The STFM Presidential Themes: Leadership and Advocacy in Academic Family Medicine

Jerry Kruse, MD, MSPH

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I am energized by the things that have been accomplished in the past year at STFM. As my presidential theme, I will continue the theme of leadership and advocacy begun by Jeri Hepworth, PhD, immediate past president of STFM. In the current health care and educational climate in America, leadership and advocacy skills for family medicine educators are more important than ever.

I am also particularly energized to be an STFM representative to CAFM, the Council of Academic Family Medicine, an organization of the leaders of the four academic family medicine organizations: the teachers—STFM, the residency program directors—the Association of Family Medicine Residency Directors, the researchers—the North American Primary Care Research Group, and the department chairs and administrators—the Association of Departments of Family Medicine (ADFM). I am energized to be a member of CAFM at a time when a strong, unified voice from academic family medicine is essential as health care and education are transformed to meet the future needs of our country.

I have been fortunate to serve my academic career at two institutions that are dedicated to both educational innovation and to practice transformation. I was a learner at the University of Missouri at Columbia in the 1970s and 1980s. I learned from mentors like Jack Colwill and Jerry Perkoff, and I learned with many colleagues who subsequently have played key roles in advancing the teaching and scholarly activities of family medicine.

My current academic home is the Southern Illinois University School of Medicine. SIU was founded on the principle of continuous educational innovation. Through 40 years of innovation, the motto at SIU has been this: “If it ain’t broke, make it better.”

As an STFM Board member, I have learned that this is also the philosophy of the leadership and of the staff of STFM—a philosophy of continuous innovation and improvement—a philosophy that has given vibrancy to the organization and a positive energy to transform healthcare through education.

The governance, executive, and management functions of STFM have moved this organization forward by the articulation and implementation of a new strategic plan that positions STFM as the leader in training, in leadership development, and in the creation of new information that improves family medicine education. The team in Leawood, KS, led by Executive Director Stacy Brungardt, CAE, has a vision for innovation and is always willing to take the risk to do it better.

This vision is now being realized through a large number of new and continuing STFM initiatives, like those listed below, that give support to the essential functions of family medicine educators. Here are four of over 40 initiatives found at www.stfm.org:

1. CERA, a national educational research alliance—www.stfm.org/initiatives/cera.cfm
2. The Residency Competency Assessment Toolkit—www.stfm.org/rc toolkit/
4. Teaching Physician.org, a resource for community preceptors—www.teachingphysician.org/

My presidential function in this area is an easy one: to encourage creative people who are working collectively to make STFM the
indispensable academic home for all family medicine educators.

The more difficult issues for STFM and for the discipline of family medicine are external to our organization. The continuum of medical education is disjointed. Health care in the United States is fragmented, costly, and relatively ineffective. Neither the educational system nor the delivery system encourage careers in family medicine.

I am a member of the COGME, the Council on Graduate Medical Education. COGME advises Congress and the Secretary of HHS on issues related to the physician workforce. At COGME, we hear the latest information from researchers, economists, and other experts.

David Walker was previous head of the Government Accountability Office. He is a brilliant analyst whose economic predictions are almost always right on target. This is what Walker had to say to CBS news (www.cbsnews.com/2100-18560_162-2528226.html): “US health care costs are number one in the world. We spend 50% more of our economy on health care than any nation on earth... We have above average infant mortality, and below average life expectancy... We’re gonna have to dramatically and fundamentally reform our health care system over the next 20 years. If we don’t, it could bankrupt America.” It’s Walker’s opinion that health care costs are the one thing that can bring the US economy to its knees.

This spells trouble for all Americans. This spells urgency for family medicine educators. And this spells opportunity for family medicine educators, opportunity like we have never had before.

What do we know about these opportunities? We know that when the patient-centered medical home (PCMH) incorporates the four essential functions of primary care, health outcomes improve and costs go down dramatically.

From the TransformMed National Demonstration Project, we know that incorporation of the effective elements of the PCMH occurs when there are prospective financial incentives to do so.

From the work of Kevin Grumbach and Paul Grundy at the Patient-Centered Primary Care Collaborative, we know that structured systems of care coordination and high-functioning data management systems improve outcomes and lower costs (www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf).

From COGME and from our colleagues in Canada, we know that substantial financial incentives for care coordination transform practices and influence student career choice to achieve the balanced workforce we need.

At STFM, we know, and we profess, that family medicine education is at the heart of health care transformation.

At STFM, we know, and we profess, that our government, our colleagues, our students, and our patients look to us to develop a well-trained workforce to serve as the foundation of the health care system.

So, STFM must take a more aggressive position of external leadership to develop alliances that will bring forth the changes needed to influence career choice of students and transform our practices and our educational environments.

