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.

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From the Association of Family Medicine Residency Directors

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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-

economic health care disparities are increasing. Clearly, now is the time for innovation.[2,4]

The AFMRD is making a concerted effort to assist residency programs that are considering an electronic health record (EHR) system. At our Program Director's Workshop (PDW) in June 2005, vendors were invited to demonstrate their EHR systems. They presented business plans to program directors, describing how their EHR systems would affect not only the residency programs' financial bottom line but also quality and patient safety. The AFMRD has also been working with family medicine residency programs and the Residency Review Committee for Family Medicine to promote innovative ideas in family medicine education, with several residency programs suggesting alternative curricula and educational tracks while still meeting all program requirements.

To encourage high-quality leadership, the AFMRD created 3 levels of awards: bronze, silver, and gold, which were presented for the first time in June. To promote ongoing faculty development, key to providing high-quality education for our trainees, the PDW joined with the National Institute for Program Director Development (NIPDD) to offer introductory and advanced fellowships.

Mastering complex chronic cases will require a skilled workforce. Residency training will equip our trainees with the tools needed to ensure lifelong learning, to use technology and evidence-based medicine, and to optimize the health of the populations they serve. The AFMRD, which is also committed to recruiting and mentoring students, is publishing a "cookbook" for mentoring medical students as well as to help students understand the benefit of a career in family medicine. The goal is to recruit only the best and brightest, both intellectually and emotionally.[2,4]

The osteoporosis and diabetes preceptorships continue to be well received as evidence-based educational training programs for residents. Besides their educational value, the programs are designed as a resource for research and training in the core competencies of "systems-based practice and practice-based learning." The AFMRD board is researching the programs' impact on clinical care and core competencies. Outcomes- and clinical-based research are vital components of the future of family medicine.

Collaborations and effective medical teams are central to health care environment improvements and quality improvement. Our preceptorships represent a successful collaboration of family medicine, other primary care disciplines, specialists, allied health professionals, educators, and researchers. Within our own family of organizations, we have ongoing dialogue and project planning with STFM, ADFM, ABFM and AAFP. Discussions with STFM leadership have focused on joint curriculum development. Conversations with ADFM have focused on implementation of electronic medical records and their role in the future of family medicine. AFMRD leaders visited the ABFM at their home office in Lexington, Ky. Our 2 organizations have maintained an active dialogue as both plan strategies and innovations that will benefit both organizations.

Webster's dictionary defines quality as a distinguishing attribute, an inherent feature, a degree of excellence, and an acquired skill or accomplishment.[5] Perhaps, the most important qualities we can instill in our graduating residents are the ability to ask questions that lead to research, and open minds that will lead to innovation. We must also instill the desire to change and evolve, to confront complacency, and challenge the specialty to a higher standard.

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RESEARCH INVOLVING LATINO POPULATIONS

The US Latino population, at more than 31 million, is the largest minority group in this country, and their numbers are expected to reach more than 96 million in the next 50 years.[1] This reality, along with the health disparities faced by Latinos,[2] highlights the need to promote research involving this population. As stated by the Office on Minority Health: "Hispanics/Latinos are disproportionately underrepresented in research activities. Without adequate and targeted research, Hispanics/Latinos are disadvantaged in policy making,