What does this mean to our stakeholders?

We are going to have a sharper focus on activities and initiatives that you have helped identify as high priority to you and the discipline. For example, based on feedback from you, we plan to create a national residency curriculum, likely in partnership with others.

This also means that the bar has been raised for our existing programs. Their continuation will depend on the extent to which they continue to have a significantly positive impact on our members and whether they contribute in a meaningful way to advancing family medicine. Without this critical examination, we run the risk of creating an even larger inventory of programs and not having the resources to give the highest impact programs their proper attention. By trying to do everything, we will do few of the important things well and will become a mediocre and irrelevant organization.

STFM Strategic Priorities (Not Listed in Rank Order)

Professional and Leadership Development. STFM will be the leader in training, leadership development, and creation of information that improves family medicine education and teaching.

Scholarship and Innovation. STFM will be the authority for innovation and research in family medicine education.

Workforce Development. STFM will promote family medicine workforce development through innovation, curriculum development, and practice redesign in teaching sites.

Professional Relationships. Relationships developed through STFM will enhance the professional well-being, vitality, and growth of members and the discipline.

Policy Advocacy. STFM will develop and utilize its members' expertise to positively influence legislation and regulations that have an impact on family medicine education and workforce development.

The strategies related to this plan can be found on the STFM Web site. The staff and Board are adding timelines and responsibilities and already acting on several of the strategies in the plan.

Creating a high-performance organization is much more than developing a strategic plan. There are other critical elements integral to our success that require specific attention, such as a focus on innovation and being relevant to members and an ability to adapt to and manage change. The main takeaway should be that STFM leadership is paying attention to all these factors. We're a work in progress but a Society that's headed in the right direction.

Stacy Brungardt, CAE, STFM Executive Director

ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP

From the Association of Departments of Family Medicine

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LEADERSHIP IN AN AGE OF UNCERTAINTY AND AUSTERITY

Not in recent history have times for academic family medicine been so uncertain. As recently reported in the *New England Journal of Medicine*,[1] we are witnessing health care policy during an age of acute uncertainty, but long-term austerity.

We are facing a myriad of challenges that are posing a test for everyone in the discipline—whether chairs, residency directors, faculty, or trainees. Indeed, it is very difficult to determine which direction the wind is blowing and how to prepare for the next few years, let alone the next few decades. Below are enumerated but a few of the more common and extreme scenarios we are anticipating:

- The fate of health care reform is unclear. The Accountable Care Act is under threat in the courts and in the political process. If it goes forward, there will be fundamental changes to Medicaid and Medicare that will influence patients, patients' choice, and the institutions where they seek care
- Clinical revenues may be severely curtailed. The rate of medical inflation is unsustainable and significant cuts may be on the near horizon, starting with Medicare's sustainable growth rate (SGR)
- How medical services are paid for is already undergoing profound alterations and more changes are virtually certain to be implemented. Some insurers, such as in Massachusetts, are considering paying less to high-spending hospitals, while bundled payments are being strongly considered
- Graduate medical education funding is threatened and may be on the Congressional chopping block in the near future
- NIH funding lines are extraordinarily low with no signs of improvement in the near future—or other sources to compensate for the drop
- All institutions that support family medicine are under threat and many are in economic straits—whether hospitals, medical centers, or medical schools

What is clear is that budgets for departments and residencies in family medicine are likely to come under growing pressure in the next few years—and many have already, as we face the potential "perfect storm" of

simultaneously reduced clinical, research, and educational funds for our academic units and for the organizations that host them.

The urge may be to hunker down and conservatively manage our scarce resources and our portfolio of programs—and take fewer risks. Paradoxically, this is clearly a time when we need to expand the primary care workforce, and when there appear to be bountiful opportunities for innovation, program expansion, and entrepreneurship. In addition, 10 years into the patient-centered medical home (PCMH) and residency reform efforts, we seem to be generally on the right course regarding practice transformation and student interest.

How are we to reconcile these opposing forces and plot the way forward? Although there is no single formula, some suggestions come to mind, including those learned from our colleagues in other professions and other countries:

- Reaffirm one's core values and goals; improving the health of the public is what academic medicine must be about
- Act boldly, while watching finances, making sure "no money is left on the table" (careful billing, pursuing management in addition to fee for service fees, etc) and building reserves when possible
- Examine other means of reaching our goals—especially if they are more fiscally sound
- Speak with one voice and with a focused and repeated message to any and all who will hear us
- Develop advocacy skills and use that power to educate legislators on what is at stake for the public. All of us in family medicine, whether we are faculty, residents, students, chairs, residency directors, or physicians in practice, need to understand how we can impact the process through advocacy. If each of us takes a student or resident along in an advocacy activity, we double the number of family medicine advocates
- Invest in faculty development long term
- Look for new opportunities and keep your fingers on the pulse of your hospital, medical center, and medical school
- Canada—when faced with budget cuts and a decline in student interest in family medicine, they invested in family medicine education

As we plan programming for the fall 2011 meeting of the Association of Departments of Family Medicine and our 2012 winter meeting to follow, we will be working with our colleagues to help us all understand the vagaries of navigating through these times while staying above water and even seizing the unanticipated opportunities out there! As each of you look to the future, we encourage you to consider how to navigate the turbulent waters ahead, while moving the discipline and the health of the American public forward.

Jeffrey Borkan, MD, Phd; Ardis Davis, MSW; Thomas Campbell, MD; and Richard Wender, MD. This commentary was written by the ADFM Executive Committee

Reference

1. Oberlander J. Health care policy in an age of austerity. *N Engl J Med.* 2011;Aug 31 [epub ahead of print].

From the Association of Family Medicine Residency Directors

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IMPLICATIONS OF THE 2011 ACGME DUTY HOUR RULES

In May 2010, Dr Thomas Nasca, Accreditation Council for Graduate Medical Education (ACGME) CEO, outlined the process of revising the 2003 duty hour requirements. He stated the overriding principles of patient safety and excellent patient care in teaching settings, delivering outstanding education today to achieve these goals in the future, and educating residents in a "humanistic educational environment that protects their safety, and nurtures professionalism and the effacement of self-interest that is the core of the practice of medicine and the profession in the United States." He continued,

> It should be emphasized that all 3 of these principles are equal, and must be fulfilled. They are not mutually exclusive goods; they are absolute 'goods' and must be achieved. Furthermore, those principles and their articulation in standards go far beyond the issues of resident duty hours.[1]

Program directors certainly agree with these principles. A majority of family medicine program directors in a 2009 study, however, disagreed that Institute of Medicine (IOM) duty hour recommendations (which significantly contributed to the ACGME final requirements) would help to achieve these absolute "goods."[2] Over 70% believed patient access to care would decrease; over 90% thought the rules would exacerbate a "shift-worker mentality" in residents; over 80% believed they would result in "graduating doctors who are not experienced enough to practice independently;" and over 90% thought they would result in "graduating doctors who generally take less ownership and do not know patients as thoroughly as in the past." Over 80% did not believe the duty hour changes would result in residents "becom-