We would add that reviewing the applications of funded CTSAs, engaging funded CSA researchers as consultants, and approaching the CTSA process as team players are all potentially productive strategies. The CTSA Web site of the National Center for Research Resources of the NIH contains a plethora of information as well as links to all currently funded CTSA Web sites.[3]

A final strategy that we will mention is that 8 of our respondents indicated that they would be applying as a collaborative institution rather than as a lead institution. As mentioned above, 1 family medicine department is currently participating through a collaborative arrangement. This may be a productive strategy for departments that have a distinctive contribution to make, but are located in institutions that would not otherwise be competitive for a CTSA. Collaboration across institutions and between CTSAs is strongly encouraged as part of the vision of accelerating research findings into improved outcomes for patients.

Bernard Ewigman, MD, MSPH; Mark S. Johnson, MD, MPH; Ardis Davis, MSW, and the CTSA Strike Force
Members of the CTSA Strike Force: Mark S. Johnson, MD, MPH (Chair); Ardis Davis, MSW; Peter Carek, MD; Bernard Ewigman, MD, MSPH; Lee Green, MD, MPH; Carlos Jaen, MD, PhD; Rick Kellerman, MD; Erik Lindbloom, MD, MSPH; Terry Steyer, MD; Hope Wittenberg

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From the Association of Family Medicine Residency Directors

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PERCEIVED IMPACT OF PROPOSED INSTITUTE OF MEDICINE DUTY HOURS ON FAMILY MEDICINE RESIDENCY PROGRAMS

The ACGME is faced with an enormous challenge. On the 25th anniversary of the Libby Zion case[1] and the 5th anniversary of the ACGME Duty Hours,[2] the Institute of Medicine (IOM) released a December 2008 report calling for a revision in duty hours and trainee supervision.[3] The ACGME is asking the graduate medical education community to collaboratively address concerns raised by the IOM about resident schedules and safety of patients and trainees. In discussions following the release of the IOM report, opportunities for improvement as well as threats to the educational process and the viability of some residency training programs have emerged.

The Association of Family Medicine Directors (AFMRD) surveyed its membership utilizing an online survey instrument (Zoomerang). As of February 26, 2009, 60% of the program directors responded to the survey. This represents a broad representation of programs by geographic region, community type (rural, suburban, urban), program administration, and program size.

The results of this survey clearly identify numerous issues regarding implementation of the IOM recommendation. For instance, two-thirds or more of the program directors responded that it would be "very easy" or "easy" to implement:

- In-hospital call every third night, no averaging
- 10 hours off after day shift
- Internal and external moonlighting within the 80-hour weekly limit

Furthermore, two-thirds or more of the directors responded that it would be "difficult" or "very difficult" to implement:

- Ensuring a 5-hour protected sleep period between 10 PM and 5 AM in a 30-hour period
- Limiting residents to a 16-hour shift
- 12 hours off after night shift
- In-hospital night shift 4-night maximum; 48 continuous hours off after 3 or 4 nights of consecutive duty
- 5 days off per month; 1 day (24 hours) off per week, no averaging; 1 48-hour period off per month

In addition to the difficulties noted with implementation, the residency program directors expressed concern regarding detrimental effects on medical education as well as potential decrease in the quality of care provided. Over 90% of the program directors expressed concerns about:

- Graduating doctors who generally take less 'ownership' and do not know patients as thoroughly as in the past
- Residents developing a 'shift-worker mentality' that the IOM rules would exacerbate
- Future doctors being less prepared for the work-hour demands of practice

The untoward effect of the proposed changes in work hours was reflected in the finding that two-thirds

or more of the program directors believe that implementation of the IOM recommendations would NOT:

- Improve patient safety
- Improve resident education
- Produce more compassionate and more effective family physicians

Finally, nearly two thirds believe that:

- In their own institution, implementing the requirements would result in decreased patient access to care
- Implementing IOM requirements would result in graduating doctors who are not experienced enough to practice independently
- If the IOM duty hour recommendations are implemented, family medicine training may need to add an additional year of training

The program directors also expressed significant concerns regarding financial issues as well as transferring the work associated with patient care to other healthcare professionals with either less extensive training or to individuals who are not governed by work duty hour restrictions:

- Nearly one-fourth of all program directors responded that full implementation would threaten their program's viability.
- Two thirds of program directors anticipated that implementation could only be accomplished with more resources (personnel, faculty, finances).
- Over one-half of program directors estimated the additional annual financial cost for program implementation of the recommendations at >$100,000.
- Over 70% responded that the minimum time period notice needed before the IOM recommendations could be realistically implemented at >12 months.

To assist the ACGME, the AFMRD Board believes that the following principles should govern any decision regarding implementation of the proposed IOM recommendations or any other further restrictions:

- No evidence exists that current duty hours have reduced errors.
- Any new duty hour rules should be evidence based and validated by a series of observational studies designed to detect the intended and unintended impact of the proposed limitations on duty hours.
- Every residency program must focus on appropriate resident supervision to reduce inevitable errors of resident training.
- Any efforts to reform duty hours should not further threaten the ability to produce the number of family physicians needed to serve the country.

Family medicine welcomes the opportunity to participate in this important dialogue, which must protect patient safety and resident well being, while maintaining excellence in education.

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From the North American Primary Care Research Group

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ASSESSING THE QUALITY OF PRIMARY CARE RESEARCH IN THE UNITED KINGDOM: THE 2008 RESEARCH ASSESSMENT EXERCISE

Universities in the United Kingdom receive separate funding from the government for their teaching and research activities. For the past couple of decades, the research grant of each institution has been determined by the results of national peer-based Research Assessment Exercises (RAE) conducted in 1986, 1989, 1992, 1996, 2001, and 2008 (http://www.rae.ac.uk/). The amount of money received depends on both research quality (with higher quality work attracting disproportionately more money than lower quality activity) and total number of people evaluated.

For the 2008 RAE, universities were invited to submit information about research active staff to 1 of 67 discipline-specific subpanels comprised of experts in the field or users of research. Universities were free to decide how many staff and to which subpanel they wished to submit. Details were supplied about 4 research outputs (predominantly academic papers, books, or monographs) produced between 2001 and 2007 by each fulltime staff member, with reductions allowed for circumstances which could have adversely affected an individual's contribution to the submission, such as family or domestic matters, illness or disability, engagement in major long-term projects, or early career status. Information was also supplied about the number of research students, studentships, postgradu-