simultaneously reduced clinical, research, and educational funds for our academic units and for the organizations that host them.

The urge may be to hunker down and conservatively manage our scarce resources and our portfolio of programs—and take fewer risks. Paradoxically, this is clearly a time when we need to expand the primary care workforce, and when there appear to be bountiful opportunities for innovation, program expansion, and entrepreneurship. In addition, 10 years into the patient-centered medical home (PCMH) and residency reform efforts, we seem to be generally on the right course regarding practice transformation and student interest.

How are we to reconcile these opposing forces and plot the way forward? Although there is no single formula, some suggestions come to mind, including those learned from our colleagues in other professions and other countries:

- Reaffirm one's core values and goals; improving the health of the public is what academic medicine must be about
- Act boldly, while watching finances, making sure "no money is left on the table" (careful billing, pursuing management in addition to fee for service fees, etc) and building reserves when possible
- Examine other means of reaching our goals—especially if they are more fiscally sound
- Speak with one voice and with a focused and repeated message to any and all who will hear us
- Develop advocacy skills and use that power to educate legislators on what is at stake for the public. All of us in family medicine, whether we are faculty, residents, students, chairs, residency directors, or physicians in practice, need to understand how we can impact the process through advocacy. If each of us takes a student or resident along in an advocacy activity, we double the number of family medicine advocates
- Invest in faculty development long term
- Look for new opportunities and keep your fingers on the pulse of your hospital, medical center, and medical school
- Canada—when faced with budget cuts and a decline in student interest in family medicine, they invested in family medicine education

As we plan programming for the fall 2011 meeting of the Association of Departments of Family Medicine and our 2012 winter meeting to follow, we will be working with our colleagues to help us all understand the vagaries of navigating through these times while staying above water and even seizing the unanticipated opportunities out there! As each of you look to the future, we encourage you to consider how to navigate the turbulent waters ahead, while moving the discipline and the health of the American public forward.

Jeffrey Borkan, MD, Phd; Ardis Davis, MSW; Thomas Campbell, MD; and Richard Wender, MD. This commentary was written by the ADFM Executive Committee

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IMPLICATIONS OF THE 2011 ACGME DUTY HOUR RULES

In May 2010, Dr Thomas Nasca, Accreditation Council for Graduate Medical Education (ACGME) CEO, outlined the process of revising the 2003 duty hour requirements. He stated the overriding principles of patient safety and excellent patient care in teaching settings, delivering outstanding education today to achieve these goals in the future, and educating residents in a "humanistic educational environment that protects their safety, and nurtures professionalism and the effacement of self-interest that is the core of the practice of medicine and the profession in the United States." He continued,

> It should be emphasized that all 3 of these principles are equal, and must be fulfilled. They are not mutually exclusive goods; they are absolute 'goods' and must be achieved. Furthermore, those principles and their articulation in standards go far beyond the issues of resident duty hours.[1]

Program directors certainly agree with these principles. A majority of family medicine program directors in a 2009 study, however, disagreed that Institute of Medicine (IOM) duty hour recommendations (which significantly contributed to the ACGME final requirements) would help to achieve these absolute "goods."[2] Over 70% believed patient access to care would decrease; over 90% thought the rules would exacerbate a "shift-worker mentality" in residents; over 80% believed they would result in "graduating doctors who are not experienced enough to practice independently;" and over 90% thought they would result in "graduating doctors who generally take less ownership and do not know patients as thoroughly as in the past." Over 80% did not believe the duty hour changes would result in residents "becom-

ing more compassionate, more effective family physicians;" in fact, only 0.8% believed this would occur.

In July 2011, the ACGME's revised duty hour rules went into effect, in part based on voluminous research into the effects of fatigue and sleep deprivation on performance, but also due to external political pressures that forced the ACGME to take action and try to preserve the vestiges of a profession before Congress, governmental agencies, and activist groups forced more draconian measures. Considering the previously surveyed opinions of program directors, one can draw 2 conclusions concerning the impact of duty hour revisions on the quality of our residents' education and on patient care. The first possibility is that program directors collectively were wrong and that the duty hour changes will in fact result in better family physicians and improved care for patients. This is 1 circumstance where most program directors hope they were indeed wrong.

The other possibility is that the collective wisdom of the group responding was generally correct. Regardless, Congress, advocacy groups, residents, and recently graduated family physicians (who may not fully appreciate their level of preparedness or have a basis for comparison) will not likely agree to go back to less restrictive duty hour rules. Assuring adequate experience levels for independent practice, teaching professionalism, and providing residents a glimpse of the joy of deep and meaningful patient relationships needs to be addressed in new ways.

John Wooden said, "If you don't have time to do it right, when will you have time to do it over?" The realistic answer is never, CME reforms notwithstanding. As family medicine educators, we need to get it right the first time! As the effective amount of training time continues to diminish (1 estimate is that a resident now will train the equivalent of 2.4 years compared to a 3-year residency of the past), we owe it to our residents and the public to honestly and actively study the length of family medicine residency training to minimize any unintended negative impact of duty hour restrictions. Producing quality family physicians cannot be even partially sacrificed for other important goals such as meeting primary care workforce needs. We need to assure that a board-certified family physician stands out from mid-level practitioners and other generalist physicians, both in scope of practice and skills. This may require more time than we currently give ourselves to provide our residents the new skill set needed to lead in the future health care system.

Joseph Gravel, MD; Stoney Abercrombie, MD; Sneha Chacko, MD; Karen Hall, MD; Grant Hoekzema, MD; Lisa Maxwell, MD; Michael Mazzone, MD; Todd Shaffer, MD; Michael Tuggy, MD; and Martin Wieschhaus, MD

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From the North American Primary Care Research Group

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LESSONS LEARNED FROM REBUILDING A PRIMARY CARE INFRASTRUCTURE: A CANADIAN PERSPECTIVE

The Canadian health care system began to crumble in the 1990s after its foundation, primary care, had been neglected for more than 2 decades. Canada has spent the last decade trying to fix the problem and restore and strengthen its primary care system. While there is much work left to be done, much has been accomplished. Here are a few pearls of wisdom learned along the way and what is still in the works to bring primary care back to the core of the Canadian health care system.

1. Don't Think Your System is Always the Best

Policy-makers and the health care establishment were inattentive to the weakening of the Canadian primary care infrastructure. Physicians in training were increasingly choosing specialties over family practice to be able to pay off their student loans.[1] As a result, first contact with the medical system for many patients became emergency departments and walk-in clinics since many Canadians could not find a family doctor. Our specialist colleagues were being asked by patients to do the job of family doctors. These were just a few symptoms of a sick system that needed some serious attention.

2. The Solution of Simply Spending More Money is Unsustainable

Despite huge amounts of money being thrown at the Canadian system, international reports indicated that Canada was losing ground among industrialized nations in terms of the quality of primary care. Countries that had invested in their primary care systems were well ahead of Canada—even after spending fewer resources.[2,3]