

the session is conducted and if an interpreter is needed. For it was the construction of Louisa's genogram during the home visit that revealed an X symbol (ie, signifying death) over her beloved brother-in-law's name that brought forth her unspoken grief and the need for Kleenex for the patient and her providers.

Thank you very much for your letter and excellent points.

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## New Research

### Faculty Development as a Strategy for Retaining Family Physicians in Academic Medicine

#### To the Editor:

Evidence over the past 3 decades suggests that insufficient training in research, scientific writing, cultural competency, and communication is strongly associated with the low retention rates of family physicians in academic medicine.<sup>1-3</sup> In this letter, we report on preliminary outcomes from a formative evaluation of a combined faculty development program designed to address these faculty needs<sup>3,4</sup> at two US medical schools, one of them a historically black medical college.

#### Program Description

Using funding from a multi-institutional Bureau of Primary Health Care (BPHC) grant from the Health Resources and Services Administration, the two family medicine departments at the Charles R. Drew University of Medicine and Science (Drew) and the University of California, Los Angeles (UCLA) collectively established a combined faculty development program to address the recent decline in faculty promotion of family physicians. At the time of program inception in 2003, only five family physicians at UCLA were senior faculty (out

of approximately 18) and none at Drew (out of nine).

The Drew-UCLA Faculty Development Program (DFDP) was developed and implemented as a 3-year demonstration project comprising two program tracks (Track 1 and Track 2). Track 1 was a rotating 12-month series of workshops on medical education, patient-centered care, practice-based research, cultural competency, and skills for academic advancement (eg, scientific writing, grant writing). An interactive Web-based educational resource (WebCT) was implemented as an adjunctive tool for self learning and self-assessment. Speakers for the didactic workshops were drawn from a pool of senior faculty representing both primary care and specialty disciplines at both universities. Track 2 was designed to be a more-rigorous curriculum that involved quality mentorship of interested junior faculty by senior professors at Drew and UCLA.

The DFDP was structured and designed to include features known to be essential elements of outstanding faculty development: senior leadership and mentorship, ongoing input from relevant stakeholders, program emphasis on participative governance, effective communication and networking, and a built-in plan for evaluating program fidelity.<sup>2,4</sup> The latter included a baseline faculty needs assessment (n=27) and focus group (n=10), an organizational readiness-to-change survey of clinical staff (n = 61), and periodic reviews of faculty activities at both institutions.

#### Results

The program achieved 80% of its first-, second-, and third-year objectives (eg, establishment of the Track 1 core workshops, good attendance of program activities, establishment of the WebCT as a self-learning tool). However, indicators of progress such as attainment of extramural funding, improved publication record, and number of academic promotions among eligible junior

faculty were equivocal. Analysis of the program data suggests that the lack of protected time and the growing demands on family physicians to provide clinical services contributed to lapses in the commitment by faculty interested in the Track 2 curriculum.

#### Comments

Like many faculty development programs in family medicine, the financial sustainability of our program is dependent on ongoing support from BPHC grants, with limited alternative sources. We encountered several institutional barriers that also limited the impact of our program on academic advancement of family physician faculty. Some of these barriers included a limited number of senior faculty with experience mentoring family physicians, a lack of protected time for junior faculty to pursue meaningful scholarly activities (eg, peer-reviewed publications or pursuit of a public health degree), and an academic rank that remains below other disciplines at each university. Targeted adjustments<sup>4</sup> in the future, including identifying alternative funding sources and mentorship opportunities, may help improve the quality of our program, but advocating to university leadership to protect the time of junior faculty in family medicine will also be critical for increasing scholarly productivity—ultimately, the primary criterion for academic promotion.

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## REFERENCES

1. Komaromy M, Grumbach K, Drake M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med* 1996;334(20):1305-10.
2. Bland CJ, Stritter FT. Characteristics of effective family medicine faculty development programs. *Fam Med* 1988;20(4):282-8.
3. Correa N, ed. *Caring for Hispanic patients*. Leawood, Kan: National Hispanic Medical Association and American Academy of Family Physicians, 2005.
4. Rust G, Taylor V, Herbert-Carter J, Smith QT, Earles K, Kondwani K. The Morehouse faculty development program: evolving methods and 10-year outcomes. *Fam Med* 2006;38(1):43-9.

