Dumbing down of academic family medicine

A manifesto for change

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Some say that family medicine has "come of age," that it has passed through adolescence into maturity. I have some reservations. While this might be true for clinical family medicine, academic family medicine seems to be still in diapers. Unless things change in the academic departments of family medicine across Canada, we will remain in this state of immaturity.

Good things have been done, however. Family physician researchers now have grants from the Medical Research Council; concepts, such as the patient-centred approach to care, have been developed; the four principles of family medicine have grown into pillars of truth accepted by most; and several departments have international projects in family medicine. But is this enough? Unless we make radical changes in the structure and function of academic family medicine departments and unless we see ourselves radically differently, we will not progress to a mature academic discipline with a foundation based on its own research.

The word manifesto in its simplest form refers to a "proposal," but it projects visions of drastic change, ultimatums, and revolution. I propose a revolution in academic family medicine! This manifesto contains three premises, eight recommendations for change, a model, and a prediction.

Three premises

Premise 1: faculty members of academic departments of family medicine do too much clinical work. Academic family physicians across Canada will tell you they do 6 half-days per week in clinics, maybe even 7, 8, or 9. It seems everyone has at least half a day to do the scholarly work required as faculty members. This is laughable. Doing 7 half-day clinics does not leave 3 half-days for other things. After doing paperwork, handling patient interruptions, and calling back patients, about a half-day is left—just enough time to start thinking about teaching or administration. Forget about research!

Most of us came from busy practices where we worked full-time; 10 half-days per week. The idea of having 2 or 3 half-days to do scholarly work seemed decadent. We come to family medicine departments to change the system, to work hard, and show residents what being a family doctor is really like—noble, but much more appropriately done as a community preceptor, not as a physician in an academic department of family medicine. Certainly we need good family physician clinicians out there caring for patients and teaching our residents. If that is what you want to do exclusively and you are not interested in academic family medicine, than that is where you should be. That is where you are needed.

It does not take long for family physicians who have joined academic departments as full-time faculty members to realize they have not been given the time to do the research and scholarly work that is generally expected. In order to maintain their income, they must maintain a high level of clinical practice.

Premise 2: faculty members of academic departments of family medicine do not do enough research, writing, or other scholarly work. If you spend most of your time seeing patients and teaching residents and medical students in clinics, no time is left for scholarly reflection, research, proposal writing, or writing for publication. Most faculty members squeeze in the required amount of lecturing, seminars, and small-group teaching. In fact, teaching has become *the* academic component of family medicine. Research and publication, which are seen as the de facto definition of "academic" in all other disciplines, are often seen as an option in family medicine, for which there is rarely time. This is what I mean by the "dumbing down" of family medicine. We are

not a credible academic discipline in the eyes of other health care disciplines and certainly not in the eyes of non-health care disciplines whose heart and soul is defined by their scholarly work.

Premise 3: if the current situation does not change, it will prevent family medicine from maturing as an academic discipline. If what we do in departments of family medicine can be done just as well, or better, by community preceptors, why do we need departments of family medicine? If all we have time for is seeing patients, teaching while we see patients, and giving a few seminars here and there, why maintain expensive university-based departments of family medicine?

Community-based family medicine and academic family medicine are not two different disciplines. We are codependent, two parts of a whole. The purpose and objectives for each part are different but equally important. From the perspective of resident teaching, the objectives of a rotation in academic family medicine should be to provide an environment where there is time during each clinic to discuss cases in some detail, to discuss management alternatives, to do chart reviews, and to discuss evidence-based approaches. Patient volume per clinic must not be, of necessity, as great as it would be in a non-academic patient care setting. There should be a well organized schedule of teaching: time to do audits, to work on resident projects, to read around cases and ideas, and to get involved in or informed about family medicine research.

In a community-based rotation, the objectives are to allow residents to experience practice the way it will likely be when they finish their training. There must be supervision and teaching, but experience and volume are more important. This is where the "apprenticeship" approach is appropriate. But if all our teaching is in this model, we will slide into mediocrity: not because this part of training is any less important than the academic rotation, but because it is insufficient, in itself, to produce well-rounded, well trained family physicians.

Eight recommendations for change

Recommendation 1: departments of family medicine must maintain their current level of clinical activity. Departments have a responsibility to patients with whom they have contracted to provide care. Departments have created a schedule of resident rotations around a certain volume of practice. That volume must be maintained in order to maintain teaching.

