

NAPCRG newsletter

February 2002

Volume 30, Issue 1

Community Connections

NAPCRG is a community of people devoted to generating new knowledge that advances the ability of primary care clinicians to improve the health of individuals, families, and communities. We approach this task grounded in our local sense of place and community. This local sense is anchored in our connections, with family, friends, antagonists, neighbors, and colleagues. Some of these people may be patients, students, teachers, or mentors. Local bonds give us perspective and storied roots as we develop more distant relationships. The connections between the local and the distant, the personal and the collective, the supportive and the challenging are often unapparent, but always transpiring.

NAPCRG benefits greatly from the local grounding of its members. When we come together at our meeting, in our newsletter, in our research collaborations, and in our political actions, the diversity of our experience provides richness to the commonality of our purpose. NAPCRG members coming together have helped us see the importance of involving the communities we serve in the research we do. Our joining together has fostered multimethod research approaches that blend the strength of members' quantitative and qualitative expertise. Connections among NAPCRG members have led to initiatives to foster international collaboration, resident research, faculty development, participatory community clinician research, cure, care, or prevention of specific illnesses, health systems and services research, and new theoretical perspectives. NAPCRG's Community-oriented Primary Care special interest group is specifically devoted to

developing links between primary care and community needs and resources.

The events of September 11 remind us to consider the connections that are not always apparent, as well as attending to those that are obviously

president's message

within our circle of influence. The early pursuit of connections that stretch us in ways that are sometimes uncomfortable may keep us from later needing to develop hostile connections to defend ourselves. The need for heroic action may be forestalled by quietly building shared knowledge through seeking to understand disparate viewpoints.

As primary care researchers, we bring together many disciplines and traditions. As NAPCRG offers us a source of strength, ideas, and connections to help with our local tasks, let's also develop connections that challenge us. The theme of next year's meeting is "Building Research Capacity," with a subtheme of research relating to health and health care disparities—geographical, racial, economic, and international. Let's invite those who challenge us locally to participate in our explorations together. Let's develop links with those who might seem like adversaries, and work to understand the differences. Let's make the sometimes uncomfortably challenging connections with diverse communities, other generalists, specialists, and categorical thinkers, and bring these connections to our work together. Let's diminish the gap between those who generate knowledge about primary care practice

and those who use that knowledge. Let's invite to next year's meeting those who challenge us, support us, learn from us, and teach us. Let's develop connections with the generation before and the generations to come. Let's involve, with an open mind, those who may appear to be adversaries. Their different approach to common problems that we are collectively committed to solving may be the difference that matters.

—Kurt C. Stange, MD, PhD
Case Western Reserve University

inside this issue

Diverse Research
Methodologies Required.... Page 2

The Myth of Fellowship Page 3

Results of 2001 NFPWS Page 4

Call For Pfizer Award
Nominations..... Page 4

2001-2002 Wood
Award Donors Page 5

Themes From 2001
Annual Meeting Page 6



Diverse Research Methodologies Required to Meet New Health Care Challenges

When you think you are successful, it is sometimes because you think you are very good. When you think you are very good, you are sometimes reluctant to change.

The statement above came from **Robert Graham, MD**, director of the Agency for Healthcare Research and Quality's Center for Practice and Technology Assessment, who addressed the need for family practice and family medicine researchers to explore and validate new methodologies rather than to rely on the randomized controlled trial to "know." Dr Graham addressed members of the 29th Annual Meeting of the North American Primary Care Research Group on October 17, 2001, in Halifax, Nova Scotia.

Dr Graham predicted that the methodologies perfected by medical research during the past century may be insufficient to confront the health care challenges that we will face during the next 20 years—and that complacency is likely to discourage traditional medical researchers in academic medical centers from properly surmounting these challenges.

"Our academic medical enterprise in the United States has enjoyed so much success over the last 50 years that it may not be properly anticipating the challenges it will encounter in the next 20 years." Dr Graham suggested medical research could benefit from employing the research principles practiced by business and the military. Even more significantly, he used chaos theory to draw a parallel between diversity in nature and diversity in family practice patient practices.

