AFMRD 1990-1995

Forward

To everything, there is a season ... (Ecclesiastes)

For family medicine residencies and directors, the 1970s may be characterized as the pioneer era. The discipline started with fewer than twenty residency programs, most retooled from the general practice era, and by 1980 had built more than 380 programs. The Residency Assistance Program (RAP) was formed to facilitate the building, and importantly to ensure excellence in what was constructed. The 1980s was a maturational phase, during which the directors of these programs began collectively to perceive a need for an effective political voice, particularly with the Residency Review Committee for Family Practice (RRC-FP). Initial questions included: Could the current family medicine organizations meet their needs? Would there be enough time and energy to add an organization for program directors? Alvin Haley, MD, and Gerald Stuckey, MD, program directors from Indiana, thought so. Daniel Ostergaard, MD, vice president for Education and Scientific Affairs of the American Academy of Family Physicians, was supportive of the development of a new organization, if that's what would work best for program directors', or improving program directors representation in the AAFP, or both.

This book describes how the idea of an organization, having evolved from the maturation of the discipline and its training programs, came to result in the leadership organization known today as the Association of Family Medicine Residency Directors (AFMRD). Thanks are due to many who helped develop the organization, from the members of the 1989 Steering Committee (Alvin Haley, MD, Richard Layton, MD, Charles Payton, MD, and Norman Kahn, MD) with the facilitation and support of Jane Murray, MD, then director of the Division of Education of the AAFP, to the first presidents whose leadership has literally catapulted the organization to a position of prominence in the "family" of family medicine (Richard Layton, MD, Stephen Brunton, MD, Mary Willard, MD, John Saultz, MD, David Mersy, MD, and Penelope Tippy, MD). Rheta Williams served as assistant staff executive, managing the day-to-day operations.

Today, the association continues to accomplish its mission and goals through its many projects and liaisons. Indeed, the energy and vision of the nation's residency directors have produced not only an organization which is a full member in the family of family medicine organizations, but is a respected leader. It represents the nation's residency directors and serves as their political voice. Its first priority goal, representation on the RRC-FP, is now reflected in that program directors hold four of the ten seats, plus an alternate position. It has had unprecedented input to the RRC-FP for revising the written accreditation requirements. It is an organization that boasts more than 95% of those eligible as members. It has provided a network for mutual assistance among residency directors and has built an institute for developing new directors.

In five packed years, there are many stories to be told. We hope you enjoy this book, which catalogues the organization's rapid evolution during its first half decade. We would like to thank all of the members of the AFMRD who continue to invest their energies in training the highest quality family physicians.

First You Identify a Social Need

Ideas have a time and place. In 1941 when a delegate to the American Medical Association (AMA) House of Delegates called for a certifying board in general practice, it was not yet time for this idea. In fact, 28 years would pass before the twentieth primary specialty board would be approved.

Post-World War II medicine was demonstrating a bias away from general practice. The GI bill offered financial assistance for residency training, but there were no residencies in general or family medicine. Hospitals were beginning to require board certification for privileges and restricting access to the operating room to only those with surgical specialty training.

During the post-war period, however, much would change -- in medicine, in society, and in the organizations with a stake in the new specialty. Among the developments in medicine affecting the growth of family medicine as a specialty was the information explosion that was leading to increasing specialization. The 1966 Report of the Citizens Commission on Graduate Medical Education, entitled "The Graduate Education of Physicians" and commonly called the Millis Report, emphasized the fragmentation in patient care that was occurring. To maintain their skills and knowledge, physicians were being trained to care for only a portion of a patient's health. Few were being trained for comprehensive and ongoing care.

By the 1960s, the general public was also becoming aware of what this specialization meant to them as patients. It was increasingly difficult to find a physician to be a continuous, comprehensive provider of medical care.
Societal changes influenced the development of family medicine residencies in a second way. By the late 1960s the youngest "baby boomers" were expressing their highly developed social consciousness in many spheres. Some young people considering medical careers sought to serve society by providing comprehensive care, often in underserved areas.