The first alliance in this essential process is within our own discipline, CAFM. CAFM has helped unify academic initiatives in family medicine. For example, CAFM recently endorsed a process to develop a curriculum to educate and empower family medicine teachers to lead change to transform their practices, curricula, and institutions. STFM and ADFM are taking the lead to make this essential step a reality. Also, the advocacy arm of CAFM has developed an initiative to systematize advocacy efforts in each of our departments and residency programs through the CAFM Advocacy Network (www.stfm.org/advocacy/network.cfm).

Most importantly, CAFM has provided the structure for academic family medicine to have a united voice, a voice that is now developing and gaining strength. Advocacy for health care system transformation and advocacy for better education are intimately linked. CAFM and the American Academy of Family Physicians have their own legislative and advocacy priorities, but when appropriate, we unite our voices to achieve and sustain the transformation in health care practice and education that is needed.

We must also have the ear of legislators and regulators and become their go-to resource. Faculty development in governmental advocacy must be a top priority.

We must be the partners of business and industry and of health care insurers. We must work with them to design a pervasive system of community-based care that unites primary care, mental health care, and public health under the roof of the PCMH, and that ensures the financial incentives that support the education in this environment that is so desperately needed.

Academic family medicine must work with accrediting agencies and licensing boards to improve the continuum of medical education.
Organizations like the National Board of Medical Examiners, the Liaison Commission on Medical Education, the Accreditation Council on Graduate Medical Education, the American Board of Medical Specialties and its various specialty boards, and the Federation of State Medical Boards all have influence on the length and continuum of medical training, but collectively they have not been successful in producing a smooth continuum. COGME has called for Congress to convene a summit of accrediting, certifying, and licensing bodies to do just that. STFM should help facilitate this process.

To do these things, STFM must take the lead to develop the leaders of the future for family medicine. There are many ongoing STFM initiatives for leadership development. But we still need more leaders. I have two examples.

First, there are many leaders among us who are in hiding. My personality is one of an introvert, and I never sought leadership positions. Early in my residency I was described as “painfully quiet.” A turning point in my career occurred a few years ago at an ADFM meeting. I was approached by the presidential triad—Mark Johnson, MD, MPH; Sam Matheny, MD, MPH; and Warren Newton, MD, MPH. They asked me to chair the ADFM Legislative Affairs committee. I responded that I had no experience in either advocacy or legislative affairs. They responded that they had noticed the way I analyzed and presented information and that I would excel in this capacity.

I accepted, had the good fortune to work with Hope Wittenberg in the Governmental Relations office, became chair of the STFM Legislative Affairs committee, then the Academic Family Medicine Advocacy Committee, and then was appointed to COGME. None of this may have happened had the ADFM leaders not encouraged me. We all need to look for leadership capability in those who would not naturally step forward, and we all need to step forward when asked.

Here is the second thought on leadership. The new generation of students, residents, and family medicine educators has a new set of leadership skills, based on information technology and group dynamic. They will lead in a vastly different way than previous generations. We see them every day at home. We see them at our annual meetings. We must recognize them, understand them, and support them.

American health care is in peril. The situation is urgent. Family medicine past, present, and future provides the best solution. Twice before there have been waves of popularity of careers in family medicine for medical students, peaking near 1980 and again near 1997. Unfortunately, interest waned after both of these peaks (Strike One and Strike Two). Starting in 1998 and continuing to 2009, there was a dramatic fall in interest in primary care in the United States, likely because of societal attitudes and falling primary care income relative to specialty income. This fall in interest has coincided with the rapid increase in health care costs and the relative worsening of health care outcomes pointed out by David Walker.

But, in the past 2 years, there are the first signs of improvement. Since 2009, there has been a modest increase in student interest in careers in family medicine. In the 12 months ending in March 2012, health care spending as a percentage of GDP has leveled, and the health care price inflation rate is at its lowest level in 40 years. Now is the time for family medicine educators to seize the attendant opportunities and to ensure that the current positive trends rise to the appropriate levels and do not wane as they have twice before. We do not want to be the generation that whiffs at Strike Three.

And so, there is change in health care like never before. You can feel it.

We have challenges and we have opportunities like never before. You can feel it.

I look forward to working with you to meet the challenges, to meet your needs, to meet the needs of our learners, to meet the needs of our institutions, and to meet the needs of our patients, our families, and our communities, as we improve health, health care, and health care education in the United States.

STFM—Transforming Health Care Through Education. I am proud to be your president.

CORRESPONDENCE: Address correspondence to Dr Kruse, Southern Illinois University, Department of Family and Community Medicine, PO Box 19671, Springfield, IL 62794-9671. 217-545-0200. jkruse@siumed.edu.