"Diversity is not just a social imperative, it is a biological imperative. For a strong viable organization or team, make sure there is a diversity of experience and perspective. That organism interacts with a very complex environment. If you have a homogeneous entity, increasingly the chances are that it can be overwhelmed by the complexity of the environment to which it must respond—it doesn't have enough tools," said Dr Graham.

While careful not to discount the randomized controlled trial (RCT) as a

critical methodology for deriving evidence in support of an intervention, the director of the Center for Practice and Technology Assessment, the entity responsible for the US Preventive Services Task Force, illustrated the manner in which the traditional RCT may not be the correct methodology for all cases. He suggested that the possibility that "a very public recall" by the Food and Drug Administration in the United States of a cardiovascular drug because of documented interactions with an antifungal, discerned only after the drug was marketed and used in the population, would have been "counterintuitive 10 years ago."

"The speed of approval for drugs by the FDA has increased significantly over the last 5 years with an accompanying small spike in public recalls of drugs because of unintended, unexpected adverse reactions, suggesting that the basic science for review and approval for safety and efficacy, which is very classical, is meeting a population that is far more complex. Interactions may be too unpredictable based on the population at large," said Dr Graham. "The development of medical science is approaching the point where the old hypotheses don't work anymore. There is only so much power for the complex questions and variables that we pour into an RCT."

Dr Graham called for departments of family medicine located in academic medical centers to contribute to a better understanding of how different research models can be integrated into the armament available to us for knowing the truth. He made frequent reference to the aspiration of researchers for ascertaining the truth with the simple concept of "knowing."

"The challenge to family practice is to become an active and effective agent within our dominant medical research community for examining an array of additional tools that may be necessary and appropriate for understanding the environmental cause and effect of disease among our populations," said Dr Graham.

"How can an underfunded entity be a change agent," the former



Robert Graham, MD (pictured right, with glasses), director of the Agency for Healthcare Research and Quality's Center for Practice and Technology Assessment, speaks with Chien-Wen Tseng, MD, University of California, Los Angeles after his plenary address.

executive vice president of the American Academy of Family Physicians asked the audience, suggesting that it may be unlikely to expect change to come from an entity such as family practice. Answering his own rhetorical question, Dr Graham asserted that revolution typically comes from the underdog, not from the long successful.

"It is unusual for change to come from the top," he said. Drawing from **Thomas Kuhn, MD**, who coined the phrase "paradigm shift" in the 1950s and Malcolm Gladwell, author of the recent how-to-succeed at business book, *Tipping Point*, Dr Graham asserted that a successful enterprise is likely to answer questions for how things change in the same way that it always has.

"It has hypotheses and tries to answer those hypotheses with the models that it has used all along; it's our hypothesis and we're sticking to it!" The underdog is the one who comes along and says, "No, it's not square, it's round!"

Dr Graham admitted that it is not effortless to introduce new paradigms to established entities ("Sometimes you shoot the first few people who say, 'new paradigm.'") but that family medicine and family practice has a responsibility to come forward with new ideas. He also acknowledged that family medicine will not find "love and respect by doing what

.....

Continued on Page 8

The Myth of Fellowship

Ah, fellowship. There was a time when most family physicians never did fellowships. Didn't need 'em, I guess. Even if you had worried that you might need one, they didn't have them. Well, times are different. Most budding young researchers, and budding old ones too, find themselves in some sort of fellowship—research, faculty development, health policy. I'm in my second one right now, and probably my last one if my wife has her way. But it does make me uniquely qualified to comment on some of the interesting myths of fellowship. Interesting, because they're not always what they're cracked up to be but also interesting because without them, you can become easily flummoxed.

