Over the past decade, our discipline has taken significant steps to improve scholarship in our training programs. Nearly a third of our residencies are now members of the Family Physicians Inquiry Network (FPIN), a collaborative effort to engage faculty and residents in critical assessment of the medical literature. We have completed the Preparing the Personal Physician for Practice (P4) experiment, the first study to rigorously assess residency curriculum change in a national sample of programs. More recently, we have launched the CAFM (Council of Academic Family Medicine) Educational Research Alliance (CERA) to bring together faculty members from around the country who are interested in educational research. In part, these efforts were undertaken because of changes in residency accreditation requirements enacted by the Accreditation Council for Graduate Medical Education (ACGME), but we also hope that improving scholarship will stimulate innovation in primary care practice and education. Considered in a historical context, these accomplishments suggest that we may at last be making progress toward building a culture of inquiry for our field.

Nevertheless, we still have a long way to go. Scientific scholarship is a formal approach to learning involving three steps: a creative process in which a new idea or insight is devised, a rigorous and systematic evaluation of this new idea, and a communication process in which the evidence is shared. The middle step is our problem. Our discipline is good at developing and sharing new ideas but weak at providing evidence that they are new and actually improve outcomes. Proving an idea is new requires careful review of the existing literature. Rigorous methods of evaluation and analysis are required to prove that the idea improves outcomes. Because few of us were trained to think in this way, we have spent much of the last 40 years churning new ideas within our practices and training programs while missing opportunities to generalize what we have learned to other settings.

Great scholarship starts with extensively and carefully reading what other scholars in our field write. The more we read, the better we read; and the better we read, the better we write. Serious scholarly reading in a field as broad as family medicine is no easy task. Most of the medical literature is about the diagnosis and treatment of diseases in a biomedical model while family physicians generally provide care to communities and families in a biopsychosocial model. It is easy to search MEDLINE for a biomedical topic but try searching for papers about continuity of care or group visits, and you will experience first hand how hard it is to overcome the limited taxonomy by which medical knowledge is organized. And yet there are scores of new papers on these topics every year, written by authors from all over the world and spread out in dozens of journals. Good scholars are good readers in the subject they study; they can find and assess information in the literature and thereby determine what is new knowledge and what is not.

Unfortunately, reading skills, while necessary, are insufficient for good scholarship. Rigorous scholarship requires us to assume an idea does not improve outcomes and then provide convincing evidence to refute the assumption. The gold standard by which scholarship is measured is peer review. It may be an oversimplification, but something is proven when
our peers think that it is proven. So, participating in peer review is an essential step in learning how to prove things. The fastest way to make our scholarship more rigorous is to stop accepting new ideas without proof. Scholarship is a way of thinking about the world; it is not a ticket to punch on the road to professional respectability.

So how can I prove to you that visiting a patient in his/her home or in the hospital is worth your time when my “proof” is the look in the patient’s eyes? Medicine is both an art and a science; not everything can be proven with data. Just as we cannot scientifically prove that something is beautiful or that someone is kind, our scholarship must be a blend of proof and narrative, a mixture of knowledge and values. Even though we need to improve our analytical skills, we cannot afford to lose our story-telling heritage. Indeed, the most important truths lie at the interface of art and science where we can both test our new ideas and explore our beliefs. Story telling is scholarly when it teaches us something about our values. Sharing stories can inspire us, but new ideas must be proven, and this requires evidence; we cannot afford to confuse these two scholarly traditions.

STFM aspires to be the “indispensable academic home for teachers of family medicine.” We remain a society of teachers, devoted to teaching. Teaching is about sharing what we know and requires relational skills; scholarship is about learning what we don’t know and requires analytical skills. Both require creativity. Teaching and scholarship go together like two sides of a coin, and we will need both to transform primary care. The best way to master both is to join together in learning communities like STFM and to raise our standards regarding proof. If we train residents and students the way we were trained, they are unlikely to be better at this than we have been. Scholarship in our residencies is essential, not because the ACGME says so but because the next generation will need these skills to make our health care system the best it can be.

References

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