Organizationally, precursors to board certification developed throughout the period. In 1947 the American Academy of General Practice (later Family Physicians) was established. Also in 1947 the Davis-Truman Special Committee of the American Medical Association (AMA) studied conditions of general practice; this was just the first of several committees that would examine various aspects of the issue over the next 20 years. In 1948 residencies in general practice began to develop, and pilot residencies in family medicine were set up in 1959.

By 1965, after repeatedly voting down resolutions to create a certifying board, the Congress of Delegates of the Academy voted to authorize application for a certifying board. Once committees delineated the core content for the residency curriculum and the "Special Requirements for Residency Training in Family Practice," the stage was set. Finally, following approval by the Liaison Committee for Specialty Boards, the Advisory Board for Medical Specialties, and the AMA Council on Medical Education, the American Board of Family Practice, Inc. (ABFP) was incorporated on February 8, 1969.

Accredited Programs

Accredited Residency Programs in Family Practice as of May 30, 1969

Hoag Memorial Hospital Family Medical Clinic
Newport Beach, California

San Bernardino County General Hospital
San Bernardino, California

Los Angeles County Harbor General Hospital
Torrance, California

General Hospital Ventura
Ventura, California

University of Miami Family Health Center
Miami, Florida

Wesley Medical Center
Wichita, Kansas

University of Maryland Hospital
Baltimore, Maryland

Harvard Medical School
Family Health Care Program
Children's Hospital Medical Center
Boston, Massachusetts

University of Minnesota Health Sciences Center
Minneapolis, Minnesota

Research Hospital and Medical Center
Kansas City, Missouri

West Jersey Hospital Northern Division
Camden, New Jersey

Hunterdon Medical Center
Flemington, New Jersey

Deaconess Hospital
Buffalo, New York

University of Rochester
School of Medicine and Highland Hospital
Rochester, New York

St. Joseph's Hospital
Syracuse, New York

Moses H. Cone Memorial Hospital
Greensboro, North Carolina

Flower Hospital Family Care Center
Toledo, Ohio

University Family Medicine Clinic
University of Oklahoma Medical Center
Oklahoma City, Oklahoma

York Hospital
York, Pennsylvania

University Family Health Service
University of Wisconsin Medical Center
Madison, Wisconsin

The Specialty Takes Root

Within a few months of the approval for the American Board of Family Practice, 20 residency programs had been approved by the AMA Council on Medical Education. These programs had met the "Special Requirements for Residency Training in Family Practice" that had been approved in December 1968 (see Appendix). These "essentials," as they were commonly known, described a three-year program that covered family medicine, internal medicine, pediatrics, psychiatry, obstetrics and gynecology, surgery, and community medicine. This later was considered to be one of the unique components of family medicine.

Fundamental to these and subsequent family medicine programs was use of the model family medicine center. Whether a freestanding clinic or an outpatient wing of a medical center, the family medicine center offered the residents opportunities to follow their own patients, perform a variety of outpatient procedures, and experience a medical practice much like the one they would eventually establish. The programs were designed to provide a socioeconomic cross section of patients, as well as an age range from newborn to nursing home patient. Residents gained experience working with allied health professionals in a collaborative environment.

Such training was designed to prepare the resident for an office-based practice. Even more importantly, he or she could provide comprehensive continuity of care to meet socially identified needs.

Interest in the new specialty grew quickly. In fact, in 1974 one expert suggested that there would not be enough residency openings for all interested medical graduates that year.

A Voice of Their Own

Putting their indelible stamp on these newly developing programs were the directors. In the early days, some even brought their own patients into the model family medicine center to establish a patient base for the residents.

