ing more compassionate, more effective family physicians;" in fact, only 0.8% believed this would occur.

In July 2011, the ACGME's revised duty hour rules went into effect, in part based on voluminous research into the effects of fatigue and sleep deprivation on performance, but also due to external political pressures that forced the ACGME to take action and try to preserve the vestiges of a profession before Congress, governmental agencies, and activist groups forced more draconian measures. Considering the previously surveyed opinions of program directors, one can draw 2 conclusions concerning the impact of duty hour revisions on the quality of our residents' education and on patient care. The first possibility is that program directors collectively were wrong and that the duty hour changes will in fact result in better family physicians and improved care for patients. This is 1 circumstance where most program directors hope they were indeed wrong.

The other possibility is that the collective wisdom of the group responding was generally correct. Regardless, Congress, advocacy groups, residents, and recently graduated family physicians (who may not fully appreciate their level of preparedness or have a basis for comparison) will not likely agree to go back to less restrictive duty hour rules. Assuring adequate experience levels for independent practice, teaching professionalism, and providing residents a glimpse of the joy of deep and meaningful patient relationships needs to be addressed in new ways.

John Wooden said, "If you don't have time to do it right, when will you have time to do it over?" The realistic answer is never, CME reforms notwithstanding. As family medicine educators, we need to get it right the first time! As the effective amount of training time continues to diminish (1 estimate is that a resident now will train the equivalent of 2.4 years compared to a 3-year residency of the past), we owe it to our residents and the public to honestly and actively study the length of family medicine residency training to minimize any unintended negative impact of duty hour restrictions. Producing quality family physicians cannot be even partially sacrificed for other important goals such as meeting primary care workforce needs. We need to assure that a board-certified family physician stands out from mid-level practitioners and other generalist physicians, both in scope of practice and skills. This may require more time than we currently give ourselves to provide our residents the new skill set needed to lead in the future health care system.

Joseph Gravel, MD; Stoney Abercrombie, MD; Sneha Chacko, MD; Karen Hall, MD; Grant Hoekzema, MD; Lisa Maxwell, MD; Michael Mazzone, MD; Todd Shaffer, MD; Michael Tuggy, MD; and Martin Wieschhaus, MD

References

1. Nasca TJ. An open letter to the GME community. May 4, 2010. http://www.acgme.org/acwebsite/dutyhours/dh_index.asp.
2. Carek PJ, Gravel JW, Kozakowski S, Pugno PA, Fetter G, Palmer EJ. Impact of proposed institute of medicine duty hours: family medicine residency directors' perspective. *J Grad Med Educ*. 2009;1(2):195-200.

From the North American Primary Care Research Group

Ann Fam Med 2011;9:559-560. doi:10.1370/afm.1328.

LESSONS LEARNED FROM REBUILDING A PRIMARY CARE INFRASTRUCTURE: A CANADIAN PERSPECTIVE

The Canadian health care system began to crumble in the 1990s after its foundation, primary care, had been neglected for more than 2 decades. Canada has spent the last decade trying to fix the problem and restore and strengthen its primary care system. While there is much work left to be done, much has been accomplished. Here are a few pearls of wisdom learned along the way and what is still in the works to bring primary care back to the core of the Canadian health care system.

1. Don't Think Your System is Always the Best

Policy-makers and the health care establishment were inattentive to the weakening of the Canadian primary care infrastructure. Physicians in training were increasingly choosing specialties over family practice to be able to pay off their student loans.[1] As a result, first contact with the medical system for many patients became emergency departments and walk-in clinics since many Canadians could not find a family doctor. Our specialist colleagues were being asked by patients to do the job of family doctors. These were just a few symptoms of a sick system that needed some serious attention.

2. The Solution of Simply Spending More Money is Unsustainable

Despite huge amounts of money being thrown at the Canadian system, international reports indicated that Canada was losing ground among industrialized nations in terms of the quality of primary care. Countries that had invested in their primary care systems were well ahead of Canada—even after spending fewer resources.[2,3]

3. Spending the Majority of Resources on Health Systems, Hospitals, and Specialties is Not the Answer

Provincial governments expanded emergency rooms and funded more specialists, while primary care slowly continued to crumble. Quadrupling the size of emergency departments and not spending any money on the primary care sector did not solve the problem. The cost of caring for patients in the emergency departments far exceeded the cost of delivering primary care yet the quality of care was inferior.

4. Establish Measures of Performance for the Primary Care Sector

The quality of care in hospitals was the focus of public debate since there were few decent measures of performance of the primary care sector.

5. Fix Primary Care First; Then Put Money Into the Rest of the System

International research shows that countries that invest in primary care as the foundation of their health care system have better outcomes: their citizens live longer and have a better quality of life.[4]

6. The System Needs to Be in Balance

Primary care physicians need to be the cornerstone of the health care system. They need to care for the whole patient, not just a single condition. Specialists cannot be specialists without this balance. The other components of the health care system depend on a solid and stable primary care foundation.

7. Significant Investment in Reforming the Primary Care Sector is Necessary

In the past 10 years, Canada has spent hundreds of millions of dollars to reform the primary care sector, including: electronic health records (EHRs), blended systems of remuneration for family doctors, multidisciplinary teams, and requirements for accountability.

8. Research Ensures the Money Has Been Well Spent

We must study the effects of our financial investments, compare results among communities, and examine the data on patient outcomes.[5]

The Canadian Institutes of Health Research (CIHR) convened a 2-day summit in 2010 with key stakeholders to discuss the state of primary care research nationally and internationally, and to explore new applications for Canada. In 2011, CIHR initiated a 10-year research plan that can not only support the delivery of high-quality, community-based, primary health care across Canada, but also build a strong, evidence-based research capacity and infrastructure.[6]

Canadian PHC researchers have come together to form the Canadian Primary Health Care Research Network that will coordinate Canadian research efforts and work toward enhancing the quality, access and cost-effectiveness of Canada's health care system.

9. Technology and Innovation Are Keys to Success

Modern information technology tools and new analytical techniques will unlock our understanding of what makes primary health care effective and inform us of what is needed to improve the quality and cost effectiveness of the entire health care system.

This article was adapted by Joan Hedgecock, MSPH, NAPCRG Member Services Manager, and Kristin Robinson, NAPCRG Public Relations Specialist, from an original manuscript by William Hogg, MSc, MClSc, MD, CM, FCFP, Professor and Senior Research Advisor in the Department of Family Medicine at the University of Ottawa and C.T. Lamont Primary Health Care Research Centre of the Élisabeth Bruyère Research Institute in Ottawa, Ontario. The article is printed here with permission granted by the Canadian Family Physician. *The citation for the original article is: Hogg W. Rebuilding the primary care infrastructure one research project at a time.* Can Fam Physician. *2011;57:1121-1122.*

References

1. Canadian Resident Matching Service. 2002 R-1 Match reports: history of family medicine as the career choice of Canadian graduates. 2002. http://www.carms.ca/eng/operations_R1reports_02_e.shtml#table7.
2. Starfield B. *Primary Care: Balancing Health Needs, Services and Technology.* New York, NY: Oxford University Press; 1998.
3. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.
4. Davis K, Schoen C, Stremikis K. Mirror, mirror on the wall: how the performance of the US health care system compares internationally, 2010 update. *Commonwealth Fund Report.* 2010.
5. Starfield B. Primary care in Canada: coming or going? *Healthc Pap.* 2008;8(2):58-62, discussion 64-67.
6. CIHR Roadmap Signature Initiative in Community-Based Primary Healthcare. 2011. http://www.cihr-irsc.gc.ca/e/43249.html.