Family Medicine Updates

From the Association of Departments of Family Medicine

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AN UPDATE ON FAMILY MEDICINE PARTICIPATION IN CLINICAL AND TRANSLATIONAL SCIENCE AWARDS (CTSAs)

Family medicine researchers play leading roles in many of the 38 institutions that have received Clinical Translational Science Awards (CTSAs). We have described the purposes, successes, and strategies for engaging in institutional CTSA applications in past *Annals* columns in 2007 and 2008.[1,2] We refer interested readers to those columns and the cited references for rich sources of background material. NIH plans to award 50 to 60 CTSAs and applications for the next round due in October 2009. Our purpose here is to provide an update on family medicine participation in CTSAs.

We conducted a Web-based survey of the 145 Chairs of departments (which includes allopathic, osteopathic, and large regional medical center members of ADFM) in October 2008 and received responses from 69 departments (48%). Of these 69, 22 (32%) departments were in institutions that had been awarded a CTSA. The medical school in which the department was located was the lead institution in all but 1 case, in which the department was located in a collaborating institution. Of those who have not yet been awarded a CTSA, 44 (64%) had applied for a planning grant, and 17 received a planning grant. We conclude that a majority of the medical schools in this sample would like to obtain CTSA funding.

Among our respondents, family medicine faculty have leadership positions in 12—about one-third—of all funded CTSAs. These roles include leading units devoted to engaging the community in research, leading the development and implementation of practice based research networks, and directing training units in clinical translational research. Family medicine faculty also have important roles in bioinformatics, clinical trials, epidemiology, biostatistics, and knowledge translation components. In each of these instances, family medicine faculty contributed directly to the success of their institution's CTSA application. In several cases, participation by family medicine was instrumental in achieving funding on the first submission, and in several additional cases family medicine participation was instrumental in getting funded on a revised application.

Despite these key roles, the majority of family medicine departments do not have substantive involvement in a CTSA. Either their medical school does not have a CTSA, or the department does not have faculty with the requisite experience to contribute meaningfully. In contrast to the first 2 rounds of CTSA applications, in which we learned of several departments with valuable research track records who, by their estimation, were not sufficiently included in their institutional CTSA proposal, none of the respondents to this survey indicated that they had not been appropriately engaged. Examination of the 38 funded CTSAs reveals that areas such as community engagement and practice based research, the primary components to which family medicine has made essential contributions, are important elements for successful funding in most, though not all, instances. Many respondents indicated that their institution, department, or both lacked the infrastructure to be competitive for these awards.

The original budgets for the CTSA were reduced, which affected 71% of our responding institutions. Somewhat to our surprise, only 40% of our respondents said that the budget cuts specifically impacted components that involve family medicine faculty. The often expressed perception that community engagement and practice-based research were cut more than other CTSA components was not supported by the responses we received. Of course, we do not know what the original allocation was relative to other components, and our anecdotal impression is that only some CTSAs have managed to support community engagement and practice-based research at levels adequate to build a robust infrastructure for research in these settings.

For departments that plan to participate in future CTSA applications, our respondents made recommendations along the following themes:

1. Identify strengths that the department can contribute to a successful application.

2. Focus on "T2" translation, especially community engagement, community based participatory research and practice based research.

3. Educate the principal investigator through personal meetings and in writing about what you have to offer.

We would add that reviewing the applications of funded CTSAs, engaging funded CSA researchers as consultants, and approaching the CTSA process as team players are all potentially productive strategies. The CTSA Web site of the National Center for Research Resources of the NIH contains a plethora of information as well as links to all currently funded CTSA Web sites.[3]

A final strategy that we will mention is that 8 of our respondents indicated that they would be applying as a collaborative institution rather than as a lead institution. As mentioned above, 1 family medicine department is currently participating through a collaborative arrangement. This may be a productive strategy for departments that have a distinctive contribution to make, but are located in institutions that would not otherwise be competitive for a CTSA. Collaboration across institutions and between CTSAs is strongly encouraged as part of the vision of accelerating research findings into improved outcomes for patients.

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From the Association of Family Medicine Residency Directors

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PERCEIVED IMPACT OF PROPOSED INSTITUTE OF MEDICINE DUTY HOURS ON FAMILY MEDICINE RESIDENCY PROGRAMS

The ACGME is faced with an enormous challenge. On the 25th anniversary of the Libby Zion case[1] and the 5th anniversary of the ACGME Duty Hours,[2] the Institute of Medicine (IOM) released a December 2008 report calling for a revision in duty hours and trainee supervision.[3] The ACGME is asking the graduate medical education community to collaboratively address concerns raised by the IOM about resident schedules and safety of patients and trainees. In discussions following the release of the IOM report, opportunities for improvement as well as threats to the educational process and the viability of some residency training programs have emerged.

The Association of Family Medicine Directors (AFMRD) surveyed its membership utilizing an online survey instrument (Zoomerang). As of February 26, 2009, 60% of the program directors responded to the survey. This represents a broad representation of programs by geographic region, community type (rural, suburban, urban), program administration, and program size.

The results of this survey clearly identify numerous issues regarding implementation of the IOM recommendation. For instance, two-thirds or more of the program directors responded that it would be "very easy" or "easy" to implement:

- In-hospital call every third night, no averaging
- 10 hours off after day shift
- Internal and external moonlighting within the 80-hour weekly limit

Furthermore, two-thirds or more of the directors responded that it would be "difficult" or "very difficult" to implement:

- Ensuring a 5-hour protected sleep period between 10 PM and 5 AM in a 30-hour period
- Limiting residents to a 16-hour shift
- 12 hours off after night shift
- In-hospital night shift 4-night maximum; 48 continuous hours off after 3 or 4 nights of consecutive duty
- 5 days off per month; 1 day (24 hours) off per week, no averaging; 1 48-hour period off per month

In addition to the difficulties noted with implementation, the residency program directors expressed concern regarding detrimental effects on medical education as well as potential decrease in the quality of care provided. Over 90% of the program directors expressed concerns about:

- Graduating doctors who generally take less 'ownership' and do not know patients as thoroughly as in the past
- Residents developing a 'shift-worker mentality' that the IOM rules would exacerbate
- Future doctors being less prepared for the work-hour demands of practice

The untoward effect of the proposed changes in work hours was reflected in the finding that two-thirds