Part clinician, part administrator, part teacher, these individuals had -- and still have -- a unique position within their medical communities. Perry Pugno, MD, MPH, has described some of the challenges:

1. A director's job is a lonely one. Physician colleagues see the director as a representative of the administration; to management, he or she is a physician. There are few peers within the hospital with whom to talk.
2. The role has parenting dynamics. Directors guide the residents through the educational process, while also teaching teambuilding, decision making, resource development, and other skills commonly associated with parent-child coaching.
3. Directors are "on call" practically 24 hours a day with regard to the residents under their charge.
4. The relationship with the residents is intense, lasting three years during which they are often undergoing major life changes such as marriage and family.
5. Directors have to model being a good physician. They are called on to constantly maintain their clinical credibility in a job in which a good portion of the time is spent in non-clinical work.
6. Directors are required to be both educators and managers, but few have formal training in either the education process or management skills.
7. While the gratification is significant, it tends to be delayed until residents have established their own practices within their communities.
8. These challenges and the unique nature of the job were significant factors in the directors' need for an organization of their own and led to the formation of the Association of Family Practice Residency Directors (AFPRD).

"Hospitalization" has become a part of the orientation for family medicine resident at the Long Beach program. Rosa Solorio, MD, and Stephen Brunton, MD, Program Director, are attending to Susan Jung, MD, resident "patient."

Like family medicine certification, the idea of a special association took a while to find its moment. Its roots are in Indiana, where Alvin J. Haley, MD, was president of the Indiana Academy of General Practice (later Family Physicians) in 1969. At that time, as the specialty was getting its official start, he suggested creating a liaison committee between family medicine program directors in Indiana and the Academy.

Open discussion forums were held during 1987 and 1988 Family Practice Program Directors Workshops. The American Academy of Family Physicians (AAFP) Division of Education formally surveyed program directors in 1988. The response was strong -- over three quarters of directors returned the surveys and over 70% of these supported the idea of a separate organization.

The reasons for starting the program directors group remain clear to those involved in the early discussions.

"It was a confluence of timing that the directors group needed a separate voice," says Richard L. Layton,

MD. "We sought to form a nucleus to focus on tasks that needed to be done."

"Directors represent a fairly specific constituency with specific interests," Dr. Pugno points out. "There was no structure for assuring program directors' priorities were expressed."

Those priorities that needed a voice included representation on the RRC-FP, a strong presence in Washington, DC, and communication among directors and within the "family" of family medicine organizations.

Inevitably, not everyone favored creation of another organization. Even Dr. Layton, who would be elected the group's first president, originally advised against yet another group. "I and others originally felt we didn't need to duplicate what was being done."

Concerns were also expressed about the burden of another meeting to attend and the potential impact the new group would have on the existing family of organizations.
Nevertheless, none of the objections seemed powerful enough to stand against the building momentum of support. In early June 1989, just prior to the Program Directors Workshop, a special session was convened with 150 directors on hand. Dr. Layton, as chair of the AAFP Commission on Education planning committee for the Workshop, chaired this discussion. As a result, a steering committee was formed, comprised of Alvin J. Haley, M.D.; Norman B. Kahn, Jr, M.D.; Richard L. Layton, M.D.; and Charles Payton, M.D., with Jane Murray, M.D., AAFP division director of education, serving as facilitator.

Within two days this group, along with Roland Goertz, M.D., and Elizabeth A. Burns, M.D., met and established a set of six goals for the prospective organization. These were:

1. A voice in existing organizations
2. A voice in the RRC-FP
3. Lobbying in Washington, DC
4. Preservation of ties with the AAFP
5. Communication among program directors to establish what they wanted from such an organization, and
6. Membership for all program directors, one vote each, with a proxy mechanism.

A core group of program directors met frequently and worked to create AFMRD, including (left to right): Richard L. Layton, MD, Alvin J. Haley, MD, Norman B. Kahn, Jr., MD, and Charles Payton, MD.

