to 40 years out of residency. Of those faculty who are less than 5 years out of residency, three of six scored as impostors (50%). Of those faculty who were 5 to 10 years out of residency, two of four scored as impostors (50%). Of those faculty who were 10 to 15 years out of residency, three of eight scored as impostors (37.5%). Of those faculty who are greater than 15 years out of residency, two of 10 scored as impostors (20%). With this small sample size, it does appear that the impostor phenomenon diminishes with experience; however, it may take a significant amount of experience (over a decade) to extinguish impostor-like feelings.

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REFERENCE


New Research

Family Medicine Interest Groups Impact Student Interest

To the Editor:

The American Academy of Family Physicians (AAFP) Commission on Resident and Student Issues (CRSI) regularly invests in family medicine interest group (FMIG) activity at US medical schools. As the liaison to this commission from the Association of Departments of Family Medicine, the first author conducted a PubMed search and found only one article specifically evaluating the activities of FMIGs.1 We undertook a survey to catalog the activity of FMIGs, assess the investment in FMIGs, and identify how FMIGs are being evaluated.

Three e-mails containing the survey were sent to all family medicine academic units (departments, divisions, and non-organized schools) at the 124 medical schools and 11 geographically separated campuses listed in the AAFP’s Activity in US Medical Schools, Reprint 164 (January 2003). The survey was internally validated and reviewed by three department chairs prior to release. Departments failing to respond to the e-mail canvass were contacted by phone or fax.

A total of 116 responses (85%) were returned. Of respondents, 99% (115) have FMIGs at their medical school. Thirty-five departments (30%) report that their FMIG had disbanded at least once in the past 20 years. Only 18 (16%) departments assign more than 10% full-time equivalence (FTE) of a faculty physician to FMIG support. Seventy-nine (68%) departments assign nonphysician staff to FMIGs but most (64%) for less than 1 half day per week. Two thirds of departments spent $1,400 or less annually to support FMIG activities. Two schools spent $5,000. Funds came from family medicine departments, medical schools, and state AAFP chapters. A few FMIGs undertook student fund raising activities. Formal student feedback (37%), student attendance at FMIG programs/activities (26%), school match rate into family medicine (28%), and word of mouth/anecdotal reports (9%) are used to assess FMIG activities. Using the 2002 Match results,2 we used odds ratios, chi square, and correlation statistics to evaluate the relationships between students entering family medicine and our survey results of the investment, faculty time, or activity types of the FMIGs and found no significant relationship. There was also no relationship between these factors and whether the medical school was public or private.

Contrary to the study published in 1995,1 this survey failed to demonstrate an association between FMIG activity at a medical school and the number of students entering family medicine. The early 21st century reflects a different environment for recruitment than did the mid-1990s. It is possible that students with fringe interest in family medicine are more likely to respond to FMIG overtures during high primary care match years than during low-entry years. Several respondents expressed a belief that FMIGs preserve family medicine interest more than they recruit to the specialty. The 30% suspension of FMIG activity rate over 20 years indicates more group fragility than previously described. Our survey updates the current activity of FMIGs in the United States, revealing that they remain a prevalent student activity.

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REFERENCES


Comment

80-hour Workweek—One Solution

To the Editor:

With the incoming class of new residents this summer, the 80-hour workweek and accompanying duty hour rules implemented by the Accreditation Council for Graduate Medical Education (ACGME) in July 2003 reach their 1-year anniversary. Residency programs across the country, some successful and others not, have struggled to arrange schedules, hours, and duties to comply with the new guidelines. As my intern year at Bryn Mawr Family Practice Residency concludes, the pragmatic approach taken by the residency has ensured that all resi-
dents are in full compliance with the duty hour requirements.

As I reflect on the year, the residency made choices to ensure compliance by weighing two important principles—teaching for residents and service to the hospital. Simply stated, for interns to work fewer hours on inpatient rotations, there either had to be less work or more physicians doing the same amount of work. To achieve this, the residency asked an important question of the interns—where do you feel you get the least teaching? After some debate, the weekend calls, specifically Saturday and Sunday, seemed to be a time of hurried note writing, fast rounding, and less teaching.

The Bryn Mawr Hospital has the fortune of being staffed by 24/7 hospitalist groups in both medicine and pediatrics. With their gracious support, Saturday and Sunday in-house call and Sunday rounding duties were eliminated, allowing the six-intern class to take call roughly once per week in medicine, ICU (Intensive Care Unit), and CCU (Critical Care Unit). This also guaranteed a minimum of 1 day in 7 free of duty. The 2-month pediatric rotation was divided into a month of night float and a month of days, allowing ample night time admission and critical decision-making exposure plus daytime continuity rounding. As a result of these decisions, the duty hour tally fell well below 80, and post-call interns are allowed to leave the hospital by 1 pm.

Duty hour compliance presents a difficult choice between teaching and service. Programs lacking the resources to solve this problem ultimately have to face the reality of residents doing more with less or maintaining the status quo. The compromise reached at our hospital represents a model that, while not applicable to all residencies, is working.

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