consultations that members of the ADFM Research Committee have been offering for several years in conjunction with national meetings.

Curriculum WG

The following core curricular topics have been identified to date as a focus for more development of online training and in-person sessions at national meetings of family medicine organizations through BRC:

- Building cultures of inquiry in departments and residency programs
- Approaches to value-added collaborative, transdisciplinary research
- Research leadership development
- Faculty development, support, and skill development in research
- Building and maintaining research teams
- Financing and staffing research infrastructure
- Developing and leveraging family medicine research laboratories

Extended Consultation Service (ECS) WG

The ECS is an initial, 2-year consultation provided by senior research leaders for 2 groups (yet to be selected) of department and institutional leaders seeking to develop, invest in, and implement bold capacity building strategies. The focus will be on developing small cadres of principal investigators into larger, self-sustaining research enterprises within and/or among departments and/or institutions.

Assessment and Evaluation WG

Measurable outcomes will be defined and collected along with rich qualitative and contextual information at specified intervals for formative feedback, and for short-term and long-term programmatic impact, using a realist evaluation framework. We will place a particular emphasis on long term impact of the ECS, as the ultimate impact of this effort may materialize within the 2-year consultation, but more likely will require several years and even a decade to fully realize.

Engagement WG

Formal engagement with organizations beyond NAPCRG and ADFM includes, to date, the College of Family Physicians of Canada (CFPC), and most recently, the Society of Teachers of Family Medicine (STFM). Each has sponsored representatives on the BRC Steering Committee. We expect these and future partners to bring critical leadership, constituencies who may benefit from this initiative, programmatic reach for BRC offerings, and in-kind resources such as Annual Meetings, journals and mechanisms for communication, education, training and consultation.

ADFM, FMAHealth, and CERA have recently fielded a survey to establish baseline measures of research capacity and productivity in US and Canadian DFMs and to establish trends over time. BRC will use this survey as 1 source among many to inform BRC program development and evaluation.

More will be necessary to complete this work. Much more. The BRC Engagement Work Group seeks and welcomes partners and supporters who share our vision of building a solid foundation on which family medicine and primary care research in the US and Canada can thrive and transform care in North America.

Bernard Ewigman, Frederick Chen, Ardis Davis, Lee Green, Dana King, Tony Kuzel, David Schneider, Tom Vansaghi

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AFMRD Association of Family Medicine Residency Directors

From the Association of Family Medicine Residency Directors

Ann Fam Med 2016;14:586-587. doi: 10.1370/afm.2010.

PHYSICIAN WELLNESS: CHANGING THE CULTURE

"We need to protect the workforce that protects our patients."[1] *— Tim Brigham, MDiv, PhD, Senior Vice President, Education, ACGME*

At least 400 physicians in the United States each year die by suicide. Depression and burnout in physicians is endemic, and in most cases, physicians are "suffering in silence."[1]

Physician suicide risk is at least double that of the general US population and is commonly linked to depression and substance use.[2,3] Burnout is defined as emotional exhaustion, depersonalization, and a decreased sense of accomplishment, which leads to decreased physician effectiveness. Estimated rates of physician burnout range from 25% to 70% and often begin in residency training. Physician burnout affects quality of care and patient safety. In addition, the increased job turnover, reduced productivity, and decreased patient engagement associated with burnout has serious implications for public health.

Physician burnout involves an interplay of internal factors, resilience, and external factors. Risk factors included pessimism, perfectionism, maladaptive

coping strategies (including substance use), lack of autonomy, poor relationships with colleagues, lack of time for self-care activities, complicated patients, and career choice regret. Other contributing factors include increased documentation and administrative tasks, growing patient loads and work hours, increased computerization, and loss of workplace autonomy; in short, the "mounting pressures of clinical care" that are "approaching the limits of personal accommodation."[1] Additionally, medical culture tends to stigmatize error, emotional vulnerability, mental illness, and help-seeking. Key barriers to seeking help are lack of time, concern about credentialing or licensing implications, and perceived lack of confidentiality or access.[2]

Efforts to improve physician wellness have focused on promoting mindfulness and self-awareness, supporting resiliency, providing peer support and sense of community, and improving access to and de-stigmatizing utilization of behavioral health services. The role of duty-hour limitations, pass/fail grading systems in medical school, schedule changes, and engaging physicians in quality improvement initiatives have also been explored. Recognizing that the physician work environment contributes to burnout, Bodenheimer, et al, as well as others, propose health systems measure physician and staff satisfaction to achieve the Quadruple Aim: enhancing patient experience, improving population health, reducing cost, and improving the work life of clinicians and staff.[4] More research is needed to determine the long-term effectiveness of interventions to improve physician wellness.

How can medical organizations, including those in family medicine, work to improve physician wellness? Alarmed by recent resident deaths by suicide, the Accreditation Council for General Medical Education (ACGME) held a Symposium on Physician Well-Being in November 2015, which included an AFMRD representative. The goals of the symposium were to understand the problem, begin a national dialog, and collaborate across organizations to create positive, transformational change in resident well-being and training environments.[1] The ACGME's Clinical Learning Environment Review (CLER) program is creating a new focus area to address physician well-being and a follow-up ACGME symposium is planned for November 2016.

Other organizations are also focusing on the issue. The American Academy of Family Physicians (AAFP) and the Family Medicine for America's Health initiative have committed to addressing physician wellness to maintain a healthy workforce to improve the health of the nation. The Society of Teachers of Family Medicine (STFM)'s inaugural twitter #STFMChat in February 2016 discussed physician wellness. In July 2016, AAFP leadership attended a summit of stakeholders convened by the National Academy of Medicine. This summit involved the American Medical Association, the American Association of Medical Colleges, the ACGME, and the Center for Medicare Services, among others. The AFMRD has established a physician well-being task force and plans special programming for the March 2017 Program Directors Workshop.

Although there may not yet be consensus on how to improve physician well-being, many national organizations, including those in family medicine, are now urgently seeking gains. Improvement is imperative for the health of our profession, our specialty, and our nation.

Katy Kirk, MD, MPH, and Steven R. Brown, MD, FAAFP

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From the North American Primary Care Research Group

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NAPCRG ANNUAL MEETING DISTINGUISHED PAPERS

NAPCRG's Annual Meeting is a forum for primary care researchers from across the globe to gather and present their research, collaborate for new research, and foster growth for up-and-coming researchers. The 2016 Annual Meeting was held in Colorado Springs, Colorado, November 12-16, 2016.

Three papers were selected and given the special designation of "distinguished paper" for excellence in research based on the following factors: overall excellence, quality of research methods, quality of the writing, relevance to primary care clinical research, and overall impact of the research on primary care and/or clinical practice.

Below are brief summaries of this year's distinguished papers; complete abstracts are available on the NAPCRG website.