Mentorship (originally the Greek cross-dressing and trusted advisor to Odysseus; not related to Mentos, a popular breath mint)—There's no doubt that mentorship is a good thing. Unfortunately, for many fellows, mentorship can mean wandering down the hall looking in on empty offices or praying that you will have some vague sliver of common research interest with a busy faculty member. There's usually a mad rush to find a mentor early on in fellowship. But it's not easy at all, finding a mentor. Mentorship is

a relationship and takes time, compromise, and sometimes sacrifice. Some fellows will never find a single mentor but will come to learn what many senior faculty have known all along. Mentorship often comes from many people—someone who teaches you statistics, someone who helps you

fellows corner

write papers, and someone who introduces you at wine-and-cheese receptions. Often, mentorship comes from other fellows. I've learned as much from my fellowship colleagues as from quarterly meetings with a faculty advisor. Get what you can from the mentorship buffet at your fellowship, and don't forget—it's okay to share.

Finding the right research question—Fellows, especially family medicine fellows, spend a lot of time trying to come up with the right research question. The advice abounds: you need something compelling; something informed by your clinical work; something that has good policy implications. Heretical state-

ment dead ahead: Sometimes it's okay to leave behind the slavish devotion to the "Scientific Method" and look at finding a good question that can actually be answered by the data that exists. You're not going to finish a randomized control trial as a fellow, nor will you do the new Framingham study. Most likely, you'll come up with a good question and realize there's no good existing dataset to answer it. Sure you can spend the next 2 years collecting the data to answer your question, but let's not underestimate the value of going to the existing data first, BEFORE your excellent question. If you spend some time getting to know a dataset, like HCUP, or MEPS, or the Medicare cost reports, most bright, ambitious family physicians (Fellows) can come up with a pretty good question, or even two. Trust me. 3–6 months later, cha-ching!

Analysts—Every fellow needs an analyst. What kind of analyst are we talking about? Both kinds. But mainly the statistical/data guru/SAS-jockey kind. You will hear that fellows need to do their own analysis. And in part that is true. Just like we all had to do internship—painful, valuable, pay your dues. But if you look a little further down the road, I don't see a lot of senior researchers, policy makers, or department chairs doing their own analyses. In fact, most of the successful physician-researchers in family medicine have succeeded by teaming with a good analyst.

Now there are a lot of junior faculty who have to do their own analyses. And they are the ones who need the other kind of analyst too. But if you can, get an analyst for your work. Ideally, you'll learn how to work with an analyst during fellowship. If they're good, and you can stay on at your site afterward, you've started building a strong physician-researcher/analyst dyad. This dyad is, I think, the key to a successful research career. You need the analyst to do the data work, the analyst needs you to do study design, come up with good questions, and write the grants. It's a mutual termite/wood-digesting microbe thing, not a human/leech thing.

High salaries—these remain a myth.

—Frederick Chen, MD, MPH
University of Washington

The *NAPCRG Newsletter* is published by the North American Primary Care Research Group, 11400 Tomahawk Creek Parkway, Suite 540, Leawood, KS 66211, 800-274-2237, ext. 5422, fax: 913-906-6096, napcrg@stfm.org. NAPCRG Web site: www.napcrg.org. For membership information, contact Jenny Wood by e-mail, depasst@stfm.org, or at the address above. The *NAPCRG Newsletter* is published quarterly and welcomes letters to the editor about issues of general interest to the membership. Submit correspondence to Editor John Ryan, DrPH, Department of Family Medicine, University of Miami, PO Box 016700 (R-700), Miami, FL 33101, 305-243-2870, Fax: 305-243-2905, johnnryan@miami.edu.

President

Kurt Stange, MD, PhD

Past President

Ann Macaulay, MD, CCFP, FCFP

Editor

John G. Ryan, DrPH

Executive Director

Stacy Brungardt, MA

Member Services Coordinator

Jenny Wood

Copyright 2002 by the North American Primary Care Research Group

Not Enough Family Physicians to Meet Patient Needs

Results of 2001 National Family Physician Workforce Survey Released This Past October

The number of family physicians is no longer adequate to meet the needs of Canadians, and this serious and growing deficiency threatens the future viability of the health care system. That's the conclusion of the most comprehensive survey of family doctors ever undertaken in Canada. There are not enough family doctors to serve the population according to the 2001 National Family Physician Workforce Survey (NFPWS), the results of which were released at the College of Family Physicians of Canada (CFPC) 2001 Family Medicine Forum held last October in Vancouver.

