

ferent markets. Family physicians are even acquiring "hybrid vigor" as they pursue Masters' degrees, fellowship training, CAQs, and dual certification. Demand is high for residencies that encourage such vigor via special foci and extended training.<sup>5</sup>

Of course, the dichotomy of "intelligent design" and "evolution" is not absolute. Residents must acquire a core set of knowledge, skills, and attitudes to become family physicians. However, ADFM believes that we should not limit innovations to carefully controlled "experiments" in a few residencies around the margins of dangerously restrictive requirements. We should instead encourage residencies to find the most successful practicing family physicians in their communities, study what they do, and prepare residents to practice and adapt like these exemplary doctors. Then we should get out of the way and see what evolves.

*Michael K. Magill, MD,  
and the Association of Departments of Family Medicine*

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**From the Association  
of Family Medicine Residency Directors**

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## EXPERIMENTATION AND INNOVATION IN FAMILY MEDICINE RESIDENCY EDUCATION: THE TIME IS NOW

By this time, most of you have heard or read about the joint initiative between the American Board of Family Medicine and the Association of Family Medicine Residency Directors called "Preparing the Personal Physician for Practice" or the P4 Initiative. As stated in the recent Call for Proposals,<sup>1</sup> "The purpose of P4 is to learn how to improve the graduate medical educa-

tion of family physicians such that they are prepared to be outstanding personal physicians, working in new models of practice. The innovations tested by P4 residencies are expected to inspire substantial changes in the content, structure and location of training family physicians and guide future revisions in accreditation and certification requirements."

From the beginning, it was felt that the P4 Initiative would succeed or fail based on the creativity and tenacity of the folks in the trenches, ie, the residency program directors and their faculty. Therefore, prior to this year's Program Director Workshop (PDW), input was solicited from directors on the current status of residency education. The magnitude of the response (over 200 directors offered input) and the thoughtfulness of the comments demonstrated to me a significant interest in this project and a readiness for change in our graduate medical education system. Following is a synopsis of the responses received from the directors, combined with opinions expressed during the discussion forum, which was held at the 2006 PDW. These comments capture the full range of ideas expressed by the directors and though not meant to be a formal analysis of the responses, I think the comments do offer insight into our directors' thoughts and desires for the future.

In response to what important aspects of residency education need to *change* in the future, we received comments around the themes of decreased regulation, more curricular flexibility, more practical learning in "real-world" settings, guidance on how to adopt new technology, help in identifying new funding sources, help in developing a viable financial model for practices, and better ways to assess and assure the competency of our graduates.

In response to what important aspects of residency education need to be *preserved*, we received comments relating to continuity of care, breadth of training, intellectual curiosity, the personal, continuous doctor-patient relationship and the core, universal training that all residents receive, so there's consistency across the spectrum of what all family physicians can do; ie, "training can't become totally variable."

When asked to fast forward 5 years, after the residency experiments are completed, *what must we know that we currently don't*, we received comments relating to how we could use more technology to improve quality and outcomes, what teaching methods are actually effective, what educational outcome measures are meaningful, how to better assess and assure competency and that the New Model of Practice is financially viable and relevant. It was clear from the comments that we need to better understand what experiences during residency are most effective in training knowledgeable and skilled family physicians.

The comments regarding *barriers* to change were somewhat predictable. Directors saw the major impediments to change revolved around inadequate funding, lack of access to technology and an EHR, lack of faculty time and support, overregulation by our accrediting bodies such that it is "creativity stifling," and increased service requirements by the sponsoring institution making educational innovation difficult. There was also the feeling that many programs have difficulty embracing the concept of change.

Lastly, we wanted the directors to portray what their *ideal graduate* would be in 2015. The responses hinged around the graduate's ability to use technology and systems to provide comprehensive, high-quality, evidence-based care to people of all backgrounds, to be an excellent communicator, and to be a competent, caring, and compassionate physician who provides personalized care to patients. I thought one response worth quoting (probably from a director who recently underwent a RRC site visit) was that the ideal graduate in 2015 will be "a walking testimonial to the ACGME's 6 competencies."

Regardless of what we learn at the end of this 5-year experiment, in many ways, I believe the P4 Initiative has already been a success. As seen in the above comments, there appears to be significant enthusiasm for change. The next few years offer an incredible opportunity to embrace change and look at all the possibilities afforded us through both TransformMED's National Demonstration Project and the P4 Initiative. These are indeed exciting times and I look forward to seeing the outcomes of these experimental initiatives.

Samuel M. Jones, MD  
President, AFMRD

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From the North American  
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## REPORT FROM THE 2006 NAPCRG ANNUAL MEETING: ANTIMICROBIAL USE IN PRIMARY CARE

The 2006 NAPCRG Annual Meeting held October 15-18 in Tucson, Ariz, featured plenary speakers who highlighted the role of primary care research in developing strategies to address the important public health issue

of antimicrobial resistance. J. Todd Weber, MD, FACP, who is the director of the Office of Antimicrobial Resistance in the Coordinating Center for Infectious Diseases at the Centers for Disease Control (CDC), emphasized the dangers of antimicrobial resistance by describing the lack of new antibiotics to replace older antibiotics with high-resistance profiles. For example, studies show an increasing prevalence of Methicillin-resistant *Staphylococcus aureus* (MRSA) with devastating consequences of necrotizing pneumonia, sepsis, septic emboli, necrotizing fasciitis, and mortality. Dr. Weber reported that most of the new drugs approved in recent decades have been chemical modifications of existing drugs, not novel drug classes, with only 2 new antibiotic drug classes having been approved by the US Food and Drug Administration since 1968.

Although inappropriate antibiotic prescribing is declining in the primary care setting, further reductions are needed. To that end, Dr. Weber described the "Get Smart" campaign, which represents an effective collaboration between the CDC and external partners to develop a successful public health program to decrease unnecessary antimicrobial use and reduce the spread of resistance. He discussed the continuing importance of primary care research for improving preventive strategies that decrease the incidence of resistant infections, describing the epidemiology of antibiotic use and infections, and developing interventions that decrease inappropriate use of antimicrobials. Dr. Weber stated interventions should be developed both for health care providers and the general public, since the use of antibiotics without a prescription is also a growing concern, especially within Latino communities outside the United States.

This theme was highlighted in the plenary of Paul Little, MD, MBBS, a general practitioner from the United Kingdom who is a professor of primary care research at the University of Southampton. While discussing his journey as a clinical researcher, Dr. Little presented his work on improving antibiotic prescribing within the primary care visit, which includes studies on using delayed antibiotic prescriptions. He believes that the immediate prescription of antibiotics can 'medicalize' a self-limited illness. Dr. Little also described strategies to improve patient education within visits, which could lead to less antibiotic prescribing while maintaining patient satisfaction. His work is an example of practical research that directly informs the practice of primary care and which derives its questions from common problems in that arena.

Dr. Little listed the need for ideas and passion as key ingredients for a clinician to develop a successful research career. Research training, adequate funds, multidisciplinary teamwork, and the support of senior lead-