fielded in the United States) is challenged by a recent survey of adults about their experiences with primary health care in the United States, Canada, New Zealand, Australia, and the United Kingdom. That study found that, "Across multiple dimensions of care, the United States stands out for its relatively poor performance. With the exception of preventive measures, the US primary care system ranked either last or significantly lower than the leaders on almost all dimensions of patient-centered care: access, coordination, and physician-patient experiences."[2]

Because of the current political polarization in the United States and spiraling federal deficits, many feel it is unlikely that there will be a systemic overhaul of the health care system in the near future. However, it is entirely possible for states, localities, large and small employers, and family physicians both individually and collectively to create new models of primary health care that deliver improved performance across all six key dimensions. Community integrated and professional coordinated models of care seem to be worth looking at in detail, and their apparent individual shortcomings might well be remedied by system redesign, perhaps with little need for added resources. NAPCRG will continue to be a critical venue for the international exchange of experiences and ideas that can help guide those efforts.

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From the American Academy of Family Physicians

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NEW POLICY, DUAL RESIDENCY PROGRAMS SUPPORT FPS WHO PROVIDE EMERGENCY CARE

Family physicians who are asked to obtain certification in emergency medicine in order to staff emergency rooms may liken that requirement to a "keep out" sign hanging above the ER door. To assist these family physicians, the Academy has developed a policy (see below) to support them in practicing "the whole scope of practice that they were trained to provide, including emergency care," according to AAFP President Larry Fields, MD, of Ashland, Ky.

The policy gives family physicians who work in emergency rooms "leverage in case they run into credentialing problems with their hospitals," said Fields. Some family physicians are having difficulty continuing to provide emergency care because they are not certified in emergency medicine, he explained.

"We wanted a policy so our members who are currently working in emergency rooms will be able to keep doing that and to protect our members who go to the emergency room on an occasional visit," said Fields. For about 1,500 to 2,000 family physicians, emergency room work is their only practice or a major part of their practice, and about half of family physicians provide at least some emergency medical services, according to a 2005 survey of AAFP active members.

The new AAFP policy on FPs in emergency medicine affirms, "In rural and remote settings, family physicians are particularly qualified to provide emergency care." Why the phrase particularly qualified? "In rural and remote areas," said Fields, "there is usually not proximity to physicians in other medical specialties who might provide support. We (family physicians) are trained to take a broad look at a patient with a problem, decide what's appropriate to do and do it. We're accustomed to seeing the undifferentiated patient, for example, with chest pain and figuring out—is it a cardiac problem or a stomach problem?" About 23% of the Academy's active members are located in rural areas.

Family physicians are needed in ERs because not enough physicians are being trained in emergency medicine residencies to work in all the areas where emergency physicians are needed, said Fields. The American College of Emergency Physicians agrees, as indicated in an ACEP statement that says "there is currently a significant shortage of physicians appropriately trained and certified in emergency medicine."

The shortage in part led the American Board of Emergency Medicine and the American Board of Family Medicine to recently release guidelines for hospitals and other residency sponsors with accredited programs in family and emergency medicine on offering combined residency training that will lead to dual board certification in family medicine and emergency medicine.

When first discussed in 2005, 72 family medicine residency programs expressed interest in offering this

type of dual training, according to Perry Pugno, MD, MPH, director of the AAFP Division of Medical Education. He expects at least 3 or 4 programs to launch dual training in 2006.

Dual family and emergency residency training is a resource for residents who plan careers that combine family and emergency medicine, such as in rural practices where family physicians often staff emergency departments, said Pugno.

The dual residency approval will help preserve family physicians' role in emergency departments, ensure medical coverage of EDs in underserved areas and address emergency medicine's desire for board-certified ER directors, according to Mark Belfer, DO, director of the family medicine residency program at Akron General Medical Center in the Northeastern Ohio Universities College of Medicine hospital consortium. Belfer served on the AAFP Commission on Education during the ABFM-ABEM discussions.

"The reason (these guidelines) came about was because several family physicians in rural areas were getting shut out of emergency rooms where they'd been working for years," he said. "ABEM's goal is to have all emergency rooms staffed by board-certified emergency medicine doctors."

The guidelines stipulate that graduates of combined training programs can sit for certification in each specialty and practice as family physicians, emergency medicine physicians, or both. They also can enter subspecialty training programs approved by either board or undertake research.

Approved programs must provide 30 months of training under the direct supervision of each specialty, according to the guidelines, for a total of 60 months of training. Six months of training should be provided under each specialty in the first year. Continuous assignments in 1 specialty should not be less than 3 months or more than 6 months in that specialty.

"The curriculum must assure a cohesive, planned educational experience and not simply comprise a series of rotations between the 2 specialties," the guidelines say. "Duplication of clinical experiences between the 2 specialties should be avoided."

The 2005 AAFP Congress of Delegates rejected a joint policy statement that was written by a task force that included AAFP members and members of the ACEP Board of Directors. This led the Academy late last year to establish the Task Force on Emergency Medicine with members from the Academy only. That task force recently sent a draft policy to the AAFP Board of Directors, which revised and adopted the statement during the Board's March 7-12 meeting in Washington, DC.

The new task force, which Fields chairs, will flesh out the Academy's policy in a position paper that will cover such topics as the role of family physicians in emergency departments, said Fields. The task force will try to develop the paper and submit it to the Board this summer so the Board may send it to the Congress of Delegates for consideration September 26-28 in Washington, DC, Fields added.

Jane Stoever & Leslie Champlin
AAFP News Now

POLICY ON FPS IN EMERGENCY MEDICINE

Family physicians are trained in the breadth of medical care, and as such, are qualified to provide emergency care in a variety of settings. In rural and remote settings, family physicians are particularly qualified to provide emergency care.

Emergency department credentialing should be based on training, experience and current competence. Combined residency programs in family medicine and emergency medicine, or additional training, such as fellowships in emergency medicine or additional course work, may be of added benefit.

Excerpt from statement adopted by AAFP Board of Directors, March 2006

From the American Board of Family Medicine

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AMERICAN BOARD OF FAMILY MEDICINE ELECTS NEW OFFICERS AND BOARD MEMBERS

The American Board of Family Medicine (ABFM) is pleased to announce the election of 4 new officers and 3 new board members. The new officers elected at the ABFM's spring board meeting in April 2006 are: Karen B. Mitchell, MD, of Rochester, Mich, elected as Chair; David W. Price, MD, of Broomfield, Colo, as Chair Elect; Richard D. Clover, MD, of Louisville, Ky, as Treasurer; and Joseph Hobbs, MD, of Augusta, Ga, as Member-at-Large, Executive Committee. In addition, the ABFM welcomes this year's new members to the Board of Directors: Thomas P. Gessner, MD, of Latrobe, Penn; John R. Bucholtz, DO, of Columbus, Ga; and Craig W. Czarsty, MD, of Waterbury, Conn.

The new ABFM officers will each serve a 1-year term: