

Why Family Practice Research?

IMAGINE FOR A MOMENT that you are chair of the family practice department at your area's nearest medical school. It is the first Thursday of the month and time for the monthly meeting of department chairs. You will be there, as will the chairs of medicine, pediatrics, obstetrics, and surgery. The dean and the chairs of radiology, pathology, ophthalmology, and anesthesiology will be there, too. Just as we've all wanted for so many years, family medicine has a "seat at the table"—not just at your nearby medical school, but also at nearly every medical school in the nation.

At the meeting, the discussion focuses, as it has at nearly all chairs' meetings in recent memory, on the clinical practice plan. Is the plan making or losing money? Is everyone working at maximum efficiency? How are we doing with billing and collections? Are the specialty departments getting adequate reimbursement under managed care contracts? Are the primary care physicians being sufficiently productive and generating referrals for the specialists?

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It's been a long time since the discussion at any of these meetings has been dominated by topics such as the quality of educational programs or the importance of research conducted by investigators in your department or others. Sure, there are announcements about these topics, and they come up for comment. But these topics almost never receive the attention, the in-depth discussion, and the special meetings that are devoted to clinical productivity issues. It is the clinical enterprise that takes the front seat and that dominates everyone's attention, at it has in most medical schools for the last 10 years.

Although the scenario described here may come as a surprise to community-based family physicians, it is one that many medical school department chairs will recognize. As clinical reimbursements have fallen and state support of medical schools has failed to keep pace with the growing costs of operation, the administrative emphasis at most medical schools has become heavily focused on clinical productivity. Indeed, for many family practice departments, clinical work is the primary, and often the sole,

source of income for discretionary spending, and the department's growth and development depend on the ability to generate this clinical income.

Given such emphasis on clinical activity, it is not surprising that the study by Mainous et al¹ in this issue of the ARCHIVES found that most family medicine department chairs place a relatively low priority on research. Mainous et al surveyed family practice department chairs in the United States and found that, when asked to rank the priorities of their departments, most chairs ranked research as fourth on a list of 5 priorities—below clinical activities and below most educational activities.

Why should readers of this journal, mostly family physicians in clinical practice, care about whether family medicine departments place a high priority on research? I believe there are several reasons they should care. Among the most important reasons are that (1) we need good family medicine research to identify the best way to practice, and (2) unless family medicine research defines the best way for family physicians to practice, the standard of care for family physicians will be determined by someone else.

HOW CAN WE PRACTICE GOOD FAMILY MEDICINE WITHOUT GOOD RESEARCH?

Family practice clinicians are interested in providing the very best care to patients. This in turn requires information about the best and most cost-efficient ways to diagnose and treat the common problems encountered in practice. Unfortunately, without good primary care research on which to base our clinical care, it is impossible for clinicians know the best way to practice.

Currently, family medicine research into common clinical problems is relatively limited. In fact, a brief search of the literature will turn up almost no family medicine research activity into many of the most frequent conditions we see in practice—the common cold, hypertension, rashes, and others. The family medicine research activity that does exist on these topics is mostly descriptive in nature; ie, the research has studied how physicians and patients deal with the problem, rather than having determined the best way to deal with the problem.

This paucity of outcomes-based research in family medicine has left us in a situation whereby most of what we know about how to diagnose and treat these and other common problems is derived from the expert opinion of specialists and from research generated in tertiary care research settings. As numerous authors have noted, such information may or may not be applicable to primary care practice in general, or to family practice in particular.

For example, diagnostic tests have a different significance depending on the patient population in which the tests are obtained. A positive antinuclear antibody test in a patient with joint pain is likely to signify the presence of disease in a rheumatologist's office, while the same positive test in the "unselected" patient population of a family practice office is most likely a false-positive result. Similarly, liberal use of computed tomographic and magnetic resonance imaging in a neurology practice for the evaluation of headache is likely to turn up occasional brain tumors and other intracranial lesions, while frequent use of such imaging on unselected patients in the family practice office will generally waste a lot of money.

