Family Doctor

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of FAMILY PHYSICIANS

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Focus:

Medical Politics

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- Navigating Vaccine Hesitancy and Disinformation in our New Media and Political Landscape
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From the Executive Vice President

By Vito Grasso, MPA, CAE

When presented with the topic for this issue of ***Family Doctor***, I wasn't certain whether "medical politics" referred to politics within the medical profession or how physicians interact with and influence politics in general. In either case there have been significant changes in the past three decades that are worth noting. I reference the last three decades because that timeframe corresponds with my own tenure as NYSAFP EVP and I have certainly witnessed a lot of changes in the landscape of politics both within and external to the medical profession.

Internally, the dominance of the AMA in representing organized medicine, although beginning to erode, was still undisputed among medical specialties in 1994. Growth in the size and political sophistication of other health care professions was challenging the influence of medicine in forming health care policy. Fragmentation of the profession by specialty and transition from private independent practice to employment as the primary practice setting for most physicians, has accelerated the decline in physician imprimatur and influence.

Externally, growing partisanship of the two major political parties has caused barriers to governing which has dramatically diminished public confidence in government and in politicians. This has influenced advocacy strategy. As policy makers have become primarily partisan and ideological, arguments based on reason, science, evidence and other objective criteria have become less persuasive. Compromise and consensus are no longer part of the policy making process. Policy has become the captive of political power in the moment and varies with the results of elections swinging through an arc of conservative, moderate and liberal tendencies based on which party has control.

Concern about the influence of physicians on public policy has focused on the reactionary posture of the Trump Administration and the exploitation of the COVID crisis to undermine public confidence in science. It may be, however, that public perception of the medical profession began to change prior to the advent of the MAGA movement and the elevation of anti-vax champion Robert Kennedy to the leadership of the Department of Health & Human Services.

COVID has certainly had an impact on public trust in the medical profession, science and the public health system. Research by David Lazer of Northeastern University found that public trust in physicians and hospitals fell from 71.5% in April 2020 to 40.1% in January 2024.

Politicians are acutely aware of changes in public opinion. The decline in public confidence in physicians is apparent to policy makers and the increased political activity of other health care interest groups, particularly on issues where there is disagreement with physicians, and has resulted in adoption of policies which are averse to medicine or contrary to recommendations of the medical profession. Additionally, the demands of practice often deprive physicians of time to participate in advocacy.

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> *Politics and medicine used to be about patients. Somehow the political landscape of health care has become dominated by the business of providing health care.*

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As health care costs have risen uncontrollably, and the business of health care has become the largest sector of the economy, the interest of patients and providers has increasingly been subordinated to the protection of the business model which has become dominant in health care. Efforts to transform healthcare into a truly patient-centered and evidence-based system have largely been prevented by the influence of businesses that profit from health care. The essential argument against transitioning to a publicly funded and managed health care system based on the premise that health is a human right and access to affordable quality health care is an entitlement just as access to public utilities, police and fire protection, and the myriad other services provided by government, has been successfully rebutted by the argument that protecting capitalism should be prioritized over the interest of the public in having access to health care.

We seem incapable of having rational discourse about the dysfunction in our healthcare system or the best options for improving it. Costs are increasingly offloaded onto patients to protect profits of shareholders because preservation of capitalism is more important than providing care. Prior authorization and other administrative practices are protected despite the obvious impediment they present to timely and necessary care. Expanded scope of non-physician clinicians is routinely championed as a cost-reduction strategy regardless of the risk patients are subjected to.

We continue to work to improve conditions for patients and physicians. That work becomes more difficult every year. Many of the issues we will engage on this year are issues we have dealt with for many years before. The interests that resist change in health care have succeeded in shifting the focus of debate about the system from patient care to socialism. At its essence, health care is about patients whose lives are threatened by disease or injury and whose vulnerability in their moment of need reduces their ability to take care of the problem themselves. Unlike other economic transactions, consumers of health care need a system built on the best human qualities, not the most efficient or more profitable business practices.

Politics and medicine used to be about patients. Somehow the political landscape of health care has become dominated by the business of providing health care. Prioritizing business interests over patients predates the Trump Administration and will not end with that Administration. The Affordable Care Act originally included a public option which was conceived as a pathway to single payer. Intense lobbying by health insurance plans resulted in abandonment of the most significant and reformative aspect of the original ACA. The result has been even more waste and less patient empowerment than before.

Politics is about power. The power to win elections and the power to determine what parameters will be paramount in making policy. Physician influence in politics has declined as other influencers have been more adroit in investing in and engaging in political action. Public opinion polls, however, have consistently shown that physicians remain the most trusted source of medical advice for patients. Somehow, we must figure out how to capitalize upon this public confidence and trust in reasserting the voice of physicians in the debate over health care policy. A paucity of elected officials at the state and national levels are physicians but it is apparent their voices carry much weight when they speak, especially on matters of health care. Perhaps more physicians, frustrated by the burdens of practice, will gravitate toward elected office rather than management or retirement. That would certainly change the power calculus and redefine the role of medicine in American politics.

Upcoming Events

2026

Congress of Delegates Convenes Virtually Opening Session
May 9, 2026

Congress of Delegates Reconvenes at the Desmond Hotel
May 16-17, 2026

Summer Cluster in Penn Yan at Keuka College
August 8-9, 2026

Regional Family Medicine Conference at NYU Langone
October 10, 2026

Albany Report

By Reid, McNally & Savage

March 23, 2026

Successful, But Unconventional, 2026 NYSAFP Advocacy Day

We would like to recognize the nearly sixty family physicians, residents and students who signed up to join us at the State Capitol in Albany on Monday, February 23rd for NYSAFP's annual Advocacy Day. We were very disappointed that we had to cancel the day due to the severe snow storm that hit parts of the state, but we pivoted the day to a virtual Toolkit, with several advocacy actions detailed for members to take. Thank you to all who sent letters, made calls, and a special thanks to Vito Grasso, NYSAFP EVP, and Donna Denley, Director of Finance, for their assistance with planning and executing the day, as well as to Dr. Scott Hartman and Dr. Sarah Minney who elected to move their team's meetings to Zoom!

Importantly, all of the physical 2026 Advocacy Day materials detailing the budget and legislative priorities of NYSAFP were hand-delivered to over seventy legislative offices by our staff. Our firm and NYSAFP President Dr. Christine Doucet, also met virtually with Assembly Health Committee Chair Amy Paulin's office on February 26th. NYSAFP also submitted testimony for the February 10th Health/Medicaid Joint Legislative Budget hearing to make lawmakers aware of the Academy's budget priorities, as outlined below:

- Support the Governor's inclusion of continued funding for Doctors Across NY (DANY) and Area Health Education Center workforce programs, while urging expanded support under DANY for private practicing physicians and inclusion in the Final Budget of legislation (S.1634, Rivera/A.1915A, Paulin) requiring health care plans to spend a minimum of 12.5% of their overall healthcare spending on primary care services.
- Opposition to problematic Executive Budget proposals that would eliminate physician supervision of physician assistants, cut funding to the State Excess Medical Malpractice program and require participating physicians to pay 50% of the cost, and transfer oversight of physicians, PAs, and special assistants to the Department of Health from the State Education Department.
- Adult Vaccine Reporting to the statewide and city immunization registries similar to pediatric vaccines.
- Vaccine Integrity Act to address recent issues with the Advisory Committee on Immunization Practices (ACIP) by creating an alternative for recommended vaccination through the NYS Commissioner of Health based on national medical guidelines.
- Support prior authorization reforms included in the Governor's Budget to require insurers to report utilization review data, expand continuity-of-care protections, publish drug formularies online, and limit utilization reviews for chronic conditions to once annually per approved treatment.
    - Also pending legislation (A3789, Weprin) which would ensure utilization review criteria are evidence-based and peer reviewed, require timely prior authorization decisions (72 hours standard, 24 hours for emergencies), and prevent repeat prior authorization once approved.

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- Universal healthcare coverage through a single payer health system and much-needed insurance standardization/simplification.

State Budget Update – One House Budget Bills Released

On March 9th, the Senate and Assembly released their own one-house budget bills in response to what the Governor proposed and with their own priorities. Please see their budget actions of particular interest to NYSAFP priorities below:

The Senate and Assembly accepted DANY and AHEC funding levels and the Senate added $500,000 in support of AHECs. Additionally, both houses rejected PA independent practice and the proposal for oversight of physicians, PAs, and special assistants to be shifted from the State Education Department to the Department of Health. They also both rejected the Excess Medical Malpractice Program restructuring and funding cut and proposed to extend the program through June 30th, 2027, as NYSAFP requested. We were happy to see that in early March, over 40 Academy members sent letters voicing their opposition to the Physician Assistant Independent Practice Proposal through our grassroots advocacy tool. Messages were sent to 63 different legislators and the Governor received dozens. **We greatly appreciate your advocacy efforts!**

The Senate and Assembly also included the Governor's prior authorization reforms, however with the Assembly modifying the language to only allow prior authorization for patients undergoing treatment for a chronic health condition under the following circumstances: When nationally recognized clinical practice guidelines (1) recommend follow-up care to assess possible negative side effects of a treatment; (2) change substantially; or (3) recommend a change in treatment based on a change to the chronic health condition. Both houses also rejected the Executive Budget proposal to remove continuous eligibility for Medicaid and CHIP for children up to age six.

Further, we were happy to see that the Senate included language and $6 million in funding to codify and sustain the NYS Abortion Clinical Training Program, noting that the Assembly also provided $5 million for abortion clinical training as well as other possible uses. As a refresher, $4 million in funding was included in the SFY 2026 Enacted State Budget for this program, however the bill (S.1438-A, Krueger) language was not, and both houses did not pass the legislation by the end of the 2025 session. To advocate for this to be included in the final state budget, RMS is working among a coalition in support of this proposal. Dr. Paladine and Dr. Prine will join a meeting scheduled later in the month with central staff in the Assembly to provide key perspectives on the need for resources and training for residents and providers and the impact this has/could have in the future on access to abortion and other reproductive care.

New measures from the Senate one-house budget bill include language to affirm consent can be given by any person for reproductive healthcare, a proposal for the Gender Affirming Care Access Program (which NYSAFP has been strongly in support of), and a new proposal by the Assembly that would create an Essential Plan Contingency Fund with an allocation of $2.4 billion from the general fund if the federal government does not approve NY's request to return to New York's Basic Health Program.

Positively, neither house included wrongful death legislation which the Governor has now vetoed four years in a row. The Senate also included positive language to reform the Office of the Medicaid Inspector General's (OMIG) audit processes which the Academy supported through joint letters and a memo in support.

Overall, the Legislature provided substantive support in their one house proposals for many NYSAFP priorities thanks to the critical advocacy efforts of Academy members. For more information comparing the Executive Budget to the Senate/Assembly One-House Budget Bills in the Health/Mental Hygiene sectors, please review our comprehensive HMH Budget Update.

With this step in the budget process completed, three-way negotiations are now ongoing between the Governor and Legislature – all of the items mentioned above are tentative and being discussed. Several issues are contentious including preventing police from working with ICE, addressing the high cost of utilities, and raising corporate franchise and personal income taxes on the very wealthy.

The SFY 2026-27 final state budget deadline is April 1, though it appears that extensions may be needed with the biggest topic of discussion being Governor Hochul's push for adjustments to be made to the Climate Leadership & Community Protection Act. Her justification, recently released through an Op-Ed, is that the NYS Energy Research and Development Authority found that meeting the Climate Act's 2030 targets could cost over $4,000 annually for upstate oil and gas households and $2,300 for NYC natural gas households. She states that changes are critically needed to "keep New York State on our path to a greener future in a way that is affordable for New Yorkers." At this point, we are keeping the pressure on over the coming weeks to advocate for NYSAFP's priorities in this year's budget.

NYSAFP will provide a member update on the Final State Budget outcomes related to priority areas once the final deal comes together and the budget is passed. Following the budget's enactment, NYSAFP will continue to advocate for the advancement of its legislative priorities during the remainder of the session which is scheduled to end in early June 2026.

NYSAFP Mental Health Initiative Dinner on March 12

Maggie Shugrue from our firm was pleased to join Academy leadership for this dinner and fireside chat with community-based organizations, providers, health systems and insurers, and others to discuss challenges and solutions to improve integration of primary care and mental health services. We welcomed NYS Office of Mental Health Commissioner Dr. Ann Sullivan, as well as several program leaders within the agency, as a keynote speaker and it was a great event to begin to form a coalition and launch the Academy's campaign to promote integrated care.

We thank all members for your interest and participation in NYSAFP advocacy efforts on behalf of members and your patients. We encourage all to get involved through the COD, annual Advocacy Day and by responding to NYSAFP Action Alerts throughout the year to reach out to your state legislators to ask for their support of family medicine!

TWO VIEWS:
Advocacy in Family Medicine

VIEW ONE

DIRECTING TRAFFIC AT THE INTERSECTION OF HEALTHCARE, POLICY, AND POWER: INVOLVING NEW PHYSICIANS IN ADVOCACY

By Kristin Mack, DO, MS, FAAFP

The Accreditation Council for Graduate Medical Education (ACGME) mandates advocacy training for all U.S. residency programs, yet provides minimal operational guidance. The program requirements that residencies follow to maintain accreditation specify that advocacy curriculum be relevant to the unique geographic and social context of the communities served and that residents develop the ability to promote health policy within the complexities of the health care system. While no specific information is given on how to format this education, it does describe what would be high-level skills and successful outcomes, leaving many programs uncertain about implementation with such little guidance. After all, what the ACGME calls becoming "social justice advocates for their patients and their communities, engaging in health policy... and mitigating the impact of structural social determinants on health outcomes," sounds like a lifetime of work. While the ACGME requires advocacy exposure, it is unsurprising that some programs have not operationalized it as a true curricular priority. This is a mistake.

Advocacy receives greater emphasis in ACGME family medicine requirements than in many other specialties, and this makes perfect sense given that resident physicians training in family medicine (FM) practice at the interface where systemic barriers most directly shape patient care. Whether restrictive organizational policies, insurance denials, workforce shortages, or fragmented systems, FM physicians are often the ones who have to push through the first barriers to get care for their patients. As graduate medical educators who are cognizant of the increasing weight of these daily realities, we can armor our new physicians with the ability to make change that matters through a robust advocacy curriculum.

Physicians need to be experts on detecting problems: whether internally a disease is affecting their patient or an external systemic barrier is causing them harm. Omitting advocacy from comprehensive training will lead to new physicians who only recognize the first category. If we are not taught to see problems, we cannot diagnose them. New physicians who lack advocacy training will be less equipped to identify and remove systemic barriers that increasingly contribute to morbidity and mortality in modern health care.

Advocacy training, then, is essential in today's medical practice, but the next practical question is unavoidable: where does it fit within already overburdened residency schedules? Faculty across the country acknowledge that residency training is stretched thin. Adding even one more requirement, risks dilution rather than transformation. The issue, however, is not whether time exists—it is whether advocacy education is valued enough to be protected.

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VIEW TWO

FULL-SPECTRUM CARE AT THE FRONT LINES: FAMILY MEDICINE IN THE POST-DOBBS ERA

By and Mariela Cabrera, DO; Jessica Mitter-Pardo, DO and Ivonne McLean, MD, FAAFP

Recent changes in the U.S. reproductive health care policies, particularly the erosion of federal protections and widening state-level variation, have had significant implications for family medicine physicians, who often serve as the first point of contact for reproductive health care services.[1] Half of US counties do not have a practicing OBGYN, and family medicine providers are at the forefront of bridging access to care, providing essential and life-saving reproductive measures such as contraception counseling, prenatal care, miscarriage management, and abortion care.[2] Policy changes that restrict or complicate access to abortions and related services disrupt continuity of care, create clinical uncertainty, and increase administrative and ethical burdens for family physicians, even in states where abortion remains legally protected. Moreover, recent highly publicized announcements have fueled confusion and cast doubt among providers and patients about the safety and availability of medications with well-established and studied safety profiles, such as mifepristone and Tylenol. This not only affects relationships and trust within the clinical space but also influences insurance coverage and medical education, thereby shaping clinical practice beyond state borders. While our political climate has severely disrupted reproductive care delivery, there is hope for family physicians to combat these limitations and help uphold every patient's right to reproductive and sexual health care.

Even in abortion-protected states, such as New York, family medicine physicians can play a critical role in advocacy. Advocacy efforts are crucial to safeguard access to care, address the inequities faced by marginalized populations, and mitigate the spillover effects of restrictive policies elsewhere, such as increased patient travel and strained healthcare systems. Family physicians are uniquely positioned to advocate at the institutional, state, and national levels by leveraging their close patient relationships, community presence, and broad scope of practice. Family medicine physicians can play a pivotal role in shaping reproductive health policy by engaging with professional organizations such as the New York State Academy of Family Physicians (NYSAFP) and the American Academy of Family Physicians (AAFP). Through these bodies, physicians can join advocacy commissions or special interest groups focused on reproductive health, such as the AAFP Reproductive Health Member Interest Group, which helps signal the importance of keeping reproductive health at the forefront of priorities for the organization. Family doctors can also contribute to policy development and help craft position statements that guide legislative priorities by participating in resolution writing or offering testimony

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Programs that have successfully integrated advocacy into residency training demonstrate that meaningful education does not require excess time; it requires intentional design.

At the University of New Mexico Santa Fe Family Medicine Residency Program (UNMSF), Dr. Mario Pacheco had enough vision two decades ago to be certain that advocacy training got a spotlight instead of an extracurricular activity or a lunchtime lecture. At UNMSF, the advocacy curriculum is a protected four-week block during PGY-2, structured to immerse residents in legislative, community, and systems-level engagement. Situated in the state capital of New Mexico, the program leverages proximity to policymakers as a living classroom. What distinguishes this model is not geography alone, but the decision to allocate time explicitly - signaling that advocacy is part of professional formation, not a peripheral interest. Current Program Director, Dr. Elizabeth Koffler, and Advocacy Faculty Leads, Drs. Alicia Gonzales and Kristy Riniker, have worked to sustain the program by building structures that allow community doctors to support residents during this rotation. They developed an innovative 'Doctor of the Day' program for legislators which served to form relationships at the capitol building, which has provided downstream support for their residents in order to offload some of the expenses this type of approach could incur. And, they are careful to note that continuity clinic time is still protected during this rotation as well. Dr. Mario Pacheco speaks with pride about the evolution of a curriculum he initially had to defend and justify. "It takes creative initiative to build, flexibility to grow, and institutional support to maintain," he reflects.

The Albany Medical Center Saratoga Hospital Family Medicine Residency Program (AMCSH) in New York State is a new program established in 2023. As founding Program Director, Dr. Ephraim Back prioritized institutional support for advocacy education from the outset. This early commitment allowed the program's advocacy curriculum to be intentionally designed and implemented. The author serves as advocacy faculty and contributed to the curriculum's development. While the AMCSH residency program does not include a protected four-week rotation, its advocacy curriculum is intentionally structured longitudinally. During PGY-1, part of orientation is devoted to an introduction to advocacy when they learn about US government structure and do basic research into the individuals who represent them in local and state government. Then, in PGY-2 residents have protected time to process how to build upon their existing projects with an advocacy lens. By PGY-3, residents are expected to complete their advocacy work and demonstrate measurable impact, as defined with faculty mentorship - whether through engagement with a state legislator, formal testimony in a congressional setting, or other meaningful outcomes. All residents are encouraged to participate in designated NYSAFP events and plan accordingly to attend as often as possible. Even in the short time for this residency's existence, they can tout that they created a resident chapter within NYSAFP in their inaugural year. They have sent at least one resident, and often several, to participate every year in Advocacy Day and have sent a voting and alternate delegate to the NYSAFP Congress of Delegates (COD) annually as well. In addition to planned engagements, the residents have advocacy-dedicated didactics in all three years.

Whether rooted in decades of refinement or launched within a brand-new residency, these family medicine residency programs (FMRP) are real-world models in advocacy training. Both the UNMSF and AMCSH program faculty and leadership are following a shared principle: intentional design, protected space, and institutional commitment to ensure their success. When time is protected, even modestly, it communicates that physicians are expected not only to treat disease, but to understand and influence the systems shaping their patients' care. Newly appointed AMCSH Program Director, Dr. Sean Roche, is taking the reins and he too finds purpose in advocacy for the residents. He states, "If we want to improve primary care in the United States, family medicine physicians need to know how to talk to leaders and to become leaders themselves. A residency curriculum that includes advocacy helps to develop physicians who will speak up for our profession and our patients." Program directors have changed in both the UNMSF and AMCSH programs and both programs have sustained a commitment to institutional support across these leadership changes because they see value in the education for their residents. Advocacy training succeeds when it is structurally protected.

Faculty who teach advocacy consistently describe a similar and valuable journey in their residents' experiences. Many residents begin uninterested in government altogether, but after realizing that many physician advocates view it is an effective way to combat the daily struggles of the profession, interest builds. And interest continues to grow with their introduction to groups of physicians working toward goals on various topics they do find interesting: food as medicine, food deserts, prior authorization limitations, single payer support. In both the UNMSF and AMCSH programs, faculty observe that even residents who began the rotation with minimal interest often find a passion project.

Moral injury, a term popularized in recent years, refers to the struggle physicians experience when they have less power to impact their patients' lives. Physicians who engage in advocacy efforts report feeling that it adds meaning to their career because they understand which powers have been stripped of physicians and how to work toward regaining what has been lost. It is well known that the work of delivering primary care is wrought with daily struggles that lead to moral injury and burnout, but advocacy can be the antidote. Making advocacy training a priority of resident education gives new physicians a substitute for a defeatist mentality that has doomed empathetic physicians over time.

Further, advocacy is never a singular activity. Group work and coordination of like-minded people is what wields results, so there is an important bonding that happens. As Advocacy Lead for the NY program, but not a core faculty member, my time with residents is limited in comparison. But, because the nature of the work they do in advocacy is personal and purposeful, this often leads to me forming deep bonds with the energetic next generation of physician advocates. Dr. Ephraim Back said "It has been really gratifying to see how many of our residents are excited to get involved in advocacy activities, both locally and regionally. Not only does it introduce them to the broader dimensions of medicine and policy, but it also gives them the opportunity to build relationships with other young physicians forming connections that strengthen their professional networks and provide long-term collegial support." When physicians understand

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on resolutions. This can provide an opportunity for providers to introduce policy that solidifies patient protections or reaffirms support for reproductive health issues at the organizational level. Both the NYSAFP and AAFP also offer opportunities to meet directly with lawmakers during lobby days to amplify physicians' clinical perspectives. Family doctors, as both constituents and healthcare providers, can leverage their unique position to hold legislators accountable and advocate for increased protections of reproductive health care and the patient-provider relationship. Physicians can additionally serve as delegates to state and national congresses, where they propose and debate resolutions that shape official policy platforms of the organization. By leveraging these structured channels that shape organizational priorities, family physicians can advocate to protect and expand access to comprehensive reproductive health care.

Additional opportunities for leadership and skill-building exist through organizations dedicated specifically to reproductive health. One of the leading networks in reproductive care training and education is the Reproductive Health Access Project (RHAP), which aims to fill gaps in clinical care and education through its fellowship program, network, continuing education, and extensive resources and protocols for managing reproductive health clinical scenarios. Founded by family physicians, this network has been a leading force for advocating for access to abortion care in all states, highlighting the breadth and profound impact that family medicine plays in reproductive justice. The organization also offers regional and state "clusters" to become involved in through the Reproductive Health Access Network, which mobilizes primary care clinicians nationwide to build power and expand sexual and reproductive health care advocacy and provision. Family physicians can also engage with groups such as the Society of Family Planning and Physicians for Reproductive Health, the latter of which offers a nine-month Leadership Training Academy focused on communication, media engagement, and policymaker interaction. Even without formal training, family doctors can draw upon their close community ties and patient experiences to pen powerful op-eds or letters to the editor that can clarify medical facts and counter misinformation about contraception and abortion with trustworthy explanations. Publishing in both local and national outlets allows family doctors to reach broad audiences while also reinforcing their roles as credible public health voices.

