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Family Medicine

PRESIDENT'S COLUMN

Using Our Agency–Pushing Forward and Pushing Back

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The specialty of family medicine is the fruit of a health care system reform movement that is ongoing. Providing primary care services to people is what we do, but advocacy for patients and communities is a major reason why family medicine exists. The introductory definition of our specialty in the Accreditation Council for Graduate Medical Education (ACGME) program requirements stresses our advocacy in advancing health equity for all, promoting social justice and ethical principles, and contributing to health policy on the local level and beyond.[1]

Long-standing movements are often catalyzed by tipping-point events. Are we in such a time right now?

The CEO of UnitedHealthcare was brazenly targeted and gunned down on a Midtown Manhattan street; what followed was intense pent-up anger expressed online against the health insurance industry, with thousands of posts about denied coverage leading to avoidable suffering and/or deaths.[2,3] On the physician front, nearly 300 primary care physicians employed by Massachusetts General Brigham notified the National Labor Relations Board that they want to form a union[4]; at another academic hospital 800 residents announced their intention to join a resident union, a rapidly growing phenomenon.[5] Private equity's role is now in the public's consciousness with (ironically named) Steward Health Care's recent bankruptcy in Massachusetts. Years of wealth extraction from community-provided assets to enrich their leaders has led to hospital closures and sell-offs, further harming already underserved communities.

Nationally, a recent Gallup poll[6] shows Americans' rating of health care quality is the lowest in 24 *years*, with a majority rating quality as fair (38%) or poor (16%). Health care insurance coverage is rated even lower with only 28% rating it as excellent or good, and only 19% are satisfied with its cost.

Our own specialty is also in a tumultuous period requiring targeted and sustained advocacy efforts. Hospital administrations at Boston Medical Center (BMC) and West Suburban Medical Center near Chicago announced policy decisions negatively impacting family physicians delivering maternity care. This resulted in petitions signed by the greater family medicine community. Over 1,300 signatures within several days from family physicians nationwide helped convince the BMC administration to reconsider, a remarkable departmental leadership achievement by two STFM past presidents there, with the help of many others. The need is great for effective family physician advocacy skills—sometimes offense, oftentimes defense—during what may be an ongoing slow collapse of our nation's health care system.

On top of all that, this month our nation will have a new presidential administration and a new Congress, creating new opportunities and new challenges. To name only a few, "Make America Healthy Again" related initiatives, changes affecting Medicare, Medicaid, and Affordable Care Act coverage, state oversight of reproductive services, deregulation, attention to skyrocketing pharmaceutical prices, and the selection of nontraditional health care-related agency leadership at the Department of Health and Human Services (including the National Institutes of Health, Food and Drug Administration, and the Centers for Disease Control and Prevention) are all in play. The continued ubiquitous growth of artificial intelligence requires much thought about its policy implications and the role of regulation while providing new opportunities for family medicine. Most other policy changes (eg, climate, immigration, energy, criminal justice, law enforcement, diversity, equity, inclusion, and accessibility) also have significant health-related implications. Regardless of policy agreement or disagreement there will be uncertainty and disruption of the status quo, resulting in numerous opportunities for active advocacy.

What is the role of STFM in this milieu? Our board of directors believes we have a large responsibility to do what we can to help prepare effective family physician advocates. STFM's advocacy-related first goal in the 2025 Strategic Plan is that "STFM will champion family medicine education, research, and workforce recruitment and retention by equipping family medicine educators and learners with skills to advocate for

issues important to the discipline, their communities, their practices, their patients, and themselves." Our second major goal is to advocate for family medicine writ large. This includes partnering with other organizations to increase primary care investment and workforce; identifying and advocating for education research funding; and leading the Academic Family Medicine Advocacy Committee's work (currently chaired by Winston Liaw, MD, MPH) in its legislative or regulatory priorities. The Council of Academic Family Medicine's Director of Government Relations Nina DeJonghe, MPP, expertly leads our implementing these efforts.

What is your role as a family medicine educator in teaching advocacy? Advocacy skills are important to teach on personal, practice, community, local health system, and policy levels. Family medicine was the second specialty (after pediatrics) to require advocacy ACGME milestones that specifically articulate (under Systems-Based Practice) resident formative development in system navigation and fulfilling the family physician's role.[7] ACGME advocacy-related program requirements include ensuring residents demonstrate competencies in advocating for quality patient care and optimal patient care systems.[8] We need to further develop competency-based training in this area to help our learners create a better health system for themselves and their future patients.

Formal advocacy curricula in our residencies are still lacking, with only one-third of program directors in a 2020 study[9] reporting a mandatory advocacy curriculum. This is probably even an overestimate due to self-report bias. In some residencies the mandatory curriculum was as little as 1 hour of didactics. Most residencies focused on community advocacy, which is a great place to start. To improve advocacy training, perhaps one faculty member in each residency (and medical student education division) can serve as a designated advocacy champion. If you are reading this, it could be you.

To make this easier, STFM offers free, readily available, off-the-shelf online advocacy curricular support, both on the health systems level[10] (which includes analyzing health systems data) and training in legislative advocacy skills.[11]

We need to articulate to our learners why family medicine organizations and political action committees (such as FamMedPAC) matter in advocacy. We need to strongly encourage they become American Academy of Family Physicians (AAFP) and state chapter members after residency graduation. Supporting attendance at the AAFP Family Medicine Advocacy Summit held each spring in Washington, DC can be career-changing. Advocacy can serve to diminish feelings of burnout, particularly due to moral injury, by using one's agency as a physician to give voice to patients' and one's own needs. With guidance, intraorganizational advocacy within our own challenged institutions is also a good place to start. We can also explicitly encourage engaging with a non-family medicine advocacy organization that best fits interests and beliefs.

To close, two writings in particular inspire me in my own advocacy efforts. The first is Robert F. Kennedy's speech to the youth of South Africa,[12] that includes four inhibiting "dangers" that impede advocacy: of futility (the belief that there is nothing one can do); of expediency (that hopes and beliefs must bend before immediate necessities); of timidity (the lack of moral courage); and of comfort (the temptation to follow the easy and familiar path of personal ambition and financial success).

And written more recently, Donald Berwick's commentary[13]:

> The work of a physician as healer cannot stop at the door of an office, the threshold of an operating room, or the front gate of a hospital. The rescue of a society and the restoration of a political ethos that remembers to heal have become the physician's jobs, too. Professional silence in the face of social injustice is wrong. It is chilling to see the great institutions of health care, hospitals, physician groups, scientific bodies assume that the seat of bystander is available. That seat is gone. To try to avoid the political fray through silence is impossible, because silence is now political. Either engage, or assist the harm. There is no third choice.

A millennia-old saying comes to mind. "If not us, who? And if not now, when?"

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