"Primary medical care may be a right, but it is not a reality for hundreds of thousands of Canadians," says **Don Gelhorn, MD**, president of the CFPC, which conducted the survey. It has been estimated that as much as 30% of the population is currently having difficulty accessing a family physician.

NAPCRG members **Steve Slade**, coordinator of the Workforce Survey, and **Inese Grava-Gubins**, both from the CFPC, presented the results of this survey at the NAPCRG 2001 Annual Meeting in Halifax in their paper session titled "Canadian Family Physicians: The Whole Story—A Report on the 2001 NFPWS."

The Workforce Survey found that two thirds of all family physicians in the country are no longer routinely accepting new patients, suggesting that their practices are already full.

In addition, more than 67% say they now must battle delays and long waiting times to obtain needed services for their patients. Shortages of family physicians, nurses, and other health care professionals—evident in all provinces and regions—are seen as one of the most critical problems plaguing the system.

These shortages are also taking a toll on the existing workforce. Family physicians providing regularly scheduled services, along with after hours on-call duties, are now working an average of 73 hours a week. "Our workforce is exhausted," Dr Gelhorn notes.

A growing and aging population and restructuring of hospitals and other institutions have placed additional pressures on the workforce. In addition to their regular office practice, some 55% of family physicians also do house calls and provide patient care in the home, 35% also look after patients in hospitals, and 24% also work in a variety of long-term care facilities.

"As family doctors, we're doing everything we can to fill the growing gaps in the system. But we are only so many people with so many hours in the day," says **Nick Busing, MD**, past president of the CFPC and chair of the NFPWS Steering Committee.

The 2001 survey was sent to all family physicians and general practitioners in Canada. With a response rate of 51% (14,319 responded), the results are considered accurate within plus or minus 0.64% 19 times out 20.

The CFPC estimates that Canada currently requires at least 3,000 additional family physicians, and it notes that the situation is deteriorating with the country now producing fewer

family physicians than a decade ago. By 2011, this shortfall could widen to at least 6,000 unless immediate action is taken.

Because they are responsible for providing more than 90% of all primary care medical services in Canada, the growing shortage of family physicians threatens the long-term sustainability of the health care system.

The National Family Physician Workforce Survey is an on-going initiative of the CFPC, the first study having been carried out as a sample survey in 1997/98. "In 2001, we reached out to all of Canada's family doctors, asking them to tell us about the role they play in delivering health care services to Canadians," said Mr Slade. "This new information can now be used to inform our decision making and help to shape the future of family medicine in Canada."

For more information, contact **Steve Slade, CFPC**, at 905-629-0900, fax: 905-629-0893.

NAPCRG Seeks Practicing Physician Researchers for Awards

NAPCRG announces two awards for practicing family physicians who conduct research. Practicing physicians are encouraged to apply for the following awards by the May 24 deadline.

NAPCRG's Pfizer Investigator in Practice Award comes a \$10,000 stipend to allow the winning physician to devote approximately 10% time to a 1-year research project. The award also reimburses the physician for travel expenses incurred to attend the NAPCRG Annual Meeting to present the results of the research.

The **Pfizer Research Scholarships** are offered each year to three physicians who submit outstanding research papers for presentation at NAPCRG's Annual Meeting. This scholarship award will pay the travel,

lodging, and registration fees for the winners to attend the 2002 Annual Meeting, to be held November 17–20 in New Orleans.

Both types of awards require that applicants be engaged in direct patient care in a non-teaching setting at least 50% of the time and be a NAPCRG member or willing to become one. The application information and criteria are posted on the NAPCRG Web site at www.napcrg.org/awards.html.

Please note that the 2002 awards are dependent upon confirmation of continued funding by Pfizer.

For more information, contact **Jenny Wood** at NAPCRG, 800-274-2237, ext. 5422, depasst@stfm.org.

