

# Family Medicine Updates



From the Association  
of Family Medicine Residency Directors

*Ann Fam Med* 2012;10:174. doi:10.1370/afm.1394

## A FAMILY MEDICINE RESIDENCY PROGRAM CURRICULUM RESOURCE

Family medicine has been thrust into the national spotlight by the Affordable Care Act of 2010 bringing the concept of the medical home to the forefront and placing family physicians at the hub of the medical care delivery model of the future. These events also task training programs across this country with the burden of producing the right product to meet the demands of what our health system needs: competent, well rounded family physicians. How can we insure quality of our graduates and consistency of our product as training programs?

One answer is to ensure that we train all of our physicians in a core set of skills and competencies. A robust core curriculum resource would ensure that residency graduates have access to peer-reviewed tools to help them achieve a consistent set of clinical and professional skills to meet the primary care needs of our communities. By creating a web-based resource for all family medicine residencies to use, we can provide a consistent framework for faculty and residents to guide their learning and develop competence in the broad scope of the practice of family medicine.

We currently reinvent curricula over and over again in our 450-plus programs across the country. We have a pool of brilliant faculty who create outstanding tools to teach these core concepts to their residents, but those tools stay locked in their individual programs and rarely make it out to other residencies. By better collaborating and harnessing our current individual curriculum development efforts, we could all benefit from the creativity of our educators. Sharing and distributing the best content would improve the consistency of our educational product—a well trained family physician.

AFMRD and STFM are working to develop a globally available, web-based curriculum resource using the AAFP's recommended curriculum guidelines as a framework. It is time to move forward on converting these well-written resources into a dynamic web-based

online resource with peer-reviewed contributions that will improve and standardize our teaching. This project requires planning, coordination, and cooperation.

Collectively we can produce a high quality product that can be provided at a far lower cost than what we currently pay in faculty time for our own reinventions of the wheel. If we can unite around this project, the rewards will be great for our specialty, our residents, and most of all, our patients. In 5 years, we could have a better understanding of what our residents are being taught across the country, we could have outstanding teaching tools at our fingertips for every core topic we need to teach, and we could be confident that the next generation of family physicians will be ready for practice in a system in dire need of our skills. It's time to move forward on developing this national resource. No one else can do this but us. Look for more detailed information to reach you later this spring.

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From the North American  
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*Ann Fam Med* 2012;10:174-176. doi:10.1370/afm.1390.

## THE PERSONAL FACE OF PRIMARY CARE RESEARCH

*David Katerndahl, NAPCRG's 2011 Wood Award winner, reflects on the personal impact of primary care research on not only patient's lives, but the lives of those participating in the research and primary care research investigators as well. In the following essay, Katerndahl shares some personal experiences with this as he shared when accepting the Wood award at the NAPCRG Annual Meeting in November 2011.*

Does our research really make a difference? Most of us chose a life in primary care because we wanted to make a difference in people's lives. I once calculated the potential impact of a research study published in a primary care journal<sup>1</sup>. For example, with a monthly rate of 100,000 online hits and assuming that two thirds of those are from providers, an article on depression

published in *Annals of Family Medicine* could potentially affect the care of 1 million depressed patients over the subsequent year. In addition, such an article affects the faculty reading the article who teach, on average, more than 7 family medicine residency graduates each year as well as the more than 4 researchers who subsequently cite it. Thus, in 1 year, a well-read article can potentially affect the care of 70 times as many patients as seen by a practitioner in his/her lifetime. But the impact of our research has, in fact, a personal face, reaching far beyond such abstract numbers.

In fact, is impact-free research possible? Or does the reactive arrangement that we call "the research design" necessitate change? Indeed, even non-interventional research has the potential to evoke unforeseen effects in those who participate.

Early on, the focus of my research was panic disorder and, although a skeptical collaborator believed that I was "studying something that didn't exist", the research subjects, trapped within their homes, often expressed relief when discussing their anxiety, social fears and limitations. When we almost inadvertently discovered a history of childhood sexual abuse, these women would often burst into tears, stating that this was the "first time they had disclosed this trauma to anyone." Although this was a source of concern for human subjects review committees, these women uniformly made such disclosures with a sense of relief.

But personal impact goes beyond a simple unburdening; it can literally change lives. Even among women in violent relationships who intended to remain with their abusive partners, study participation frequently affected change, convincing women to leave the relationship.<sup>2</sup> These women often told us that, through the study, they gained insight and felt empowered. One woman's story was particularly dramatic. During the course of the study, this young woman who had been verbally and physically abused for more than a year told us that her daughter was also being victimized, but requested that we not report it. Legally, we had no choice but to inform Child Protective Services. For a week, we heard nothing from her despite our efforts to make contact. When we finally did, instead of being angry with us, she told us that within a week of our report, caseworkers had forced the violent spouse and father to vacate, causing the woman to say that "participating in our study was the best thing that had ever happened to her."

But our research affects more than our subjects; it potentially affects our readers as well. Last spring, we published an article about the complexity of primary care practice, comparing it with that of ambulatory cardiology and psychiatry.<sup>3</sup> Although pleased with its acceptance by editors, we were surprised when a frus-

trated and besieged practitioner thanked us and wrote that the article had "inspired him in a way he hadn't known" before.

