

NAPCRG newsletter

September 2005

Volume 33, Issue 3

NAPCRG's Open Shop: Board Moves to Ensure Transparency, Representation, Access

Maurice Wood, the founder of NAPCRG and its first president and executive director, left a wonderful legacy for the organization. In NAPCRG'S first few years of existence (1972–1980), the annual meeting would normally be attended by 120 or fewer participants. This small group rapidly understood the nurturing character of the group and often became good friends. Maurice's style of leadership promoted an atmosphere of supporting and sharing. There was an anti-bureaucratic attitude among early members that endorsed the 5-minute Annual Business Meeting, a feature of NAPCRG that has become sacrosanct.

NAPCRG meetings were organized and run each year by local volunteers in the location chosen for the meeting. With Maurice's retirement, professional association managers from the Society of Teachers of Family Medicine were contracted to run and manage the organization. Beginning in the late 1990s, the expectations of the organization grew from running an annual meeting to becoming the voice for research in the family of family medicine. The 90s have seen dramatic growth in meeting attendance from 250 people attending meetings early in the decade to 624 in 2003 in Banff. Discussion at a recent NAPCRG Board of Directors retreat led to a projected 1,500 members, and 1,200–1,300 attendees at each meeting, within 5–7 years.

Inclusive Leadership

Everyone wants NAPCRG to retain its beloved characteristics. We

have heard that the brief business meeting and lack of understanding about NAPCRG'S history may give first-time members a perception of a "closed shop" run by a small clique. This feedback is disturbing, since it runs counter to the intent of NAPCRG. In planning for the future, how can we make the organization's policies and practices more transparent and continue to create an environment that is perceived to be inclusive and nurturing for all members? The Board discussion led to some actions, starting with a confirmation that all NAPCRG constituencies should be represented in the leadership. Representation of students, residents, fellows, and community clinicians, as well as academic researchers from the United States, Canada, and internationally, is essential. Board members will canvas members of their constituency once a year or whenever an issue important to the constituency is raised.

Reviving Interest Groups

NAPCRG plans to do a better job at introducing new members to the concept of NAPCRG interest groups. Interest groups can be formed by any member who makes a request to the NAPCRG office with an area appropriate for NAPCRG and a volunteer willing to chair the group. The future of the interest group is entirely dependant on the participant's passion for the topic and the leadership that emerges. The beauty of interest groups is their grassroots origin and the bottoms-up strategy that may lead to exciting projects that affect a large number of members and enhance the discipline.

New Membership Committee

NAPCRG has also created a new Membership Committee chair position on the Board of Directors and a new standing committee on membership. This group will be diverse in nature and will keep its finger on the pulse of issues of greatest importance to the membership. To help assist the committee in its thinking, President-elect **Perry Dickinson, MD**, led a subcommittee of the Board to create general questions for a member needs survey. Newly appointed Membership Committee Chair **David Katerndahl, MD**, and **Sandra Burge, PhD**, took the lead on writing questions on specific content areas related to research technology, methods, and design. Other subcommittee members included **Erik Lindbloom, MD**; **Melissa Beagle, MD**; **Frederick Chen, MD, MPH**; **Arch Mainous, PhD**, **Sue Tatemichi, MD**, and **Stacy**

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Research Involving Latino Populations

The US Latino population is now the largest minority group in this country and continues to rapidly increase in size. The 2000 census reported more than 31 million Latinos, and this number is expected to grow to more than 96 million in the next 50 years.¹ This reality, along with the health disparities faced by Latinos,² highlights the need to promote research involving this population. As stated by the Office on Minority Health, "Hispanics/Latinos are disproportionately underrepresented in research activities. Without adequate and targeted research, Hispanics/Latinos are disadvantaged

in policy making, resource allocation, program planning, and program implementation activities."³ However, there are a number of challenges that must be addressed when planning research involving Latinos. This article will address a few of these challenges.