2001-2002 Wood Award Donors

NAPCRG would like to thank and recognize the following institutions and individuals who contributed to the Maurice Wood Award fund in 2001 and 2002. These funds help support the travel expenses, honorarium, and plaque that honor the Wood Award winner. If you are interested in donating to the fund, send your check to NAPCRG, c/o Wood Award fund, 11400 Tomahawk Creek Parkway, Leawood, KS 66211. Contact Stacy Brungardt with questions, 800-274-2237, ext. 5406, napcrg@stfm.org.

Medical College of Georgia
Foundation Dept of Family Medicine

Jan Barnsley, PhD
University of Toronto

James Barrett, MD
Dartmouth Medical School

James Calvert, MD
Cascades East FPR

Alvah Cass, MD, SM
University of Texas Medical Branch

Edward Ciriacy, MD
Lino Lakes, Minn

Patricia Cole, MD
Hennepin Family Practice

Colleen Conry, MD
University of Colorado

Glen Couchman, MD
Scott & White Clinic

Steven Dosh, MD
UPRNet

Laurie Dunn, MSc, BScPhm
University of Toronto

Bernard Ewigman, MD, MSPH
University of Missouri-Columbia

Patricia Fontaine, MD
University of Minnesota

Theodore Ganiats, MD
University of California-San Diego

Lillian Gelberg, MD, MSPH
University of California-Los Angeles

Larry Green, MD
Robert Graham Ctr, Washington, DC

Kim Griswold, MD, MPH
SUNY at Buffalo

David Hahn, MD, MS
Dean Health System

Anthony Kendrick, MD, FRCGP
University of Southampton

Lyndee Knox, PhD
University of Southern California

Alex Krist, MD
Virginia Commonwealth University

Ann Macaulay, MD, CCFP
McGill University

Ruth Elwood Martin, MD, CCFP
University of British Columbia

Diane McKee, MD
Albert Einstein COM

Jack Medalie, MD, MPH
Case Western Reserve University

Job FM Metsemakers, MD, PhD
Maastricht University

William Miller, MD
Lehigh Valley Hospital

William Norcross, MD
University of California-San Diego

Michael Parchman, MD
University of Texas HSC

Theodore Phillips, MD
Lopez Island, Wash

William Phillips, MD, MPH
University of Washington

Lewis Rose, MD
San Antonio, Tex

Walter Rosser, MD, CCFP
University of Toronto

Albert Rudock, MD
Victoria, Australia

John Scott, MD, PhD
UMDNJ-RWJ Medical School

Milton Seifert, MD
Excelsior, Minn

Maira Stewart, PhD
University of Western Ontario

Barbara Yawn, MD, MSc
Olmsted Medical Center

Stephen Zyzanski, PhD
Case Western Reserve University

Ryan Selected for National Fellowship on Primary Health Care Policy

John G. Ryan, DrPH, NAPCRG Newsletter editor and director of the Division of Primary Care/Health Services Research and Development in the Department of Family Medicine and Community Health, University of Miami, was one of 30 health professionals in the United States selected to participate in the Secretary's Policy Fellowship in Primary Health Care. The program is a 6-month intensive curriculum, which also includes 4 weeks of on-site training, primarily in Washington, DC. Dr Ryan will gain knowledge in primary health care programs and policy issues as they relate to the US Department of Health and Human Services, as well as their applicability on the local, state, and institutional levels. Secretary Tommy Thompson requested approximately 70 organizations to nominate candidates who are capable of making unique contributions to the fellowship, demonstrate a commitment to primary health care, have health policy experience, show potential for utilizing the fellowship experience, and represent the nominating organization.



Pfizer Selection Committee Chair and Practitioner Representative to the NAPCRG Board Ellen Wiebe, MD, Vancouver, British Columbia (left), presents Michelle Greiver, MD, CCFP, a practicing physician from Willowdale, Ontario, with a certificate honoring her as the 2001 Pfizer Investigator in Practice Award winner. The application deadline for the 2002 Pfizer Investigator in Practice Award is May 24, 2002.