Recommendation 2: family medicine faculty members must do less clinical work and more academic work. Therefore, more academic faculty members are needed. We have created a system where a large volume of clinical work is needed to provide care to patients with whom we have contracted. This same system, however, makes it impossible to provide that care and still allow academic family physicians the time to properly perform academically. There is no time to do research, write, or obtain grants.

Recommendation 3: faculty members' incomes must not decrease in this change in workload emphasis. The recommendation is not that faculty members do less work, but rather less clinical work and more academic work. Academic and clinical work must be equally valued in the academic world of family medicine.

Recommendation 4: faculties of medicine must provide better core funding for departments of family medicine. The above recommendations cannot be implemented unless more core funds are available for family medicine departments. Family medicine is central to the health care system of Canada. The conceptual, scientific, and evidence-based underpinnings of family medicine must be further developed and strengthened. Faculties of medicine must recognize this and provide the required financial and infrastructure support.

Alternative funding systems, rostering systems, salary systems, or other creative ideas need to be developed if departments are to have more faculty members receiving competitive incomes. This is the most difficult recommendation to implement. It is our next big battle. The outcome is critical to our survival.

Recommendation 5: academic activity and output by departments must increase. This includes research proposal submissions to granting agencies, publications in peer-reviewed journals, and total grant dollars. Departments must also develop research infrastructure in their departments with Masters- and PhD-level research associates to support faculty research initiatives. Training programs in family medicine or primary care research must be developed.

Recommendation 6: maintenance of employment and promotion must be contingent on academic productivity. If family physicians decide to take up academic careers, they must realize that academic productivity is expected. Academic family physicians should be paid to do academic work and, if productivity is not forthcoming, they should be fired! Right now if an academic family physician did no clinical work, dismissal would be quick. If we expect to wear the title of "academic," we should expect the same consequences.

I realize we are trained to do clinical work and often come into academic positions without expertise in research and scholarly endeavours, but there must be progress and evidence of productivity within a reasonable period. The department must also provide an environment with the necessary support and infrastructure.

Recommendation 7: department heads must raise their expectations of faculty members regarding academic activities. When a faculty member meets with the department head annually to discuss how things are going, the head should not ask "did you publish this past year?" or "did you do any research?" The head should say "tell me about your publication(s) in the past year" and "tell me about your research and grants." It should be expected that these have occurred, just as it should be expected that patients are being cared for and teaching is being done.

Recommendation 8: the College of Family Physicians of Canada (CFPC) must emphasize academic productivity and a balanced workload for faculty members. The CFPC should look more closely at academic productivity during accreditation. Raise your academic standards. Expect more academically from departments. Expect that faculty members do no more than 3 or 4 half-day clinics per week. If academic family physicians are expected to teach, do research, write for publication, work on committees, and do other administrative work, it is unreasonable to expect them to do more than 30% to 40% clinical work. This is the key to all the rest. If you expect it, departments and faculties of medicine will comply or face losing accreditation in one of their largest training programs.

One model for an academic department of family medicine

In this model, faculty members in the department of family medicine are grouped in teams of three. Each team manages the equivalent of one practice with each of the three faculty members having about one third of a practice or about 33% of their time in clinical work. Each team has one or two residents, depending on patient volume and number of residents in the program. There is a team nurse and a receptionist. The number of teams in a department would depend on the number of residents in the program and the number of patients for which the department has contracted to provide care. Only one faculty member per team holds a clinic on any given half-day. The residents and nurse are key to providing continuity within the practice. If there were five clinical teams in this department, the call schedule would be 1 in 15. Call would include residents and obstetric call.

Faculty members teach during clinic time, do resident seminars, are involved in undergraduate teaching, sit on committees, and do research. There is a "research unit" or "research resource unit" within the department with expertise and an infrastructure to help with grant proposals, writing for publication, and conducting research once funds are obtained.

Expectation for writing and research is high. Performance in all aspects of the job as a faculty member is expected: clinical, research, teaching, and administration. Some differences exist among faculty members. The research director, while expected to be involved in all these aspects, would weight his or her academic work toward research. Others might be expected to be more involved in teaching or administration. But all faculty members are involved in all aspects: we are generalists, after all.

Prediction

If academic family medicine in Canada does not radically change how it sees itself, how it is structured, and how it functions, we will see the demise of family medicine over the next 5 years. It would be replaced by a matrix of competing groups of rural physicians, emergency physicians, walk-in clinic workers, hospitalists, psychotherapists, and general practitioners doing what they did before 1954, with no foundation on which to stand.

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