beneficial in clinical learning.

EHRs may facilitate the delivery of health care quality, but, for the novice clinician, prompts, templates, existing drug and problem lists, and past medical histories could interfere with acquiring information synthesis skills critical to clinical reasoning and decision-making. How students' active or observational use of EHRs relates to learning the content of a FM Clerkship is yet to be determined. However, HIT adoption, implementation, and use must not emphasize process over content and render educators blind to how these technologies facilitate or impede clinical education.

FM education must be prepared to accommodate HIT evolution in all clinical venues. The clerkship faculty must provide appropriate mentorship for the effective use of EHRs as a means to achieving both quality and enhanced learning. Teaching sites with EHRs should consider developing student training modules for EHRs. For teaching sites without EHRs, paper processes to achieve quality goals must still be addressed to illustrate provision of care where the full suite of health care information technologies may not be routinely available.

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This commentary was written by members of the ADFM Medical Student Education Committee, with review and comment from the ADFM Executive Committee

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From the Association of Family Medicine Residency Directors

Ann Fam Med 2009;7:471-472. doi:10.1370/afm.1047.

IS THE FAMILY PHYSICIAN IN OR OUT OF HOSPITAL MEDICINE? A DISCUSSION OF PERTINENT PERSPECTIVES TO CONSIDER AS WE ADDRESS INPATIENT CURRICULAR REVIEW

The impact of the hospitalist movement upon family medicine training is in the forefront of conversation throughout family medicine and among other disciplines. The ACGME Review Committee for family medicine has called for program director input for the upcoming revision of the requirements. As we formally approach curricular change, there are important perspectives and questions to consider. How does the philosophy of family medicine impact curricular change? Are credentialing and career implications influencing the family physicians' decision to care for hospitalized patients? Are political, social, and environmental factors presenting new challenges for family physicians caring for hospitalized patients? What training model provides the best outcomes for the patient?

While considering inpatient curricular change, we can reflect on the philosophy of family medicine as a starting point. In theory, we can remember anatomical teaching which emphasized that function follows form. With this in mind, the philosophy of our discipline has determined training and training has dictated practice. Is the philosophy of family medicine changing? Or, is the philosophy the same with a change in the role of the family physician?

Given the development of hospitalist programs in multiple specialties, there are new environmental and political factors that are impacting our discipline. One family physician shares, "I came from a hospital where … family medicine hospitalists were doing …the same things as the internists, at the hospital where he wanted to transfer (his practice), family practitioners… didn't do inpatient work. I was told that… the hospitalist group would be 'more comfortable' with an internist."[1]

Although such inequities occur, Carek, et al, note that the care provided by a (family medicine) teaching service …compared favorably with the care provided by other physicians.[2] And largely, according to the AAFP "81.3% of respondents state that hospital care for their patients is provided by themselves, a part-

ner or group member or voluntarily by a hospitalist arranged by the respondents….[3]

Since credentialing is linked to training and training to the curriculum, should the training requirements differ if a graduate decides to become a hospitalist, practice the full scope of family medicine or selects outpatient only? What is the patient-centered approach to this decision?

At the recent Program Director's Workshop, some program directors suggested intensifying hospital training by adding a fourth year to the current curriculum. Also, hospitalist fellowships have developed. Any additional training evokes the concern of other directors that additional training will require additional training of all family physicians caring for hospitalized patients.

Some educators believe that whether or not a family medicine graduate cares for hospitalized patients, hospital training is the foundation for developing competency to care for patients in and out of the hospital setting.

Considering that a number of family medicine graduates decide not to care for hospitalized patients, how do social, lifestyle, and individual preferences impact the future of the family doctor choosing hospital care? Are we seeing a movement away from family physicians caring for hospitalized patients due to the duty hour impact? Are there political, environmental, and social constraints that deter young physicians from caring for hospitalized patients?

Socially, there is discussion that the resident physician should be trained to treat the community they serve. What training model provides the best service to the community? Considering that many family physicians relocate after their initial post-graduation job, how should physicians train for a variety of unknown future practices?

AFMRD is developing a survey instrument to capture the family medicine program directors' opinions on these critical questions.

To best answer the question "Is the family doctor in or out of hospital medicine?", we should consider our specialty's core attributes and philosophies by learning from past generations of family physicians, anticipating the training needs of our next generation and being attentive to the political and environmental issues now affecting credentialing and the careers of current family physicians. Given our specialty's unparalleled emphasis on patient-centeredness and patient advocacy, focusing on what is best for the patient is perhaps the best strategy to wisely address these difficult scope of practice questions.

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From the North American Primary Care Research Group

Ann Fam Med 2009;7:472-473. doi:10.1370/afm.1048.

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