In this issue of *Family Medicine*, we feature a paper by Bolon and Phillips and an accompanying editorial by Ferrer regarding the availability of research training in family medicine. As we seek to define the Patient-centered Medical Home and transform primary care, building a robust research infrastructure has never been more important for our discipline. Many of the barriers that make it difficult for us to establish such an infrastructure, such as insufficient funding and limited institutional support, lie outside of our immediate control. These two papers add to a growing list of articles describing these challenges. Their analysis is accurate and their points are well taken, but it is also important to consider barriers to primary care research that lie within our own departments and residencies. As we advocate for better research funding and greater support from the world of academic medicine, we must also reflect on those factors we have the power to change on our own.

So consider conducting a small experiment in a typical family medicine department or residency. Convene the faculty and ask them to list the most important reason why each of them chose an academic career rather than entering clinical practice. Almost universally, our faculty will state that they work in academic medicine because they love to teach. Our principal academic organization is the Society of Teachers of Family Medicine (STFM). We refer to our residencies as “teaching programs,” and much of our creative energy is devoted to developing new curricula. Ours is a culture of pedagogy; our greatest professional satisfaction often comes from the time we spend teaching students or residents about family medicine and socializing them into a world in which teaching is a preeminent virtue. It seems almost heretical to raise the issue of pedagogy’s dark side, but consider the basic assumptions we make as we approach our teaching duties. Assumed in a culture of pedagogy is the notion that we have knowledge, skills, and attitudes to share with learners. The focus is on what we already know and can do. So what happens if our teachers do not really know what the family physician of the future will need to know? What if the skills required for the Patient-centered Medical Home are yet to be invented? A culture of pedagogy works fine when the world is stable and predictable, but it will usually fail to create new ideas because it is too focused on teaching the old ones. We cannot learn about what we do not know if we are busy teaching about what we do know.

An inherent distrust of new information and a deep skepticism about scientific evidence are deeply imbedded in our culture. Such skepticism has largely been adaptive for most of our 40-year history as a discipline. In his historic essay titled “Family Medicine as Counterculture,” Gayle Stephens, MD, wrote:

> We simply do not believe that all health problems have technological solutions. Perhaps that is the essence of our difference. We believe different things about science and its power. Science is not only a method for deriving quantitative data from carefully controlled experiments; it is also a faith—that nature is orderly, consistent, and ultimately rational.

Young researchers in family medicine encounter barriers to success that are far more pervasive than simply having insufficient funding for their work. They also work in a field in which practicing family physicians are unlikely to read their papers or act on their findings. Their academic colleagues who are not engaged in active research are often less than supportive of their efforts. Many of our department chairs and most of our residency directors have little more than a basic understanding of the challenges facing young researchers. It is one thing to have grants rejected, it is another to feel that no one really notices even when you succeed. We have tried to rectify this problem by requiring a greater educational focus on critical reading in our residency programs, and we now require that residency faculty members engage in some form of original scholarship. Are these requirements having the desired effect? Can
we build a research culture within a field that values teaching so single-mindedly?

Perhaps our culture of pedagogy is itself a major part of our problem. Instead of defining ourselves as teachers, we might reconsider our academic identities to be defined by learning. If family medicine were to create an internal culture of inquiry to replace our culture of pedagogy, things might look very different to young researchers. Our students and residents would learn less from us, instead of learning with us as we invent the future. Culture cannot be changed by wishful thinking, but we certainly can learn from other fields how such a change might take place. In their insightful book titled The Research-productive Department, Carole Bland, MD, and her colleagues offer us useful suggestions. They studied how academic departments in many different disciplines built successful and sustaining research programs. Writing in the book’s final chapter, they state:

The highly research-productive department is a carefully constructed mosaic of individual, environmental, and leadership features. When this mosaic is developed and continually nurtured, the result is synergistic—it creates a research-conducive organization that is more than the sum of its parts, and it yields researchers who are better and more productive than they would be elsewhere.¹

Successful research is all about culture. We need fellowship programs and we need primary care research funding, but we also need an academic culture that values new knowledge at least as much as it values creative teaching. This will not happen until we are willing to look at the dark side of our own identities as teachers. The changes underway in family medicine cannot succeed without new ideas being rigorously tested in our own departments, residencies, and practice networks. Making this a reality may be the most crucial leadership challenge facing us as health reform moves forward. Perhaps we can take some degree of comfort in knowing that this change is not dependent on anyone but us.

REFERENCES