Family Medicine Updates

From the Society of Teachers of Family Medicine

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NEW EDITORIAL LEADERSHIP FOR *FAMILY MEDICINE*

On March 1, 2010, I became the 4th editor in the 31-year history of the journal *Family Medicine*. Since then, I have been asked dozens of times to describe what changes are in store for the journal. Thus far our focus has not been on what to change but on clarifying our mission for the future. The Society of Teachers of Family Medicine publishes *Family Medicine*, so the journal has always focused on publishing articles related to educational research and curricular innovation. These are topics of primary interest to teachers working in residency programs and medical school departments and such teachers make up a majority of our journal's readers. Over the years, *Family Medicine* has become a major voice for innovation in medical education. Our training programs have never been in greater need of well-tested new ideas than they are today. We cannot expect our graduates to deliver evidence-based primary care by teaching them in programs that are fundamentally entrenched in outdated or unproven teaching methods. So it remains a goal of the journal to foster such innovation by publishing papers about educational research. This has been our focus for over 30 years, but does it really define our mission? What is the overriding purpose for *Family Medicine*?

Academic family medicine is, of course, much more than just teaching. Faculty members engage in clinical practice, conduct clinical research, and study innovations in health policy. So the scope of *Family Medicine* needs to be as broad and comprehensive as the daily work of its readers. As 20th century family medicine is transformed into a new model of primary care based on the patient-centered medical home, the need has never been greater for our clinical, educational, and policy work to be tied together in the research we conduct and the papers we write. All of the journals in our discipline must work together to build these interconnections because important new discoveries are likely to take place at the interface between clinical practice, clinical teaching, and health policy. In addition to medical school and residency educational research, *Family Medicine* will publish more papers about primary care workforce policy, interdisciplinary clinical and educational models, international issues in medical education, and community-based education. We will also continue to publish papers about new strategies to develop and retain the faculty workforce needed for a reformed health care system. Thus, the mission of *Family Medicine* is to facilitate communication among scholars, educators, and policy leaders interested in preparing the best possible workforce to care for communities of people.

Fortunately, our discipline is served by a family of journals that compliment one another. A new model of clinical care cannot evolve without a new model of clinician and this new clinician will not arise from old models of medical school and residency education. Just as research in our field requires a diversity of methods, a new model of primary care requires clinical, educational, and policy innovation. So I hope that regular readers of the *Annals of Family Medicine* will also be regular readers of *Family Medicine* and vice versa. Over the next few months, *Family Medicine* will begin to change in ways designed to enhance innovation at the interface between clinical practices, teaching programs, and research enterprises. In doing so, we will work to support and compliment the other journals in family medicine, both in America and internationally. There is much to be done and much is at stake.

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From the Association of Departments of Family Medicine

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THE CHALLENGE TO BUILD RESEARCH CAPACITY IN FAMILY MEDICINE: IS OUR DISCIPLINE READY?

Research in family medicine is critical to the success of our discipline. Research enables improved patient outcomes, more informed health policy, more effective education and training strategies, and enhanced academic credibility. As health care reform is implemented in the United States, there is an increased need to investigate

translational opportunities to improve patient health and safety at reduced costs. A strong research foundation is needed for our future. Is family medicine ready for this challenge? The answer is as yet unclear.

To begin with, there is no ongoing comprehensive assessment of family medicine's research capacity. This limits strategic planning to grow research for the discipline and develop and train researchers to support the increasing needs of robust primary care. Different attempts to monitor family medicine's research capacity have been published, but these efforts have been individual, one-time efforts focused on publications and grants.[1-3] Metrics by which research capacity should be measured and monitored needs to be better defined and ongoing assessments should be regularly maintained.

Some of the limited or indirect measurements of our research capability have been worrisome:

• The Development of the NIH Roadmap and the Clinical and Translational Science Awards (CTSA) generated opportunities for some departments of family medicine.[4] An update from a year ago showed that roughly one-third of all funded CTSAs have family medicine faculty in leadership positions.[4] The authors noted that while this is good for a few, the majority of family medicine departments do not have substantive involvement in a CTSA. This may be due to medical schools not having a CTSA or that the institutional CTSA commitment to community engaged research is not linked to their family medicine departments.

• Lucan, et al concluded, after a thorough investigation of family medicine's involvement in NIH that

> ...departments of family medicine and family physicians in particular, receive a miniscule proportion of NIH grant funding and have correspondingly minimal representation on standing NIH advisory committees. Family medicine's engagement at the NIH remains near historic lows, undermining family medicine's potential for translating medical knowledge into community practice, and advancing knowledge to improve health care and health for the US population as a whole.[5]

Not all the blame falls on NIH, however: family medicine researchers submit very few grants, compared with other disciplines. Additionally, NIH Research Project Grant tracking data shows that since 2006 the number of family medicine grants submitted to NIH has declined.

• ADFM assessed research capacity in a survey of departments of family medicine conducted Dec 2009-Jan 2010 with 92 department chairs responding. Departments of family medicine have significant variability in research capacity, with many having no researchers, and few departments having greater than 10 research full time equivalents. Roughly one-third of departments reported no faculty participating on grant review panels and another third had only 1 to 2 faculty members participating on panels.

