Leadership Development

Task force members agree that identifying and developing future leaders in the discipline should be a major priority. Terry Steyer, STFM president-elect, is forming a leadership workgroup consisting of STFM members who will meet face-to-face and by conference call to identify needs of future leaders, plan developmental activities to meet those needs, and specify outcome measures to assess the success of the leadership development activities. The STFM Board voted to support this workgroup with $7,000. This workgroup will develop a comprehensive leadership plan with assessment measures and collaborate with the STFM Nominations and Executive Committees to identify, select, and develop future leaders. Other possible ways of developing leaders include ensuring that former/current Pisacano Fellows belong to and participate in STFM activities and monitoring conference proceedings to identify developing leaders.

Dissemination of Task Force Outcomes

The task force will disseminate its work in multiple ways. One, it will publish summaries of accomplishments in the online *STFM Messenger.* Two, it will present a seminar on its work at the 2009 STFM Annual Spring Conference. Three, it will prepare a project summary poster that can be viewed near the registration desk at the 2009 STFM Annual Spring Conference. Four, it will post project information and materials on STFM's Family Medicine Digital Resources Library (http://www.fmdrl.org). Fifth, it will submit separate presentation proposals on the 4 priority projects for the 2010 AAMC Annual Meeting. Sixth, it will submit proposals to present project outcomes at AAFP, RPS, and PDW meetings.

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From the Association of Departments of Family Medicine

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DEAR MR. PRESIDENT: REFORM HEALTH CARE, AND KEEP IT SIMPLE

Dear Mr. President,

Congratulations on your election. We, the nation's departments of family medicine, look forward to giving you a hand with health care reform. Compared to other rich nations, we know that our health outcomes fall far short, our health care costs are very high, and access to care is altogether inequitable. Rectifying these problems seems a daunting task, but when attention is paid to the abundant evidence, the solution boils down to 2 simple essentials—universal access to healthcare for all Americans, and much more emphasis on primary care, preventive medicine, and public health.

You may ask: "How will we pay for greater access and for more primary care?" Solid evidence shows that the initial cost for this type of reform is recouped within 2 years and then there are substantial savings. Just ask Senator Richard Burr of North Carolina. He can tell you about his state's great Community Care of North Carolina program.[1]

Like oil companies, we in academic family medicine are concerned about pipelines. For the best health care system, we need to train more family physicians. Ask Senator Edward Kennedy of Massachusetts. His state introduced a program of universal health care coverage in 2006, but it failed to flourish because there were not enough primary care physicians to care for all of the people suddenly insured.[2] And guess what? It's going to get worse. Currently, 32% of US physicians practice primary care. Over the last 3 years, the number of medical school graduates who will practice primary care is only 16%, and federal programs that will reverse the trend have been eviscerated.

Here's an example: Since 2000, the funding for Federally Qualified Health Centers (FQHCs) has nearly doubled to almost $2 billion. This is laudable. However, over the same time period, the funding for the programs that train the physicians most likely to practice in FQHCs (Title VII, Section 747) has been cut by 55%. This is appalling. Ask Senator Evan Bayh of Indiana if the new Lucas Oil Stadium would have been built if Indianapolis didn't have a pipeline of loyal Colt fans or the promise of a pipeline of conventions. The pipeline of family physicians is running dry.

Would you like some good reading? We recommend an article by Barbara Starfield, pediatrician and one of the nation's foremost clinical epidemiologists. Her comprehensive review of the literature on systems of effective health care is in *The Milbank Quarterly*.[3] Here's what our country needs:

1. *Patient-Centered Medical Homes*. Ubiquitous physician-directed practices that emphasize first-contact care, patient-centered care over time, comprehensive care, integration of care among health care disciplines and within communities, family and community orientation, and cultural competence. (You don't need to measure much here; practices like these improve outcomes and lower costs by their very nature.)

2. *Universal access to care guaranteed by publicly accountable bodies*. We don't necessarily need a single payer; we just need public accountability for those who do pay.

3. *Low or no copays or deductibles for primary health services*. Led by the growth of Health Savings Accounts (HSAs), out-of-pocket expenses are soaring. The GAO found that HSAs are nothing more than veiled tax shelters.[4]

4. *Similar professional earnings for primary care physicians relative to other specialists*. Recent RVU updates, care coordination payments and pay-for-performance are right on target. Make sure they measure and reward practices that in reality improve the health care system.

Here's what is really amazing: These things naturally occur when there is an adequate workforce of family physicians. If you want an illustration, ask Leiyu Shi of the Johns Hopkins Bloomberg School of Public Health. His studies consistently find that poor health care outcomes due to gaps in socioeconomic status are eliminated by high concentrations of primary care physicians.[5]

Well, that's about it. In the long run, these changes will pay for themselves many times over. And the measurements won't be nearly as cumbersome as you might think. It will take some guts to take on the special interests that will be resistant to such change, but family medicine is ready to step up to the plate.

Jerry Kruse, MD, MSPH, and
the Association of Departments of Family Medicine

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A PROCESS FOR CHANGE: A METHODOLOGY FOR ACADEMIC FAMILY MEDICINE

The Association of Family Medicine Residency Directors (AFMRD) Board of Directors recently rekindled the discussion pertaining to maternity care education in family medicine residency programs. At present, the ACGME-RRC for family medicine requires programs to provide 2 months of educational experience in maternity care as well as delivery experience that entails a minimum of 40 deliveries by each resident over the 3-year program, of which a minimum of 10 must be continuity deliveries. At least 30 of the total deliveries must be vaginal deliveries. The current discussion is meant to address the following issues:

1. A decreasing number of physicians in active practice and who graduated from a family medicine residency program provide maternity care. Many programs are concerned that they are being required to provide an experience that a majority of the graduates will not use upon graduation.

2. Many programs have difficulty meeting RRC-FM requirements for maternity care education. Maternity care is the most frequently cited curricular area noted by the RRC-FM. The RRC-FM issued an average of 6.6 citations per program. Maternity care, family medicine center patient encounters, and gynecology curricula were the most common areas of noncompliance citations. In addition to meeting minimal delivery requirements, a majority (58%) of programs responding to a questionnaire stated that they had difficulty in recruiting a faculty member with delivery skills. With this high rate of citations, the quality of education in maternity care for family medicine residents is inconsistent.

In order to provide a position statement that best reflects the experience and expertise of its membership, the AFMRD Board of Directors conducted a process that would allow a significant amount of input from program directors as well as information from other sources.