gaps within the discipline by initially summarizing existing leadership development programs: (http://www.stfm.org/leadership/leadershipuser.html). This group also prepared a leadership survey which identified the greatest areas of need including financial management, grant writing, budgeting, working with the media, publishing, and advocacy skills. STFM was deemed as a key source of leadership training and will focus on "emerging leaders" in STFM groups and committees and leadership opportunities at STFM meetings. Care is being exercised to coordinate with other excellent leadership programs in the discipline.

Summary

With limited funding, the STFM special task force on the future of family medicine has made substantive progress in addressing 4 focused areas of need within the discipline and built a strong foundation for the patient centered medical home of the future. Please use the resources our Society's members have developed to enhance the future of our specialty.

Jeff Susman, MD, Jim Tysinger, PhD on behalf of the STFM Special Task Force on the Future of Family Medicine
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ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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OUT OF THE IVORY TOWER: ENGAGING THE NATIONAL DIALOGUE ON THE PATIENT-CENTERED MEDICAL HOME

Popular myth holds that medical school department chairs sit in ivory (or ivy) towers, far from the din of humanity, health, and illness. Nothing could be further from the reality for the vast majority of family medicine chairs and faculty. Although research, education, and scholarly work hold high esteem, there is clear and ever-growing engagement among chairs of family medicine in important clinical areas including operations, patient care, community service, and transformation of practices to meet the needs of our patients and our discipline.

Annual survey data in 2007 documented that two-thirds (68%) of Chairs of Departments of Family Medicine spend 10%-30% time on clinical care, and in 2008, survey data revealed that same proportion are directly involved in major clinical operations in their own institutions. Chairs are actively training the family physicians of the future. Our 2008 survey data reveal more than two-thirds (78%) of chairs have clerkship students work with them in clinic, and 86% of chairs precept residents in family medicine centers. Since establishing a standing Clinical Committee in 2004, ADFM has increased its clinical focus through advocacy, advancing implementation of electronic health records in departments, and publications concerning clinical innovations in academic health centers[1,2] and advanced access in academic settings.[3,4] Clinical content at the annual ADFM winter meetings has increased substantially since 2005, culminating in 2009 with a full-day theme session concerning the Patient-Centered Medical Home (PCMH) and the Patient-Centered Primary Care Collaborative (PCPCC). Paul Grundy, MD, president of the PCPCC, attended the 3-day conference and actively engaged with ADFM members driving practice transformation.

A critical outcome of the 2009 ADFM winter meeting was the strategic decision to become more directly involved with the PCPCC. Immediately following from the winter meeting, we took advantage of the PCPCC's many teleconference opportunities to learn more and to engage our leadership and members. In May, ADFM was invited to be a member of the PCPCC Advisory Committee which has opened up additional direct avenues for this engagement, such as being invited to participate on their newly formed Legislative committee. Given the growing importance of this movement, we asked Kevin Grumbach and Mary Hall (Vice-Chairs of the ADFM Legislative Affairs Committee) to participate in this committee as our liaisons and they have taken active roles.

The PCPCC continues to expand in its scope of activity, while remaining focused on fomenting the adoption of its agenda (http://www.pcpcc.net). Many of us are increasingly impressed by its energetic partnership of employers, health insurance, healthcare, practitioners, consumer groups and academics. As a member of the Advisory Committee, ADFM participates with the PCPCC Executive Committee in many of the core activities. As ADFM President, Jeffrey Borkan attended the September 1, 2009, Strategic Planning Meeting (about 30 attendees, including an AAFP representative and Al Talia, representing the Robert

Woods Johnson Medical School.) The meeting was impressive:

- The range of PCPCC stakeholders, already large, is growing, and now lists over 500 members. It includes not only the original signatories—including family medicine (AAFP), pediatrics (AAP), internal medicine (ACP), and osteopathy (AOA), but also a growing number of employers, insurers, nurse practitioners, pharmacists, consumer groups, and non-profits
- PCPCC is aggressively lobbying for healthcare reform and they seem to be getting traction with representatives and staff members in both houses of Congress
- The 4 virtual PCPCC "Centers" are each active—with more being considered
- The conceptual principles of PCPCC are dynamic, eg, the recent addition of behavioral mental health issues in the PCMH model

What is significant about ADFM being engaged in the PCPCC? ADFM is the only family medicine organization—besides the AAFP—providing partial balance to the plethora of internal medicine-dominated primary care and think tank organizations. The leadership and members of the PCPCC are ever more impressed by what they are seeing family medicine departments, organizations, and practices across the country accomplishing, and hopes that we will both help lead the local efforts and train those who will work in the medical homes of the future. Several ADFM members have provided or will provide keynote addresses and supporting documents at their summits and meetings—adding a host of new ideas and concepts to the PCMH movement.

How can ADFM meet the challenge to get involved as a positive force for change, and cope with the ever expanding PCPCC organization? The ADFM Executive Committee and leaders of the Clinical Committee (Tom Campbell and Libby Baxley) have discussed the need to form an ADFM PCMH task force to coordinate and direct our efforts. Such a task force will include clinical, legislative, and research representation. Libby Baxley, Maryjean Schenk (President Elect), Mike Magill (Immediate Past president) and others will take active roles in leading the effort. We plan to work closely with the family of family medicine in advancing transformation of our discipline to meet the needs of patients for generations to come.

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This commentary was written by members of the ADFM Executive Committee

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FAMILY MEDICINE: WHAT ARE WE GRADUATING?

As the family of family medicine begins the process of revising the Residency Guidelines for Family Medicine, it may be time to look back over our progress to date in order to steer our efforts in the best direction in the future. What is the difference in our present product versus our ideals as our "founding fathers" delineated them in our "constitution" of 1968?

The original guidelines from family medicine covered a mere 3 pages laying out the length of training, and general content, as well as proposed categories of programs that reflected and embraced the wide variation of locations where family medicine physicians lived and worked.[1] Our founding document also defined the family medicine physician in 4 domains. First, the family medicine physician was to serve as the physician of first contact with the patient who provided an entry for the patient into the health care system. Second, the family physician was tasked to evaluate the patient's total health care needs and to provide personal medical care and referral management. Third, our graduates were to provide continuous and comprehensive care as well as the coordination of care. Lastly, the vision asserted that family medicine physicians were to provide care for the patient within the context of the patient's family and social milieu.

Current guidelines include these attributes; future decisions in new guidelines will need to address the appropriateness of these parameters in the 21st century. Our current question is whether or not we and