“STRATEGY, STRATIFICATION AND THE ROLE OF HIGHER EDUCATION IN TRAINING MORE PRIMARY CARE PHYSICIANS IN THE ERA OF THE AFFORDABLE CARE ACT”

by

REBECCA LANE SANDIDGE

(Under the Direction of Sheila Slaughter)

ABSTRACT

Increased access to primary care is the bedrock upon which the Patient Protection and Affordable Care Act (ACA) is founded, thereby necessitating growth in the health care workforce. This multiple case study explores how within the “field” of medical education strategic actors are varying institutional strategies in response to the incentives in Title V – Health Care Workforce to educate and train more primary care physicians. It also examines how the legislation may be exacerbating existing stratification within medical education in a single state. Findings suggest that the ACA fails to address the main impediment of increasing the primary care physician supply, signaling that the shortage of physicians will continue or that other health professions will subsume more primary care responsibilities. Furthermore, strategic action in response to the ACA is partially based on the prestige economy and thus can be explained by a commitment of academic leaders to maintain stratification within medical education.

INDEX WORDS: Medical Education, Institutional Strategy, Affordable Care Act, Strategic Action Fields, Prestige Economy

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DEDICATION

To my beloved mother, Dr. Linda Rochell Lane, whose rich legacy inspires me to believe in more, accomplish more and give more of myself to the pursuits and people I cherish. I hope you are smiling down with pride.

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CHAPTER ONE

INTRODUCTION

The passage of the Patient Protect and Affordable Care Act (ACA, PPACA, or Affordable Care Act) is an imperfect solution for health care policy. It attempts to cover all citizens while still sustaining earlier policy decisions that created protected populations (such as the poor and the elderly through Medicaid and Medicare) and favored professional autonomy for medical doctors. The basic premise of the ACA is to contain cost while providing options for affordable health care to the indigent, the under and uninsured, rural, and minority populations ("Patient Protection and Affordable Care Act," 2010a; Starr, 2011). The authors of the legislation plan to accomplish these goals through a series of federal regulations and tax cuts which will allow 32 million new Americans to enter the health care system (Levitt, Rousseau, Singh, & Ying, 2013). Unlike Britain, which treats health as service similar to public education, or Canada, which makes health care a right for all citizens, the ACA seeks to make health care affordable, which is a much more limited goal, but is a direct result of earlier policies that made other options politically unsavory or unrealistic given the social context (Starr, 2011). In order to reach this balance of actuarial fairness with expanded access, the Affordable Care Act is based upon increasing access to and availability of primary care services. Primary care[1] is less expensive to administer than medical specialties and studies have shown that health care systems based on primary care are more cost effective and overall, patients receive quality care (Bennett & Phillips, 2010).

[1] Primary care specialties, as defined by the Affordable Care Act, are family medicine, internal medicine, general pediatrics, and general obstetrics and gynecology.

The current health care system in the United States, however, is based upon specialty services. The disproportionate growth of medical specialties when compared to primary care or general practice, results from years of unbridled growth and limited regulations on the numbers and salaries of specialists (Ludmerer, 2005; Starr, 2011). Within higher education, specialized medical knowledge has been allowed to flourish based on the ability of clinical researchers and basic scientists to secure federal and private grants focused on specific strands of knowledge (Slaughter & Rhoades, 1996, 2005). To compound the issues, primary care specialties as a residency choice among recent medical graduates has steadily declined over the past 12 to 15 years (Bennett & Phillips, 2010; Steinbrook, 2009). As such, American medical doctors, both in private practice and in academic medicine, have benefited in terms of income and professional autonomy under the current health care system. Although primary care is a less prestigious and lucrative career path, primary care is central to the work of physicians (Brint & Brint, 1996). Additionally, hundreds of millions of dollars have been allocated as a result of the Affordable Care Act to increase the number of primary care providers. Therefore, the leaders of the medical profession, specifically those in medical education, must wrestle with how to encourage enough students to pursue general practice in an increasingly competitive market that favors specialization.

While a significant amount of media attention and scholarly research has been given to the merits and utility of the Affordable Care Act (Starr, 2011), less attention has been focused on the implementation of the legislation (Berman et al., 2012; Shomaker, 2011; "U.S. osteopathic medical schools by year of inaugural class," 2013), especially as it relates to expanding and educating the primary care health care workforce with the specific goal of increased access to primary care in rural and medically underserved areas ("Patient Protection and Affordable Care

Act," 2010a). It is commonly held that medical doctors have entered into a social contract with the general population and thus must work to meet the population's needs (Freidson, 1970, 1986; Rueschemeyer, 2009). Because of this public trust, the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), medical specialty professional organizations and higher education institutions have agreed upon a baseline level of knowledge and training that will prepare medical students to practice medicine and, simultaneously help to sustain professional dominance (Barzansky, 2010). After receiving a bachelor's degree, typically with a major in a basic science, students enter medical school, also referred to as undergraduate medical education. Undergraduate medical education lasts four years and consists of preclinical and clinical education. Newly graduated medical doctors then enter a residency program, also known as graduate medical education, which is three to seven years or more of professional training under the supervision of an attending physician. After completing their residency physicians are then eligible to apply for their license to practice medicine in a certain state. Despite the common curricula and length of education, variations exists in the training in terms of exposure to basic and clinical research, the types and number of elective rotations, and latent and manifest goals regarding the placement of recent graduates in inner city, impoverished or rural locations. The variations in portions of the curriculum and institutional goals can also be linked to power, politics, and economic factors as institutional leaders jockey for a competitive advantage and institutional prestige as medical school leaders seek to differentiate their particular school in the medical educational market and in society (Bastedo, 2005). Because these interests are often at odds, any change to the curriculum may provide insights into how institutions are balancing pressure from multiple actors in regards to educating physicians. Moreover, training

may be differentiated based on the type of institution or the type of students that institutions recruit and train.

Since the crux of the Affordable Care Act hinges on increased access to primary care for all American citizens, it is imperative to bolster the corps of primary care health care professionals. Given this specific aim, the implementation of the ACA provides unique challenges for American medical education. Previous public policy supported and constructed an American health care system based on specialization with limited safeguards for maintaining an adequate supply of primary care physicians (Bennett & Phillips, 2010; Starr, 2011). As such, for the new legislation to be successful, not only does a cultural shift need to happen in medical education, but also specific strategy will need to be implemented to increase the training and production of primary care practitioners. The historical account below outlines how the current system came to be and begins to reveal why different institutions may have diverse goals in regards to the types of physicians they recruit and train.

The Ascent of Medicine and the Primary Care Physician

Sub-specialties were not always the favored professional path in allopathic medicine. In fact, during the years that medicine was being cemented as an elite profession and the medical curriculum was being formalized, it was the general practitioner, or the primary care physician, that was lauded as the pinnacle in medicine. Specialists were seen as "quacks" to be mistrusted because they were usually trained or affiliated with proprietary medical schools (Ludmerer, 1985, 2005; Starr, 1982). Many of the well-known physicians that helped to move American medical education to the forefront of training, such as William Osler and Paul Harvey, were general practitioners who favored teaching and hands on learning (Ludmerer, 2005). Yet, as the American Medical Association (AMA) was politically engaged in lobbying to discredit other

forms of medical training, such as proprietary medical schools and spiritual healers, the organization's leaders were simultaneously laying the foundation for the ascent of the specialist and the descent of the general practitioner.

In the late 1800's the American Medical Association began to petition the federal and state governments for increased regulations over what types of institutions could grant medical doctor degrees and the types of training that should certify qualified healing (Bullough & Bullough, 2009; Ludmerer, 2005; Starr, 1982). In 1910, in conjunction with their lobbying efforts, the AMA, through the Carnegie Foundation, supported the publication of *Medical Education in the United States and Canada*. Abraham Flexner, a high school educator and medical aficionado, penned a scathing report concerning the overall condition of medical education, noting the inconsistent quality of medical training and the deplorable physical conditions of most of the country's medical schools (Flexner, 1910). In his report, commonly referred to as *The Flexner Report*, he advocated for a system of medical education that had stricter entrance requirements and mirrored the training occurring at the Johns Hopkins University: a curriculum based on basic science followed by an intense period of clinical training in a hospital setting (Flexner, 1910). *The Flexner Report* was also the first document to explicitly make medical education a public health concern by advocating that the lay population expect to receive the best care from the most able students who were trained at the country's best universities (Flexner, 1910; Starr, 1982).

As a result of the tandem efforts of the lobbying by the AMA's leadership and the publication of *The Flexner Report*, there were a plethora of changes to medical education during the period between 1910 and 1920. Many of the country's medical schools either closed or consolidated as the leaders joined public and private universities. Universities that acquired

medical schools also scrambled to become affiliated with a community hospital or to acquire a hospital of their own. Proprietary schools were forced to close and other forms of healing were delegitimized as a result of stricter state regulations (Ludmerer, 1985, 2005). In addition, the government sanctioned the formation of the Liaison Committee for Medical Education (LCME), which is the national licensing agency that administers the United States Medical Licensing Exam (USMLE) as well as oversees the Continuing Medical Education (CME) requirements. While any person was free to be trained in various healing techniques, only those who passed the LCME exams could be licensed to practice medicine in the United States. Although hundreds of medical schools closed between 1910 and 1920, a comparable number were not reopened, nor were the number of seats extended to allow for more students to enter the university affiliated medical school. Flexner noted that medical training should be long, arduous, and only open to the most talented students (Flexner, 1910). As a result medical education became more competitive and a false scarcity in the number of doctors was created. The increased competition and the relative scarcity of a "properly" trained doctor afforded physicians under this new system to experience an increase in both prestige in society as well as the salary they were able to command (Bullough & Bullough, 2009).

The Rise of the Specialist

From 1920 to 1945, most physicians were general practitioners, although some specialties, such as ophthalmology, were formed during this time frame. In 1945, however, the focus of medical education and medical practice began to shift with the publication of S*cience: The Endless Frontier*, by Vannevar Bush. A chief official in the White House, Bush championed the expansion of basic science research as a way to help distinguish America as the greatest country. Flexner too had seen basic science as a pathway to greatness and, in mimicking the

German model of education, advocated that American medical education be based on basic science (e.g. biology, physiology, and chemistry). Bush's report coincided with the growing involvement of a number of wealthy socialites (such as John D. Rockefeller's wife) who lobbied congress for the formation of grants and centers focused on specific areas of health and illness (Ludmerer, 2005). Therefore, between 1945 and 1950, an influx of federal and private grant dollars became available through the National Institutes of Health (NIH) and other government agencies, to research specific scientific phenomenon or biomedical ailments. A significant portion of these new federal dollars were also directed toward building medical centers, which resulted in the creation of academic medical complexes that also had foci on specialized topics and did not include provisions for primary care stability (Ludmerer, 2005; Starr, 2011).

As a result of the expanding federal budget for specific types of research, a premium was place on specialized knowledge in medical education, as well as across all facets of higher education. Basic science and clinical researchers, both of whom had responsibilities in training medical doctors, were able to garner national reputations and increased salaries (supplemented with grant dollars) by focusing on specialized knowledge (Slaughter & Rhoades, 1996). The late Twentieth and early Twenty-First Centuries saw a rapid explosion in scientific and technological discoveries and biomedical advancements, thus expanding knowledge and making it impossible to know everything well. As such, faculty who were trained as specialists replaced medical faculty members that favored primary care (Ludmerer, 2005). Specialty professional associations were formed and, unlike in other countries in which the federal government directed the growth of certain specialties, it was the professional associations in conjunction with the LCME that determined growth areas (Starr, 2011). Residency opportunities in certain specialties became more competitive (e.g. Radiology and Dermatology), especially as salaries, unbridled by

federal or state policy, continued to increase (Starr, 1982). As such, students and leaders in professional associations lobbied for earlier exposure in medical school to those topics, clinical experiences, and research that would make medical students more competitive for these elite residencies (Anderson & Kanter, 2010). With shifts in favoritism toward specialized knowledge, generalist knowledge and primary care was relegated to a "second class status" as it was unable to keep pace with the upper class and elite trajectory of the profession (Ludmerer, 2005; Slaughter, 1997; Starr, 2011).

The favoritism of specialized medicine was also entrenched within the general higher education context. Tenure and promotion were increasingly based on research, and less on teaching and service. The premium placed on generating commodifiable knowledge was twofold: first, in order to contribute to the university's overall budget and secondly, to provide additional income to the individual faculty member (Slaughter & Rhoades, 1996, 2005). The advent of rankings further tipped the scales in favor of research, as prestige and quality of an institution were gauged based on the number of award winning faculty and notable publications and much less on the quality of the faculty's teaching ability (Kezar, 2012; Shin & Toutkoushian, 2011; Toma, 2012). The reliance on specialized knowledge to generate funding was compounded by the current period of austerity in higher education resultant of the Great Recession (2007-2009). Since state and federal funding sources are decreasing, American universities are being called on to be more self-reliant and entrepreneurial in order to generate multiple revenue streams (Bastedo, 2012). Even in the applied field of medicine where it seems apparent that teaching should matter, promotions and tenure are still based heavily on research and publications in select peer-reviewed journals.

In addition to the lack of primary care mentors, the decreasing exposure during medical school, and the premium placed on specialized knowledge and research, primary care may have also become a less attractive career path given the overall cost of medical education. In the century since the publication of *The Flexner Report*, the structure of medical education has remained fairly stable and impervious to reform (Anderson & Kanter, 2010). In addition to expressly stating that medical training should be long, Flexner also believed that it should be expensive, as a means to gauge quality and to help delegitimize cheaper medical institutions (Flexner, 1910). As such, the average length of education and training a medical student must complete before they are able to practice is between seven and ten years, and the average debt incurred is approximately $120,000 ("2013 All schools summary report," 2013; Steinbrook, 2008, 2009). Primary care is the lowest paid medical career path, and some specialties earn two to three times as much as an average primary care physician (Bazemore et al., 2009; Bennett & Phillips, 2010). In the face of staggering debt, students may also be more inclined to choose a specialty with a more competitive salary in a career path that is also more respected within the field of medicine and in society at large (Steinbrook, 2009).

Societal Needs and the Current State of Medical Education

Some scholars posit that too much stake has been put into the lasting influence of *The Flexner Report* on medical education (King, 1984; Papa & Harasym, 1999; Seigel & Starr, 2008). For example Papa and Harasym (1999) contend that significant shifts in the approach to medical education have occurred approximately every twenty years since 1951. Additionally, in 2000 and 2010, The Association of American Medical Colleges (AAMC) produced reports reviewing American medical school curricula, highlighting the degree to which medical education has continued to advance and respond to societal concerns. Although the title of these

reports helped to signify the historical significance of *The Flexner Report* (they have the same title as the original document) the AAMC studies expressly highlight how the medical curricula have morphed beyond Flexner's original idea in attempt to silence critics of the rigidity of medical education.

Physicians practicing medicine in the 21st century must undoubtedly navigate a more complex health care system, and the successful navigation of these complexities inevitably effects public perceptions of responsiveness of medical education to societal needs. The implementation of the Patient Protection and Affordable Care Act is the most prominent example of how the health care system continues to become more complex and reliant on primary care (Starr, 2011). Title V – Health care Workforce, of the ACA lists as a high priority the "development of an integrated, primary care health care workforce" and has specific provisions to enhance primary care education, training, and recruitment in preparation for the 32 million new people predicted to enter the health care system by 2019 (Levitt et al., 2013; "Title V," 2010). In response to amplified calls for accountability, evolving technology innovations, and federal regulatory changes in the health care system, medical educators must creatively balance basic science knowledge with rapidly expanding new knowledge, in a fiscally responsible manner, while increasing institutional rankings (Mechanic, 2006; Vandermiden & Potter, 2010). Societal pressures for education reform are reflected in a proliferation of reports being produced from professional organizations, private foundations, advocacy groups, and individual authors (Skochelak, 2010).

Although there have been some changes to the medical education system, these changes have been incremental and have not resulted in the types of changes, nor at the speed, desired by those groups calling for change. Medical education and curricular reform is also impacted by the

larger university context within which it is housed. Often, the premium in higher education is placed on specialized knowledge or disciplines that can generate revenue or garner prestige (Slaughter, 1997; Slaughter & Rhoades, 2005). Because medicine is one of the few professions that has garnered high levels of autonomy and economic vitality, society as a whole has been willing to grant physicians a certain level of professional latitude (Freidson, 1970). As a result of this unprecedented professional authority, scientific medicine has traditionally remained aloof and quiet when critiqued by the lay population and continues to be minimally regulated by the government or other agencies (Freidson & Lorber, 1972; Ludmerer, 1985; Pescosolido & Boyer, 2010; Starr, 1982). Additionally, the current undergraduate medical training curriculum is quite dense. As such, university administrators must balance curricular concerns with the need to attract the best faculty and top students in order to maintain or increase their prestige (Bastedo, 2012; Toma, 2012). Thus strategic decisions must also maintain and reflect this delicate balance.

Theoretical Overview

In their work on Strategic Action Fields, authors Fligstein and McAdam (2011, 2012) seek to explain how change and stability in modern institutions is achieved by social actors. In their treatment, strategic action fields (SAFS), which are constructed meso-level social orders, are the building blocks of larger proximate fields. In order to understand organizational change or stability it is imperative to focus on the interdependence of strategic action and proximate fields. Field stability depends on the degree to which particular resource dependencies can or cannot be managed within the proximate field. Therefore, the basic premise of their theory is that all organizations within a proximate field are interdependent because no single entity controls all the necessary resources (Fligstein & McAdam, 2012). As such, organizational strategy hinges on becoming more autonomous via controlling scarce resources and by garnering

more power either as an individual or as an organization (Davis & Cobb, 2009; Pfeffer & Salancik, 1978).

Because SAFs are situational, there is constant jockeying for power, although challengers are not trying to drastically redefine the field and, in fact social reproduction is the overwhelming outcome. Even in the most stable fields incumbents constantly negotiate with challengers to institute piecemeal adjustments instead of radical change. As such, incumbents and challengers who undertake strategic action must be able to use whatever power they have developed to secure the willing cooperation of others who are at differing levels in the field (Fligstein & McAdam, 2011, p. 7). DiMaggio and Powell (1983) contend that moves toward innovation within a field causes more similarity than diversity within the strategic action and proximate fields ultimately leading, in the aggregate, to homogeneity in structure, culture, and output (p. 147). Additionally, the value placed on reputation (power) encourages homogenization as organizations seek to ensure that they can offer the same benefits as their competitors in a field (Toma, 2012). As such, organizational change can be better predicted by diagnosing the sources of interdependence. Therefore strategic action hinges on becoming more autonomous and is driven by power dynamics, individual aggrandizement and increased profits (Davis & Cobb, 2009; Pfeffer & Salancik, 1978). Strategic action also necessitates surveying the external environment for turbulence to identify what exogenous shocks will provide enough disruption for individual or collective challengers to capitalize on in order to increase their power and control within a given strategic action field (Fligstein & McAdam, 2012).

In the proximate field of medicine, primary care has been the challenger role for decades. The strategic action field of higher education, specifically medical education, plays a key role in acting as gatekeepers to the medical profession. Academia defines the boundaries of relevant

knowledge and serves to legitimize the training an individual receives through the granting of degrees and certificates (Brint, 1994). Both the curriculum and disciplines are socially constructed by a profession and the university and therefore apt to change based on external shocks or shifting priorities (Slaughter, 1997). The development of specialized knowledge results when facets of knowledge develop a social or economic niche or when the university and the profession redefines what knowledge is worth keeping as the knowledge base expands. The actual type of work done by individuals is also essential to professionalization theory (Abbott, 1988). The key to being an elite profession is to not allow the core functions of the profession to become routinized. The ability of a profession to sustain its jurisdiction lies partly in the power and prestige of its specialized academic knowledge. Therefore, the academy is necessary in order to help elite professions decide what a core function is and delineate what work that can and should be moved to a more fringe position.

Medical specialists' role as incumbents in both proximate and strategic action fields is also evident when examining the curriculum associated with the training needed to enter the field. The medical curriculum has remained relatively stable since the *Flexner Report*, and the majority of the reforms have focused on evaluating the effectiveness of a particular delivery method and less on the knowledge that students' should learn (Anderson & Kanter, 2010; Dexter, 1994; Ludmerer, 1985; Papa & Harasym, 1999). Slaughter (1997) suggests, however that curriculum theorists take a more critical stance by first evaluating what knowledge is valued by the university and society by examining the intersection of the state, professional associations, and economic factors on how curricula are created and reformed. Curricula reform tends to privilege disciplines and fields that maintain resources, prestige, and careers, while de-valuing career paths that are disproportionately populated by women and minorities (Bastedo &

Gumport, 2003). As such, within higher education, specifically medical education, the creation of certain programs or particular curricular developments are more related to competitive dynamics and institutional prestige than workplace or social needs (Bastedo, 2012)

As such the challenger, primary care physicians, have not been able to mount a successful strategic initiative in either the proximate field or the strategic action field to address the persistent primary care physician shortage over the past 12 to 15 years. The medical education curriculum has remained relatively stable and there has been little incentive to bolster the training or exposure to primary care. Yet, the passage and implementation of the Patient Protection and Affordable Care Act seems to be a significant exogenous shock to allow incumbent leaders in medical education to jockey for new power and new prestige. Given the directives of Title V-Health Care Workforce in the Affordable Care Act and the millions of dollars allocated to bolster the health care workforce, academia and the medical profession are being heavily incentivized to respond more effectively to the need for more primary care physicians. For example, $125 million dollars has been appropriated for public or private institutions to establish or expand academic programs in primary care, to propose innovative approaches to clinical teaching using models of primary care, to provide financial assistance for traineeships and fellowships for physicians who plan to teach or conduct research in primary care, and as awards to institutions that have a record of training the greatest percentage of providers who enter and remain in primary care ("Title V," 2010, pp. 498-499).

Given the centrality of primary care to a physician's work, the leaders of medical education must find creative methods to encourage enough students to pursue general practice in an increasingly competitive market that still favors specialization (Abbott, 1978; Freidson & Lorber, 2009). Despite the impending need for primary care physicians, the entire field of

medical education does not have to respond in the same way. Given that stratification already exists within higher education, often reinforced by the rankings, I posit that different types of schools will respond to the incentives in the ACA fin various ways and with various intensities.