Unless we develop top-notch clinical research programs in family practice, we are destined to continue practicing with specialty-derived recommendations, without knowing if these recommendations provide the best approach for our patients. This method of clinical care does not seem like the best way to meet our responsibilities to our patients, nor is it an effective way to develop the discipline of family medicine.

WHO SETS THE STANDARD OF CARE FOR FAMILY PHYSICIANS?

Most family practice physicians have been in situations in which individuals other than family physicians determine the standard of care for family physicians. For example, many family physicians find that when they apply for hospital privileges, individuals in other specialties have a major say in what family physicians can and cannot do. In some cases, this "say" amounts to de facto veto power. Similarly, when faced with a malpractice allegation (something that happens at least once to most family physicians over the course of a career), family physicians often find that expert witnesses from other specialties provide guidance to the court about what a family physician should or should not have done. This occurs even though these specialist physicians often practice in a milieu that is far different from that of the family physician whose practice is being scrutinized. Family physicians are also frequently confronted with clinical practice guidelines that dictate the way they should practice. These guidelines are typically generated in specialty practices with little or no involvement from family physicians, and are based on research and expert opinion generated by subspecialists.

A principal reason why these "other" individuals are able to set standards for family physicians is that there is insufficient research in the family medicine literature to permit identification of optimal practice by family physicians. In contrast, the literature of other specialties often contains an extensive research base, one that can be queried to define best practices in various clinical situations. Despite the fact that this research may not be specifically applicable to our patient populations or practice settings, it is the best evidence available and we are expected to conform to the practice standards derived from that evidence.

WHO KNOWS BEST?

Until and unless we develop a functional research base to define optimal clinical care in family practice, we will be reliant on others to recommend what is best for our patients. Some family physicians are content with this approach, believing that "specialists know best" and deriving much of their approach to patient management and their ongoing education from the advice and guidance of specialty consultants.

I do not mean to suggest that our specialty colleagues haven't a great deal to offer, and that we should not learn from them and seek their advice. Nor do I suggest that they are not critical participants in the health care system who enhance the well-being of our patients. However, the specialists' training and their approach to care is based on what works best and is most cost-effective in their practice settings. Specialty practices often operate under different logistical circumstances and have different reimbursement schedules from primary care practices. Most importantly, specialty practices involve selected patient populations for whom the probability of diseases and outcomes may be different from what we encounter in our frontline primary care practices. We need research based in primary care settings to assure that we know what is best in that setting.

WHAT CAN YOU DO?

There are several things that practicing family physicians can do to support and stimulate research in family medicine. Taken together, they could go a long way toward stimulating interest in and development of research in our discipline.

First, practicing family physicians should follow and read the clinical research published in family medicine journals. The US-based family medicine research journals include *Archives of Family Medicine*, *Family Medicine*, *Journal of the American Board of Family Practice*, and *Journal of Family Practice*. Regular perusal of these journals will identify articles reporting research that may

provide insights into the best way to treat patients in clinical family practice.

Second, practicing physicians should be wary of blindly accepting specialty-based recommendations as the standard of care for primary care practice. When such recommendations do not make sense for our practices, we should not feel compelled to accept them without first confirming that the patient populations and clinical scenarios from which the recommendations were derived are appropriate to our practices and patients. We can't go wrong by insisting on high-quality primary care-based research to guide our practices.

Finally, practicing family physicians should consider participating in practice-based research networks.² Such networks have been or are being established by family medicine departments around the nation, with support from the American Academy of Family Physicians, federal agencies, and other organizations. These networks link clinicians in geographically dispersed practices to a central research office that is usually located at the medical school. Physicians in the network typically develop clinical questions and medical school-based researchers design studies to answer those questions. The practicing physicians collect data, which are then analyzed and

reported by researchers at the medical school department. Research conducted by practice-based networks is potentially valuable because the research setting is primary care practices, rather than tertiary specialty-based practice. Sustaining practice-based research networks over the long term requires an enduring commitment from practice-based clinicians participating in the network. If you are interested in becoming part of such a research network, the first step is to contact the American Academy of Family Physicians or your nearest medical school-based family medicine department.

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