Family medicine's defining strength is the continuity of care across the lifespan, allowing family medicine doctors to address reproductive and sexual health comprehensively. Family physicians provide services spanning contraception counseling, sexually transmitted infection screening, gender-affirming care, prenatal and postpartum care, fertility discussions, pregnancy loss management, abortion care, and menopause management. Like chronic disease management, these services are integral to whole-person care and should be regarded as core competencies of the specialty. Consequently, strengthening provider knowledge, comfort, and competency in reproductive and sexual health is essential, now more than ever. One of the most practical steps for strengthening provider skills is to improve reproductive and sexual health education during residency training. This medical knowledge should be standardized through the development of ACGME competencies that reflect practical skills in reproductive health care. Residency programs should ensure robust, hands-on experience in contraception counseling and provision, including long-acting contraception insertion and removals, medication management for early pregnancy loss, and options counseling. The development of a new curriculum does not have to be onerous, and can combine direct clinical experience with high-quality, standardized learning modules online, away rotations, or guest lectures in a didactics model. Because family medicine providers often practice in rural or underserved areas, with limited access to subspecialists, residency programs must prepare their residents to provide a broad scope of reproductive care effectively and competently upon graduation.

Faculty development and continuing medical education are equally important. Family medicine providers who provide direct care and supervise trainees need to maintain their knowledge and skills to provide quality care. Professional bodies such as the NYSAFP and AAFP can support this need by expanding continuing medical education opportunities and procedural workshops. As mentioned above, organizations like RHAP are leading networks in expanding clinical knowledge; however, it is vital that credentialing bodies also prioritize these competencies by investing in faculty continuing medical education, hosting procedural workshops, developing toolkits, and facilitating conversations regarding care. When credentialing and governing bodies demonstrate commitment to reproductive healthcare, it normalizes these services as core components of family medicine rather than add-ons. It is imperative that any education or training in reproductive health services be rooted in trauma-informed and LGBTQ+ inclusive practices. Trainings to address provider and staff attitudes and implicit bias toward abortion and reproductive care in family medicine are needed to improve and promote equitable care.[3]

Another practical step to increasing reproductive health care in primary care is to focus on the infrastructure that supports this care. Family physicians can advocate for their clinics and institutions to be equipped with the supplies necessary to provide same-day contraception, STI testing, manage early pregnancy loss, and abortion. Electronic health systems should be optimized with templates for various health concerns, and can include decision support algorithms to help improve ease of managing various reproductive health concerns within primary care. Establishing clear referral pathways for complex conditions ensures continuity and expedited care in a collaborative model. In places with less access to specialty care, establishing telehealth partnerships can reduce barriers and increase support for providers and patients.[4] Ultimately, reproductive and sexual healthcare are central aspects of family medicine. Investing in education, mentorship, and infrastructure increases the overall access that patients have to these services. Taking these steps as a field can advance reproductive autonomy, preventive care, and health equity.

Despite the tumultuous status of our nation's reproductive health policies, successes in advocacy efforts provide hope. For instance, New York's Shield Law, passed in 2023, protects family medicine physicians and other clinicians providing legal reproductive and gender-affirming care from out-of-state investigations, civil liability, and professional discipline.[5] It prevents NY state agencies from cooperating with hostile actions, prohibits subpoena enforcement for

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how systems function and how to influence them, they are less likely to feel trapped by them. Together, they build confidence and the sustainability that comes from group networking for strength of voice.

The other common experience for residents is feeling underqualified or out of place in conversations with legislators, policy experts, or health system leaders. Advocacy, even on a subject matter they are passionate about, initially feels foreign, formal, and certainly outside the traditional clinical skill set. Yet with structured exposure and mentorship, residents discover not only competence, but conviction. Dr. Kristy Riniker at UNMSF states, "Residents often walk into meetings with legislators questioning whether they belong in the room. Part of our role is to humanize government representatives and help them recognize that they are professionals, constituents, and credible voices who deserve to be heard. For me, success is seeing residents gain the comfort and confidence to have intelligent, respectful conversations about legislation. The residents work to understand what policies mean, who the key stakeholders are, and how family physicians, as trusted community leaders, can engage thoughtfully across the political spectrum. That comfort level becomes the foundation for lifelong advocacy."

Strong advocacy training programs can take pride in equipping trainees with tools that extend beyond the exam room - tools for engagement, influence, and change. Importantly, the impact is not limited to policy outcomes. According to Dr. Pacheco, whose lens is the most enduring, he sees residents with increased confidence navigating administrative barriers, a stronger sense of agency within their institutions, and a clearer understanding of how decisions are made.

Programs with strong advocacy curricula also report an additional benefit: recruitment. UNMSF notes they have had specific candidates seek them out due to their strength of advocacy training and skills development focus. Protected advocacy education signals to prospective residents that a program recognizes both the challenges and the possibilities of modern practice and commits to training that extends beyond the limitations sometimes experienced in the exam room.

Dr. Elizabeth Koffler, UNMSF Program Director states, "The additional time and expense required for advocacy training have proven their value, and it's worth continuing to keep it a hallmark of our program. I'm proud that our residents have helped advance specific legislation, stepped into union and advocacy leadership, and even met with the governor. This is exactly how we hope to attract and train mission-driven residents who are deeply committed to community and advocacy."

The growing interest among residents in programs with robust advocacy curricula signals something larger: family medicine, unique among other specialties in its broad scope, longitudinal relationships, and proximity to systemic breakdowns, can provide a powerful voice. When family physicians read phrases such as *systemic failures, restrictive organizational policies,* or *insurance-driven care plans*, they are not just abstract language to them, they are real stories they have lived through. Collectively they can give endless examples of specific patients whose care was delayed, diluted, or denied.

Consider the intent of a current New York Senate bill to "remove unnecessary administrative requirements that impede timely patient access to medically necessary care, delay continuity of care, and divert health care professionals' time from delivering needed health care." For family physicians, this is not theoretical. In this case, prior authorization requirements, which routinely compel physicians to defend evidence-based clinical decisions in peer-to-peer reviews delay care after physicians have already made decisions based on appropriate training and clinical judgment. The issue is not professional ego; it is the reality that administrative barriers can postpone diagnosis, disrupt continuity, and erode patient trust. In some cases delays lead to patient harm; in all cases they erode the physician-patient relationship.

Now imagine family medicine residents trained not only in clinical reasoning but in systems literacy, providing testimony on bills like this one. Imagine them articulating, with credibility and scientific grounding, how patient outcomes are affected. This is not just imaginary - it is possible. It is necessary. Physician perspectives and lived clinical experience can be given a megaphone.

Though massive system changes are enticing, sometimes advocacy means personal and local. Dr. Mario Pacheco notes that one of the residents in the UNMSF program faced restrictions on where she would be able to practice, but with the program's mentorship and her developing advocacy skills, she was able to navigate a change for herself and others. Her working through her own restrictions with legislators meant more opportunity for building the physician workforce in their region, a stabilizing and beneficial outcome. A resident from the AMCSH program was passionate about how artificial intelligence (AI) could play a beneficial role in her future as a physician. She was also concerned about the negativity surrounding any mention of AI in the medical world. With guidance, she researched and found there was a bill in the NY Senate that was well written to allay fears of overuse of AI and also included her hope to see it used properly in documentation efforts. She wrote a letter to her senator as an exercise, but was shocked when I suggested that she should send it. And she did. In that moment for her, a bridge formed from academic interest in a topic to being a credible expert to support it. She felt empowered.

Both UNMSF and AMCSH tout the importance of their state-based AAFP programming as helpful for the logistics and experiences for their residents. In New Mexico, faculty get state-wide support for their efforts and like-minded physicians networking to help support their efforts for their advocacy rotation.

The New York State Academy of Family Physicians (NYSAFP) has been active for many years in healthcare advocacy, representing physicians across the state and is strong in putting advocacy leaders into the national American Academy of Family Physicians (AAFP). The NYSAFP not only accepted AMCSH as a resident chapter in their inaugural year, they have encouraged their participation at every level. An expert from Reid McNally & Savage spoke to residents during a didactic session. Residents have been appointed onto state commissions, and NYSAFP commits to assuring scholarship availability for all residents in NY programs so they can participate in advocacy events without incurring financial burden. Every year at NYSAFP COD, residents are mentored by physicians experienced in parliamentary procedure, and the entire body is proud when a resident rises to give testimony. Residents have the

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opportunity and are encouraged to give formal testimony on numerous topics spanning a wide variety of issues - from housing costs for residents in NY to medical aid in dying. No matter the outcome of the vote, they benefit from revisiting and post-analysis from the physician mentors around them.

Early advocacy experiences in supportive environments build confidence that carries into more complex arenas, where policy change often unfolds over years rather than moments. Whether in government or within health systems, proposals are rarely adopted on the first attempt. As residents quickly learn, being told no is not the same as having done nothing—each effort advances the continuum of change. Advocacy requires patience, and asking this from new physicians is not particularly difficult. Naturally, the enduring educational efforts to which they have already committed make them well suited to the concepts of resilience and slow change. Even when issues are repeatedly set aside, physicians who remain present at the table keep the credible clinical perspective visible to those in power.

Dr. Alicia Gonzales at UNMSF is ready to go one step further. “Family medicine practice is very different from what was once expected of us. Just seeing patients is no longer the full scope of the work. Advocacy work can open career pathways for family physicians, including movement into policy and elected leadership as our role in the healthcare environment continues to evolve.” Though advocacy on health related topics varies from electoral politics, she says the changeover into the world of politics is not unreasonable for physicians to consider. She hopes that one day one of their program’s graduates will run for office.

For most, family medicine physicians will practice medicine and not make this leap into politics, but their advocacy education will prepare them to translate what they already witness daily into constructive policy influence. Family medicine physicians see poor policy consequences affect their profession and patient care whether they want to or not. Within the realities of modern practice, advocacy skills have become essential, not optional. When taught intentionally, advocacy training equips physicians with the tools for progress. They do not have to simply endure systemic pressures, they can help shape the systems. The benefits of such training extend well beyond residency, shaping professional identity, expanding career pathways, and sustaining engagement with medicine over time. If we can imagine a large cohort of well-trained physician-advocates directing traffic at the intersection of healthcare, policy, and power, we can all confidently hope for a better future.

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medical records, and protects against license penalties. This law was largely advocated for by family medicine physicians working within reproductive health, and it not only protects clinicians who provide abortion but has also laid the foundation for increased access to medication abortion across the nation. About 1 in 5 abortions are done through telehealth, by family medicine physicians, and these services have reached even the most restrictive states.[6] Policy successes like this show the power of family medicine and testify to the need for family medicine providers’ active engagement in policy discussions, public education, and professional organizations.[7] This is essential for advancing reproductive justice and ensuring that family medicine continues to deliver patient-centered, evidence-based care in an evolving policy landscape.

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The Medical Aid in Dying Act

By William Klepack, MD

The Medical Aid in Dying Act has been discussed for many years but now with its passage, practitioners and patients will be confronting its complexity in the real world. The Act addresses one of the most sensitive and personal aspects of a person's life. My long career as a family physician provides me with the background to reflect upon the Act. I offer the following as my personal reflections.

A person's needs, priorities, beliefs, and goals as they grapple with their approaching death are among their most intimate and personal ones. It is the rare person who can deal with it alone. Whether they choose to seek the counsel of their practitioner is one of the choices they must make. If they seek the counsel of their physician, that conversation is among the most challenging to have for the practitioner as well as the patient. Ideally the physician will allow and facilitate the patient to explore their beliefs, help them clarify their priorities, and establish their goals. A thoughtful and compassionate practitioner can be among the patient's most helpful supports, and is challenged to lay aside personal opinions to allow the patient to fully verbalize theirs. It is so easy for a practitioner to limit the exploration the patient must do, but to do so risks much. Should the physician find themselves unable to lay aside personal beliefs while the patient is in the process of doing their exploratory work, they should tell this to the patient. That way the patient can decide whether to seek the support they need elsewhere.

Once the patient has come to a decision, if that decision is to ask for medical assistance in dying, the physician must reconcile their practice of medicine with the aid the patient is requesting. Just as patients preserve their freedom to accept or refuse medical advice, a practitioner retains the right to participate or not participate in modes of treatment. Should the physician find that assisting a patient in their decision to access medical aid in dying is not possible for them, they should assist referring the patient to one who can.

Some will say that referring a patient for such care is tantamount to providing such care. I believe that many of us in the profession would deny such a linkage and affirm that referral is responding with compassion to the needs of their patient in distress. The practitioner's referral may come with additional recommendations to the patient, which may include consulting with a mental health professional and/or a faith counselor. But the patient must not be coerced and must be free to explore and exercise their belief system. At issue is how best to help the patient clarify their beliefs and goals.

I should clarify that the Act mandates that a patient fully understand their conditions and options for care, and that a mental health consultation and a second opinion from a consultant be done in the case of the practitioner supporting the patient's decision for medical aid in dying.

The passage of the Medical Aid in Dying Act does pose challenges for practitioners and their patients. Such challenges are not new. We physicians encounter them commonly in our work to heal when we can, mitigate when we can't, and comfort always. However, we live in an age in which modern medicine can cease to comfort, and to mitigate if carried too far in situations of poor prognosis. In such situations the practitioner is well advised to confront the facts with compassion in line with their patient's beliefs, and goals.

https://www.albanylaw.edu/government-law-center/medical-aid-dying-act

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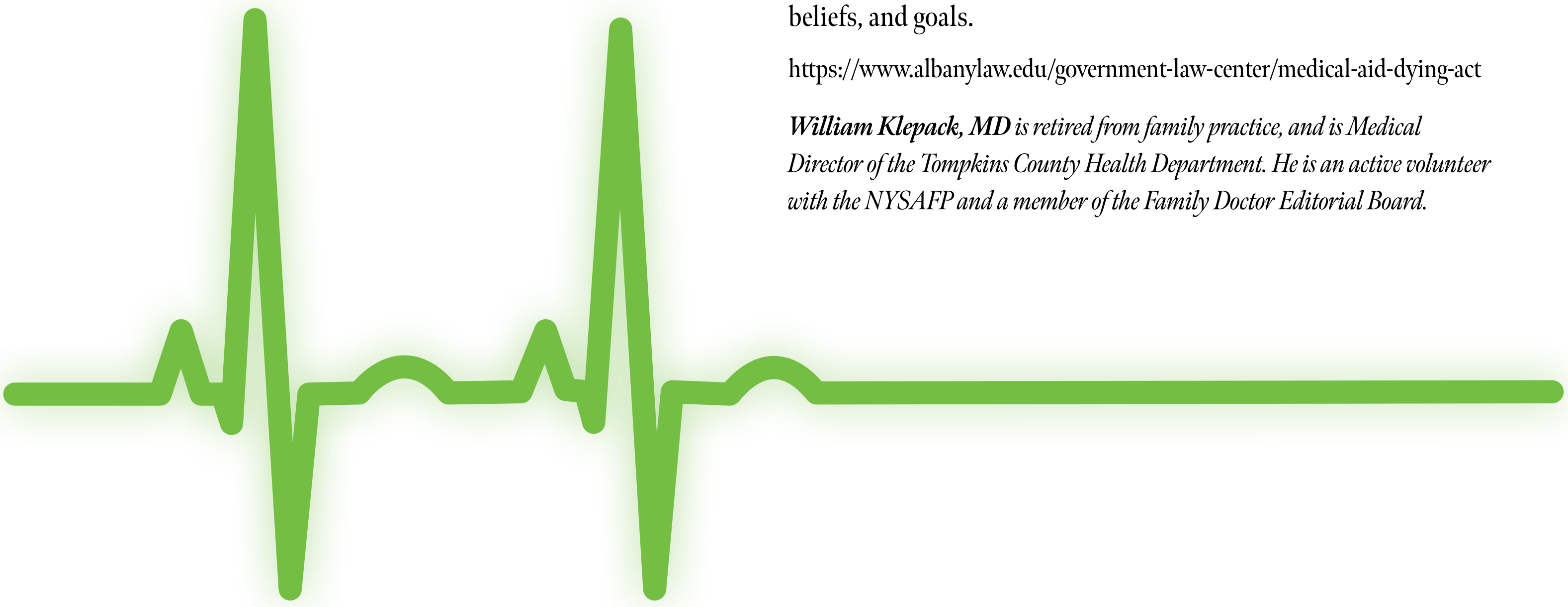

Gender Affirming Care in the Primary Care Office

By Brigid Mack, MD

As leaders in our communities throughout the state, family medicine physicians in NY are in a unique position to not only advocate for our transgender and gender non-conforming patients on a local and state level but also to provide life-saving affirming care where patients are their most comfortable – in the primary care office!

In the last 10-15 years, the societal and political landscape around the LGBTQIA+ community has fluctuated dramatically. A particularly vulnerable subset of that population are transgender and gender non-conforming individuals. From the castigation of youth for merely wanting to engage in competitive sports to broader attempts to identify and isolate anyone outside of the gender binary, transgender (TG) and gender non-conforming (GNC) Americans have been forced to protect themselves in increasingly desperate, expensive and labor-intensive ways. Individuals and families have uprooted themselves in hopes of landing in a place whose politics and society are at least tolerant, if not welcoming. New York has been recognized as such a state, with legislation and policies in place to protect these vulnerable citizens.[1] TG/GNC people, who have for perhaps decades been forced to present themselves to the world constrained by the physical gender expression they were born into, are now able to affirm their true gender identity through a variety of medical and surgical means.

Clinical Vignette

You have known Abby K, both as her family doc and in the community, for at least a decade. Her kid is the same age as your oldest, even having been in the same pre-K class. She and her wife, also your patient, have had increasing marital struggles of late, so you have seen them both for sleep disturbances, anxiety, etc. Abby has also struggled with her weight over the years, developing mild insulin resistance as well as elevated blood pressure over the same period. As your kids' interests and paths diverge and your practice gets busy, you lose track of Abby for a bit, until one day you see a new patient on your schedule with the same last name, Daniel K.

Entering the room tentatively, you start to introduce yourself when you realize Daniel K. is? was? Abby K. After a few moments of light-hearted pleasantries, you ask Daniel what brings him in today after a year plus gap. In a relieved manner, Daniel quickly catches you up on his journey. He had always been unhappy in his body, but had struggled for decades to put a name to the issue. While in counseling, at first surrounding the marriage difficulties, Daniel became more and more confident that the root of his long-standing emotional struggles was his gender identity. He has been working with his therapist for more than a year, has changed his hair and clothing style to better match his true self. Daniel sought out a specialized practice for hormone therapy to bring about physical changes that would allow him to present a masculine face to the world. He is pleased with the progress to date, but is hoping that you, as his primary doc, could take over his testosterone prescription. What do you say? …

Gender-affirming care is a broad term, encompassing simple lay techniques such altering one's hair or clothing style, to intricate, highly-specialized, multistep surgical procedures.[2] Gender affirming hormone therapy is the use of common medications with decades of safe, reliable use in both the endocrinology and primary care settings in a new patient population. There are widely-accepted and recognized national and international society guidelines and standards of care for the care of transgender and gender-nonconforming patients.[3,4] Unfortunately, the access and acceptance of these safe, evidence-based practices varies wildly throughout the United States. The ability to provide gender-affirming care is well within the scope of family medicine physicians, and the numerous independent primary care offices throughout New York State are less restricted/threatened by the policies and proposals that the current federal Department of Health and Human Services has put forth.

Despite the origins of gender-affirming healthcare in Western medicine reaching back more than a century, and the societal and religious recognition of transgender and gender non-conforming individuals going back millennia, struggles to integrate, accept and treat TG/GNC people persist in the United States. Transgender children and youth especially, have been the focus of innumerable local, state and federal legislative efforts. These laws and policies have focused on limiting the scope of legal affirming care, isolating the children/youth from peers, and leaving both parents and healthcare providers open to prosecution. In New York, there has been progress in protecting both TG/GNC patients and their physicians from malicious prosecution by both federal and other state agents.[5] Although frustrating that such protections are necessary, it leaves primary care doctors in NYS with a uniquely influential position to be the advocate for our patients' needs. See Table 1 (page 14) for the DSM 5-TR criteria for Gender Dysphoria in Adults.

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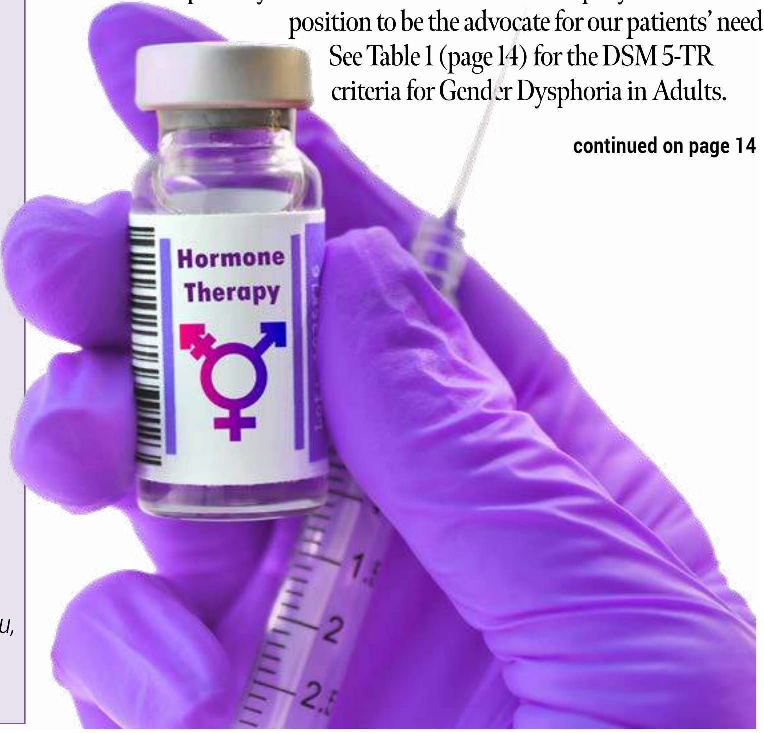

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Table 1

Gender Dysphoria in Adults: a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria[6]

The gender-affirming hormone care needed by each individual patient is in fact, just that, individual. For those adults whose secondary sex characteristics are distressingly feminine, initiation of systemic testosterone therapy can provide a range of masculinizing changes, some permanent, some less so. An adult whose gender identity is decidedly female, or at least more feminine than they can currently present confidently, may benefit from starting an "androgen blocker" and systemic estradiol. As with many medications, exogenous hormones have certain serious risks and benefits, which require a thoughtful, unhurried discussion prior to starting them. Family doctors have the benefit of a longitudinal relationship with our patients, seeing individuals not just in the four walls of the office but often as part of family and community systems. Initiating a medication that has the potential to impact a patient's long-term cardiovascular health, mental health, fertility, cancer risks, etc. should never be rushed. In counseling my own TG/GNC patients, I find I use the common adage, "It's a marathon, not a sprint." See Table 2 below for examples of nonclinical forms of being gender affirming.