Medical Education and the ACA

The need to increase the primary care workforce, specifically the number of primary care physicians, in American is not a new concern (Bennett & Phillips, 2010; Steinbrook, 2009) but the Affordable Care Act presents new challenges and new incentives that have the potential to recalibrate how the leaders of medical education respond to this demand. While the majority of political punditry centers on the legality of the legislation, the funding structure, or even Republican or Democratic values on health care, a more basic question is not being addressed, at least not publicly or in the literature: what is being done to ensure that there are enough primary care physicians in the system to handle the projected influx of new patients? The legislators address this issue in Title V – Health Care Workforce, which is dedicated to recruiting, educating, training, and expanding the health care workforce.

Although Title V provides incentives for a myriad of health professions, physicians have positioned their profession at the top of the proverbial health provider food chain. This is primarily due to the sustained collective ability of medical doctors to leverage new hierarchies of power and to establish and control new markets (Starr, 1982; Vandermiden & Potter, 2010). Given their prominence in health care, allopathic medical doctor education programs are considered central organizations in the larger medical education Strategic Action Field (SAF) (Fligstein & McAdam, 2011, 2012). In addition to garnering significant power relative to similar organizations, central organizations tend to be fairly stable; therefore changes in their structure,

strategy, goals, or recourse dependencies have a tendency to be indicative of significant external shocks. Thus, if central organizations respond to a shock, the rest of the SAF will also respond.

If the Affordable Care Act is a significant exogenous shock, multiple areas within medical education, such as the curriculum or admissions policies, will be impacted, but institutional strategy tends to be more malleable and responsive to immediate shocks or opportunities. Consequently, a focus on institutional strategy is key to understanding how medical education leaders determine if their particular institution will respond to the new societal demand for more primary care physicians and in what ways. Institutional strategy also expressly defines how the leaders are framing the problem, the topics they deem important, and in many instances the strategy reflects available resources or the need to secure more resources (Geiger, 2005).

While it is important to have an in-depth knowledge of how the legislators and authors of the Affordable Care Act envision bolstering the corps of the health care workforce, the different incentives that are available to individual students and institutions, and to identify any points of contention that make implementation of the act difficult from an institutional level, it is also imperative to understand how the leaders of medical education are setting their institutional strategy in response to the incentives and the ways in which the Affordable Care Act may be exacerbating stratification within medical education. Therefore, higher education vise-a-vie medical schools, has a significant responsibility in training enough new physicians to meet impending workforce demand. Yet, medical education as an entity has not received the level of academic research as other portions of the academy (such as undergraduate education, faculty, and student engagement). Thus, given the critical role education will play in meeting a specific

societal need, it is fitting to apply higher education frameworks to the analysis of the strategy leaders of medical are using and why in the era of the Affordable Care Act.

CHAPTER TWO

REVIEW OF LITERATURE

For this chapter I present a brief review of the literature centered on the necessity of educating more American trained primary care physicians, the persistent difficulties in meeting this need and recommendations for alleviating this problem. I begin with a macro review of higher education literature to present the broad discussion of current opportunities and challenges present in graduate and professional education. Subsequently, I narrow the discussion and review the literature focused on medical education and enumerate the challenges this group of scholars have found in attracting, educating, and maintaining student and professional interest in primary care. I then turn my attention to review policy reports that were produced on the heels of the passage of the Affordable Care Act and that are centered on medical education. I conclude with addressing the usefulness of integrating all three strands of research in order to produce a more cohesive understanding of the challenges present in medical education in regards to primary care and how medical education leaders are altering the policies and practices to meet a growing societal need of access to primary care.

Graduate and Professional Education

Graduate and professional education played a unique role in the creation of the American research university. In her comprehensive review of the rise of graduate education and the subsequent strain graduate programs often place on administrative decisions and resources, Gumport notes that starting in the 1940's, universities began to be seen as a national resource for basic science research and training. This change in perspective crystalized during war times

when the federal government began to invest heavily in the development of specific graduate programs tied to national defense, technology, and health (Gumport, 2005). The development of robust graduate programs allowed university leaders to better attract desired faculty talent, as well as top students who hoped to be trained by a noted scholar in particular academic discipline. Hence, graduate and professional programs aided in increasing an institution's intellectual heft and social cachet. Yet, despite what appears to be a symbiotic relationship, Gumport notes that the connection between universities, academic research, and federal government remains tenuous at best, and the strain has become more apparent in recent decades. Federal funding is inconsistent: support is pulled in economic downturns or in response to shifts in political ideology, resulting in the downsizing of research programs or leaving faculty and administrators scrambling to secure additional support (Gumport, 2005). Additionally, certain academic disciplines are championed over others making it difficult for the consistent development of a sustained research and training program for all parts of the university, especially for those areas, historically the liberal arts, not closely aligned with specific political or societal agendas (Slaughter & Rhoades, 2005).

While Gumport provides a robust review of the historical underpinnings of the current American graduate education system, she neglects to extend her analysis to include professional schools[2]. This omission is not uncommon in higher education research. Professional schools receive comparatively less scholarly attention when compared to graduate school (Ethington & Smart, 1986; Lovitts & Nelson, 2000; Mullen, Goyette, & Soares, 2003) and when professional schools are researched it typically in tandem with graduate education (J. C. Hearn, 1987; Nerad

[2] Professional schools are defined as post-baccalaureate training programs that prepare students for a defined career field, including but not limited to medicine, law, and business.

& Miller, 1996; Weiler, 1991). While not a widespread topic of scholarly focus, the research on graduate and professional education expands our understanding of important higher education issues such as college access, return on investment, and diversity.

As a body of literature, higher education studies on post-baccalaureate education have primarily looked at the transition from undergraduate to graduate and professional school. A majority of the studies provide analysis on the barriers to entry, especially among women and minorities (Ethington & Smart, 1986; Mullen et al., 2003; Pascarella, Wolniak, Pierson, & Flowers, 2004). Those studies that move beyond matriculation tend to focus on persistence and attrition, again with the unit of analysis being the female or minority student experience (Lovitts, 2001; Lovitts & Nelson, 2000). Few studies, however, consider the larger connection between graduate education and university-wide strategic action, or how graduate and professional school leaders are adjusting their strategies in relation to external and internal pressures. Additionally, because post-baccalaureate education is often viewed monolithically, as few authors have flushed out the nuances that exist between the curriculum, strategic goals, or student experiences in graduate school when compared to professional schools.

For example, in her 2003 study, Millet uses quantitative analysis to assess how undergraduate debt and other factors may impede entry to graduate or first professional school. Although debt in higher education has been heavily studied, Millet seeks to winnow what she sees to be inconsistent findings and develop a greater understanding of how students think about debt. She discovers that undergraduate debt did not have a significant effect on enrollment in a student's first choice graduate or first professional degree program and instead finds the strongest correlation between parental income and the likelihood to enroll (Millett, 2003). This is an interesting finding because most studies of graduate and professional education, and

especially medical education, focus on student debt and lowering the amount students borrow with the hopes of increasing matriculation into graduate and first professional schools. In her 2004 article, Perna extends the discussion of impediments to enrolling in a post-baccalaureate program, specifically for women, by explicitly integrating race/ethnicity, sex, cost benefit analysis of expected return, and social and cultural capital along with parent income as independent variables in her models. Perna also notes that the results of econometric studies are contradictory; however by incorporating social and cultural capital into traditional econometric approach, she finds that her models were better able to predict post-baccalaureate enrollment decisions (Perna, 2004, p. 521).

Higher education studies focused more on professional school, specifically medical schools, are growing, albeit slowly. Moskowitz (1994) presents a brief historical review of which medicals schools train the highest number of Black physicians in conjunction with the Association of American Medical Colleges' push to graduate 3000 underrepresented minority (URM)[3] physicians by 2000. In this brief analysis, the author also reviews application trends at elite universities as well as highlights which undergraduate schools have the best track record of producing the most Black medical school applicants. In a more quantitative examination of medical school trends, Cantwell, Canche, Milem, and Sutton (2010) evaluate the effectiveness of the Holistic Admission Process (Shapiro) in increasing diversity in the medical student body. In 2008 the AAMC piloted the HAP at two medical schools in an effort to continue the organizations' commitment to increase diversity in medical school beyond the "3000 by 2000"

[3] This term accounts for Hispanic, Native American, and African American students who are underrepresented in medicine as defined by the Association of American Medical Colleges (Association of American Medical Colleges, 2011).

campaign. Opponents of the HAP posited that the new admissions practice would reduce traditional quality indicators as well as disadvantage non-URM applications. The authors found however, that the policy helped to increase the admission rates of URMs while simultaneously "helping to increase the academic credentials of both URM and non-URM applicants without unfairly favoring URM applicants over non-URM" (Cantwell et al., 2010, p. 35). Both studies highlight the importance of diversity to not only medical education, but in helping society reach its goals of producing more physicians willing to serve in medically underserved areas. Overall however, the body of literature for graduate school guided by higher education frameworks is just more robust than the literature on professional schools.

Medical Education and Academic Health Centers

Outside of the higher education literature, there is also a strand of scholarly discourse focused solely on academic medicine, which encompasses the entire lifecycle of educating and training of physicians from undergraduate medical education through residency and includes Continuing Medical Education (CME). It is in this body of research that the challenges in recruiting and maintaining a US trained primary care workforce have been enumerated and scrutinized (Barrett, Lipsky, & Lutfiyya, 2011; Bennett & Phillips, 2010; Dick III, Wilper, Smith, & Wipf, 2011). Similar to the higher education research, one of the most studied barriers to entry to medical school is student debt and the cost of medical training (Dorsey, Nincic, & Schwartz, 2006; Jolly, 2005; Morrison, 2005). Despite the consensus in the literature around the expense in training physicians, dissonance exists on how strong a factor student debt is on specialty choice. In 2005 Jolly used data from the 2003 All Schools Report, a yearly report produced by the Association of American Medical Colleges (AAMC) based on survey data collected from graduates from all US medical schools, to determine if any trends existed in debt

levels among recent medical school graduates' residency selection. Jolly is specifically concerned with the feasibility of young physicians in primary care to pay back loans based on the current market. While he notes the increasing cost of higher education in general, he finds the increases in medical education particularly troubling, although he concludes that there is no convincing evidence that links specialty choice and debt (Jolly, 2005). Jolly spends a great deal of time describing the context of the situation but draws limited conclusions and presents conservative recommendations in an attempt to "report the facts about tuition and indebtedness" (Jolly, 2005, p. 527).

The majority of scholars, however, posit that indebtedness negatively influences specialty choice. It can be inferred from the majority of these studies that indebtedness ultimately decreases diversity in the physician workforce. For example, Steinbrook (2008) notes how the cost of medical education is outpacing the Consumer Price Index as well as the compensation of primary care physicians and specialists. In his article, which is principally a commentary based on data produced by the AAMC, Steinbrook notes that the trend at public universities is particularly troubling because the majority of medical students attend these schools, thus signaling that a greater percentage of students will graduate with higher levels of indebtedness. Morrison (2005) noted that 32% of 2002 graduates indicated that their debt level influenced their specialty choice, leading her to lament how the current system of medical education is forcing students to mortgage their futures. Building off Steinbrook and also relying heavily on data provided by the AAMC, Adashi and Gruppuso (2010) comment on how the increased cost of attendance and the decline in affordable loan options (due to the increase in interest rates on subsidized and unsubsidized loans) has led to more physicians graduating with "educational mortgages" (p. 764). They acknowledge that the refunding of the National Health Service Corp

through a onetime $500 million dollar allocation in 2009 were steps in the right direction, however, the authors also submit that simply providing more financial assistance is not enough to ameliorate the larger problem. Adashi and Gruppouso state that changes to the physician compensation system as well as addressing the rising cost of attendance is also needed to ensure that highly compensated medical disciplines are not chosen over "less-well-compensated counterparts, including primary care" (p. 764). The authors build off recommendations in the 2009 Josiah Macy, Jr. Foundation report in advocating for a shorter, three- year curriculum, but also recommend combined BS/MD programs and accelerated residency programs as other ways in which medical schools can decrease cost of attendance.

In their study, Dorsey, Ninic, and Schwartz (2006) evaluated the relative financial impact of some of the more widely advocated solutions to decreasing the financial burden of medical education. The authors calculated the net present value of decreasing tuition, decreasing training by one year, increasing house staff salaries and decreasing graduate medical education training by one year for entering medical school in AY 2003-2004. Based on their analysis, the authors conclude that the most effective financial means for decreasing the large financial burden of medical education is to reduce the duration of training. The authors found that just shortening training by one year would yield from US $160,000 to US $230,000 (depending on specialty) primarily because physicians would be able to realize their full earning potential sooner. They note that their recommendations differ from popular rhetoric, which usually centers on decreasing the cost of education or even increasing student loans. Although they review some of the successful three year programs in the US, the authors fail to provide a robust analysis as to why these programs have not been more popular, especially since they note there is no substantial empirical evidence to show a difference in "objective measures of student

performance between students from a three-year and four-year curriculum" (Dorsey et al., 2006, p. 248). The authors also fail to understand some of the larger cultural, societal, or even policy issues that may have and continue to hinder the growth of three-year or combined BS/MD programs. Even though they posit that universities could keep total tuition the same and effect net revues, they authors do not explore why such a proposal would not be attractive to most medical schools.

Much of the literature on medical student debt, excluding the AAMC All Schools Report, is **antidotal**. Thus it is difficult to assess the value of the recommendations that these authors put forth. Scholars in both medical education and higher education spheres tend to agree that the cost of attendance and subsequent indebtedness are among the more significant barriers to choosing primary care, but few articles address the innovative ways in which medical schools are addressing these challenges (Dorsey et al., 2006). The collective body of research seems to produce somewhat limited, often repetitive recommendations – frequently centered on increased federal funding and addressing the pay differential between primary care and more lucrative specialties.

Although much of the published literature on medical education centers primarily on the challenges inherent to medicine, there is a burgeoning arm of research that considers how the challenges in terms of cost and culture surrounding primary care training may be tangentially related to or exacerbated by the larger university context within which schools of medicine operate. This research on Academic Health Centers (AHC) generally investigates market demands and how location, type of school (either public or private), and relationship with or ownership of training hospital necessitates different strategic actions (Pardes, 1997; Reuter & Gaskin, 1997). While research on Academic Health Centers integrates both higher education and

medical education stands of research, economic and market dynamics tend to be the crux of the foci. Additionally, the majority of the recommendations and conclusions are directed toward the clinical arm of the enterprise. This could be because that such a small percentage of the revenues at both public and private medical schools comes from the parent university/government appropriations. For example in fiscal year 2013, 39% of all medical school revenues were generated by the schools' practice plan ("Fully-Accredited Medical School Revenue by Source 129 Medical Schools," 2014). When broken down by type of school, practice plans accounted for 43% of private school revenues and 34% of public school revenues, while hospital care accounted for 16% and 19% respectively of all revenues generated ("Fully-Accredited Medical School Revenue by Source 129 Medical Schools," 2014). The heavy reliance on clinical care to generate revenues may highlight why the larger university administration is not necessarily a focal point in medical education studies. Yet, despite the lion's share of revenue being generated from clinical care, roughly a quarter of all recorded revenues for FY2013 were generated from grants and contracts awarded to school of medicine faculty and tuition and fees – both of which are governed by broader university policies ("Fully-Accredited Medical School Revenue by Source 129 Medical Schools," 2014). Thus non-school of medicine administrators do wield a modicum of fiscal control and may be more readily able to interject themselves into medical school strategy processes than previous research has highlighted.

There are a handful of articles that address the importance of university governance to medical school policy. For example Barrett (2008) briefly explores the different organizational structures that exists in Academic Health Centers and presents a continuum from full organizational integration (e.g. tightly coupled) to limited integration (e.g. loosely coupled) (p. 805) and the opportunities and challenges present to medical leaders in each type of

organizational structure. The author, who is the former Senior Vice President of Health Affairs at UF Health Sciences Center, advocates for a more unified organizational structure similar to the structure in place at the University of Florida. In addition to presenting a case study and historical analysis of UF's organizational structure, Barrett also presents a balanced review of the ways in which various organizational structures impact funding and strategic decision-making. He also provides anecdotes about the benefits and difficulties in working in an organization with a lot of redundancy(Barrett et al., 2011, p. 807). While Barrett provides examples of different organizational structures at both the public and private medical schools, he does not delve into which system might readily lend itself to a specific type of school or gauge the overall effectiveness of these various models at these types of schools.

While Barrett provides an in-depth analysis at one institution, Blumenthal, Weissman, and Griner (1999) use qualitative data collected from interviews and observations at five different academic health centers to understand how leaders alter their institutional strategy in highly competitive markets. Similar to Barrett, these authors investigate the entire continuum of medical education from admission through residency and onto Continuing Medical Education (CME) as well as the differences between institutions with robust clinical or bench science research agendas. In a competitive market, it is extremely difficult for academic health centers to recoup the costs from revenues generated from patient care, because price-sensitive consumers tend to patronize cheaper institutions. The care provided at an AHC is more expensive due to the fact that "providing trainees with the necessary clinical experiences raises the costs of patient care, because trainees take longer to perform routine patient care tasks, use more diagnostic and therapeutic services, and require faculty supervision" (Blumenthal et al., 1999, p. 1047). The authors briefly review how the parent university's strategy may impact the AHC, although the

review is conducted from a more monetary vantage point (such as recruitment of new researchers and reducing costs). The authors do not address primary care in their analysis, however specialization was seen as vitally important to the administrators at each AHC in order to compete in a crowded market terms of generating research or patients. Thus, the authors found that a lot of resources were dedicated to further defining and marketing these specialties and not going to primary care or the center's social mission (Blumenthal et al., 1999).

In an earlier work, also focusing on academic health centers, Blumenthal et al defined the social mission to include research (applied and basic), patient care and the training of new physicians (1997). The social mission is seen as a vital part of the academic health centers in terms of providing health access to diverse patients, usually through the affiliated safety net hospital, necessary for clinical research and physician training. The authors conclude that the social mission is a social good that is essential to the vitality and sustainability academic health centers and recommend that academic health centers should not be completely emboldened to pursue competitive markets, especially when considering the research, teaching, and patient care (typically at safety net hospitals) when setting or implementing their institutional strategy. In fact, the authors found that most academic health centers in their study could not support their social missions, especially the research agenda, without funding from the government; therefore government funding greatly influenced institutional strategy surrounding the social mission aspects of the AHC (Blumenthal et al., 1999, p. 1048).

Not all authors are in agreement about the reliance on federal dollars to fund medical education, even those aspects that fall under the social mission. For example, in their 2011 article, which largely centers on student debt and medical workforce diversity, Greysen et al briefly review the way in which federal grants and contracts fueled an insatiable appetite for

research dollars, while also criticizing the federal government for not including a sustainable model for the education of students. Their critique is a part of a larger historical review of both the macroeconomic issues as well as the university-level culture that created a culture of reliance on federal funding in medical education at both institutional and student level. They conclude that more transparency and standardization in terms of how institutions fund medical education is a fundamental step toward curbing student debt. The authors posit that such moves will subsequently increase workforce diversity, which is seen as vital to growing the numbers of physicians who pursue primary care. Yet the authors' examination of the link between medical school initiatives and the parent university strategy is brief and focuses on the larger funding structures supporting medical education and clinical research. Additionally, the authors do not explore how a school's mission, or how a leader's decision-making in lieu of this mission may or may not affect the types of grants or contacts pursued by certain medical school.

Policy Reports

On the heels of the 2008 election of President Barack Obama, whose presidential platform included the provision of some form of universal access to health care, a barrage of policy reports were produced on the contemporary state of medicine and medical education as well as providing recommendations as to what policy provisions should be included in the impending legislation. For example, in 2008 the Association of Academic Health Centers (AAHC) produced a report outlining the challenges associated with consistently training an effective health care workforce ("Out of order out of time: The state of the nation's health workforce,"). The report is fairly multifaceted in its assessment of the macro-level political, educational, and financial issues exacerbating the short supply of US trained primary care health professionals. Of note is the authors' treatment of the relationship between medical schools and

their parent university and the role university administrator have in the overall success and vitality of academic health centers ("Out of order out of time: The state of the nation's health workforce," 2008, p. 46). The authors are critical about how the ebb and flow of national and private funding to certain training techniques or hot topics leads to inconsistency in the production of the domestic health care workforce and that a concerted effort by legislators and health care administrators should be given to create a more sustainable funding model ("Out of order out of time: The state of the nation's health workforce," 2008). The authors also recommend creating a coordinated body to oversee health care job placement and hiring trends.

The breadth of the issues and health professions (including physicians, nurses, and allied health professions) covered in the 2008 AAHC report precludes the authors from deeply delving into the issues specifically impacting the domestic physician workforce. In fact many of the training problems the authors address (e.g. the rise in clinical doctorates) and the resulting solutions are not relevant to medical doctor education. Additionally, since the AAHC is an advocacy group representing nonprofit instead of for-profit and proprietary medical schools (pp. 47-49), the authors fail to equally provide critiques of both for-profit and non-profit institutions. For example, the authors lament the rise of entrepreneurial ventures and academic capitalism, but neglect to review how these issues are also effecting traditional academic institutions (Slaughter & Rhoades, 1996, 2005).

In 2013, the AAHC issued a follow-up report assessing the implementation of the Affordable Care Act based on the recommendations the organization presented in their earlier policy report. By and large the authors' note that the ACA missed the mark on many key indices, such as failing to help grow the health profession faculty base in order to keep pace with the opening of new health schools. The authors commend the formation of the National Health Care

Work Commission, which is supposed to oversee national trends in the primary health care workforce, but are critical of the fact that no funding has been appropriated for the Commission to convene or enact policy. Thus, the authors call on legislators to focus on fully funding those aspects of the ACA that will allow for an integrated approach to the distribution of health care workers across the United States and more consistent education and training across all medical schools. The authors also request that additional funding be appropriated to provide more training opportunities for both the current and new health care workforce on the changing health care technology.

