted to establish the AAFP Center for Health Information Technology. The center, based in the Academy's Leawood, Kan, office, has been charged with a heady mission: to promote and facilitate the adoption and optimal use of health IT by AAFP members and other office-based clinicians. AAFP leaders expect the center to become a national resource for information and communications technology.

"The establishment of the center signals the need to move from paper-based to computerized information systems in the family physician's office," said AAFP Executive Vice President Douglas Henley, MD. "The activities of the center will improve the quality and safety of medical care and, in turn, increase the efficiency of health care delivery."

The Academy's second move turned heads in both health care and technology corners. In November, AAFP held a news conference at the National Press Club in Washington to announce partnerships with 9 leading IT companies. The initiative sends a clear signal that the Academy's top leadership is serious about moving the specialty of family medicine into the world of electronic health records (EHR) as quickly as possible.

In fact, the Academy has a lofty goal: to have 50% of active members using EHRs by the end of 2005.

The recently secured agreements should help bring that goal to fruition. To date, the partners are A4 Health Systems, GE Medical Systems Information Technologies, Hewlett-Packard, MedPlexus, Inc, MedPlus, Inc, NextGen Healthcare Information Systems, Inc, Physician Micro Systems, Inc, Siemens Medical Solutions Health Services Corp and Welch Allyn, Inc.

The Academy's Web site at http://www.aafp.org/x24906.xml serves as a starting point for gathering product information. Academy members can pick and choose from a variety of hardware and software options at prices discounted from 15% to 50%. All information is easily accessible. Members just log in with their AAFP identification numbers and quickly link to partners' Web sites for product and pricing information.

As one business partner pointed out, the EHR initiative is not about a group of companies creating one new product. It's about building a new network to allow existing products to communicate with one another.

Guiding Principles

Each company involved in the principled group-purchasing agreements has pledged to uphold the Academy's 4 guiding principles for the initiative.

Affordability offers the key to unlocking technology's door and ushering in thousands of small to medium-sized family medicine offices. The physicians in these practices represent the backbone of family medicine, and while most recognize the benefits of EHRs, many say they cannot afford the start-up costs.

Compatibility represents another vital component of the initiative; the prospect of incompatibility alarms potential users. Most family physicians have neither the time nor the money to replace an existing system because it won't support necessary upgrades and additional components.

Interoperability means that data can be shared among the clinician, laboratory, hospital pharmacy and patient—regardless of the application or application vendor.

Data stewardship promises that clinicians will retain control of data produced as a product of their EHR systems.