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NORTH AMERICAN PRIMARY CARE RESEARCH GROUP POSITION STATEMENT ON THE DEFINITION OF BEHAVIORAL AND SOCIAL SCIENCES RESEARCH

Efforts to Define

Within the National Institutes of Health, the Office of Behavioral and Social Sciences Research (OBSSR) coordinates behavioral and social sciences research (BSSR) efforts across institutes. As part of its authorizing legislation, Congress asked OBSSR to "develop a standard definition of the field to assess and monitor funding in this area."[1] The current standard was developed in 1996 and revised in 2019 after an open request for input from the public.[1] In order to ensure that the revised definition was aligned with the tenets of primary care research, the Research Advocacy Committee of NAPCRG submitted comments in February 2019.

The OBSSR definition of BSSR spans a variety of fields, and links BSSR to biological and ecological contributors to disease. However, the previous definition left out fundamental unifying principles, as well as several, primary care–relevant fields which we believe exist firmly within BSSR. Our response reflected these views.[2]

Unifying Principles

Whether utilizing mathematical models, qualitative exploration, or mixed methods, a unifying feature of BSSR is its recognition of research that is difficult or impossible to control via experimental settings. Statistical models rely on answers that are possibly true, assessed through calculations of probability. In any statistical model that is non-definitional, the error term contains everything that could not be measured, or properly operationalized. Likewise, studies that rely on qualitative techniques intrinsically accept a non-positivist, non-reductionist view, and embrace complexity in searching for answers to research questions. Similar to primary care research, BSSR embraces probability, error, and approximation in the process of answering complex questions about both social structures, and the inner lives and expressed behaviors of the individual in the context of those social structures.

Domains to Include in the Definition

While the previous definition of BSSR was wide-ranging, there were notable exclusions.[1,2] One notable area we believe falls within the BSSR umbrella is public health, and all of its embedded subfields, such as environmental health, organizational administration, and health policy research. Similarly, the socioecological model and epidemiology should be mentioned by name,[3] and we believe it is worth considering that whether one is studying economics, psychometrics, sociological demography, quantitative policy research, biostatistics, or epidemiology, all are utilizing similar methods derived from the General Linear Model of statistics. All use the same fundamental quantitative procedures and use qualitative research to inform what quantitative exploration cannot.

Additionally, education research, the field of study examining learning processes and the human attributes, interactions, organizations, and institutions that shape educational outcomes, as well as quality improvement and program evaluation are core fields that utilize social and behavioral science principles and methods. Educational and program evaluation designs belong within the broader family of BSSR studies, and many primary care researchers are actively engaged in research on educational and training methods, as well as the related area of health workforce composition.

Finally, we believe primary care research needs to be included in the definition of BSSR. As primary care researchers, working in departments of family medicine and in other specialties, we engage in all of these research designs, and employ theories and methods from every field mentioned in the current definition. Primary care research is a unique context for the application of BSSR. More than the translation of laboratory findings or the execution of clinical trials, a major domain of primary care research is the study of the longitudinal expression of wellness and disease, and the interaction between the individual and their own behaviors, their families, and their communities.[4,5] Primary care research also studies how it ensures an adequate distribution of medical expertise throughout the health workforce, via medical education and workforce policy studies.[6] Primary care research evaluates primary care systems via quality improvement and health services research, the interplay between social determinants of health and the individual, as well as the factors that create and perpetuate health disparities.[7] In short, as a frequent con-

text and site for BSSR studies, and as a home to many BSSR researchers, we believe primary care research belongs in the definition of BSSR.

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From the American Board of Family Medicine

From the Association of Family Medicine Residency Directors

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FAMILY LEAVE FOR FAMILY MEDICINE RESIDENTS: TIME FOR A NEW WAY FORWARD

Female resident to fellow classmates: *"I wanted to let you know that I am pregnant… and I am sorry."*

Restrictive residency training program policies and culture regarding Parental and Family Leave are common and have not changed significantly over time.[1] Residents who have children during residency continue to face barriers to receiving adequate time away to care for themselves and their newborns. New parents often still face negative cultural biases related to the perceived impact on their education, clinical work, and sharing of workload among colleagues.[2,3] While family leave in residency training was historically utilized for birth mothers, it has in recent years begun to be considered for fathers and other non-birth parents. Graduate Medical Education (GME) programs nationwide will see an increase in the number of residents requesting Parental and Family Leave, especially with women now comprising more than 50% of medical school graduates, and with shifting cultural norms toward diversity of parenting roles and family structures.

Allowable time away from training is affected by multiple issues, some of which may not be coordinated or consistent with each other. These include human resource policies of different institutions in which residency programs reside, varying definitions of Family Leave types, American Council on Graduate Medical Education (ACGME) training requirements, and medical specialty boards' requirements for board eligibility. The ACGME has had no specific leave policy on parental leave; rather, allowable time away from training has largely been determined by the medical specialty boards. Leave policies of sponsoring institutions add another dimension to the equation that residents and their program directors must consider in planning for time away for residents welcoming a child into their family.

Numerous articles have been published on this topic in recent years, largely focused on the variability of approaches to leave-of-absence decisions that result in inequity both across and within residency programs.[4-7] Specialty boards contribute to this inequity with wide variation in the time required to become board eligible at the end of training.[8,9] Currently, American Board of Family Medicine (ABFM) policy does not distinguish parental or family leave from a "general leave" policy. Family Medicine residents are limited to 1 month of leave per academic year, for any reason. This is among the least amount of time allowed across boards[3] and has been called out by Family Medicine residents as being "least family friendly" of the specialty boards. Both anecdotal and survey findings across specialties have reported 2 major drivers of resident choice to return to training sooner than required after childbirth: (1) a strong desire to not have to extend their training to become board eligible, and (2) a pervasive culture within medical training that is less supportive of new parents than it is of those residents whose leave results from a serious personal medical condition or illness and/or death of an immediate family member.