In 2009, the Robert Graham Center, with support from the Josiah Macy, Jr. Foundation, produced a report assessing the factors that influence medical student and residency choices. Unlike the AAHC reports, which were primarily a review of current literature, the authors of Robert Graham Center report used a wide range of qualitative data on which to run their models to inform their recommendations. Furthermore, unlike the AAHC, the Robert Graham Center report is solely focused on physicians, although it includes both osteopathic and allopathic doctors in the analysis. The authors use a broad brush to define barriers to entry to primary care and offer an even broader swath of recommendations at both the medical school and societal levels. At the medical school level, for example, the study found that providing undergraduate clinical rotations in primary care, rural and community centers helps to create a more favorable impression of primary care professions. At a more macro-level, the authors echo sentiments of other reports in the need to ameliorate the pay differential primary care professions and other sub-specialties (Bazemore et al., 2009) . The authors also find that historically public medical schools have produced more primary care physicians when compared to private institutions,

however the authors do not control for institutional selectivity or specialty serving institutions in their analysis; nor do they provide robust recommendations around this finding.

The Robert Graham Center/Macy Foundation report is a widely referenced policy report. For example, many of the institutional level recommendations the authors put forth clearly informed Emory University's Woodruff Health Sciences Center Primary Care Strategic Plan. Additionally, at the a macro-level, the influence of this report is also seen in the ACA as evidenced in the reauthorization of funding for Title VII of Public Health Service Act, which was one of the main recommendations the authors put forth (Bazemore et al., 2009). Yet, although the influence of the authors' recommendation is clearly seen, the effectiveness of these recommendations has not been measured to date. While the report is ripe with recommendations, the authors do not provide a blueprint for how medical schools should implement them. Also, the recommendations are applied indiscriminately regardless of the type of institution, even though the authors find that public and private medical schools have different degrees of success in producing primary care physicians. This document, like other reports, focuses heavily on the inverse relationship between medical student debt and careers in primary care, yet the report does not provide recommendations as to how to help alleviate student debt load or how to make medical education more cost effective. Lastly, the report was released one year before the ACA was signed into law, and thus it is necessary to see how institutions are responding to more funding and increased national attention on the need to train more primary care physicians.

Summary

While there is a plethora of literature on medical education, rarely have scholars sought to understand the strategic decisions of medical education leaders vis-a-vis higher education constructs. In the cannon of higher education literature, medical education is typically studied in

concert with other graduate and professional programs and is seldom separated out as a singular point of inquiry (Cantwell et al., 2010; Moskowitz, 1994). As such, the same rhetoric surrounding the barriers to entry are reproduced and highlighted, but limited attention is spent on elucidating how administrators or faculty are working to ameliorate these obstacles. Nor is there a robust discussion around how these strategies may vary based on the type of first professional degree (e.g. M.D., J.D. Ph.D., etc.) or how external influences, such as the allocation of significant federal dollars to a specific education aim, impact institutional strategy.

Within the scholarly literature produced by leading medical education authors, the challenges to recruit and maintain a consistent primary care workforce are enumerated, with debt and the pay differential between primary care doctors and other specialists cited as the foremost issues. Often, the recommendation is to reduce the indebtedness of students, but limited scholarly attention is given to the ways in which medical school leaders are implementing policies and procedures to remedy this and other problems. While policy reports tend to produce broad recommendations, rarely do these studies produce follow-up reports measuring the effectiveness of the initial recommendations. The void in the literature also remains in how medical school leaders are partnering with the larger university to strategize and implement effective methods to increase enrollments. The articles on Academic Health Centers (AHC) move closer to informing our understanding of the relationship between medical schools and the larger university, yet the discussion tends to be fleeting (Blumenthal et al., 1999; Greysen et al., 2011) and rarely do recommendations center on how medical school leaders can alter or have altered their strategy in a holistic sense to overcome pervasive challenges.

This dissertation seeks to add to the existing literature by specifically assessing how medical school leaders partner with the parent university to produce and implement strategy. As

the review of literature highlights, the need to increase the number of American trained primary care physicians is not a new, but the Affordable Care Act presents new challenges and incentives that have the potential to recalibrate how the leaders of medical education respond to this demand. With the allocation of hundreds of millions of dollars to medical education and curriculum development, increases in primary care research and the reauthorization the National Health Service Corps and other loan forgiveness models, legislators are heavily incentivizing individual students to seriously consider primary care as a career choice, and are also attempting to compel medical school leaders to make primary care a point of distinction for their institutions. This is not to imply that institutional strategy is simply crafted by following the money, however as history has demonstrated, the influx of new dollars to institutional coffers is often a motivator (Gumport, 2005). Additionally, higher education vis-a-vis medical schools, have a responsibility to ensure that enough physicians are trained to meet a societal need. It is a part of the inherent social contract between higher education and society (Brint & Brint, 1996; Freidson, 1986; Rueschemeyer, 2009; Starr, 2011). Thus, given the critical role education will play in meeting a specific societal need, it is fitting to apply higher education frameworks to the analysis of the strategy leaders of medical are using to increase the product of primary care physicians in the era of the Affordable Care Act.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Given that the implementation of the Patient Protection and Affordable Care Act is a contemporary phenomenon that is currently unfolding, qualitative methods are applicable to exploring the proceeding research problems (Merriam, 2009). As highlighted in the review of literature, medical education within the context of higher education is an area that has received limited research attention and historically the research questions, which are usually more quantitative in nature, have centered on barriers to entry, attrition among students of color and women, and indebtedness (Ethington & Smart, 1986; J. C. Hearn, 1987; Perna, 2004). Based on the robustness of the available data, however, I also believe that qualitative methods will prove useful in extending the discussion around professional education and that this analysis will result in a rich, thick description of a current phenomenon (Merriam, 2009).

As a researcher, I am well situated to conduct qualitative analysis. I have a role in constructing the meaning of the data interpretation and the results (Charmaz, 2006; Merriam, 2009). Although I do not know any of the legislators directly, I am a United States citizen and I am impacted by the legislation. I also have a background as a staff person in medical education administration at a highly selective medical school and I am intimately aware of the bureaucracy involved in setting and acting on institutional strategy. Thus, my interests were piqued when considering how institutional strategy at various medical schools could be shifted as a result of the Affordable Care Act. I also worked for the research focused arm of the medical school and witnessed firsthand how specialized knowledge and academic research were often favored over

primary care. In fact, the medical students who I worked with were not allowed to graduate until they had an article published in what the program's advisory board considered a tier-one research journal.

Given my professional background, I do have grounded concerns about the willingness of medical schools to readily respond to the incentives in the ACA to increase primary care physicians. While my professional experience gives me an advantage in that I am keenly aware of the nuances of medical school administration, my knowledge may also be a limitation because I enter with some preconceived notions about the overall willingness or ability of institutional leaders to respond favorably to producing more primary care physicians and research in general medicine. My role as researcher, however, is to reflect on those views, chronicle them, and rely on rich, thick description of the data and data analysis to guide my conclusions.

Research Design

For this analysis, I conducted case studies at three research sites to discover how the leaders of medical education are responding to the need for more primary care in the era of the Affordable Care Act. In order to understand the exogenous shock provided by the Affordable Care Act and any subsequent changes to institutional strategy or the curriculum in the field of medical education, document analysis is essential to the study. Additionally, I sought to inspect the ways in which medical curricula are already differentiated, exploring how different levels of material resources and manifest and latent institutional goals concerning primary care informs different college administrations' responses to the problem of producing more primary care physicians. Although a qualitative study, I decided to study medical schools in a single state because that somewhat controls context. Specifically, I posit two research questions:

1. How might the Patient Protection and Affordable Care Act be exacerbating stratification within medical education, as evidenced by the curriculum?
2. Which institutions are going to respond to the incentives in the Patient Protection and Affordable Care Act to expand and sustain the primary care curriculum and why?
    - Proposition 1: The more elite the institution and the student body, the less responsive the institution will be to the incentives in the PPACA.
    - Proposition 2: The less elite the institution and the student body the more responsive the institution will be to the incentives in the PPACA.
    - Proposition 3: Elite institutions will figure out a way to respond to certain incentives without significant changes to the curriculum or institutional strategic goals.

Document Analysis Design. Document analysis is essential to my study as the Affordable Care Act is the stated exogenous shock to the proximate field of medical education. Documents are created in a social context and are understood in a twofold manner: by the story that the authors of the documents are trying to tell and how the recipients interpreted the message (Prior, 2003). Therefore it is the goal of the social science researcher to unearth the context in which the documents were created and the multiple ways in which they are understood in that context (Prior, 2003). Documents are important to qualitative research because they provide clues as to the how the problem was originally defined, potential clues to how the problems can be solved, as well as insights to any political underpinnings that were guiding the authors or that could influence interpretation (Prior, 2003).

The Patient Protection and Affordable Care Act is considered a generative document in that it dictates future action and how future documents on similar policy issues will be framed (Prior, 2003). The Affordable Care Act is approximately 1000 pages long and is divided into seven titles. A bi-partisan commission wrote the final version and President Barack Obama signed the legislation into law in March 2010. Official copies of the document can be accessed at www.healthcare.gov or www.whitehouse.gov. Topics addressed in the document include definitions of relevant terms, funding sources, structures of government agencies,

implementation timelines, and penalties if certain actions do not occur. The analysis for this study focused on Title V- Health Care Workforce. Title V is 96 pages long and is divided into eight subtitles that address different aspects concerning the recruitment, retention, education, training and expansion of the health care workforce. I conducted the document analysis to better understand how the legislators and authors of the Affordable Care Act envisioned bolstering the corps of the health care workforce, the different incentives that are available to individual students and institutions, and to identify any points of contention that make implementation of the act difficult from an institutional level. Secondly, knowledge from the document analysis was used to write the interview protocol and guided supplemental questions I asked during the interviews. Lastly, the document analysis was used in generating themes during the induction process when I analyzed the final transcripts of the interview – to identify where institutional leaders agree with the federal policy and where their views of expanding the health care workforce diverge.

I used three different qualitative methods to conduct the document analysis of Title V – Health Care Workforce: an induction, a conceptual analysis/narrative, and a found poem. In order to construct the narrative, I conducted a thematic analysis looking for repeating words or phrases in order to determine what, if any, concepts could possibly be converted into a narrative (Riessman, 2008). Given that Title V covers a broad spectrum of topics, and was written by multiple authors, the text lacks neat boundaries indicative of interview transcripts or even documents written for one audience and by one author (Riessman, 2008). After identifying themes, I utilized a layered account to construct the text, weaving my personal experiences as a United States Citizen and a medical educator in with the research questions and the data (Ellingson, 2009). I adapted the methods outlined by Riessman and Ellingson because my data

are from public policy and not from interviews or dialogues that tend to lend themselves more readily to narrative analysis. By weaving my personal, more informal narrative in with the more formal language of the ACA, I believe I constructed a narrative that captures the tone and formality of the legislation but is more conversational.

The supplemental questions guiding my induction analysis were: Where is there evidence of vague language and why might this language be present? What professions or what characteristics are left out of this overview section and in what ways will these omissions shape the subsequent discussion about the expansion of the health care workforce? In order to address these questions, I divided the subtitle into four categories and then developed rudimentary themes to help further analyze the data (Charmaz, 2006). For some of the themes I used taxonomies to try to further group the data into more meaningful subcategories (Maragret LeCompte, 2000). The categories are: skills professionals should possess or tasks them should be able to do; specific professions or health career pathway training programs; the targeted populations to be served; and the projected geographic regions or locations that should experience an increase in access to health delivery and services.

In creating the "found poem" I did a cursory overview of Title V (Commeryas & Karly, 2002). I scanned the document to find key words or phrases that honed in on both the ideological (i.e. who is an ideal health care professional) and structural (e.g. implementation strategies needed to reach the established goals, etc.) aspects of the Title (Commeryas & Karly, 2002). Although I identified the passages in a chronological order based on their appearance in the text, I was sensitive to the frequency with which words or phrases where used and those phrases that were vague or not clearly defined by proceeding or subsequent text. Redundancy signaled these phrases importance to the authors' vision of the legislation and vagueness is

important because the authors broke from the mundane, prescriptive nature of the text. Lastly, the authors' had a very specific timeline on when these changes should be implemented. It was important to include this to highlight the ambitious and aggressive nature of the legislation.

After selecting the highlighted text, I grouped the phrases based on themes. The first group was comprised of words and phrasing that described skills and abilities the ideal healthcare professional will possess. The second group was more of the practical aspects, such as the different ways monetary resources will be distributed to reach implementation and recruitment goals. I also selected words that described the primary population that will benefit from this new band of health care professionals and I also incorporated elements of the explicit timeline given to realize these goals.

found poem

180 days after the date of enactment of this Act
Qualified health professionals
Familiar with evidence-based methods, culturally competent, health literate
Interested in retaining or upgrading their education
Will agree to provide care -
To vulnerable populations.

180 days after the date of enactment of this Act
$125,000,000 will be appropriated.
$8,000,000 will be granted.
$17,000 will be loaned.
To encourage innovation to address population needs -
Based on the sense of Congress (with the supervision of a physician).

Narrative. While I believe some form of health care reform is necessary, I am skeptical that the Patient Protection and Affordable Care Act (PPACA) is the perfect solution– especially as it concerns the recruitment and retention of the Health Care Workforce. Maybe I am jaded. I have worked in medical education and I am intimately aware of the bureaucracy needed to make even minute changes to the curriculum or to the recruitment strategy. As a purveyor of higher

education in general, and a doctoral student focused on medical education, I also recognize this as a unique time for medical education. The potential exists for the ACA to usher in the next era of medical education, which has remained relatively stable since 1920 (Ludmerer, 2005). As such, how is the legislation going to encourage reform to education that will bolster the corps of primary care physicians? How does the language of the act frame or dictate where and how this growth will occur? Is there any evidence of an attempt at social reproduction or stratification in the language used?

Title V – Health Care Workforce addresses the recruitment, retention, expansion, education and training of physicians and allied health professionals needed to support the millions of new patients expected to enter the health care system by 2014. That seems relatively small but, as an educator and researcher, my bias is toward the need for more and better education. Yet, I also recognize that medical education is in a unique position having responsibilities for educating new physicians as well as a role in the delivery of health care (Ludmerer, 2005). As such, tensions exists between what medical education can provide, and what the public, the health care industry, the medical profession, and individual students expects medical education to provide. The majority of the strategies geared toward the "support and development of primary care training programs" link financial aid to need and career plans ("Title V," 2010). Establishing need, although imperfect, is fairly straightforward as it is primarily based on income data. Career plans are fluid on the other hand. For example, I wanted to be a high school history teacher and eventually be the superintendent of a public school system. I graduated with dual bachelors' degrees in History and Social Science Education and even passed the PRAXIS II. Yet, I am not a high school teacher. In fact, I have never taught. Despite all the training I chose a different path based on what I was exposed to during my

undergraduate and graduate education, my life's experiences and ultimately what I found interesting.

Exposure to different specialties and career tracks, not cost, may be the culprit thwarting policy makers' attempts to encourage more physicians to go into primary care. A good education has the potential to expose students to something that will alter their professional journey and career goals. Exposure and human unpredictability crushes education policy's rigidity and spoils a policy makers best laid plans to funnel students into certain careers and professions in order to reap specific positive externalities. As such, does verbiage exists in Title V of the Affordable Care Act that focuses on the structure of the medical curriculum, what students are exposed to, and when? Subtitle D highlights a focus on increasing funding to institutions that have a record of training the "greatest percentages of primary care providers" as well as to institutions with "innovative programs" focused on training primary care physicians "who plan to teach" in a medical school or in a community based setting" or who "plan to conduct research" in a primary care field ("Patient Protection and Affordable Care Act," 2010a). This is a unique focus, but is it enough? Five years after the PPACA was signed, I am still reeling with questions. Maybe that is why I became a researcher instead of a teacher – I have too many questions and not enough answers.

Induction. The induction analysis primarily centered on Subtitle A – Summary, which are the first four pages of Title V- Health Care Workforce of the Patient Protection and Affordable Care Act (PPACA). Subtitle A provides the purpose of Title V and defines what key words or phrases mean in this portion of the legislation. Subtitle A further clarifies what occupations or professions are considered a part of the Health Care Workforce, although greater detail is given in the subsequent subtitles. As such, it sets the tone for the rest of Title V and

provides key insights as to how the proceeding subtitles will outline the specific ways the health care workforce will be expanded and enhanced in order to "improve access to and delivery of health care services" to a broader swath of Americans ("Patient Protection and Affordable Care Act," 2010b). The authors of the act primarily reference the Public Health Service Act in order to define key health positions, relevant terms, and health. Subtitle A also introduces new terminology, as well as expands upon or clarifies definitions in other legislation, including but not limited to the Public Health Service Act (42 U.S.C. 296), the Social Security Act (42 U.S.C. 1395), the Workforce Investment Act of 1998 (29 U.S.C. 2801) and the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).

A reoccurring pattern in Subtitle A is the use of vague language to describe projected skill sets, the processes by which a person will gain the desired skills, or the metrics that will be used to assess the skills. For example, a health care career pathway is defined as a "rigorous, engaging, and high quality set of services that includes an articulated sequence of academic and career courses, including 21st century skills" ("Patient Protection and Affordable Care Act," 2010b, p. 470). The authors of the legislation highlight 21st century skills yet do not define what comprises a 21st century skill set, how these skills differ from the other skills obtained in a "rigorous or high quality academic sequence," or why these particular skills are vital to "improving access to and the delivery of health care services." Another example of vague language in terms of skills health care professionals will possess is cultural competency. Cultural competency is positioned to be an essential skill given the expressed purpose of the PPACA to improve access and delivery of health care services to "low income, underserved, underinsured, minority, health disparity, and rural populations" ("Patient Protection and Affordable Care Act," 2010b, p. 470). Yet, despite this very detailed list of who shall be served,

what types of skills or traits are necessary for a culturally competent health care profession is less clear. In fact, sec 5002 (15) reads that "cultural competency shall be defined in a manner consistent with section 1707 (d)(3)" of the Public Health Service Act. Although the Public Health Service Act outlines that information and services should be provided in the language, educational, and cultural context that is most appropriate for the individuals for whom the information and services are "intended," what is lacking is the matrix by which health care professionals will be evaluated to ensure that they possess these traits.

Although 14 different health care careers and training programs are listed in Subtitle A of Title V, physicians and medical education training are missing from the discussion. Since Title V addresses issues of enhancing education and training, increasing the supply of workers, providing support to the current workforce, and improving the primary care workforce, it is odd that medical doctors, the profession that has reached the pinnacle of the proverbial health care professional workforce, is missing from the summary and over section of Title V. In fact, physicians are only mentioned once in Subtitle A, under the section regarding physician assistance education programs in which it reads that PAs are "qualified to provide primary care medical services with the supervision of a physician"

Comparative Case Study. While the documents provide insights in regards to how legislators envision the expansion of primary care education and services, the case study provided information about the current environment that the legislation is affecting as well as how education administrators understand what the legislation is mandating them to do (Prior, 2003). A case study is an appropriate methodology when the lines between the current phenomenon and context are blurred (Yin, 2009). As the PPACA is still being enacted, a case study will reveal immediate implications of the legislation and may provide insights in regards

how institutional strategy is being altered to meet the demands to produce more primary physicians and to act upon the monetary and other incentives.

I conducted a multiple, holistic case study at three different schools of medicine in the same state to research the ways in which the Affordable Care Act may be exacerbating stratification within medical education and the different ways institutional leaders are responding to the incentives to expand and sustain primary care training. The study is considered a multiple, holistic case study because the data will not be pooled across all the cases. Instead, it will be considered individually during the analysis and to help develop broader themes of what is happening in medical education in the era of the Affordable Care Act (Yin, 2009, p. 59).

Case Selection. Since statistical generalizability is not the goal of qualitative research, nonprobability, or purposeful sampling, is the most appropriate technique for qualitative studies (Merriam, 2009, p. 77). Merriam further clarifies that as a result, case selection should be guided by selecting *information-rich* cases; cases from which the most can be learned (p. 77, emphasis in original). Case selection should also be guided by theoretical concerns (Creswell, 2009; Yin, 2009). For example, the review of literature presented earlier suggests that because medical doctors are regarded as an elite profession, then allopathic medical education programs are considered central organizations in the medical education Strategic Action Field (SAF). Central organizations tend to be fairly stable, therefore changes in their structure, strategy, goals, or resource dependencies, tend to be indicative of significant external shocks and will impact the rest of the SAF (Fligstein & McAdam, 2011). Due to the overall number and various histories of allopathic medical schools, there is considerable stratification and thus not all schools have the same amount of power or influence. Therefore, not all schools will respond to external shocks in

the same manner. Given the variability among the programs, theoretical concerns therefore compel me to limit sampled cases to schools that grant allopathic medical doctor degrees.[4]

Creswell (2009) and Merriam (2009) outline several different purposive sampling techniques. Cases may exhibit qualities that are typical to a particular phenomenon while others may be atypical. Still others may be selected in chain or snowball method, in which data collected at one site, guides the selection of the next site. Each of these techniques offers advantages to the researcher interested in refining understanding of a particular phenomenon. Yin (2009) notes that when using a multiple case study design it is appropriate for a researcher to choose sites for theoretical replication; to select case sites so that each site predicts contrasting results but for anticipated reasons (p. 54). Merriam (2009) and Creswell (2009) refer to this as maximum variation. This technique allows the researcher to select cases that she presumes will present extreme variance of a phenomenon. Lastly, case sites may also be selected based on the researcher's access to information and potential key informants for the study (Merriam, 2009, p. 79). Because stratification is an important concern of this project, however, maximum variation is the most appropriate selection method for my proposed study.

