must be equipped to answer this call through leading at many institutional levels while leading their own faculty and departments through uncertain times. An important element of facing these challenges is understanding family medicine's position of power and relevance within the larger environmental context. As challenged recently, Chairs of Family Medicine must find meaning in answer to a fundamental question: "Are we institutional leaders who happen to be family physicians, or are we family physicians who happen to work at academic health centers?"[4]

Ardis Davis, Steve Zweig, John Franko, Amanda Weidner

References

1. Biebuyck JF, Mallon WT. *The Successful Medical School Department Chair-A Guide to Good Institutional Practice.* Washington, DC: Association of American Medical Colleges; 2003.
2. Grigsby K, Hefner DS, Souba WW, Kirch DG. The future-oriented department chair. *Acad Med.* 2004; 79(6):571-577.
3. Kastor J. Chair of a department of medicine: now a different job. *Acad Med.* 2013; 88(7):912-913.
4. Plenary session at the 2015 Annual ADFM Winter Meeting: Thomas L. Schwenk, MD; *Family Medicine and Academic Medical Centers: Strangers in a Strange Land.* Savannah, GA, 2015.

From the Association of Family Medicine Residency Directors

Ann Fam Med 2015;13:285-286. doi: 10.1370/afm.1795.

THE COUNCIL OF ACADEMIC FAMILY MEDICINE PROCEDURAL AND MATERNITY CARE TRAINING GUIDELINES: A BETTER PATH TO CONSISTENCY IN COMPETENCY ASSESSMENT IN FAMILY MEDICINE

As an organization devoted to training residents to deliver high-quality family medicine care to their communities, we have struggled to determine those procedures in which we should require all residents to develop competency. To date we have lacked consistency in educational standards for both procedural and maternity care training. This lack of standardization has led to a wide range of skills (or lack thereof) in our graduates, which has impacted our scope of care and potentially endangered our credibility as a specialty. A consistent methodology in determining competency has also been lacking.

The latest guidance by the RC-FM is, "Residents must receive training to perform clinical procedures required for their future practices in ambulatory and hospital environments."[1] In the FAQ related to this, the RC-FM states, "As the list of procedures performed by the practicing family physicians varies based upon the needs of the community, the program directors and members of the faculty should develop a list of required procedures based upon the needs of their FMP (family medicine practice) and recommendations of organizations…"[2]

In response, the Council of Academic Family Medicine (CAFM) formed 2 task forces in the spring of 2014. The AFMRD took the lead on developing these guidelines, working with faculty members across the country to provide input into the process. The Society of Teachers of Family Medicine (STFM) Maternity Care and STFM Hospital and Procedures groups formed much of the task forces. After conference calls, a careful literature review, and collaborative efforts, draft guidelines were completed in December 2014. Next steps: gather broader input from family physician educators, update the guidelines based on this feedback, then return the documents to CAFM for final approval.

The task forces agreed upon a better method of determining competency that actually passes the common sense test—blending a minimum experience with a standardized competency assessment tool that breaks down the skills that need to be demonstrated by the trainee. The key feature is not relying on numbers alone and, in fact, the minimum numbers are reserved for the most skilled residents, not for the average resident. Most residents will need to exceed the minimum number for complex procedures before they are ready for competency assessment and to potentially be signed off as ready for independent practice.

The Maternity Care Guidelines outline training expectations for the 3 tiers of maternity care already being practiced in our family medicine community. These tiers are designated Ambulatory Maternity Care, Comprehensive Maternity Care, and Advanced Maternity Care. Instead of having a one-size-fits-all requirement from the RC-FM, we will have recommendations that reflect what individual residents are seeking in their training, based on the community in which they intend to practice. However, since maternity care is within the domain of our specialty, all programs are expected to offer Ambulatory Maternity Care training to residents to allow them to possess basic spontaneous delivery skills and sound prenatal care training. Even if a graduate does not plan to provide prenatal care for their patients in their practice, they must still possess knowledge of the medical complications of pregnancy and to be able assess the maternity care their patients may be receiving from another physician.

