faculty is to the students. Whether this new focus will translate into more students going into areas of need remains to be seen. We will be training students to be members not just of a discipline, but of a profession.

Lloyd Michener, MD

From the Association of Family Practice Residency Directors

BEING SUCCESSFUL WITH FAMILY MEDICINE RESIDENCY RESEARCH: LESSONS LEARNED FROM OTHERS

The American Academy of Family Physicians and the Program Requirements for Residency Education in Family Practice acknowledge the importance of research during residency training.[1] The Accreditation Council for Graduate Medical Education requires formal scholarly activity to occur in residency programs through their core competencies of medical knowledge, practice-based learning and improvement, and systems-based practice. Finally, Stange et al[2] recommend that the generation of relevant knowledge should be supported through incorporating the pursuit of new knowledge as a central feature of training programs and policy.

Despite these recommendations, Mainous and colleagues[3] found that research appears to have a minor role in academic family medicine. Of a potential rating of 5, research was ranked fourth in a survey of chairs of institutional members of the Association of Departments of Family Medicine. Approximately 10 peer-reviewed articles per year were published per department. Departments in less intense institutions published a median of 0.7 articles, whereas those in research-intense institutions published 0.5 ($P = .30$).

Although research is often included in the residency curriculum, it is not always a required component. In a survey of family practice residency program directors, Neale[4] found that 48.6% of respondents reported requiring a resident research project, but only one fourth linked annual resident promotion to progress on the project. The top 2 reasons for requiring resident research were to develop critical thinking and patient care skills and to understand the medical literature. The top 2 reasons for not requiring resident research were the attitude that research isn't necessary and lack of faculty or time.

Residency programs can further integrate research into their curriculum and make scholarly activity a priority. Residency directors model research behavior and should look to successful researchers as they develop their curriculum. Gonzales et al[5] noted several key elements of a successful research program for medical students. A development program (eg, the Family Medicine Scholars Program), financial support for student research, a core of faculty mentors, a strong coordinating effort by the predoctoral office, and research agendas geared to student schedules increased the number of students involved in primary care research, presentations, and publication.

In a survey of community residency faculty and nonfaculty family physicians who published at least 1 article during a 2-year period, Hueston and Mainous[6] found that 60% of community faculty and nonfaculty family physicians reported previous research experience in the undergraduate, medical school, or residency level. The respondents noted several keys to their success: a mentor, a supportive infrastructure, and an inherent enjoyment of research. Interestingly, research training received during residency was evaluated as poor.

In a follow-up interview, Dr. Hueston said curiosity is a key element in being a successful researcher. "While some people are just born curious, I think we can train our learners to be curious through modeling traits, such as the reliance on evidence-based information and challenging expert opinions, that should be part of the approach of any successful teacher."

On a cautionary note, Dr. Hueston notes that "the mistake that most people make in choosing a research topic is biting off more than they can swallow. Usually, residents have to hone down their initial idea into smaller component projects that are essential to finding out the answer and, more importantly, are feasible."

Family medicine programs should be able to learn from lessons of successful researchers as they further implement research into the curriculum. To be successful, the programs need to have research as a priority. As noted by Stange et al, "we cannot let the competing demands and threats of the current environment dissuade us; they make the need and opportunity even stronger."

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From the North American Primary Care Research Group

THE GENESIS OF THE NORTH AMERICAN PRIMARY CARE RESEARCH GROUP

NAPCRG is the only organization dedicated to expanding the body of knowledge that supports effective delivery of primary medical care to diverse patient populations. Its mission addresses the needs of multiple medical specialties, patient care environments, national populations and research methodologies. The 2003 NAPCRG annual meeting returns to Banff Springs, the location of an organizational milestone in the memories of long-time members. At that first meeting many founding members realized their efforts to engender a multidisciplinary, multimethod, and multinational research organization were successful. Newer NAPCRG members know the unique role the organization, yet many are likely unaware of the details of its origins. We asked one NAPCRG founding father, Maurice Wood to reflect on the genesis of NAPCRG.

John G. Ryan, DrPH

NAPCRG: The Beginning

During the 1960s and 1970s, many in the newly established primary care departments throughout North America recognized the need for an organization to expand academic primary care research while continuing to nurture the rich tradition of research in private practice. Gene Farley wrote that this was "a time of high hopes that the people could make changes in society [by reforming] the health care system to serve the needs of traditionally ignored populations." Gene and others felt that "new knowledge was needed" to care adequately for those populations.

Gene led the establishment of the Family Medicine Program at the University of Rochester, NY, which from the beginning purposefully integrated service, demonstration, and research, and included practice and information systems. Gene recruited David Metcalfe in 1969. David, a member of the Royal College of General Practitioners (RCGP), was experienced in using age, sex, and morbidity indices that had been used in the United Kingdom since 1955.

Recognizing a void in the primary care movement in the United States, David appreciated the importance of roles undertaken by the STFM and the AAFP but saw a knowledge base was lacking. He advocated for generating an "innovative research capability" unique to primary care.

I had the good fortune of being recruited the Medical College of Virginia in 1969. Together with Fitzhugh Mayo and Kinloh Nelson, we established the Medical College of Virginia's Department of Family Practice. My membership in the RCGP gave me a knowledge base similar to David's, and I had years of practice-based research experience. Fitzhugh, a family physician in Virginia and an independent researcher in private practice, had undertaken clinical research in his own practice by recording and retrieving clinical data for his pioneering epidemiological studies. By 1972 the department had 3 training programs using problem-oriented medical records that were linked to demographic and clinical data sets.

Fitzhugh believed that a unique organization was necessary to build an infrastructure in family medicine to facilitate research and education based on service.

These perceived needs and the jointly held convictions led to a seminar-workshop in April 1972 entitled *Data Recording, Data Retrieval and Research in Primary Care*. The conference, cosponsored by the Family Medicine Program of the University of Rochester and the Department of Family Practice of the Medical College of Virginia had 50 attendees from 28 family medicine programs in the United States and Canada. Participants concluded that an interactive group should be organized to stimulate research in community-based settings; they elected a steering committee consisting of Lou Filiatrault from the University of Minnesota, David Metcalfe, and myself. We were charged with defining suitable goals and a structure for the group. By May 1972 we distributed a position paper that defined goals; we solicited funding to support a second meeting in the fall of 1972 and annual meetings, which began in 1973.

In retrospect, our first meeting in 1972 responded to an overwhelming need for an office practice information system. Our original goals were written to meet that need. We have largely achieved our original goals, although a unified data recording and retrieval system never became established in North America. In NAPCRG, work on such systems continues today; however, I remain somewhat disappointed that we haven't yet achieved our informatics goals in our own backyard. Nevertheless, I am hopeful that the work pursued by several groups in the United States will ultimately yield an important information system that will continue to push the frontiers of primary health care for the sake of research, education, and service.

Maurice Wood, MD