There were 146 Liaison Committee of Medical Education (LCME) accredited medical schools in the United States, yet only 125 were fully accredited for AY2012-2013 (most current

[4] Osteopathic Physicians (or Doctors of Osteopathy) are physicians licensed to practice medicine within the United States and represent approximately 60% of osteopathic physicians practice in a primary care specialty ("What is a DO?," 2014). Approximately 20% of all physicians trained in the United States graduate from one of the 26 American Osteopathic Association (AOA) fully accredited medical schools; the other 80% of physicians are trained at one of the 125 Liaison Committee on Medical Education (LCME) fully accredited medical schools ("Trends in osteopathic medical school applicants, enrollment, and graduates," 2012) ("Medical school directory," 2013). While over 90% of the LCME medical schools are affiliated with a university, only 33% of the AOA accredited medical schools have similar institutional structures, with the vast majority being affiliated with health science institutions that only grant graduate and professional degrees. Additionally, approximately 15% only have provisional accreditation and roughly a third of the institutions have been founded less than 10 years ago ("U.S. osteopathic medical schools by year of inaugural class," 2013; "What is a DO?," 2014). Despite the fact that a majority of osteopathic doctors are in a primary care specialty, as a set of institutions osteopathic medical schools present their own set of unique challenges that are outside of the scope of this research study.

data available).[5] Out of this set of institutions, 75 are public and 50 are private. The average number of medical schools per state is 2.8 and the largest concentration of medical schools is in the Southeast (n=34 or 27%).[6] Additionally, there are three medical schools located at or affiliated with Historically Black Colleges and Universities (HBCU): Howard University College of Medicine, the Meharry Medical College, and the Morehouse School of Medicine. The Uniformed Services University of the Health Sciences, F. Edward Hébert School of Medicine has the special mission to enroll and train students who are currently on active duty in one of the four branches of the United States military.

When considering where to conduct my research, the state of Georgia stood out for a number of reasons. First, Georgia is located in the most densely populated region of medical schools. Second, Georgia offers a diverse range of intuitions: out of the four medical schools located in the state, one is a public school, three are private schools, and one of the private schools is affiliated with an HBCU. Only Tennessee offers a similar break down of institutions in terms of type. Third, each institution is a fully accredited medical school that submitted a "snapshot" for inclusion in the Association of American Medical Colleges (AAMC) Supplement which highlights the changes in medical education from 1910 to 2010 (Anderson & Kanter,

[5] Preliminary status must be granted before a newly formed program can recruit and enroll applicants. Provisional accreditation, which is the second step, means students enrolled in the program may continue into their third and fourth years of medical education. Once a class graduates, as long as the school is in compliance, then a school is considered fully accredited. Accreditation with probation means that an accredited program is not in substantial compliance with accreditation standards. Programs placed on probation retain their accredited status with all of the rights and privileges conveyed by such status, but are subject to withdrawal of accreditation if noncompliance issues are not satisfactorily addressed within a 24-month period("Medical school directory," 2013).

[6] The type of university (public or private) and geographic region (e.g. north, west, etc.) were obtained from the National Center for Education Statistics (NCES) Institute for Education Sciences (IES) Integrated Postsecondary Education Data System (IPEDS). The Southeast region is comprised of: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

2010).[7] Lastly, I had sufficient access to potential key informants for the study at three of the four institutions (Merriam, 2009, p. 79). Given the diversity of institutions, Georgia presented a rich location to select sites for case study research (Yin, 2009). While Georgia has four medical schools (Emory University School of Medicine, Medical College of Georgia at Georgia Regents University, Mercer University School of Medicine, and Morehouse School of Medicine) only three were selected as case sites for this study. Mercer University School of Medicine was not included in the study because of my limited access to key informants at the site, because of the overlap between the stated missions of Mercer University School of Medicine and Medical College of Georgia, and due to limited resources. Additionally, the three selected schools reported curriculum reform in at least five of the nine areas emphasized by the 2010 AAMC Supplemental Report as key elements in medical education (Anderson & Kanter, 2010). The AAMC Supplemental Report specifically shows how the curriculum was changed the first decade of the 21st Century and may provide early clues to how institutional leaders thought they should structure their curriculum in response to the possibility of the ACA. Thus, while not using all four medical schools as case sites may be considered a potential limitation of this study, I consider that the three case sites selected provided the widest diversity in terms of student profile, national rank, research agenda, and commitment to primary care.

Case Study Sites. Emory University School of Medicine is a private institution located in Druid Hills, a historic Atlanta suburb. Founded in 1854, the school of medicine includes its primary teaching location on the University's main campus, as well as clinical instruction sites at

[7]In honor of the centennial anniversary of the publication of *The Flexner Report*, the AAMC produced a report highlighting the changes in medical education over the past century. Administrators from 128 of the 146 LCME medicals schools submitted a "snapshot" answering questions about their school's educational programs. After a brief synopsis of the changes at all participating schools, a school-specific report followed. As such, this report provides a comprehensive overview of what has been occurring in medical education through 2010.

six area hospitals and centers. The school currently enrolls 531 medical students and trains approximately 1,200 residents and fellows in 88 accredited programs ("About," 2014). The 82-person MD-PhD program is one of the 40 Medical Scientist Training Programs (MSTP) sponsored by the National Institutes of Health (NIH).[8] Emory University School of Medicine is currently ranked 24th on the *US News and World Report Best Medical Schools: Research* rankings and 48th on the *US News and World Report Best Medical Schools: Primary Care* rankings.[9] Annual tuition and fees are approximately $50,484.

The Medical College of Georgia at Georgia Regents University (MCG) is a public institution located in Augusta, Georgia. As the founding school of Georgia Regents University, the Medical College of Georgia was established in 1828. MCG includes its primary teaching location on the University's main campus in Augusta, as well as clinical instruction sites at 135 hospitals and centers in Albany, Athens, Savannah, Brunswick and Rome. The school currently enrolls 908 medical students, 95% of whom are Georgia residents, and trains approximately 600 residents and fellows in 42 accredited programs ("Medical college of Georgia facts," 2014). Between 30 and 40 percent of MCG graduates practice in primary care and roughly a quarter of all graduates practice in the state of Georgia ("Medical college of Georgia facts," 2014). MCG is currently ranked 75th on the *US News and World Report Best Medical Schools: Research* rankings and 82nd on the *US News and World Report Best Medical Schools: Primary Care*

[8] Medical Scientist Training Program (MSTP) is a designation for 43 MD-PhD programs that receive substantial federal funding from the NIH. MSTP supports the training of students motivated to pursue careers in basic biomedical or clinical research. The program provides a maximum of six years of support and includes stipend, tuition allowance, and modest sums for travel, equipment and supplies. MSTP trainees incur no payback obligation.

[9] US News and World Report Rankings are used as a rudimentary way to denote a university's past focus and perceived success in primary care training.

rankings. Annual tuition and fees are approximately $31,100 for residents and $58,300 for non-residents.

Morehouse School of Medicine (MSM) is an independently chartered institution located in downtown Atlanta. Founded in 1975 as the first medical school established at a Historically Black College or University, the Medical Education Program at Morehouse College separated from Morehouse College in 1981 although it still has as its core mission to increase the diversity in health care ("About us," 2014b). The Morehouse School of Medicine is home to six research centers and institutes, one of which is The National Center for Primary Care at Morehouse School of Medicine. The school currently enrolls 278 medical students and offers residency training in seven accredited programs ("About us," 2014b). MSM also has a manifest goal of addressing primary health care needs of those who are underserved ("About us," 2014b). Morehouse School of Medicine is currently unranked on the *US News and World Report Best Medical Schools: Research* rankings and 26th on the *US News and World Report Best Medical Schools: Primary Care* rankings. Annual tuition and fees are approximately $46,638.

Data Collection Strategy and Analysis

Data collected through semi-structured interviews is the primary data collection strategy at the core of many qualitative research projects. It was important then to select both interview questions and participants that provided a range of perspectives about the project's research purpose (Merriam, 2009; Yin, 2009). As such, I posed questions about the current state of the medical school, current primary care training, and plans to expand elective offerings and in which areas, awareness about the incentives in the PPACA, curriculum changes, current and projected funding sources, and other indicators of the leadership's responsiveness to the Affordable Care Act. I initially sought to interview people in five different positions: the chief

academic officer over health affairs, the dean of the school of medicine, the vice dean of academic affairs for the school of medicine, the executive or associated dean of clinical affairs, the associate dean of clinical education, and the chief operating officer or chief financial officer for the school of medicine (the position that oversees sponsored grants and contracts as well as the budget). The initial and follow-up invitations to participate in the study were sent via email. Tertiary requests were a telephone call. These sampling decisions reflect the concerns outlined in the history and literature review about the ways in why different institutions are going to respond to the incentives in the ACA and how these responses may be indicative of exacerbated stratification within medical education. Although I contacted each of the people listed above, most of the interviews I conducted were with proxies as determined by the initial contact or by key informants.

Institution	Interviewee*
Emory University	Executive Associate Dean Executive Associate Dean Director Strategic Planning
Georgia Regents University	Senior Associate Dean and Strategic Plan Steering Committee Member
	Associate Professor and Medical Director
	Associate Dean and Chair of Curriculum Committee
Morehouse School of Medicine	Vice President
	Department Chair and Strategic Plan Committee Member
	Professor and Former Chair of Curriculum Committee

Table 1 Interview Participants by Institution (*full titles not included to protect anonymity)

I conducted a document analysis as a second data collection source. I reviewed the current curricula to determine how much undergraduate and clinical time is dedicated to primary care, reviewed the schools snapshot submitted as a part of the 2010 AAMC Supplemental Report, and assessed each school's mission statement and the annual state of the school report to deduce clues about the institution's leadership perspective on the significance of primary care in medical education and the role primary care will have in future plans/strategy. Some of the participants

provided supporting documents during their interview, which I also reviewed and included in my overall analysis. These data are selected to understand how different institutional context may provide more opportunities for expansion of primary care training and to further develop the hypothesis as to which institutions will be the most responsive to the incentives in the Affordable Care Act.

Induction was the primary analysis method of the data collected from the interviews and the document analysis in order to determine relevant themes. I reviewed each interview and document at each school for a priori codes as determined by the guiding theories but also searching for emergent categories. The codes were placed into different categories. Given the number of data sources, it was also useful to divide each of the categories into subcategories based on taxonomies (Charmaz, 2006; Maragret LeCompte, 2000). The taxonomies were based on repeated words or phrasing as well as where the each interviewee or author put a natural emphasis. In some instances, taxonomies may also be determined based off a simple word count (Margaret LeCompte & Preissle, 1993). The categories and subcategories determined emergent themes for each institution. I engaged in constant comparison across each of the interviews and documents for each institution to determine emergent themes and a similar strategy was employed to find themes that were relevant for the collection of cases as well (Charmaz, 2006; Merriam, 2009). While conducting the induction I was mindful of the use of vague language around specific topics, as well as to the groups of people that are screened out of the discussion at each institution, as this too provided clues as to existing or exacerbating stratification and also provided clues to responsiveness.

Studying Up

A study of institutional strategy is inherently a study of power and elite status. Those in senior leadership who control a budget, manage full time staff and are able to leverage personal and professional relationships in order to influence change typically set institutional strategy. In order to understand a particular strategy in response to the Affordable Care Act and why that particular course of action was chosen necessitated that I interview those academics and administrators who are either loosely or directly involved with shaping institutional policies. Thus, I solicited participation from, among other positions, deans, vice presidents, and chief budget officers in the medical school at each case site. Several scholars have noted that rarely do social science researchers study the social conditions of groups with privilege or analyze the institutions that wield social and political power (Gaztambide-Fernández & Howard, 2012; Nader, 1972; Priyadharshini, 2003). Lack of access, unclear methodological practices, insufficient resources, and lack of sufficient time are listed as reasons for the elite being under researched (Gusterson, 1997). This lack of studying up is even more prevalent in higher education research (Priyadharshini, 2003). While the aforementioned barriers may be contributing factors, some scholars posit that it is scholars' reluctance to acknowledge their status and influence as academic insiders that primarily contributes to this lack of analysis on higher education power structures (Gaztambide-Fernández & Howard, 2012; Priyadharshini, 2003). While most research faculty may not wield as much power as senior university administrators, most academics have thrived in the current higher education system, especially tenured track faculty, and thus may shy away from being critical of the system in which they have achieved professional success.

The dearth of research analyzing elite institutions is more pronounced when attempting to understand the relationship between medical education and the university, and the majority of those studies focus on barriers to entry to graduate/professional school and do not delve into analyzing the guiding operating strategy (Bedard & Herman, 2008; Millett, 2003; Perna, 2004). The elite status medical doctors have in civil society is seemingly, albeit begrudgingly, reciprocated in the academic arena. Many medical schools enjoy a significant level of independence from the parent university that other academic departments do not have as a result of lucrative research grants (both federal and private) and as well as the ability to generate revenue through clinical practice due to their relationship with academic health centers (Ludmerer, 2005, pp. 145-146). Therefore medical school leadership is able to pay their faculty higher salaries when compared to other academic departments (J. Hearn, 1999). This independence results in far less interaction between the medical schools and the parent university. This relative autonomy is something few other academic departments, excluding possibly the business school, enjoy; thus placing the school of medicine faculty and administration in a place of privilege in the university system. Because of this, the leaders of medical education (e.g. the Dean of the School of Medicine or the Associate Dean for Medical Education, etc.) are some of the most elite administrators on college campuses.

Like many others who study people at the helm of powerful organizations, I struggled to gain access to participants. Thomas (1993) notes that there is a distinct difference between being visible and being accessible. This is particularly relevant when considering higher education research. The fundamental ethos of American higher education is that the chief academic officer is to be the "first among equals" (Martin & Samels, 1997). Therefore if the faculty are supposed to be accessible to students and the general public, in theory so should any university

administrator. Thus, it was easy to find the name and contact information of many of the people in positions I wanted to interview. Making direct contact, however, was more challenging. For example, at one case site it took four months before I conducted my first interview. I emailed and called approximately ten people at this particular medical school, all of whose contact information I got from the "contact us" page or from informants I knew professionally. Yet, the majority of the participants at this one case site did not respond to my first two requests to participate in my research study. It was not that they declined to participate; the potential participants just did not respond to my email requests or return my telephone calls. In fact, it was not until I used an informant, whom I have known since childhood and who was on the faculty at this certain medical school, that I was able to secure my first interview at this case site. Even with this informant's assistance, often virtually introducing me to potential participants, it took a total of eight weeks to complete all the interviews at this one site.

While I expected to leverage the professional connections I made as a former school of medicine employee to gain access to key participants, I was a bit naïve about the salience of those connections for me as a researcher. Thomas (1993) warns that "recognizable affiliations and personal contacts can only be qualifiers. They [elite participants] are not likely to open doors unless accompanied by a compelling reason as to why someone should see you." (Thomas, 1993, p. 85). At the case site where I had the most difficulty gaining access, I initially tapped my tertiary connections and failed to give my informants a meaningful way to communicate the value of my research study to the prospective participants and thus my requests often went unacknowledged. While the informants knew me as a capable mid-level administrator, they were less aware of my aptitude as a researcher and thus unwilling or unable to provide additional commentary beyond "I worked with her." At another case site, while I was easily able to gain

access to participants via my connections, I initially failed to establish myself as enough of a medical school insider to garner credibility and trust (Thomas, 1993). One interviewee raised concerns about my series of questions and how I referred to some of the granting agencies responsible for distributing ACA grants and fellowships. My inability to establish enough insider credibility may have led to an early participant dropping out of the study.

Other scholars have commented on the necessity for the researcher to simultaneously position herself as an open graduate student and a knowledgeable academic when studying the elite (Gaztambide-Fernández & Howard, 2012). This constant shift in stance during many of the interviews also underscores the power I have as a researcher – even as a graduate student researcher. Although these research participants wield an inordinate amount of power and influence in the professional setting, each participant has vulnerabilities especially when they express thoughts that deviate from the established rhetoric or verbalize contradictions in their own thinking (Priyadharshini, 2003). For example, one participant asked that I wait to start recording until they stated their general thoughts about the curriculum and expansion plans (both facilities and increased enrollments). Even after I started the recording the interview this participant repeatedly said, "Maybe I shouldn't say this on tape." My dual positions as insider and open graduate student may have made some participants more comfortable to explore various opinions on the Affordable Care Act, yet having access to their musings put me in a position of power, however briefly, and may have contributed to some of the hesitance of some administrators to participate in my research study.

Thomas (1993) also notes that powerful people, even the most visible, are skilled at isolating themselves from unwanted disturbances and often have a layer of gatekeepers and guards to protect their time. For example, while it was my aim to meet with people in specific

positions at each case site, the majority of the interviews I conducted were with approved proxies. When I was able to negotiate a meeting with a person in a targeted position, compromise was necessary and I was not able to gain complete access on my terms (Priyadharshini, 2003). For example, the dean of one school of medicine, whom I knew indirectly, suggested that I reach out to one of the Associate Deans on the senior leadership team to interview. While I was able to easily secure the proxy's contact information from the university website and even connect with their administrative assistant, I had to answer a series of what I labelled "pre-screen questions" and send a summary of my research questionnaire for review before I was granted an interview.

Limitations and Trustworthiness

My dissertation, as previously noted, is inherently a study of power and the powerful in higher education. Thus critical social theory, especially the vein put forth by the Frankfurt School and bolstered by the postmodernist traditions, provides a meaningful theoretical framework with which to contextualize this study. Critical Theory, which builds off the Marxist and Neo-Marxist traditions, is particularly interested in illuminating the ways in which the state intervenes in social and economic matters to keep capitalism from collapsing and how this intervention helps to reproduce the status quo (Agger, 2013). In this study the state is personified by Title V of the Affordable Care Act, and the ways that the legislation's language attempts to incent medical school decision makers to behave a certain way. While the verbiage is directed toward the broad audience of medical and health care education institutions, the state only needs some medical school leaders to acquiesce to their requests in order to meet the state's needs and ultimately society's need (Agger, 1991, 2013). As such, a robust social complexity is unearthed in understanding those institutions that comply with the call and those medical school that have the freedom to choose otherwise (Bohman, 2015). Habermas, a prolific Frankfurt School

scholar, posited that communication, be it oral, visual, or written, is a way to form consensus through rational discussion even if the proposition is irrational or significantly disadvantages a group or groups of people (Agger, 2013). Because communication is an interactive action, it is necessary to understand how the readers of the legislation, in this case medial educators, interpret the legislation, and how this interpretation colors their understanding of their institution's role in meeting the stated need of more primary care physicians.

Much like the theorists of the Frankfurt School I deviate from a purely Marxist treatment of the research problem in an attempt to broaden the analysis and pull in multiple social theories (Agger, 1991, 2013). In focusing on allopathic medical education, and thus the bourgeois, those in the paraprofessional or auxiliary health professions have been screened out of the discussion. Such a treatment may lead one to assume that paraprofessionals are idle bystanders and not involved in determining how the implementation of the Patient Protection and Affordable Care Act should and will impact their training and career options. A purely Marxist treatment of the topic would necessitate a greater focus on those health careers deemed working class or less prestigious. In my current study, a more Marxist approach would also dictate that I ask different types of questions of institutional leaders as well as that I interview medical students, faculty and those who are not in positions of power.

By also focusing on external agents such as the state, the locus of power is positioned outside of the university, assuming that university and medical education administrators are beholden to external forces. Focusing on external agencies and executive leadership in the medical school also positions students as recipients of the curriculum and not co-creators in shaping their learning environment, which runs counter to some student affair literature. Lastly, by selecting institutions in the same state, the generalizability may be limited. While

generalizations are not the goal of qualitative research, focusing on one state does screen out the effect of interstate politics or isomorphism between sub groups of schools (such as elite institutions) on institutional response to the incentives in the Affordable Care Act.

Despite these limitations, I contend that critical theory offers both a substantial way to frame the research questions and my methodology. While critical theory highlights the importance of communication in assessing power, postmodern scholars (Prior, 2003) expanded Habermas' concept of communication and provides interpretative tools, through discourse analysis or deconstructing text, to illuminate hidden assumptions and arguments, thus allowing the "subtext" to be studied as well (Agger, 2013, p. 96). Additionally critical theorists, in their rejection of positivism, call for academics to reflect on their politics and note how those beliefs influence their understanding of the problem and the conclusions they reached. Acknowledging how, as a researcher, I have a role in constructing the meaning of the data interpretation and the results in the study also aligns with the basic tenants of qualitative research and thus supports the methods used in this study (Charmaz, 2006).

Efforts to utilize multiple sources enhance the validity and reliability of the study. Particularly, issues of validity were addressed by using multiple sources of evidence and by using pattern matching to code interviews and documents (Merriam, 2009; Yin, 2009)**.** Close adherence to the case study protocol as outlined by Merriam and Yin (2009) address reliability. I conducted ten in-person interviews and followed a semi-structured interview protocol with probes. Participants were informed that their professional title as well as their institution would be used in the final research report. Although given the opportunity to decline, all research participants agreed to have their interview audio recorded, using Apple Voice Memos, a free recording application available on all Apple products. All interviews were fully transcribed and

interviewees were given the opportunity to request to review and respond to portions of the final paper for accuracy, referred to as member checking (Creswell, 2009). Participants also had the opportunity to request the full transcript of their interview. One interviewee made such a request, and subsequently decided to withdraw from the research study. Member checks ensured that errors in the transcription or misstatements by the interviewees are corrected and any additional commentary provides an additional source of data. I coded the documents and transcripts using the student version of QSR International's NVivo 10 looking for connecting threads and reoccurring descriptions, highlights, points of contention and evidence of the guiding theoretical framework (Ness, 2010).

Test	Case Study Tactic	Phase of Research in which tactic occurs
Construct Validity	Use of document analysis and interviews. Member Checks and the use of key informants to review a draft report. Operationalizing key terms	Data collection Data collection and composition Research design
External Validity	Using multiple theoretical frameworks provide alternative explanations which ground the research.	Research design
Internal Validity	Use of rival explanations to explain key findings.	Data analysis
Reliability	Development and use of a case study protocol	Data collection

Table 2 Adapted Model of Case Study Tactics for Four Design Test(Yin, 2009, p. 41)

Summary

This research design allowed me to study institutional strategy at three institutions with varying degrees of manifest commitments to producing primary care physicians and thus varying strategies in terms of responding to the incentives in Title V of the Patient Protection and Affordable Care Act. Collecting data from multiple stakeholders and sources provides a holistic perspective for the proceeding analysis. Additionally, as a professional who has spent many years working in graduate and professional education at a private research university, I have an

informed perspective on implementing institutional strategy in response to exogenous shocks. Yet, I have not held a position that directly influenced intuitional strategy and in that respect I am an outsider to the intricacies of setting and implementing strategy in response to external and internal forces. The methodology and research design selected allowed me to conduct my research with the assumption that universities can and do respond to larger societal needs, but also provided the needed latitude to explore the rationales and context in which different strategies are enacted and the challenges in balancing strategic goals with societal needs. I expect that there is indeed more that medical schools could and should be doing to train more primary care physicians, as well as a sensitivity to the complexities surrounding implementing a cohesive and effective strategy that marries an institution's mission with the a broader external need.