First, there is much variability within the Latino population based on country of origin and acculturation status. Two out of five Latinos are foreign born, and many of those born in the United States adhere to customs from their country of origin. It is simplistic to overlook the variability existing between Latinos from different countries, since

this can affect health behaviors.⁴ Thus, we need to routinely assess Latinos' countries of origin and understand the significance of the answer. Acculturation, the process of assimilating to the majority culture, must also be considered, since it has also been shown to influence health-related behaviors.⁵⁻⁷ Acculturation is affected by many individual factors, such as a person's age upon arrival to the United States, level of education, number of years in the United States, and other support systems. The environment into which one is assimilating can also impact acculturation. In the past, Latinos were likely to settle in metropolitan areas with already large Latino populations, such as

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NAPCRG Members Receive *Family Practice* Discount

NAPCRG is pleased to announce a new partnership with Oxford Journals. Effective for 2006 subscriptions, NAPCRG members will be eligible for a reduced subscription rate to *Family Practice*. In 2006, this will be \$122 US, a discount of more than 70% from the standard personal subscription rate.

About the Journal

Family Practice is an international journal aimed at clinicians, teachers, and researchers in family medicine, general practice, and primary care in both developed and developing countries.

The journal offers its readership an international view of the problems and preoccupations in the field, while providing a medium of instruction and exploration. The journal's range and content covers such areas as health care delivery, epidemiology,

public health, medical education, and medical sociology. It aims to be interdisciplinary, and contributions from other disciplines of medicine and social science are always welcomed.

On-line Features and Functionality

Family Practice uses the latest technology to speed up the publication process and add greater functionality to published papers. *E-letters* is the newest feature to be introduced. This feature allows you to respond to articles and give your comments on-line. *E-letters* both stimulate academic debate and enhance the content.

The journal also offers an Advance Access (rapid on-line publication) system where manuscripts are copyedited, typeset, and posted on-line weeks in advance of their appearance in the printed

issue. This means that increased speed of publication is achieved without any loss of quality.

Family Practice operates a full on-line submission and peer-review system. This simple and secure service speeds up the peer-review process and provides worldwide on-line access to information on your paper's status 24 hours a day, 7 days a week.

For more details on *Family Practice*, including a free, on-line sample copy and instructions to authors, visit www.fampra.oxfordjournals.org.

To order your subscription at the reduced rate, contact: Customer Services, Oxford Journals, 2001 Evans Road, Cary, NC 27513, United States. 919-677-0977, ext. 6686 or 800-852-7323 (toll-free in USA/Canada). Fax: 919-677-1714. jnlorders@oupjournals.org.

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Research Involving Latino Populations

New York and Miami. This strategy allowed for Latinos to live in areas that were already accommodating to their culture and language. More recently, Latinos have dispersed out of these highly concentrated locales to smaller cities or more rural areas without a previous large influx of Latinos. Latinos in these areas may face difficulties in overcoming language and cultural barriers that are no longer faced by those in more urbanized areas. Due to these differences, although it may be easier to recruit within Latino populations in established, large metropolitan areas, research from other communities is also needed. Consequently, care must be taken during sample selection to make a project's results meaningful to different Latino communities.

Recruiting Latinos for research projects also involves unique issues. Standard recruitment practices, such as recruiting from clinics or through mainstream media, may not be effective since this may not reach the desired population. It is vital to understand the influence on recruitment of language barriers, immigration status, and distrust toward the mainstream culture. Misperceptions, poor education, and distrust regarding research must also be addressed. Minority communities may not want to participate in research because of past experience in which they have been used, rather than engaged as full partners. Involving knowledgeable community members early in the research process may help overcome this barrier. The principles for community-based research articulated by NAPCRG⁸ are particularly relevant for research with and for Latino communities.

A final key ingredient is having qualified bilingual/bicultural researchers on the team. NAPCRG and academic health science centers should focus on how such

investigators can be developed and retained. Some examples of developing centers of excellence for Latino health research include the University of Texas Health Science Center, which includes sites in San Antonio and Houston, and the University of California, which includes sites in San Diego and Los Angeles. It is noteworthy that NAPCRG is planning its 2008 meeting for Puerto Rico, in a specific effort to make the meeting more accessible to Spanish-speaking countries in the Western Hemisphere. Look for a growing visibility of research for and with Latinos at NAPCRG meetings.

—*Vanessa Diaz, MD, MS*
Medical University of
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NAPCRG Communications
Committee Member

Patricia Tellez-Giron, MD
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Chair, Latino Health Council

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Board Meeting Highlights

The following actions resulted from the April 30, 2005, NAPCRG Board of Directors Meeting held in New Orleans.

