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.

Paul Callaway, MD

From the North American Primary Care Research Group

Ann Fam Med 2007;5:185-186. DOI: 10.1370/afm.690.

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,

and back to the patient. CBPR gives traction to ideas that have been percolating in clinical primary care research for the last century.

Julie Stevenson and the Robert Wood Johnson Foundation Prescription for Health Program have put together an outstanding annotated bibliography on the history and recent advances in CBPR, available through the STFM Family Medicine Digital Resources Library at http://www.fmdrl.org/879. CBPR has moved from the fringe of clinical research to become a standard, widely accepted research method. This annotated bibliography provides a single document to assist the novice in beginning his/her own work in CBPR. It provides the seasoned researcher with a wealth of information on successes, failures, and outcomes in participatory research. This manuscript has distilled the more than 100 articles about CBPR into a quintessential primer on participatory research.

This work is not a metaanalysis, nor is it an exhaustive list of all the articles published on CBPR. The success of CBPR would make that undertaking nearly impossible, and certainly unreadable. The Agency for Healthcare Research and Quality has provided a comprehensive literature review on CBPR. This work really is a guided tour, describing the state-of-the-art in CBPR. Ms Stevenson serves as the docent on this tour and covers major themes, definitions, policies, guidelines, evidence, and insights on CBPR. This manuscript could serve as the core reading list for an introductory curriculum on CBPR.

The benefit of participatory research goes far beyond the simple notion of asking a patient what he/she thinks about a research idea. Participatory research occurs in the community, where people live their lives, and live their medical care. Participatory research allows for studying the process of wellness and illness, the manner in which individuals seek diagnosis and treatment, the interplay between patient and health care provider or institution. It is in participatory research where what matters to the common folk bubbles up to the clinical trial, where the act of living one's life is inextricably connected to living one's health, and where that interface between a patient's daily life and health care's greatest aim can be explored and medical care improved.

Use this annotated bibliography. Keep a copy on your desk. Read the papers cited within. Practice participation. Discover good things.

John Westfall, MD, MPH, and
Julie Stevenson, MA, University of Colorado HSC