CHAPTER FOUR

CASE ANALYSES

Introduction

A field consists of organizations that face similar opportunities and constraints (Fligstein & McAdam, 2011). Field members typically share an understanding of resource allocations and who possesses status within the field. Additionally, members tend to accept the reality of stratification. Challengers seek to improve their individual position rather than fundamentally altering the field, partly because they share meaning-making structures with other members of the field (Fligstein & McAdam, 2012).

I conceptualize allopathic medical schools in the United States as a field because they closely conform to these conditions. Medical schools follow a similar curriculum and compete for similar resources such as students and revenues from a variety of external sources (Ludmerer, 1985, 2005; Starr, 1982). Hierarchies in medical schools closely follow those within the broader field of higher education and this stratification is widely understood. Status is typically conferred based upon research activity and the residency placements of medical doctor graduates into elite sub-specialties. As a result, external support for research, that is, grants and contracts won through competitions, and robust undergraduate medical and graduate medical education in super sub-specialties as orthopedics or urology, confers both status and revenue. Therefore changes in federal health care policy toward different types of medical care or research creates an opportunity to understand the field dynamics of US medical schools.

Based on this conceptualization of allopathic medical schools as I field, this chapter is dedicated at understanding in what way the Patient Protection and Affordable Care Act and the national shift in attention toward primary care altered the curriculum or institutional strategy at three schools of medicine in the a single state. Each case is comprised of five parts. The introductions provides a brief overview of the school of medicine and the type of medical school they represent as compared to the others in the study. The second section relies heavily on public and archival documents to provide context concerning local or institutional current events influencing curriculum changes or the implementation of new strategy. The third and fourth section uses the interview data to understand and outline how each of the participants understand their institution's historical relationship to primary care and how that historical stance is or is not morphing as a result of Title V – Health Care Workforce of the Patient Protection and Affordable Care Act. The final section provides analysis of the school based on the literature surrounding status and stratification within the field of medical education.

Emory University School of Medicine: "Creating a Primary Care Narrative"

Introduction. During the fall of 2014, the Emory Healthcare community received worldwide attention as three patients infected with the Ebola virus were successfully treated at Emory University Hospital. Emory University Hospital, which is located on the Emory University campus and is within walking distance to the School of Medicine, is one of the four hospitals in the country that have a special bio containment unit or isolation ward designed to house and care for patients suffering from highly lethal and contagious illnesses ("Emory University Isolation Unit," 2015). Also within walking distance to the School of Medicine is the Centers for Disease Control (CDC), whose mission is to use science, research, and advance technology to detect and respond to emerging health threats and to address the pervasive health

problems causing death and disability for Americans ("Mission, Role, and Pledge," 2014). Many of the School of Medicine faculty members hold joint appointments with the CDC or clinical appointments in one of the specialized units in Emory University Hospital. Although there are six teaching hospitals affiliated with the School of Medicine, most medical students will do at least one clinical rotation at Emory University Hospital due to its proximity to the school and the exposure to some of the most unique medical challenges of the day.

Thus the Emory University School of Medicine represents a highly selective medical school with a robust research agenda and a national reputation for successfully handling some of the country's most complex medical cases. This specialized research focus is not haphazard. In the Emory School of Medicine Mission Statement biomedical science or research is mentioned in each of the four sections ("About," 2014). Conversely primary care is not directly mentioned at all. The "About" and "Quick Facts" sections of the school's website notes that in addition to the national reputation concerning the treatment of infectious diseases, the School of Medicine faculty are at the forefront of research and treatment in heart disease, cancer, neuroscience, translation, orthopedics, pediatrics, renal disease, ophthalmology, and geriatrics ("About," 2014). Medical school faculty received $330.5 million in sponsored research funding in fiscal year 2013 and the school is consistently ranked in the top 25 nationally by *US News and World Report* in NIH dollars received ("About," 2014). The incoming MD class is approximately 138 students, which represents about 2% of all applicants to the program. In addition of being one of the 40 institutions in the US to have its MD/PHD program designated as an NIH sponsored Medical Scientist Training Program (MSTP) and Emory has a partnership with the highly ranked Biomedical Engineering program at the Georgia Institute of Technology, and medical students can also receive joint master's degrees in Clinical Research (MCR) and Public Health (MPH).

The School of Medicine also offers five allied health programs, but only the Physician Assistant and Doctor of Physical Therapy programs, which are ranked fourth and seventh respectively by *US News and World Report*, are highlighted on the "About" and "Quick Facts" pages. Lastly of note, is that approximately 25% of all physicians currently practicing in Georgia have trained, either as a medical student or resident, at the Emory University School of Medicine.

School in Context: History of the Primary Care Strategic Plan. The evolving primary care narrative, in the context of Emory's explicitly research oriented mission, can be seen as early as 2004, with the implementation of the new medical school curriculum. The deans of the Office of Medical Education and Student Affairs (OMESA) led the initiative to revamp all four years of the undergraduate medical curriculum. The manifest goals were to create a more flexible, integrated, competency based curriculum, that included higher faculty interaction with students, increased education in the ambulatory setting, and to provide an extended experience in intellectual scholarship (Eley & Otsuki, 2010, p. S167). The overhaul of the curriculum also provided a clear roadmap of the four different phases, Foundations, Applications, Discovery, and Translations, of an Emory medical student's educational process from incoming student to proficient practitioner/learner. Although none of the phases explicitly deals with primary care, primary care exposure was increased, especially during the Applications phase. In addition to skills and knowledge, the curricula reform also contained an explicit recognition of the social compact between medicine and society and the responsibility of physicians to "place the welfare of their patients and society above self-interest" (Eley & Otsuki, 2010, p. S169).

Yet the introduction of goals around the importance of primary care to medical education did not result in a radical departure in what the medical school leaders deemed as critical to an Emory education. The evidence of this is seen in two of the more substantial changes to the

curriculum, the creation of the Ambulatory Care block and the Discovery Phase. The Ambulatory Care block, which is a three month interval during the 12 month Applications Phase in the third year of medical school, is the period when instruction is focused on clinical primary care. Students spend six weeks, or 12 weeks of half days, rotating in adult primary care, three weeks in the pediatric primary care setting, and three weeks learning the fundamentals of primary care in ophthalmology, otolaryngology, orthopedics, urology, dermatology, and palliative care (Eley & Otsuki, 2010). While the addition of the Ambulatory Care block can be viewed as a nod toward the importance of primary care training to the overall Emory student experience, especially since the Ambulatory Care Block is the largest block in the Applications Phase, the addition of the Discovery Phase is consistently touted as a hallmark of the new curriculum. Unlike Ambulatory Care, which is just ¼ of the total time spent during the Applications Phase, Discovery, or research, received the distinction of being one of the four fundamental phases of the Emory Medical School medical training, along with the Foundations, Applications, and Translation Phases. Additionally, research is a key component to how the School of Medicine leaders define an intellectually curious and competent graduate, and the Discovery Phase, which is two months longer than the Ambulatory Care Block, allows time for "clinical or bench research, international experience, or other academic inquiry" and can be extended for up to 17 months (Eley & Otsuki, 2010).

The first class to complete the new curriculum graduated in 2011, amid changing health care market place dynamics, in large part spurred by the passage of the Affordable Care Act in 2010. Changes to the School of Medicine were also occurring around this time, as Dr. Christian P. Lawson, the former Emory School of Medicine Surgery Chair, was named the new Dean of the School in 2012; replacing Thomas J. Lawley who had served in the post for 16 years.

Shortly after Larsen took the helm of the School of Medicine, the senior management of the Woodruff Health Science Center (WHSC), the governing body that oversees all of the health sciences education and Emory Healthcare, put forth a charge to develop a strategic plan that would integrate primary care efforts across all WHSC entities including developing new models of care, training of the next generation of primary care providers and identify research opportunities (*Woodruff Health Sciences Center Primary Care Strategic Plan: FY14-FY18*, 2014). A task force, comprised of representatives from 14 different areas of the WHSC body, was developed to create a plan that would rectify how, as an academic medical center which "traditionally focused on the breadth and depth of specialist physicians," they could successfully redistribute the mix of physicians trained at and attracted to Emory to meet the market demand for a "strong primary care base" (*Woodruff Health Sciences Center Primary Care Strategic Plan: FY14-FY18*, 2014, p. 9). This renewed focus on primary care was presented as "imperative to succeed in this new value-based environment" in which "healthcare spending would continue to decline" and in which the new financial models reward "value creation behaviors" and "team performance" (p. 10).

The final Woodruff Health Center Primary Care Strategic Plan was presented to senior management in February 2014 and included a 14-point implementation strategy. Each strategic action was categorized by which of the five focus areas[10] it fell into and which part of the university mission of research, education, or clinical care it addressed. The Task Force members ranked each strategic action based on impact and ease of implementation, and then conducted a vote to determine which points were salient to the success of the overall primary care strategy.

[10] Five focus areas were designed to frame the strategic plan: workforce, sites of care/access, transforming care delivery, population health management, and culture.

The five strategies that received the highest impact scores also garnered the most votes as being essential to the strategy. Out of this group of five strategies, 60% addressed the research mission of the university, although some of the strategic points also addressed the education and clinical missions as well. Interestingly, 50% of the strategies that were voted as least important to the strategy addressed the education portion of the university mission, even though most of these strategic actions were also considered easy to implement and included such strategies as: establish linkages/partner with community and social service resources to meet patient needs and increase awareness of and promote primary care career paths (p. 13).

Emory University's Relationship to Primary Care. The document analysis reveals that the senior leadership of both the School of Medicine and the Woodruff Health Sciences Center (WHSC) recognized the growing importance of primary care in the new health care market. While the school created a narrative around Emory University's relationship to primary care, the strategy is fraught with cultural tensions evidenced in the document analysis and were discussed during the interviews. One of the major hurdles to a full acceptance and implementation of the primary care strategic plan is the Emory culture. While the WHSC Primary Care Strategic Plan Task Force highlighted culture as one of the five focus areas, the interviewees clarified why the cultural shift may be more challenging than expected. For example, a school of medicine strategic leader noted that a pervasive culture shift is needed, despite the adoption of the strategic action plan:

> I think the focus for us is very much internal culture change; to basically get everybody on board with this, to have people realize the value of primary care, to reallocate some of the residency slots. I mean there are a lot of internal politics that need to be worked out to get people on board.

There was an acknowledgement that Emory's historical relationship with specialty care and the community's association of Emory with complex cases is a partial impediment to a progressive

cultural shift. One dean who works with students during the Applications and Translation phases of the curriculum noted:

> You know, right or wrong Emory's history is around specialty care. That's kind of its culture, it's kind of what we are known for. We are on the news right now. We are known for taking care of really sick patients with Ebola, with high intensity infectious disease, critical care, etcetera, etcetera. I think you would be hard pressed to have the public know anything about primary care from Emory per se.

Another interviewee also reflected on the historical relationship Emory has had with primary care to current strategic initiatives: "We really needed to focus on the culture; the whole culture of the organization because primary care has historically been devalued." This historical culture around specialty care also influences student expectations and student culture. Specifically, one dean who works with all students during their undergraduate medical education highlighted that while "Students can come to Emory and they can go into primary care and any of the specialties in medicine" part of the struggle administrators' face is making primary care attractive to students. The dean continued by saying: "I think the key to getting more students to go into primary care is for society to give primary care more respect, and the respect it deserves. That's not in our control."

Thus a complex interplay between external and internal views of the School of Medicine particularly, but also encompassing Emory Healthcare and Emory University, as specialist and inquiry driven clearly impacts the rate at which a cultural shift around primary care education can successfully occur. One administrator noted that Emory's own varied relationship with primary care could be the reason internal stakeholders may be hesitant to support a push to increase the role primary care has in the overall Emory strategy. The clinical dean stated "You know Emory has kind of had a schizophrenic role with primary care over its lifetime." Consequently this inconsistent stance may be the reason why senior leaders did not infuse more

primary care exposure into the curriculum. The other dean reflected, "I wish we were forward-thinking enough to do the kind of the things I was talking about doing, which is, as an academic institution, investing more heavily in primary care."

While musing about the difficulty of widespread culture change, all three interviewees were keenly aware of the distinct position the School of Medicine has in the larger medical education landscape, especially in Georgia. As noted earlier, Emory has a national reputation of handling complex medical cases. Emory University has the only National Cancer Institute-designated Cancer Center in the state and also receives the highest amount of NIH funding of any medical school in Georgia. What emerged as a result of Emory's national reputation as a research institution was a belief that Emory University School of Medicine might not have to be, nor should they be, a dominant player in primary care since other institutions are leaders in this area. For instance, one strategic leader reflected on the historical role of private and public universities in producing primary care physicians:

> I think state schools have been a little bit more focused on primary care development. So if you look at the *US News and World Report* and you look at the top schools for primary care programs, the vast majority on that list are state schools or public schools. I think that private schools have been more focused on training specialists and subspecialists. And I think that public schools see as a huge part of their mission sort of training the primary cares for their state.

Due to this accepted, somewhat self-serving view of stratification, the interviewees also acknowledged a need to be a value add to the current medical education landscape and not pursue grants or initiatives that would conflict with other institutions whose missions and legacy are more closely tied to primary care. One dean in medical education stated, "HRSA here has relationships with Morehouse, as they should. They're dedicated to primary care…Their goal is to produce primary care physicians, so we've got to support them in that, right?"

Emory School of Medicine Case Analysis. The interviews and document analysis highlight that the primary care narrative for Emory University is still evolving chiefly because primary care has only recently been positioned as essential to the vitality of the enterprise. For example, in the opening section of the Woodruff Health Sciences Strategic Plan the authors concede, "Without changes to how primary care is delivered, the growth in primary care physician supply will not be adequate to meet demand." In creating a strategic action plan for the entire health sciences complex, senior management is also in line with the authors of the Affordable Care Act in acknowledging that the primary care shortage will need to be addressed from multiple types of health care providers. The addition of the Ambulatory Care Block in 2007 to the new medical doctor curriculum shows administrators in the school of medicine acknowledged the increasing importance of primary care in the education of a well-rounded physician before the ACA was ratified. In reflecting on why a primary care block was necessary, one dean in medical education stated:

> Not that we want them all [students] to be primary care specialists necessarily, but we do think every doctor should be cognizant of some of those things I discussed with you - especially the role of the family and the community in the health of the individual patient. And we think that primary care provides the best examples of that… we really want students to get the flavor of what it means to see people over time, know them well, and provide that kind of support in a community. That's why we have very much increased our students' exposure to primary care when we revised our curriculum.

Although the draft of the new curriculum started in 2005, Foundations, or the first year of the curriculum was not implemented until 2007, with a new phase added every year until 2011 when the full curriculum was in place. Therefore the students entered the first iteration of the Ambulatory Care block during the 2009-2010 academic, in the midst of the ratification of the Affordable Care Act. Given the explicit goal for the curriculum to have market value and for Emory physicians to be adept at entering any specialty, it can be reasoned that the legislation did

tangentially shaped and continues to shape the Ambulatory Care Block. The Affordable Care Act affects multiple areas of the health care system, but there is an emphasis in the legislation on expanding access to primary care and also on expanding the primary care workforce. Thus in order for the new curriculum to educate physicians to enter the new health care market means that the Emory medical doctor curriculum must be somewhat aligned with the Affordable Care Act.

While there is consensus around the importance of primary care to a successful American health care system, the School of Medicine senior leaders diverge with the authors of the ACA in terms of what methods are best for attracting students, specifically Emory medical students, to pursue primary care. For example, Subtitle C, titled "Increasing the Supply of the Health Care Workforce" revamps portion of the Public Health Service Act (42 U.S.C. §§ 292q-292s) concerning minimum length of service and the maximum amount of federal student loan forgiveness for students who agree to practice primary, specifically in disparate or medically underserved areas after graduation ("Patient Protection and Affordable Care Act," 2010a, pp. 541-544). Although appealing, one senior administrator noted that this form of loan forgiveness might not be particularly attractive to Emory medical students:

> Our students pay big tuition…. I think it's very hard when you tell people where they are going to have to practice…The truth is, people don't want to live in a county with less than 25,000 people. It's very rural. Most of the people who grow up in the United States are not growing up rural. Most people in the medical school are not growing up rural. Medicine in 2014 is increasingly teamwork. Who's your colleague? It's unusual for people to want to go to a rural area and just be the only family practitioner in the county.

Another interviewee was irresolute about how this incentive would fair with Emory medical students and simultaneously expressed frustration with the current definition of medically underserved areas:

> I think until we are clear and comfortable that practicing you know in an inner city place Grady…people will probably be reluctant to do it. You know it is unlikely. One of the challenges you run into in healthcare, particularly physician distribution, is that physicians tend to concentrate in cities, suburban areas, and less in rural areas unless that is where they are from. So the reality is that the likelihood that you can convenience people to go into a rural environment for the sole purpose of paying back their loans, probably is low. There are going to be some, sure. But, if you can define some of the inner city areas as underserved then you might get more people to do it.

Yet one senior administrator believed that loan forgiveness would be attractive to Emory students due to the debt load the student typically carry. The strategic administrator summed it up like this, "It's [loan forgiveness] huge… I think the forgiveness of loans or a reduction in the student debt load can help to, I guess, enable people to make the choice to go into primary care from a purely financial uh aspect."

What emerges from this case analysis is that as an institution, Emory University School of Medicine has a clear understanding of where the institution is positioned in the medical education strategic field. This clear understanding of the intuition as an academic medical center attached to a highly selective research institution muddies the implementation of the primary care strategic plan. Successfully implementing the primary care strategic plan is more complex than simply an internal cultural shift because, as one dean remarked, "The problem is that there is perverse incentives here. If we do better in primary care and keep people out of Emory Hospital, we lose money." Thus the strategic action must find a way to provide more robust offerings by way of training and care in primary care that also ensures the academic medical center remains profitable.

Yet being responsive to the growing primary care need does not necessitate a radical change from the reputational markers used to distinguish the School of Medicine, especially when market place dynamics are considered. The Affordable Care Act includes incentives for research, faculty development, and the creation of centers of excellence in primary care ("Patient

Protection and Affordable Care Act," 2010a). Despite the incentives in the ACA for research and knowledge production, these specific incentives may not be considered viable to the faculty and scientists at Emory. As the strategic leader stated:

> I think that there is much more interest and need for health services research, and so I think it will help to change our focus on the types of research grants that we go after. Um, you know with primary care there's not a whole lot of basic science research that goes on. It is more about care models, care delivery, those sorts of things. So I think that we will gravitate more towards that type of research.

For example, in Section 5301 of the Affordable Care Act, $125MM was appropriated for Fiscal Year 2010-2014 to support and develop primary care training programs, expand residency programs for physicians teaching in community-based settings, and award need-based financial aid to physicians in primary care ("Patient Protection and Affordable Care Act," 2010a, pp. 544-547). Yet this amount, and others allocated in the legislation, did not provide a large enough incentive for the majority of the Emory faculty to actively pursue many of the grants provided by HRSA. The dean of curriculum stated: "I think the max award for any of the Affordable Care Act ones [grants]…It's like $650,000, which is a drop in a bucket when you think about training hundreds and hundreds of students." The attractiveness of the HRSA funds to Emory faculty may also be diminished because as the curriculum dean said, "we have the funds to do the right thing." The dean of clinical education noted that The Emory Medical Care Foundation will "award small, $25,000 to $30,000 grants to faculty members that have been here less than 5 years…it is a way to help them get started in their research enterprise." Priority for these internal grants is given to faculty who spend more than 50% of their time at Grady Hospital (the community hospital affiliated with Emory).

Lastly the ACA funding may not be as attractive to Emory administrators and faculty because "among other factors, institutions that have a record of training the greatest percentage

of providers going into primary care, provide training with vulnerable population and those institutions that submit joint applications with community centers ("Patient Protection and Affordable Care Act," 2010a, p. 546). As such, the dean of curriculum noted that ACA grant money would also be "much more likely to help Morehouse than it is to help Emory" because of Morehouse's established reputation in primary care education. Emory also may have screened themselves out of consideration due to the fact that the Woodruff Health Sciences Center Primary Care Strategic Action Plan Task Force did not view partnerships with community centers as a priority in implementing the WHSC strategic action (*Woodruff Health Sciences Center Primary Care Strategic Plan: FY14-FY18*, 2014, p. 13).

Another major incentive in the Affordable Care Act to assist with the recruitment and retention of primary care physicians and to encourage those physicians to practice in medically underserved was the reauthorization of the National Health Service Corps ("Patient Protection and Affordable Care Act," 2010a). As two of the interviewees stated, however, the tuition reimbursement incentives for medical students are not attractive enough for the Emory School of Medicine student body to overwhelmingly respond to such awards. Thus there is no impetus of the strategic leaders to actively change their recruitment strategy to be more in line with those federal incentives or guideline.

The initiatives that bubbled to the top as viable centered on increasing and improving team-based models of care, particularly in the Patient Centered Medical Home initiative, which addresses more the topics in Title III – Improving Quality and Efficiency of Health Care, of the Affordable Care act and less to do with educating and training the health care workforce. Emory University currently operates a Patient Centered Primary Care clinic and both the strategic plan and the strategic leader talked about the need for this to be expanded, both from a revenue stand

point but as well as a potential training site for students. All three interviewees talked about the school of medicine forming partnerships with community hospitals in order to expose students to community care during the student Outpatient Experience during the foundations phase, to provide junior clerkships during the Applications and Translation Phases of the curriculum. In both the strategic plan and the strategic leader noted the need to expand Graduate Medical Education (GME) residency slots, something that happens after a student completes, or is near completion of their undergraduate medical education.