Credit: AFMRD

Following a July 1989 meeting with the AAFP Commission on Education where AAFP support for the new organization was reaffirmed, the planning committee set to work on the nuts and bolts of creating a functional organization. In a November meeting, they reviewed bylaws from similar groups. Committee members selected three names to be put to a vote at the June 1990 Program Directors Workshop: (a) Association of Family Medicine Residency Directors; (b) Association of Residency Directors in Family Practice; and (c) Family Practice Residency Directors Association.

The committee also devised an organization structure that resulted in several of the group's continuing strengths. All program directors -- and only directors -- would be eligible for membership, with one vote for each member.

"The group is profoundly democratic," emphasizes past president John W. Saultz, M.D. "Officers are elected by the members and policies are established by members. This gives the president significant power as she or he is speaking for the entire membership."

This power is enhanced by the single membership category, which includes directors from all types of programs, as Mary Willard, M.D., points out.

"Representing only program directors is an asset because it gives focus to the organization's activities and policies. The group composition gives validity to comments and stands on issues."

By the time of the June 1990 workshop, the planning committee had also worked up a budget, a slate of officers, and an agenda for the attendees' approval. One issue they needed to resolve was the group's relationship to AAFP. The academy would provide administrative support as it had done in the early years of the STFM. The program directors surveyed in 1989 had overwhelmingly supported a group that "related within the AAFP structure." Yet this left considerable latitude.

AFMRD Founders (front): Jane L. Murray, MD; Alvin J. Haley, MD; (back) Norman B. Kahn, Jr., MD; Richard L. Layton, MD; Charles Payton, MD. Credit: AFMRD

Ultimately, the directors were given several choices, including an independent organization, a constituent chapter of AAFP with resolutions going to its House of Delegates, a forum of the Commission on Education, or the status quo. The choice was an independent organization.

The first board of directors were elected at the Program Directors Workshop in 1990 and included:
President: Richard L. Layton, M.D.
President-elect: Stephen Brunton, M.D.
Immediate past president: Alvin J. Haley, M.D.
Secretary / treasurer: Penelope K. Tippy, M.D.
Members at large: Elizabeth A. Burns, M.D.; Norman B. Kahn, Jr, M.D.; and Mary Willard, M.D.

"The election of an immediate past president set the tone for AFMRD," suggests Dr. Layton. "This was a working group that didn't stand on titles!"

On August 31, 1990, articles of incorporation were filed in Missouri for the Association of Family Medicine Residency Directors. Program directors had a voice; they now had to work to make it be heard.

The Voice is Heard

By consensus, the most important place for the directors' new voice to be heard was on the Residency Review Committee for Family Practice. This committee of the Accreditation Council for Graduate Medical Education (ACGME), with representatives from the AMA, AAFP, and ABFP along with a resident, is responsible for accrediting residency programs. Not surprisingly, the directors felt they should be represented on the RRC. This goal had been strongly articulated from the beginning of discussions to form an organization.

Perry A. Pugno, MD, was asked to provide several alternatives as logos/seals for the newly formed organization. In 1991, the seal was officially adopted. The four quadrants refer to the primary elements of the program director's job -- education, clinical medical practice, administration, and scholarly research and writing.

In January 1991, the group was able to provide a list of several program directors for consideration for a seat on the RRC-FP. When Dr. Layton met with the AAFP Commission on Education in February, the commission agreed to take into consideration particularly directors from community-based programs when filling vacant positions. While no seat would be assigned to directors, nominations would regularly be sought from AFPRD members.

A year later, Don McHard, M.D., a program director from Phoenix, Arizona, joined the RRC-FP as the nominee of the AAFP. By May 1995, four members of the committee, including its chair, David Holden, MD, and former president of AFPRD, Stephen Brunton, MD, were community hospital residency program directors.

