similar scholarly symposium provides the intangible benefits and rewards of a retreat (ie, improved resident morale, cohesion, social support, and camaraderie) while providing a forum for scholarly presentation.

Peter J. Carek, MD, MS
Asma Jafri, MD
Members, Board of Directors,
Association of Family Medicine Residency Programs (AFMRD)

References

1. DeHaven MJ, Wilson GR, Murphree DD, Grundig JP. Family practice residency directors' views on research. *Fam Med.* 1997;29:33-37.
2. Oeffinger KC, Roaten SP Jr, Ader DN, Buchanan RJ. Support and rewards for scholarly activity in family medicine: a national survey. *Fam Med.* 1997;29:508-512.
3. Addison RB, Riesenberg LA, Rosenbaum P. Psychosocial support services for family medicine resident physicians. *Fam Med.* 2004;36:108-112.
4. Winter RJ, Unti SM, Rubenstein JS, Burg FD, Stockman JA. Resident, faculty and residency program development. An integrated approach through annual retreats. *Am J Dis Child.* 1991;146:905-906.

From the North American Primary Care Research Group

Ann Fam Med 2004;2:521-522. DOI: 10.1370/afm.225.

NETWORKS FOR NEW KNOWLEDGE IN FAMILY MEDICINE

Gayle Stephens, MD, claimed that the research laboratory of family medicine must be the practice—it is both the source of our questions and the place where we must seek answers.[1] This belief is the basis for the formation and growth of practice-based research networks (PBRNs). PBRNs are groups of practices affiliated with one another and often with academic institutions or professional organizations for the purpose of answering the questions that arise from daily practice and of most importance to clinicians and patients.[2] The Federation of Practice Based Research Networks (FPBRN) now includes 75 US members and 5 international affiliates.The American Academy of Family Physicians sponsors the National Network for Family Practice and Primary Care Research (the National Research Network), established in 1999 and continuing the work of the Ambulatory Sentinel Practice Network (ASPN). Both national networks and a growing number of regional PBRNs have been formed or developed with the support of the Agency for Healthcare Research and Quality. It is estimated that approximately 1 in 10 family physicians in the United States now participates in a PBRN, making these organizations a potent vehicle for direct and rapid dissemination of research findings that can improve the outcomes of care.[3]

Some recent examples of the impact of PBRN research on practice[4] include questioning the routine use of CT scans of the brain in every new headache patient,[5] the routine performance of D&Cs following miscarriage,[6] and the routine prescription of antibiotics for uncomplicated acute otitis media.[7] Regional networks have demonstrated that brief interventions by primary care physicians can significantly reduce problem drinking by patients,[8] and that family physicians routinely weave preventive service delivery into both acute and chronic problem visits.[9] They are also providing new insights into the processes by which practices can improve their care.[10] US and international PBRNs are just now publishing fundamental studies of the nature of medical errors in primary care practices, as seen by both physicians[11] and patients.[12]

Administrators of successful PBRNs take care to involve participating physicians in the selection of questions for study, to create protocols that minimize the impact of the study on the ongoing business of the practice, and to provide timely feedback of study results that can lead to improvements in the participating practices. Awareness of peers who are participating, and recruitment by colleagues whom they respect are also important. A rural Virginia family physician echoed these themes in recent interviews: "I like to know that I am helping produce knowledge that improves care. I enjoy being involved in developing a study - not just one of the practices that submit data. I make it clear from the beginning what information I want to get out of the study." (James Ledwith, MD, personal communication, June 29, 2004)

What is involved with participating in a PBRN, and how does one join? For physicians who are part of the Academy's National Research Network, the work is estimated at 30 minutes per week for a 2- to 3-month period. Physicians can choose from a menu of network projects. The Network is actively recruiting new members, with an emphasis on physicians working in large metropolitan areas and caring for underserved populations; minority physicians; and physicians working outside of academic units. The Network's Web site has up-to-date information on current projects and on how to become a participating member.

Your patients need you to contribute to the new knowledge that will improve their primary health care. Find out which PBRNs are in your part of the country and which colleagues are participating in PBRNs (through PBRN Web sites, local academic units, or state and national academy offices). Give those colleagues a call and find out about their experiences. Then add some spice to your practice life by becoming one of the

thousands of physicians who are creating the best, most relevant evidence for the delivery of family medicine.