Conclusion. One of the more notable impacts of the Affordable Care Act on the institutional strategy at the Emory University School of Medicine is an explicit dialogue concerning the best way to balance the school's local and national reputation as a specialist and research driven institution with a general acknowledgment that primary care is important to a more sustainable model of care. While the Affordable Care Act provided enough of an external shock to increase the rhetoric around the institution's role in educating and training more primary care doctors, none of the incentives in Title V were particularly alluring to encourage a departure from the standard operating procedure. In fact, the interviewees articulated that the incentives in ACA were more apt to assist the medical schools in the state that have a historical or longstanding relationship with primary care than were to help Emory. This stance highlights what Taylor (in press) refers to as the prestige economy in higher education. While colleges and universities are under increasing pressure to diversify their revue streams, not all sources are funding are prized. Faculty and administrators at elite, resource rich universities have more flexibility in determining which types of funds to pursue. While exposure to primary care is important to the undergraduate medical curriculum, these changes were instituted prior to the ACA being ratified. Additionally, the interview participants generally agreed that the incentives

put forth by Title V would not be overwhelming appealing to the student body. As a result, it is unlikely that a swell of Emory students will clamor for more exposure to primary care than what the curriculum currently provides or that more students would be interested in the specific loan forgiveness programs. The analysis also shows that the senior management is not completely aloof to the Affordable Care Act. The leadership determined that the greatest opportunities for Emory to be a value add in the larger discussion is in value-based and efficient models of care that is more closely tied to the market place need (for a school and society perspective).

Georgia Regents University: "It's Not Easy Being a State School"

Introduction. In January 2013, Dr. Ricardo Azziz, the chair of the Campus Consolidation Task Force and the former president of Georgia Health Sciences University, was appointed president of the newly formed Georgia Regents University (GRU). A consolidation of Augusta State University (ASU) and Georgia Health Sciences University (GHSU), Georgia Regents University, which includes regional campuses in Albany, Savannah/Brunswick, Rome, and Athens,[11] was one of four mergers that occurred in a rather swift state wide consolidation program that reduced the total number of institutions in the University System of Georgia from 34 to 31. In September 2011, University System of Georgia (USG) Chancellor Henry (Hank) Huckaby announced that a Campus Consolidation Task Force had been assembled to determine the state institutions to be merged in an effort to enable USG to better use its resources to increase the scope of academic programming and to increase college graduation rates as a part of a statewide initiative called Complete College Georgia[12] ("News release archive: Releases filed

[11] Although the GRU has a four-year partnership with the University of Georgia, the majority of MCG students are trained at the Augusta, or main campus, location. Since many of the key strategic leaders are located at the Augusta campus, this analysis will focus on the dynamics driving strategy at the main campus.

[12] Complete College Georgia is a joint partnership between the University System of Georgia (USG) and the Technical College System of Georgia, with support of the Governor's office, with the primary goal of increasing the

under campus consolidations," 2014). In November 2011, the Board of Regents approved the six guiding principles, which aligned with Complete College Georgia, to be used to select the first wave of campus consolidations. Three months after making the announcement of the consolidation plan, eight institutions were identified to be merged in order to "ensure the System has a 21st century structure with the right network of institutions offering the proper range of degrees"[13] ("News release archive: Releases filed under campus consolidations," 2014). Chancellor Huckaby appointed campus-working groups, comprised of internal and external stakeholders from each campus, to develop a consolidation plan that would result in complete integration in approximately 18 months. In August 2012, Georgia Regents University was selected, out of three possible choices, as the name of the newly consolidated Augusta State University and the Georgia Health Sciences University. In December 2012 the Southern Association of Colleges and Schools (SACS) gave its approval to the four consolidated institutions and in January 2013 the Board of Regents finalized all of the consolidations at which point all of the institutions began to operate under their new names and missions to provide academic programming, and to recruit and enroll students (Kelderman, 2012).

Thus the Medical College of Georgia (MCG) at Georgia Regents University represents a public medical school with specific ties to the state in terms of funding and meeting the state's

number of undergraduate degrees offered by USG institutions. The six consolidation guiding principles aimed at helping to the state meet the Complete College Georgia goals are: Increase opportunities to raise education attainment levels, improve accessibility, regional identity, and compatibility, avoid duplication of academic programs while optimizing access to instruction, create significant potential for economies of scale and scope, enhance regional economic development, and streamline administrative services while maintaining or improving service level and quality (Millsaps, 2011).

[13] During this timeframe the University of North Georgia was formed from the merger of Gainesville State College and North Georgia College & State University, Middle Georgia College and Macon State College were consolidated to form Middle Georgia State College, and Waycross College and South Georgia College merged to form South Georgia State College.

academic and health care needs. The school's commitment to "improving the health of Georgia" (Robinson & Yu, 2013) is evident throughout the strategic plan, research agenda, training sites, and the current compilation of Georgia's health care workforce. For example, as the state's only public medical school, the institution offers 135 clinical training sites across Georgia to expose students to the various clinical settings available in the state ("Medical college of Georgia facts," 2014). The connection to the state is also evident in the school's mission, vision and values with the claim that "MCG will lead Georgia and the nation to better health" stated twice in the strategic plan (Robinson & Yu, 2013). The school's main research initiatives on cardiovascular biology and disease, cancer, neurosciences and behavioral sciences, public and preventive health, regenerative and reparative medicine are said to be at the forefront of their research agenda because these are the "illness that affect most Georgians" ("Medical college of Georgia facts," 2014). In terms of student make-up, approximately 95% of the current students are Georgia residents, and approximately 20% of the physicians practicing in Georgia were educated at the Medical College of Georgia ("Medical college of Georgia facts," 2014). Although primary care is not mentioned in the school's mission, vision and values nor highlighted in the Dean's strategic plan, on the Fast Facts page it is noted that 38% of the 2013 MCG graduates pursued primary care.

School in Context: Mergers, Expansion, and Upholding the State's Mission. Georgia Regents University was formed in 2013 by consolidating Augusta State University and Georgia Health Science University (GHSU). An opportunity identified with merging these two institutions was the prospect to create a comprehensive research institution that provides high-quality undergraduate programs and top-tier health education and research that meets regional and statewide needs while also leveraging the close geographic proximity of the two

campuses(Donowitz, Anderson, Cominelli, & Germino, 2009). While Chancellor Huckaby and other University System of Georgia (USG) administrators were generally optimistic about the consolidation some challenges also emerged early in the process. For example, the significant differences in the schools' institutional missions, organizational structures, and governance were viewed as a concern. Moreover, the complexities associated with the current and evolving health system structure were also identified as impediments to the integration process ("Georgia Regents University," 2013). As a former University System of Georgia regent reflected "to even suggest any kind of merger of Georgia's only medical university with a state university with a 7,000-student population is unimaginable" (Shelnut, 2012). Despite these challenges many in the Augusta community viewed the merger as a bastion of needed economic vitality for the city as well as strengthening the reputation and reach of the medical school: "The great strength of a clinical enterprise embedded in a great university is one of the most powerful tools in our country" ("A show of strength - Merger of two Augusta universities would signal huge growth," 2012).

The widespread community support quickly eroded, however, when Georgia Regents University was selected as the university's official name. The three final names, Georgia Arts and Sciences University, Georgia Regents University, and University of Augusta, emerged from more than 1,200 initial submissions (Corwin, 2012). After significant market testing, Georgia Regents University was the only one found to be relatively neutral and was seen as helping to expand donor support because it was bigger than one city ("News release archive: Releases filed under campus consolidations," 2014). Many community members and Augusta State University students and alumni alleged, however, that removing Augusta from the name was erasing the former school's identity and failed to acknowledge the university's connection to the city and the

region. Although Dr. Ricardo Azziz had been deeply involved in the Augusta community for a number of years serving as the president of Georgia Health Sciences University as well as the chair of the Campus Consolidation Task Force, he was cast as untrustworthy since he was seen as down playing his role in the selection of the university's name. Nonetheless, amid rallies, protest, and an online petition, the Board of Regents ratified the name and in January 2013, Georgia Regents University began to operate under its new name and with Dr. Azziz at the helm as the institution's first president.

Dr. Azziz appeared to be the preferred choice to lead the consolidation task force[14] and the new university given the role, or expected role, Georgia Regents University would play in the health education for the state (Corwin, 2012). Azziz stated that the new university would continue to respond to state health care needs with an educational "model that takes in all levels of health profession degrees" and that the university "will serve the state in a greater capacity that …will emphasize a hub-and-spoke model for the delivery of advanced degrees" (Corwin, 2012). Additionally, Georgia Governor Nathan Deal (R) set a goal for the consolidated university to become a top-50 research institution, which Azziz noted would take an increase in NIH funding to "at least $80 million…It will also mean doubling the research space and hiring an additional 100-150 scientists" (Corwin, 2012). Lastly, it was the expectation that the consolidation would help USG secure the state's second Nation Cancer Institute-designated Cancer Center, besides Emory University's Winship Cancer Center, which would also help fulfill the strategic plan of the university being a top-50 research university.

[14] Dr. William Bloodworth, the then President of August State University, announced his retirement in 2011, effective July 2012

In light of the recent and tumultuous merger, the Medical College of Georgia five-year strategic plan is centered on aligning the school of medicine's goals with Georgia Regents University: "What will happen over the next five years is implementation of a multifaceted plan that, in alignment with Georgia Regents University's strategic plan…strengthens our very core, our teaching mission, as well as our absolutely parallel missions of research and clinical care" (Robinson & Yu, 2013, p. 2). In fact, two separate pages are dedicated to illustrating how MCG's mission, vision and values as well the strategic foci directly align to the Georgia Regents University's *Transition Forward*. Additionally, many of the goals/strategic actions outlined under each focus areas are also directly aligned with *Transition Forward*. For example, increased research production and expansion of facilities were cited as strategic priorities in both documents (Robinson & Yu, 2013).

Based on the need to establish a stable connection to the parent university, the Medical College of Georgia Strategic Task Force may have opted not to include an explicit value proposition around primary care. Senior leaders could have also deemed it unnecessary to include an explicit primary care statement because the curriculum and clinical experiences at MCG implicitly address this issue. For example, in the 2010 AAMC report reveals that all medical students were required to do rotations in ambulatory and critical care, and emergency medicine during their fourth year (Albritton, Boyd, Fincher, & Thomas, 2010). Additionally the majority of the community based clinical clerkship sites are in primary care practices located in rural or medically underserved areas, thus ensuring all students receive multiple points of exposure to primary care (Albritton et al., 2010). Senior leaders may have also thought it frivolous to include an explicit primary care directive given the mandate to meet the state's health care needs, which currently includes training more primary care doctors.

Medical College of Georgia's Connection to Primary Care. Although Georgia Regents University is a new institution, the Medical College of Georgia has served as "the state's medical college" since 1828. Being Georgia's only public medical school clearly shapes the strategic goals and priorities. The recent merger and the need to establish a clear tie to the parent university complicated strategic leaders' efforts to create a separate, more federally focused strategy. As such, the themes that emerged concerning the Affordable Care Act and primary care were tightly coupled with state needs and GRU strategic priorities. This formal relationship with the state also influences all aspects of the undergraduate and graduate medical experiences, even residency placement expectations. For example, one senior leader who served on the MCG strategic task force and is a senior associate dean in the school of medicine noted:

> We've always been capitated by the state to produce a certain number of physicians that not only will be in family medicine, but stay in family medicine, but we also have to make sure that a certain number of those stay within the state. So, we have to maintain a five-year rolling average to 50% of our graduates from our GME programs staying in the state.

This commitment to meet the state's health needs encompasses all aspects of the education process and has also prompted the expansion of the medical doctor class. As a senior faculty member and former chair of the curriculum committee stated:

> We're [Georgia] short of physicians, and the (United States. Office of scientific research and development. & Bush) government basically said ten years ago or whatever, eight years ago and said, 'What we need is we need to have more medical students, so increase medical school enrollment by 30% by the year 20-something.' MCG has done their part, for sure. I don't know that the other schools have …I don't think Emory has grown very much. Morehouse isn't that big either.

From educating enough physicians to ensuring physicians are exposed to primary care and other critical need areas, the state's health care needs not only contours the strategic policies concerning growth, but also admissions policies. One of the challenges that Georgia, like other states, is facing is constrained physician distribution as well as shortages in high-need specialties.

Consequently the admissions committee considers, among other factors, if a students is from a rural area, as he or she is not only more likely to return to that area of the state, but also tends to be more inclined to pursue a primary care specialty. One center director summed up MCG's commitment as such:

> From my understanding is that they are definitely looking at applicants - students that are applying for medical school - and they're truly looking at applicants to see if they are interested in going into rural medicine as well as primary care medicine. They're looking at that at the admissions level.

The strategic planning committee dean provided clarity in terms of the importance of having diversity in hometown as one of the consideration factors in the admissions process:

> Our admissions committee look(s) at where our students come from and try to make sure that as we look at students, that we are trying to get some of the best and brightest from every section of the state to make sure that not only are they bright students, but they're geographically dispersed as well…And by getting that diversity, you might be looking at students who may be more likely to go back and immediately serve the types of communities that they grew up in as opposed to getting everyone from the metro-Atlanta area…We expect that they are going go down to Howard, Georgia and deliver services, that probably won't happen.

The school's commitment to educating and exposing students to primary care, as well as training student to practice in health disparate areas also emerged when considering the curriculum. For example, MCG recently instituted academic houses that groups faculty and students at various years in the medical curriculum together in a mentorship relationship. As the center directed stated "50% of the clinicians are primary care and kind-of have a one-on-one relationship with the students." Although not desinged specifically with pimary care exposure in mind, being paired with a clinicain who practices primary care, in conjunction with other aspects of the cirrulum, is viewed as encouraging students to seriously consider primary care specialities. The center director, who also is a primary care physician, continued:

> Throughout those four years, not only does the curriculum introduce patient family-centered care, patient center medical home concepts into the curriculum, but they are

> kind of affiliated or mentored with someone in that primary care arena…It's informal and they feel more comfortable asking us - me as a clinician and the researcher – questions… about what their career choices can be at an early stage.

While sensative to the state's health care needs, many of which are in line with the federal mandate to train more primary care physicians, each of the interviewees articulated a plethora of challenges to attracting their students to go into primary care. One of the major obstacles to enticing MCG students to puruse primary care is debt load, which is in line with much of the current literature (Greysen et al., 2011; Jolly, 2005; Steinbrook, 2008). More so than salary descrepancies or managing debt, the administrators also commented on how part of the education process is managing and reshaping student's expactations of a physician's lifestyle. The senior faculty reflected that "There's a lot of people that want to go into primary care, plenty in the med school. What happens is they see the lifestyle." Frustration with the primary care lifestyle seems to surface when comparing residency-training programs, ability to pay back loans, and the quality and type of work primary care physicians do. For example, students are jaded when, as the center director noted, "Your primary care physicians almost do as much training as your specialists…[and] their debt load when they come out is about the same…Sometimes it's hard to convince students to go into a primary care specialty when they see that there's a huge difference in salaries." The senior associate dean also noted the students' tension with lifestyle expectations and how tension influences speciality choice:

> "But what's happening is they're leaving the medical school with a quarter million dollar plus in loans. They are looking at how fast they need to pay that back in about 10 to 15 years or so. And then, they begin to realize that, quite frankly, it leaves them marred. Not that they can't pay for it. If they're going to make $100,000 plus in salary, they can pay back a quarter million, they can do that, but it doesn't leave them the margin for the lifestyle that they are expecting after having invested as much as they've invested. And sometimes, they make decisions based upon lifestyle needs and not what their interests are."

Lifestyle is more than about pay, however, as the senior faculty, who is also a practicing physician in a primary care reflected. The work that primary care physicians do is arduous at times, especially compared to some of the super-supspecialities that comand higher salaries.

> How much emotional trauma do you get when you deal with people that are under anesthesia that you're operating on? Whereas how much emotional trauma you get when you're in a clinic when people are in pain, they're sick, and they're grumpy, and they've had to wait two hours…So the primary care people end up having this huge job, they get less reimbursement, and now you throw on the electronic medical records…because we now are required to do that… They [primary care doctors] do a full day of clinic and then they might have ten charts they have to do still and take them home and do them on their home computer.

Medical College of Georgia Case Analysis. What emegered from the document analysis and the interviews is that MCG is clearly connected to the state and meeting the state's medical needs. The recent merger and the need to develop a clear strategy connecting the Medical Collge of Georiga to Georgia Regents University took preceedent over forming a distinct strategy in response to the Affordable Care Act. Thus any rhetoric around the Affordablbe Care Act was clearly couched in meeting an existing state priority or a student need. For example, the center director and faculty member believed that the ACA assisted in amplifying the conversation around primary care education among senior leaders: "I think that the Medical College of Georgia is now, with the Affordable Care Act coming out, seeing that not just only the United States but the state of Georgia, there's a lack of primary care." However, as one senior leader noted, the urgency to educate more primary care physicians has less to do with strategic planning or the Affordable Care Act and more so about the evolving health care environment:

> Primary care is embedded in our strategic plan, but it's embedded in that strategic plan just like it would have been embedded if there were no ACA. The fact that we're moving a lot more aggressively with regards to primary care is not because of our strategic plan, it's because of the healthcare environment it's changing. And if we are going to survive in

> that environment, we're going to have to create models of care that respond to the mandates of the changes that are out there.

While the ACA may have assisted in heightening the importance of primary care in meeting the state's health care needs, neither time or funds have been allocated to crafting a strategic stance in regards to Title V of the ACA. The senior assocate dean and Medical College of Georgia Task Force Member stated:

> What we've done as an institution is we have generically responded to the implementation of the ACA. So, we're checking off boxes like any other institution. For me to even remotely suggest to you that we have a primary care strategic realignment that is occurring in response to the ACA that is specific of primary care, that's not true.

The tenured faculty echoed that no formal strategy was in place, but posited that a strategic plan would likely be developed given the everpresent need for more external resources, "I think it [ACA] will influence our strategic plan, because any institution will go where the money is. If there's a pot of money out there that says, 'The federal government is going to incentivize these kind of things.' The institutions will do those kinds of things to get the money."

What also emerges from this case analsysis is a clear idea of where the Affordable Care Act could bolster efforts already in place to recruit students into primary care. The interviewees were cautiously optimistic that the monetary incentives in the ACA would be attractive to MCG students and would bolster aspects of the current curriculum focused on primary care. The interviewees agreed that a good deal of the current student body had a modicum of interest in primary, and the respondants were hopeful that more of these students would fully exploring these interests if they knew it was a finacially viable career path. The center director noted that "The students are asking what scholarships are out there for us so that we can lessen our debt load." The associate dean believed that

> Loan forgiveness programs that are targeting primary care, if they are done appropriately, could actually be the thing that tips the decision for many students who want to do

> primary care… I think that you might increase the likelihood that those students who are suited for family medicine will not make those lifestyle decisions, because the impact is going to be less.

Thus the reauthuthorization of the National Health Service Corps were generally viewed favorablly. While hopeful that the funding could persuade students to consider primary care seriously, there was also a sense of frustration with the legisltation in that it failed to adquately help faculty and staff educate students about the funding opportunities available. The center director commented, "All of the Affordable Care Act, I may not need to know, but I need to know those things that can encourage our students and residents to go into primary care and to go into rural health." For the senior faculty member, loan forgiveness was a first step, but failed to address the fundamental issues detracting students from pursuing primary care: "I think you can throw all the money you want in trying to make it look good. But, for want of a better term…how can you dress up a pig? The students will see through it."

Conclusion. While the Affordable Care Act provided a shock to the the proximate field of medical education, the reliance of MCG on the state of Georgia for funding, and frankly for vallidation of their new identity, took precedence over immediate efforts to form an explicit strategy to pursue any incentives in the Affordable Care Act. Not having a formal strategy concerning federal funding in place may hamper faculty and administrators' ability to compete successfully for national funding when they are able to shift their focus from state mandates to federal grant dollars. Federal grants tend to be more competative and, although the state priorities with regard to producing more primary care workers is in line with federal initiatives, ample time is needed to flesh-out the nuances and create a cohesive narrative around state and federal objectives. More resource rich schools such as Emory University, or schools directly aligned with the federal priorities such as Morehouse School of Medicine, are presently working on

forming and amending their strategies to collect the maximum amount of federal support (Taylor, in press). Even if the elite schools do not prefer the types of grants and contracts available in the ACA, the leaders at such institions are nimble and resource rich enough to decide if and when they want to enter the fray. The delayed response on the part of MCG to developing a strategy for collecting federal support increases stratification across higher education, but also may be the impetus of downward movement of middle class publics, such as Georgia Regents University, to the lowest strata of research universities (Taylor, in press).[15]

Although a cohesive institutional strategy does not currently exist, this does not signal a dissconnect from the Affordable Care Act by the senior leaders at MCG. In many ways, the federal legislation bolsters current institutional policies, such as the focus to enroll students from all regions of the state and to try to discover a student's interest in primary care during the admissions process. Moreover, the loan forgiveness portions of the legislation were viewed favorably, therefore, if any immediate strategy is implemented, I posit it would center on how to best communicate the loan forgiveness options to the student body. Such a communication strategy, in conjuction with consistent exposure to primary care in the MCG curriculum, as well as greater opportunities for mentorship with primary care faculty, and the opportunity to train in more health disavange areas, may help to alleviate the pressure the interviewees felt in making primary care more attractive to their student body.

[15] To explore stratification changing field dynamics, Taylor (in press) categorized public research into four groups: middle class, elite, strivers, and poor relations. The University of West Virginia was highlighted as archetype middle class institution. The University of West Virginia was also indicated as one of Georgia Regent University's peer schools. As such, that is why I classified Georgia Regents as a middle class university for this analysis.

Morehouse School of Medicine: "The People's Champion"

Introduction. On September 11, 2014, Dr. Valerie Montgomery Rice made history when she was inaugurated as the first female president and dean of the Morehouse School of Medicine (MSM). In her investiture speech, Dr. Montgomery Rice provide an outline of her vision for the Morehouse School of Medicine to become a recognized leader in creating health equity in local, national, and global communities in response to a health care system that requires change and innovation (Montgomery Rice, 2014). As a member of the historic Atlanta University Center Consortium, the largest consortia of African-American private institutions of higher education, MSM has a history and existing commitment to channeling research and resources toward the advancement of "minority, economically disadvantaged, and under-served communities" specifically around areas of health and health access ("About Us," 2014a). The bevy of inaugural events, which also coincided with the Morehouse School of Medicine's fortieth anniversary, focused on the themes of student scholarship and support, expanding the school's social mission, and community engagement. There were forums and discussions around improving access to health care and increasing awareness of community health and eliminating health disparities.