- Approved the 2005–2006 budget, with \$350,270 projected in income and \$342,497 projected in estimated expenses. The proposed 2005 Annual Meeting budget was also accepted.

- Approved the movement of \$112,000 from NAPCRG's interest-bearing checking account to its long-term investment accounts. NAPCRG has approximately \$400,000 in its investment accounts.

- Approved the Nominations Committee Recommendation to appoint **Dan Merenstein, MD**, Academic Family Medicine Organizations Legislative Subcommittee liaison for a 3-year term.

- Created a subcommittee to develop questions for a member needs survey. Approved expenditure of \$1,300 for administrative support to conduct survey.

- Approved the expenditure of one prize of \$100, to be used in a drawing as an incentive for residents and students to complete a survey at the National Conference for Family Medicine Residents and Medical Students.

- Adopted a policy that NAPCRG will not allow advertising on its listserve.

- Requested that the Membership Committee discuss recommendations from attendees at a 2005 NIH funding meeting in Madison, Wis and report back to the Board with its recommendations.

- Charged the Executive Committee with creating a process for determining who qualifies for waived registrations at the NAPCRG annual meeting.

UK Lessons for US Primary Care

Primary care is now acknowledged to be a foundation of effective, sustainable health care for populations, with favorable effects on access to care, comprehensiveness, continuity, efficiency, and equity.¹ In addition, variation in health care arrangements and policies across nations presents opportunities to compare and learn across national boundaries about what is working and how well in primary care.

The relatively poor performance of the US health care system has provoked a willingness to change that in a well-performing system would probably not exist.² Primary care physician offices in the United States are being redesigned somewhat haphazardly with numerous opportunities to improve and some opportunities to diminish the desired effects of primary care. The United Kingdom's primary care system, despite being acknowledged as already strong, is also in the midst of dramatic changes orchestrated through the National Health Service.³ This combination in the United States and the United Kingdom is potent and presents immediate opportunities for decision makers in both countries to guide the "re-make" of primary care with more real-world experience than is available in either nation alone.

In early June 2005 there was a face-to-face exchange visit between representatives of the Washington, DC-based Robert Graham Center and the National Primary Care Research and Development Centre in Manchester, United Kingdom, to take advantage of this opportunity.

This visit was not requested by any organization but rather grew out of the work of both of these centers. Six examples of "30,000-foot level" conclusions reached on the basis of the specifics learned during the visit are:⁴

1. In both the United Kingdom and the United States, policy makers have begun to realize the great potential in primary care. However, the systems of care delivery and business plans for primary care are not adequate. Even though it need not be, some revisions now underway may be converting the physician's role as a trusted personal physician doing hugely meaningful work, to a job-holder with a rulebook. The net impact of such changes may not be positive for physicians, patients, or health care systems.

2. Experiments in primary care delivery abound in both countries, and decisions are being made quickly, with only preliminary or no evaluation. Imbedding evaluations in new approaches/programs and responding to findings in nearly real-time is possible in both countries. Sharing findings from real-time evaluations can also occur quickly, to mutual advantage.

3. No one knows how to structure practice and primary care physician compensation to incentivize and cover the full costs of robust primary care, but it is clear that further investments in primary care are necessary to garner its powerful, salutary effects for entire populations. The United Kingdom is making deliberate investments into its primary care infrastructure,

while the United States seems to be bleeding revenue out of primary care while increasing its overhead. With an amazingly thin evidence base, both countries are pushing rapidly toward paying for performance improvements in practice, and this approach is having an effect on primary care practice—sometimes for the better. If some portion of primary care payment is based on performance measures, it will be necessary in the United States, as already done in the United Kingdom, to establish a denominator (eg, a register of patients for which the practice can be held accountable) for practices to use in assessing their performance.

4. Teamwork is no longer elective in primary care, but a huge gap still exists between the teamwork that is feasible through asynchronous, information technology-enabled care and what is currently happening. Many case studies are in play in both countries, under differing conditions. Training and educational strategies for teamwork among health professionals are lagging badly in both countries, and this is likely to emerge soon as a rate-limiting step in providing high-performance primary care.

