

health as will overall improvements in their economies. To expect African family medicine to carry out the agenda of primary care described in these articles is to ask of it what it has neither chosen nor can deliver.

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developing a sustained partnership with patients, and practicing in the context of family and community.”⁵ This is what the family doctor and the health care teams should offer to all people.

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Primary Care Is Important for Africa

To the Editor: The comments made by Dr. Downing in his communication regarding a need to evaluate the benefits of primary care are accurate. Studies do need to be conducted in the developing and emerging world to determine whether the principles of primary care and family medicine do improve health. As noted by Montegut,¹ it is unrealistic to expect that family physicians could be trained to offer primary care for all rural areas. The family physician can play a role, however, in the health care team that includes nurses and health care workers in the more remote areas. It is this delivery model which needs attention for the delivery of primary care.

Starfield, Shi, and Mancinko² review multiple studies from developing countries as they relate to primary care. One study describes a reduction in health disparities associated with socioeconomic disadvantage in 7 African countries as a benefit of primary care.³ Another study which was an analysis of preventable deaths in children showed that 63% of these deaths could have been prevented by full implementation of primary care with interventions that included addressing diseases common to Africa such as diarrhea, pneumonia, malaria, and HIV/AIDS.⁴

In comparing health care systems, one must be careful in defining the principles of primary care. First contact care is not defined as “gate-keeping,” longitudinal care is not related only to chronic disease, and comprehensive care including preventive health must account for the local diseases which in Africa include malaria, tuberculosis, and HIV/AIDS and not be viewed solely as related to “check-ups.”

One needs only look at the Institute of Medicine’s definition of primary care to understand how this approach to health care is applicable to all populations. “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs,

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Integrative Medicine Increasing in Family Medicine Residency Programs

To the Editor: We commend and strongly support the effort of the *Journal of the American Board of Family Medicine (JABFM)* and the American Board of Family Medicine to address the issue of redesigning Family Medicine (FM) residency. Such forward and creative thinking has become essential in a rapidly changing era of health care and post-graduate medical education. The series of articles^{1–5} presented a creative number of options for residency redesign. As a consortium of academic health centers committed to integrative medicine (IM), we wish to share another—that of incorporating a robust IM curriculum within the standard 3-year FM residency. As alluded to in Dr. David’s article, several programs have created a 4-year FM residency which include IM or other areas of concentration such as sports medicine or a master’s in public health.²

A group of 8 existing FM residency programs (University of Arizona, Tucson, AZ; Beth Israel, New York City, NY; Carolina’s Medical Center, Charlotte, NC; University of Connecticut, Hartford, CT; Hennepin County Medical Center, Minneapolis, MN; Maine Medical Center, Portland, ME; Maine-Dartmouth, Augusta, ME; and University of Texas Medical Branch, Galveston, TX) are now participating in an Integrative Medicine In Residency (IMR) Project. They are currently in the process of developing a 3-year pilot curriculum to be implemented in July 2008 in which the didactics of both IM and FM are woven together via online curriculum support. The content of the curriculum is being informed by a needs assessment survey

completed by faculty and residents of these programs. This stakeholder-based process and teaching strategy will provide for a scaleable in-depth approach rooted in our discipline's core values and traditions while incorporating IM's innovative ways to educate and practice primary care. The areas of emphasis include:

1. Relationship-centered care, communication and motivational interviewing,
2. Collaborating with broadly conceived teams of health professionals including complementary and integrative practitioners,
3. Recommending a full spectrum of evidence-based, cost-effective therapeutic options for our broadly constituted, ethnically diverse, and underserved communities,
4. Using a mind-body-spirit, bio-psycho-social approach to treat and support the health of each individual,
5. Respecting the natural capacity of the body and the patient to heal,
6. Acknowledging the importance of physician self-care and well-being.

The possibilities for enhanced training are myriad, particularly for many chronic conditions in which traditional medical interventions may come up short. Some examples of integrative approaches include: the use of fish oil as part of secondary prevention of cardiovascular disease, management of elevated triglycerides, as well as for stroke prevention; the use of an elimination diet to assess gluten sensitivity or milk product intolerance in the treatment of irritable bowel syndrome; and the use of mind-body interventions for migraines.

IM has become a leading edge of thought, practice, and education at a time when FM has to respond compassionately and comprehensively to patients within a dysfunctional and unsustainable health care system. Faculty development and teaching methods must keep pace with providing practices that empower both future physicians and patients toward maintaining health. We believe this cohort of pilot programs will provide an excellent model for residency education as we all move forward into this uncharted terrain.

The flowering of our specialty as it renews itself in the years ahead is supported through the principles and values of IM. This change is firmly rooted in FM's tradition of leadership in educational innovation and dedication to the primacy of whole-patient care.

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Dr. David declined to respond since he is in agreement, but would like to acknowledge their innovative initiative in residency education.

The Case For A Broad Base

To the Editor: The article by Dr. Whitcomb¹ in the July–August issue was most interesting and timely. In discussing the future of family medicine, it is imperative that we as a discipline solicit input from those outside the specialty and from outside of the field of medicine, as he so eloquently stated, to ensure that the changes we contemplate are in the public's best interest. As physicians, our professional self-interest must take a back seat to what is best for our patients. The invitation to an intensivist to share his opinions on the future of our specialty in the *Journal of the American Board of Family Medicine (JABFM)* is an important step in the right direction. May this dialogue continue!

Dr. Whitcomb's observation regarding the strength and opportunities for our specialty in the area of outpatient care of chronic illness is most astute and indeed mandates increased focus in family medicine's training programs. However, the suggestion of changing the focus of the discipline to exclusively chronic disease management may not be in the best interest of either the public or of the specialty.

Family medicine has traditionally included a very broad-based training. Although individual family physicians often tend to narrow the scope of their practice over the years, they begin equipped for a wide range of practice possibilities. These "pluripotent stem cells"² of the medical profession may later be found staffing emer-