Thus the Morehouse School of Medicine represents a medical school that has a historical mission of serving disadvantaged communities as well as enrolling a diverse set of students. In addition to the school's historical connection to Morehouse College, an all-male Historically Black College and University, the school's mission statement clearly references a pledge to "increasing diversity of the health professional and scientific workforce, and addressing primary healthcare needs… with emphasis on people of color and the underserved urban and rural populations in Georgia and the nation" ("About us," 2014b). The "Quick Facts" section of the

school's website also notes that MSM has been recognized as a leader in primary care training by the Association of American Medical Colleges (AAMC). This reputation as a primary care trailblazer is also bolstered by the NIH funded National Center for Primary Care[16] at Morehouse College, which provides research around and training in the value of primary care. MSM offers five specialized master's programs and three dual degree programs. Out of the school's seven residency-training programs, four are in areas of primary care and the majority of clinical training occurs at Grady Memorial Hospital, one of the largest public hospitals in the Southeast. Lastly of note is that approximately 65 percent of the students who completed their residency training at MSM have elected to stay and practice in Georgia ("About us," 2014b).

School in Context: New President New Era. Dr. Montgomery Rice's appointment as president and dean of the Morehouse School of Medicine initiated changes that effected how senior leaders, faculty and staff coalesced around the strategic priority of "leading the creation and advancement of health equity," in the 21st Century ("President's mid-year report," 2015). A plethora of the new tactical priorities seek to leverage the School of Medicine's historic commitment to primary care in the current health care environment. In conjunction with a slew of new senior administrative hires and academic appointments, a task force was convened in July 2014 to draft the five year strategic plan to better position the school for increased recognition and funding given this period of amplified attention on the importance of primary care to meeting national health goals. The plan was implemented over a seven-month time period with the final version presented to the Board of Trustees in February 2015.

[16] The National Center for Primary Care of Morehouse School of Medicine exists to promote excellence in community-oriented primary health care and to service as a national resource for encouraging doctors to pursue primary care. NCPC staff conducts research, advises on health policy, supports health advocacy, and provide education and training to faculty and current physicians.

One of the principal areas of growth, identified as a result of the Strength Weaknesses Opportunity Test (SWOT) analysis and other benchmarks, is the need to establish a more aggressive research agenda. In fact, the need to produce more research cuts across all three of the strategic vision imperatives ("Update on the strategic planning initiative," 2015).[17] While research and securing individual grants is an important part of the tenure and promotion process at many colleges and universities, research has had a less significant role at MSM. In the 2010 AAMC report it was noted that teaching contributions play a significant role in the appointment and promotion of faculty and, at that time, there was no tenure system in place (Elks, 2010). Although the school recently received substantial grants from the National Institutes of Health, the Centers for Disease Control, and the Kennedy Forum, the majority of the funds are allocated toward pipeline development, strengthening community partnerships, and other activities that are not directly tied to traditional knowledge creation or bench science ("President's mid-year report," 2015). Thus, one of the first strategic imperatives is "translating discovery into the health equity" and includes establishing a nationally recognized community of scholars at MSM as well as commercializing and disseminating MSM discoveries ("Update on the strategic planning initiative," 2015). Such moves push Morehouse toward valuing more traditional methods of reputation building and peer recognition.

Another component of the strategic plan, which builds off the MSM mission to "increase the diversity of the health professional and scientific workforce" is to secure endowment funding and other philanthropic support for student scholarships ("Update on the strategic planning initiative," 2015). As a part of the inaugural events, President Montgomery Rice unveiled her first major development campaign, the Presidential Scholarship Fund, to help lessen the debt of

[17] The three vision imperatives are translating discovery into health equity, building bridges between health care and health, and preparing future health learners and leaders

MSM students. It is foundational year, the fund raised $2.9 million dollars for scholarships ("President's mid-year report," 2015). More scholarship dollars is couched as imperative to the continued success of Morehouse School of Medicine maintaining its place as “the national leader for training high-quality primary care physicians” ("Update on the strategic planning initiative," 2015, p. 42). The aggressive fundraising campaign also supports facilities expansion goals and developing “innovative new curricula,” which is couched as vital to bolstering Morehouse’s national reputation as a bastion of diverse and qualified primary care and community health talent ("Update on the strategic planning initiative," 2015). The incoming M.D. class is approximately 80 students, and the goal is to increase the class size to 100 students. While securing funds is a necessity, finding ample real estate proves challenging due to the MSM’s location in downtown Atlanta. Nonetheless in the first six months of FY 2015, donor support had nearly quadrupled last year’s efforts for the same time frame ("President's mid-year report," 2015).

The current favorable health care environment is also viewed as an opportunity to develop an identity separate from Morehouse College ("Update on the strategic planning initiative," 2015). Although the institutions share the same name and a similar legacy of educating a large number of African American and other underrepresented students, the institutions have been separate entities for 34 years. The closeness in proximity of the two campuses as well as the Morehouse name confuses donors and appears to have presented fundraising challenges in the past for the School of Medicine ("Update on the strategic planning initiative," 2015). Thus a strategic initiative is building a brand identity that leverages the Morehouse name, but is distinct in the health care and health environments ("Update on the strategic planning initiative," 2015). Increases in scholarly work around health equity, health

innovation, urban health, and other topics are seen as essential to building a national reputation. New trustee appointments and increasing the frequency with which prominent health care professionals guest speak on campus are also positioned as helpful in order to increase the school's endowment and donor support separate from Morehouse College.

Morehouse School of Medicine's Relationship to Primary Care. As highlighted in the document analysis, the Morehouse School of Medicine's connection to primary care is clearly articulated and is being positioned as an area of strength. As one of the vice presidents said: "We're particularly interested in primary care. So primary care is what we do." In fact, all the interviewees seemed to derive a clear sense of direction and purpose from the MSM mission. As a result, educational successes were also couched in reference to this mission. For example, a senior faculty member reflected:

> Morehouse, from the start of our existence, was actually founded to try to increase the primary care workforce. We're very happy with our students that want to do sub-specialty care, want to do anesthesiology or radiology. But we really do take pride in the students that go on to primary care, because that's really at the core of our mission - primary care, especially among the medically under-served.

Beyond mere rhetoric however, a deep pride in training students to be primary care practitioners emerged. In many ways, primary care was positioned as an ethical underpinning of what it means to be a competent and caring doctor. Therefore, primary care transcends all medical subspecialties. The department chair noted:

> We try to help the students see themselves as practitioners that are also engaged with the communities that they are working with in various ways. We have this little saying that you can be a primary care ophthalmologist or a primary care surgeon because we're interested in you being totally engaged with your patients regardless of the care that you're doing.

Equally as pervasive as the importance of primary care to the institution is the value of social justice or social mission in how MSM students are trained. For example, the vice president stated,

> I think it was a 2011, 2012 national study, and they looked at medical institutions and which ones served the social mission the best. The social mission of care for vulnerable populations. Morehouse School of Medicine was number one. We're number one in the nation in this area.

The senior faculty member and former chair of the curriculum committee noted that the curriculum is designed to train Morehouse graduates "to be good role models for care for the under-served." The community is positioned as partners in both the overall education process and in the creation of new knowledge. In thinking about the curriculum, the department chair said:

> We actually put the students in a community for the year and they have to do an assessment of the community. They work with the community leaders to analyze the assessment and identify the health needs for the community. Then in the second semester, they design, evaluate, and implement an intervention with the community's participation. That's gone a long way. I think that's largely how we came about being recognized as number one in social mission nationally.

The Morehouse School of Medicine's reputation for producing primary care doctors and working with the local community shaped the interviewees understanding of the institution's distinct position in Georgia's medical education landscape. The senior faculty member and former chair of the curriculum committee stated: "It's really, when you think about it, Mercer and Morehouse that are providing the bulk of the primary care physicians in Georgia, but Augusta and Emory are providing more of a traditional medical student output, which is more sub-specialty oriented." The willingness to accept and perpetuate this stratification among the state's medical schools is somewhat self-serving, because many of the interviewees view the current health care landscape

as an opportunity for MSM to corner a portion of the medical education market from other, more resourced institutions.

> We have no qualms about our academic partners in the state providing more sub-specialty oriented care; it really is a nice fit. And as Morehouse has continued to mature, the relationship with Emory really has evolved. It really is much more cooperation than it is competition any longer.[18]

Morehouse School of Medicine Case Analysis. The Affordable Care Act presents an unique opportunity for increased national exposure and recogntion for the Morehouse School of Medicine. The school's mission and overall strategic priorities clearly align with the aims of Title V of the Patient Protection and Affordable Care Act. For example, Subtitle A of Title V opens with, "The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations" ("Title V," 2010). The MSM mission reads "MSM is dedicated to…addressing primary health care needs through programs in education, research, and service, with emphasis on people of color and the underserved urban and rural populations in Georgia and the nation" ("About us," 2014b). With such similaries in prorities to the legislation, Morehouse should have an advantage is being able to more quickly and easily align its strategic intiatives with national priorities. One of the school's vice presidents believed that Morehouse's long and successful track record would prove beneficiail in this new health care environment: "When you look at the ACA and what that particular part of legislation does in terms of the workforce, that dovetails almost-- that fits very well with what our mission has been historically."

[18] The senior faculty member noted that when Morehouse School of Medicine first opened the school contracted with Emory University to provide certain elements of the MSM curriculum. Over time MSM was able to provide all elements of their curriculum and a large part which changed the nature of their relationship with Emory School of Medicine.

While there is a clear connection between the federal legistation and Morehouse's national repurtation, part of the strategy is finding a balance between what iniatives to pursue and clearly articulating Morehouse's ability to successfully meet the nation's growing need. Thus, the strategy must be broad, appealing, and easy to articulate, as the vice president noted:

> We have to communicate effectively with major constituents on a number of different things, which means that part of strategy has to be - where do we connect with people? Regardless of ethnicity, regardless of political affiliation, regardless of geographical location, How do we connect? What's the common language that people understand with regard to care? And develop messaging that kind of cuts through their divisiveness of politics and federal government, in particular, in a way that allows us to benefit from any increased money that are [sic] coming for institutions that focus on primary care, primary care medicine.

Part of developing a broad appeal is to publish more on success measures, with the aims of increasing the visability of Morehouse's achievement record. The need to increase publishing also surfaced in the strategic plan as an area of opporutnity in all three of the school's vision imperatives. The vice president continued: "We are developing papers…both for peer review journals, also for lay people. Because that's a critical question, 'How do you do it? And how have you been able to do it so well?'" It is equally as important to the strategy however, that the plan be seen as a natural manifestation of the school's mission. For example, a senior leader reflected: "That's what Morehouse School of Medicine is [primary care], and we do it because of our mission. And ACA…we think it aligns well, but the label is not necessarily important, it's what's behind it."

Despite a confidence in the historical connection to primary care, there was an awareness that other, more richly resourced institions might also be altering their strategic foci or curriculum to better position themselves to receive federal funding. Such changes in strategy migh disrupt field dynamics and the interviewees seemed hesitant as to how the school would fare if directly pitted against different types of medical institions. What emerged was a sense of

ownership of primary care, evidienced by the the years Morehouse has devoted to educating primarily primary care physicians. The senior faculty and former chair of the curriculum committee stated "our curriculum really is devoted towards primary care, and we're happy with other people not doing primary care." The center director, while unethusastic about new competition, was confident in Morehouse's long success record:

> Seeing that there are funds available, that all schools will probably have a primary care track where they will try to recruit those students who say they're interested in primary care. So that will make the competition a little bit more difficult for us. But I think that our years of work in the area would shine because we know how to bring them in, train them, send them out, and they do well in their particular areas.

Competition notwithstanding, Morehouse seems poised to benefit from the ACA funding because "among other factors, institutions that have a record of training the greatest percentage of providers going into primary care, provide training with vulnerable population and those institutions that submit joint applications with community centers" ("Patient Protection and Affordable Care Act," 2010, p. 546) are given priority in funding decisions. A distinct part of the Morehouse curriculum and education model is partnering with the community and training students to view themselves as members of the community as opposed to an outside entity studying the community. The interviewees saw the community as active participants in the research process, which all three of the interviewees felt distinguished Morehouse among other institutions. The center director stated:

> We engage the community initially and say, 'this is what we found as an issue for your particular community. If you see this as an issue for your community too, would you partner with us…in looking at this problem and coming up with resolutions for the problem?" And then also, when you work with the community, they also participate in any financial benefits such as if you get a grant they're written into the grant.

Conclusion. The Affordable Care Act provides an opportunity for the Morehouse School of Medicine to influence directly the national narrative around expanding the primary

care workforce. The Morehouse School of Medicine Strategic Plan, which is inherently a primary care strategic plan given the school's historical focus on that specific area of care, is about capitalizing on the current market place dynamics to help better position the institution in the academic medicine strategic field and, more broadly, in the national discussion concerning primary care education, training, and production. Given the similarity between portions of the Affordable Care Act and the MSM mission, vision, and strategic goals, it is logical to conclude that the MSM senior leaders will be aggressive in their pursuit of many of the institutional focused incentives to help bolster the financial stability of the medical school. In fact all of the interviewees implicitly agreed that most of the incentives in Title V of the Patient Protection and Affordable Care Act would benefit the institution as a whole as well as their student body.

Many of the emerging strategic imperatives center on commodifying knowledge and positioning for prestige based on increased research production (Bastedo, 2005; Slaughter & Rhoades, 1996). This is not surprising given that competitive funds won through grant processes are among some of the most valued in academia in that they contribute heavily to rankings (Taylor, in press). Yet, such strategies may take time to materialize given that a traditional tenure model, based on publications, is not currently utilized at Morehouse. It may also take time to change the culture to one in which faculty are actively on board and thriving in a new model of increased research production. Additionally, publishing in elite peer reviewed journals is a tedious and often drawn out process, with the average review period for highly ranked peer-reviewed journals in primary care or academic medicine taking up to 90 days. As such, increased recognition in high impact peer review journals could take years to materialize, at which point the national landscape around primary care may have shifted.

Lastly, the competition for the funds in the Affordable Care Act may not be as intense as some of the interviewees hypothesized because the types of funds available are generally viewed as undesirable given the granting agency is not the NIH or more prestigious government agency (Taylor, in press). Thus, while Morehouse may be successful in obtaining many of the new grants and contracts available under ACA, overall reputation and prestige may only see marginal increases in the field of medical education. Nonetheless Morehouse School of Medicine seems the best positioned to capitalize successfully on the current health care environment and the incentives provided in the Affordable Care Act.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

This dissertation seeks to examine how senior leaders in medical education are altering curriculum or institutional strategy in response to new federal legislation. The two overarching research questions guiding this inquiry intended to provide a qualitative understanding of the influence of the Patient Protection and Affordable Care Act on institutional strategy and curricular reform at allopathic medical schools within a single state. Additionally, I sought to examine the ways in which medical curricula were already differentiated, exploring how different levels of material resource, and manifest and latent institutional goals concerning primary care informs different college administrations' response to the problem of educating and training more primary care physicians. As I formally stated in Chapter Three, the two research questions are:

1. How might the Patient Protection and Affordable Care Act be exacerbating stratification within medical education, as evidenced by the curriculum?
2. Which institutions are going to respond to the incentives in the Patient Protection and Affordable Care Act to expand and sustain the primary care curriculum and why?

The theory of Strategic Action Fields (SAF) guided my explanation of how change and stability in medical education is achieved by social actors (Fligstein & McAdam, 2011, 2012). The theory allows for the consideration of stratification and interdependence in a field, which consists of organizations that face common opportunities and constraints, to explain power distribution, variations in how different social actors respond to external and internal social disruptions, and how these actions, in the long term, result in social reproduction. I also relied on Taylor's (in press) explanation of the field dynamics of stratification among US research

universities to guide my understanding of the varying levels of response to the incentives in Title V of the Affordable Care Act.

Each of the preceding cases included analysis based on the aforementioned research questions and guiding social theories. This chapter uses the same analytical tools for a comparative analysis to understand how each of the medical schools relate to *a priori* themes, formalized as postulates in Chapter Three. The cross case analysis also reviews the emergent theme of the overarching unattractiveness of primary care as a health profession and the belief among interview participants of the legislation's inability to change this reality.

Understanding the "Shock" of the Affordable Care Act

Although there is considerable dissonance in the literature concerning the flexibility of the allopathic medical education curriculum (King, 1984; Papa & Harasym, 1999; Seigel & Starr, 2008), scholars tend to coalesce around the notion that major shifts in federal health care policy are likely to disrupt the status quo of medical education (Ludmerer, 1985, 2005; Starr, 1982). The Patient Protection and Affordable Care Act (PPACA or ACA) did serve as a shock to the field of US medical education, primarily, just like Medicaid and Medicare, because the legislation changes the medical reimbursement structure from a fee-for-service model to a value-based or efficiency model ("Patient Protection and Affordable Care Act," 2010a; Starr, 2011). As such, physicians entering the workforce will practice in a different health care environment than those students who graduated even five years earlier. In order to adequately prepare their students to succeed in this new environment, medical educators must, at a minimum, review their curriculum and strategies to ensure their graduates' success.

A priori, I posited that Title V of the Affordable Care Act was a significant enough of an external shock to result in changes to both the medical school curriculum in terms of increased

exposure to primary care, and in institutional strategies concerning securing more primary care grant awards. What emerged is that institutions have or have developed a primary care strategy, but that these strategies do not involve curriculum changes that intersect with the needs of the ACA. For example, at the Medical College of Georgia at Georgia Regents University, one senior leader commented, "We haven't specifically said here is our ACA strategy, but obviously…we are trying to develop those relationships with the exchanges and to the extent we can slowly build our workforce to support it." An administrator at Emory University School of Medicine noted that the goal was to "improve the US News and World Report rankings for Best Medical School for primary care," and most of the new strategies at Emory were tied to the research mission of the university, not the curriculum or workforce expansion (*Woodruff Health Sciences Center Primary Care Strategic Plan: FY14-FY18,* 2014). Even the Morehouse School of Medicine, the goals of which are most closely aligned with the aims of the Affordable Care Act, had not developed a clear approach to securing funds from the ACA. As a MSM vice president recalled: "The concept is clear, you got to [sic] treat people; people need to be healthy. And we need to be on the right side of that….So what I would say…is that Morehouse School of Medicine had been on this course for 40 years. We're going to stay on this course."

What also emerged across all three case sites is that most institutional strategies are geared toward realizing state level gains instead of directly meeting national needs. While less prevalent at Emory University School of Medicine, each of the institutions were clear about how they were helping to meet Georgia's health care needs. For example, even though the analysis includes two private institutions, all three of the medical school's website highlight the percentage of their graduates or residency trainees that are currently practicing in Georgia. While I expected the state to influence policy, I framed the state at the federal level, however the

local state seemed to have greater influence on institution-level strategy, at least as it concerns primary care (Agger, 2013). In fact, most of the respondents seemed to couch their answers about their institution's strategies in terms of fulfilling state health care priorities. A senior faculty member at the Morehouse School of Medicine provided this overview of the school's institutional strategy:

> Our new president and dean really wants to focus more on the rest of Georgia. Some of it is…trying to keep more of our Georgia physicians in Georgia. So, even just from that perspective, that's one of the reasons why Dr. Montgomery Rice talks about why class expansion is important, to have a more meaningful voice in the health of Georgia.

Even if the respondents were uncertain of the specific strategy, most used their familiarity with state imperatives to flesh out how they thought their institution would proceed. The senior faculty member and former curriculum committee chair at MCG said this when asked about the role of primary care in shaping MCG's strategic goals, "I don't know of anything specific in primary care from the institution's side for the State of Georgia, other than to say, 'We need more primary care people.'…It will influence our strategic plan."

While the general research questions guiding this study focused on national level politics, strategic action hinges on senior leaders leveraging any advantage and influence they have to jockey for power (Fligstein & McAdam, 2012; Toma, 2012). As such, senior leaders at the three case sites may be able to wield more power or realize the greatest immediate gains by focusing on state needs. Such strategy is not wholly misaligned with the ACA, as portions of Title V encourage community partnerships and other local level initiatives. For example, a health care career pathway is defined as a high-quality set of courses and services that, among other things, "is aligned with the needs of health care industries in a region or state" and priorities in funding are given to those institutions that partner with "state and local agencies" ("Patient Protection and Affordable Care Act," 2010a). Therefore, by focusing on the state of Georgia, the

administrators at each of the case sites are aligned with many of the legislation's aims to help the larger nation state.

Another area this study sought to clarify was how institutional strategy and curriculum change would be differentiated at diverse types of institutions. Specifically I posited that medical schools were already stratified and therefore curricular changes after 2010, the year the legislation was passed, and intuitional strategies (or lack thereof) with regard to ACA would reinforce existing stratification. While I found differences in terms of primary care training, there was not much change in the institutions' curriculum since the passage of the Affordable Care Act. The Emory University School of Medicine, which had undergone the most recent curriculum reform, began implementing the new the new curriculum in 2008, prior to the legislation being ratified. While I hypothesize that modifications to the curriculum were made during the four-year implementation phase (2008-2011), especially in 2010, the ACA was not the catalyst for Emory's curriculum reform. The Medical College of Georgia was in the first year (2014) of implementing a house system in order to group medical students with a mentor to allow for more communication, transparency, and connection to the institution. According the senior faculty member and department chair, the majority of the house mentors are primary care physicians, yet the program is not solely a primary care initiative nor was the impetus for the curricular change understood as a part of a larger response to the Affordable Care Act. Morehouse School of Medicine did not have any major curricular initiatives on the horizon, as the main focus was on expanding the medical school class and increasing donor support. As a result, the Affordable Care Act did not directly impact curriculum at the three case sites and thus did not seem to exacerbate stratification as evidence by the curriculum.

