will include liaison members from other family medicine organizations.

NPI will be taking STFM in some new directions as it develops promising approaches to the needs of the discipline. We believe this initiative is an important step by the Society as we move the Future of Family Medicine forward.

William Mygdal, EdD
STFM President

Call For Nominations for Research Awards

Submit Your Nomination for 2006 Curtis Hames Research Award

The Society of Teachers of Family Medicine is accepting nominations for the 2006 Curtis G. Hames Research Award in Family Medicine to be presented at the 2006 Annual Spring Conference, April 26-30, in San Francisco, Calif. The award, supported by the Hames Endowment of the Medical College of Georgia, is intended to honor those individuals whose careers exemplify dedication to research in family medicine.

The award recipient is selected by a committee representing STFM, the American Academy of Family Physicians, and the North American Primary Care Research Group. Previous Hames Award recipients are on the STFM Web site listed at http://www.stfm.org/awards/awardhub.html.

Nomination letters and CVs must be postmarked by November 11, 2005, and should be addressed to STFM, 11400 Tomahawk Creek Parkway, Leawood, KS 66211. Contact Kay Frank, STFM, with questions at 800-2742237, ext. 5402, kfrank@stfm.org.

Could Your Last Study Win the STFM Best Research Paper Award?

The Research Committee of the Society of Teachers of Family Medicine is now accepting nominations for the 2006 STFM Research Paper Award, to be presented at the 2006 Annual Spring Conference, April 26-30, in San Francisco, Calif.

The award is intended to recognize the best research paper published by an STFM member in a peer-reviewed journal between July 1, 2004, and June 30, 2005. The STFM Research Committee bases the award selection on the quality of the research and its potential impact. Previous STFM Best Research Paper Award recipients are listed on the STFM Web site at http://www.stfm.org/awards/awardhub.html.

Ten copies of the paper should accompany each nomination letter that documents the potential effect of the paper and its importance to patients' health and well-being.

November 11, 2005, is the postmark deadline for nominations. Send nominations to STFM, 11400 Tomahawk Creek Parkway, Leawood, KS 66211. Contact Kay Frank, STFM, with questions at 800-274-2237, ext. 5402, kfrank@stfm.org.

Traci Nolte
STFM Communications Director

References

1. Future of Family Medicine Project Leadership Committee. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med.* 2004;2(Suppl 1):S3-S32.

From the Association of Departments of Family Medicine

Ann Fam Med 2005;3:468-469. DOI: 10.1370/afm.399.

FAMILY MEDICINE LEGISLATIVE ADVOCACY: OUR POWERFUL MESSAGE

The discipline of family medicine stands at a critical juncture. We face the pressures of dwindling medical student interest and a shift in workforce policy toward a greater emphasis on market-driven forces. Population-based studies show that care provided by family physicians results in lower health care costs and improvements in quality and health outcomes. The regulatory influence of government agencies upon health policy has never been more important than it is now.

The Academic Family Medicine Advocacy Alliance (AFMAA) organizes legislative activities for ADFM, STFM, AFMRD and NAPCRG. At the annual Congressional Conference in April 2005, our members met with legislators and government officials. Senator Barak Obama expressed a clear understanding of our character when he pronounced: "Family physicians are the doctors who always put the interest of their patients ahead of their own." This sentiment was shared by other legislators who, if properly informed, could be champions for policies that will benefit the health of the people of the United States. Unfortunately, they are not yet properly informed.

The Power of the Proper Composition of the Physician Workforce

Legislators were attentive to information from recent studies of health outcomes, which indicate that higher quality care can be achieved at a lower cost when the physician workforce is composed of the appropriate proportion of generalist physicians.[1-6] These data suggest a potential cure for a health care system that Sena-

tor Obama described as "in the throes of a meltdown." They were captivated by this information because the changes necessary for improvement in quality and reduction in spending could be described in simple terms. Even though this information is the compelling foundational argument for all legislation that supports the practice of family medicine, it is neither understood nor well articulated by most family physician clinicians or educators.