Table 2

Non-Medical Gender Affirming Care	
Social Transition	Adopting a new name & pronouns, assisting in 'coming out' in a variety of settings (e.g. partner, family, work, house of worship)
Appearance/Grooming	Changing hair, grooming, clothing style, binding or augmenting chest, packer (for genital bulge), electrolysis/ laser hair removal
Voice/Communication	Speech therapy
Legal documentation	Changing legal gender marker, birth certificate, passport, etc.
Counseling / Interpersonal Support	Therapy regarding internal/external stigma, in-person/online support groups, peer mentorship within TG/GNC community

https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care[7]

Understanding where the patient in front of you is 'coming from' is incredibly important for the management of chronic conditions, and being transgender or gender non-conforming is no different. A patient has likely spent many months, if not years, working up the courage to approach you with this issue. In the US, the progression from rejection to acceptance and now back towards repression of transgender people has been marked in recent decades. It is common for TG/GNC people to have struggled to accept this part of themselves for a long time prior to seeking care. A middle-aged transgender woman may have, as an adolescent, put forward a masking, almost-cartoonishly masculine front, before the independence of adulthood allowed her to explore her deeper feelings and sense of self. Alternatively, a young adult or even late adolescent may seek reassurance and affirming-care having felt isolated and 'in the wrong body' since puberty. TG/GNC people may have researched surgical as well as hormonal therapy options from resources ranging from Reddit and local/online support groups to the Endocrine Society and WPATH/US-PATH. As a primary care physician, your role is to evaluate the person in front of you, providing appropriate care – whether that is a prescription or a behavioral health recommendation or a surgical referral. Are the signs and symptoms they describe within themselves consistent with gender dysphoria or gender incongruence? As family medicine physicians, we make diagnoses daily, including ones that blur the line between strictly medical and mental health (e.g. obesity – MASLD and insulin resistance, as well as binge-eating disorder or anxiety). Diagnosing and initiating treatment for transgender and gender non-conforming patients is similar. There will undoubtedly be patients whose specific case details warrant a referral – perhaps to psychiatry, perhaps to endocrinology – but the majority of transgender patients can be treated and monitored efficiently in their primary care medical home. See Tables 3, 4 and 5 on page 15 for basic dosing guidelines for gender affirming hormone therapy (GHT).

A primary care physician is adept at taking the patient's entire clinical picture into consideration when making a medication change. The initiation of gender-affirming hormone therapy is no different. There may be indications to check certain baseline labs prior to starting exogenous hormone therapy or a potassium-sparing diuretic for example. The monitoring of ongoing gender-affirming hormone therapy is a combination of clinical response and minimizing risks associated with supraphysiologic doses. Both the patient and the physician should be familiar with a rough timeline over which outward changes can be anticipated, knowing that each patient's response is unique. The goal of gender-affirming hormone therapy is to improve the ability of the patient to present their true selves outwardly to both a mirror and the world. As mentioned previously, gender affirming care is not limited to hormones alone; surgery, speech therapy, electrolysis, name and gender marker changes among others may be part of a patient's holistic care. The driving force behind the specifics and their timing is the transgender / gender non-conforming patient themselves.

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Table 3

Masculinizing GHT	Low dose	Starting dose	Max dose	
Testosterone cypionate	20mg/week sq or IM	50mg/wk sq or IM	100mg/wk sq or im	Could double dose for q2wk dosing
Testosterone enathante	20mg/week sq or IM	50mg/wk sq or IM	100mg/wk sq or im	Could double dose for q2wk dosing
T topical gel 1%	12.5-25 mg Q AM	50mg qAM	100mg qAM	May come in pump or packet forms
T topical gel 1.62%	20.25mg qAM	40.5 - 60.75mg Q AM	103.25mg qAM	

https://transcare.ucsf.edu/guidelines/masculinizing-therapy[8]
https://www.rainbowhealthontario.ca/TransHealthGuide/pdf/QRG_mascHT_rev2021.pdf[9]

Table 4

Feminizing GHT	Low dose	Typical starting	Max dose	
Estradiol oral*	1mg/day	2-4mg/day	8mg/day	Consider bid dosing at higher doses
Estradiol transdermal	50mcg	100mcg	100-400mcg	May require PA for multiple patches
Estradiol valerate	2mg q week	4mg qwk	20mg qwk	

https://transcare.ucsf.edu/guidelines/feminizing-hormone-therapy[10]

Table 5

"Anti-Androgens"	Low dose	Typical starting	max
spironolactone	25mg qday	50mg bid	200mg bid
finasteride		1mg qday	5mg qday
dutasteride		0.5mg q day	
bicalutamide		50mg once or twice a week	Very potent antiandrogen used by oncology – very low but very real risk for hepatotoxicity

https://transcare.ucsf.edu/guidelines/feminizing-hormone-therapy[10]
https://www.rainbowhealthontario.ca/TransHealthGuide/pdf/QRG_femHT_2021.pdf[11]
https://www.ncbi.nlm.nih.gov/books/NBK603726/?report=printable[12]
https://www.mayoclinic.org/drugs-supplements/bicalutamide-oral-route/description/drg-20072486[13]

A physician in New York is able to provide gender-affirming healthcare in the confidential manner all medicine should be, without the risk of persecution or prosecution by outside entities or officials. While the Dept of Health and Human Services has proposed rules and policies that would stymie the provision of transgender care in large hospital settings, the sanctity of a private physician office remains not only intact, but explicitly sheltered in NYS. As family medicine doctors, we should feel confident in our knowledge not only of our patients but our medical management skills for our transgender and gender non-conforming patients.

Clinical Vignette, con't.

...You reassuringly smile at Daniel K., "I have managed testosterone before. I would be happy to continue this medication for you. Let me just be sure we are both understanding its risks and your goals first..."

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Rising to the Challenge: Navigating Vaccine Hesitancy and Disinformation in our New Media and Political Landscape

By Elise Lavery, MD, FAAP

As a pediatrician and faculty member at a family medicine residency program, my professional relationship with my patients and families centers on the well child visit. These appointments are the core of preventative medicine—a time for evaluating milestones, discussing nutrition, and providing protective vaccinations. However, the past year has been the most challenging of my career. In the past, vaccine hesitancy was present but sporadic; I dealt with the occasional parent who wished to "spread out" a schedule or expressed concern over a specific ingredient. Today, the atmosphere has shifted. Some form of vaccine hesitancy—from subtle skepticism to outright refusal—arises in nearly every visit.

Several factors have fueled this worsening mistrust. First was the COVID pandemic. Mixed messaging regarding masks and evolving guidelines were often interpreted as incompetence, feeding directly into conspiracy theories. Others feared the rapid rollout of a novel vaccine, not realizing that mRNA technology had decades of research behind it. This was further complicated by a political polarization that siloed people into camps based on their politics rather than medical evidence.

The most influential shift, however, is that families are now getting their medical information from "influencers" rather than traditional authorities. Up to 70% of Generation Z receives health information on social media, primarily through short-form videos like TikTok or Reels. Studies show these platforms are filled with misinformation, allowing anti-vaccine voices to dominate the conversation.[1] Medical institutions, bound by HIPAA and evidence-based guidelines, have been far too slow to respond. Unfortunately, influencers are adept at personal storytelling and "click bait." Their content is entertaining and drives engagement in a way that "boring," evidence-based fact-checking cannot.

Perhaps the most unsettling factor has been the elevation of vaccine skeptics to the highest levels of government. Individuals like Robert F. Kennedy Jr. leading the Department of Health and Human Services (HHS) has provided official legitimacy to long-debunked theories. As the former chair of Children's Health Defense (an anti-vaccine activist group), Kennedy has a documented history of claiming medical experts are compromised by "Big Pharma" and quoting questionable, non-reproducible studies to validate his false claims.

Now that the leadership of the CDC, FDA, and NIH are political appointees with agendas that diverge from scientific consensus, the primary care physician has lost a powerful tool: the appeal to authority. We are in an era where the government itself may tilt the online conversation toward "medical freedom" at the expense of public health, leaving individual clinicians to defend science in isolation.

Academic journals frequently propose counseling techniques like motivational interviewing (MI) or AIMS (announce, inquire, mirror, secure) as the primary tools to combat hesitancy. While these are excellent communication approaches, they are often disconnected from the reality of modern primary care. A typical well-visit must cover growth, development, chronic issues, and social stressors—all within a 20-minute window. MI is labor-intensive; it requires time and multiple steps to be effective. In a high-volume clinic, spending 15 minutes navigating a parent's concerns about "vaccine shedding" means neglecting a child's developmental screening. Furthermore, most insurance models do not reimburse for the extra time required for vaccine counseling, and separate "counseling only" visits suffer from high no-show rates.

The common advice to practitioners to "have an online presence" is not only impractical—it can expose them to online harassment. The medical community has seen a rise in coordinated digital attacks that go far beyond mere disagreement. In this hyper-politicized landscape, primary care doctors are framed as "elites" pushing pharmaceutical agendas. This narrative is easily exploited by social media algorithms. When a pediatric office in Pittsburgh posted a video supporting the HPV vaccine, they were targeted by a global anti-vaccine network.[2] Within days, they received over 10,000 harassing messages; their Yelp and Google ratings were decimated, and their staff and patients were targeted. In Idaho, a nurse practitioner was forced to shut down his social media pages after receiving threats for promoting a seasonal flu shot.[3]

Small practices lack the financial, legal, and technical savvy to navigate these attacks. While the American Academy of Pediatrics (AAP) offers "Vaccine Confidence" toolkits, they offer no legal protection, no IT support for "doxing," and no institutional shield against reputational damage. The Pittsburgh group that experienced the online attack created a toolkit called "Shots Heard Around the World" to help others. While an excellent start, we need more robust support from our larger institutions. This lack of protection results in the most informed voices being the ones most afraid to speak.

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We are also facing the challenge of managing large groups of unvaccinated patients alongside increasing outbreaks of preventable illnesses in our clinics. This is especially fraught in states like Montana, Iowa, and Idaho, where "medical freedom" laws may prevent dismissing unvaccinated patients.[4,5] We must transition from a passive stance to a structured, policy-driven approach. I propose policies that balance empathy with our medical obligation to protect the vulnerable.

In cases of vaccine refusal, the "choice" should not be an easy one. Clinics should implement a mandatory "vaccine policy explanation" visit. This is not a debate; it is a billed session where the clinician outlines the risks the family is introducing to the community. We must use plain language to explain that a choice not to vaccinate is a public choice: if an infant in the waiting room contracts pertussis from their child, that is a medical consequence, not a personal liberty. Where legally permissible, clinics should choose a dismissal policy for families who refuse the primary series or if opting for a "spaced out" schedule fail to complete it on a clinic determined timeline. This provides an informal safety contract for the rest of the clinic patients, particularly newborns and the immunocompromised.

In states where laws prevent dismissal, we must implement strict waiting room safety protocols. This includes segregated scheduling where unvaccinated children are seen only during designated times, mandatory masking for all unvaccinated individuals over age two, and isolation room policies for cases of rash and fever. As "medical freedom" legislation threatens to frame public health measures as "discrimination," professional societies must provide the written protocols and legal protections necessary for clinics to maintain safe environments.

Finally, we have to address the social media gap. Most clinicians lack the time for online advocacy, and even fewer can afford to be targets of online harassment campaigns. Large healthcare networks and universities have been slow to offer protections, partly because they are reluctant to adopt "controversial positions"—a category that now, incredibly, includes basic childhood immunizations. This caution is also driven by a new financial reality where government funding is increasingly tied to political alignment. For a large university or hospital system, taking a firm stand on public health runs the risk of being denied crucial funding that was never previously at risk.

Despite these barriers, universities and large healthcare networks must take the lead. Medical schools should integrate social media communication into their curriculum, teaching students how to analyze fraudulent media and create "storytelling" content. Residency programs should implement mandatory advocacy and media rotations, integrated into existing blocks like our "HEAL" (Health Equity, Advocacy, and Leadership) program at our institution. Every department should have faculty and resident teams producing content for institutional handles. Promotion and tenure tracks for faculty should involve various communication platforms. But, importantly, allowing flexibility for those who wish to remain behind the scenes and not public facing. Faculty and residents could contribute scripts or research under the protection of the institution's IT and legal departments, allowing for a personal presence without exposing individuals to personal harassment.

Every major medical center should have IT departments trained specifically to thwart online attacks—securing accounts, scrubbing personal data, and coordinating with platforms to remove defamatory reviews. This institutional shield is a crucial way to encourage participation in a hostile digital landscape.

We can continue to rely on brief, 20-minute encounters to fight a 24/7 deluge of disinformation, or we can demand the infrastructure necessary to support our doctors. Parental choice is a value, but it does not grant the right to endanger others. Medical offices are not public forums; they are centers of science and safety. It is time for our professional societies, large hospital networks and universities to stop putting the burden on the smallest clinics. They should work to provide the guidelines, legal protections, and digital presence required to support frontline doctors. If we do not show up with the full weight of our institutions behind us, not only are we failing to support our primary care doctors, we are failing to protect our patients.

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Health Care and U.S. Immigration Enforcement: What Physicians Need to Know

By Sheila Ramanathan, DO

How Did We Get Here?

Recent changes to the prior administration's immigration policy occurred on January 20th, 2025 with the circulation of a memo titled "Protecting the American People against Invasion." This negates a prior directive by the Department of Homeland Security (DHS) that there are enforcement "priorities" and expands the number of individuals who could be subject to enforcement measures. The DHS released a statement regarding "protected areas," a policy which rescinded safeguards that restricted US immigration enforcement in hospitals, clinics, schools, and places of worship. The rescinded "protected areas" policy was guidance created from a memo in 2011 which restricted arrests, detentions, and interrogations in or near spaces where individuals seek medical care. Despite discouraging these actions, the previously established memo from 2011 was never an enforceable prohibition.

The removal of the "protected areas" policy results in fear of deportation or detention when seeking access to medicine and treatment. Due to avoidance of medical care, patients' health suffers, resulting in worsening outcomes from delays in treatment of serious health conditions. This also threatens the stability of healthcare as twenty percent of the healthcare workforce is comprised of immigrants.[1] Failure to address this can lead to losing valuable employees and worsen healthcare worker shortages leading to even worse patient outcomes.

Human Medical Rights

Despite these changes, all individuals in the United States have rights regardless of immigration status. Every individual has a right to privacy due to the Health Insurance Portability and Accountability Act (HIPAA). An individual's personal health information is protected information. Every individual has a right to emergency medical care through the Emergency Medical Treatment and Labor Act (EMTALA). Healthcare workers have no legal obligation to determine or report a patient's immigration status. Protected health information (PHI) is restricted from disclosure to authorities as part of HIPAA except in specific instances, such as a subpoena or warrant. Despite this, certain states may have adopted legal requirements to determine immigration status, however there are limitations and patients are not required to answer.

PHI should not be disclosed by law enforcement unless required by judicial warrant, subpoena, or other legally mandated order.[2] HIPAA protections extend to anyone in the United States including those in detention by immigration authorities.

Right to Refuse

Casual requests from law enforcement in emergency rooms or outpatient centers do not justify disclosure and could violate patient privacy and civil rights. Legal consultation is appropriate, and/or consulting institutional guidance is always best prior to responding to law enforcement requests for patient-specific information. The Fourth Amendment requires a warrant for any searching of private properties. Healthcare centers have the right to refuse warrantless searches of private areas (e.g. examination rooms). Public areas, however, (e.g. lobbies) may be subject to search. The right to remain silent constitutionally protects medical staff and patients, both of whom are permitted to remain silent when questioned by law enforcement. There are legal protections medical centers can assert if confronted with warrantless police or immigration enforcement action.[3]

Steps for Clinicians

Healthcare workers have legal rights and ethical responsibilities to provide spaces that prevent immigration enforcement at medical sites, particularly when such action may pose a direct risk to a patient's health.[4] Healthcare facilities provide treatment for the entire community, and prioritizing patient trust and

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Figure 1 : Know Your Rights App[3]

Empower yourself with Know Your Rights 4 Immigrants app. Use this app to prepare, learn and respond if you are at risk of being detained by deportation agents. This app is available in 16 languages and it has the ability to read your rights out loud to an ICE or law enforcement agent and send a message to an emergency contact. Available for both iPhone & Android phones.

Saadi Altaf, "Health care and US Immigration Enforcement: What providers need to know" Physicians for Human Rights, March 2025 accessed 12/9/25

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confidentiality is an ethical obligation for all clinical interactions. Should detention occur, the patient's physician should attempt to coordinate with the patient's lawyer to contribute to the resulting legal case. Documenting and verifying active history of trauma as well as prior examinations can help verify the patient's claims. It's also helpful to provide letters or affidavits to contribute to a patient's legal case advocating against removal or deportation of family members as this may dramatically impact an individual's health status if caregiving is involved.

Physicians should emphasize to patients that immigration status is irrelevant to a patient's right to medical care.[2] Examples of phrasing can include, "We provide care regardless of immigration status" and "You have the right to remain silent if approached by immigration authorities." Ethical best practice advocates against asking about a patient's immigration status.[5] If required, this information should be kept separate and secure from medical records. When it is required to document legal status for establishing eligibility for programs like Medicaid it's helpful to use indirect language. If immigration status must be documented in the medical record, effective phrases could be "the patient demonstrates immigration stressors" or " the patient is ineligible for insurance." During visits it helps to open a dialogue with patients, for example: "Many of my patients are currently experiencing anxiety about immigration problems" and then offer reassurance.

Texas and Florida notably require documentation of immigration status. Should state law require asking a patient's status, advise patients that they are under no obligation to answer. A reasonable script would be, "I am required to ask you the following question about your presence in the United States. You do not have to answer this question."[2]

It's important to monitor and address rumors since false reports with inaccurate information spread fear. NYC Health and Hospitals, in response to misinformation that the system was handing out information to Immigration and Customs Enforcement (ICE), issued a statement on January 30, 2025, "We care about your health, not your immigration status. Despite misinformation on Instagram, NYC Health + Hospitals/Elmhurst is NOT reporting any person or patient seeking care to the police. All New Yorkers should seek care without fear." Misinformation should never be a reason for lack of access to medical care. In offices and public spaces, share and display "know-your-rights" information prominently and emphasize that ICE cannot enter private medical spaces without a judicial warrant. Provide this information in multiple languages relevant to your specific patient population. See Figure 1 on page 18.

Staff should offer deportation preparedness kits as it is helpful for immigrant parents to determine adult guardians for their children. Encourage considering power of attorney for minors to avoid the foster system and obtain alternative contact information to remain in contact with minors during detention or deportation. It's important to summarize patient medical information to have available for the family, should your patient be detained or deported. Minors should have a copy of medical and immunization records made available to a trusted adult. A copy of the child's birth certificate, and immigration related documents like passports should also be given to a trusted adult. Children receiving public benefits may lose access with a parent's deportation as in the case of food stamps or Medicaid coverage. A minor's school records should also be given to their potential guardian.

Judicial vs. Departmental Warrant

Physicians should not feel solely responsible when advocating for patients and staff at an institution. All medical facilities should have clear, consistent protocols when immigration agents arrive and facilities should establish institutional preparedness. Healthcare facilities must offer training to prevent agents from entering restricted, private spaces unless verified by a designated staff member and a judicial warrant is presented.

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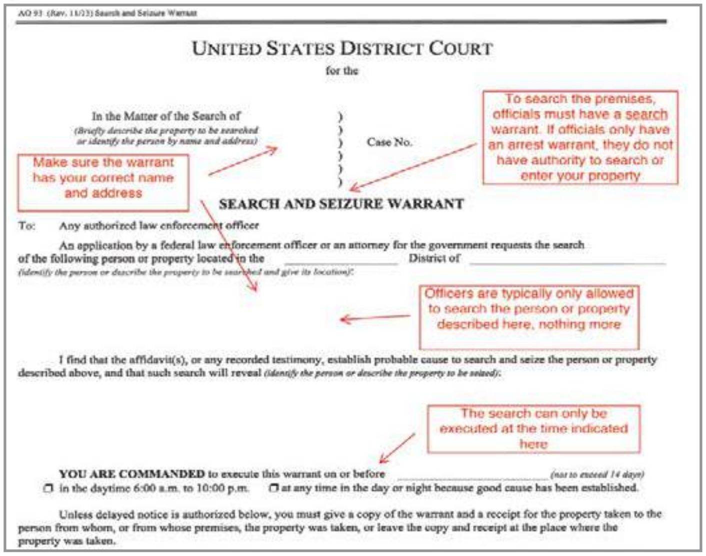
Figure 2

Example of Search Warrant



AO 93 (Rev. 11/13) Search and Seizure Warrant

UNITED STATES DISTRICT COURT
for the

In the Matter of the Search of
(Briefly describe the property to be searched or identify the person by name and address)

Case No.

To search the premises, officials must have a search warrant. If officials only have an arrest warrant, they do not have authority to search or enter your property

Make sure the warrant has your correct name and address

SEARCH AND SEIZURE WARRANT

To: Any authorized law enforcement officer

An application by a federal law enforcement officer or an attorney for the government requests the search of the following person or property located in the ______ District of ______
(identify the person or describe the property to be searched and give its location):

Officers are typically only allowed to search the person or property described here, nothing more

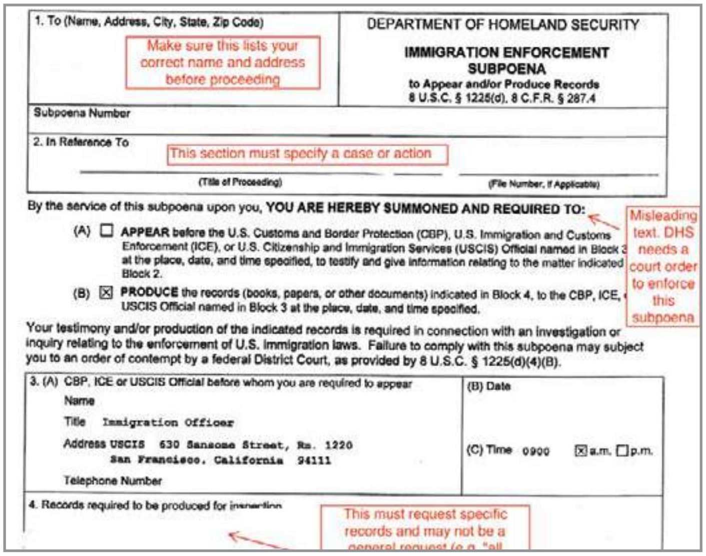
I find that the affidavit(s), or any recorded testimony, establish probable cause to search and seize the person or property described above, and that such search will reveal *(identify the person or describe the property to be seized)*:

The search can only be executed at the time indicated here

YOU ARE COMMANDED to execute this warrant on or before ______ *(not to exceed 14 days)*
☐ in the daytime 6:00 a.m. to 10:00 p.m. ☐ at any time in the day or night because good cause has been established.

Unless delayed notice is authorized below, you must give a copy of the warrant and a receipt for the property taken to the person from whom, or from whose premises, the property was taken, or leave the copy and receipt at the place where the property was taken.

Example of Immigration Subpoena



1. To (Name, Address, City, State, Zip Code)

Make sure this lists your correct name and address before proceeding

DEPARTMENT OF HOMELAND SECURITY

IMMIGRATION ENFORCEMENT SUBPOENA
to Appear and/or Produce Records
8 U.S.C. § 1225(d), 8 C.F.R. § 287.4

Subpoena Number

2. In Reference To

This section must specify a case or action

(Title of Proceeding) (File Number, If Applicable)

By the service of this subpoena upon you, **YOU ARE HEREBY SUMMONED AND REQUIRED TO:**

Misleading text. DHS needs a court order to enforce this subpoena

(A) ☐ **APPEAR** before the U.S. Customs and Border Protection (CBP), U.S. Immigration and Customs Enforcement (ICE), or U.S. Citizenship and Immigration Services (USCIS) Official named in Block 3 at the place, date, and time specified, to testify and give information relating to the matter indicated Block 2.

(B) ☒ **PRODUCE** the records (books, papers, or other documents) indicated in Block 4, to the CBP, ICE, USCIS Official named in Block 3 at the place, date, and time specified.

Your testimony and/or production of the indicated records is required in connection with an investigation or inquiry relating to the enforcement of U.S. immigration laws. Failure to comply with this subpoena may subject you to an order of contempt by a federal District Court, as provided by 8 U.S.C. § 1225(d)(4)(B).

3. (A) CBP, ICE or USCIS Official before whom you are required to appear
Name
Title Immigration Officer
Address USCIS 630 Sansome Street, Rm. 1220
San Francisco, California 94111
Telephone Number

(B) Date

(C) Time 0900 ☒ a.m. ☐ p.m.