The Comprehensive Maternity Care criteria now include labor management as a key portion of experi-

ence requirement. With the current duty hour requirements, many residents manage women in labor for extensive periods of time, often making complex care decisions, but would receive no credit by credentialing bodies for that experience. The guidelines have a similar experience criteria model as the procedure guidelines—the minimum number of deliveries is 40, but in addition, they should manage an additional 40 patients in labor (that they may not deliver) during their training.

The Advanced Maternity Care tier outlines the expectations for training residents, and often fellows, to gain operative obstetrical maternity skills and management of higher risk pregnancies. This robust level of training is often needed in rural and underserved areas of our country and will create skilled providers of maternity care that those communities need.

We are entering an era of greater accountability to our communities we serve. Having these training guidelines for maternity care and for procedures will help us ensure we are training skilled family physicians with a sufficiently broad scope to provide care of higher quality that meets more the needs of their patients. We encourage broad adoption of these guidelines and tools in order to enhance both the skills and credibility of our graduates.

These working guidelines can be found on the AFMRD website, http://www.afmrd.org.

W. Fred Miser, MD; Michael Tuggy, MD
Natasha Bhuyan, MD; Gretchen M. Dickson, MD, MBA; James W. Jarvis, MD; Lisa Maxwell, MD; Michael Mazzone, MD; Tom Miller, MD; Karen Mitchell, MD; Stephen Schultz, MD; Todd Shaffer, MD, MBA

References

1. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Family Medicine. July 1, 2014, page 18.
2. Frequently Asked Questions: Family Medicine Review Committee for Family Medicine. http://acgme.org/acgmeweb/Portals/0/PDFs/FAQ/120_family_medicine_FAQs_07012014.pdf. Accessed Mar 13, 2015.

From the North American Primary Care Research Group

Ann Fam Med 2015;13:286. doi: 10.1370/afm.1801.

NAPCRG CONGRATULATES THE 2014 PATIENT CHOICE AWARD WINNERS

At the 2014 Annual Meeting in New York, New York NAPCRG challenged its poster presenters to enter their posters in the Patient Choice Awards, a new initiative geared to engage patients with primary care researchers. Participating researchers were asked to answer, in layman's terms, the question: "So what?" or how is the research relevant to patients? Researchers had to explain the significant impact the research would have on human health and/or why it should matter to patients, community members, and family physicians.

Patients participating in NAPCRG's PaCE project, which engages patients and primary care clinicians in the larger context of primary care research, judged the posters and chose 2 winners.

The winners were:

Does Case Management Address the Needs of Patients With Mild Dementia and Their Caregivers in Community-based Primary Health Care? A Mixed Methods Study Design.
Vladimir Khanassov, MD, MSc, Resident in Family Medicine and Isabelle Vedel, MD, PhD, Assistant Professor, McGill University

Knowledge, Practices and Attitudes on Diabetic Foot Care Among Patients With Diabetes at the Family Health Clinic at the University Hospital Robert B. Green Downtown Campus in San Antonio, TX
Anna Cecilia Tenorio, MD; Robert Ferrer, MD; Sandra Burge, PhD, Fozia Ali, MD, Babaran M; Del Rosario A; Estacio M; Herman S; Lopez G; Vasquez A, The University of Texas Science Center at San Antonio

The Patient Choice Awards is one of many initiatives that are a part of the PaCE project, a program funded by the Patient-Centered Outcomes Research Institute (PCORI). Through the PaCE project, NAPCRG will develop a robust community of patients and primary care providers with knowledge and understanding of the unique features of patient-centered outcomes research related to primary care.

Too often, community partners in health research consist of health professionals and organizational leaders. PaCE aims to identify partners who are the "non-usual suspects"—people who are not necessarily medical or public health professionals, who are not aligned with a particular professional or personal research policy agenda, and whose local influence is defined within the context of the community versus job titles or credentials.