The studies from Johns Hopkins[1-3] and Dartmouth[4-6] are powerful population-based investigations that examined health outcomes and quality indicators in industrialized nations, states, and counties. In composite, the data suggest that optimal health outcomes occur when 40% to 50% of the physician workforce is made up of family physicians, general internists, and general pediatricians.

The Dartmouth studies examined entire Medicare data sets for several years, and compared the spending by each state with 24 quality indicators.[4-7.] As annual spending per Medicare beneficiary increased, quality of care declined significantly. As the number of generalist physicians increased, the quality of care improved and the costs declined. Conversely, as the number of specialist physicians in the population increased, the quality indicators declined and the costs rose.

States at the 75th percentile of quality spent about $1,600 less per beneficiary per year than states at the 25th percentile, and states at the 75th percentile in spending had about 40% fewer generalist physicians per capita than states at the 25th percentile (2.4 vs 3.9 per 10,000 people). An appropriate increase in the proportion of generalist physicians will lead to improved quality and savings of perhaps $60 billion or more per year for care of the nation's 41,000,000 Medicare beneficiaries.

Radical changes in the US health care system must occur to support this balanced workforce, including examination of medical school admissions, increased reimbursement for generalist physicians who provide personal medical homes for patients, and incentives for systems that demonstrate high quality. The balance of spending for health care must shift toward preventive medicine and public health policies that provide access to health care for all.

Two things must be done to properly inform those who make laws and implement policy. First, we must develop enduring relationships with our legislators. We must also become conversant in the studies that show the positive effect of our discipline on the nation's health outcomes. Our legislators already know that we are passionate about the health of our patients and our nation. Now we must become their trusted advisors who can demonstrate that our passion improves outcomes and lowers costs. They will be eager to listen to this story.

Jerry Kruse, MD, MSPH,
Association of Departments of Family Medicine

References

1. Starfield B, Shi L, Grover A, et al. The effects of specialist supply on populations' health: assessing the evidence. *Health Aff (Millwood).* 2005;24:317-324.
2. Shi L, Starfield B, Kennedy B, et al. Income inequality, primary care, and health indicators. *J Fam Pract.* 1999;48:275-284
3. Starfield B. New paradigms for quality in primary care. *Br J Gen Pract.* 2001;51:303-309
4. Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Aff(Millwood).* 2004;W184-W197
5. Fisher ES, Wennberg DE, Stukel TA, et al. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Ann Intern Med.* 2003;138:273-287
6. Fisher ES, Wennberg DE, Stukel TA, et al. The implications of regional variations in Medicare spending. Part 2: Health outcomes and satisfaction with care. *Ann Intern Med.* 2003;138:288-298
7. Jencks SF, Cuerdon T, Burwen DR. Quality of medical care delivered to Medicare beneficiaries. *JAMA.* 2000;284:1670-1676

From the Association of Family Medicine Residency Directors

Ann Fam Med 2005;3:469-470. DOI: 10.1370/afm.400.

QUALITY IN RESIDENCY EDUCATION

In discussing the concept of quality, I am reminded of the old Zenith advertisement, "quality goes in before the name goes on."[1] Quality must be a requisite to be called a family doctor.

Concepts and standards of quality continue to evolve. Advances in technology, rising health care costs, increasing health disparities, and shifting population demographics will shape the future concept of health care quality. The Future of Family Medicine (FFM) project offers a template for acquiring the skills and resources needed to thrive in an ever-changing environment. The AFMRD has reformatted its strategic plan to reflect the FFM recommendations.[2-4]

This year's AFMRD presidential theme is "Forging the Future of Family Medicine Through Quality and Innovation." Innovation will be a key driver and marker of health care quality in the future. Compared with health care outcomes in countries with fewer health care dollars, our expensive, high-technology health care results in poorer outcomes, and racial and socio-