

family medicine, internal medicine, pediatrics, psychiatry, obstetrics and gynecology, surgery, community medicine, and research. Key to the training was the family medicine practice, offering residents experience with their own patients in an environment similar to their eventual practice. Often, these practices evolved from the program director's own patient panel that they brought to newly developing programs.

Residents treated all ages and sexes of patients across care settings alongside faculty that included physicians, behavioral health providers, nutritionists, social workers, and others. Despite having minimal or no training in either management or educational theory and design, program directors took on the roles of both faculty manager and resident educator.

By May 30, 1969, 20 residency programs were accredited in Family Practice. By 1975, 3,720 family practice residents had joined 250 programs.

It would be more than 10 years before program directors came together to form the Association of Family Practice Residency Directors (AFPRD) in 1990, led Dr Richard L. Layton, MD as the first President.

Why did family practice residency programs become so popular? Perhaps medical students, patients, hospital administrators and communities recognized what Gayle Stephens postulated in *The Intellectual Basis of Family Practice*:

Family physicians know their patients, know their patients' families, know their practices, and know themselves. Their role in the health care process permits them to know these things in a special way denied to all those who do not fulfill this role. The true foundation of family medicine lies in the formalization and transmission of this knowledge.

What all this means is that the family physician's role has some constants and some variables; there is no homogeneity nor complete interchangeability among all family physicians... medical educators must look carefully at the role requirements for physicians serving the health needs of a particular area, design a program to meet the obvious components of that role, and allow enough flexibility for special circumstances.

We continue to strive as program directors to help our residents learn their patients, patients' families, practices, themselves and the communities that they serve. Our programs owe a debt of gratitude to these early pioneers, many of whom continue to train residents today as one of the more than 500 accredited family medicine residency programs.

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RELEVANT OUTCOMES FOR PATIENT-CENTERED INTERVENTIONS FOR PERSONS WITH MULTIMORBIDITY: EXPERTS' DISCUSSION

Although patient-centered interventions for persons with multimorbidity are increasingly implemented in primary health care, evidence on effectiveness is still scarce and inconclusive.¹ One potential explanation is the inconsistent use of outcome measures and a lack of a specific multimorbidity-adapted outcome measure.^{1,2} Using the 2015 North American Primary Care Research Group (NAPCRG) Annual Meeting, a forum was held with the goal of creating a list of relevant outcomes and to discussing methods of measurement.

Forum Process

The forum started with presentations on topics related to multimorbidity: concepts, definition, consequences, development of patient-centered outcome, and 2 intervention research examples. Results of a previous short survey on outcome relevance from the International Research Community on Multimorbidity platform were also presented.³ The online survey included 27 researchers. The main conclusions were that the most relevant outcome type was patient-reported outcome and most relevant domains of outcomes were self-management, quality of life, empowerment, and health behaviors.

Following the presentations, participants were divided into 3 small discussion groups and provided with 3 clinical vignettes (1 for each group) including 3 questions to initiate the discussion: (1) Have you experienced an intervention in multimorbidity and can you share that experience? (2) Which patient-perceived outcomes have the potential to be modified by the intervention? (3) If you had to build a single patient-perceived measure, what would be the outcomes to consider in order to capture the impact of the intervention?

Summaries of discussions were presented during a subsequent plenary session by each group and identified facilitators were invited to analyze the results on the spot to identify the consensual and relevant elements identified by the groups.

From the discussions, a list of relevant outcomes was created, grouped by categories and prioritized by the participants as the most important to consider when designing intervention for people with multimorbidity. Following the forum, the list of outcomes was

reduced by conducting a thematic analysis. Outcomes that were related but named differently by the participants were grouped into constructs.

Results

Thirty-two participants from 6 different countries (Canada, United States, France, Belgium, Australia, United Kingdom) contributed to the discussions. They included general practitioners, nurses, social workers, and epidemiologists.

Thirteen outcome constructs (Table 1) were identified as important by the participants. Among these, 3 were identified as very relevant by all groups: quality of life; functional status; and goal attainment considering patient preferences. Three other outcomes were identified by at least 2 groups: general well-being; diseases knowledge and insight; and patient activation.

Participants identified that potential new measures should rely on a conceptual framework, include a variety of outcomes constructs and weight constructs to patients' preferences.

Discussion

This forum gathered a sufficient number of knowledgeable participants from multiple fields and countries to allow a rich discussion. Furthermore, a post-NAPCRG blog posted in CMAJ by MacAuley, who participated in the forum discussion, reported that it was an insightful discussion on measurement by the world leaders in multimorbidity research.⁴

An extensive list of important outcomes was produced. The results offer an expert identification of multimorbidity-relevant outcomes, also suggesting that attempts to develop outcome measures should

rely on a conceptual framework and be weighted to patients' preferences.

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AAFP TAKES LEADERSHIP ROLE WITH LAUNCH OF CENTER FOR DIVERSITY, HEALTH EQUITY

When patients visit a family physician, there are often more than physical symptoms influencing their health. There is growing recognition that the social determinants of health also are critical factors that affect individuals and families.

If expanding access to care is the first step in health reform, caring for vulnerable populations is the next one, according to physician panelists who spoke at a March 28, 2017 forum in Washington, DC, on high-value primary care for underserved communities.

Continuing a long history of tackling disparities in patient care head on, Julie Wood, MD, MPH, AAFP senior vice president of health of the public and science and interprofessional activities, announced the launch of the AAFP Center for Diversity and Health Equity, an initiative that will focus on addressing the social aspects of health care.

"The AAFP has developed its Center for Diversity and Health Equity to take a leadership role in addressing social determinants of health, nurturing diversity and promoting health equity through collaboration, policy development, advocacy and education," Wood told *AAFP News*.

Table 1. Outcomes Constructs Identified as Important by Participants

No. of groups identifying the outcome	Outcomes constructs
3	Functional status Quality of life Goal attainment considering patient preferences
2	General well-being Disease knowledge and insight Patient activation
1	Health Status Patient-centered care Perceived care coordination Physical activity level Self-efficacy Self-management Treatment burden