Larry A. Green, MD, has served the University of Colorado in Denver as program director and chair in the Department of Family Medicine and was a contributor in the development of the Ambulatory Sentinel Practice Network. He assisted with the establishment of the Robert Graham Center in Washington, DC, where he now Senior Scholar in Residence. He currently directs the Prescription for Health, a 5-year program of The Robert Wood Johnson Foundation in partnership with The Agency for Healthcare Research and Quality. He is a recipient of the Hames and Wood Awards for career and lifetime research accomplishments and has been elected to the Institute of Medicine. Dr Green will serve the ABFM on the Research and Development Committee and the Examination Committee.

Alain Montegut, MD, has been a family physician for almost 25 years and has practiced in both a solo and a 30-physician group setting. He is currently the program director of the Family Medicine Residency Program at Maine Medical Center in Portland, and is also the director of the Division of International Family Medicine Education and a clinician with Casco Bay Family Physicians. Dr Montegut will serve on the ABFM Credentials Committee and the Communications/Publications Committee.

Daniel Winstead, MD, is the Robert G. Heath Professor and Chair, Department of Psychiatry and Neurology at Tulane University School of Medicine. He is also staff psychiatrist at Tulane University Hospital and Clinic, DePaul/Tulane Behavioral Health Center, and the Veterans Administration Medical Center. He serves as a consultant psychiatrist at the Feliciana Forensic Facility in Jackson, La, and senior visiting physician in psychiatry at the Medical Center of Louisiana in New Orleans. Much of Dr Winstead's career has been involved in teaching and writing in the field of psychosomatic medicine, consultation/liaison psychiatry and geriatric psychiatry. Dr Winstead will serve one the ABFM Information and Technology Committee.

The remaining current members of the Board are: Ross R. Black, II, MD, of Cuyahoga Falls, Ohio; H. James Brown, MD, of Syracuse, NY; Elizabeth Ann Garrett, MD, of Columbia, Mo; Joseph Hobbs, MD, of Augusta, Ga; David W. Price, MD, of Broomfield, Colo; Dennis R. Schaberg, MD, of Memphis, Tenn; Russell R. Snyder, MD, of Galveston, Tex; and Jon S. Thompson, MD, of Omaha, Neb. The ABFM Board of Directors looks forward to working with the new members as it moves forward with its plans for implementation of the Maintenance of Certification for Family Physicians (MC-FP) and the important task of sustaining the mission of the ABFM.

From the Society of Teachers of Family Medicine

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DIETRICH RECEIVES CURTIS G. HAMES RESEARCH AWARD, CALL FOR NEW MODEL PAPERS

Allen Dietrich Receives the 2005 Curtis G. Hames Research Award

The 2005 Curtis G. Hames Research Award was presented to Allen Dietrich, MD, at the Society of Teachers of Family Medicine (STFM) 2005 Annual Spring Conference. Dr Dietrich is professor of community and family medicine, medicine, and pediatrics at Dartmouth Medical School. Every year, this award is presented to an individual whose career exemplifies dedication to research in family medicine. The award is named for Dr Curtis Hames, a pioneering family physician, practice-based researcher, and faculty member at the Medical College of Georgia. Sadly, this year we must refer to the late Dr Hames, who passed away in January. During more than 40 years of busy clinical practice in Claxton, Ga, Dr Hames ran an epidemiologic study that resulted in hundreds of articles in medical journals worldwide on subjects including cardiovascular disease, genetics, cancer, pollution, infectious disease, and psychosocial aspects of illness. The Hames Award Selection Committee consists of representatives from STFM, the American Academy of Family Physicians (AAFP), the North American Primary Care Research Group (NAPCRG), and the Hames Endowment of the Department of Family Medicine, Medical College of Georgia.

