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Family Medicine

SPECIAL ARTICLE

Overcoming Mission Competition in Departments of Family Medicine

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ABSTRACT

Departments of family medicine are centered around the tripartite mission of education, research, and clinical care. Historically, these three missions have been balanced and interdependent; however, changes in the funding and structures of health systems have resulted in shrinking education and research missions and an increased emphasis on clinical care. In the wake of waning state and federal contributions to primary care research, many departments of family medicine have adopted a private practice approach. This approach is centered on generating revenue for the institution, incentivizing physicians to remain clinically focused through productivity and intense attention to volume targets. As a department's focus shifts to the clinical care mission, education and research are increasingly neglected and underresourced. Meanwhile, the administrative burden of electronic health records (EHRs) has further encroached on time previously allocated to research, with the EHR burden disproportionately affecting the primary care workforce. To counteract mission competition in departments of family medicine and to recover the vital missions of education and scholarship, devising a clear plan for reclaiming and sustaining a tripartite mission is important. Advocating for increased primary care research funding, enhancing EHRs, balancing clinical and education metrics, and supporting primary care research, especially for groups underrepresented in medicine, are interventions to help fully support education and research missions and to recover and sustain mission balance in departments of family medicine.

INTRODUCTION

The work of academic medicine relies on the missions of teaching, clinical care, and research. These missions are critical for all academic departments, including departments of family medicine, which often are perceived as clinically focused.[1] Because medical schools have had to increasingly rely on revenue from clinical care to subsidize teaching, a resulting imbalanced emphasis on clinical care may threaten the academic tripartite mission and the role of family medicine physicians as teachers or researchers. The long-term effects of this direction are not yet fully understood but are likely far-reaching in scope.

Despite current trends, gains have been realized in promoting family medicine activities beyond clinical care. Family medicine organizations, including the Association of Departments of Family Medicine, the Society of Teachers of Family Medicine, and the North American Primary Care Research Group,[2–5] have worked to create infrastructures for scholarship and education[2,3,6] through successful initiatives,[4,5,7] grant and mentorship programs, dissemination of scholarship,[2,5] tools and databases,[5] and advocacy for needed resources.[3,5] The literature highlights examples of successful research enterprises, which are characterized by an intrinsic motivation for family medicine research and committed chair support.[6] Literature also shares gains in building rural primary care research and strategies to increase family medicine scholarship.[7,8] In addition, there is concern that the growth rate of family medicine publications has been underestimated, possibly diminishing the impact that family medicine has had in the medical literature.[9] That said, a strong need remains to further build the capacity and funding infrastructure for family medicine research.[10,11]

This paper serves as a call to action for academic medical centers to prevent mission competition in departments of family medicine. We call on academic medicine organizations, medical societies, accrediting bodies, allies, and others to join us in the push to eliminate mission competition through the following:

1. Increase and sustain advocacy for primary care research funding.
2. Implement widespread technologies to off-load the administrative electronic health record burden and improve the efficiency of clinical encounter documentation.
3. Leverage the use of clinical productivity to maximize education and research missions and to focus beyond clinical care.
4. Amplify efforts of societies and organizations that represent the interests of family medicine.
5. End institutional racism as a driver of clinical care inequity.

CALL TO ACTION

Increase Advocacy

While external funding for family medicine research is thought to be showing a slight upward trend,[7,9,12] fewer family medicine departments are receiving National Institutes of Health (NIH) funding, and those that are, often receive less funding than other specialties.[12] We need increased and continuous advocacy for primary care research funding. The American Academy of Family Physicians has advocated for the Department of Health and Human Services (HHS) to strengthen primary health care, specifically asking HHS to request increased federal funding for primary care research.[13] Federal funding for primary care research has remained largely unchanged over the years, with departments of family medicine regularly receiving less than 0.2% of total research funding dollars from NIH.[11]

Implement Technologies

Likewise, we need to implement technologies that make clinical encounter documentation in the electronic health record (EHR) more efficient, especially for academic physicians who have work roles beyond direct patient care. While scribes have been used to improve efficiency and lower physician burnout, their use fails to solve the root problem of the documentation burden.[14,15] EHRs have been cited extensively as a source of physician burnout and dissatisfaction.[16,17] Improving EHRs with self-documenting technology and exploring ways to use technology to reduce the EHR burden[18] are necessary to meet the growing demands placed on primary care physicians.

Technology also should be leveraged to pursue improvement in population health and quality metrics, with a particular emphasis on off-loading the burden from primary care.[19] When technology is integrated to improve patient experiences, access, and outcomes, particular attention should be given to ensuring that the clinicians monitoring and responding to this technology will have adequate resources and time to do so.