Based on the previous research, this lack of change to the curriculum is not unanticipated (Geiger, 2005). The Patient Protection and Affordable Care Act is a relatively new piece of legislation that is still being executed and there is a substantial amount of insecurity concerning the longevity of the law. A senior leader from the Morehouse School of Medicine commented on this uncertainty when discussing the school's strategy:

> The one thing about it-- and this is legislation, and you have a lot of uncertainty as to whether or not they're going to make effort to repeal something and keep something, so that is still kind of-- that's not something that we necessarily think about, per se.

The literature review shows that curricular change is rare because the curriculum is related to competitive dynamics and maintaining prestige (Bastedo, 2012; Bastedo & Gumport, 2003; Geiger, 2005). The medical curriculum has remained fairly impervious to change (Anderson & Kanter, 2010; Barzansky, 2010; Ludmerer, 1985) and while the ACA provided a shock to increase rhetoric and strategies concerning primary care training and education, it is still a plagued piece of legislation. Since the permanency of the legislation is uncertain due to threats of repeal, there is no apparent competitive advantage to broad based change to the medical education curriculum at this time (Bastedo, 2005; Slaughter, 1997).

Institutional strategy, which is more malleable than curriculum, revealed that stratification exists within medical education, and is being exacerbated by the Affordable Care Act. Interview participants at all three case sites had a clear sense of the medical school hierarchy in Georgia. This *de facto* acceptance of stratification helped many of the interviewees elucidate their understanding of their institution's strategy, as well as helped them hypothesize future strategic action in regards to primary care education. For example, the Emory School of Medicine dean noted that "HRSA here has relationships with Morehouse, as they should…I think that HRSA money is much more likely to help Morehouse than it is to help Emory." A

Morehouse School of Medicine faculty member summed up the in-state stratification like this: "When you think about it, Mercer and Morehouse are providing the bulk of the primary care physicians in Georgia, but Augusta and Emory are providing more of a traditional medical student output, which is more sub-specialty oriented." A senior leader at MCG noted that there were a number of economic forces at play causing faculty to spend less time teaching and more time doing clinical work, but then the interviewee quipped that, "I don't know about Emory. They have lots of money."

According to the guiding theory, the acknowledgement among senior leaders that an intra-state or field hierarchical structure exists frames social actors efforts with regard to improving organizational position (Fligstein & McAdam, 2012). Institutional strategy is about leveraging relationships for organizational gains, which entails forming collations and securing cooperation from others as well as capitalizing on environmental changes to improve position (Fligstein & McAdam, 2012). Incumbents are likely to let certain challengers realize small gains in order to help ensure long-term field stability. Additionally, most challengers in a field are seeking to garner as many resources as necessary to mimic incumbents and improve their position or reputation.

When comparing cases, Emory University School of Medicine was positioned as the most resource-rich and thus most elite medical school in Georgia. As such, many of the strategic initiatives at Morehouse School of Medicine and the Medical College of Georgia encompassed either forming tactical partnerships with or directly imitating some the structure and strategy at Emory. For example, one MSM faculty member stated that "As Morehouse has continued to mature, the relationship with Emory really has evolved. It really is much more cooperation than it is competition any longer." This sentiment was also reflected by an Emory dean who, in

discussing Emory's role in producing more primary care physicians and competing for federal dollars, held that "We don't really have a strong relationship with HRSA's [sic] side right now. Not that we don't want to, but they've got a partner. We respect Morehouse. I mean they're doing a good thing." There was an implicit acknowledgement that Emory would not compete with Morehouse in primary care, especially as it relates to some of the incentives in Title V of the Affordable Care Act. It could be surmised that because primary care is not a prestigious medical occupation, Emory has no real impetuous to actively increase its primary care focus. This *de facto* acceptance of field stratification allows Morehouse to pursue more federal grants and for Emory to appear cooperative.

The relationship between the Medical College of Georgia and Emory University School of Medicine is more complex given that one of the explicit goals for Georgia Regents University is to become a top 50 research university (Corwin, 2012). Thus, a part of MCG's institutional strategy is mimicking some of those actions that have made Emory successful, such as securing more NIH research funding and the state's second Nation Cancer Institute-designated Cancer Center (Corwin, 2012). The Georgia Regents University-University of Georgia medical partnership is about leveraging resources to increase training capacity, but also allows the MCG to increase its number of research scientists to help improve reputational rankings. Although MCG is imitating portions of the Emory organization, MCG's current institutional strategy is less about directly competing or unseating the Emory University School of Medicine. Instead the strategy is couched as being the best state school for medical education in Georgia (Millsaps, 2011). It can be argued, however, that since MCG is the only state medical school in Georgia, the institution is inherently the best state medical school in Georgia and thus the goal is frivolous. Yet, strategic action is about piecemeal and incremental changes to first mimic

incumbents, and then use those changes as leverage to improve overall field position (DiMaggio & Powell, 1983; Fligstein & McAdam, 2012; Toma, 2012).

While the comparative case analysis highlights intra-state stratification, it also foregrounds that different types of institutions are responding to the incentives in Title V of ACA through varied means. As proposed in the initial research questions, as an elite institution Emory University has the flexibility to respond to certain incentives without significant changes to larger institutional manifest or latent goals. Alternatively, Morehouse School of Medicine's historical connection to primary care necessitates that the school's leadership respond more directly. Although the MSM does not currently have a specific Affordable Care Act strategy, this institution stands to gain the most from having a robust plan for securing the largest amount of national funding as possible. While Emory University has more flexibility to determine if and what incentives the school will actively pursue, the Medical College of Georgia does not yet have that luxury. As the state's medical school, MCG is directly capitated to address state health care needs, which currently involve increasing the primary care physician workforce. While HRSA's funds are less desirable than NIH funding in terms of helping the MCG reach the goal of being a top-50 research institution, the need to diversify revenue streams in a time of constrained state appropriations and resistance to tuition increases may compel MCG to develop a more robust narrative around and the state's need for more primary care.

Emergent Theme

What emerged from the interviews is that Title V –Health Care Workforce fails to address the entrenched negative perceptions of being a primary care physician. Historically, primary care has the lowest prestige among allopathic medicine specialties, for myriad reasons including low pay in relation to debt load (Bennett & Phillips, 2010; Jolly, 2005; Steinbrook,

2008). Beyond low pay, what surfaced during the interviews is that many students, faculty and physicians find primary care work unappealing. As one Emory senior leader, who is a primary care physician by training, noted rather simply, "Medicine [referring to primary care] is hard." The Affordable Care Act does not go far enough to incite change in a primary care physician's lifestyle, thus continuing the trend of making it difficult for medical schools to adequately train enough students for this career track. The MCG department chair, who teaches and practices in a primary care specialty reflected on the perceived challenge in keeping students interested: "They [medical students] see that…they [primary care physicians] work very hard but they don't get, especially at academic institutions, the same prestige and the same salaries and the same recognition as some of our specialists." Even the faculty and staff at MSM, the institution whose mission is most closely aligned with primary care, find that "Our challenge is to make primary care attractive enough that they will see that as something that they can do and that they will enjoy doing."

Strategic Action Fields would suggest that since few medical schools have built a reputation in primary care, medical students are responding to the strategies of medical leaders and pursuing those career paths that are valued within their profession (Fligstein & McAdam, 2012; Freidson, 1986). Therefore, the difficulty does not exist in changing the rhetoric around the usefulness of or need for primary care, which the Affordable Care Act does, but in making the career path more attractive to encourage new strategic action, which the legislation fails to do. In fact, some of the interviewees commented that the Affordable Care Act maybe exacerbating the problem. The push toward electronic medical records, the influx of patients needing primary care and the stagnant growth of the primary care workforce are ways that the ACA is intensifying the lack of appeal of primary care specialties for allopathic doctors thereby

diminishing the likelihood that a significant number of medical schools will change their strategies in favor of primary care (Bastedo, 2005; Fligstein & McAdam, 2012). Lastly, because so many of the incentives are aimed at increasing the supply of primary care workers in the allied health and nursing professions, the legislation may also be sending an unintentional message that primary care work is not necessarily the type of work physicians need to do (Abbott, 1988; Brint & Brint, 1996).

Conceptual Findings

The examination of how institutional strategy and curricula at schools of medicine are modified or even created in response to federal legislation yield important findings related to this study's research questions. Specifically this study revealed that different types of medical schools are responding to Title V of the Affordable Care Act in varied ways. A significant portion of this variance in response to the legislation can be explained by broadening the discussion to consider the overall hierarchy of US public and private universities.

Guiding my understanding of stratification in medical education is Taylor's analysis of the increasing stratification within the field of research universities (Taylor, in press). Pulling heavily from international ranking systems, instructional capacity measures (e.g. faculty per 100 full-time equivalent) and research capacity (e.g. R&D expenditures per FTE), Taylor used multi-year latent class analysis with research dollars as the dependent variable to created four classes of public universities and four classes of private institutions that were standardized, but in which membership could fluctuate. The analysis found changes in the hierarchy of public universities over an eight-year period but, by contrast, the membership in the classes of private research universities was fairly stable. The author concluded that the greatest driver of this growing stratification was research revenue, specifically federally sponsored R&D. He tied this

stratification to policies of the "submerged state" and its tendency to allocate funds via competitions or invisible benefits such as tax credits, the majority of which tend to favor elite universities. (Taylor, in press). Thus, Taylor recommends that administrators' strategic actions be understood in the context of rapidly increasing stratification.

As Taylor (in press) outlines, externally sourced research funding, especially federally sponsored R&D, is associated with status and determines a university's class membership. Emory University is an elite private university, which Taylor considers to be a fairly stable university class, due to its capacities for instruction and substantial support for research as evidenced by the large representation of doctoral students. By comparison middle class public universities, of which Georgia Regents University would likely fall due to its relatively low tuition levels, reliance on state government for funding, and modest research revenues, make up the most volatile strata, with the tendency to move down in classification because, on average, they are not as well-resourced to compete for federal and public funds consistently (Taylor, in press). Although the Morehouse School of Medicine does not have an undergraduate component and thus does not fit neatly in Taylor's classification structure, I suggest it would be considered a tuition-focused elite, because research revenues play a relatively minor role in the school's operations and practice less selective admissions than peer institutions (Taylor, in press) .

In addition to research revenues driving stratification Taylor infers that a hierarchy exists in the preferred types of allocations that is also underscoring institutional strategy. While amassing additional funding is essential to improving a school's ranking and reputation, federal dollars confer more status than state allocations, and tuition dollars are among the least desirable funding sources (Taylor, in press). Even within the realm of federally sponsored R&D, some granting agencies, such as the NIH or Department of Defense, carry more cachet than awards

from other federal agencies, such as HRSA. This hierarchy in funding types and sources provides a possible explanation as to why none of the case sites in this study have developed a robust strategy regarding Affordable Care Act funding since the granting agency is HRSA. Yet, as the research shows, the need to increase funding and secure any type external funding is essential to higher education strategic action, and thus may compel a middle class college such as the Medical College of Georgia at Georgia Regents University or a tuition-focused elite, such as Morehouse School of Medicine, to actively pursue the ACA funding in the near term.

This study also brings to the foreground how mandates to meet state demands makes it difficult for public universities to compete with elite private institutions for R&D resources, faculty talent and even top students (Taylor, in press). Due to the robust research agenda and the heft of their endowments, elite universities are better able to diversify their resource and research streams, giving strategic leaders a level of flexibility to pursue new ventures, but also the luxury to primarily seek those funds that help to maintain or increase overall prestige. Middle class public universities are so beholden to state funding that it is challenging for senior leaders to allocate funds or time to rigorously pursue a plethora of competitive research grants that are not directly tied to state priorities. For example, while somewhat advantageous for the Medical College of Georgia administration to pursue the Title V ACA funding aimed at meet state needs, the administration's response will be delayed due to the need to first establish a unified institutional identity and then align strategic priorities with this new identity and state mandates.

While the Medical College of Georgia will eventually compete for the Title V Affordable Care Act funding, I suggest that it will be more difficult for the institution to be successful because other universities, especially the elite universities, will have had the time to create more nuanced strategies. For example, a nuanced strategy for Emory University School of Medicine

entails securing ACA funding that supports current primary care initiatives. In Title V, Subtitle D, money has been allocated for schools to offer Continuing Medical Education (CME) courses relevant to providing care through patient centered medical homes ("Patient Protection and Affordable Care Act," 2010a, pp. 1317-1318). Emory currently offers a plethora of CME courses, many of which are in primary care and the interviewees commented that the patient center medical home is seen as a potential growth area for the clinical arm of the school. Thus, obtaining an ACA grant to expand CME offerings allows Emory to support primary care training and enhancement without a drastic departure from its own prestige-oriented strategy. Additionally, priorities in ACA awards are given to schools that already have relationships with HRSA, which compels schools to enter the foray early, as in the potential case of Emory, or play up existing relationships, as in the case of Morehouse.

By contrast, this study also illustrates how having a narrow research agenda or mission, as in the case with the Morehouse School of Medicine, may make it difficult to compete with elite colleges for grants across a broad spectrum. While tuition-focused elites may have more discretionary funding to potentially allocate to exploring new granting opportunities, these institutions typically are more centered on instruction or only have a narrowly defined research agenda (Taylor, in press). For example, the majority of the research, resources, and training at Morehouse School of Medicine have been directed toward primary care to the detriment of other, more research-inclined areas or medicine such as dermatology and ophthalmology (there are no faculty in these areas). Thus, the school lacks the depth of faculty to diversify the research agenda either too broadly or too quickly. By contrast, the Emory University has a robust and nationally recognized research agenda spanning multiple, research intensive areas of medicine and health care. Therefore, Emory truly opt out of pursuing much of the Title V ACA funding

but the strategic leaders at the Morehouse School of Medicine must capitalize on this current health care environment that favors primary care before national priorities shift.

Implications for Research

This study examining how federal legislation informs, modifies, or establishes curriculum reform and institutional strategy yields insights unique to medical education strategic action, and is also relevant to other facets of higher education. Findings from this dissertation support and add to the existing literature on the pervasiveness of stratification in higher education as well as how stability and change are achieved in the field of medical education. Interview participants used their *de factor* acceptance of stratification within medical education in Georgia to frame effective strategic action in response to Title V- Health Care Workforce of the Patient Protection and Affordable Care Act. The research supports the current literature that curriculum changes in response to market dynamics are slow to materialize and that institutional strategies are more malleable, providing clues to what, if any changes to curriculum, might eventually occur. The study also reveals some of the challenges institutional leaders face in expanding or changing their current research agenda to compete with more resourced or elite institutions. The research participants also coalesced around the idea that while the ACA is helping to change how the public views the role of primary care in meeting societal needs, the legislation stops short of helping educators increase the perception of primary care among medical students. This fact highlights the challenges the nation will continue to face in ensuring an adequate primary care physician supply. Ideally this research will contribute to the literature by modeling how higher education frameworks can be applied to understanding phenomenon occurring in graduate and professional education, thereby extending our knowledge of how these portions of the university contribute to the academic enterprise.

There are other possibilities for future research stemming from this study. First, researchers could replicate this study across states to further flesh out the variations in the way institutional strategy is set and implemented based on state needs. Further research, after the 2016 presidential election, may continue to highlight how strategy changes in a new political environment. Additional research across subsets of medical schools, such as middle class universities or super elite institutions, may reveal how administrators frame their strategy in response to their peer group or immediate competitors, providing insights to the overall complexities of setting and implementing a broad institutional strategy that must address multiple needs and constituencies.

Further exploration of graduate and professional education, specifically medical education, offers multiple opportunities for research. This study identifies the similarities between happenings on the undergraduate and graduate and professional sides of academia, leading for a general broadening of the scope of higher education research. Additionally there are current debates rising in higher education, such as the reliance on adjunct faculty that parallel happenings in medical education (i.e. the use of and reliance on of clinical faculty) that might provide insights on how to research mutual beneficial solutions.

Lingering Questions

This research study also raised new questions about the intersection of politics and institutional strategy, the rebranding of primary care as a desirable profession and the increasing responsibility of allied health professionals in addressing the nation's primary care needs.

Although this research study focused on federal legislation, the interview protocol did not ask specific questions concerning the interviewees' political affiliation or support of the legislation. Thus politics were screened out of the formal discussion. Building off the work of

Dupree (2013), whose study aimed to elucidate of how policymakers utilize various information sources in crafting higher education tuition policies, it would be interesting to examine the extent to which the current political environment informs how institutional leaders establish strategy. Especially, how do collegiate administers use political happenings to justify strategic action? This is a particularly relevant question when considering public universities and the varied higher education governance arrangements (i.e. governing boards versus coordinating boards, etc.).

One of the emergent themes of this study is the overall difficulty of primary care work. The laborious nature of primary care is viewed to be one of the many reasons why primary care specialties have struggled to garner a modicum of professional prestige. While it can be inferred from the current literature that primary care needs to be rebranded (although no particular author uses this terminology) the question that remains unanswered is which entity should champion the task? As this study shows, the Affordable Care Act effectively highlights the societal need of primary care, but the authors fail to address the day-to-day work and processes that make it an unattractive specialty choice. As such, what additional policies are needed to move the needle to incentivize more physicians to pursue primary care? Is it possible to make the work more attractive? If so, should the "rebranding" of primary care occur at the university level as this is the first place students are formally exposed to all facets of the medical profession, or is this something that should be aggressively addressed within medical professional organizations such as the American Medical Association or the Association of American Medical Colleges? Should the federal government bear the brunt of the rebranding given the passage of the ACA, or will it take some combination of all three entities championing the task for change to occur? Additionally, beyond more students pursuing primary care, I am also struck by what metrics

would be used to define a successful rebranding strategy and what would a successful implementation strategy entail?

Lastly, I wrestled with the increasing role of allied health professionals in meeting the nation's primary care needs. The induction I conducted as a part of the documents analysis of Subtitle A, which provides an overview of the content of Title V- Health Care Workforce, reveals that physicians are largely screened out of the discussion. Yet, 14 distinct healthcare or allied health professions are mentioned and repeatedly highlighted throughout the entirety of Title V in regards to loan forgiveness, expanded training options, continuing education and other areas to drive this group of professionals toward actively pursuing primary care careers. The same provisions are not so readily available for physicians. Additionally, many of the interviewees noted that the majority of the incentives, especially those that dictate where people live or the time of service to pay back loans, are not attractive to physicians. As such, physicians may be inclined to pursue higher paying specialties with fewer restrictions as opposed to fully considering the government payback options. Yet, allied health professionals may not have as many alternatives as physicians to reduce debt or increase pay. Thus, should this omission of medical doctors from much of Title V be viewed as an implicit signal that the authors of the Affordable Care Act and other health care leaders view primary care as something that should be addressed by allied health professionals? If physicians will continue to take this *laissez faire* approach to primary care, what does this mean for medical doctors' overall role in the health of the nation and their influence over future health care policy, especially policies directed toward primary care?

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APPENDIX A

INTERVIEW PROTOCOL

Opening Statement

Thank you for agreeing to participate in this research study concerning institutional strategy in addressing the need for more primary care in the era of the Affordable Care Act. The series of questions will focus on the current role primary care has in shaping your institution's student recruitment and residency placement goals, faculty and institutional research agenda, and curricular offerings. You will also be asked about the ways in which your institutional strategic goals may or may not change as a result of the incentives available through Title V – Health Care Workforce of the Affordable Care Act.

This interview **will/will not** be audio recorded (*based on the participant's consent form*) and later transcribed. Participation in this interview is voluntary. If, at anytime during the interview you no longer wish to participate, please let me know and I will stop the recording device and stop taking notes. There will be time at the end of the interview to ask me questions you may have concerning the research study or how the data will be used.

Interview Questions

1. Tell me about how your role influences the school of medicine's institutional strategy, curriculum, student and faculty recruitment goals, grants and contracts, or research agenda?
2. What has been the role of primary care (family medicine, general internal medicine, or general pediatrics) in shaping your school of medicine's strategic goals as it relates to curriculum content, student and faculty recruitment, clinical teaching, and research?
3. What are the greatest areas of opportunity for your school of medicine under Title V of the Affordable Care Act?
    a. If participant answers that they do not see any opportunities ask why (s)he believes this to be the case and skip to question 4.
4. How will the available financial incentives in Title V of the Affordable Care Act help to facilitate your institution's development in these specific areas?
    a. If the participant is unaware of the incentives, the interviewer should provide examples of each of the different types of incentives available.

   b. How will you prioritize these new strategic initiatives and why is this the particular order of importance?
5. What opportunities presented by Title V of the Affordable Care Act do you believe are outside the strategic goals for your school of medicine?
   a. If the participant answers that none of the opportunities are outside of the institution's strategic goals ask why (s)he believe they believe this to be the case.
6. How will the availability of new federal grants and contracts to schools of medicine "who train the greatest number of physicians who enter and remain in primary care" influence your school of medicine's student recruitment strategy and your undergraduate medical school curriculum?
7. In what ways will the increase in funds to forgive medical school loans for physicians entering into primary care or who are willing to practice in medically underserved areas" influence your student body's specialty or subspecialty choices?
   a. If the participant thinks it will increase their student body's matching in these areas ask how the school of medicine will respond to support these student interests?
   b. If the participant responds that it will not change their study body's match preferences ask them why they believe this is the case?
8. How will the availability of new federal grants and contracts to schools of medicine "who improve clinical teaching and research in primary care or enhance training and faculty development in primary care" influence your institution's strategic goals concerning faculty recruitment, research and professional development?
   a. Why do you think this is the most appropriate strategic response?
9. What are the challenges your school of medicine will face as a result of the explicit focus of Title V of the Affordable Care Act to increase the primary care work force?
   a. What is your institution's strategy to address these specific challenges?
10. Are there topics or areas concerning your institution's strategic response to Title V of the Affordable Care Act that we have not covered that you wish to discuss?

Closing Statement

We have reached the end of my questions concerning your institution's strategy in response to the Affordable Care Act. What questions do you have for me concerning this particular research study?

You may receive a transcript of your interview in the future via email. If you choose, you can review the transcript and make changes or edits. You can also use that time to ask additional questions or provide clarifying information. This is an optional process and you may choose not to provide any edits. Again, thank you for your participation.