Wood Award Nomination Reminder

March 5, 2002 is the deadline for submitting a nomination for the 2002 Maurice Wood Award for Lifetime Contribution to Primary Care Research. Nominations must include a letter describing the nominee's contributions to primary care research and state why the person should be a candidate. Include the nominee's CV with the nomination letter. Send nomination's materials to napcrg@stfm.org, or mail them to NAPCRG, 11400 Tomahawk Creek Parkway, Leawood, KS 66211. A description of the award and list of previous winners can be found at www.napcrg.org/awards.html#research.

Themes From 2001 Annual Meeting Papers

Knowing and Doing

Moderating the third Health Care Delivery/Health Services Research session at the 29th NAPCRG Annual Meeting reminded me how important it is for family physicians and general practitioners to ask the questions and find the answers. It also reminded me of the importance of the partnership between practicing physicians and scholars with research design and analytic skills. The five papers presented used sophisticated research approaches to explore three different issues affecting many people in all countries. The first paper, on the effect of health policy on access to medication for elderly people, analyzed an administrative database and conducted a survey that achieved a high response rate (86%). The second and third papers confirmed the important role of continuity in health care provision at the end of life, based on an elegant analysis of existing data sets. The fourth and fifth papers used a combination of analysis of cervical smear reports and a survey to develop recommendations on the best cervical smear technique.

Discussion of the papers ranged from "how did you do it?" (\$5 accompanying the survey questionnaire probably bumped up the response rate in the first paper) and "why did you do it?" (why survey a population for the third study, instead of a sample?) to "what can we do with these findings?" Naturally, the last question attracted most interest, and we ran out of time trying to answer it. The final sessions, on cervical smears, left us with clear messages on how to smear (not with a broom and using selective pre-smear swabbing) but what can we do to help the poor and sick to the health care they need, in the face of contrary regulations? And if continuity of care has such a positive effect on meeting patients' needs of the health care system at the end of their lives, how can we make sure this happens? There are two places this moderator thinks the unanswered questions lead us: (1) to the importance of family physicians' involve-

ment in politics, policymaking, and management, and (2) to the importance of continuing developing strong partnerships with research methodologists who can collaborate to answer increasingly critical questions with increasing scientific innovation and rigor. From NAPCRG 2001 we know some new things. Let's use this knowledge ourselves, if we can, and make sure we pass it to others also.

—Susan Dovey, MPH, Robert Graham Center, Washington, DC

Practice-based Research III

The six presentations in Practice-based Research III generated lively discussion. **Stefan Grzybowski, MD**, University of British Columbia, presented a descriptive study of a peer support writing group. He found a significant increase in production and publication of papers during the time the group functioned compared to a previous similar period.

Cathy Thorpe, MA, University of Western Ontario, presented a qualitative study with in-depth interviews of key informants on the acquisition, implementation, and utilization of information technology by family physicians. Her group uncovered key themes including space, legibility, access, and organization of patient records, and a desire for a paperless office.

Sara Rodgers, BSc, University of Nottingham, estimated the community prevalence of renal impairment through computer-assisted data collection in general practices within a community research network in the United Kingdom. She found an estimated prevalence of 1.27% among more than 60,000 patients. These patients often need drugs that must be used with caution, indicating a place for computerized decision support in general practice. In research directly addressing clinical decisionmaking, **Kendra Schwartz, MD, MSPH**, Case Western Reserve University, presented a cross-sectional study of physician agreement on the assessment of symptoms and signs relevant to sore throat differen-

tial diagnosis. Clinician pairs agreed on 78.9% of their assessments.

An emerging theme in primary care is integration. **Joan Mitchell, RN**, Centre for Studies in Family Medicine, London, Ontario, reported a descriptive study of an innovative role for the primary care nurse practitioner in providing acute care in the home. The study revealed the intensity and acuity of services that can be provided in the home and community setting, given adequate support.

Equity of care and addressing unmet community needs are important in primary care. A retrospective case-control review of primary care records by **Leslie Roberts, BSc**, University of Birmingham, revealed that schizophrenic patients had higher consultation rates but were less likely to have blood pressure and cholesterol checks. Their smoking status was recorded less often than for asthmatic patients.

