

The Leadership Forum

Words of Wisdom Revisiting Mission Integration in Academic General Medicine

Dr. Katrina Armstrong is a Professor of Medicine at Harvard Medical School (HMS) and Physician-in-Chief of the Massachusetts General Hospital Department of Medicine in Boston, Massachusetts. karmstrong6@mgh.harvard.edu



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The current tripartite mission of academic medicine (patient care, research, and education) can be traced to the 1910 Flexner Report on medical education in the United States. Among the multiple recommendations to improve the quality of medical education, the Flexner Report strongly supported the integration of medical education with universities as well as hospital clinical services, in order to bring scientific discipline to training and clinical practice. Over the next decades, the ideal of a professor who excelled at patient care, investigation, and research became the currency for success at many academic institutions.

However, beginning in the middle of the century, this model of mission integration began to change. Biomedical research increasingly focused on basic science, making it harder for clinicians to succeed in investigation. Clinical pressures increased as the need to generate large financial margins by incentivizing clinical productivity became apparent. The increase in the regulation of graduate medical education created the need for faculty with specific expertise in educational administration. Together, these forces

led to increasing specialization of academic faculty within a specific mission—including the “80-20” model for investigator effort that was linked to increased productivity and widely advocated. As a result, many academic health systems now have high levels of “mission segregation” at the level of people, space, and money.

There are several reasons to consider whether this pendulum may have swung too far. Morale in academic medicine has fallen, in part because of the emphasis on standardization over individual opportunity. The subspecialization of clinical services has been linked to higher costs and care fragmentation. Despite the increase in research dollars and publications, relatively few discoveries have had a clinical or public health impact. Growing evidence suggests that diversity of experience and perspective is critical for innovation. While a segregated system is clearly easier to manage, these challenges have sparked debate about the potential downsides of the current approach and a growing interest in the potential benefits of mission integration. General internal medicine is particularly suited to experi-

ment in this area given its strong commitment to all three missions, comfort with ambiguity, and commitment to innovation.

These experiments can occur at several levels. At the level of the individual faculty member, support for clinicians to develop skills and experience in research and education may increase their ability to sustain engagement in those missions as well as provide connections to sources of salary support. The ability of research faculty to maintain an active clinical practice may be creatively remodeled with shared panels, advanced practice clinicians, and telemedicine. At the division level, incentives can be developed to encourage cross-fertilization including diverse participation in educational activities, inclusion of diverse faculty in research proposals, and integration of clinical and investigative activities. And at the level of the system, space planning can be used to encourage connections across individuals and infrastructure can be developed to support major priorities that reflect mission integration such as translational research, educational innovation, and the learning health care system.