Leverage Productivity

To maximize education and research missions, we also need to leverage clinical productivity. Performance in departments of family medicine is often measured in volume projections and relative value units, which have incentivized family physicians to maximize the number of patients seen. Additionally, through referrals for imaging, tests, procedures, and specialist evaluations, family physicians' clinical work feeds the revenue of the entire health system. Yet, how much of the revenue generated for health systems returns to family medicine departments as an investment or subsidy is unclear.

Decreasing the burden of clinical demands has many benefits to health care. The Patients Before Paperwork initiative of the American College of Physicians aims to challenge unnecessary burdens to practice and rejuvenate the patient-physician relationship.[20] In addition, scaling back productivity metrics can be instrumental in promoting clinician wellness.[21] As value-based programs gain increasing traction, recognizing how various incentive structures and approaches have shown heterogeneous results in performance improvement is important.[22] For academic contexts, while focusing on meeting quotas may result in higher salaries and more revenue generated, this direction has left little time for research, scholarship, and innovation; leaders should pay especially close attention to the way incentive structures impact these areas.

Amplify Efforts of Societies and Organizations

Societies and organizations that represent the interests of family medicine also should continue and amplify efforts to protect faculty time for education and research.[23] We believe that the reductions in protected time to teach resident physicians will cause further erosion of graduate medical education and cause even more alarm over mission competition. While recent efforts by the Accreditation Council for Graduate Medical Education (ACGME) to establish reasonable minimum standards for core residency faculty time has been an appreciated step,[24] further efforts are needed to ensure that individual programs, with varying experience and resources, receive the flexibility and support necessary to promote resident physician competency. The ACGME requirements for learning collaboratives, individualized learning plans, and scholarly activity goals are noble and, if successful, will support the academic mission in family medicine; however, without necessary resources and interdisciplinary teams (eg, data analysts, librarians, administrative support), this task further encroaches on faculty's limited time.[25]

Support and advocacy from national organizations and department leadership should include facilitation of administrative time for scholarly activity oversight, faculty and staff development, infrastructure, and allocation of resources to meet the program requirements for resident scholarly activity. In light of the recent data on declining training exam scores,[26] societies should explore additional data that speak to resident physician competency and preparation for independent practice. As more time is shifted from teaching to the provision of care, resident professionalism, patient safety, innovations in residency education, and numbers of family medicine residents pursing physician-scientist or medical education careers are likely to be negatively affected.

End Institutional Racism

Protected time for research is also critical for academic faculty to engage in the activities required for advancement in academic rank. Faculty with less than 25% protected time for scholarship are less likely to be promoted to associate or full professor.[27] This time should be paid for primarily by the clinical revenue-generating engine of the academic health system; department-level investments should protect faculty time in support of research and education missions. Another source of funding for protected time is philanthropic support from foundations or endowments.

In addition to protecting time for education, requiring protected time for research is vital to sustain research missions. Minoritized faculty especially need this time because they may have more clinical assignments than their well-represented counterparts;[28] this clinical imbalance may exacerbate promotion disparities. Therefore, we need to end institutional racism as a driver of clinical care inequity.[28,29] Further, with recent bills making diversity, equity, and inclusion illegal and the dismantling of these offices across many state institutions, this recommendation carries added significance. Historically, discrimination pushed physicians underrepresented in medicine, including Black, Latinx, and other minoritized groups, away from research and scholarship and led to the closing of many historically Black medical schools,[30–32] resulting in an estimated 35,000 fewer Black medical school graduates.[32]

In addition, because primary care specialties are more diverse than medical subspecialties[33] and family medicine department chairs also have greater diversity than specialty counterparts,[34] one might argue that a persistent racist perception exists of primary care inferiority and inability to produce meaningful scholarship.[35]

Creating opportunities to develop family medicine researchers, especially from minoritized groups, is a step to dismantle institutional racism and promote equity. Health system leaders should partner with academic institutions, funding agencies, diversity and inclusion leaders, and primary care leaders to increase the numbers of primary care and family medicine researchers from minoritized groups.[36]

CONCLUSION

Mission competition, which has been facilitated by diminished primary care and research funding, is a critical threat to the education and research missions of departments of family medicine. To restore mission balance and rekindle academic research and innovation, we must continue to advocate for primary care research funding, demand improvements to EHRs that can off-load burden from clinicians, and adjust clinical productivity metrics to consider research and education missions. We also must continue advocacy efforts and gains related to protecting time for teaching and scholarship in family medicine residency programs and end institutional racism as a driver of clinical care inequity. By focusing on these recommendations, we can promote physicians' wellness and excellence across missions in our academic health centers.

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