Advocacy and Self-Reliance

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(Fam Med 2013;45(6):443-4.)

For over a decade, our discipline has invested substantial time and treasure in building an ambitious advocacy program. Our national and state academies have advocated in the public sector at the local, state, and national level for health reform and the patient-centered medical home (PCMH). In the private sector, we have established the Patient-centered Primary Care Collaborative with business leaders and other medical organizations seeking better reimbursement for primary care. Our academic organizations have joined together through the Council of Academic Family Medicine (CAFM) to advocate for family medicine residencies, an increased emphasis on primary care in medical schools, and for primary care research funding. We have developed a training program to teach faculty and residents about how to advocate for family medicine and started an annual Family Medicine Congressional Conference to carry our message to the highest levels of national government. Along the way, we have learned that effective advocacy is an ongoing challenge that takes years of persistent work.

These efforts have produced major accomplishments. Health reform legislation passed the US Congress and was signed into law by the President. Both public and private insurers have begun to pay for expanded primary care services in the PCMH. Many states are reforming their Medicaid programs using the PCMH, and health care systems are again investing in primary care. Advocacy has been a major pillar of our discipline’s strategic plan and forms a keystone of STFM’s vision for academic family medicine. I have supported these efforts for years. And yet I remain ill at ease with the notion of advocacy on such a grand scale, and it has been hard to put my finger on exactly why. Perhaps I would like our work to be noticed and appreciated without having to call attention to ourselves. Maybe I suffer from a reticence to seek acclaim that harkens back to more innocent days, but I suspect that I am not alone in feeling this way. I had trouble articulating this concern until I recently had occasion to re-read Emerson’s essays on Self-Reliance and Compensation. These essays, written in 1841, became major building blocks in the foundation of the American character. I have read them repeatedly over the years and find them inspiring. They speak to the importance of the individual and of independent thought and of the danger inherent in seeking the approval of others. Reading them again reminded me that I chose family medicine, in part, because it is medicine’s most self-reliant discipline and that self-reliance is essential to our being able to practice in communities where there are few other resources. In Self-Reliance, Emerson writes:

“What I must do is all that concerns me, not what the people think. This rule, equally arduous in actual and in intellectual life, may serve for the whole distinction between greatness and meanness. It is the harder, because you will always find those who think they know what is your duty better than you know it. It is easy in the world to live after the world’s opinion; it is easy in solitude to live after our own; but the great man is he who in the midst of the crowd keeps with perfect sweetness the independence of solitude.”

Any successful organization must balance its attention between the inward and the outward. I am not suggesting that we reduce our advocacy efforts, but effective advocacy works...
by altering the perceptions of those we are trying to influence, and this requires an outward focus. Attending national meetings sometimes feels like we are all standing in a circle facing outward trying to convince people outside of our discipline to understand us, to respect us, and to reward our efforts more generously. Too much inward focus risks narcissism, but too much outward focus threatens self-reliance and, without self-reliance, family medicine begins to look like any other special interest in the medical crowd. If we focus too much attention on what others think or do, we risk paying too little attention to what we need to change ourselves—and this could be a real problem because the evidence strongly suggests that primary care needs to change a lot for real health reform to succeed. This is not to say that we have entirely neglected self-improvement. We have installed new electronic health records, participated in medical home demonstration projects, and worked to develop team-based care. We have initiated a Conference on Practice Improvement and supported demonstration projects on the PCMH. But we talk a great deal about what we need from others and in doing so, we imply to a generation of young family physicians that the solutions to our problems lay outside, not inside our discipline. In reality, this might not be the case.

Now we stand at the threshold of receiving better payment, and we will soon be faced with trying to prove that this increased payment for primary care will produce the holy grail of better outcomes and patient experiences with lower total cost. Will this grand experiment work? Are we ready for the task? Be careful in choosing your answer, because we thought the experiment of managed care would work in the 1990s, and that is not what the judgment of history tells us about that period. It is certainly true that we have far more tools this time around. Data from electronic information systems have the capacity to help us recognize patients at risk earlier in the process. The use of teams can expand the power of continuity of care and allow us to reach patients in far more creative ways than we could 15 years ago. But do we really know what to do with these data or how these teams should function?

STFM’s vision is to be “the indispensable academic home for teachers of family medicine.” A home should be a place where we tell each other the truth, even when it might not be easy to hear or to say. While we cannot afford to cease our advocacy efforts, it is time to balance them with a renewed focus on the quality of the products we produce. Our practices must achieve the full promise of the PCMH, and our educational programs must produce graduates capable of doing this work at the highest level. This needs to occur in every practice, every department, and every residency; and no one else can do this for us.

For over 40 years, practicing family physicians have supported our academic programs by teaching our students and participating in practice-based research efforts. It is now time for our academic programs to repay them by developing the tools needed to rigorously evaluate outcomes and by producing new graduates who can contribute immediately to the change process. Seizing the future will require a willingness to question everything about our daily work, to admit that we are far short of where we need to be, and to engage the next generation in the most important work there is in American medicine at this moment in history. Consider Emerson’s words in the essay on Compensation:

“Our strength grows out of our weakness. The indignation, which arms itself with secret forces, does not awaken until we are pricked and stung and sorely assailed. A great man is always willing to be little. Whilst he sits on the cushion of advantages, he goes to sleep. When he is pushed, tormented, defeated, he has a chance to learn something; he has been put on his wits, on his manhood; he has gained facts; learns his ignorance; is cured of the insanity of conceit; has got moderation and real skill. The wise man throws himself on the side of his assailants. It is more his interest than it is theirs to find his weak point.”

References

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