5. Both countries are over-consuming international medical graduates from developing countries, probably to their own advantage but likely to the detriment of the donor nations.

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mission & goals

Formed in 1972, the North American Primary Care Research Group is a multidisciplinary organization for primary care researchers in the United States, Canada, Mexico, the Caribbean, and throughout the world, with a mission to develop, disseminate, and promote new knowledge regarding primary care.

NAPCRG's goals are to:

- Serve as an incubator for new ideas
- Increase the capacity for conducting quality research
- Provide appropriate forums for presentation of original primary care research
- Enhance communication among primary care researchers
- Integrate primary care research, patient care, and education

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UK Lessons for US Primary Care...

6. Measuring physician practice, difficult as it is, is progressing in both countries. Both qualitative and quantitative methods are required to understand practices, and routine data from practices is essential. Standards for information systems are being established more slowly in the United States. To be sufficient, primary care information systems must be able to aggregate data necessary to measure performance and incorporate ordering principles (classification) and terminology capable of creating and analyzing episodes of care as they occur in primary care.

It would be advantageous for key US organizations devoted to optimizing primary care to sustain for the foreseeable future exchanges with other countries to enable the United States to see itself more clearly, import innovations of relevance, and elude avoidable mistakes. While there is much to learn in many countries, UK-US exchanges present immediate opportunities with particularly great relevance. It is not as if there is little to learn from one another. Rather it is how much can be learned that can find prompt application in the redesign of primary care that is underway.

—*Martey Dodoo, PhD*
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National Primary Care Research and Development Centre, Manchester, United Kingdom

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Wonca Offers Daily Journal Alerts Via Their Web Site

The Web site of the World Organization of Family Doctors (Wonca), www.globalfamilydoctor.org, is offering practical help to family doctors in the form of its Journal Alerts, which are sent every weekday by e-mail.

Wonca staff scan more than 60 family medicine, general, and specialty journals and news services and prepare synopses of the latest information on clinical research and reviews, disease outbreaks, and medical news, which are posted on their Web site every weekday. Journal Alerts will keep you advised of what has been posted that day.

To enroll for Journal Alerts, go to www.globalfamilydoctor.com/enrollment.htm, enter your email address, and click 'Submit'.

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Canadian Program May Help Achieve FFM Research Goals in US Residencies

One of the goals of the US-based Future of Family Medicine Project is to increase research activity in all family medicine residency programs. The Five Weekend Research Capacity Building Project, developed and tested in Ontario, might be adapted to help meet this goal.

The project is designed for community-based clinicians to learn how to ask and answer a research question arising from their clinical practice. Five concentrated training sessions occur on weekends, reducing practice time required, separated by 2-month "back-home" blocks during which participants implement learnings. The weekend sessions follow a consistent pattern of individual introductions/interests/updates on Friday evening, then intensive theory and application training on Saturday, followed by individual work plan development (for the 2 months back home) on Sunday. Group size is limited to 10 to ensure adequate attention to every member.

Nine participants from the Ontario College of Family Physicians (OCFP) participated in the pilot program, bringing a wide variety of interests and questions. The five sessions and intervening back-home blocks ran as follows:

Weekend 1: Personal questions from practice; question refinement; searching the relevant literature

Block 1: Literature review; question refinement

Weekend 2: Literature review, continued; quantitative research methods; finalizing literature review

Block 2: Developing a systematic review of the literature on the question

Weekend 3: Critique of literature reviews; qualitative and mixed methods research; devising a research plan

Block 3: Refining the research plan

Weekend 4: Presenting research plans for critique; composing a concept paper; how to finalize research plan

Block 4: Writing concept paper

Weekend 5: Presentation and critique of concept paper by the group

All participants reported that the group learning process and the joint ownership of all the projects was of great benefit, and a second program was mounted at Queens University. As requested by the first group, a detailed manual on CD-ROM was provided. Subsequently, OCFP has received a \$960,000 CDN grant to run 14 programs in seven centers across Ontario. Each program has a clinician researcher and a non-clinician researcher as co-facilitators who themselves have undergone faculty development.

