Increasing scholarship in family medicine has been a stated goal by a variety of authors for many years.\textsuperscript{1,2} Strategies ranging from making a business case to participate in research to requiring trainees to participate in scholarship have been proposed as ways to increase scholarship and research. One author has suggested that a business case for provider participation in practice-based research networks (PBRNs) may exist if both direct and indirect financial benefits are identified.\textsuperscript{3} The Accreditation Council for Graduate Medical Education is increasingly emphasizing scholarly activity as a component of residency education, and a lack of faculty scholarly activity is a common citation given to family medicine residency programs by the Review Committee for Family Medicine.\textsuperscript{4} However, forcing people to participate or convincing individuals that participation in research is a lucrative financial activity does not seem to align with the creativity and inquisitiveness required to successfully create new knowledge and overcome the multiple barriers to doing research.

Two articles in this month’s issue of \textit{Family Medicine} touch on this topic of increasing scholarship, and both are on the right track. Sahin et al studied factors related to family physicians’ participation in research.\textsuperscript{5} Lawson et al focus on creating a culture of inquiry in family medicine.\textsuperscript{6} Both articles make compelling cases for strategies to increase scholarship. However, is the rate limiting variable to increasing scholarship a lack of resources or rather a lack of interest and desire? Perhaps this is a false dichotomy.

Attempts to increase scholarship in family medicine have led to a variety of initiatives focusing on differing levels of scholarship. Many would contend that it is a lack of resources. Resources for funding research and the time to conceptualize and conduct research are critical to producing advances in knowledge. Many departments of family medicine have faculty who have integrated into larger research centers in academic health centers like cancer centers and centers based on Clinical and Translational Research Awards (CTSA). These centers tend to have access to money for pilot studies, statistical help, and patient populations. However, few family physicians have tapped into these resources. Some infrastructure initiatives like the Council of Academic Family Medicine Educational Research Alliance (CERA) and the Grant Generating Project have been created to support individuals not at one specific institution as part of a larger group who want to do scholarly activity but could benefit from help from the larger family medicine community. The evidence shows that providing resources and infrastructure is a successful strategy in producing scholarship. But these initiatives can only work for individuals who want to use them.

On the other hand, a variety of studies have shown that most individuals participate in research because they want to be part of the research process.\textsuperscript{7} PBRNs are becoming exceptionally commonplace in family medicine. The Agency for Healthcare Quality and Research’s registry of primary care PBRNs includes more than 150 registered networks (http://pbrn.ahrq.
Most participants in PBRNs and clinical trials networks do so because they like the intellectual stimulation and want to help answer questions and create new knowledge. It has also been noted that the most common barriers to community clinician participation in clinical research relate to beliefs that clinical research is too burdensome and has little benefit for the participating clinician or patient.

Rather than focusing on one factor versus another it becomes clear that we need to combine ways to increase the desire for intellectual stimulation inherent in asking and answering novel and meaningful questions while at the same time providing mentoring and a supportive infrastructure. The infrastructures are being built for interested participants who want to do low resource educational research (CERA), clinical research in practice (PBRNs), and large peer-reviewed investigations (CTSAs and the Grant Generating Project).

We must continue to encourage students, residents, fellows, faculty members, and community providers to ask novel questions and learn to use valid research methods. Patients will benefit from these answers. Several things may help to merge culture with infrastructure. First, start small and allow the participants to see some success while making the question relevant to the participant’s interest and the bigger community. Long delays between idea generation to study completion and study completion to dissemination of results kills enthusiasm in new researchers. Early projects should keep data collection time to a minimum by using existing data from electronic health records, the National Center for Health Statistics, or existing survey infrastructure. The beaming faces when individuals see their name in print for the first time around a project in which they feel invested is a joyful scene. Mentors can then get these individuals hooked and help to move to projects that may not have such immediate gratification.

Second, engage the individual in seeing that their research can make a difference and that other individuals care. We can all help in this process by reading each other’s work and supporting forums in which research results are discussed. Knowing that their work is appreciated and that they have made a difference is important to developing researchers. In fact, it is important for all of us.

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