



From the Society of Teachers
of Family Medicine

Ann Fam Med 2008;6:473. DOI: 10.1370/afm.895.

A NEW, DYNAMIC RESOURCE FOR BOTH STUDENTS AND TEACHERS OF FAMILY MEDICINE: THE FAMILY MEDICINE RESEARCH WIKI AT FMDRL

If you have ever wondered how to get started with a quality improvement project or how to pick the right statistical test for your data, or how to get your first research manuscript published, the Family Medicine Research wiki was designed for you. The wiki is a collaborative Web document that contains a growing collection of research methods related links, hints, resources, and guides. The content of the wiki can be viewed by anyone who has Internet access. You can get to the research wiki by using a search engine such as Google and typing in the search term "FMDRL research wiki" or you can find it by typing the following URL into your Internet browser: <http://www.fmdrl.org/group/index.cfm?event=c.showWikiHome&wikid=29>. To edit or add to the wiki, you must first become a member of the FMDRL Group on Teaching Research in Residency.

Some of the valuable information you can find on the wiki includes tools for getting started in family medicine research; scholarly projects in residency training; IRB issues and participant safety; qualitative, quantitative, and other research methods; funding opportunities for family medicine research; and tips for disseminating your work (publishing and presenting).

Many of you have probably used the largest wiki on the Internet, Wikipedia, a user editable, Web-based encyclopedia that contains an astounding array of information. Just as any member of the Internet community can contribute to the Wikipedia, members of the family medicine research community can contribute to our research wiki. A wiki is a collaborative, dynamic document that is only as good as the contributions it gets from users. If you have a favorite Internet link for teaching a statistical method, or a document describing your residency scholarly project curriculum, we encourage you to add to the wiki.

The first step is to get a free account on FMDRL if you don't already have one, and check the box to join the Group on Teaching Research in Residency. Once you have logged into your FMDRL account, you will have editing privileges for the wiki. Editing or add-

ing content to the wiki is almost as easy as using a word processor and our wiki has a page with detailed instructions about how to edit or add to the wiki. People who are new to wikis are sometimes reluctant to try editing the wiki for fear of breaking something, but the wiki tracks every change, so there really is nothing you can do to it that cannot be easily reversed. So, go ahead and make a contribution but be warned that wiki editing can be an addictive sport.

The Family Medicine Research wiki is housed in STFM's Family Medicine Digital Resources Library, <http://www.fmdrl.org>.

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From the Association
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Ann Fam Med 2008;6:473-474. DOI: 10.1370/afm.893.

RESIDENCY EDUCATION—COMPETENCY AND INNOVATION

Family medicine residency programs must take the lead in educating physicians to practice evidence-based personalized medicine that achieves the highest standards of efficient quality care. Such physicians are needed to meet current health care needs, to expand medical care delivery capabilities for the baby boomer generation, and for emerging comprehensive models, such as the patient-centered medical home.¹ For family medicine to succeed in meeting this challenge, greater flexibility to innovate as requested by the Future of Family Medicine Project must be granted to our residency programs by the residency review committees (RRC), the Accreditation Council for Graduate Medical Education (ACGME), etc.² Currently, innovation can only be implemented if all existing requirements are met. This leaves little room for flexibility and new conceptual models of training.

Family medicine residency programs can be conceptualized to encompass 3 educational stages: foundation building, ambulatory competency, and enhancement tracks. The foundational and ambulatory stages are common to all programs. The foundational stage generally consists of 15 to 18 months education in core rotations such as pediatrics, medicine, obstetrics, surgery, and a combination of essential medical and surgical specialties largely taught in the hospital setting.

The development of ambulatory competency occurs simultaneously with the foundation stage and

extends beyond it. The skills required for competence in this stage are not defined solely by patient volumes or time spent in the program. Each physician enters their residency with interpersonal skills honed by their life experiences and educational background. The fine-tuning occurring in the residency enables them to develop superb doctor-patient relationships, gather accurate medical histories, perform appropriate physical exams, and communicate treatment plans and prognoses to patients and their families all of which can be competency tested. Additionally, skill sets to manage the common medical, surgical, and emergency and urgent problems need to be taught.

The final stage in training would be focused on the acquisition of mastery in 1 or more enhancement tracks. These tracks comprise those unique skill sets needed to fill the basket of services in the practice setting desired by the resident and their areas of special interest.³ They may include learning advanced procedural skills, advanced obstetrics, sports medicine, geriatrics, or other unique content areas. These tracks will not be defined solely by patient numbers or time in the program. Limiting factors may be an appropriate patient population from which to learn the skills, an appropriate curriculum, and the faculty's competencies in these areas.

Although 3 stages can be identified, their educational components will often overlap; skills such as the ability to obtain a medical history and perform a physical exam will be common to all 3. Each stage can be subdivided into specific components which can be competency tested. The competency in most areas will not require a specific number of procedures to be performed, a predetermined number of patient encounters, or specific length of time in the program. Mastery will be shown to have been obtained when the resident demonstrates competency according to evidence-based principles utilizing evaluation techniques appropriate to the component being tested; for example—clinical demonstration, cognitive testing, oral discussion and/or medical simulation.

There will be some competencies which may require a specific number of patients seen in the clinical arena. For example, while many aspects of obstetrics can be competency tested, such as antenatal care, others such as delivery management may need exposure to a wide range of case situations. Decisions such as performing an episiotomy, repairing a fourth degree laceration,

management of dystocia, or the use of a vacuum extractor require experience. To competently learn some required ob skills, a range of deliveries may need to be identified to ensure that the conditions leading to the competent use of these skills will be optimized.

For these changes to take place, the RRC and ACGME must allow flexibility in residency content beyond that found in the foundational and ambulatory stages today. Reducing absolute requirements of time and/or numbers would allow more curricular time for flexibility and innovation. Competency for independent practice must be redefined periodically in all programs.⁴ This educational model should foster an attitude of life-long learning for our graduates who will expect a high standard of quality and competency-based practice to guide their medical care and future skill acquisition.⁵ This type of flexibility is capable of providing the physicians for medical home practices who can meet the demand of our evolving health care system.

This commentary was developed by the ADFM Residency Committee to further advocate for significant change in our residency educational programs.

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References

1. Roberts RG, Snape PS, Burk K. Task Force 5. Report of the task force on family medicine's role in shaping the future health care delivery system. *Ann Fam Med.* 2004;2(Suppl 1):S88-S99.
2. Bucholtz JR, Matheny SL, Pugno PA, et al. Task Force Report 2. Report of the task force on medical education. *Ann Fam Med.* 2004;2(Suppl 1):S51-S64.
3. Kahn NB Jr. The future of family medicine: a collaborative project of the family medicine community. *Ann Fam Med.* 2004;2(Suppl 1):S3-S32.
4. The Accreditation Council for Graduate Medical Education (ACGME). ACGME Program Requirements for Graduate Medical Education in Family Medicine. Revised Jul 1, 2007. http://acgme.org/acwebsite/downloads/rrc_progreq/120pr07012007.pdf.
5. Jones WA, Avant RF, Davis N, et al. Task Force 3 Report. Report of the task force on continuous personal, professional, and practice development in family medicine. *Ann Fam Med.* 2004;2(Suppl 1):S65-S74.