Adaptation to a residency program would place the program during the second or third year of training. Since the sessions are divided into 4–5 hour segments, each could be delivered in once-weekly half days. Residents would be allowed protected time to do program work between seminars, and the blocks might still run about 2 months. If a concept paper or research proposal is not required, then the entire program could be shortened to three seminars and two intervening blocks of time, but group size should be maintained at 8–10 for optimum interaction among peers.

Residents will become experts in their own question, will participate in learning about applied research methods, and will gain critical appraisal and literature searching skills. Facilitators promote a fun, relaxed atmosphere and invite people with special expertise to sessions as needed. Programs such as this can lead to many more resident presentations at NAPCRG.

Detailed evaluations and more information about current programs are available on the Web site at www.med.queensu.ca/fmed/. Click on 5 weekend course for information.

—Walter Rosser, MD
Queen's University

CFPC Section of Researchers
Representative to the NAPCRG Board

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NAPCRG's Open Shop...

Brungardt, CAE. Our expectation is that the results of the survey will help us gain a better understanding of the needs of our members and what programming and skills they want to address these needs.

Annual Meeting Changes

To overcome the "closed shop" perception, the Board plans to conduct a Q&A session at the 2005 Annual Meeting where Board members will share information about leadership selection and conference programming selection processes. They'll also respond to questions, comments, criticisms, and suggestions. This action will allow retention of the 5-minute business meeting, yet maintain accountability of the Board to the members. Continuing to promote

mentoring programs, increased SIG activities, participation by more students and residents, and enhanced communication about organizational processes, should help members feel informed and engaged as our organization increases in number.

We continue to be grateful to Maurice Wood and his early management philosophy and hope that these steps and others that you suggest will help NAPCRG retain its status as the most beloved research organization anywhere.

—Walter Rosser, MD
Queen's University

CFPC Section of Researchers
representative to the NAPCRG Board

Frederick Chen, MD, MPH
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Stacy Brungardt, CAE
NAPCRG Executive Director

Findings From Student and Resident Education II Papers Presented at NAPCRG 2004

The 2004 NAPCRG Annual Meeting provided a valuable forum for the presentation and discussion of medical education research. The session explored diverse aspects of student and resident education.

Federal, state, and local policy does affect student and resident education. **Mary Merchant, PhD**, University of Iowa, presented the negative impact of the Health Care Financing Administration regulations and integration with non-family medicine clerkships on medical student clinical skills in “Skills Acquisition During a Family Medicine Preceptorship: Documentation of a Negative Effect of HCFA Regulations, Curriculum Change, and Use of Residency Sites.” Almost half of state chapters of the American Academy of Family Physicians report decreased funding for family medicine residencies, which will result in residency closures as presented by **April Everett, MD**, Georgetown University, during “State Funding for Family Medicine Residencies.”

Four papers explored knowledge, skills, and attitudes in residency education. **Margaret Love, PhD**, University of Kentucky, discussed similarities and differences among family medicine residency and community family physician practices in Kentucky, with implications for pediatrics education, in “Practice Content in Residency Practice Compared to Community Practice: A Study by the Kentucky Ambulatory Network.” **Justine Wu, MD**, University of Rochester, described the level of interest in and support for abortion training by family medicine residents and faculty during her paper “Abortion Training in Family Medicine: A Survey of New Jersey Family Medicine Residency Programs. Procedural Skills Training in a Family Medicine Residency—A Curriculum Evaluation” presented by **John Edwards, MD**, Madigan Army Medical Center, detailed the impact of procedure rotations, residency

training and practice environment on outpatient procedures. **Marcia Taylor, MD**, Medical University of South Carolina, presented “The Relationship Between the National Board of Medical Examiners Prototype of Step 2 Clinical Skills

Exam and Residency Performance” revealing that GPA and interpersonal score were the best predictors of quartile ranking and average score in residency.

—*Inis Jane Bardella, MD*
Indiana University

NAPCRG 2005 Annual Meeting News

NAPCRG’s 2005 Annual Meeting, October 15–18, in Quebec City, is just a few short weeks away. By now, you should have received your preliminary brochure in the mail. The brochure is also posted on the NAPCRG Web site at www.napcrg.org.