4. Records required to be produced for inspection

This must request specific records and may not be a general request (e.g. "all

From the American Civil Liberties Northern California, Protecting Immigrant Community Members Accessing Health Care, PG 6.
URL: https://www.aclunorcal.org/docs/kyr-accessing_health_care.pdf

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A part of training should entail a protocol for law enforcement requests. All public-facing staff should be trained regarding how to speak with immigration agents and have contact information for the designated administrator when encountering immigration authorities. Hospital staff can refuse to provide private patient information to authorities unless a judicial warrant or court order for a specifically-identified individual is produced.[5]

Administrative warrants issued by the DHS, ICE, or Customs and Border Protection (CBP), are not judicial warrants or court orders.[6] Any documentation produced by immigration officials claiming to possess a judicial warrant or other court order should be examined by the institutionally-designated staff member who will need to first confirm the documentation is signed by a judge or magistrate judge. Second, the staff must confirm the specific address on the warrant of the premises to be searched. Third, the staff should confirm the warrant is completed during a specified time as noted on the warrant. Any warrant must be issued within the past 14 days or otherwise is invalid. These pieces of information must be present for immigration officials to legally carry out a search or arrest in a private place. See Figure 2 for an immediate example. For further guidance, a fact sheet is available when receiving an immigration warrant or immigration subpoena. (https://www.nilc.org/wp-content/uploads/2025/01/2025-Subpoenas-Warrants_.pdf).

Plain View in Public Areas

Immigration authorities are permitted to enter public areas of any medical center without a judicial warrant or the institution's consent and may question, search or arrest anyone who is present.[7] Protocol may include advising nearby individuals to remain silent. However, no one should be specifically directed not to answer immigration agents. Never physically interfere with immigration officers, rather staff should respond with this verbal example, "I know my right to remain silent and I choose not to respond to your questions."[2] Law enforcement is able to examine anything that is in "plain view" in a public area. For example, ICE may visually inspect files and paperwork that are visible from the visitor's side of the reception desk.[2] Never leave patient information in plain view in a public area. Agents may not move items in plain view to expose other portions of an item or what is underneath it unless agents can produce a judicial warrant.[8] Understand "plain view" applies to "plain hearing" and any conversations overheard by nearby officers in a public area, even if spoken in a private area are considered plain view.[9]

If an arrest warrant is produced by immigration, the institutionally-designated staff member must review the document for the same legal elements needed for a search warrant. The arrest warrant is only permitted to arrest the named individual, and staff should not interfere.

Additional site searches or questioning of other individuals is permitted.[3] Non-obstructive documentation of the arrest by bystanders or staff is reasonable to ensure a clear record in the event of excessive use of force or violation of civil rights. Refusal to consent to a warrantless search of a facility's private areas is permissible and reasonable.

Understanding Probable Cause

There is a caveat to the requirement of a warrant to search a site, and that is probable cause. Immigration agents may search a private area and seize items found if they have "probable cause" to believe that the search may reveal unlawful activity that is occurring, has occurred or will occur.[2] An agent may justify a reasonable person's judgement that individuals or things connected with illegal activity will be discovered in a specific place.[10] When utilizing "probable cause" a search may be determined to be unjustified if it endangers the life or health of an individual.[2] Staff should document what was searched, seized documents, questioned individuals, and arrests. While agents may not be required to cite a specific justification for probable cause to the targeted medical facility, this will need to be specified in front of a judge. Information as to what was obtained, locations searched, and clear documentation that the facility does not consent to a warrantless search is helpful when pleading the case of violation of constitutional rights when the case is brought up for judicial review.

Institutional Measures

It is important to designate a person or committee to assume responsibility when addressing immigration agent requests. This is necessary for the constitutional protection of staff and patients. Protocols should be grounded in legal protection of the Fourth Amendment which prohibits ICE from entering private areas without a judicial warrant or to perform searches without probable cause. A confirmed judicial warrant must be presented prior to searching private spaces with said individual present to monitor that the specific limitations of the warrant are carried out as well as to obtain badge numbers, affiliated federal department, and identification of the agents involved. If the necessary criteria are not specified on the warrant, this individual must be trained to deny entry of immigration officials that are using only an administrative warrant or no warrant. This individual should be accessible 24 hours a day or in shifts shared with a group of trained individuals. One member of this group should keep abreast of any changes to protocol or law as it pertains to immigration enforcement. A written policy statement can be given to immigration agents. Offering staff "know your rights" training can help prepare for events when immigration officials contact a medical facility.

It is important to support staff during this time of crisis. Provide supportive services for immigrant employees and educate as well as dispel misinformation. If necessary offer counseling and mental health services.

Focus on Supportive Measures

Changes to healthcare delivery may be needed, and prioritization of telehealth can assist with access. However, specific populations may have limitations to internet access and working with local community partnerships can assist in improving this while providing a safe location to access telehealth services. Out of pocket payment plans may be necessary to avoid enrolling in Medicaid or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Offering resources to legitimate legal sources can be immeasurably helpful to avoid notario fraud. "Notario" scams target

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immigrants where individuals pose as legal experts (notaries) and offer unauthorized immigration services. In these cases documentation may be confiscated, incorrectly filled out, or poor legal advice may be offered resulting in detention or deportation.

Resources for Patients

Lawyers for Civil Rights offers an Immigrant Defense Hotline: Call 617 988-0606 and the Emergency Immigration Hotline: Call 1-844-500-322 – website: https://conocetusderechos.org/ as both provide legitimate legal services for those struggling with immigration status. Additional resources are listed in order to obtain further information on evaluating judicial warrants, dealing with immigration in the emergency department, and other topics reviewed.

National Immigration Law Center (NILC) – Health Care Provider & Patients' Rights on Immigration Enforcement: https://www.nilc.org/resources/healthcare-provider-and-patients-rights-imm-enf/

Doctors for Immigrants –Welcoming and protecting immigrants in a healthcare setting: https://doctorsforimmigrants.com/wp-content/uploads/2020/01/WelcomingProtectingImmigrants-toolkit-3.pdf

National Immigration Law Center Fact Sheet on Immigration Subpoenas and Warrants: https://www.nilc.org/wp-content/uploads/2025/01/2025-Subpoenas-Warrants_.pdf

Emergency Room Specific Toolkit: https://www.law.georgetown.edu/health-justice-alliance/wp-content/uploads/sites/16/2021/05/Police-in-the-ED-Medical-Provider-Toolkit.pdf

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"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

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Beyond the Exam Room:

Why Family Physicians Should Advocate for Universal Healthcare

By Anjali Prakash, MBBS

As family physicians we strive to provide the highest quality care for our patients. We stay current with clinical guidelines, apply sound clinical judgment, and engage patients in shared decision-making to deliver evidence-based, patient-centered care across the lifespan. Within a single hour, we might treat a child's acute respiratory infection, counsel on postpartum contraception, and discuss options for colorectal cancer screening. Yet, even when we practice the most ideal medicine, the structure of the health system in which we deliver care profoundly shapes patients' access, outcomes, and continuity of care. The systems surrounding our exam rooms, such as insurance coverage and reimbursement models, often determine whether evidence-based care is accessible, sustainable, or even possible. Universal healthcare represents one approach to aligning our values with our delivery system.

What is Universal Healthcare?

Universal healthcare refers to a health system in which all people have access to essential health services—preventive, acute, and chronic—without financial barriers, regardless of income, employment, or insurance status.[1] It emphasizes equity, continuity, and affordability of care, and evidence shows that universal healthcare would yield measurable improvements in both population health and practice efficiency.[2] The United States (US) remains the only high-income nation without universal health coverage, operating a fragmented multi-payer system that leaves millions uninsured or underinsured despite spending more per capita on healthcare than any other country. One strategy for providing universal healthcare in the US is the implementation of single-payer national health insurance, also known as "Medicare for All." In this system a single government-funded public agency organizes healthcare financing, but the delivery of care remains largely in private hands.[3]

What Does the Evidence Show?

Universal healthcare will improve health outcomes and reduce mortality

Universal healthcare could substantially improve population health. Economic modeling estimates that a single-payer universal system would save approximately 68,000 lives and 1.73 million life-years annually compared to the current system.[4] Between 2009 and 2019, avoidable mortality (deaths preventable through timely access to quality care) increased in all US states while decreasing in most comparable countries with universal coverage.[5] One analysis concluded that government-financed universal systems increase life expectancy by 1.3 years, reduce under-5 mortality by 8.7%, and decrease catastrophic health expenditure by 3.3 percentage points compared to fragmented systems.[6]

Universal healthcare will reduce medical debt

Medical debt affects nearly 20% of Americans, and is associated with worse health status, more premature deaths, and higher all-cause mortality at the population level, creating a vicious cycle where financial barriers to care worsen health outcomes that family physicians are tasked with managing.[7]

An individual or family is considered to have "healthcare cost burden" if their out-of-pocket spending exceeds 10% of the household income. Universal coverage would dramatically reduce the financial burden of healthcare on American families. Currently, 27%-45% of non-elderly adults live in families experiencing at least one form of healthcare financial strain (high out-of-pocket costs, medical debt, or foregone care due to cost).[8] Medical bills comprise more than half of all unpaid personal debts sent to collection agencies, and one in ten families with medical bill problems has declared bankruptcy.[9] Nearly one-fifth of adults with chronic conditions reported being unable to see a physician due to cost, and notably, this prevalence is increasing even among insured patients due to rising deductibles and copayments.[10]

Universal healthcare will result in cost savings due to improved administrative efficiency

Economic analyses consistently project net savings from single-payer systems. Administrative costs in the US healthcare system make up 34.5% of national health expenditure, totaling $812 billion in 2017, compared to just 17.0% in Canada's single-payer system, with the gap widening over time.[11] The Organisation for Economic Co-operation and Development (OECD) is an international group of 38 primarily high-income countries, established in 1961 to promote policies that improve economic growth. Analysis of OECD countries found that single-payer systems were associated with healthcare expenditures 0.75 percentage points lower as a proportion of GDP, which would equate to the US saving well over $1.5 trillion over ten years.[12] One comprehensive analysis estimated 13% savings in national healthcare

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Figure 1. The United States lags its international peers considerably on health system performance

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: Exhibit 2:Overall Performance Ranking. The Commonwealth Fund. *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System – Comparing Performance in 10 Nations.* New York: The Commonwealth Fund, 2024. https://www.commonwealthfund.org/sites/default/files/2024-09/Blumenthal_mirror_mirror_2024_final_v2.pdf

expenditure, equivalent to more than $450 billion annually, primarily through simplified payment administration (median savings of 8.8%) and reduced drug costs.[4, 13] The entire system could be funded with less financial outlay than currently incurred by employers and households combined with existing government allocations.[4]

Universal healthcare will improve access and equity

Universal coverage would eliminate cost-related barriers to care. Currently, 15.7% of Americans report skipping healthcare due to cost—far exceeding the 9.1% average among OECD countries.[10] Among US adults with chronic conditions, 18.7% report cost-related unmet needs, compared to just 1% in Canada.[10] Low-income Americans face particularly severe disparities; among adults aged 55-64, those with low income in the US have worse health outcomes than their low-income counterparts in England, which provides universal coverage through the National Health Service.[14] See Figure 1.

Potential Challenges

Complexities with implementation, political feasibility and transition period disruptions

Transitioning to universal healthcare would require unprecedented political coordination and sustained commitment. Historical evidence from countries that successfully implemented universal systems demonstrates the need for strong, unified governments at critical junctures.[15] The US political system, characterized by divided government and powerful interest groups, presents substantial obstacles. Creating such a system would necessitate fundamental restructuring of the healthcare industry, affecting insurance companies, pharmaceutical manufacturers, hospitals, and physician practices. Moving from the current multi-payer system to a single-payer model would disrupt existing coverage arrangements for the approximately 180 million Americans with employer-sponsored insurance. While the overall system would provide better coverage, the transition could create uncertainty and resistance among those satisfied with current arrangements. Labor contracts with negotiated health benefits would require renegotiation, and the private insurance industry would face massive contraction or elimination, affecting hundreds of thousands of jobs.

Utilization increases, supply constraints and geographical inequities

Expanding coverage to all Americans with no out-of-pocket costs would increase healthcare utilization. Economic analyses predict ambulatory visits would increase by 7-10% and hospital use by 0-3%.[16] While these increases are modest and offset by administrative savings, they would occur within a healthcare system already facing physician shortages and capacity constraints in many regions. Supply limitations, including a finite number of physicians, hospital beds, and other resources, could lead to longer wait times for some services, particularly in underserved areas, unless accompanied by substantial investments in healthcare infrastructure and workforce expansion. Even with universal coverage, substantial geographic variation in healthcare quality would likely persist. This variation reflects differences in healthcare infrastructure, workforce distribution, social determinants of health, and state policy environments that universal coverage alone would not eliminate. Achieving equitable outcomes would require targeted investments in underperforming regions.

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Ongoing cost control and incomplete financial protection

While single-payer systems generate administrative savings, controlling overall healthcare costs requires sustained effort. The US would still need to address high prices for pharmaceuticals, medical devices, and procedures—factors that drive spending independent of insurance structure. Countries with universal coverage employ various cost-containment strategies including price negotiations, technology assessments, and budget caps, which may face political resistance in the US context. Without effective cost controls, even a single-payer system could experience unsustainable spending growth. While universal coverage would substantially reduce financial hardship, some out-of-pocket costs might remain depending on program design. Many universal systems include modest cost-sharing for certain services or exclude some benefits (e.g. dental, vision, long-term care). The extent of financial protection depends on specific policy choices regarding covered services, cost-sharing requirements, and supplemental insurance options.

A Tale of Two Countries

As a family physician who trained and practiced in Australia before moving to the United States, I observed stark differences in my ability to provide care for vulnerable patients in the two countries.

While practicing in Australia, I treated a new patient who had recently left a violent relationship. She could not afford out-of-pocket fees, but her consultation was covered through Medicare, the national insurance system. She had complex physical and mental health needs requiring medication, diagnostic evaluation, and psychological referral. All medication and services were covered by Medicare, and despite a recent change in her circumstances, no additional administrative work was required to ensure access to care.

In contrast, my experience in the US illustrates how insurance fragmentation can directly limit patient care. I saw a patient experiencing homelessness whose Medicaid coverage was inactive. Because of this, I could not prescribe his usual antihypertensive medications or treatment for benign prostatic hyperplasia (BPH). Our shelter-based clinic maintains a limited supply of medications, allowing temporary treatment for his hypertension, but not his BPH. Although I referred him to our insurance specialist for assistance, Medicaid activation required additional administrative steps. During this delay, he developed worsening urinary symptoms and incontinence due to lack of medication access.

These contrasting encounters illustrate how health system design can determine whether physicians are able to deliver quality guideline-concordant care, particularly for patients already facing social vulnerability.

How Can Family Physicians Advocate for Universal Healthcare?

Family physicians can play a pivotal role in advancing universal healthcare by engaging in evidence-based advocacy at the clinical, community, and policy levels. This includes educating patients and policymakers about how coverage gaps affect health outcomes, contributing frontline perspectives to legislative discussions, and participating in organized medicine initiatives that promote equitable access to care. Because universal healthcare reform is ultimately a policy challenge, effective advocacy requires understanding that political strategies will vary across contexts and must address both policy design and implementation challenges.[17] Family physicians should support disadvantaged groups in building political power and amplifying their voices, as well as convince opponents that access to healthcare benefits everyone.[17]

Physicians for a National Health Program is an organization that equips clinicians with research, policy briefs, and advocacy training to support systemic reform,[18] while the American Academy of Family Physicians offers policy statements, advocacy toolkits, and opportunities to communicate directly with legislators.[19] By leveraging these platforms, family physicians can extend their commitment to patient well-being beyond individual encounters and help shape health systems that enable consistent, comprehensive care for all.

Conclusion

The evidence suggests that universal healthcare in the US would likely produce substantial benefits in terms of lives saved, financial protection, and healthcare access, while generating net cost savings through administrative efficiency. However, successful implementation would require navigating significant political challenges, managing transition disruptions, addressing supply constraints, and implementing cost-containment strategies. Experience from other high-income countries shows that universal coverage is achievable with sustained political commitment and careful system design. For family physicians, universal healthcare would fundamentally transform practice by eliminating cost-related barriers that currently prevent patients from accessing preventive care and chronic disease management, reducing the administrative burden that contributes to physician burnout, and allowing physicians to focus clinical time on evidence-based care rather than insurance authorization processes. By advocating for universal healthcare, family physicians can address the root cause of access inequities that undermine their ability to provide comprehensive, continuous care to their patients.

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Editor's Note:

From Bill Klepack, MD, Editorial Board, Family Doctor

[This] is a very well written and clearly stated review of the economic issues surrounding single payer healthcare. What [might] make this article even more interesting would be to tackle a thorny issue – addressing political control and influence.

The handling of the pandemic in the early years of the Trump administration graphically displayed the extent to which an administration was prepared to go to distort the public health message and even engage in promoting quack remedies and advice. This problem was further amplified by Governor Cuomo's covering up misjudgments made in the transferal of nursing home patients back to their facilities post-hospitalization, and then covering up the data about outcomes. It was made even more disturbing by the Commissioner of the Department of Health not stepping forward and providing accurate information.

The sum total of such actions has been to clearly inform the public that healthcare information, priorities, and actions are fair game to be used for political/ideological ends. Trump in the spring of 2020 advocated not testing for Covid (because, I believe, no data was better than adverse data for his political ambitions). If single payer healthcare is not properly isolated from politicians, it will be used for political gain at the public's expense. The events of Trump's 2nd term amplify this concern when one looks at what has happened at the FDA, CDC, ACIP, and what may well happen soon at the USPSTF.

Single payer is dead in the water if the political conundrum is not solved. I used to think modeling its governance after the Federal Reserve Board was a model that would do it. It may still be, but, if the Supreme Court rules adversely in the case now before it, it will no longer suffice as a model.

The New York Health Plan is also flawed. It stipulates that in the event of an impasse the Commissioner of the Department of Health will be the arbiter, and, if needed, the Governor will decide. The former is a political appointee of the Governor, and the latter is a politician.

A frank discussion centered on this issue is needed and a resolution found. The public will not go for single payer otherwise.

Beyond the "Like": A Framework for Social Media Professionalism as a Physician

By Christine S. Persaud, MD, MBA; Laurenie Geraldine Louissaint, MD, MS; Ahmed Ashai, MD and Stephen Hongach, DO, MS

Background

Over the years, medicine and politics have played a central role in occupying the landscape of digital discourse. For the family physician, social media is a tool for fostering social connection, professional networking, advertising, and patient education. Yet, engaging in such discourse and sharing one's views or stance on certain topics may carry significant risks regarding employment and possible ethical breaches.

Methods/Approach

This article synthesizes current professional guidelines from the American College of Physicians (ACP) and the Federation of State Medical Boards (FSMB) with scenarios faced by primary care clinicians navigating controversial healthcare policies, administrative workflows and their social media footprint.

Key Findings

The intersection of social media and medical politics necessitates a "digital dual-citizenship" strategy. Key areas of focus include: 1) The "anonymity fallacy" and the permanence of digital footprints; 2) Managing patient connection requests and the "friending" dilemma; and 3) Addressing "clickbait" medical misinformation while adhering to evidence-based standards.

Introduction

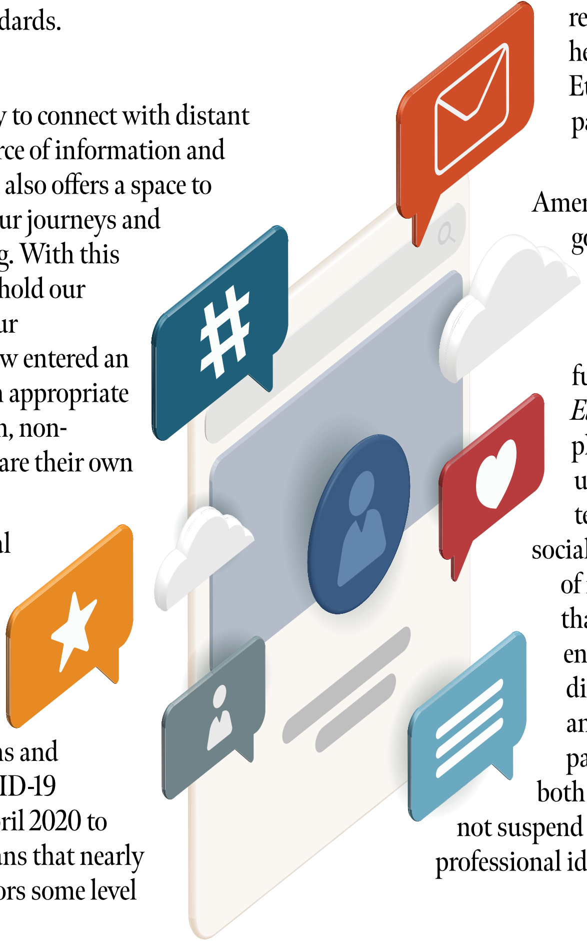
Social media has evolved from a way to connect with distant friends and family into a primary source of information and personal expression. For physicians, it also offers a space to humanize our profession by sharing our journeys and perspectives beyond the clinical setting. With this visibility comes a responsibility to uphold our professionalism beyond the walls of our institutions and practices. We have now entered an era of medical influencers—some with appropriate credentials, and others not. In addition, non-medical individuals are also able to share their own opinions online.

The necessity for professional digital conduct has never been more urgent. Recent data highlights a staggering erosion of public confidence in the medical establishment. According to a study published in *JAMA Network Open* (2024), public trust in physicians and hospitals plummeted during the COVID-19 pandemic, dropping from 71.5% in April 2020 to just 40.1% by January 2024.[1] This means that nearly 60% of the U.S. population now harbors some level of distrust toward medical professionals. Earlier research from the *Journal of General Internal Medicine* (PMC1484714) reminds us that while trust in a personal physician often remains higher than trust in the "system," systemic distrust significantly impacts patient outcomes and compliance.[2] In this climate, every post, comment, and "like" from a physician can either help bridge this gap or widen it.[3] Given the amount of medical misinformation on social media, physicians play a vital role in spreading evidence based medical information and attempt to reestablish the trust in doctors through relatability.

The "Anonymity Fallacy" and the Permanence of Digital Footprints

Many physicians operate under the "anonymity fallacy," the belief that pseudonyms, private accounts, or "opinions are my own" disclaimers provide a protective shield. However, the FSMB warns that digital content is nearly impossible to delete permanently and can be easily traced back to the author.[4] The AMA Journal of Ethics emphasizes that these guidelines should be viewed as a starting point for reflection rather than a simple checklist; the same ethical standards regarding patient privacy and professional decorum apply regardless of account privacy settings.[5] Physicians hold fiduciary responsibilities and are expected to exercise heightened judgment in public discourse. Ethical restraint online is not censorship—it is part of professional responsibility.

Many physicians overestimate First Amendment protections, which primarily limit government action, not private employers. Even public employees may face discipline if online speech disrupts operations or impairs institutional function, as established in *Pickering v Board of Education* and *Garcetti v Ceballos*.[3] Employed physicians are often subject to strict conduct unbecoming clauses that can lead to termination for controversial political or social posts. While advocacy is an essential part of medicine, the FSMB reminds practitioners that their online persona can reflect on the entire medical community, necessitating a distinction between public health advocacy and partisan vitriol that might alienate patients.[4] In short, the "anonymity fallacy" is both technological and legal. Digital platforms do not suspend fiduciary duties or regulatory oversight, and professional identity persists online.



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Managing Patient Connection Requests and the "Friending" Dilemma

Physicians often have to face the challenge in the duality of their social media presence. The boundary between personal and professional life can be blurred when a patient sends a friend request. Physicians face the challenge between professionalism and the humanistic part of the human connection which can be challenging. The ACP and FSMB both strongly recommend that physicians maintain separate professional and personal profiles to avoid these ethical gray areas.[3,4] When a patient reaches out on a personal platform, the physician should decline the request and address it in person during the next clinical encounter. A simple, polite explanation stating that it is a professional policy to keep social media separate to protect patient privacy usually suffices. As the AMA Journal of Ethics suggests, "friending" patients can lead to unintended boundary crossings, such as a physician gaining access to personal information about a patient that was not shared in a clinical context, potentially complicating the therapeutic relationship.[5] Another consideration can be thought of as a dual-citizenship strategy. An example would involve using professional platforms like LinkedIn or X for a clinic, networking, and education while keeping personal platforms strictly private and focused on non-medical life. Either strategy may be employed by physicians to keep the patient-doctor relationship secure. With these privacy setting guardrails in mind, clinicians may not always have control over their social media footprint. With new social media features, a simple like, share, repost or sharing one's opinion under a separate post can also hold evidence of that footprint .