Of course, the RRC-FP was not the only group with which directors sought dialogue and participation. Almost immediately after AFPRD was formed, it assigned liaisons to the Family Practice Working Party, the Residency Assistance Program (RAP) Project Board, the AAFP Commission on Education, the AAFP Student Interest Task Force, and the Association of American Medical Colleges / Forum on the Transition from Medical School to Residency. Eventually, it would take part in the Academic Family Medicine Organizations (AFMO) as well.

"AFPRD has served as a successful mechanism for family medicine group unity," says Dr. Haley. "This was one of the roles originally envisioned for the group."

The organization has also been a "model for organizational consensus building," says Dr. Pugno, both within itself, as an "opportunity for program directors to get on their soapbox," and among the family of organizations.

All these networking activities have contributed to the significant and concrete participation of program directors in a variety of activities within the first few years of the group's existence. For example, in 1992 AFPRD was asked to nominate program directors for the Home Study Self-Assessment Advisory Board. Ultimately, all members of this board were selected from AFPRD nominees.

In 1993 AFPRD members approved a series of principles for reform of the "Special Requirements for Residency Training in Family Practice." These rules determine a program's accreditation and cover items such as the number of faculty, size of the family medicine center, resident rights, and curriculum. The four most important issues dealt with in the reform document, as outlined by Dr. Saultz in Highlights (Aug. 15, 1993) were:

1. The requirements should define curriculum areas in terms of what family physicians do, not by the names of other specialties, e.g., care of children, rather than pediatrics.
2. The requirements should identify family medicine faculty as primary teachers for all curricular areas.
3. Arbitrary time limits should be eliminated from various curricular areas.
4. Programs should begin to move toward a competency-based curriculum, rather than a time-based one.

The reform suggestions were submitted to the RRC-FP, as well as the STFM, AAFP, and ADFM. By mid-1995 the RRC-FP had drafted its revised document, including many of the AFPRD suggestions. The draft was submitted to the organizational parents of the RRC-FP: the ABFP, AMA, and AAFP for final comments before being submitted to the Accreditation Council for Graduate Medical Education for approval.

In the past, the RRC-FP had been open to suggestions from program directors for requirement revisions. However, this time the group was able to take a proactive stand to make its members' view known early in the process. It was for just such actions that the AFPRD was formed.

A Question of Ethics

Interest in family medicine was strong during the developmental years of the 1970s. For example, in 1975 the NRMP fill rate was over 85%. But in 1988, student interest in family medicine, along with the other primary care specialties, began to decline, reaching its nadir in 1991 at 65%.

Not surprisingly, this declining student interest in family medicine and other primary care specialties was of great concern to residency program directors. This issue was repeatedly discussed at Program Directors Workshops throughout the period prior to AFMRD formation -- and after. In the August 1991 Highlights, Stephen Brunton, MD, AFMRD president, wrote:

"The major focus [of the June Program Directors Workshop] was the alarming decline of student interest in primary care, in general, and family medicine in particular... The other increasing concern is the strain that this crisis will place on our members, and the action they may take to remedy their own resident

shortfall."

The time had come for AFPRD to assume leadership by developing ethical guidelines for resident recruitment.

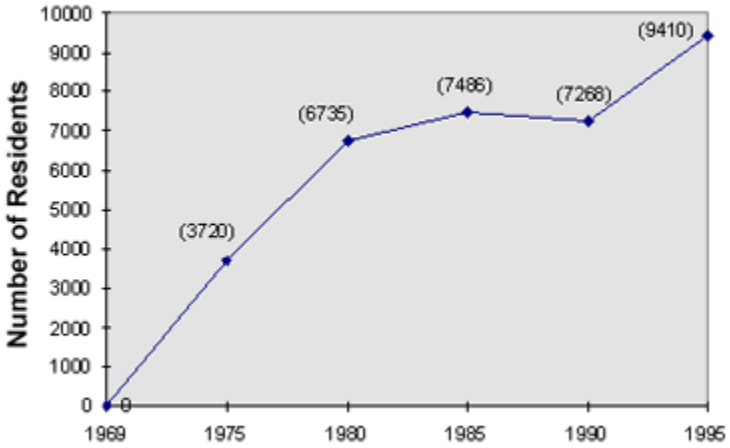
Dr. Willard headed a group of 14 members. A survey of directors had given them the direction and examples of the kinds of activities under question. What the committee produced, according to Dr. Willard, was "a functional working document." The guidelines were widely disseminated to program directors.

