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Family Medicine Issues a Call for Papers—The New Model of Family Medicine

Family Medicine, the journal of the Society of Teachers of Family Medicine, requests submission of papers reporting on the "New Model of Family Medicine" described in the Future of Family Medicine report.[1] Papers submitted in response to this call for papers should describe implementation of one or more elements of the New Model in a community practice or academic setting or both. For example, papers could describe implementation of a personal medical home, patient-centered care, team care, or another underlying characteristic of the New Model. They could also describe development and evaluation of specific New Model elements, such as group visits, open/advanced access, quality assurance and safety, and/or electronic medical records. Finally, papers could describe innovations in residency education, reimbursement, the role of family medicine in academic health centers, improvement in quality of care, or other areas of experimentation recommended in the report.

Highest priority will be given to papers that report on all 3 of the following: (1) how the component of the New Model was adapted to your practice setting, (2) details of how the component was implemented, and (3) objectively measured outcomes that ensue as a result of implementing a component of the New Model.

Manuscripts should be submitted and prepared according to *Family Medicine's* instructions for authors, which can be found at http://www.stfm.org/fmhub/instruct.html. Presubmission questions can be addressed to the editor, Barry D. Weiss, MD, at bdweiss@u.arizona.edu. There is no specific deadline for submission of these manuscripts, since papers on this topic will be considered on an ongoing basis. However, manuscripts submitted before the end of 2005 will be considered for publication together in a special series of articles.

Traci Nolte, Communication Director
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COMPELLED TO FAIL? THE INNOVATOR'S DILEMMA AND FAMILY MEDICINE RESIDENCY PROGRAMS

The Future of Family Medicine (FFM) Project is emphatic in its call for change in family medicine residencies: "Innovation in Family Medicine residency programs *will be supported by the Residency Review Committee* for Family Practice through 5 to 10 years of curricular flexibility to permit *active experimentation* and ongoing critical evaluation of competency-based education, expanded training programs, and other strategies to prepare graduates for the New Model [emphasis added]."[1] The FFM Project report asserts residencies should "actively experiment" with: 4-year curricula, adaptation to local community needs, enhanced education in maternity, orthopedic or emergency care, evidence based practice, scholarship, "patient-centered knowledge," informatics, professionalism, and interdisciplinary learning. Innovation in residency training is essential to renewal of our discipline.

Family medicine was innovative when it began in the 1960s. Residency programs have become progressively more structured, however, as requirements of the Residency Review Committee for Family Medicine (RRC-FM) have become detailed, specific, and prescriptive.[2,3]

Family medicine now appears to be facing Christensen's "innovator's dilemma"[4]: earlier successes achieved by well-established industry or business can cause vulnerability. New businesses initiate lower cost strategies that, although of low quality by the former criteria, better meet customer needs. The established industry's investment in sustaining its way of work compels it to avoid innovation, even when it knows it must change to survive. With time, an innovative upstart can improve to the point where it eliminates the formerly dominant company. Strategies to cope with this dilemma[5] have been described for health care in general[6] and family medicine in particular.[7]

Quality certification programs in established industries are by nature conservative: they protect the dominant model. RRC-FM requires periodic review and cites programs for failure to comply with specific requirements. The "frequency and distribution of citations has not varied much in the past 5 to 10 years"[2] despite enormous changes in delivery of health care.

Does the stable pattern of citations reflect an enduring weakness of the training model represented by our RRC requirements? Consider the most frequent citation by the RRC-FM, regarding residents' experiences in maternity care.[2] Perhaps widespread inadequacy of maternity training reflects a fundamental flaw in a model of practice that recalls a time most family physicians provided maternity care. It is time for the community of family medicine to consider whether the enduring pattern of citations reflects critical weaknesses in the training model we ask the RRC-FM to uphold on our behalf.

It is time for residency training to be redesigned from the ground up, rather than simply tightening requirements on a failing model of clinical practice and education.[8-10] Christensen's description of disruptive innovation would suggest family medicine should eliminate its high-cost, complex, and customer-unfriendly model of training in the family medicine center in favor of more innovative, low-cost, accessible care. Pediatric residencies, for example, may use an apprenticeship model for training in which one pediatrics resident is assigned for continuity experiences in a private pediatrician's office throughout the 3 years of residency.[11,12] Experimentation with this model in family medicine seems a natural and appropriate innovation. Yet Christensen might predict we, through our RRC-FM, would require such initial experimentation to show results identical to the old model. We would impose such rigid requirements as to kill innovation before it can grow into excellence.

Thus, asking the RRC-FM to support innovation without understanding the process by which fundamental and disruptive change occurs may be a formula for failure. The role of the RRC-FM historically has been to enforce more specific requirements, not to encourage the kind of risk-taking and reconceptualization of training essential to innovation. We should take seriously the call in the draft revision of the RRC-FM requirements for "responsible innovation and experimentation,"[3] while avoiding the urge to require that innovative changes show results identical to those of the dominant model.

ADFM urges the AAFP, departments of family medicine, residency programs, and especially the RRC-FM, to acknowledge the dilemma of innovation. We must create experiments with potential to supplant the educational model many of us have worked so hard to create. Some may achieve excellence by measures very different from those of existing programs. Upending and replacing our hard-won, well-developed model of residency training could be the key to survival of family medicine.

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GRADUATE SURVEYS: AN OPPORTUNITY FOR RESIDENCY RESEARCH

Because of the educational demands placed upon family medicine residency programs, research and other forms of scholarly activity are often difficult to incorporate, initiate, and complete. With minor alterations and a small amount of additional work, many activities associated with a residency program can be developed into research projects. For example, the family medicine residency programs affiliated with the South Carolina Area Health Education Consortium (SC AHEC) have utilized the required graduate survey as a research tool.

Based upon the Program Requirements for Residency Education in Family Practice, each program must maintain a system of evaluation of its graduates. The residency should obtain feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, and