Addressing "Clickbait" Medical Misinformation While Adhering to Evidence-based Standards

Emerging new social media platforms such as TikTok, Instagram Reels, and Threads present similar challenges. In an era of viral medical misinformation, physicians have a duty to uphold and emphasize the importance of consistent, evidence-based, and professional communication without falling into the engagement trap. The FSMB explicitly states that providing inaccurate medical information online can be grounds for disciplinary action.[4] While correcting misinformation is vital, the ACP suggests that physicians should prioritize evidence over emotion, counteracting clickbait with clear, cited, and accessible information that focuses on the science rather than attacking the source.[3] Overly aggressive correcting misinformation by online users, often reinforces distrust rather than changing their minds. Furthermore, it is critical to maintain content guardrails by ensuring that any medical advice shared is general in nature and includes a clear disclaimer that the interaction does not constitute a formal doctor-patient relationship.

Conclusion

By establishing clear personal-professional boundaries and understanding the administrative implications of their digital presence, family physicians can effectively participate in social media while fostering a safe environment within their practice for patients, colleagues, staff and learners regardless of their political, religious or world views.[5]

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Prevention Under Political Pressure:
Fluoride Facts for Family Practice

By Mary Rose Puthiyamadam, MD; Samantha Williams, MD and Daniela Pinzon, MD, MPH

Introduction

Dental caries remain one of the most prevalent chronic conditions, affecting 60–90 percent of the world's population.[1] One of the most effective tools in combating cavities is fluoride, delivered either through community water fluoridation or topical applications such as toothpaste. Recognizing this, we began to consider applying fluoride varnish during well-child visits. As we consider ourselves equity champions, we are aware that many of our patients lack dental insurance. Traditionally, our role in supporting their oral health has been to advise parents to wipe infants' gums after feeding and, as children grow, to brush and floss twice daily while limiting sticky, sugary foods.[2,3] However, with a desire to do more than simply provide counseling, we explored incorporating fluoride varnish into well-child visits. Around that time, a news report referring to fluoride as a "neurotoxin," prompted further investigation.

Fluoride becomes incorporated into tooth structure during development, providing protection across the entire tooth surface. After tooth eruption, fluoride exerts topical effects by integrating into the enamel surface and increasing resistance to acid attacks. It also provides ongoing benefits through its presence in saliva, which continuously bathes the teeth. The preventive effects of combined exposure, such as fluoridated water alongside fluoride toothpaste, are additive and enhance overall caries prevention.[1]

Fluoride reduces dental caries by decreasing demineralization, enhancing remineralization, and inhibiting bacterial metabolism.[1] Community water fluoridation at a concentration of 0.7 ppm is recommended by the U.S. Public Health Service and endorsed by major health organizations as a safe and cost-effective public health intervention that significantly reduces dental caries.[3] An important but often underrecognized benefit of community water fluoridation is its ability to reduce socioeconomic disparities in oral health. By providing equitable access to fluoride regardless of income, education level, or access to dental care, it improves outcomes among vulnerable populations.[4]

According to the Environmental Protection Agency, between 2016 and 2021, 99.99 percent of community water systems maintained fluoride levels below the 2.0 mg/L safety threshold, with only 0.01 percent of measurements exceeding this level.[5]

People of all ages are encouraged to brush twice daily with fluoride toothpaste to prevent dental caries. The American Academy of Pediatrics recommends initiating fluoride toothpaste use with eruption of the first tooth. For children younger than three years, a smear or grain-of-rice–sized amount should be used. Once a child reaches three years of age and can reliably spit, the amount should be increased to a pea-sized portion. Parental supervision is recommended until approximately ten years of age. Children should spit without rinsing after brushing to minimize ingestion while maintaining therapeutic fluoride levels in saliva.[3,6]

So where does the idea that fluoride is a neurotoxin originate? And should family practices pursue varnishing with only fifteen minutes for a well-child visit?

Community Water Fluoridation

Community water fluoridation has long been recognized as an effective public health strategy for reducing dental caries. As a population-level intervention, it benefits individuals served by community water systems (CWS). A national analysis of water fluoridation across the United States reported that, in 2020, approximately 72.7% of the U.S. population received water from a CWS, and 62.9% of those individuals were served by systems that met the U.S. Department of Health and Human Services (DHHS) recommended fluoridation standards.[7] By comparison, 69.2% of the population received water from a CWS in 2006.[7]

Coverage varies by state, with Hawaii, New Jersey, Oregon, and Idaho having the lowest percentages of the population receiving optimally fluoridated water.[7] Notably, Hawaii ranked lowest among all 50 states and has also reported high rates of dental caries among children.[8] These state-level disparities underscore the ongoing need for targeted public health efforts to expand access to optimally fluoridated water, particularly in states with limited coverage and elevated caries prevalence.

Community water fluoridation represents preventive infrastructure that reduces individual and systemic disparities. Removing or weakening this infrastructure shifts the burden of prevention to individual families, disproportionately affecting those with limited financial or dental resources.[3,9] The anticipated public health consequences of removing fluoride from U.S. public water systems could result in approximately $9.8 billion in additional dental treatment costs over five years among children ages 0–19.[9]

The Neurotoxin Narrative: Evidence and Context

Recent public statements describing fluoride as a "dangerous neurotoxin" have renewed debate about community water fluoridation. These claims draw from selective toxicologic data at higher exposure levels and a growing body of

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neurodevelopmental research. Interpreting this literature requires careful attention to dose, exposure timing, study design, and clinical context.

Fluoride can cause adverse effects at sufficiently high exposure levels. Chronic intake above recommended thresholds has been associated with skeletal fluorosis in regions with naturally elevated groundwater concentrations. In the United States, the Environmental Protection Agency sets a maximum contaminant level of 4.0 mg/L to prevent skeletal fluorosis, while community water fluoridation is maintained at approximately 0.7 mg/L to balance safety and caries prevention.[5]

Neurocognitive Outcomes

The 2024 National Toxicology Program monograph concluded with moderate confidence that higher fluoride exposure is associated with lower IQ in children.[10] A 2025 systematic review and meta-analysis in JAMA Pediatrics analyzed 74 studies and reported inverse associations between fluoride exposure and children's IQ across study designs.[11] In pooled analyses of 13 studies using individual-level urinary fluoride data, a 1 mg/L increase in urinary fluoride was associated with a 1.63-point decrease in IQ, and 1.14 points when restricted to studies rated low risk of bias.[11]

Urinary fluoride reflects total exposure from water, food, and dental products and may better capture overall exposure than water concentration alone. A 2023 dose-response meta-analysis reported a linear association between higher fluoride concentrations and lower IQ above 1 mg/L, with less consistent findings at lower concentrations and stronger effects in higher-risk-of-bias studies.[12]

Most studies included in meta-analyses were observational, and many were conducted in regions with fluoride concentrations exceeding U.S. community water levels. Association does not establish causation, and residual confounding remains a concern.[11] It is important to note that IQ scores are not a perfect measure of cognitive function across different populations; the metric may not fully capture the range of neurodevelopmental abilities and was not designed to assess diverse cultural or socioeconomic contexts.

Prospective Cohort Studies

Several North American cohorts have examined prenatal fluoride exposure near recommended fluoridation levels. In the Canadian MIREC cohort, higher maternal urinary fluoride during pregnancy was associated with lower IQ scores in boys.[13] A subsequent Canadian study reported associations between maternal fluoride exposure and executive function in preschool children.[14] In the Mexican ELEMENT cohort, higher prenatal urinary fluoride concentrations were associated with modest reductions in child IQ across developmental time points.[15] A U.S. study in Los Angeles County reported associations between maternal urinary fluoride and neurobehavioral outcomes at 36 months.[16]

Although these prospective studies offer better exposure assessment than ecological analyses, they remain observational and face important limitations. Uncontrolled confounding from maternal nutrition, co-exposures to other environmental toxins, or socioeconomic factors may influence observed associations. Exposure misclassification is possible, as urinary fluoride reflects short-term intake rather than cumulative exposure. Outcome measures, such as IQ, are culturally and contextually limited and may not fully capture the neurodevelopmental domains of interest. Taken together, these methodological constraints mean that the modest associations observed cannot establish causation, supporting the continued safety and public health benefits of fluoridation at recommended levels.

Thyroid and Systemic Outcomes

Thyroid function has been evaluated in relation to fluoride exposure. A 2024 systematic review identified dose-related increases in TSH at approximately 2.5 mg/L water fluoride, with less consistent findings for urinary biomarkers.[17] A Canadian pregnancy cohort reported increased odds of primary hypothyroidism with higher fluoride exposure.[18] In contrast, a 2025 rapid systematic review found no evidence of adverse thyroid or neurological effects at concentrations below 1.0 mg/L, with most reported effects occurring above 1.5 mg/L.[19]

Prevention and Equity

Dental caries has been described by the American Academy of Pediatrics as a "silent epidemic," disproportionately affecting children who are young, living in poverty, and from minority communities.[3] Oral health disparities reflect broader structural inequities.

Preventive interventions such as fluoride varnish (FV) are especially important for children at elevated risk. The AAPD recommends fluoride varnish application every 3 to 6 months for high-risk pediatric patients.[3] Medicaid programs in all 50 states reimburse both physicians and dentists for providing fluoride varnish, increasing access to preventive care. Additionally, under the Affordable Care Act (ACA), insurers are required to cover preventive services recommended by the USPSTF and Bright Futures without cost-sharing.[3]

Despite policy support, utilization remains suboptimal. Only 5% of well-child visits among privately insured children in Maine, Connecticut, New Hampshire, and Rhode Island included fluoride varnish application.[20] Although use increased following the ACA mandate, overall rates remain low.[21]

Implementation studies suggest that training programs and workflow integration, including embedding varnish into electronic order sets, significantly improve uptake.[22,23] Strengthening preventive delivery within primary care, alongside maintaining community-level fluoridation, is central to reducing oral health disparities.

The Family Physician's Role

Recent political shifts provide an opportunity to thoughtfully reassess long-standing public health recommendations while reaffirming our commitment to evidence-based care. In doing so, it is essential to distinguish between credible scientific findings and selective reporting of data.

Community water fluoridation remains one of the most studied and effective public health interventions for the prevention of dental caries. At recommended levels, it has been demonstrated to be both safe and beneficial. Studies reporting associations between fluoride exposure and cognitive or behavioral effects have primarily involved populations exposed to fluoride concentrations far exceeding those used in regulated U.S. community water systems.

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Public health policy must account for the totality of evidence and the broader determinants of health. Dental disease is strongly linked to disparities in access to preventive and restorative care. For populations with limited dental services, interventions such as fluoride varnish are evidence-based strategies that reduce caries risk and mitigate long-term health consequences. Untreated dental disease can result in pain, infection, impaired nutrition, lost productivity, and increased healthcare costs across the lifespan.

Maintaining community water fluoridation at recommended levels, alongside targeted preventive services in primary care, supports health equity and reduces avoidable disease burden. As a family physician, when my patients lack access to dental care, I am prepared to incorporate fluoride varnish as a practical, evidence-informed measure to protect their oral health. This approach balances advocacy, clinical judgement, and patient-centered care–addressing the dilemma of limited time while promoting comprehensive, preventive strategies.

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Empowering Family Medicine Physicians
to Navigate Abortion Care During Political Uncertainty

By Rebecca Collins, DO, MPH, CPE, FAAFP; Samantha Cardoso, MPA; Samantha Rai, MD and Usha Modukuru, DO

Introduction

Since the overturning of Roe v. Wade, countless women across the United States are experiencing emergent situations for access to reproductive care. In June 2022, the Dobbs v. Jackson Women's Health Organization Supreme Court decision changed the course of abortion care, leaving states to set their own laws and restrictions on abortion care services. As of March 2026, 41 states have abortion bans in effect as seen in Figure 1.[1]

Prior to the Dobbs ruling, it was estimated that 24% of pregnancy-capable individuals in the U.S. would have an abortion by the age of 45.[2] As a result of the Supreme Court decision, states, such as New York, have upheld its commitment to reproductive healthcare by approving Proposition One, amending the New York constitution to protect reproductive healthcare, including abortion care. Governor Hochul declared New York to be a 'safe harbor' for women from around the country to come and seek abortion services, as a multitude of states actively limited access.[3-4] Meanwhile, other states, like Texas, have enforced restrictive bans and have criminalized abortions, for anyone engaging in actions of solicitation, aiding, attempt, and conspiracy in abortion care access, which has shown significant increases in maternal morbidity and perinatal mortality rates across Texas.[5-7] The Dobbs ruling sparked national outcry and confusion over the legal implications and risks in delivering and seeking reproductive healthcare, particularly in the management of ectopic pregnancies, miscarriages, and other causes of pregnancy loss. Physicians have reported feeling moral distress—a feeling of powerlessness to do what is right, including when they are prevented from providing necessary health care.[8] Along with moral distress, there is a heightened level of fear and stigma associated with providing abortion care during this period. One study followed 28 family medicine resident physicians for 7 years post residency and reported that only a few continued to provide abortion care due to state-specific laws, lack of mentorship, collegial/institutional support, and the stigma of providing abortion care.[9] After the ruling, the American Academy of Family Physicians stated that the ruling, "criminalizes evidence-based medicine, threatens the patient-clinician relationship, and exacerbates health disparities in maternal mortality and morbidity."[10]

Family physicians play a critical role in providing comprehensive reproductive healthcare access and guiding patients to credible and reliable information for a shared and informed decision-making approach to care. Family physicians, along with OB-GYN physicians and advanced care providers, are critical in filling the gap in reproductive healthcare needs. However, only 40% of OB-GYN physicians report providing routine abortion care for their patients

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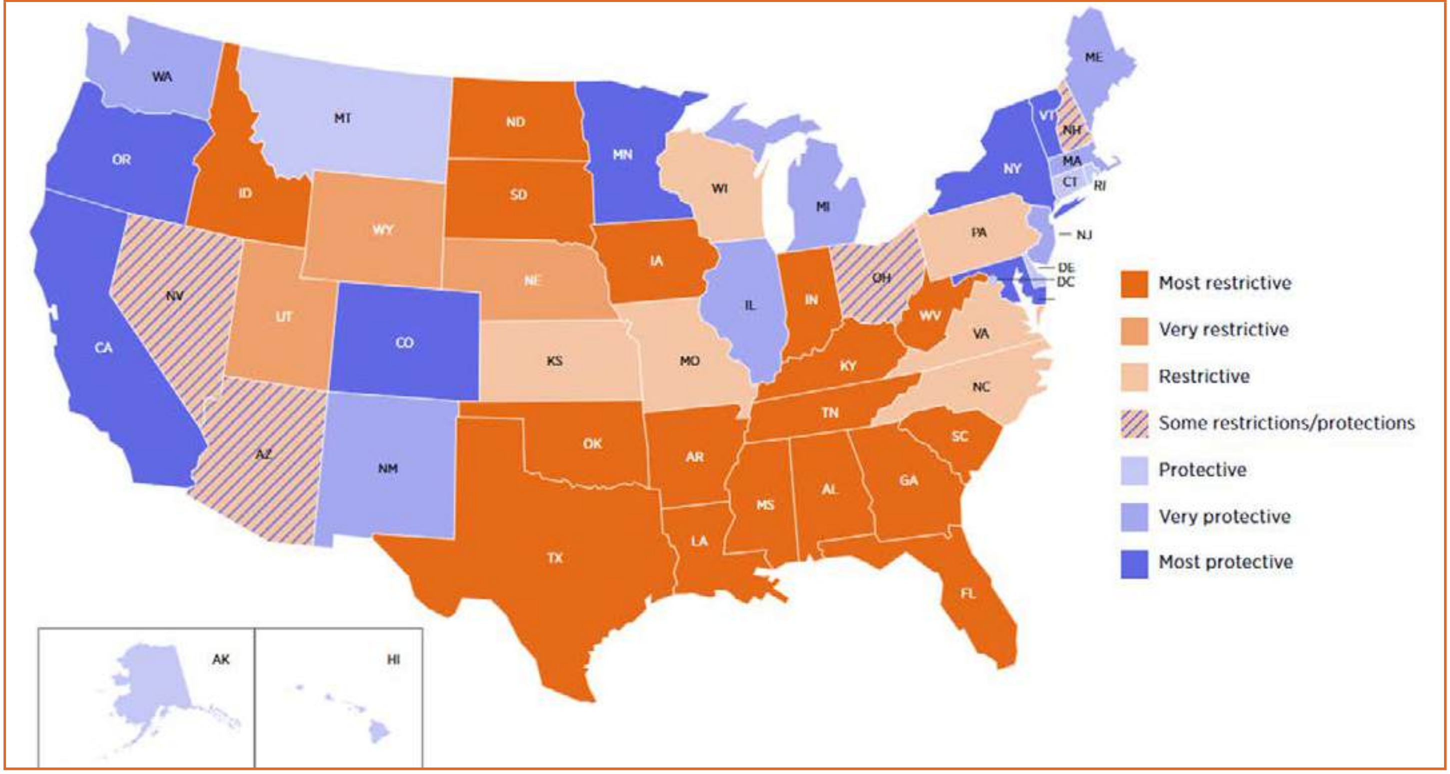
Figure 1. Interactive Map: US Abortion Policies and Access After Roe. Guttmacher Institute.



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after completion of residency, and only 3% of family physicians were providing abortion care 3 years post-residency, signaling the need for family physicians to act swiftly and bridge this gap in care.[11-12] Family physicians can provide abortions safely and effectively in the outpatient setting, drawing on skills that are core components of family medicine, such as counseling, pregnancy diagnosis, determination of gestation age, procedural skills, and medication management.[13] Though family physicians are well-equipped to provide abortion care, many feel unable to, due to a myriad of challenges and barriers, included but not limited to, insufficient training/education, ambiguous legal and institutional policies, resource deficiencies, personal and professional afflictions (e.g. stigma/belief systems), etc. Many family medicine residency programs and medical schools do not offer abortion care training, furthering the gaps in clinical skills and learning for future practice in reproductive care.[14-15] Studies show that in areas with state-level abortion bans, there are further declines in reproductive health education and training, with half of matriculating medical students receiving their medical education in states with banned or restrictive abortion laws.[16]

In response to these governmental changes, our residency program created an abortion care training curriculum to increase family medicine trainees' knowledge, skills and comfort around abortion care and options counseling. Over the course of 3 years, we followed 24 residents who demonstrated a significant increase in competency in performing abortions and comfort with providing informed, comprehensive options counseling to their patients. Our findings, coupled with other studies, can help guide and empower family medicine physicians to navigate abortion care, extinguish fear and stigma, teach and lead UME and GME trainees, and more comfortably educate patients on their options and access to compassionate and comprehensive healthcare.

The Current Landscape of Abortion Care in the U.S. and New York State

With the Dobbs v. Jackson Women's Health Organization Supreme Court ruling, there has been a windfall of state restrictions and as of January 2026, 41 states have enforced abortion bans across the U.S.[1] Each state's handling of abortion care restrictions varies significantly, with some restrictive states banning abortion completely, without exemptions for cases of rape or incest.[10] With the variability and rapid evolution of these restrictions and laws, the availability of clearly defined guidelines for physicians and other abortion care providers becomes ambiguous and precariously risky, especially in restrictive states where abortions are criminalized. Across the country, 61 cases have been identified where people were criminally investigated or arrested for allegedly ending their pregnancies or assisting another person to end their pregnancy.[10] With regards to insurance coverage, the Hyde Amendment removed federal funding from Medicare, Medicaid, and Children's Health Insurance Program (CHIP) recipients who are seeking abortion care services, disproportionately impacting Black and Hispanic pregnancy capable people across the U.S.[17] Moreover, patients seeking mifepristone for medication abortions have been logistically impacted by updates to the U.S. Food and Drug Administration risk evaluation and mitigation strategy (REMS). The FDA has removed the option for in-person pharmacy dispensing and added a new pharmacy certification process.[18] With these challenges and restrictions, abortion care services are currently primarily performed at freestanding clinics specializing in reproductive healthcare with some inclusion of private office-based practices and telehealth clinics offering medication abortions.[19]

At present, New York is considered a very protective state alongside 10 other states whose status ranges from protective to very protective.[5] New York State law permits abortions within 24 weeks from the commencement of pregnancy, and after 24 weeks to preserve the pregnant person's life. With the passage of the 2019 Reproductive Health Act, abortions have been removed from the criminal code, provisioned into public health law, with the allowance of abortion without needing documentation detailing reasons why, and permission for abortion past 28 weeks in cases of non-viable fetus or a life-threatening complication.[20] Additionally, New York provides public funding for abortions and requires state-regulated private insurers to cover "medically necessary" abortion care, including the coverage of abortions in maternity care for all private insurance plans and ensures abortion care clinician protections unlike other restrictive states, where legal action has been taken.[21]

Across the U.S., the feeling of moral distress among physicians has increased after the Dobbs ruling decision, and even more so for healthcare teams practicing in restrictive states as opposed to protective states. The distress stems from uncertainty regarding the national legal climate, fears for patients and colleagues in restrictive states, and institutional restrictions.[8] Nationally, the medicolegal landscape continues to evolve with state-specific laws being reviewed and interpreted by healthcare institutions whose policies need to abide by state law, but also ensure safe and evidence-based practices for quality reproductive healthcare services for patients and assurances for physicians and others providing abortion care.

Challenges and Barriers to Navigating Abortion Care

Navigating abortion care has presented several challenges and barriers for physicians looking to either integrate, expand, and/or perform abortion care in their practice care settings, including restrictive or ambiguous legal and institutional policies, staff and workforce apprehension and reluctance, lack of support systems, stigma and personal beliefs, psychological safety concerns, and training educational gaps.

Despite New York's legal protections, ambiguity and lack of clarity in legal and institutional policies persist. One study surveying several maternal healthcare specialists at 17 New York State regional perinatal centers that provided abortion care reported that 79% of survey respondents reported facing barriers to providing abortion after 24 weeks, which included, most commonly, staff resistance and institutional policy.[20] In this same study, a few of the regional perinatal centers faced regional access disparities, resulting in having to refer patients to receive abortion care services at another and often further institution, even out-of-state, due to the ambiguity of the language by institutional policies.

