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Abstract

The predictions point toward increasing difficulty in recruiting academic faculty in Family Medicine. The 2017 AAMC Final Report, "The Complexities of Physician Supply and Demand: Projections from 2015 to 2030" predicts significant physician shortages by 2025.[1] Changes in practice styles, patient demographics, delivery models, retirement goals, and economic trends make the recruitment of academic faculty more challenging as the physician workforce shrinks.

The purpose of this descriptive report is to share how we developed and implemented an academic faculty model that would nurture residents from our program to become members of the Family Medicine faculty, rather than rely on traditional recruiting practices that had proven to be unsuccessful.

This process incorporates a faculty/resident needs assessment, development of a customized third-year rotation in academic medicine, completion of faculty development training, a specialized mentorship program, and focused orientation. Following this plan, we successfully recruited 3 new faculty physicians for our residency program. Implementation of a plan to recruit residency graduates may bring new faculty to other residency programs that are facing challenges recruiting academic physicians, especially in regional medical campuses that are not associated with a medical school.

Introduction:

Family medicine residency education involves a broad range of medical knowledge and experience obtained through hospital and ambulatory settings. It is a demanding process for learners and educators. The absence of educators is among the greatest threats to the long-term training of competent family medicine physicians. Guidance from seasoned practitioners is essential to ensure that nascent physicians are able to translate facts into evidence-based, patient-orientated actions.

What Has Changed?

In response to both internal and external forces, practice profiles have changed dramatically over the last 2 decades. Before the mid-nineties, most family physicians joined private practices or group practices with a shareholder option, and practiced in full-scope family medicine models. Now, as revealed in one study in 2014, 58% of family medicine physicians are employed by a group or hospital,[3] and their practices are strictly ambulatory models. Physicians are less involved in national academies, limiting their ability to advocate for themselves. Market changes have had a significant impact. Prior to the mid-nineties, private payer insurance provided the best return for physicians. Today government sponsored programs are the leading payers. Changes in national healthcare policy are leading to increased uncertainty in developing new practice models. Now, with the majority of family medicine physicians practicing in primarily outpatient settings with no obstetrics, or choosing specific practice models, physicians who have been out of residency for a number of years have not retained the full-scope family medicine skills that are essential in academic medicine.

The Supply and Demand Mismatch

With an aging population there is an increased need for primary care physicians. By the year 2030, primary care workforce is projected to be understaffed by 7 300 to 43 100 physicians.[1] The supply component of the equation is partially addressed by the increase in medical schools in recent years, and a slight increase in family medicine residency positions in the past 2 decades. However, these increases in supply alone have not and will not adequately satisfy the demand. The average family medicine physician, retiring at age 65, will create an absence that will be felt in both private and academic arenas.[4] The academic family medicine workforce faces immense hurdles in providing faculty with a broad-based clinical experience.

Family Medicine programs across the country have been recruiting faculty in increasing numbers in the past 5 years. When asked, the participants of the Association of Family Medicine Residency Directors (AFMRD) Annual Meetings, "How many family medicine physician faculty are you currently recruiting?" more than half of the respondents since 2012 have indicated that they are recruiting at least one, and by 2016 that percentage had risen to nearly 75%. Further, not only are more programs recruiting faculty, but the time it takes to fill a position is increasing. During the

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same AFMRD Annual Meetings, more than half of respondents reported that the positions took more than a year to fill.

Methods:

Needs Assessment

Our program at a regional medical campus recently faced a shortage of 3 faculty, with 5 more contemplating retirement in the next 5 years. Such a shortage would make fulfilling our mission as a department more difficult, and put excessive stress on the remaining faculty. Knowledge of the broader academic scope was rare among our first round of applicants. We recognized that recruiting experienced faculty from other residency programs is not a sustainable option and poses its own challenges and consequences, as residency programs around the country are facing the same challenges. Family medicine residents are typically groomed for careers in outpatient primary care since their residency places an emphasis on longitudinal patient-centered care. It is therefore important that perceived interest in academics is stoked. Faculty in our department are expected to take part in teaching in the hospital inpatient setting, but are not expected to take call for obstetrical deliveries. Recent graduates from our program are proficient in all clinical expectations of a faculty member. A needs assessment was performed to identify current and upcoming gaps in faculty skill sets (Table 1). With this information we were able to identify specific residents with particular interest in skills that fit our anticipated needs for the future. We then approached them about joining our department upon graduation.

