Woods Johnson Medical School.) The meeting was impressive:

- The range of PCPCC stakeholders, already large, is growing, and now lists over 500 members. It includes not only the original signatories—including family medicine (AAFP), pediatrics (AAP), internal medicine (ACP), and osteopathy (AOA), but also a growing number of employers, insurers, nurse practitioners, pharmacists, consumer groups, and non-profits
- PCPCC is aggressively lobbying for healthcare reform and they seem to be getting traction with representatives and staff members in both houses of Congress
- The 4 virtual PCPCC "Centers" are each active—with more being considered
- The conceptual principles of PCPCC are dynamic, eg, the recent addition of behavioral mental health issues in the PCMH model

What is significant about ADFM being engaged in the PCPCC? ADFM is the only family medicine organization—besides the AAFP—providing partial balance to the plethora of internal medicine-dominated primary care and think tank organizations. The leadership and members of the PCPCC are ever more impressed by what they are seeing family medicine departments, organizations, and practices across the country accomplishing, and hopes that we will both help lead the local efforts and train those who will work in the medical homes of the future. Several ADFM members have provided or will provide keynote addresses and supporting documents at their summits and meetings—adding a host of new ideas and concepts to the PCMH movement.

How can ADFM meet the challenge to get involved as a positive force for change, and cope with the ever expanding PCPCC organization? The ADFM Executive Committee and leaders of the Clinical Committee (Tom Campbell and Libby Baxley) have discussed the need to form an ADFM PCMH task force to coordinate and direct our efforts. Such a task force will include clinical, legislative, and research representation. Libby Baxley, Maryjean Schenk (President Elect), Mike Magill (Immediate Past president) and others will take active roles in leading the effort. We plan to work closely with the family of family medicine in advancing transformation of our discipline to meet the needs of patients for generations to come.

Jeffrey Borkan, MD, PhD
Michael Magill, MD
Maryjean Schenk, MD, MPH
Ardis Davis, MSW
This commentary was written by members of the ADFM Executive Committee

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From the Association of Family Medicine Residency Directors

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FAMILY MEDICINE: WHAT ARE WE GRADUATING?

As the family of family medicine begins the process of revising the Residency Guidelines for Family Medicine, it may be time to look back over our progress to date in order to steer our efforts in the best direction in the future. What is the difference in our present product versus our ideals as our "founding fathers" delineated them in our "constitution" of 1968?

The original guidelines from family medicine covered a mere 3 pages laying out the length of training, and general content, as well as proposed categories of programs that reflected and embraced the wide variation of locations where family medicine physicians lived and worked.[1] Our founding document also defined the family medicine physician in 4 domains. First, the family medicine physician was to serve as the physician of first contact with the patient who provided an entry for the patient into the health care system. Second, the family physician was tasked to evaluate the patient's total health care needs and to provide personal medical care and referral management. Third, our graduates were to provide continuous and comprehensive care as well as the coordination of care. Lastly, the vision asserted that family medicine physicians were to provide care for the patient within the context of the patient's family and social milieu.

Current guidelines include these attributes; future decisions in new guidelines will need to address the appropriateness of these parameters in the 21st century. Our current question is whether or not we and

our graduates hold firm to this definition, or whether a majority tailor their practice to a narrower spectrum of care. Clearly, residents enter traditional family medicine practices, but they also opt for fellowships in geriatrics, obstetrics, and sports medicine and practices that embrace hospital medicine; they work in emergency departments, health departments, and Veterans' hospitals. Also, clearly, these graduates consider themselves family medicine physicians, although their career paths may not adhere to the strict definition as outlined in our founding documents.

There is no national database that answers the question, "where are our graduates, and what exactly are they doing?" Logically, we also cannot answer with complete confidence the question as to whether or not our residency programs prepared them for the world at large. The AMA collects physician data from specialty boards, state medical boards, and societies and publishes data on physician specialty and distribution, but does not drill down to the detail of practice profiles of family physicians.[2] Several states also track physician resources, but still leave crucial questions unanswered that address the need for feedback on our residency programs. Although we are required to survey our residents following graduation, we use no consistent instrument across all programs, nor do we know if a single instrument could be designed to embrace all variations of family medicine residency programs to help us answer these questions. Several publications deal with regional outcome data, and at least 1 P[4] project attempted to grapple with the concept of a common post graduate survey instrument.[3]

It follows that we may need to ask ourselves, is it time for a universal survey that would help the discipline answer the thorny questions of our role and worth in the healthcare system. Do we need to expand the definition of the family physician to include alternate types of practice? And, lastly are our values antiquated, are our visions of ourselves valid, or should we change?

Karen Hall, MD; Stoney Abercrombie, MD; Sandra Carr, MD; Joseph Gravel, Jr, MD; Grant Hoekzema, MD; Stanley Kozakowski, MD; Djinge Lindsay, MD, MPH; Elissa Palmer, MD; Todd Shaffer, MD, MBA; Martin Wieschhaus, MD

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From the North American Primary Care Research Group

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RESEARCH CAPACITY BUILDING IN FAMILY MEDICINE: THE IMPACT OF THE GRANT GENERATING PROJECT

Background

Leading family practice research often involves interdisciplinary teams, multi-method approaches, and the collection of resource-intensive primary data in the practice setting. However, the cost structures of most medical schools, community residency programs, and practices do not provide salary support for family physicians or family medicine researchers from other disciplines to engage in research or scholarship. As a result, the biological, behavioral, health services, and medical sciences depend primarily on external grant support for sustained productivity. For family practice to significantly grow its research capacity, investigators in the discipline must be able to apply for and obtain major research grants from one of 3 primary sources—the pharmaceutical industry, the federal government, and foundations.

This medical research funding is by far the largest level in the history of the world, yet family medicine researchers have not tapped into this resource. To develop successful research grant applications, family practice researchers need consultation, time, peer review, and technical assistance. One or more—or all—of these resources often are lacking in their institution, department, division, residency program, practice, or other organization.

The Grant Generating Project (GGP) has successfully brought together many of these components into a "fellowship without walls" for family practice researchers who lack them in their home environments. The GGP fits with the research and scholarship capacity-building needs of various organizations in the "Family of Family Medicine Organizations"—including the American Academy of Family Physicians' Plan to Enhance Family Practice Research, North American Primary Care Research Group's Committee on Building Research Capacity, the Society of Teachers of Family Medicine, and the Foundation of the American Academy of Family Physicians.

Established during the 1995-1996 academic year through the efforts of the NAPCRG Committee on Building Research Capacity (BRC), the GGP seeks to equip family medicine researchers with the skills