Reasons to Attend

Experience NAPCRG’s Annual Showcase—Our annual meeting provides the best opportunity for camaraderie with colleagues from around the world with an interest in primary care research through sessions, informal gatherings, and social events.

Discuss Great Research Presentations—The annual meeting will offer more than 300 sessions in a variety of presentation formats to help you gain new ideas and vital information to use in your research.

Experience Highlighted Poster Session time—Due to the popularity of our posters, we offer our two poster sessions in a 1 hour and 1:15 minute block of time with no competing sessions. Attendees can maximize their time viewing the research and talking to poster presenters. Posters are also open for viewing, without being staffed, during other conference times.

Develop International Research Collaborations—The Society for Academic Primary Care (SAPC) is the organization in the United Kingdom most comparable to NAPCRG. There are several efforts to build collaborations between SAPC and NAPCRG, including a mutual exchange of one of the

best paper presentations at the organization’s annual meetings, which began in November 2004. We also have a terrific relationship with the College of Family Physicians of Canada Sections of Researchers, and we plan to host the CFPC Section of Researchers Executive Committee at our 2005 meeting. Other groups that will meet during our conference include the International Federation of Primary Care Research Networks, the Federation of Practice Based Research Networks, and the editorial boards of two research journals, the *Annals of Family Practice* and *Family Practice*. This truly is the gathering place for primary care researchers from around the world.

Participate in Networking—The conference schedule provides ample quality time to make connections and contacts with your peers through special interest breakfasts, dine-out opportunities, the conference mentoring program, and evening functions.

Attend Special Sessions on FFM—NAPCRG will hold two Future of Family Medicine sessions and one special NAPCRG Board session at its 2005 meeting: (1) General session on October 16 to share information on FFM and strategies being implemented to accomplish the 10 recommendations. (2) Half-day preconference workshop on October 15 that will bring together leaders in quality assessment and improvement with primary care researchers to explore the link between QI and research. (3) Special session led by members

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NAPCRG 2005 Annual Meeting News . . .

of the Board of Directors to share information on leadership development opportunities and respond to questions about the organization.

Attend a Great Party—NAPCRG will host a fabulous party on October 17 at the Le Capitole de Québec. The evening event will take advantage of a talented trio and fantastic theatre in

Quebec City. We'll have food, fun, and plenty of time for talking to your NAPCRG colleagues. This will be an evening to remember.

Go to www.napcr.org to register or contact Kelly Becker (kbecker@stfm.org) for more information.

Funding Opportunities in Training and Research and Career Development

The American Cancer Society's (ACS) grants program includes a focus on beginning investigators, a special initiative for research targeted to the poor and underserved, and an enhanced commitment to clinical and applied research. In response to identified needs in cancer control, ACS also sponsors grants in support of training for health professionals seeking to develop their clinical expertise and/or their ability to conduct independent research.

The ACS is pleased to invite applications for the October 15, 2005 deadline for following grants:

- Cancer Control Career Development Awards for Primary Care Physicians
- Mentored Research Scholar Grants in Applied and Clinical Research
- Research Scholar Grants in Cancer Control: Psychosocial and Behavioral Research
- Research Scholar Grants in Cancer Control: Health Services and Health Policy Research
- Research Scholar Grants in Basic, Preclinical, Clinical, and Epidemiology Research
- Postdoctoral Fellowships

For a full description of all ACS grants, including eligibility, applications, instructions, and policies, consult the ACS Web site www.cancer.org/research. For additional questions, contact ACS at 404-329-7558 or grants@cancer.org.

Conference calendar

NAPCRG Annual Meetings:

33rd NAPCRG Annual Meeting
October 15–18, 2005
(Saturday-Tuesday pattern)
Hilton Quebec
Quebec City

34th NAPCRG Annual Meeting
October 15–18, 2006
(Sunday-Wednesday pattern)
Hilton El Conquistador
Tucson, Ariz

35th NAPCRG Annual Meeting
October 20–23, 2007
(Saturday-Tuesday pattern)
Sheraton Vancouver Wall Centre
Vancouver, British Columbia

Other Conferences of Note:

**College of Family Physicians
of Canada**
2005 Family Medicine Forum
December 8–11
Vancouver, British Columbia
www.cfpc.ca

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