## EBM a Challenge for International Medical Graduates

### To the Editor:

Evidence-based medicine (EBM) is encouraged in postgraduate education, but many curricula lack key elements such as evaluation, access to resources, faculty development, or training regarding pre-appraised summarized evidence-based resources.<sup>1</sup>

In 2005, early in the development of a new EBM curriculum in the University of Alberta (U of A) Family Medicine Residency Program, we hoped to identify the residents' perceptions, skills, and barriers to EBM, particularly the influence of their medical school of graduation. We separated the residents into three groups based on medical school of graduation: graduates of U of A, Canadian graduates not from U of A, and international medical graduates (IMGs). We developed a survey based in part on previous questionnaires,<sup>2,3</sup> pilot tested with three residents, modified for clarity, and distributed to residents at their Academic Half-Day. The study received ethical approval from the Health Research Ethics Board, U of A.

Of 92 available residents, 62 (67.4%) responded. Most (70%) residents reported a positive attitude toward EBM, and 73% felt it improved patient care. EBM was

felt to be practical, faculty members were considered supportive, and time was not a substantial barrier for the majority of respondents. There was no relationship between the demographic variables of gender, age, and program (rural/com-bined) and the responses ratings of any questions. Unfortunately, more than 50% felt that EBM training in medical school was inadequate in quantity and quality. Residents who graduated from Canadian medical schools other than the U of A rated EBM training in medical school higher for quantity (Kruskal Wallis 15.4,  $P < .001$ ) and quality (Kruskal Wallis 12.5,  $P = .002$ ) than graduates from U of A or IMGs. IMGs were more likely to report basic computer skills as a barrier to EBM practice (Kruskal Wallis 6.059,  $P = .048$ ).

The study findings reveal that many of the residents, particularly IMGs and those from U of A, felt that EBM education in medical school was inadequate in quantity and quality. The limitations in undergraduate EBM education at the U of A are known and presently being addressed by the Undergraduate Committee. The situation for IMGs is unlikely to change soon. Studies in non-Western countries suggest that there are significant barriers to EBM education, including negative attitudes among faculty<sup>4</sup> and only 40% of clinicians having heard of the EBM concept.<sup>5</sup> Unfortunately, there are no studies directly comparing the EBM education of international graduates and graduates of Western countries. However, a recent US study of practicing clinicians found that international graduates were less likely to practice evidence-based preventive care.<sup>6</sup>

While graduates of Canadian medical schools are not limited by their computer skills, IMGs are. No study has specifically reported computer skills as a possible barrier to EBM. However, poor access to the Internet and evidence-based resources in other countries, as

described by clinicians in Saudi Arabia<sup>5</sup> and trainees in China,<sup>4</sup> may be contributing to limitations in computer skills among IMGs. Another possible factor may be the older average age of IMGs.<sup>7</sup>

This small study suggests that IMGs have limited EBM training before residency, and computer skills are a barrier to their EBM practice. More research is required to determine if this is a concern for other training programs. Since many programs include graduates from a wide variety of backgrounds, it may be prudent to include some basic education in EBM and computer skills early in residency.

*Acknowledgments:* The rough data has been presented at the (Canadian) Western Departments of Family Medicine Annual Meeting on May 5, 2006, and the University of Alberta Family Medicine Residents Research Day on June 9, 2006. Both are small, local-level meetings.

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## REFERENCES

1. Green ML. Evidence-based medicine training in internal medicine residency programs. *J Gen Intern Med* 2000;15:129-33.
2. Thom DH, Haugen J, Sommers PS, Lovett P. Description and evaluation of an EBM curriculum using a block rotation. *BMC Med Educ* 2004;4:19.
3. Grad R, Macaulay AC, Warner M. Teaching evidence-based medical care: description and evaluation. *Fam Med* 2001;33:602-6.
4. Lam WW, Fielding R, Johnston JM, Tin KY, Leung GM. Identifying barriers to the adoption of evidence-based medicine practice in clinical clerks: a longitudinal focus group study. *Med Educ* 2004;38:987-97.
5. Al-Almaie SM, Al-Baghli N. Barriers facing physicians practicing evidence-based medicine in Saudi Arabia. *J Cont Educ Health* 2004;24:163-70.
6. Pham HH, Schrag D, Hargraves JL, Bach PB. Delivery of preventive services to older adults by primary care physicians. *JAMA* 2005;294:473-81.
7. Szafran O, Crutcher RA, Banner SR, Watanabe M. Canadian and immigrant international medical graduates. *Can Fam Physician* 2005;51:1242-3.