The presentations illustrated the range both of practitioners (family physicians, social scientists, nurse practitioners) as well as methods involved in primary care research. All of the studies were extraordinarily practical. A key theme was support for decision making in practice. Emerging technologies such as computer based medical records and new practice approaches such as an enhanced nurse practitioner role served to emphasize the fundamental principles of family practice and primary care: excellent clinical skills, serving the community, and the importance of the doctor-patient relationship. The session demonstrated that community-based studies put research to work for primary care physicians and their patients.

—David White, MD
North York General Hospital
Toronto, Ontario

2001 NAPCRG Winning Papers

Paper presentations by practitioners and fellows, residents, and students at the Halifax Annual Meeting were evaluated by session moderators, with winners announced at the closing plenary. Presentations were judged on the degree to which new and important research questions were addressed, the appropriateness of research methods, the validity of conclusions, the overall value, and the speaker's presentation style. The following were the winning 2001 paper presentations:

Best Paper by a Practicing Physician (tie)

Julia Bailey, MBBS, MRCP

London, England

Lesbians and Cervical Screening

Ranjit Singh, MD

University of Buffalo

Waging War on Errors Through Systematic Appraisal of Risk and Its Management for Error Reduction

Best Paper by a Student, Resident, or Fellow (tie)

Lesley Roberts, BSc

University of Birmingham

Are We Offering Equity of Health Care to Schizophrenic Patients?

Lou Lukas, MD

University of Michigan

Bridge Over Troubled Water: Understanding the Cultural Chasm at the End of Life in Nursing Homes

Honorable Mention Paper by a Student, Resident, or Fellow (tie)

John G. Scott, MD, PhD

UMDNJ-Robert Wood Johnson Medical School

Unnecessary Antibiotic Use in Acute Respiratory Infections

Frederick M. Chen, MD, MPH

Fellow, Agency for Healthcare Research and Quality

Accounting for Graduate Medical Education Funding in Family Practice Training

Best Poster

M. Diane McKee, MD

Albert Einstein College of Medicine

Understanding of Atypical Pap Smear Results in a High-risk Community

Honorable Mention Poster

Maeve O'Beirne, MD, PhD

University of Calgary

The Effects of On-call Duties on the Personal and Professional Lives of Alberta Family Physicians/General Practitioners

AHRQ Announces RFPs for Evidence-based Practice Centers and PBRNs

Evidence-based Practice Centers II

Proposals due: March 1, 2002

The Agency for Healthcare Research and Quality (AHRQ) has issued a Request for Proposals (RFP) to solicit proposals from institutions to serve as Evidence-based Practice Centers (EPCs) under 5-year contracts.

This RFP is the second phase of AHRQ's Evidence-based Practice Program. Like their predecessors, the EPCs II will produce evidence reports and technology assessments based on comprehensive reviews and rigorous analyses of the relevant scientific evidence. The reports and assessments will be used by systems of care, professional societies, purchasers, and others as the scientific foundation for developing their own practice guidelines, performance measures, and other quality improvement tools, and for making decisions related to the effectiveness or appropriateness of specific health care technologies.

Developmental Grants for Primary Care Practice-based Research Networks

Letter of Intent Receipt Date: April 15, 2002

Application Receipt Date: May 14, 2002

AHRQ announces the availability of developmental/exploratory grants for the purpose of assisting new or established primary care practice-based research networks to enhance their capacity to conduct research and translate research findings into practice.

Two funding categories are available under this Request for Applications (RFA). Eligible applicants may apply for one or both categories of funding: (1) Category I: Support of the development or enhancement of network infrastructure; (2) Category II: Support of exploratory or pilot research projects.

AHRQ expects to award up to \$2 million total costs in fiscal year 2002 to support the first year of projects under this RFA. It is anticipated that 25 to 30 awards for infrastructure planning/development will be made, not to exceed \$50,000 annually for up to two years of funding. In addition, 5 to 7 awards for pilot projects or feasibility testing will be made for up to \$100,000 annually for up to two years of funding. The maximum amount to be awarded under this RFA to any single applicant for the support of first year activities is \$150,000.