This year's Hames Award winner is a family medicine research pioneer in his own right. Allen Dietrich's

career has been a tireless quest to improve the quality of primary care. His research history is impressive in breadth and depth, encompassing cancer detection, medical education, disease prevention, mental health care, and more. He was one of the first family medicine residency graduates to secure a federal R01 research grant in 1986, the Cancer Prevention in Community Practice Project. This randomized controlled trial focused on changing office systems, with new staff responsibilities, a paper preventive care flow sheet, and an opportunistic screening approach. Ninety-eight practices participated in this study, comparing an intervention with more-traditional continuing medical education. The intervention increased the delivery of preventive services, and Dr Dietrich discussed the take-home message from this work at his Annual Spring Conference presentation. "The reason that doctors weren't doing better preventive services was not a matter of ignorance," Dr Dietrich said. "They all knew what the guidelines were. It was a matter of organization." A process paper also came out of the project, titled "Tools, Teamwork, and Tenacity," which was a theme that recurred often in Dr Dietrich's work.

He has since served as principal investigator on numerous multimillion dollar research grants, and whether his interventions have proved effective or not, he has always learned valuable lessons. Dr Dietrich spoke about a checklist to review when an intervention does not result in clinical improvement. The researcher must ask: (1) Was the intervention a bad idea? (2) Was it a good idea poorly executed? (3) Was it the wrong place for it? (4) Was there a measurement failure, through choosing a suboptimum instrument, target group, or time frame?

Transporting office system interventions to additional clinics proved to be complex, and success was often determined by turnover in clinic leadership. A certain amount of "voltage drop" occurred when clinics sent junior staff to train-the-trainer efforts to learn procedures they had no power to implement. Dr Dietrich drew from these lessons in his next area of intervention, primary care management of depression, in a national scale study supported by the John D. and Catherine T. MacArthur Foundation Initiative. His efforts focused on the Three Component Model (TCM) of a prepared primary care practice, care management by telephone to support the patient, and a collaborating psychiatrist. The impact of this approach has been established in a randomized controlled trial.

The challenge a researcher often faces is dissemination of an intervention once it has proved effective. Dr Dietrich discussed the importance of site selection, adequate resources, and serendipity. Through his various presentations and media appearances, he has been approached to disseminate the TCM into areas he did not originally anticipate. As a result, several of these interventions have been (or will be) introduced into military health care settings, Veterans Health Administration systems, and a variety of other health care plans.

Dr Dietrich also addressed the importance of developing a business model sooner rather than later, the "where, what, who, and how" that will allow an intervention to be sustained and disseminated once research funding concludes. Such a model can aid in the dissemination process, with the creation of "turnkey models" to share with others. Dr Dietrich explained, "If an organization contacts us and says, 'We want to do the Three Component Model,' we can offer training manuals for the clinicians, office staff, care managers, psychiatrists, and the quality improvement people in their own offices, that is, most of the materials an organization would need to move forward."

Dr Dietrich also stressed the importance of continuing in clinical practice for physician researchers. "While we may talk about our laboratories being practice-based research networks," Dr Dietrich said, "my most important practice laboratory is my clinical practice. It keeps my feet on the ground." Interestingly, Dr Dietrich did not start his career intending to be a researcher. Having served in the Indian Health Service and looking for a rural setting after his fellowship at Stanford, he started his career at Dartmouth as a clinician-teacher running the department's predoctoral program. A $2,730 research grant from the AAFP in 1983 led to a published study on improving preventive services, and a research career was born. He received the first STFM Research Paper Award in 1989 and again 11 years later. NAPCRG and the AAFP have similarly recognized his work. His election to the Institute of Medicine in 1996 reflects an extraordinary level of respect from colleagues as well as an ongoing commitment to improve medical care.

