

Letters to the Editor

Joseph Scherger, MD, MPH
 Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to jscherger@ucsd.edu. 858-232-8858. Fax: 858-565-4091. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

New Research

Areas of Concentration in Family Medicine Residency Training

To the Editor:

The Task Force on Medical Education of the Future of Family Medicine project called for residency programs to individualize learners' needs and offer expanded educational opportunities in areas needed by graduates. Traditional approaches to meeting individual residents' needs include elective rotations and post-residency fellowships.

In 2007, the Association of Family Medicine Residency Directors created guidelines for Areas of Concentration, which provide a common framework around which residents, program directors, and faculty may design optional, additional training that is above and beyond the core training in family medicine. An Area of Concentration allows residents to pursue some differentiation in their training beyond the core, yet not to the level of a year-long fellowship.

We conducted a pilot study to determine the level of interest regarding Areas of Concentration among US medical school graduates planning to enter family medicine residency training in 2007 at one or both of two programs—the Uni-

versity of Texas Medical Branch-Galveston and Cabarrus Family Medicine Residency, Concord, NC, programs. This was a convenience sample and included all applicants to either of the two programs who were US graduates and ranked by the program(s).

There were a total of four questions on the survey, addressing the students' interest in pursuing an Area of Concentration, potential areas of study, whether or not the availability of Areas of Concentration in particular programs would affect the student's ranking of programs in the Match, and an open comment box. To minimize pre- and post-Match confounding, the survey was launched after final rank lists were submitted by both applicants and programs and prior to the release of 2007 Match results. This study was reviewed and approved for IRB-waived status at the University of Texas Medical Branch-Galveston (IRB #07-098) and Cabarrus Family Medicine Residency (IRB waiver not numbered).

Forty-nine applicants met selection criteria. The response rate was 69%. Sixty-six percent of respondents indicated that they would pursue an Area of Concentration during residency, 28% were unsure, and 3% did not think they would pursue an Area of Concentration.

The top three curricular areas chosen were International Health,

Complementary and Alternative Medicine (Integrative Medicine) and Advanced Obstetrics.

A total of 62% of respondents indicated that the availability of Areas of Concentration would be likely to affect their rank order listing of programs in the Match, 24% indicated that it would not, and 14% were unsure.

The Area of Concentration guidelines provide a common framework and vocabulary for the creation, description, and study of areas of focused training during family medicine residency. Since the formation of the discipline of family medicine, there has been no common terminology to describe an area of interest, yet many family physicians have them. It is only natural for intellectually curious physicians to want to gain more depth of understanding and knowledge in areas that interest them. With the explosion of information readily available in the Information Age, new knowledge has never been more available. Perhaps the most important principle of adult learning is to enable the learners to identify and pursue their own intellectual agenda.

In conclusion, US medical school graduates applying to family medicine residency are interested in additional individualized training in Areas of Concentration. These pilot data suggest that the availability of Areas of Concentration may help

attract students to programs that offer optional focused training during residency.

Lisa R. Nash, DO

Department of Family Medicine
University of Texas Medical Branch-
Galveston

Mark D. Robinson, MD

Cabarrus Family Medicine Residency
Program, Concord, NC

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Corresponding Author: Address correspondence to Dr Nash, University of Texas Medical Branch-Galveston, Department of Family Medicine, 301 University Boulevard, Route 1123, Galveston, TX 77555-1123. 409-772-0641. lrnash@utmb.edu.

Comment

Lost in Translation: The Confusing Lexicon of the “New” NIH

To the Editor:

It was with great anticipation that I attended a recent lecture given by a highly regarded (and highly publicized) scientist from the National Institutes of Health (NIH) titled “Translating Basic Research Into Clinical Practice.” Hoping to hear about efforts to link important work in the research laboratory with improved health care outcomes in the context of relevant disease, I was instead subjected to 45 minutes of microbiologic minutia. Disappointed, I began to ponder how I fell for this unfortunate exercise of “bait and switch.” For me, the answer lies in the amorphous definition of the word *translation*. Clearly, in the mind of the lecturer this was a “translational” lecture in the truest sense of the word. As a practicing physician, my interpretation of the lecture was that the only translation I needed was help with interpreting an overwhelming volume of basic

science information related to a disease that I will probably never see. For me, the “translational” aspect of the presentation was neither practical nor useful.

The term *translation* (as it applies to research and clinical patient care) appears to be suffering from an identity crisis. As originally defined by the NIH (<http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-06-002.html>), translational research includes two concepts. T-1 research is the process of applying discoveries generated in the laboratory (bench) to clinical use (bedside). The second area of translation concerns research aimed at enhancing the adoption of best health care practices in the community. This is T-2 research.

Why these overlapping definitions? What does translation really mean to the practicing family physician? Are we merely intermediaries for recruiting and enrolling patients into large industry or federally funded trials? Is translation, therefore, nothing more than a modern term *de rigueur* for securing funding? If luminaries from the clinical center of NIH have difficulty applying the concept of translational research in tenured lectures, how is the average community-based primary care physician ever going to make sense of any of this hackneyed lexicon?

While I wholeheartedly applaud the direction the NIH is taking in terms of transforming the landscape of major US academic medical centers to make research more relevant and accessible to more patients, until some basic terms are more clearly defined, I worry that many of us laboring in the trenches of patient care will remain hopelessly lost in translation.

Mark B. Stephens, MD, MS
Department of Family Medicine
Uniformed Services University

Acknowledgments: These are Dr Stephens’ opinions. They do not reflect official policy of the Department of Defense, Department of the Navy, or the Uniformed Services University.

New Research

A Pilot Survey of Community Health Services in China

To the Editor:

We were invited to attend the Third International Symposium on Community Health Services in Beijing in the summer of 2006. We conducted a pilot survey to examine services provided in the community-based general practice in China through surveying 180 meeting attendees who were health care providers.

Facing mounting problems in worsening access to care and rising health care costs, the Chinese government issued a health policy in 1997 to support the establishment and development of community health service centers and stations.¹ Demonstration projects were implemented between 1992 and 1995 in several large metropolitan areas.² Community health services centers and stations have been established to provide basic medical and public health services including immunizations, health education, and rehabilitation, as well as traditional Chinese medicine therapies.

Our survey showed that cardiovascular disease, diabetes, and hypertension were among the top five common diseases and conditions seen in the community-based general practice. As patients present with these chronic conditions, health care providers in the community settings have to take on the challenges in effectively managing them with limited resources. Their role in coordinating the care of those who may need inpatient treatment has not been developed. While responsible for routine care of chronic conditions, the surveyed providers acknowledge the importance of community health service centers and stations in dealing with emerging epidemic diseases such as SARS and other potential threats.