Table 1: Needs Assessment—Faculty Skill Sets Survey

Faculty Members Marked All That Applied To Them

Board Certification
Family Medicine
Preventive Medicine
.Preventive Medicine
.Occupational Medicine
Hospice & Palliative Care
Disaster Medicine
Psychiatry
Certifications and Added Qualifications
Sports Medicine
Geriatrics
Medical Licensure
Allopathic
Osteopathic
Certifications
ACLS
PALS
ALSO
ATLS
AWLS
Hypertension
Wound Care and Hyperbaric Medicine
ADLS
Procedural Skills
Obstetrics
.C-section
.Vaginal Delivery
.Forceps
.Vacuum Extraction
.Ultrasound
.Amniotomy
.Internal Monitors
.Episotomy & Repair
Soft Tissue Orthopedics
.PRP
.Ultrasound
.Joint Injection
.Casting
.Strapping
.OMT
Women's Health
.Colposcopy
.LEEP
.Endometrial Biopsy
.IUD Placement
.Ultrasound
General Family Medicine
.Toenail Extraction
.Colonoscopy
.EGD
.Vasectomy
.Lump/Bump Excision
.Laceration Repair
.Bone Marrow Biopsy
.Nasopharyngoscopy
Occupational Medicine
.FAA Exams
.DOT Exams
.Audiograms
.Medical Review Officer

.Yellow Fever Vaccination
.Independent Medical Examiner
Academic Certifications
.Academic Medicine Fellowship
.Program Directors Institute
.CITI
Academic Rank
.Professor
.Associate Professor
.Assistant Professor

Approaching and Mentoring Residents

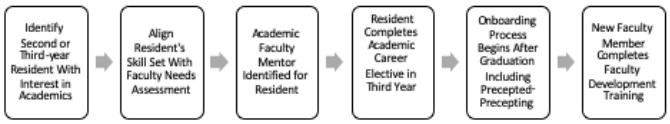
In our process, once a faculty candidate was identified we matched them with a current faculty member to nurture skills and foster growth of professional interests. We sought an early partnership that carried potential to evolve into mentorship at the faculty level, knowing that the value of mentorship in the early development of academic physicians has been recognized.[5] Faculty who already had a mentorship relation with the resident continued as faculty mentors throughout the process, as a good fit between mentor and mentee had already been established. Mentors did not receive extra remuneration.

We worked with the resident to create a customized third year curriculum aimed at exposure to academics and support for professional interests. This academic rotation was created in partnership with a sister residency program in a nearby city, allowing for a reciprocal partnership that allowed the learner to practice an academic role with residents who were not their peers. Previous work in military family medicine programs has shown this to be effective in increasing skill and interest in academic family medicine.[6] The first 2 weeks were comprised of “precepted-precepting” of other resident colleagues. In this capacity the resident functioned as what we affectionately referred to as the "pre-tending." This occurred in both inpatient and outpatient settings where the “pre-tending” was directly observed while completing the duties of a faculty attending. The “pre-tending” would oversee patient care, offer feedback and instruction to resident colleagues, and model billing and coding. Actual billing was completed under the established faculty attending. By arranging for a one-week away experience with a partner family medicine program, residents had a unique opportunity to pursue the same learning objectives while working with non-familiar faculty and overseeing unfamiliar residents. The resident obtained a unique perspective on residency education without the comfort and connection to one's home institution. The remaining time was allotted for personal clinic, assigned readings on teaching (Table 2), discussion with the faculty mentor, meetings with hospital leadership, and participation with the hospital’s medical executive committee. Feedback was delivered at regular intervals by the faculty mentor and in the moment as needed. For a timeline of the process, please see Figure 1.

Table 2: Reading Assignments for Resident Academic Rotation

Weinholtz D, Edwards J. *Teaching During Rounds: A Handbook for Attending Physicians and Residents.* Johns Hopkins University Press, 1992.
Neher J, Gordon K, Meyer B, Stevens N. A Five-Step “Microskills” Model of Clinical Teaching, *J Am Board Fam Pract*, 1992 Jul-Aug;5(4):419-24.

