

our training quite distinctive compared to many of the other institutions mentioned and perhaps opens the door to learners not seeking a larger urban center and to similar private institutions contemplating the provision of such training.

There continues to be a shortage of primary care physicians for underserved populations in this country, and there is certainly room for many different types of training in this niche—from large urban centers to urban training tracks, to FQHCs and, of course, in private health care centers. We can all be pioneers in this area and can learn from each other how to maintain our mission and goals to provide quality primary care and improve the health of our urban populations. Thank you for your interest.

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New Research

Measuring Behavioral Science Curricula in Family Medicine Residency

To the Editor:

Effective residency training in behavioral science is strongly endorsed by principal groups in family medicine. Nevertheless, residency programs put variable emphasis on behavioral science training and train residents using a variety of methods. A commonly used measure of resident and curricular performance is the American Board of Family Medicine (ABFM) In-training Exam (ITE). This study aimed to determine what features in behavioral science curricula relate to higher mean scores and score improvement on the psychogenic subsection of the ABFM-ITE.

Methods

The investigator e-mailed surveys to all family medicine program directors in the United States inquiring about programs' behavioral science curricula. He also requested permission to use program mean psychogenic subsection ITE scores for the study. The survey included 26 topics divided into five categories: program demographics, behavioral science instructors, teaching sites, teaching methods, and the degree of program emphasis on nine stated ACGME-required curricular elements. The curricular features were largely drawn from prior studies evaluating behavioral science curricula from family medicine residency programs in the United States. Curriculum performance was judged by program average third-year resident scores as well as improvement in average scores over 3 years of training.

Results

A total of 142 (31%) of all surveys were completed. Seventy-five programs (16%) also allowed permission to analyze their subsection scores. There was no difference in psychogenic subsection scores between the 75 programs analyzed and the mean subsection scores for all US family medicine residency programs. Nor was there a difference between the curricular features of the 75 programs studied and the 142 programs that completed surveys.

Curricular items that positively related to scores included: compulsory reading ($P=.01$ for mean third-year scores and $P=.02$ for Class of 2007 score improvement), instruction by either a behavioral scientist or physician but not both together ($P=.004$ for Class of 2006 score improvement), and behavioral science training in a non-psychiatric hospital ($P=.013$ for Class of 2006 score improvement). Reported curricular emphasis on three of nine topics required by the ACGME demonstrated negative correlations

with performance and improvement on the subsection: emotional aspects of non-psychiatric disorders ($P=.04$ for Class of 2007 score improvement), counseling and psychotherapy ($P=.01$ for mean third-year scores and $P=.04$ for Class of 2007 score improvement), and death and dying ($P=.01$ for Class of 2007 score improvement).

Conclusions

The observation that psychogenic subsection scores of the ITE relate very little to common teaching approaches—and even demonstrate a negative correlation with curricular emphasis on ACGME-required topics—brings the properties of the subsection into question. Specifically, it undermines the commonly held presumption that the subsection has content validity for measuring resident knowledge in the behavioral sciences. The psychogenic subsection seems to measure little of what is taught in family medicine residencies.

One limitation in the study is the small sample size and a potential for bias: only 16% of all family medicine residency programs both included surveys and gave permission to analyze subsection scores. Still, the programs analyzed seem to be an accurate representation of the general program population; the mean ABFM scores of the sample were the same as the general mean, and the curricular features of the sample were not statistically distinct from the larger body of programs that completed surveys.

This study supports prior recommendations to avoid using the ABFM ITE subsections to evaluate individual resident knowledge. It adds to that recommendation by suggesting against using subsection scores as rationale for grading or modifying behavioral science curriculum.

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Comment

Benefits of Continuity of Care

To the Editor:

The articles on continuity of care in the January 2009 issue of *Family Medicine* struck a chord with me as a full-time practicing family physician.

The article by Bennett and Baxley looked at the cause of no-show rates.¹ They found that Advanced Access appointment scheduling did not improve a dismal rate of 20.5%; other factors (notably race, insurance status, age, and attendance history) were more predictive.

The article by Phan and Brown found that continuity of care actually decreased under Open Access (ie, same day) scheduling.² Patients saw their usual provider 59% of the time through a traditional scheduling system versus 55% under Open Access. The authors speculate that lack of physician availability, inflexible same-day scheduling, and patients' sense of urgency were key factors.

A commentary by Mainous and Salisbury tried to balance the need for continuity with ready access to care.³ They suggested that both needs could be served by linking patients to a team of providers and allowing them to choose between immediate access or waiting for their usual provider.

All three papers draw necessary attention to the question of continuity of care in primary care. But, to the mind of this practitioner, they miss some obvious points. First, continuity reflects our level of commitment to ambulatory care. It struggles in teaching centers where the inpatient service, obstetrical call, and specialty rotations compete for a resident's time and attention in the family medicine center.

Second, the bridge to continuity is often the receptionist, medical assistant, educator, or mid-level practitioner. Patients know a medical team (a.k.a. a truly patient-centered home) when they experience it.

Third, the value of the doctor-patient relationship lies in its mutuality. Both patient and doctor benefit from the insight, trust, compassion, and loyalty of a good, working relationship. As Mainous and Salisbury point out, continuity of care is not an end but a means to

better relationships that no scheduling formula can guarantee. Such relationships rely upon a commitment to time in the office, self-reflection, and the value of genuine kindness.

Family physicians have always known this to be true. But sadly, in the university setting where educators compete for the respect and favor of students and residents, we have convinced ourselves that skills and procedures, snap judgments, and interventions must be taught and mastered for the survival of the discipline. What do patients need? Rarely these.

Much more often, they need someone to listen, accompany them, and give them hope. And this takes time—time in the office.

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