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There is apprehension and reluctance of staff and colleagues to perform or assist with abortion care. A study that followed family physicians, whose education included abortion care training and who provided abortion care after 5 years post residency, reported that support from clinical staff, administration, and support staff was the most mentioned barrier compared to personal belief or safety factors.[22] Several studies have shown that physicians have also experienced marginalization from some of the medical community with respect to experiencing lack of support, discrimination, and opposition towards abortion care integration in their respective institutions. This opposition contributes to challenging work environments.[23-25]

Apprehension and reluctance to perform abortions are frequently derived from the persistent stigmatization of abortion care in the national discussion. For example, though very similar, if not identical in practice, procedural or medical abortion care is often seen as different than management of pregnancy loss (“miscarriage”), with perceived stigma associated with abortion but not pregnancy loss care.[12,26] This perceived stigma has significantly contributed to how physicians feel about their own psychological safety both personally and professionally. Bayat et al. interviewed several OB-GYN and family physicians, the majority of which provided both medication and procedural abortions, and discovered that a significant barrier to providing abortion care was stigmatization and exposure to antiabortion harassment, leading to concerns for individual and familial safety.[1] One study demonstrated the emotional, moral, and professional impact of providing abortions by illustrating how many physicians and advanced care providers struggle with self-protection and privacy from legal, institutional, and societal scrutiny and their outward and public obligation to provide abortions. By choosing professional privacy, they felt that that perpetuated the notion that abortion is “immoral and illegitimate; moreover, the praise received by non-abortion-care providers felt more isolating than empowering, furthering the misconception of abortion care not considered as a standard procedure.”[27]

Research has shown that exposure to abortion care training strengthens physicians’ ability and comfort to provide abortion care and contraception counseling.[26, 28] However, after the 2022 Dobbs decision, many OB-GYN and family medicine residency programs, particularly in restrictive states, have seen a decline in residency applications from previous application cycles, with 10.5% decrease in applicants for OB-GYN residency programs and an overall 3% decrease for family medicine residency programs.[29] According to Beasley et al., as of 2023, there are “no specific requirements that undergraduate medical education include pregnancy options counseling or abortion care.” Additionally, 17% of medical schools offer formal abortion education, with only 44% of schools offering clinical abortion care experiences.[30] A study following family physicians interested in integrating medication abortion into their practice found that a lack of training and education on provision of medication abortion was a significant barrier contributing to exclusion from their scope of practice.[27] Research has also shown that although training is pertinent, having training does not guarantee job placement. Studies have found that abortion care physicians and advanced care providers may face challenges finding employment at institutions and healthcare systems that support abortion care provision.[31-32]

Facilitators for Abortion Care Expansion and Integration

As studies have shown, exposure to abortion care training and education only further supports a family medicine physician in integration and expansion in their practice. Opt-out abortion care embedded into standard residency curriculum has been shown to be successful. Nothnagle noted that a learner-centered approach to abortion care training allows residents to feel comfortable providing abortion care from a physician perspective, irrespective of personal views.[33]

Our residency program’s abortion curriculum has led to increased resident comfort with options counseling, ability to explain abortion procedures and perform aspiration abortions within a short training period (4 eight-hour days at a high-volume outpatient abortion clinic). By including opt-out abortion training, we demonstrated that after four days of hands-on procedural training and time dedicated to online reading and modules, our residents’ confidence and skills increased. We conducted a qualitative study with the curriculum’s first few cohorts of residents, using a semi-structured interview, to examine self-identified comfort with curricular areas both before and after their rotation experience. See Figures 2-4.

Figure 2. Family Medicine Residents’ Self-Reported Competency Level for Providing Options Counseling (Pre- and Post- Rotation)

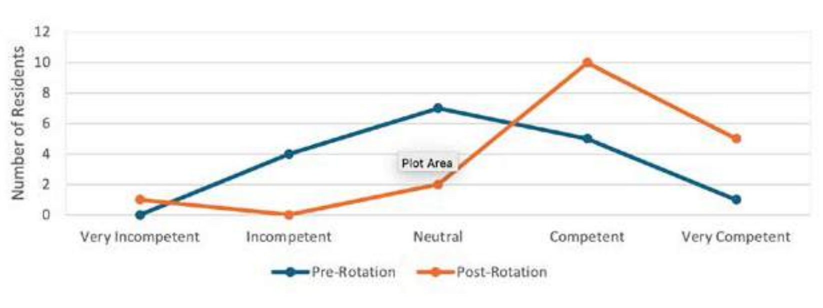

Figure 3. Family Medicine Residents’ Self-Reported Competency Level for Explaining Abortion Procedure to Patients (Pre- and Post- Rotation)

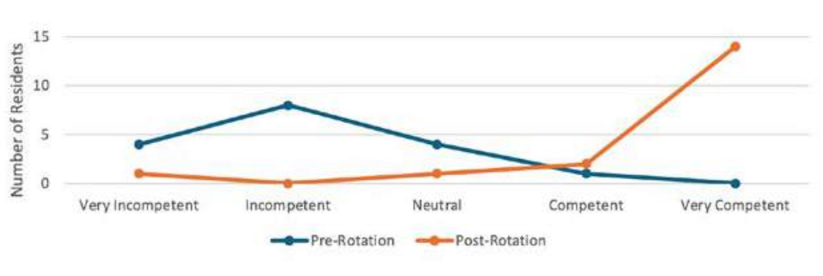

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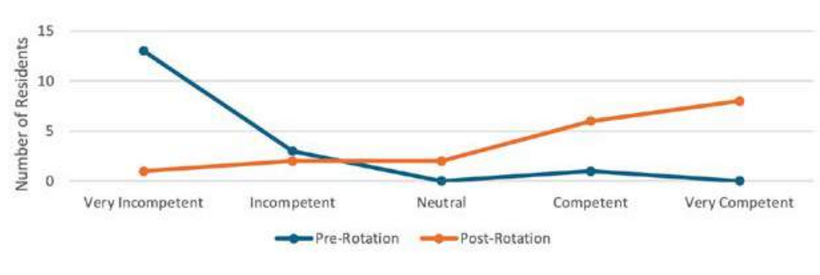
Figure 4. Family Medicine Residents' Self-Reported Competency Level for Performing an Aspiration Abortion (Pre- and Post- Rotation)



Knowing that barriers persist, we hope to see that with time and continued resident training, which now also includes competency in providing medication abortion, that we are able to graduate family medicine physicians who will go on to provide options counseling and abortion care in their communities.

When a family physician is trained in abortion care, there is great potential for these trained physicians to become future educators, only furthering the accessibility of comprehensive reproductive healthcare in the future. Patel et al. found that family physicians who provided pregnancy termination are also more likely than their peers to teach medical students, residents, and fellows. This study also revealed that family physicians who provide abortions are more likely to work at academic institutions due to the organizations' motivation to combat institutional barriers and integrate abortion into the teaching curriculum.[13]

Working for or practicing at institutions supportive of abortion care provision along with interprofessional collaboration has shown easier integration and expansion of abortion care services. Studies have shown that having support from institutions' leadership and administrative personnel was integral to advancing reproductive healthcare, because it leads to additional resources, such as protected administrative time, access to clinical guidelines and policies, grants and funding to pay for equipment and staff, medical society memberships, and supportive staff and colleagues.[23,24,26] Additionally, many studies acknowledged that physicians working for supportive institutions and with supportive staff rejuvenate a sense of purpose and duty, fosters community (both within the medical and patient community), and reinforces the vital role of being a family physician during a contentious time in reproductive healthcare.[12,26,34]

Other common facilitators mentioned throughout the literature included the benefits of practicing, integrating, and expanding abortion care in a protective state vs a restrictive state,[5,20,26] and the ease and comfort of administration of medical abortion, controlling for protective state status, availability of mifepristone, and supportive institution/staff, as an initial start to integration.[26]

Patient Perspectives

We would be remiss, in our discussion of the national and state-wide climate, barriers to abortion care and facilitators, to not mention the powerful voice of our patients. Study after study demonstrates that patients prefer to discuss reproductive health and receive abortions from their primary care family medicine physicians or advanced care practitioners.[35-36] Patients can also feel stigmatized or abandoned by providers who refer patients out to others for abortions and may have their own conflicting personal beliefs and values. In addition, the social determinants of health which are present in many of the communities that family medicine physicians care for (i.e., transportation challenges, language barriers, insurance issues, financial limitations, lack of cultural congruent care, etc.) present near insurmountable challenges when patients desire care that can be done by their family medicine physician but is only offered elsewhere. Despite opposing views, Wulf et al. reported that physicians agreed, "at a minimum, family physicians should be able to counsel patients on abortion care," and it was noted that family physicians would not be doing their jobs appropriately if they let the stigma of abortion care supersede the importance of patient care.[12]

The Role of New York State Family Physicians and Next Steps

As family medicine physicians in New York, we value the skills and training that allow us to provide care across a variety of settings and to help our patients address a broad range of needs and concerns. Our patients trust us to help them navigate what might be challenging or confusing landscapes. Some of the resources we use to train residents, such as Training in Early Abortion for Comprehensive Healthcare (TEACH), which absorbed the Reproductive Health Education in Family Medicine (RHEDI) after RHEDI lost funding,[37] and the Reproductive Health Access Project (RHAP),[38] are readily available, evidence-based, trustworthy, and invaluable tools that can help us all as we assume the responsibility of providing comprehensive reproductive health care to our patients. TEACH is a nationally and internationally recognized and free curriculum that connects residents and physicians with CME training opportunities. RHAP is easily accessible, free online, and has extensive physician and patient education that enables the busy family medicine physician to efficiently incorporate reproductive health care into primary care. RHAP recently updated their toolkit on incorporating medication abortion in primary care.[39] ReproTLC is another national organization that connects those seeking additional training to sites across the country.[40] Many family medicine physicians have participated in creating these resources, which serve as places for all of us to learn, stay up to date, and find protocols and guidance, enabling us to deepen or broaden our scope of practice to meet the needs of our patients.

Beasley et al. recommended a few additional solutions to expand abortion education, including 1) suggesting relationship-building between residency programs, hospitals, and academic institutions in protective states and those in restrictive states to bridge the educational gap by accepting out-of-state learners to train at their programs and institutions if resources allow; 2) empowering hospital and academic institutions to actively voice and affirm their collective support of abortion education and access, specifically examining their own institutional policies for stigma-associated and unclear language; 3) and encouraging network development and partnership-building

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between academic institutions, community clinics and advocacy organizations and include cost coverage for faculty to work in clinics and expand educational opportunities for learners and trainee at said clinics.[41] Additionally, in NYS Gov. Hochul recently announced $20 million in state grant funding to support eligible reproductive health care providers to integrate and offer medication abortion health care services under the NYS Supplemental Abortion Provider Support Fund. Specifically, this fund will support the recruitment, training, and retention of clinical and medical staff, costs associated with expansion of hours/times needed to provide increased access to care, care management and navigation services, uncompensated abortion-care associated services, and community outreach, marketing, administrative, and operational needs to increase abortion care access.

Conclusion

We have outlined the current landscape, challenges and barriers to providing abortion care, resources to train and the dire importance of family medicine stepping up to actively change the national landscape which is restricting access to reproductive care for our country. We have demonstrated that with minimal investment in curriculum expansion, significant gains can be made in trainees regarding competency in counseling, teaching patients and performing abortions. Our patients desire to receive this care from us, their primary care physicians, instead of being referred to unknown care teams and other locations. We encourage all family doctors to explore barriers in their communities and contact others advocating for change for support and encouragement. We join with other family medicine leaders in calling for the family medicine Residency Review Committee, the ACGME, and AAMC to require abortion training for all trainees[14] and develop partnerships and networks with community organizations, academic institutions, and hospitals across the country to expand and increase availability of training opportunities. We applaud the AAFP and ACOG for affirming that abortion education should be provided during family medicine residency training.

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From Volume to Value: Rebuilding the Clinical Note in New York Primary Care

By Saehyeon Kim, MD, PhD; Jennifer Chapman, RN, CCDS and Paula Brooks, MD

Clinical documentation in primary care has evolved substantially over the past several decades. Before the mid-1990s, physician billing for nonprocedural work was based on self-assessment of difficulty and time spent with a patient, and clinical documentation was left to the professional judgment of the physician.[4] The length of a document and what was included in it were at the discretion of the physician. Payment was largely determined by the volume of visits and procedures rather than by measured outcomes, operating under a fee-for-service model.[5]

The most significant transformation in documentation requirements occurred with the issuance of the Evaluation and Management (E&M) guidelines in 1995 and 1997—more than a decade before the Affordable Care Act (ACA). These guidelines largely redefined cognitive services as not what was done, but rather what was documented.[4] They created a complex system of rules that turned the provision of care into a two-step process: caring for the patient and then "backfilling" a note to fit an arcane documentation format. This created an imbalance of values, with coding and compliance trumping clarity and conciseness.

The ACA then fundamentally altered the broader payment structure. While public discussion often focuses on insurance expansion, its deeper impact was the acceleration of value-based payment.[5] Reimbursement became increasingly tied to quality performance, readmission rates, cost efficiency, and population health outcomes.[3] For the first time, health systems were evaluated not only on what they did, but on the measurable results.

This transformation placed primary care at the operational center of the health system.[7]

Preventive care, chronic disease management, care coordination, and risk reduction are all functions that occur primarily in family medicine. In New York, where value-based contracting and Medicaid redesign have progressed rapidly, this shift has been particularly visible.

With these changes came a new requirement: patient complexity, clinical reasoning, and quality performance had to become visible in a standardized, auditable form. As the shift from volume-based to value-based payment models progressed, the need for more structured data in clinical documentation increased. Documentation became the mechanism through which that visibility was created.

In value-based care, undocumented care did not occur.[4] Risk adjustment depends on condition specificity. Quality programs depend on documented actions. Medical necessity depends on clearly demonstrated decision-making.

The clinical note has become the language through which value is translated into reimbursement, performance metrics, and system sustainability. For many clinicians, the response has been to adopt various documentation strategies—including longer notes, increased templating, and copy/paste functions—that often increase rather than decrease documentation time and after-hours EHR burden.[1]

The Hidden Cost of Writing More

For the primary care physicians, the end of the clinic day is often followed by hours of charting. Longer notes are written in the belief that they are safer, more compliant, and more complete. In reality, excessive documentation often achieves the opposite.

Copy-forwarded text, templated review-of-systems, and auto-imported data create notes that are longer but less useful. The central clinical questions—why the patient is here, what has changed, what the clinician thinks, and what the plan is—become difficult to find. When another clinician opens the chart, the clinical story is buried beneath redundant information.

Length does not reliably improve reimbursement. It does not guarantee higher-quality care. Studies of electronic health record use have shown that documentation burden is associated with decreased efficiency and increased burnout, particularly in primary care.[1] In audits and medicolegal review, internally inconsistent documentation often becomes a greater liability than brevity.[6]

The core problem is not insufficient documentation.
It is signal dilution.

By signal dilution, we refer to the loss of visibility of clinically meaningful information as low-value text accumulates. As templated and copied content expands, the clinician's reasoning and plan become harder to find, reducing interpretability, increasing cognitive load, and creating medicolegal risk. High-value documentation preserves signal density by keeping clinical reasoning immediately visible.[2]

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A High-Signal Approach to Modern Documentation

Effective documentation in the value-based environment does not require longer notes. It requires a structure that allows a single clinical sentence to serve multiple purposes at once.

A well-designed statement can simultaneously:

- communicate the patient's condition to another clinician
- demonstrate medical decision-making for billing
- capture risk-adjusted complexity
- support quality reporting

This can be achieved through a simple format:

condition + specificity + status + plan

When documentation follows this structure, the note becomes shorter, more readable, and more defensible.

Linkage language plays a critical role. By linkage language, we mean documentation that explicitly states the clinical relationship between coexisting conditions, using terms such as "due to," "with," or "complicated by," so that diagnoses reflect a coherent pathophysiologic narrative rather than a disconnected list. In risk-adjusted systems, diagnoses that are listed separately do not convey the same clinical meaning as conditions that are explicitly connected. "Chronic kidney disease stage 3b due to diabetes" reflects complexity that would otherwise remain invisible. This improves diagnostic accuracy and risk capture without increasing note length.

Another practical test of documentation quality is whether the assessment and plan can be understood without scrolling. When clinical reasoning is immediately visible, cognitive load is reduced for every clinician who opens the chart. Continuity improves. Audits become easier to defend. After-hours charting decreases.

Concise documentation is not incomplete documentation. It includes condition-specific detail when it changes interpretation or management, while stable problems require only minimal updates. It prioritizes decision-making over data display. See Table 1 for examples of high vs. low signal documentation.

Small Changes That Make Notes Work Again

Most clinicians do not need a new template. They need a different way of thinking about the note.

Writing one high-signal sentence for each active condition is often enough to meet clinical, billing, and quality requirements simultaneously. Explicitly stating the level of risk—such as prescription drug management—makes medical decision-making visible without adding text. Avoiding the automatic import of normal or unchanged data keeps the focus on what matters today.

A brief closing statement documenting shared decision-making can strengthen medicolegal defensibility while reinforcing patient-centered care. For example: "Plan reviewed with patient; risks and benefits discussed; patient verbalized understanding and agreement."

These are small changes, but their cumulative effect is substantial. Notes become faster to write, easier to read, and more accurate representations of the care that was delivered. Clinicians spend less time charting after hours. Teams communicate more effectively. Risk adjustment becomes more accurate.

In a state where primary care is central to population health and value-based care, documentation is not a clerical burden. It is a clinical tool.

The most professional note is not the longest one. It is the one that is precise, readable, and true.

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Table 1. Examples of High-Signal Documentation Compared With Note Bloat/Low-Signal

Clinical Scenario	Note Bloat or Low-Signal Example	High-Signal Documentation
Type 2 diabetes with obesity	Patient presents today for follow-up of diabetes mellitus. Blood glucose values and most recent laboratory results were reviewed and discussed in detail with the patient. The importance of diet, exercise, and weight loss was emphasized. The patient was counseled extensively regarding lifestyle modifications and the need for improved glycemic control. Current medications were reviewed and reconciled. The patient reports variable adherence to dietary recommendations. Risks of uncontrolled diabetes including cardiovascular disease, nephropathy, neuropathy, and retinopathy were discussed. The patient verbalized understanding. We will continue to monitor and adjust management as needed at future visits.	Type 2 diabetes with class II obesity, poorly controlled with hemoglobin A1c 9.2% compared with 8.4% at the last visit while on metformin. Initiate GLP-1 receptor agonist for glycemic control and weight reduction; follow up in 4 weeks.
COPD in active smoker	Patient with known history of chronic obstructive pulmonary disease presents for routine follow-up. Symptoms were reviewed. Current inhaler regimen was reviewed with the patient and proper inhaler technique was discussed. The patient continues to smoke despite prior counseling. Smoking cessation was again encouraged and various options were reviewed. Oxygen saturation and vital signs were obtained and documented in the chart. The chronic nature of COPD and the importance of medication adherence were discussed. At this time the patient will continue the current treatment plan with close monitoring. The patient agrees with the plan.	Moderate COPD with increased rescue inhaler use associated with ongoing tobacco dependence. Escalate to LAMA/LABA therapy and initiate varenicline for smoking cessation; refer to pulmonary rehabilitation.
Major depression	Patient seen today for follow-up of depression. Mood symptoms were discussed at length. The patient reports ongoing low mood, decreased energy, and poor motivation. Sleep and appetite patterns were reviewed. Current medications were reviewed and potential side effects were discussed. The importance of medication adherence and ongoing therapy was emphasized. Supportive counseling was provided during the visit. Safety was assessed and the patient denies active suicidal ideation. The patient will continue current treatment and follow up as scheduled.	Major depressive disorder with partial response to sertraline. Increase sertraline to 100 mg, place psychotherapy referral, and review safety plan.
Atrial fibrillation	Patient with a history of atrial fibrillation presents for follow-up. Medications were reviewed and reconciled. Recent laboratory results were reviewed. The risks and benefits of anticoagulation were discussed. Heart rate control and rhythm management were reviewed. The patient denies chest pain, shortness of breath, or palpitations at this time. Vital signs were obtained. The chronic nature of atrial fibrillation and the importance of compliance with medications and follow-up were discussed. Will continue current management and monitor.	Nonvalvular paroxysmal atrial fibrillation with elevated stroke risk based on CHA DS -VASc score of 3. Risk for hypercoagulable state associated with the mechanical nature, continue apixaban for anticoagulation and maintain rate control with metoprolol.
Iron deficiency anemia	Patient presents for evaluation of anemia. Laboratory findings were reviewed in detail. Possible causes of anemia including nutritional deficiency, chronic disease, and gastrointestinal blood loss were discussed with the patient. Dietary intake was reviewed and counseling was provided regarding iron-rich foods. The patient was advised on the importance of follow-up testing. The risks and benefits of iron supplementation were discussed. The patient verbalized understanding. We will continue to monitor and reassess at the next visit.	Iron deficiency anemia with hemoglobin 9.8, most consistent with chronic gastrointestinal blood loss. Start oral iron therapy and refer for colonoscopy to identify the source.

Abbreviations:

A1c, hemoglobin A1c; COPD, chronic obstructive pulmonary disease; GI, gastrointestinal; GLP-1, glucagon-like peptide-1; LAMA, long-acting muscarinic antagonist; LABA, long-acting beta-agonist.

Before the Ban: How Legal Uncertainty and Policy Threats Reshape Gender-Affirming Care

By Atara Schulhof; Z Paige L'Erario, MD, LMSW and Adam Kronish, MD

Debates over gender-affirming care (GAC) for transgender and gender-diverse (TGD) patients have gained national attention. These debates are framed by more than enacted laws; they are shaped by perceived legal risk, policy threats, and administrative ambiguity that alter clinical practice before the courts or legislatures finish their work. This "chilling effect," well documented in other arenas of politicized medicine such as abortion care, refers to the phenomenon by which clinicians, institutions, and training programs will preemptively soften, modify, or curtail evidence-based services not because of active legal prohibitions, but because confusion, uncertainty, fear, and anticipated scrutiny discourage clear guidance, referrals, and sustained clinical engagement.[1]

GAC encompasses a wide range of medical, surgical, and other supportive services that major medical organizations such as the American Medical Association (AMA), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), and American College of Obstetrics and Gynecologists (ACOG), among others, recognize as evidence-based and life-changing for many TGD people, significantly improving their quality of life.[2–6] Yet political action and rhetoric have been targeting and contradicting these practices and gained traction rapidly.[7–9] In 2025, the U.S. Department of Health and Human Services (HHS) released a report on gender dysphoria in which they emphasized speculative and long-term risks, dismissed demonstrated benefits, and repeatedly characterized the evidence for GAC as insufficient.[10] The department then took the opportunity to attack the healthcare system and in particular, the AMA and AAP, insisting that GAC "has inflicted lasting physical and psychological damage on vulnerable young people."[11] Its list of contributors include many known critics of GAC.[11] This report arguably functions less as neutral review than as a cautionary narrative that amplifies fear and justifies retreat from established clinical practice.[10] Dr. Susan Kressly, the former president of the AAP, acknowledged her alarm by this document and reasserted that, "This report misrepresents the current consensus and fails to reflect the realities of pediatric care...[the report relied on] select perspectives and a narrow set of data."[12] Nevertheless, as of mid-2025, more than half of the states in the U.S. have enacted laws that limit or prohibit youth from accessing GAC, and many include professional penalties for clinicians who provide these services.[13]

Access to Care: Reality on the Ground

The population that needs and benefits from GAC is substantial and growing. Recent estimates suggest that there are nearly 2.1 million adults (aged 18+) and 724,000 adolescents (aged 13-17) who identify as transgender in the U.S., with roughly ⅓ of trans adults identifying as nonbinary.[14] In total, TGD youth and adults account for 1% of the U.S. population aged 13+, and around 5% of young adults identify differently from their sex assigned at birth.[15] Yet, nearly 40% of TGD youth live in states with already enacted bans on GAC.[16]

Policy shifts have been dramatic. While only a handful of states had significant restrictions before 2021, now over half the country has laws limiting or prohibiting youth GAC.[13] Many additionally have penalties that could affect clinicians' licensure or legal standing.[17]

Even in states without direct active bans, these actions disrupt care delivery. Clinics close or stop providing services, and families must travel significantly longer distances for care or upend their lives and move to get adequate care if they're able to.[18–21] This exacerbates socioeconomic inequities, as those without the means to move or travel are further affected. Additionally, providers often "over comply," reducing even services that remain lawful due to a fear of prosecution or professional consequences. For instance, many providers are avoiding direct care referrals and relying on external organizations now due to navigating uncertainty and anticipated scrutiny.[22]

Patient outcomes cannot be separated from access. Evidence consistently shows GAC is associated with improved mental health and reduced suicidality among TGD patients.[23,24] Restricting access or even "chilling" provision increases anxiety, depression, and isolation. Patients report repeated disruptions in treatment, forced travel, and financial burden as the landscapes of care shift beneath them.[7,25] When healthcare providers pull back due to their own fear, patients are left to navigate fragmented systems with diminished support. Many patients thus feel abandoned by their providers and the healthcare system.[21] This also exacerbates inequities due to geography, socioeconomic status, and other structural factors, potentially leaving many with no access to care at all.