For more information on these programs and other AHRQ grant opportunities, visit the AHRQ Web site at www.ahrq.gov/fund/grantix.htm.

Thank You

NAPCRG thanks and recognizes the contributions of outgoing Board members whose terms expired in 2001:

Chair, Committee on Building Research Capacity
Bernard Ewigman, MD, MSPH
University of Missouri-Columbia

CFPC Sec of Researchers Rep
Eva Grunfeld, MD, Dphil, CCFP
University of Ottawa

Continued From Page 2

Diverse Research Methodologies Required

the other folks have been doing.” Rather, family medicine must find a way to articulate a different set of questions and for knowing. Consequently, family medicine will gain respect based on the uniqueness of its own insight.

“It would be a contribution; it would also be in our own self-interest because the old tools are not working so well for us now and will work less well in the future.”

Returning to his theme of applying new principles in our search for knowing what works when interacting with the complex organism represented by the general population of today and the future, Dr Graham reminded his audience that “change is in the DNA of family practice; change is the history of family practice.”

“Family medicine is a reasonable nitis for developing and examining new tools to address the complex challenges that are evolving in the diverse organism of the general population.”

—John G. Ryan, DrPH
University of Miami

2002 NAPCRG Call for Papers Available

The Call for Papers for the 2002 NAPCRG Annual Meeting has been mailed and is available on-line at www.napcrg.org. NAPCRG will celebrate its 30th Annual Meeting November 17–20, 2002, at the Hyatt Regency New Orleans in New Orleans, La. This year’s meeting theme will be “Building Research Capacity,” with a sub-theme of research relating to health and health care disparities—geographical, racial, economic, and international. The deadline for receipt of submissions is May 24, 2002.

board NAPCRG members

President

Kurt Stange MD, PhD
Case Western Reserve University

Past President

Ann Macaulay, MD, CCFP, FCFP
McGill University
Kahnawake, Quebec

Secretary-Treasurer & Chair, Nominating Committee

Moira Stewart, PhD
University of Western Ontario

Chair, Committee on Building Research Capacity

Walter Rosser, MD
University of Toronto

Chair, Communications Committee

Valerie J. Gilchrist, MD
Northeastern Ohio Universities College
of Medicine

Chair, Program Committee

John M. Westfall, MD
University of Colorado

CFPC Section of Researcher Representative

Marshall Godwin, MD
Queen’s University
Kingston, Ontario

Community Hospital Representative

William L. Miller, MD
Lehigh Valley Hospital
Allentown, Pa

Fellow Representative

Frederick Chen, MD, MPH
AHRQ Center for Primary Care Research
Rockville, Md

Practitioner Representative

Ellen R. Wiebe, MD
Vancouver, British Columbia

Newsletter Editor (Ex Officio)

John G. Ryan, DrPH
University of Miami

AFMO Representative

Larry A. Green, MD
Robert Graham Center for Policy Studies
Washington, DC

Participate in NAPCRG’s Student Research Award Program

The May 2001 *NAPCRG Newsletter* announced a new research award for students called the NAPCRG Student Family Medicine/Primary Care Research Award. This award is intended to recognize outstanding family medicine/primary care research performed by a medical student.

One award may be made by each department of family medicine. The NAPCRG Board suggests that each department create a committee to review medical student applications and make the award recommendation to the department chair. Note that NAPCRG does not select the honorees; departments tell NAPCRG headquarters who should be honored from their school. NAPCRG will supply the certificate that may be framed by the department, if it elects to do so.

Please submit the names of your honorees to NAPCRG for preparation of certificates by March 1. This will ensure that staff can return the certificates to the schools by May 1 in time for graduation ceremonies. Note that departments are not tied to these dates. If you would prefer to honor a student in your department at another time during the year, that is acceptable.

The award criteria and application form are posted on the NAPCRG Web site at www.napcrg.org/awards.html#research. Contact **Valerie Gilchrist, MD**, NAPCRG Communications Committee chair, vg@neucom.edu, with questions.