Does the stable pattern of citations reflect an enduring weakness of the training model represented by our RRC requirements? Consider the most frequent citation by the RRC-FM, regarding residents' experiences in maternity care.[2] Perhaps widespread inadequacy of maternity training reflects a fundamental flaw in a model of practice that recalls a time most family physicians provided maternity care. It is time for the community of family medicine to consider whether the enduring pattern of citations reflects critical weaknesses in the training model we ask the RRC-FM to uphold on our behalf.

It is time for residency training to be redesigned from the ground up, rather than simply tightening requirements on a failing model of clinical practice and education.[8-10] Christensen's description of disruptive innovation would suggest family medicine should eliminate its high-cost, complex, and customer-unfriendly model of training in the family medicine center in favor of more innovative, low-cost, accessible care. Pediatric residencies, for example, may use an apprenticeship model for training in which one pediatrics resident is assigned for continuity experiences in a private pediatrician's office throughout the 3 years of residency.[11,12] Experimentation with this model in family medicine seems a natural and appropriate innovation. Yet Christensen might predict we, through our RRC-FM, would require such initial experimentation to show results identical to the old model. We would impose such rigid requirements as to kill innovation before it can grow into excellence.

Thus, asking the RRC-FM to support innovation without understanding the process by which fundamental and disruptive change occurs may be a formula for failure. The role of the RRC-FM historically has been to enforce more specific requirements, not to encourage the kind of risk-taking and reconceptualization of training essential to innovation. We should take seriously the call in the draft revision of the RRC-FM requirements for "responsible innovation and experimentation,"[3] while avoiding the urge to require that innovative changes show results identical to those of the dominant model.

ADFM urges the AAFP, departments of family medicine, residency programs, and especially the RRC-FM, to acknowledge the dilemma of innovation. We must create experiments with potential to supplant the educational model many of us have worked so hard to create. Some may achieve excellence by measures very different from those of existing programs. Upending and replacing our hard-won, well-developed model of residency training could be the key to survival of family medicine.

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**From the Association of Family Medicine Residency Directors**

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## GRADUATE SURVEYS: AN OPPORTUNITY FOR RESIDENCY RESEARCH

Because of the educational demands placed upon family medicine residency programs, research and other forms of scholarly activity are often difficult to incorporate, initiate, and complete. With minor alterations and a small amount of additional work, many activities associated with a residency program can be developed into research projects. For example, the family medicine residency programs affiliated with the South Carolina Area Health Education Consortium (SC AHEC) have utilized the required graduate survey as a research tool.

Based upon the Program Requirements for Residency Education in Family Practice, each program must maintain a system of evaluation of its graduates. The residency should obtain feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice, suggestions for improving the training, and

ideas for new areas of curriculum. This information is to be used as part of the program's determination of the degree to which the program's goals are being met. The program requirements recommend that a written survey after 1 year and every 5 years thereafter be conducted to collect the above data.

To fulfill this requirement and to further develop research activities into their programs, the family medicine residency programs affiliated with the SC AHEC have developed a flexible, graduate survey tool. Starting with 1999, this instrument is mailed from a central office every 5 years to the more than 1,400 graduates of the 8 programs in South Carolina. The survey has been constructed to include questions regarding graduates' demographic and practice profiles, along with the other information recommended by the RRC. In addition, the survey includes a section that is devoted to questions developed by faculty or current residents regarding research topics of current interest.

To date, the surveys have produced the desired results of providing feedback to the programs regarding their graduates as well as promoting research. From the initial survey, the program directors were able to examine the following issues: practice profiles and patterns, career satisfaction, the graduates' perceptions of the relevancy of training to practice, and activity in medical student and resident education of the graduates of the SC AHEC's affiliated family medicine residency programs.[1] Further research from this has determined whether there were important differences in practice patterns of physicians based on the academic affiliation of the residency in which they trained. Finally, several faculty members were able to evaluate the practice profiles of all female compared with male family physician graduates of SC training programs.

From the most recent survey, the program directors were again able to examine the education and practice location of and the services provided by their graduates so they could give the SC AHEC and these programs specific, up-to-date information regarding these physicians.[2] For this specific survey, questions regarding practice management curriculum; lifestyle activities, such as physical activity, tobacco use, obesity, influenza vaccination, and tetanus immunization; and interaction with pharmaceutical representatives were included as a part of additional research projects.

Not only are faculty using the graduate survey for research purposes; residents have also developed research projects using this information. During the recent SC AHEC Hickory Knob Research Symposium, William M. Tucker, III, MD (a second-year resident at the Trident/MUSC Family Medicine Residency Program in Charleston, SC), presented his project, "An Analysis of Procedure Training and Practice Trends: Which Procedures Should be Taught in a Family Medicine Residency?"

The graduate survey is one opportunity for a residency program to incorporate research and other scholarly activity. Consistent with the ACGME core competencies, critically evaluation of the manner in which program requirements are being met through research and quality improvement initiatives parallels the practice-based learning, improvement, and professionalism expected from residents. Furthermore, the presentation and publication of these projects contributes to the professional and public awareness of the discipline of family medicine.

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**From the North American Primary Care Research Group**

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# THE ANNUAL MEETING: 2005 IN QUEBEC CITY, 2004 PLENARY ON SOCIAL EPIDEMIOLOGY

## NAPCRG Prepares for 2005 Annual Meeting in Quebec

The NAPCRG Annual Meeting has historically provided the opportunity to share ideas and knowledge with individuals from around the world, and this year should be no different. The 2005 Annual Meeting will be held October 15 to 18 in Quebec City, and we have 3 outstanding plenary speakers who will provide us with a variety of insights and perspectives:

• Martin Roland, MD, a general practitioner who heads the National Primary Care Research and Development Centre at the University of Manchester in the United Kingdom. Dr Roland wrote in the September 2004 *New England Journal of Medicine* on the unprecedented move by the National Health Service to link physicians' pay to the quality of care provided.

• Michaele Christian, MD, associate director, Division of Cancer Treatment and Diagnosis, Cancer Therapy Evaluation Program at the National Cancer Institute. Dr Christian works with the Office of the