Legal Threats Before Enforcement

Even where bans are not yet fully implemented, proposed legislation and federal policy shifts are already reshaping provider and institutional behavior. For example, recent federal initiatives under the Trump administration aim to restrict funding and access for GAC and investigate hospitals and clinicians who provide it.[8,26–29] It is important, especially when discussing GAC for youth, to remember the term GAC is non-specific, and therefore interpretation is highly variable. For some, GAC can mean using one's preferred name/pronouns, supporting a social

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transition and familial support, and offering mental health access during a transition. These federal actions are opposed amongst states, medical organizations, and civil rights groups.[30,31]

These actions matter even before implementation because they generate uncertainty and fear about liability, funding, future access, and professional risk. In several cases, major medical centers such as Stanford Medicine and others have halted or scaled back gender-affirming services for youth pending clarity about such federal enforcement, despite care remaining legal in their states and jurisdictions.[32]

This pattern mirrors what was seen with reproductive health and access to abortion care after *Dobbs vs. Jackson*.[33] Clinicians changed counseling and referral practices in anticipation of restrictive state laws and fear for their risk, even in places where the laws were ambiguous or unenforced.[34]

Chilling Effects on Clinicians, Institutions, and Referral Networks

Policy threats not only influence laws on paper, but they shape how providers act. Surveys and interviews of healthcare providers found increased burnout, stress, and moral distress tied directly to hostile legislative and institutional environments that threaten GAC, not just actual laws or enforcement.[35–37] For instance, over 95% of providers of GAC, even in states with shield law protections or no laws, reported moral distress due to frustration, anticipatory distress, institutional constraints, balancing care and guidelines, wanting to do more, and the political and social pressures surrounding them.[37] Clinicians must confront ambiguous legal language, institutional risk aversion, and threats to their license, financial stability, and even personal safety and life.[36,38] This was seen in non-TGD providers, but for providers who identified as TGD themselves, distress levels were even further exacerbated.[35] Furthermore, there is targeted harassment that occurs to providers of GAC with the growing politicization and alarming rhetoric surrounding the issue, regardless of legal restrictions.[39,40] One survey found over 70% of GAC providers received threats related to their use of GAC.[39]

One study of providers practicing across different policy climates found that those in states with legislative restrictions reported significantly higher levels of distress and secondary trauma, even as they continued to serve TGD patients.[35] These patterns largely mimic what was seen in providers of abortion after the 2022 Dobbs decision.[41–44] Legislative pressures add emotional labor and ethical strain to an already-demanding practice, contributing to workforce migration and potential attrition, further exacerbating issues with provider shortages and access to GAC providers.[22,34,38,45]

Clinicians and hospitals face subpoenas and investigative actions that appear aimed not at clinical malpractice but rather just intimidating providers.[17,27,28] For instance, in 2025, a federal judge blocked a subpoena from the Department of Justice (DOJ) seeking detailed, HIPAA-protected patient information from a hospital that provides GAC.[46] Even when legally challenged, actions like this signal to providers that their clinical judgement might be scrutinized under shifting regulatory standards. This may lead to a self-protective pullback from offering full services, even when those services align with professional standards, research, and evidence.

Similarly, referral networks can fracture as clinicians hesitate to support care that could draw scrutiny or fear for their licenses and safety.[36] For example, increasingly, providers are utilizing grassroots organizations and networks rather than formal referrals to coordinate care due to restrictions and limitations.[22] Referrals are also impacted by "aiding and abetting" provisions in some laws that threaten penalties for facilitating care outside restrictive states.[29] This threatens not only direct provision of care but the entire ecosystem of longitudinal, coordinated, holistic care for TGD patients.

Training and Education

The "chilling effect" extends into medical training, education and professional development, where training in LGBTQ+ healthcare and GAC is already lacking.[47] Family medicine residency programs, other specialties, and clinical training sites are caught between adherence to evidence-based care and institutional risk policies that discourage trainees from engaging in controversial services.[34,45,48] Faculty may avoid teaching aspects of GAC and providing opportunities for shadowing or involvement in gender-affirming clinical care, especially given growing threats.[36,45] This threatens longitudinal primary care competencies and leaves a generation of providers unprepared to serve a vulnerable population.[48,49] Furthermore, this way of thinking may further discourage trainees and providers from providing other types of care deemed politically "controversial" in the future or care tailored to marginalized populations, exacerbating current health inequities.[22]

Moving Forward: Policy, Practice, and Power

For family medicine, these changes are more than abstract policy debates. They shape daily practice, ethical commitments, and who physicians can serve. Providers must be prepared to navigate evidence and risk while advocating for policies that protect both patients and providers. Institutions should clarify legal protections and support clinicians who act in alignment with professional, evidence-based standards. Professional societies also must continue litigating threats that target clinical practice, autonomy and patient rights.

Understanding and naming this "chilling effect" of recent political action and debate is itself an act of advocacy. It helps remind providers that fear is not an accident or a source of personal weakness, but a predictable outcome of hostile political, legal, and professional environments. Recognizing this impact helps healthcare reposition itself not merely as a responder to laws and political climates, but as a defender of evidence-based, patient-centered, equitable care in the face of a rapidly changing sociopolitical landscape. (See Table 1)

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Table 1: Recommended Practice Changes in a Hostile Policy Environment

Practice Area	The "Chilling Effect"	Recommendations
Institutional Policy	Halting or reducing services and support due to "anticipatory risk" and fear of federal funding loss (e.g., CMS/Medicare threats).	**Clarify and Defend** Institutions should provide clear legal guidance on what is currently legal versus what is threatened. Commit legal resources to defend clinicians against subpoenas and federal "investigations."
Clinical Practice	Over-complying, or reducing lawful services (e.g., medical and surgical services, referrals, or even mental health support or social transition) to avoid any potential scrutiny.	**Adhere to Consensus/Guidelines** Explicitly root all care in guidelines of major medical organizations (AMA, AAFP). Lead with clinical evidence, acknowledge the policy debate, challenge narratives, and return to patient outcomes.
Referral Networks	Fracturing of formal networks; providers avoiding direct referrals due to "aiding and abetting" fears.	**Grassroots Coordination** Utilize decentralized, grassroots organizations and peer-to-peer networks to coordinate care and travel for families in restrictive areas to ensure adequate access to care.
Medical Training	Residencies and other training programs avoiding GAC curricula, leaving new providers unprepared for TGD patient needs.	**Competency Preservation** Maintain GAC as a core longitudinal primary care competency. Use simulated cases or "shielded" shadowing opportunities to ensure trainees understand TGD healthcare needs.
Provider Support	High moral distress, burnout, and harassment, leading to workforce instability.	**Institutional Solidarity** Create dedicated peer-support spaces to process secondary trauma and other emotions. Normalize naming the chilling effect as a political phenomenon rather than a personal failing.
Patient Care	Patients feeling abandoned by providers and face increased travel burdens, financial strain, and poor access to care, compounding negative health outcomes.	**Equity-Centered Access** Focus on telehealth (where legal) and resource-sharing for socioeconomic support. Prioritize continuity of care to prevent the fragmentation that can lead to isolation and depression.

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The Politics of Volume: Why Capping Patient Panels in New York Could Save Primary Care

By John van Bockxmeer, MD

High-quality primary care is the foundation of a robust health system.[1] In New York State (NYS), primary care providers (PCP) are increasingly difficult to access, adversely affecting patient outcomes.[2,3] As family physicians, we view patient access as a moral and professional imperative, yet the current policy landscape treats our capacity as an infinite resource. At the intersection of medical politics and policy, the decision to leave patient panel sizes (PPS) unregulated is a choice that prioritizes theoretical attachment over functional care. This article suggests that NYS can improve access and quality by regulating patient panel sizes (PPS). There are positive and negative implications of this proposal which will be explored and debated herein. It is hypothesized that panel size regulation may improve physician retention, patient experience and create a sustainable future for primary care services.

The Historical Weight of Attachment

Understanding our current crisis requires looking at how we arrived at the concept of patient "attachment." The foundation of our primary care system was laid in 1965 with the Social Security Amendments, which signaled a federal willingness to support office-based physician consultation.[4] By 1970, following the AMA 'Graduate Education of Physicians' Mills report, family medicine was formally recognized as a specialty focused on "continuing and comprehensive health care."[5] The 1973 HMO Act formalized a "gatekeeper" role, attaching patients to a specific physician to coordinate care and drive cost savings.[6] This longitudinal relationship is now a differentiator of our specialty,[7] yet it is under siege. While many high-income nations like Norway and the Netherlands have formal mechanisms to register patient panels, the U.S. has largely left this to market forces, resulting in a "treadmill" of volume-based care.[8]

The Imperatives of Quality Improvement and Patient Experience

While attachment/empanelment is not compulsory in NYS, it is highly sought by patients.[7,8] Being unattached is associated with poor patient experience measures, feelings of vulnerability, impaired access to care, suboptimal medication compliance and increased reliance on care in the emergency department (ED).[9] The most quantifiable benefit of a PPS policy would be a direct improvement in healthcare outcomes. In 2023 the presence of a PCP in a patient's care team was independently associated with a reduction in late stage colorectal cancer diagnoses.[10] Larger unmanaged panels are correlated with poor diabetes control, missed appointments and increasing time spent on non-clinical tasks.[11]

Primary Care Exodus and Burnout

A physician's PPS directly impacts workload and care comprehensiveness. A 2025 meta-analysis concluded that patient-reported outcomes were more strongly associated with a PPS than a physician's experience or geographic location.[12,13] A non-evidence based, frequently referenced 'ideal' panel of 2,500 arose in the early 2000s and has repeatedly been deemed unfeasible, particularly as patient expectations evolve.[12,14] Our modern practice realities are nuanced as family physician panels consider factors like medical complexity, shifting patient demographics, health infrastructure constraints, regulatory organizations, payer requirements and workforce changes.[15]

Primary care underinvestment is systemic resulting with misaligned resources compared to specialty services.[16,17] 35 percent of patient visits are undertaken by PCPs but receiving only 5 percent of funding, below the 7.8 percent Organization for Economic Co-Operation and Development (OECD) average.[16] PCPs undertake hours of additional discretionary work effort to meet the needs of their panels driven by EMRs. It now takes 26.7 hours per day to provide the guideline-recommended primary care to a panel of 2,500.[18]

PCPs experience burnout at higher rates resulting in $260 million excess health expenditure per annum. Notably, 43% of burnout is attributed to escalating administrative burdens.[19] A

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projected shortage of 87,150 fulltime equivalent (FTE) PCPs nationally by 2037, is creating a downward spiral, exerting pressure on existing providers to expand panels, narrow their scope of practice or shift to concierge care.[12,20]

Wait time for family medicine has increased 16% since 2009 and NYS patients wait 3 days longer than national averages.[21,22] By 2028, NYS will experience one of the largest physician shortages in the country.[42] In August 2025, the NYS Comptroller identified several counties where 'primary care deserts' exist with fewer than four PCPs per ten thousand persons, a ratio below national guidelines.[2] As we have the fifth highest cost of living with the twelfth lowest physician salaries, innovative policy change such as implementing a PPS maximum is needed to retain our family physicians.[23-25]

The Illusion of Access: Why Capping Panels Saves Lives

A physician who remains in practice for thirty years with a capped panel provides significantly more longitudinal access to a community than one who exits after five years of burnout. A maximum panel size policy also acts as a lever for economic and social stimulation. Regulation would likely create a market-led correction, finally placing a higher economic value on primary care. With family medicine salaries in 2025 increasing by only 1.3% nationwide,[25,26] we need structural change to stimulate interest in residency training, research and advocacy.

The market for PCPs has been adversely affected by the corporatization of healthcare, the erosion provider autonomy and practice abandonment for concierge medicine.[27-29] Regulation may create a higher social and economic value placed on PCPs, increasing salaries and hopefully retaining providers.

Manageable patient panels will allow PCPs to regain nontraditional community roles. Freeing up capacity for creative problem solving unlocks significant social returns on investment (SROI). SROI frameworks are used for measuring and reporting the social, economic and environmental value created by a policy.[30] The United Kingdom (UK) has several examples of social family medicine programs evaluated by an SROI framework. A PCP social prescribing mental health program had a £4.7 social return for every £1 invested, which could be facilitated by smaller regulated PPS.[31,32] Defined PPS allows for the use of analytics and AI to review diagnoses, medication compliance and population health. This additional time gained by PCPs may help to more effectively manage chronic conditions.

The COVID-19 pandemic saw our workforce shift with provider retirements and clinical activity changes,[33] including 63% of PCPs reporting delays in achieving breast cancer screening.[34] If panels were capped, the 'clinical breathing room' gained is likely to improve detection, address psychosocial needs and potentially save lives.

Lessons from Elsewhere: Practical Implementation & The Murray Equation

Implementation does not require a new, bloated bureaucracy as several PPS calculations already exist for NYS to consider. The University of California Center for Health Quality and Innovation provides visit-based, time-based and normative-based (complexity) panel size calculations. The "Murray Equation" provides a simple, visit-based calculation: a PCP working 188 clinic days a year, seeing 20 patients per day, has a capacity for approximately 3,760 visits.[11] Assuming a median requirement of 2.5 visits per patient, the suggested maximum PPS for New York would be approximately 1,504.

We can monitor panels using the existing Health Commerce System (HCS) platform. Much like the i-Stop/PMP system implemented in 2013,[35] a panel registry could provide the objective data needed to evaluate policy effectiveness without significant disruptions to physician autonomy. HCS 'delegate' functionality would allow practice managers to audit panels without disclosing HIPAA-relevant information. When a physician approaches their maximum, an automated reminder could be triggered to suggest a panel review.

Team-Based Care vs. Task-Shifting: Navigating the Mid-level Shift

The concern that family physician panel caps will trigger an unsustainable shift toward mid-level practitioner (NP/PA) utilization is a valid political challenge. If health systems view panels as a math problem to be solved by task-shifting, we risk creating two-tiers of care.

One solution is to advocate for team-based care standards where panel caps apply to the entire patient care team, which allows advanced practice providers to be utilized to increase throughput.[36] Models such as the Veterans Health Primary Care program's 'Patient Aligned Care Team' (PACT) already set a baseline PPS of 1,200 per full-time physician.[37] Other successful examples include the regional care collaboration organizations (RCCOs) managing rural Medicaid patient panels in Colorado, where smaller panels allowed behavioural health service integration with PCPs.[38]

We must frame our plight to policymakers as a quality-of-care issue: every New Yorker deserves a primary care home where their provider has a team with the bandwidth to provide chronic, preventive, and acute care.

Cautionary Tales: Striking the Right Regulatory Balance for Patient Access

The potential challenges of implementing any PPS policy in NYS include issues of increased regulation and monitoring, reduced physician autonomy and ethical considerations related to resource allocation and patient access.

A primary concern is that capping panels could exacerbate existing access issues, potentially increasing times for unattached patients as the supply of available family medicine establishment slots becomes temporarily finite. If fewer appointments become available in an already strained system, the policy risks being viewed as a barrier rather than a solution. However, if the current physician exodus continues, patient access will be radically constrained without a PPS policy.

Physician autonomy is multi-faceted involving clinical, operational, ethical, economic and interpersonal domains.[39]

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Regulating PPS could potentially reduce operational autonomy, creating a perceived revenue ceiling, limiting those who wish to exceed the maximum.

The costs and regulatory burden associated with administering the policy may require a new division within the New York State Education Department Office (NYSED) of the Professions. A recent successful model; 'Health Connect Registry' in British Columbia, required a dedicated project team to for its creation.[40] Increasing spending on a PPS policy may carry an opportunity cost, leading to ethical questions, as expenditures on other services may be impacted.

A recent cautionary example from the Canadian province of Prince Edward Island (PEI) shows how we need a deliberate, considered approach to this topic. In May 2025 the PEI Department of Health attempted to institute the expectation that PCPs support a minimum PPS of 1,600 and treat 24 patients per day. Penalties were proposed when targets were not met.[41] This was poorly received as physicians felt it broke trust, lowered morale and would prompt an exodus of family physicians from the province.[42] While not a maximum PPS policy, this case demonstrates the resistance felt by interest groups, even with the shared goal of providing timely, high-quality care.

Conclusion: A Deliberate Move from Volume to Value

Despite challenges surrounding the practical, ethical and regulatory impact, the benefits for NYS family physicians for adopting a maximum panel size policy are far reaching, including economic and quality improvements which will see social returns on investment, market-led workforce solutions and improved patient access. By regulating panels we are not asking to do less work; we are asking for the time to do our work safely, effectively, and with the professional excellence New Yorkers deserve.

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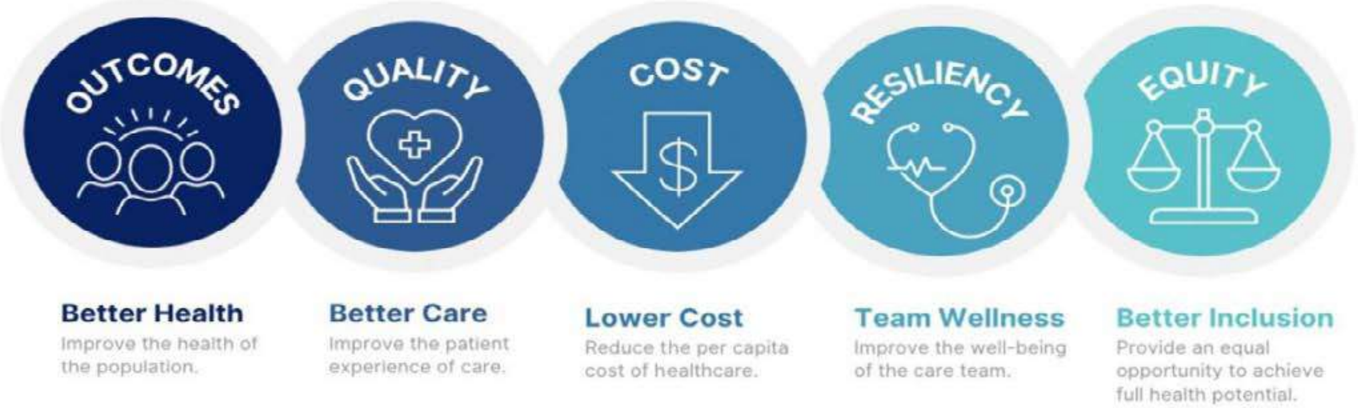
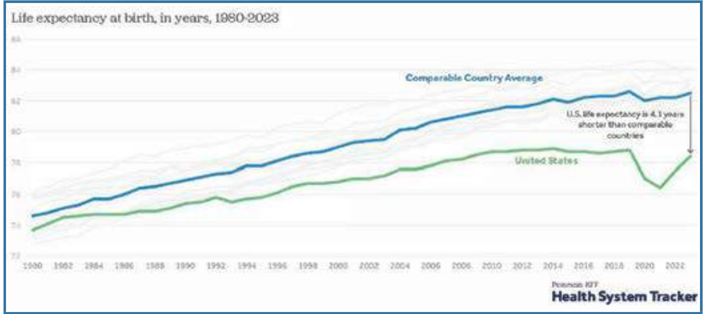
Health Policy Perspective on Payment Models and Health Systems.....from a Bicoastal Family Doc

By Tanya Kapka, MD, MPH, FAAFP



There has been only one better window of time in this century so far to thoughtfully refocus our attention on how health care is funded and delivered, and to reorient around the Quintuple Aim[1]... but we missed that first one, in 2020. That was a time when we had multiple systems fail, and the level of disruption brought on by the pandemic brought health care to its knees and demonstrated the interconnectivity of it all; we did not fix it, but rather doubled down on getting "back to normal." So although life expectancy has started recovering from the significant pandemic dip we have still been lagging other comparable countries, with the gap worsening every year since the 80s.

See figure below from KFF Health System Tracker[2]



Notes: Comparable countries include Australia. Austria. Belgium. Canada, France, Germany, Japan, the Netherlands. Sweden, Switzerland, and the U.K. 2023 U.K. life expectancy data is only for England and Wales. See Methods section of "How does U.S. life expectancy compare to other countries?"

Source: KFF analysis of CDC, OECD, Australian Bureau of StatistlCs, German Federal Statistical Office, Japanese Ministry of Health, Labour, and Welfare, Statistics Canada, and U.K. Office for National Statistics data• Get the data • PNG

Would that we had taken that opportunity to rebuild health care better as a system! Normal was not good pre-pandemic; "back to normal" now is, unsurprisingly, also not good. The lack of access to trusted health professionals and fragmentation of systems was an early warning, demonstrating how the primary care workforce has been burned out, underfunded, and with a looming workforce shortage [3] that has now accelerated, particularly in populous states like New York and California. Nationally, it is even worse in rural areas[4] and for patients served by community health centers[5], funding and access gaps further accelerated by the enormous Medicaid/ACA cuts with the current administration. Community health centers excel at doing more with less[6], reducing disparities, and providing patient-centered, integrated, evidence-based care via teams that typically reflect the communities they serve.

For the first 20 years of my career, I worked in community health centers (Massachusetts, California, and Oregon) and later in leadership for Medicaid health systems (Oregon), and can attest to how incredible they are at doing their part to meet the Quintuple Aim. I was lucky to have a National Health Service Corps Scholarship that paid for a large portion of my medical education; such a public health/primary care career became possible with the NHSC pathway. How we fund medical education as a country is deeply interrelated with who chooses the (currently) less lucrative path of primary care, and I would advocate for changing the way we fund both. Most developed countries have subsidized university and medical education which means that cost does not present the same limitation to the financial trajectories of the choice of specialty for physicians in those countries. Also, specialists do not make the vastly inflated salaries in those countries that they do here. So all these factors would need to be changed in concert to make system change. Obviously, there is no political will nationally for that now. I have been back in my home state of NY since 2021, and I want to cross-pollinate some of the impactful things being done elsewhere to benefit my beloved fellow New Yorkers. Can we make change in New York?

Let's talk about what happens if we don't. If primary care has poor access, burnout, and workforce shortages, where do people go? ERs bear the downstream burden of the cracks in the systems. Not only is this costly, it demonstrates how the lack of prevention has

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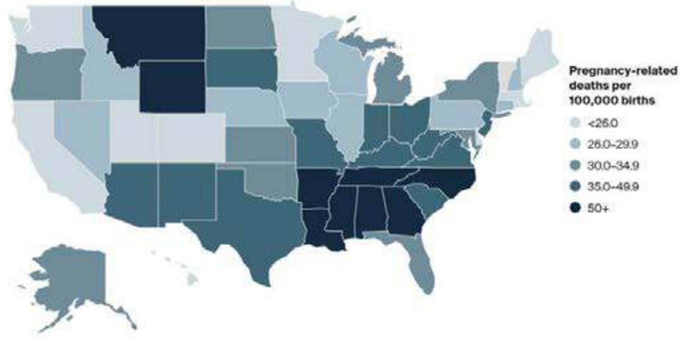
true impact on outcomes (and burns out an already-stretched ER workforce as well). And with crumbling public health infrastructure and inadequate access to coordinated primary care, it is not surprising in general that concomitant delays in care lead to an increase in later stage cancers and other potential life-threatening problems found later. Regarding cancer: from a variety of data, including a 2020 study by Mass General Brigham[7], "It was estimated that due to the COVID-19 pandemic, almost 10,000 excess deaths from breast cancer and colorectal cancer would be reported over the next decade in the United States."

Additionally, the lack of interoperability of our EMRs (even worse, health care is the ONLY industry still using faxes!) leads to duplicative care or gaps in care, following the many lines of fragmentation of our systems. Don't forget the administrative burden, where if we followed all guidelines, it is estimated we would need more hours than there are in the day (26.7)[8] to do all that is expected in a day of primary care!