Anton Kuzel, MD, MHPE
Stephen Rothemich, MD
Virginia Commonwealth University

References

1. Stephens GG. *The Intellectual Basis of Family Practice.* Leawood, Kan: STFM Foundation Publications; 1982.
2. Primary Care Practice-based Research Networks. Fact Sheet, June 2001. AHRQ Publication No. 01-P020. Agency for Healthcare Research and Quality, Rockville, MD.
3. Nutting PA, Beasley JW, Werner JJ. Practice-based research networks answer primary care questions. *JAMA.* 1999;281:686-688.
4. Lindbloom EJ, Ewigman BG, Hickner JM. Practice-based research networks: the laboratories of primary care research. *Med Care.* 2004;42(4 Supp):III45-III49.
5. Becker LA, Green LA, Beaufalt D, Kirk J, Froom J, Freeman WL. Use of CT scans for the investigation of headache: a report from ASPN, part 1. *J Fam Pract.* 1993:37:129-134.
6. Green LA, Becker LA, Freeman WL, Elliott E, Iverson DC, Reed FM. Spontaneous abortion in primary care: a report from ASPN. *J Am Board Fam Pract.* 1988:1:15-23.
7. Froom J, Culpepper L, Bridges-Webb C, et al. Effect of patient characteristics and disease manifestations on the outcome of acute otitis media at two months. *Arch Fam Med.* 1993;2:841-846.
8. Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers: a randomized controlled trial in community-based primary care practices. *JAMA.* 1997;277:1039-1045.
9. Stange KC, Jaen CR, Flocke SA, Miller WL, Crabtree BF, Zyzanski SJ. The value of a family physician. *J Fam Pract.* 1998;46:363-368.
10. Cohen D, McDaniel RR Jr, Crabtree BF, et al. A practice change model for quality improvement in primary care practice. *J Healthc Manag.* 2004;49:155-168.
11. Dovey SM, Phillips RL, Green LA, Fryer GE. Types of medical errors commonly reported by family physicians. *Am Fam Physician.* 2003;67:697.
12. Kuzel AJ, Woolf SH, Gilchrist VJ, et al. Patient reports of preventable problems and harms in primary health care. *Ann Fam Med.* 2004;2:333-340.

From the American Academy of Family Physicians

Ann Fam Med 2004;2:522-524. DOI: 10.1370/afm.226.

FAMILY DOCTORS DEMONSTRATE BENEFITS WHEN NEW MODEL OF CARE BECOMES REALITY

When patients come first, all else will follow. In abundance. Weston Welker, MD, knows that. He watches it happen every day in his Southside Family Practice in Huntsville, Ala.

Since implementing steps that have become the Future of Family Medicine recommendations, Welker's ability to provide patient-centered care has improved dramatically. He has watched patient census climb, patient compliance for chronic disease management skyrocket, and serious complications from hypertension and hyperlipidemia plummet to virtually zero.

Moreover, the changes are good for the office. With greater efficiency, revenues are up, cash flow is up, office hours are down, and debt is tumbling.

Southside's 10,000 patients expect top-of-the-line care, and they get it. With Welker and Southside's other family physicians—Thomas Armstrong, MD; Charles Mullins, DO; and Jenny Chapman, MD—the patients have a medical home that encourages healthy behavior; that emphasizes patient convenience; and that uses electronic medical records to ensure evidence based protocols, comprehensive services, and in-depth patient education.

Making It Work

Southside offers many aspects of the Future of Family Medicine's new model of care. (See http://www.annfammed.org/cgi/content/full/2/suppl_1/s3 to read the report.) The office provides one-stop shopping with its comprehensive laboratory, cardiac stress test equipment, radiological equipment for bone density scanning, sonograms, echocardiograms, and Doppler scans.

"Nine times out of 10, we can handle any initial evaluation right here," said Welker. "And the specialists across town respect the data we send them. The specialists and the hospitals see Southside as the patients' medical home. When they admit a patient, they know they can call and ask for that patient's medication list and labs, and they'll get it."

And patients know they can get a same-day appointment.

A patient with a history of anxiety attacks calls; he has severe chest pain and is on his way to Southside Family Practice. Fran Miller, Southside's business manager and a paramedic, moves the crash cart from the cardiac room to triage, where Annette Prestidge (also a paramedic) awaits the patient's arrival.

Triage tests indicate the patient is suffering an anxiety attack. The medical team switches from cardiac to psychiatric protocols, and the man returns home—without an emergency department bill.

"We have a fully equipped crash cart," said Miller. "A person coming into our office with chest pain or difficulty breathing can be stabilized before we send him to the hospital."

The team can connect the echocardiogram to a T-1 line and contact a cardiologist who sees—in real time—the test results on an encrypted Web site. If necessary, an ambulance takes the patient directly to the hospital for admission. The system costs less than the emergency department. It saves the patient money, saves the system money, and ensures high-quality care.