"This document developed at the grass roots level," says Dr. Willard. That gave it its strength.

Growth in Residents/Residency Programs

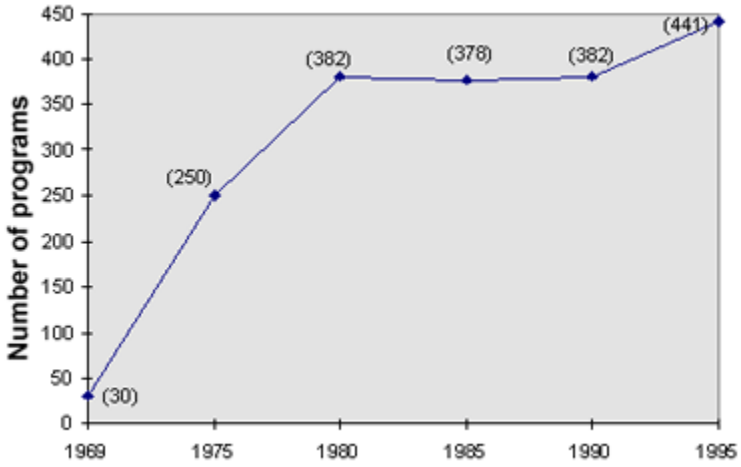
Growth in Residents/Residency Programs (1969-1995)

Growth in the Number of Residents*



*Includes first-, second-, and third-year residents

Growth in Approved Residency Programs



To Train the Trainers

The Academic Council, responsible for the National Institute for Program Director Development, includes (left to right): Norman B. Kahn, Jr, MD; Richard Lewan, MD; Franklyn Dornfest, MD; Pam Snape, MD; Perry A. Pugno, MD, chair; Edward T. Bope, MD; and Robert McArtor, MD. Missing: Robert Avant, MD. Credit: Bixler/AFMRD

AFMRD arose as a result of the unique challenges program directors face. Once the highest priority need for representation was met, the organization sought to meet additional expressed needs, such as the "Guidelines for Ethical Recruitment of Family Practice Residents." It did not have to search long for yet another challenge -- the training of new program directors.

The average director manages a $1-2 million budget. As Dr. Haley points out, "It's an oversimplification, but a program director must get the teacher, resident and patient at the same place at the same time. This is much more difficult than it implies."
The job is largely managerial, yet few new directors come to the job with management training. In part, this may account for the three-to-five-year average tenure of directors.

In 1994 AFMRD took a major step in attempting to remedy this situation with the creation of the National Institute for Program Director Development (NIPDD). Under the chairmanship of Dr. Pugno, the Academic Council has developed a "prototype adult learning model." The institute includes three structured learning sessions, an advisorship with an experienced program director, and a longitudinal project. The learning sessions, which take place in the fall, during the spring RAP Workshop, and at the summer Program Directors Workshop, cover topics such as:

- Organizational leadership
- Management skills
- Accreditation procedures
- Finance
- Faculty development
- Medical staff issues
- Resident development

The sessions are structured to enhance adult learning, with two or three short lectures followed by time to interact and process the information. Faculty are members of the Academic Council, incorporating STFM, RAP, AAFP, ABFP, and AFPRD, along with additional content experts.

"The institute is different in that the entire faculty participates throughout the entire program," emphasizes Dr. Pugno. "They are available for questions and act as facilitators [of the break-out sessions]. They work together as a team, which is good modeling for the students."

