PANEL DISCUSSION

Family Medicine and the Evolution of Academic Health Centers: A Dialogue With Leadership

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INTRODUCTION

Following are excerpts from the closing panel discussion of the session "Shaping the Future of Academic Health Centers: A Reconnaissance from the Front Lines of Medicine," held during the 2005 annual meeting of the Association of American Medical Colleges (AAMC).

A DIALOGUE WITH LEADERSHIP

J. Lloyd Michener, MD: I much appreciated the many excellent presentations today and have only 3 comments to add. The first is that we are clearly entering into a period of innovation in health care delivery. Our practices, our hospitals, and our academic health centers are changing in ways that are new for most of us. One way is through the creation of new partnerships, not only with the communities, as has been described in a number of papers today, but within our own schools, and with schools of public health, health departments, insurers, and other organizations. Units that have not previously worked together are linking to deliver better care, teach in new ways, and do better research. The term *pay for performance* was not mentioned in any of the papers today; I predict that it will soon be rare for physicians to converse long without mentioning it. And as we focus on prevention and chronic disease, we will increasingly see teams that include nurse-practitioners, physician's assistants, and nurses partnering with physicians, to the benefit of our patients.

The second point is that it is time for us to lead. Family medicine departments, because of our history and our culture, can build the bridges with communities and with academic units in ways that are harder for others. We are not the only ones who can do this, of course, just as pediatricians are not the only ones who take care of kids. But we can lead in designing the innovations in health care delivery—often using ideas from other countries because they have figured out how to get by with fewer resources than we have. We can also do the testing of the models, we can disseminate the results, and we can teach these new methods to others.

The third point is that if we are going to lead, we need to let others join us. This can't be a 1-person parade. We are going to have to be open to the perspectives, the issues, and the comments of communities, other departments, and disciplines. We are, moreover, going to need to teach others how to form teams. Imagine an academic health center of the future in which we are teaching other units how to form partnerships, how to work with other communities, and how to do health care better.

It is time for us to move beyond our traditions and boundaries, and help our academic health centers and our communities come together for the health of both.

Deborah E. Powell, MD: I agree with Dr Michener and other speakers: we will have to take teams to a whole new dimension. Academic health centers have to find a way to reward and encourage teams in research, not just teams in clinical care and teams in education. We must educate our students and residents to practice in teams. We must practice and reward team-based research.

How are we going to do that? The new policies of the National Institutes of Health (NIH) regarding multiple principal investigators (PIs) is going to help, but we must also put in place local mechanisms to support this change. A priority is to change our promotion and tenure processes to reward the research at all levels—basic, translational, and clinical—that occurs in teams across departments. I think that family medicine departments through perhaps the practice networks have the ability to lead in this area. Interdisciplinary centers may be a good focus for team-based research; the new NIH initiatives in translational centers is perhaps going to compel us to move this way.

A second priority is to develop our faculty. We can do none of this—education, clinical care, new networks, new research, new practice models—unless we have the faculty to do it. As a dean, I have huge worries about the next generation of academic faculty and certainly in academic family medicine. Our faculty need better education, starting with introducing our residents and students to the joys of academic medicine rather than sending them out quickly into practice. Our faculty need better-protected time, better infrastructure, and more help in grants writing, grants management, statistics. They need better mentoring, with institutional support like the K12s and K30s promise, and new degrees like the master of public health and the master of science in clinical research—but they also need the time to get them, and that means money. If we are going to move our institutions forward, leadership at all levels must recognize that our biggest resource is our faculty and that we are in great danger of losing that if we don't do something soon.

A final priority is that we need the ability not just to discover but to apply and translate the new knowledge into the wider community. The knowledge we discover in academic health centers through our research at all levels must be translated out into the community. We need to disseminate it and we need to have the venues in which to disseminate it.

Jeffrey L. Susman, MD: Dr Michener, I haven't heard during all of this discussion any mention of the Future of Family Medicine initiative. Is it relevant to the changes we have been discussing in academic medical centers?

Dr Michener: I think that the Future of Family Medicine project has been very helpful to the discipline in helping us realize how far we have to go and what the path might be. It is not, however, the final answer. There is a lot of room for us to figure out what works in our communities and with our partners. One size does not fit all.