Figure 1: Timeline for Training and Onboarding of Residents to Faculty



Outcomes:

Through this process, our program recruited efficiently and seamlessly on-boarded 3 new faculty members. Two of new faculty members trained under us for 3 years as residents, and one trained with us for one year as a sports medicine fellow. Right from the start, the new faculty members were well in tune with personal professional goals and were armed with experience and education regarding the function of academic medicine faculty.

This was not the end of our process, as new faculty are shown to benefit from early faculty development.[7] We have established an individualized approach to faculty development where each new faculty member pursues further training on the timeline most relevant to their role and department needs. Our 3 new faculty completed a formal faculty development fellowship. Of the 3 faculty that were recently recruited in this fashion, 2 have remained for 4 years, and one joined a non-academic clinical practice within 2 years.

Benefits and Challenges to Recruiting from Within

We identified several benefits of recruiting from within our residency program. At the culmination of residency, the potential future faculty members demonstrated a known level of academic performance and teaching ability. Milestones were measured assuring important competencies and inferring readiness for full-scope practice. Residency graduates have fresh experiences doing scholarly activity, an aspect of academic medicine that can be particularly challenging for someone who has been out of residency for a few years. Additionally, they are well-integrated into the associated healthcare network, assuring familiarity with system protocols, staff, physicians, culture, and community.

In this light, family medicine residency could be seen as a 3-year interview process. It is apparent that other industries utilize this approach, considering that General Electric, for example, hires 85% of its executives internally.[8] Academic family medicine department leadership must continuously evaluate recruitment strategies to meet department needs. Sending new faculty to an academic fellowship provides a network of faculty from other residency programs with whom to collaborate, diminishing the absence of a broader outlook brought by bringing new faculty from outside your own program. All of the faculty in our department have Fellowship or other advanced training in academic principles, and the new faculty members have acknowledged the training as an asset to help them become more quickly knowledgeable of the roles of an academic physician.

On the other hand, our approach was not without challenges. It may still be years before the resident is ready to graduate and assume the role of faculty once the need is identified. In that time, their priorities may change, and they may ultimately decide on a different practice model. Recent residency graduates have limited 'real-world' experience applying their fund of knowledge and familiarity with evidence-based medicine to a broad range of patients with widely varying comorbidities. Having worked together closely, former resident colleagues may have unique biases and insights into a newly recruited faculty member's strengths and weaknesses. The perception or assumption of knowledge and skill deficiencies can be points of exploitation by learners. In addition, care must be taken to balance professional and personal relationships with former residents as the new position of authority could obscure professional boundaries. A faculty development fellowship may present financial and logistical barriers, but there are numerous other options to consider in further refining a newly graduated resident into a fully-functioning faculty member.[9]

Next Steps:

Efforts to promote a pathway to academic family medicine in medical school may yield greater attention and enthusiasm from early physicians. At least one of our new faculty members, as a senior resident, had never even considered a career in academics until we opened a discussion.

Attention to the virtues and challenges of junior faculty mentorship and objective measures of performance at the junior faculty level can help highlight best practices for early faculty development. Furthermore, as we refine our process, we must balance the need for individualized faculty development with assurance that new faculty are gaining the common skills and knowledge to best serve their role in the department.

At times when faculty positions are all filled, we will still offer the resident rotation to allow for residents to gauge their own interest in becoming a faculty at a later date when positions become available.

Conclusions:

Our success in recruiting new faculty is a result of a methodical process of identifying residents in our program with interest in academic medicine and with skill sets that augment the mission of our department. A key to the success of our recruiting program is a mentorship plan focused on helping our new faculty members to develop and mature their skill sets in teaching, scholarly activity, and patient care. It is essential to continue to seek faculty from outside the residency program. Recruiting from within should not be the only means to fill faculty positions, as diversity of training leads to a stronger faculty. In our model, academic faculty are full-time teachers in the residency program. However, academic faculty in other residency programs may include physicians who dedicate a significant portion of their time to resident education, even if not full time. We feel that a broad range of residency models, including those in larger academic settings as well as smaller, regional campuses will find our approach useful. With diligent effort, practical application of these principles can be used by many departments to fill open faculty positions successfully.

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