Dr Dietrich paid his respects to Dr Hames in accepting the award. "It's one of the proudest moments in my professional career to win the Curtis Hames Award," Dr Dietrich said, "and I think all of us, in a way, are his heirs. I'd like to think he's smiling on us." To his initial theme of "Tools, Teamwork and Tenacity," Dr Dietrich added a fourth component, teachers, as an essential ingredient to his success and thanked numerous pivotal figures in his life and career. For his continuing dedication to advancing the science of family medicine, and his ongoing commitment to evaluating and improving the delivery of primary care, the Hames Selection Committee is honored to present the 2005 Curtis G. Hames Research Award to Dr Allen Dietrich.

Erik J. Lindbloom, MD, MSPH
Chair, STFM Research Committee and Hames Selection Committee

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Family Medicine Issues a Call for Papers—The New Model of Family Medicine

Family Medicine, the journal of the Society of Teachers of Family Medicine, requests submission of papers reporting on the "New Model of Family Medicine" described in the Future of Family Medicine report.[1] Papers submitted in response to this call for papers should describe implementation of one or more elements of the New Model in a community practice or academic setting or both. For example, papers could describe implementation of a personal medical home, patient-centered care, team care, or another underlying characteristic of the New Model. They could also describe development and evaluation of specific New Model elements, such as group visits, open/advanced access, quality assurance and safety, and/or electronic medical records. Finally, papers could describe innovations in residency education, reimbursement, the role of family medicine in academic health centers, improvement in quality of care, or other areas of experimentation recommended in the report.

Highest priority will be given to papers that report on all 3 of the following: (1) how the component of the New Model was adapted to your practice setting, (2) details of how the component was implemented, and (3) objectively measured outcomes that ensue as a result of implementing a component of the New Model.

Manuscripts should be submitted and prepared according to *Family Medicine's* instructions for authors, which can be found at http://www.stfm.org/fmhub/instruct.html. Presubmission questions can be addressed to the editor, Barry D. Weiss, MD, at bdweiss@u.arizona.edu. There is no specific deadline for submission of these manuscripts, since papers on this topic will be considered on an ongoing basis. However, manuscripts submitted before the end of 2005 will be considered for publication together in a special series of articles.

Traci Nolte, Communication Director
Society of Teachers of Family Medicine

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COMPELLED TO FAIL? THE INNOVATOR'S DILEMMA AND FAMILY MEDICINE RESIDENCY PROGRAMS

The Future of Family Medicine (FFM) Project is emphatic in its call for change in family medicine residencies: "Innovation in Family Medicine residency programs *will be supported by the Residency Review Committee* for Family Practice through 5 to 10 years of curricular flexibility to permit *active experimentation* and ongoing critical evaluation of competency-based education, expanded training programs, and other strategies to prepare graduates for the New Model [emphasis added]."[1] The FFM Project report asserts residencies should "actively experiment" with: 4-year curricula, adaptation to local community needs, enhanced education in maternity, orthopedic or emergency care, evidence based practice, scholarship, "patient-centered knowledge," informatics, professionalism, and interdisciplinary learning. Innovation in residency training is essential to renewal of our discipline.

Family medicine was innovative when it began in the 1960s. Residency programs have become progressively more structured, however, as requirements of the Residency Review Committee for Family Medicine (RRC-FM) have become detailed, specific, and prescriptive.[2,3]

Family medicine now appears to be facing Christensen's "innovator's dilemma"[4]: earlier successes achieved by well-established industry or business can cause vulnerability. New businesses initiate lower cost strategies that, although of low quality by the former criteria, better meet customer needs. The established industry's investment in sustaining its way of work compels it to avoid innovation, even when it knows it must change to survive. With time, an innovative upstart can improve to the point where it eliminates the formerly dominant company. Strategies to cope with this dilemma[5] have been described for health care in general[6] and family medicine in particular.[7]

Quality certification programs in established industries are by nature conservative: they protect the dominant model. RRC-FM requires periodic review and cites programs for failure to comply with specific requirements. The "frequency and distribution of citations has not varied much in the past 5 to 10 years"[2] despite enormous changes in delivery of health care.