tion rates of champion physicians, and heavy listserv activity. Mechanisms that were utilized by teams to improve clinical outcomes included development of interventions to impact clinical inertia, extensive use of provider-specific data, a major focus on enhancing self management support, a realization that work and improvement occurs best among multidisciplinary teams, and extensive use of group and planned visits. Changes in resident curriculum included changes in both didactic and hands-on clinical training.

Participating programs have already cited a variety of benefits from ACCC participation, including a rethinking of the way patient care is provided that is more consistent with the FFM Model (ie, group visits, self-management, multidisciplinary teams, community effort). Additional benefits have included a positive impact on departmental strategic planning; greater resident appreciation of team care; an inclusion of nontraditional roles, such as data analyst into the care process; greater group learning about the challenges of change management; enhanced connection between senior leaders and teams; and a positive impact on resident recruiting. Additionally, quality improvement work was recognized as rigorous research and a viable career focus. Lastly, there was a feeling that the collaborative helped advance the diffusion of innovation across departments within the same campus.

Several spinoff efforts have resulted from this initial academic collaborative. The AAMC's Institute for Improving Clinical Care (IICC), in partnership with the University of Pittsburgh Medical Center and the Delmarva Foundation for Medical Care, coordinated an Academic Rapid Response Collaborative for improving acute care in academic settings. In May 2006, 10 teams from North and South Carolina began participating in a 2-year collaborative to improve diabetes and CHF care in family medicine residency programs in the Carolinas. Funding from Fullerton Foundation and Duke Endowment support the design team, which includes leadership from the UNC Department of Family Medicine and USCSCOM Department of Family and Preventive Medicine. And, in February of this year, the California Academic Chronic Care Collaborative began their work to improve chronic illness care for persons who receive their care in academic health systems and to assure that clinical education occurs in an exemplary environment with teams from 8 California institutions.

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MATERNITY CARE IN FAMILY MEDICINE: A TIME FOR DIALOGUE

Maternity care is a core tenet of family medicine, and has been reaffirmed in the Future of Family Medicine report. Although there is wide regional variation in training experience, family medicine residency can prepare residents for competency in maternity care. Our nation, especially rural areas, needs family physicians who deliver babies and provide access to care. Some family medicine residency programs offer advanced skills, including management of high-risk pregnancy and operative delivery. However, many of our programs struggle with the current Residency Review Committee (RRC) requirements for maternity care. Delivery numbers (both continuity and total) vary widely across the country. Given geography, payor mix, and liability costs, some programs have no family medicine faculty to supervise residency training in maternity care. These facts produce a tension and a polarity. What is routine for some is unacceptable for others. What is routine for some is unachievable by others. The debate is not "to do" or "not to do" obstetrics; the question is "the dose."

Although current RRC requirements hold all programs accountable to the same standard, the Residency Assistance Program *Criteria for Excellence* supports a 3-tiered level of competence. Concerns over changing the numbers requirement range from support for raising the bar of competence for those obtaining maternity privileges, to fear that family medicine is "giving up on OB" if all residents do not obtain a minimum number. These positions include the following options:

Continue Current RRC "Numbers"

1. Obstetrical practice is at the heart of what it means to be a family doc, and through this experience, the practicing physician builds a practice of families.

2. Maternity training is a battle that current family physicians cannot quit.

3. The time for differentiation of providing (or not providing) maternity care should be after residency graduation, based on community needs.

4. Although not all of our members actively practice maternity care, maternity care training is essential.

5. The delivery experience is an excellent opportunity to evaluate the ability/competence of our residents.

6. Leaders in family medicine must make difficult decisions. Obstetrical training requirements must be protected.

7. Residency programs that struggle with issues of quality obstetrical care should be assisted by the AAFP.

Revised "Numbers" Approach

1. Only a portion of graduates will integrate maternity care in their practices. Although differentiation of services should occur after graduation, many residents make this choice during training.

2. Those residents who plan on providing maternity care in practice must have a competency and experience level well beyond that attainable with current RRC minimum requirements.

3. Prenatal care training is essential for all. Delivery experience should be maximized by those who are likely to choose to incorporate this into their practices.

4. Quality family medicine residents providing competent maternity care will be more likely to attract medical students to the discipline.

5. Respect for family medicine in the Academic Health Center is dependent on raising the bar on quality/competence in our programs. Maternity care represents an area where demanding a higher level of performance (including minimal numbers) may improve the credibility of family medicine training.

6. Allowing programs to shift patient care during the third trimester to residents interested in intrapartum care would provide a maximized experience for residents whose practice interests may include maternity care. (eg, all residents participate in a minimum number of prenatal visits, yet the delivery is captured by those residents who plan on doing maternity care in practice. This would allow for the continuity delivery number to go up from the current 10, to a higher number.)

7. Some programs will require all residents to participate in high-volume/risk maternity care. This differentiation will be beneficial to student applicants looking for low or high maternity care options.

As educators of tomorrow's family medicine work force, we owe our patients, and the American public, the highest level of quality. We demand this of our consultants, and should consider nothing less of ourselves. Maternity care is much more than the act of delivering a baby. Those providing this service are committing to both a body of knowledge as well as a specific skill. It is time to raise the bar on quality and competence for the maternity care services that we bring to our patients. For those providing maternity care, we should demand numbers in excess of current RRC requirements. It is also time to unshackle the burden of numbers in regions of the country where maternity care is neither practical nor possible. It is time for dialogue.

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A GUIDED TOUR OF COMMUNITY-BASED PARTICIPATORY RESEARCH: AN ANNOTATED BIBLIOGRAPHY

It seems inherently improbable that an academic researcher can ask and answer a clinical question that matters to a patient.

The US health care system is in disarray. Our medical research juggernaut is assaulted on all sides by concerns about federal financing, corporate loyalties (and royalties), and translating research into clinical practice. We spend billions of dollars, conduct more clinical trials, and obtain more "outcomes." But it seems like no one really gets any better.

There seems to be a major disconnect between academic multicenter, rigorous protocol-driven Phase III trials and actual community life and clinical practice. Treatments and guidelines rigorously studied at the academic health center frequently fail to make it into every day clinical practice or individual patient life. Practice-based research and community-oriented primary care both seek to take research out of the academic medical center into the community, and while successful, their approach may only be half right.

Community-based participatory research (CBPR) may be one approach to help us out of the mess we're in. CBPR links the researcher and the individual community member in a manner that will dramatically change both. Patients spend their time living their lives, not hanging out at a medical office. Most medical care is chosen and acted on by the patient living in his/her own personal or community context. Individuals decide when to access professional medical care, what to believe about their medical diagnosis and treatment, what over-the-counter medication to take, what supplement or complementary care to obtain, and how and when to take their prescribed treatments. Really, it is the ordinary citizen that distills all the available medical knowledge and translates it into his/her own life. Not to include them in the production of that knowledge is a grave disservice and severely limits our research findings. CBPR may be an important element of practice redesign in the coming decade to assure that changes in the clinical office reflect the needs of patients. Participatory research should be an essential element in the NIH Roadmap that seeks to quickly and efficiently link medical problem to medical researcher,