However, there may be opportunities to improve our research capacity:

• Expansion of the Agency for Healthcare Research and Quality (AHRQ) funding: AHRQ has a responsibility to support research that can improve health care quality, access and patient safety while reducing costs. The FY 2010 appropriation total for AHRQ totaled $397 million, an almost 7% increase over the total requested by the President. In addition to FY 2009 appropriations, AHRQ received $700 million to conduct comparative effectiveness research (CER) in the 2009 American Recovery and Reinvestment Act. CER is a useful tool to support clinical decision-making and improve health care quality, but family medicine researchers must become experienced investigators in this methodology to compete for funding.

• New source of federal funding for patient-centered outcomes research: HR 3590, the Patient Protection and Affordable Care Act establishes a non-profit corporation known as the Patient Centered Outcomes Research Institute administered by a governing board composed of the directors of AHRQ and NIH along with appointed stakeholders. This Institute would identify research priorities, establish research project agendas, and study how health problems can be studied, monitored, treated, and managed. The Institute would be funded through a patient-centered outcomes research institute trust fund with funds available without appropriation.

Another opportunity for building research capacity is to combine resources and work together. In the above mentioned ADFM survey, 91% of departments of family medicine indicated they would support collaborative clinical research. This is perhaps our greatest resource—the possibility of creating significant research through our pooled clinical communities to investigate strategies for improved patient care. While our readiness remains to be documented, our enthusiasm for the new opportunities on the horizon seems ripe for collaborative engagement.

This *Annals* commentary was prepared by the Chair of the ADFM Research Development Committee and members of the Executive Committee with review by the full Executive Committee.

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From the Association of Family Medicine Residency Directors

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THE FAMILY MEDICINE MATCH: BULL MARKET OR DEAD CAT BOUNCE?

This year's national Match Day results were somewhat encouraging to America's family medicine residency program directors. This year, 73 more training slots in family medicine were offered than last year[1] and US seniors filled 98 more positions than in 2009. However, only 7.3% of US medical school senior applicants matched with a family medicine residency program, and US schools are still producing fewer US family medicine residency entrants (only 44.8%) than medical schools of other nations. To put it in perspective, since 1999 the total of family medicine positions offered in the match has declined 635 positions (from 3,265 to 2,630), and filled positions have decreased 293 (from 2,697 to 2,404) as the nation struggles with exploding health care costs and access to primary care.

Medical school Web sites trumpeted this year's outcome, however. One Boston-based school wrote that 50% of their just-matched class are "headed into primary care specialties, including internal medicine, pediatrics and family practice [sic]."[2] The AAMC put out 2 press releases on Match Day[3,4] stating,

> The AAMC is extremely encouraged that more graduating US medical students this year chose primary care for their residency training. The increases for family medicine, internal medicine, and pediatrics in this year's Match are welcome steps in the right direction for improving our health care system and our nation's health.[4]

Family medicine program directors do not seem to be as sanguine as the AAMC and many of its member institutions. Perhaps it's because, according to a 2008 study published in the *Journal of the American Medical Association*, only 2% of medical students choosing internal medicine were planning on becoming general internal medicine physicians.[5] Hopefully it is not lost on medical school deans that entry into an internal medicine or pediatrics residency does not insure that the ultimate product is a primary care physician.

To use a stock market analogy, is this the beginning of a bull market for student interest in family medicine or in reality only a "dead cat bounce" (a small uptick after a precipitous fall)? Are we more likely observing a halo effect resulting primarily from the widespread coverage of health care reform and spotlight on our nation's primary care crisis during the past year?

What is the responsibility of American medical schools and our hospital-based graduate medical education system to produce actual "in-the-trenches" primary care physicians anyway? Long-term workforce trends in primary care, internal medicine, and pediatrics are problematic to meeting our nation's primary care needs. Only 7.3% of US seniors choosing family medicine will clearly not get it done either, nor will use of retail clinics, independent nurse practitioners, and other workaround strategies, all touted to be solutions.

We believe medical school deans need to take a much more proactive leadership role in disinfecting the often toxic medical school environment that prospective generalists currently need to endure before choosing a primary care career.

Additionally, current Medicare GME caps are hospital-specific but not specialty specific. Decisions about the size and type of residency programs are largely determined by hospital CEOs who report to boards and/or shareholders. Hospital CEOs are judged primarily by the financial performance of the institution in a health care system that still rewards subspecialty and procedural care and the ability to bring in research funding. Additionally, there is currently much less accountability on quality and health outcome indicators of the population served by the institution than these consumption-driven revenue streams. New models of primary care-oriented sponsoring institutions such as teaching community health centers need be explored and supported.

America's family medicine residencies can produce a primary care workforce that will cut health care costs and improve outcomes if given the support. As recently-enacted national health care reform begins, real physician workforce reform to create realignment via better use of public dollars is essential. Making US medical schools financially accountable for their inherent social (and fiscal) contracts with the public and