It is also obviously faculty-intensive learning, but as Dr. Pugno adds, "We do it because we enjoy the teaching encounter."

The advisership pairs an experienced program director with a fellow for seven months of one-on-one guidance. The fellows carry out projects specific to their residencies, with advisor assistance, that will be useful to their programs and potentially to other program directors. These projects may include studying the residency's financial impact on the medical center or creating a community health center track for residents, for example.

"Every member of the RAP panel of consultants volunteered to be advisors," says Dr. Pugno. "The success of the institute is the result of this tremendous outpouring of support from the directors."

The success has been noteworthy. Forty participants graduated from the first institute in June 1995, more than had originally been planned for. The second group had 60 members, which is expected to be the, maximum number that can be effectively accommodated at one time.

The institute was designed for new directors -- with two years or less experience, directors of developing programs and physicians planning to assume the role of program directors. However, interest from

experienced directors has been high. As a result, planners of the Program Directors Workshop and the RAP Workshop are working to develop their curricula in line with the topics covered in the institute.

Taking to the Airwaves

On September 9, 1994, the organization found yet another way to serve its members. Family Medicine Television Network (FMTN) broadcast its first program to nearly 200 residency programs throughout the United States.

Chaired and moderated by past president Stephen Brunton, MD, with content development guided by the AFMRD Program Content Committee chaired by Franklyn Dornfest, MD, the network provides interactive programs once a month on topics of value to residents and program directors. The first program, for example, on "Ramifications of Health Reform" featured Robert Graham, MD, Executive Vice President of the AAFP, Daniel Ostergaard, MD, AAFP Vice President for Education and Scientific Affairs, and David Mersy, MD, President of AFMRD at that time. Later programs dealt with headache, several types of gastrointestinal disorders, and other medical topics.

Each medical program features a family physician with substantial experience in the topic under discussion. Viewers, who can earn continuing medical education credit for participating, can ask questions via telephone.

"FMTN provides a unique opportunity for residents and faculty to interact with leaders of our discipline," said Stephen Brunton, MD. "In addition, it provides a mechanism for residency programs around the country to network about other issues of concern."

The network is presented in conjunction with Interactive Medical Network, which provided most of the necessary equipment to the registered sites at no charge. Programming costs are being underwritten by pharmaceutical and medical device companies.

Looking into the Future

The first five years of AFPRD have been ones of achievement and growth. The consensus of those involved in conceptualizing the organization is that this has indeed been a very successful endeavor.

"Membership support is incredible," says Penelope K. Tippy, MD. By 1995, over 95% of eligible directors were members.

In 1993 the AFPRD board prepared a strategic plan for its next five years. Of the 22 goals it set to accomplish by 1998, many had been accomplished by 1995, among them:

1. To have more than 90% of program directors as members
2. To continue a positive close relationship with AAFP

3. To lead the development of program directors as educators and administrators
4. To provide leadership in graduate medical education
5. To promote ethical principles among program directors, and
6. To provide training to new program directors in cooperation with RAP, STFM, and ABFP

Much remains to be done, of course. Among the issues that still need to be addressed are ways to involve more members and to include others such as former program directors or those carrying out director duties without the title; the involvement of AFMRD in retaining other specialists as family physicians; income sources for the group; and graduate medical education financing reform.

The positive view of past accomplishments leads organizers to a predominantly positive view of AFMRD's future. As Dr. Tippy predicts, "AFMRD will become even more influential with experience and 'savvy' that comes with years."

The most important task AFPRD and the other members of the family will have in the future, believes Dr. Saultz, relates to the different training that will be needed for the twenty-first century.

"Currently family physicians tend to think they are the best prepared for health care reform," he says, "but in fact no one is completely prepared. AFMRD may be in the best position to bring this about."

Finally in discussing the group's future, Dr. Layton returned once again to the primary reason for its formation in the first place -- "AFPRD is a voice that will continue to grow into a major leadership effort."