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From the Association of Family Medicine Residency Directors

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FAMILY MEDICINE: CARE FOR A LIFETIME

In 1995 the faculty of Cabarrus Family Medicine Residency held our first retreat to formulate the mission, vision, and values of a new residency program that would train residents using 4 community private practices. We decided we needed a new model for a residency within a practice. In the spirit of not taking ourselves too seriously we came up with the Tricycle Model of Training (Figure 1).

In our program the big wheel driving and guiding our program is patient care. To this day you will hear us say, "The big wheel is patient care." Our practice exists to provide high-quality patient care with teaching and research linked to patient care by a strong frame of administration. The tricycle model is a dynamic one. The leadership of our program metaphorically "rides" this tricycle over the hills and valleys of American healthcare. The point of the model is that our teaching and research are driven by patient care. That being said, the model allows for flexibility in the relative sizes of the 3 wheels. Some programs have larger research and teaching wheels than others. Clearly, all 3 wheels are necessary and valuable to "ride" our discipline forward.

The last 10 years have been a sobering time in residency training with a 53% decrease in US seniors entering family medicine residencies.[1] Residency programs spend countless hours recruiting qualified students. We have done our best to make our programs attractive to residents, but nevertheless, the numbers declined. If we reflect on the big wheel being patient care, then perhaps we should refocus our efforts, not so much on polishing our programs, but rather on making the practice of family medicine more enjoyable. The best thing we can do for recruitment to family medicine residency programs is to create a more satisfying life and career for those in practice. The good news is primary care is once again ascending in value to our health care system. The concept of the medical home makes such good sense that more and more people are beginning to support it.

Family medicine residency is the center point of a continuum of training that spans from medical school through early and later career learning after residency completion. All residency programs have office and hospital practices that must teach the skills our graduates will need to practice family medicine in the 21st century. The journey to the future begins with a vision of family medicine which I call "care for a lifetime." Here is my vision of what it could be, and what we need to train physicians to live the dream.

1. Every American has access to a medical home designed to provide primary care that keeps patients out of emergency rooms and hospitals, and improves chronic disease and preventive outcomes.

2. The medical home is funded not only by E&M codes, but also by management fees, and E-medicine fees.

3. We have translated the core values and services of family medicine so well that our patients and the public are able to articulate them.

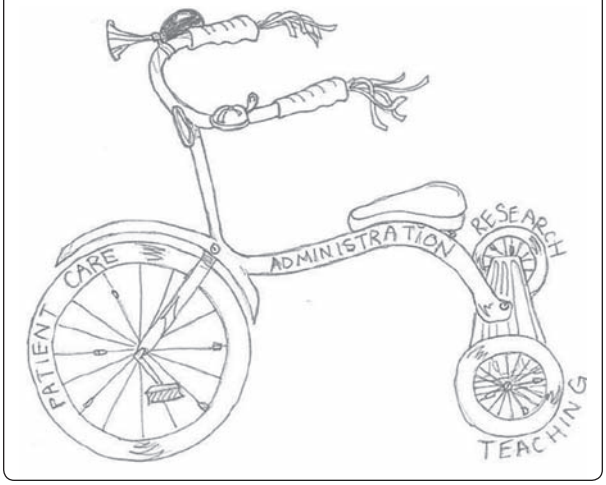
4. We have defined a core set of knowledge, skills, and attitudes that must be mastered to graduate from a family medicine residency.

5. The funding of graduate medical education is transformed to equitably cover the true costs of training residents.

6. All residents train in certified medical homes and leave residency ready to be valuable contributors to their future practices.

7. The RRC requirements reflect the core skills of practice, are outcome based, and compliance with

Figure 1.



them results in residents who are able and willing to practice in the medical home, the hospital, the home, and all venues family medicine is provided.

8. An Internet-based national core curriculum in family medicine has been established to facilitate the teaching, learning, and practice of the core across the continuum from student to practice.

9. The discipline of family medicine accepts and celebrates the fact that some family physicians differentiate beyond the core such that a new generation of family medicine specialists provide advanced services in maternity care, hospital medicine, sports medicine, research, geriatrics, palliative care, and _____ (fill in your area of focus).

10. We celebrate the ethnic, racial, gender, and professional diversity of our family medicine colleagues because we reflect a common humanity providing care for a lifetime.

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From the North American Primary Care Research Group

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VIRTUAL TEAMS: SECRETS OF A SUCCESSFUL LONG-DISTANCE RESEARCH RELATIONSHIP. A CANADIAN PERSPECTIVE

Studies show the effectiveness of interdisciplinary research teams.[1-3] Research teams are changing in terms of composition, location, and process. Grantmakers are recognizing the power of the distributed mind. When granting research awards, funders are encouraging partnerships to combine the best expertise of a variety of specialists. Collaboration allows researchers to be better placed to produce relevant results for their target audience. Decision makers gain improved understanding of the relevance and value of research.[4]

One option for creating an interdisciplinary collaborative is to form a virtual team. Virtual teams are groups of people who work interdependently with a shared purpose across space, time, and organizational boundaries using technology to communicate and collaborate.[5]

While communication technologies such as MS Communicator and Webex plus continued globalization have increased researchers' ability and motivation to work together, it is important to recognize the unique processes required to build and manage virtual teams. Virtual teamwork creates coordination challenges imposed by members' variety of schedules and different time zones.

This paper presents promising practices of successful long-distance research relationships and conducting virtual meetings that we learned through the Canadian Institute for Health Information's (CIHI) Primary Health Care (PHC) Project.* The framework followed involved 4 components: assessing, planning, implementing, and evaluating.

Assessing

Determining the proportion of time that members work face-to-face compared to virtually was a priority. Facilitating from a distance required strategic use of face-to-face communication. This choice is important when the virtual team needs to build trust, brainstorm ideas, and mediate conflicts.[6] A face-to-face "kick-off" meeting is ideal. "In-person" meetings can be arranged, cost-effectively, at conferences.

Planning

Preparing before the meeting involved circulating meeting information, ensuring attendance, and providing technology training. Planning was critical because there were no conversations around the coffee machine where team members could clarify roles.

We conducted an introductory telephone interview with each member. Questions helped identify and document members' expectations (especially scheduling preferences), build commitment, provide an overview (including members' names), and refine logistics such as obtaining their cellular number. Roles and responsibilities were defined and assigned. The Lead was the content expert who encouraged commentary and solutions whereas the Facilitator acted as moderator and timekeeper. A minute-taker was also recruited.

Establishing a shared purpose and accompanying goals and objectives is vital. Survey findings of geographically-dispersed teams suggest setting quality goals and building commitment to goals significantly affects perceptions of project outcomes.[7] Terms of Reference (comprising of background/overview, team purpose, membership selection criteria, duration of participation, responsibilities and meeting dates, venue and start/finish time) were developed for CIHI's Advisory Committees.

* CIHI's Pan-Canadian PHC Indicator Development Project brought together a broad range of PHC experts from multiple levels of the health system and regions across Canada in order to determine important measures to evaluate PHC in Canada and identify enhancements to Pan-Canadian PHC data collection infrastructure. *CIHI, Pan-Canadian PHC Indicators, Report 1, Volumes 1 and 2. Enhancing the PHC data Collection Infrastructure in Canada, Report 2*. Ottawa: CIHI; 2006.