Thomas E. Norris, MD: If we are going to pay attention to the Future of Family Medicine, we need to think about how academic health centers can transform health care. If we are to have a future, it is dependent on which of the alternative paths the future of health care in the United States takes. Where will we go?

Dr Michener: I believe that there are many people in Congress who are trying to figure out what will work better. If health care is so expensive and yields so little, what is a better model? As academic health centers, we are partners in public health and prevention, and ought to be doing demonstrations, experiments, innovations not just on genomics bench research but on how to reach our diseases and patient populations more effectively. That will be easier for some than others; I suspect it is harder in Manhattan than in rural states where most of the population comes to you. Part of our mission as academic health centers and as departments is to figure out how to get health care to work better for the people we are trying to serve. That, fundamentally, is why academic health centers exist.

Dr Powell: A few years ago, when Ed Wagner was developing the Chronic Care Model, the mantra was "this can't be done in academic health centers." Now, David Stevens with the AAMC demonstration project is showing why it must be done in academic health centers—because we train the future generations of health professionals. That is our primary responsibility. This is an opportunity for family medicine, I think, because the biggest problem facing the country is chronic care. If family medicine does not take the initiative in the academic health centers to work to develop these new care models with teams, with our trainees as our partners, then we are not going to advance health care in this country. So, from my perspective, family medicine departments have an absolutely essential role for the major health care problem that is facing us in the next 20 years. Step up to the plate—as you are doing—and design those new patterns of health care and train the future generations in it.

John J. Frey III, MD: Dean Powell, I realize that you can't speak for all deans, but I would like your sense of the group. To what extent do deans agree that population health should be the responsibility for a medical school and a major focus of education? Beyond that, how do we make the investment in research infrastructure in communities so that we can make the transformation possible?

Dr Powell: I absolutely agree that it is the business of the medical school to deal with population health in our educational programs and in our clinical programs. This is our social contract. I don't see a dichotomy between public health and medicine or competition on this: there is so much to do and we need to do it together. Because of that, we need to make sure that our medical students and our residents are educated in principles of population health and that we partner with our schools of public health to leverage our resources.

As for research infrastructure, most of us in the large academic medical centers have spent so much of our time putting in place very expensive infrastructure for basic and translational science, and we have neglected the infrastructure for clinical research both in our institutions and in our communities. I think NIH is pushing us in this direction and the public is pushing us in that direction because they are basically saying, "We are not going to give more money if we don't see results."

I am not sure all deans feel this way. I think most of them are concerned about financial resources: we've got to get support for our research, and most people believe that large clinical trials pay a lot of money. In the end, we need to make the investments. So, at our school, I am suggesting that we dedicate 2 of our MD-PhD lines and our MSTP (Medical Scientist Training Program) for clinical research. I think students want to do this. I think we haven't paid enough attention to it. So, we have to spend some money to build this up because it will pay off big time.

Stephen Hargarten, MD, MPH: Dr Powell, as you know, the research rankings of medical schools derive from NIH funding. Neither co-PI status nor Centers for Disease Control and Prevention (CDC) funding (PI or co-PI status) is included. I am trying to promote a faculty member who, if he had not been co-PI, a major NIH grant would never have been landed. How can I get that person promoted and get that co-PI status counted for a school's ranking and also get CDC to be a part of the school's ranking?

Dr Powell: I agree that CDC funding should be included: it would help me! All of us struggle with rankings. On the one hand, my faculty say why do you care so much about the NIH rankings? But rankings are what bring you faculty, get postdocs, get graduate students, and help build up your program.

Regarding promotion, every school's promotion and tenure processes are different; changing them when you are part of a large university is tough. I think, nevertheless, these are fundamental changes that we have to make in order to recognize people's efforts and reward them with promotion and tenure. Compensation systems that reflect peoples' efforts and contributions are also critical.

Macaran A. Baird, MD, MS: We have heard of partnerships of many sorts, but one of the partners that academic health centers have not traditionally included is the community. We are within an academic medical school within an academic health center within a university within a community. We have a dilemma: like baby birds with their mouth open, the public is ever more needy, but our ever more resource-constrained delivery system is trying to deliver less care instead of more.

As with barn raisings, the community can help. We recently met with a community leader who said, "We want you to do a very good job with your medical part, but this other part is our job. Why are you messing with that without effectiveness? Let us help you and together we can be more effective." It isn't necessarily about more money; it is more about opening boundaries, listening, and reframing the problem.

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