But our research can influence more than its subjects and consumers; the impact can strike even closer to home. A research assistant involved in our domestic violence agenda recently shared her story with me. Initially hesitant to work on our project, she found that, once involved, she was changed by the training she received and the personal stories that she heard from the subjects. Living in a marriage characterized by verbal abuse and distance, she had been contemplating divorce. But as she grew during the study, she confronted her husband, promoting both her self-esteem and his self-disclosure of childhood trauma. Consequently, they are now in counseling and attend domestic violence conferences together, joined in a commitment to their relationship and an end to the cycle of male-perpetrated violence in his family. In addition, through the sharing of the stories of our subjects, her emotionally-distant mother has shared her untold story of sexual assault. But such tales of personal healing, while often unacknowledged, are not all.

Ultimately, our research affects us, its investigators. You cannot listen to a tearful woman share her formerly untold story of sexual abuse or social terror without being moved in response. Only the most hardened investigators could learn of the healing evoked by their study without being changed. Research is a social activity in which all who participate, researcher included, can be transformed. I know I have been. As quantum physicists know, you cannot study an atom without affecting it, whether that atom is in a particle accelerator or the human brain. Every time we measure, we alter. Each perturbation ripples out, affecting all of those involved. Our research has the potential to personally impact each subject, each reader, each member of the research team. As researchers, we serve as change agents, while becoming changed agents.

Primary care is all about making a difference and that is no less true of our research than it is of our patient care or teaching. Often the impact of our research is very personal. We make a difference when we offer a research subject insight and validation, and when we listen to her story and allow ourselves to be changed. We make a difference in that moment of shared discovery. We make a difference when we provide a word of encouragement to a resident to submit an abstract to NAPCRG or critique a colleague's manuscript. Research is a social activity in which all who participate can be transformed. Making a difference; that's easy, we do it all the time!

David Katerndahl, MD, MA

## References

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*Ann Fam Med* 2012;10:176. doi:10.1370/afm.1392.

## PHYSICIAN NETWORKING RESOURCE DELTA-EXCHANGE NOW FREE TO AAFP MEMBERS

As part of their member benefits, all AAFP members may now sign up at <http://www.aafp.org/online/en/home/practicemgt/deltaexchange.html> for free access to the Delta-Exchange interactive physician networking resource.

This network, which was created by the AAFP's nonprofit, wholly-owned subsidiary TransforMED, opened for business in 2009 as a fee-based service. Since then, the success of Delta-Exchange, which now has 3,500 users, and the accolades of those users has convinced the AAFP and TransforMED that the resource should be made available as a benefit for all AAFP members.

TransforMED's mission is to help primary care practices transform the way they do business so they can meet the needs of a changing health care environment, and "Delta-Exchange puts the power of peer-to-peer learning to work for family medicine," said Terry McGeeney, MD, MBA, TransforMED's president and CEO.

"The questions being asked and discussions going on in Delta-Exchange are about real-world needs and problems experienced every day in practices across the country," said McGeeney. "Participation in Delta-Exchange discussions can help family physicians get motivated, get answers, and get up to speed quickly and efficiently."

John Frey, MD, of Madison, Wisconsin, discovered the benefits of Delta-Exchange many months ago and has since recommended it to a number of colleagues. "We all work in our own silos," said Frey in an interview. "The network has been a very active opportunity

for me to learn what other people are thinking and to take what I read and pass it on to other people."

Opening up Delta-Exchange as a free service to all AAFP members "provides a portal for higher levels of conversations," he added.

John Bachman, MD, of Rochester, Minnesota said he had contributed to Delta-Exchange's "Ask the Experts" area on several occasions. The network "has a lot of potential to spread ideas and help clarify issues," he said. For example, in response to another physician's question about scheduling same-day appointments, Bachman recently posted a comment sharing what his practice had learned about the percentage of appointment slots to leave open for these appointments. He noted that the staff tracked the daily number of unfilled slots for several months.

Frey summed up his reaction to news that the resource is now free to AAFP members by predicting a surge in usage. "The idea of offering Delta-Exchange free to (AAFP) members is terrific, and I really want to compliment the Academy and TransforMED for taking this action. I suspect that traffic on the network is going to increase dramatically in coming months," he said.

AAFP members interested in Delta-Exchange who are not already enrolled in the service will need to provide their member identification number to get signed up.

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AAFP News Now



From the American  
Board of Family Medicine

*Ann Fam Med* 2012;10:176-177. doi:10.1370/afm.1393

## BOARD ELIGIBILITY

The term "board eligible" has never been recognized by member boards of the American Board of Medical Specialties (ABMS), including the American Board of Family Medicine (ABFM), but the term continues to be used by credentialing organizations and others to recognize noncertified physicians as having equivalent status. In practice, no limit exists on how long a noncertified physician could remain board eligible. The abuse of the term and the status perpetuated the ability of poorly qualified physicians to practice outside of their initial certification with a risk to patients and resulted in a lack of relationship between the initial certifying examination and training as a concurrent/synergistic measure of physician competency.