During the pandemic, also on display was the inability of many of our leaders to bring basic public health concepts to the public and communicate clearly, and even more so in the context of misjudging the health and science literacy of the populace. Those failings have been well documented. But this will be hard to recover from. Current measles outbreaks are now starting to (as predicted) accelerate with reduced vaccination, presenting risk especially to babies and young children per the WHO. [9] "In 2024, 59 countries reported large or disruptive measles outbreaks – nearly triple the number reported in 2021 and the highest since the onset of the COVID-19 pandemic. All regions except the Americas had at least one country experiencing a large outbreak in 2024. *The situation changed in 2025 with numerous countries in the Americas battling outbreaks.*" And if COVID-19 was a stress test for our preexisting health system weak spots, women's health is a big one; illustrative of this is a map of maternal mortality 2019-2023.[10]

See figure below from the Commonwealth Fund mapping CDC data.[10]

There were wide interstate differences in pregnancy-related mortality ratios between 2019 and 2023.



Notes: Deaths during pregnancy through one year postpartum per 100,000 live births. Vermont is excluded from the exhibit because it reported <10 pregnancy-related deaths from 2019 to 2023.

Data: CDC WONDER Mortality Flie.

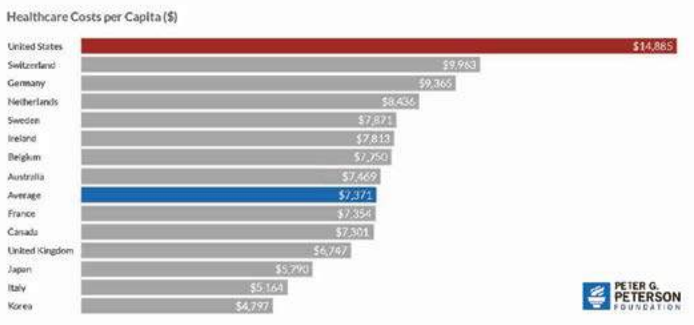
Source: Eugene Declercq and Laurie C. Zephyrin, Maternal Mortality in the United States, 2025 (Commonwealth Fund, July 2025). https://dol.org/10.26099/kdfd-fc19

These many public health red flags further demonstrate the broader context of lack of collective memory of a world before vaccines and basic public health and sanitation approaches where even young, healthy people could just sicken and die (smallpox, measles, tuberculosis) or become permanently disabled without cure (polio), not to mention when many more women faced death or disability, or loss of a child, from pregnancy and its complications.

So now it is even more apparent that not building the system we need, communicating clearly where payment goes for the right-sized (to the population) priorities, layered with the political winds and financial reorganization and widening class and economic disparities currently taking place, has now led us closer to system breakdown and farther than before from achieving public health at a reasonable cost, with coordinated delivery customized to local communities. What we need is true system reorganization. Not tweaks, not adjusting the coding guidelines (are you remembering to add G2211 to all your visits?), but changing the rules about the current insurance system and not administrating our health care professionals to the breaking point. We are the only wealthy country who performs so poorly at such outrageous cost. We cannot keep doing the same thing when it is clear that the results are poor, and the foundation is so shaky we dare not even look too closely, or it might all just collapse.

See below from the Petersen Foundation US healthcare spending data for 2023/2024:[11]

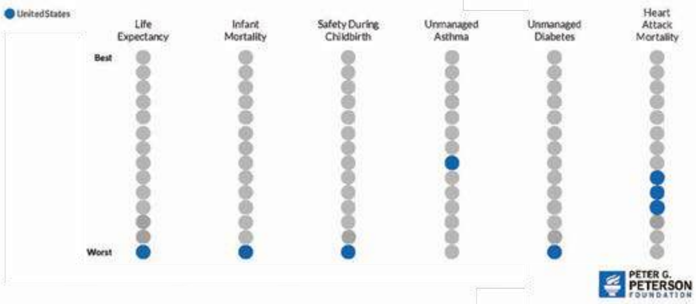
U.S. healthcare spending per capita is twice the average of other wealthy countries



Source: Organisation for Economic Co-operation and Development

Notes: Data are for 2024. Average does not include the United States. The five countries with the largest economies and those with both an above median GDP and GDP per capita, relative to all OECD countries, were included. Chart uses purchasing power parities to convert data into U.S. dollars.

The United States has worse healthcare outcomes compared to other wealthy countries



Source: Organisation for Economic Co-operation and Development

Notes: Data are for 2023 or latest available.

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I have worked in public health and systems-based delivery of care for complex and/or vulnerable populations (via government-funded organizations, Medicaid and Medicare) for over two decades now, on both coasts. I have had the privilege to do exciting cross-systems work, payment model innovation, hot-spotting and population segmentation for priority vulnerable populations, integrating behavioral health and social needs support in primary care and other settings. I mostly have delivered patient care in Spanish, taught idealistic medical students and residents, optimized high-performing team-based care to improve delivery of the best outcomes to those most in need of support, especially by improving electronic tools to do so efficiently. And I have tried as hard as I can to inspire (push?) anyone who will listen towards payment reform with more foundation in primary care and public health principles. It's not like we don't have models across the world for what works[12]! We just aren't using what we know to build a good system.

We are at a crossroads today, an intersection between health policy and delivery of care on a population level. The US should do better, but DC is not going to do it right now. New York can do better, and I know it is time to push us to try. Right now, our current systems of funding and delivery are failing nationally in all five aims: cost, population health, improving outcomes, health care workforce, and equity/reduction of disparities. So with the political and funding environment in the US one of disruption of funding and leadership, we must focus on what we can do–individually and collectively–from where we are. Health care is, after all, local.

So we get back to the basics. Data repeatedly shows the positive impact of primary care on population outcomes, as well as lower costs, when people have access. Using data from 2016-2022 (the latest year data is available), "having a usual source of primary care was associated with having nearly 54% lower total health care expenditures for adults with chronic disease, and nearly 40% lower health care expenditures for children with chronic disease, compared to those who did not have a usual source of primary care" (Medical Expenditure Panel Survey, referenced in Milbank Quarterly, 2026[13]). So let's focus on shifting payment away from some high-cost low value care to high value foundational primary care. Even just a small shift in where funding is concentrated can have an impact.

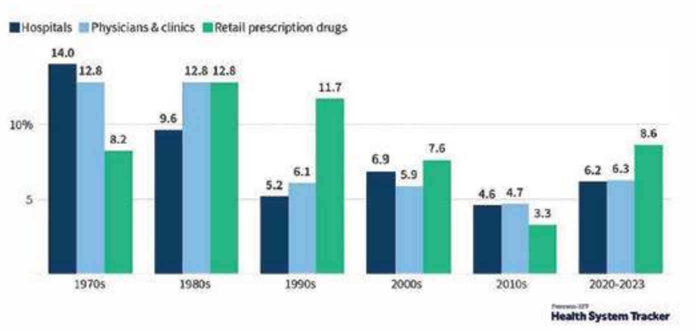
The crisis is urgent because currently, health care represents about 18% of the U.S. economy[14] (measured as a share of gross domestic product). This is unsustainable, particularly as the outcomes we get for that level of expenditure are worse than other developed countries. And with slashing of Medicaid federally,[15] with cuts more painful in states less favored by the current federal administration and/or with more rural residents, many states suddenly face funding shortfalls that disproportionately impact the most vulnerable. Medicaid is a program for low income people that is funded with a combination of federal and state funds; yet is administered and delivered by the states, with each having its own rules for coverage, administration, and delivery of services. New York can change rules, even just for Medicaid, and that could help a lot. And as a side note, those with both Medicare and Medicaid are often the most vulnerable and need the most supportive services. As the Medicare Rights Center indicates, the large Medicaid cuts with the "One Big Beautiful Bill Act", which have only just started, will increase administrative costs, drastically negatively impact state budgets for other areas of spend (e.g. schools and public services), drive providers to reduce their Medicaid access (Medicaid pays lower than other payers),[16] and "Another KFF analysis[17] shows that expansion states with large numbers of rural residents will be hit the hardest. Medicaid covers 1 in 4 adults in rural areas, a higher share than in urban areas, and plays a large part in financing rural health care services."

At least New York is a state where many in leadership positions–in politics as well as in health care organizations–verbalize commitment to principles of both cost management and public health delivery, including in reducing disparities. As one of the states projected to have some of the highest shortages of healthcare workforce in the coming years (particularly in primary care), and one with a very diverse population, we must pay attention to this developing crisis now. State-level policy advocacy by those of us who are on the front lines of primary care is something we all should be doing, right now.

Hospital care (31.2% of total spend), provider services (especially specialists) and medications (particularly targeted, albeit lifesaving, drugs) are the most expensive elements of the healthcare system.[18] Because of the way the payment structures are designed, we do not have many levers for cost controls on these categories of cost the way most developed countries do.

See below graph demonstrating a shift particularly for proportion of pharmaceutical costs (source: KFF)[18]:

Average Annual Expenditures Growth Rate for Select Service Types, 1970-2023



Source: KFF analysis of National Health Expenditure (NHE) data

What this means is that leaders such as Governor Hochul, who is considered a strong advocate for health care,[19] remain boxed into limited choices, including urgently shoring up subsidies[20] a la ACA just to pay for insurance in the face of these huge funding cuts.

So, more primary care reduces costs, improves outcomes, and robust support of the workforce and systems that provide it can be a pathway to help restore balance in our system. It is so clear that by supporting this valuable workforce as the foundation for the medical neighborhood and a proven component of success for countries who achieve population health, we can build something better.

A bridge to true health care reform can be at least started by shoring up primary care, and the time is now. This means phasing in a requirement at the state level (like in these states that are already doing it[21]) to shift funding to more foundational primary care along value based care principles, plus electronic

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interoperability requirements, all as a proportion of health care dollars. States who have done it already range from 11% in Rhode Island to 15% in California. It is early years for most, but results are promising. For example, Oregon found that a one-dollar increase in primary care expenditures was associated with $13 in savings for other services, including emergency department use and specialty care.[22] And back in 2010, Rhode Island was the first state to mandate increased investment in primary care, requiring commercial insurers to increase primary care spending by 1% annually while capping hospital price growth at Medicare rate plus 1%. By 2018, primary care's share of commercial spending rose to 12.3%. At the same time, overall health care spending growth slowed, a change attributed to the hospital price cap.[23] In Massachusetts, a state with a long history of alternate payment models (APMs) and which passed primary care legislation, a 2024 study by Freedman HealthCare found that provider organizations with higher primary care investment performed significantly better on standardized measures of quality and had lower spending on inpatient and outpatient hospital services.[24]

We need to robustly support a similar pending legislation for 12.5% in New York[25] –it is high time to do it here (we are still at only 3-5% per NY Health Foundation data[26]). The increases would phase in gradually, aligned with a shift towards alternative payment models (a financial mechanism to deliver "value-based care") which aligns payment for outcomes and access on a population level. In combination with advocacy for tuition and loan repayment support, legislation for value-based care, patient-centered electronic interoperability, and funding for improvements in the behavioral health system, we can help show, at the state level, a path to true whole-system and payment reform that lands the Quintuple Aim at last. It is what New Yorkers deserve—patient-centered care, population health, affordability, improved healthcare worker wellbeing, and to deliver on equity. As a New Yorker it pains me for us to be behind the curve, especially after my years in Oregon on the forefront of these innovations to improve quality and manage costs. My fellow New Yorkers: it's time to catch up and lead into the future!

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Patient Care by Omission: When Institutional Incentives Constrain Medical Disclosure

By Lisa Mamakos, MD, FAAFP

Contemporary discussions of healthcare reform often focus on access, cost, and outcomes. Less frequently examined—but equally consequential—is the role of communication in shaping patient care. Evidence increasingly demonstrates that how medical information is framed, filtered, or omitted is not merely a function of individual physician behavior, but a predictable consequence of institutional structures, financial incentives, and network-based care models within the U.S. healthcare system.[1-3]

Integrated delivery systems and employment-based physician models have encumbered referral patterns, frequently limiting referrals to in-network specialists and services. Although these arrangements are commonly justified on the basis of continuity of care or electronic medical record integration, empirical analyses show that institutional consolidation and accountable care structures influence clinical decision-making in ways that may not align with optimal patient outcomes.[4-6] Physicians often report limited insight into the quality or expertise of specialists within their own systems and experience implicit pressure to avoid external referrals, even when superior or more appropriate care may exist outside institutional boundaries.[7]

The ethical implications of these dynamics are especially evident in the context of information disclosure. Shared decision-making is widely recognized as a core standard of patient-centered care, requiring clinicians to present reasonable alternatives and available options, including those not offered within their own institutions.[8,9] However, studies consistently demonstrate persistent information asymmetries in clinical encounters, in which patients are not fully informed of treatment alternatives, advanced therapies, or clinical trial opportunities unless they actively inquire or possess substantial medical literacy.[10] This pattern reflects a systemic failure to exercise shared decision-making within care environments where full disclosure may conflict with institutional or financial motivations.

Oncology care illustrates these tensions with particular clarity. Financial analyses have demonstrated that reimbursement structures, hospital revenue models, and drug pricing incentives directly influence treatment availability and utilization patterns.[11-13] As a result, therapies that fall outside institutional offerings—including participation in external clinical trials or access to novel agents—may be under-discussed or omitted altogether. Barriers to clinical trial enrollment are well documented, with physician gatekeeping, institutional norms, and administrative burden identified as major limiting factors.[14-15] These barriers disproportionately disadvantage patients who lack the resources, knowledge, or advocacy necessary to independently navigate complex referral systems and clinical trial databases.

The burden of discerning omitted options often falls unevenly on patients and families. Individuals with medical training or professional connections are more likely to identify alternative therapies or external trials that others never learn exist. The ethical concern is not that such options require effort to access, but that access to potentially life-altering information should not depend on a patient's ability to challenge authority, interpret medical literature, or circumvent institutional boundaries. Research suggests that many patients hesitate to question physicians or request additional information due to fear of being labeled "difficult," further exacerbating inequities in care.[16]

Physicians themselves experience the moral consequences of these systems. A growing literature on physician burnout and moral injury links productivity pressures, high patient volumes, and administrative demands to ethical distress and professional dissatisfaction.[17-19] When clinicians are incentivized to prioritize patient flow, or more generally, throughput, over deliberation, the cognitive labor of medicine—researching options, coordinating care, counseling patients, and engaging in shared decision-making—is systematically undervalued. In such environments, advocating beyond institutional confines may carry professional risk, reframing ethical medical practice as an act of individual courage rather than a supported norm.

These shortcomings are not incidental. They are the foreseeable outcomes of a healthcare system organized around volume-based

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reimbursement, institutional consolidation, and financial incentives that are misaligned with patient-centered ethics. Studies of policy consistently conclude that incremental adjustments to evaluation and management coding have failed to adequately compensate cognitive work or address these structural deficiencies.[20,21] Meaningful reform will require a fundamental reorientation of physician compensation toward the cognitive labor and the interpersonal labor of medicine, alongside institutional safeguards that support comprehensive disclosure and patient autonomy.

Until financial and organizational structures align with ethical obligations, patients will bear the consequences of institutional constraints and incomplete disclosure—an experience shaped as much by what is left unsaid as by what is offered. Evidence-based medicine demands not only the application of scientific data to treatment decisions, but also transparent communication within systems designed to support—rather than interfere with—professional integrity and informed patient choice.

Below are proposed reforms to address the structural conditions that govern how information is generated, disclosed, and acted upon. As noted above, incremental adjustments to reimbursement codes or voluntary professionalism initiatives are insufficient. This framework for reform would aim to align institutional incentives with ethical obligations as a means of restoring transparency as a foundational element of care.

Step 1: Reorient Physician Compensation Toward Cognitive and Relational Labor

Network and clinician payment models must explicitly value the cognitive work of medicine—clinical reasoning, literature evaluation, care coordination, and shared decision-making—rather than privileging procedural volume. This requires expanding and materially increasing reimbursement for time-intensive evaluation and management services, multidisciplinary consultation, and documented shared decision-making encounters. Without correcting this imbalance, clinicians will continue to face structural disincentives to engage in comprehensive disclosure and deliberation.

Step 2: Mandate Institutional Disclosure Standards for Treatment Alternatives

Healthcare institutions should be required to implement standardized disclosure protocols that obligate clinicians to inform patients of reasonable alternatives, including options not available within the institution or network. These standards should be auditable and integrated into quality metrics, shifting disclosure from an individual ethical burden to an institutional responsibility. Such mandates would facilitate shared decision-making rather than leaving it contingent on clinician discretion or patient advocacy.

Step 3: Separate Referral Decisions from Network Financial Incentives

Regulatory safeguards must address the influence of in-network referral pressures on clinical decision-making. There should be greater transparency about referral restrictions, independent oversight of referral patterns, and protections for clinicians who recommend external care when clinically appropriate. Patients should be informed when referrals are constrained by network affiliation rather than medical necessity.

Step 4: Normalize and Facilitate External Clinical Trial Access

Clinical trial consideration should be treated as a standard component of care, particularly in fields such as oncology. Institutions should be required to screen patients for trial eligibility using centralized, interoperable databases, inform patients and the clinician when patients are eligible, and to document when trials outside the institution are discussed. Removing administrative and cultural barriers to external trial referral would reduce inequities driven by patient knowledge, resources, or professional connections.

Step 5: Protect Ethical Advocacy and Reduce Physician Moral Injury

Reform efforts must explicitly address physician moral injury by aligning professional ethics with institutional expectations. This includes whistleblower protections for ethical advocacy, reduced productivity pressures that undermine deliberative care, and institutional recognition of ethical consultation and patient counseling as core professional activities. Ethical practice should be structurally supported, not professionally risky.

Step 6: Measure Communication Quality as a Core Outcome

Finally, healthcare quality assessment must expand beyond utilization and survival metrics to include measures of communication quality, disclosure completeness, and patient understanding. Patient-reported experience measures focused on informed choice and perceived transparency can serve as meaningful indicators of ethical system performance.

Taken together, these reforms acknowledge a central reality: transparency cannot be achieved through appeal alone. It must be engineered into the financial, organizational, and regulatory frameworks that shape clinical practice. To put it very plainly, it boils down to the bottom line; money. Economic incentives are a powerful lever. Aligning them—through federal payment policy, accreditation requirements, electronic medical record standards, and liability structures—offers one of the most effective pathways to sustained change. Absent such reform, patients will continue to navigate a system in which access to information—and therefore, to choice—is unequally distributed, and ethical medicine remains dependent on individual struggle rather than institutional design.

A healthcare system worthy of evidence-based medicine must not only generate knowledge, but ensure that knowledge is fully, equitably, and transparently shared. Only then can patient autonomy, professional integrity, and clinical excellence coexist within the same system rather than in conflict.

What are your thoughts on this topic? Any suggestions for reform? Let me know by reaching out to me directly at lisa.mamakos@gmail.com

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Standing on the Physician's Political Shoulders

By Thomas C. Rosenthal, MD

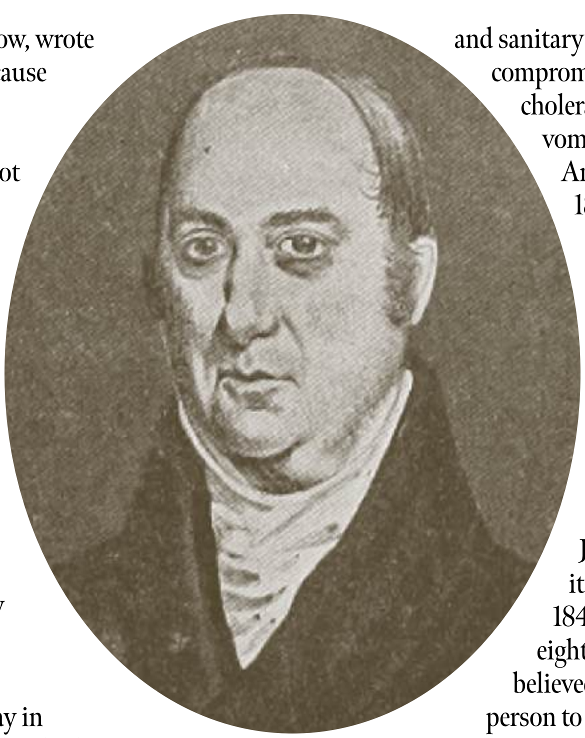
The German pathologist, Rudolf Virchow, wrote that medicine was inherently political because physicians had a duty to combat social inequality.[1] The medical issues addressed within family medicine exam rooms cannot be delivered separate from social health, cultural inequities, affordability, and sanitary conditions that impact the patient's well-being. Physicians are often the most highly educated people patients interact with; and are among the most literate members of a community. Little wonder that physicians have a long tradition of activism in all matters political. To Virchow, physicians were the "natural attorneys of the poor." Though one of Europe's most famous nineteenth-century pathologists, Virchow also served as a representative in the Reichstag.[2]

There are many roles physicians can play in politics. They may serve as advisors to individual legislators or be appointed to state and national advisory committees. Many more participate in advocacy efforts led by professional organizations or make contributions to candidates' campaigns. Doctors elected to legislative bodies are likely to be male, Republican, and come from the surgical specialties, though recent data suggests backgrounds are widening.[3]

In the revolutionary years, 26 doctors served as state representatives to the Continental Congress. In the first half of the 1800s, between twelve and eighteen physicians served each session of Congress.[4] Over the first 100 years of the republic, 252 physicians served in Congress. Twenty physicians are currently serving in the 119th Congress (2025-2027), four in the Senate and 16 in the House.

One of America's earliest political activists was Dr. Benjamin Rush (1746-1813). He was a civic leader in Philadelphia, who represented Pennsylvania in the Continental Congress and was a signatory to the US Declaration of Independence. He pushed Pennsylvania to ratify the US Constitution in 1788, led reforms in medicine, advocated for free public schools, improved the penal system, pushed for sanitation reforms, and worked to abolish slavery. Rush ultimately became an architect of American psychiatry, though his advocacy for heroic methods of bloodletting and intestinal purging was eventually discredited.[5]

By 1830, the US census noted urban communities had grown faster than rural communities. Employment was shifting from farm to shipping, manufacturing, and service; drawing immigrants and subsistence farmers into cities. Living conditions became crowded, and sanitary accommodations were often compromised.[6] By 1831, stories about Asiatic cholera, called the 'plague of India' and 'black vomit,' began to appear on the back pages of America's newspapers. In the spring of 1832, cholera landed at the Port of Quebec on an Irish immigrant ship. Within weeks it spread throughout North America.[7,8]



Dr. Ebenezer Johnson
Circa 1830

Buffalo (population 9,000) had just incorporated as a city in 1831, and its first mayor was the highly respected, apprentice-trained, Dr. Ebenezer Johnson. Six years after the opening of the Erie Canal, Buffalo was booming. On July 19, 1832, the *Buffalo Patriot* printed its first cholera report. By the next week, 184 Buffalonians had been hospitalized and eighty had died. Medical opinion at the time believed that cholera was not transmitted from person to person, but diffused by miasma; and like most American physicians, Buffalo doctors had never seen a case of cholera. Still, Mayor Johnson acted immediately by appointing the city's first Board of Health.[9,10]

Physician/Mayor Johnson appointed himself chair of this new Board of Health. Joining him were the business owner Lewis F. Allen, undertaker Loring Pierce, printer Roswell W. Haskins, and his newly designated city health officer, Dr. John E. Marshall. Mr. Haskins possessed inexhaustible nervous energy and a natural tendency to be direct. His skills soon made him the Board's public face for tracking and cataloging the epidemic. On many days, he could be seen carrying patients down the stairs of their home or tenement on his strong, broad shoulders. Those patients still alive were removed to the almshouse; others, to the graveyard.[11,12]

As cholera darted erratically up one street and down another, Mr. Pierce and a freeman Negro[i] referred to in the records only as Black Tony, made evening rounds to pick up dead bodies. Mr. Pierce's cry of "Bring out your dead!" interrupted the quiet deserted streets as he and Black Tony did their best to bury everybody within two hours of collection.[12]

Each morning, Buffalo's Board of Health met to review case reports and progress. With minor editing, they published the guidelines produced by the New York City Public Health Board recommending citizens quench their thirst with beer, wine or hard cider, rather than water. The epidemic quickly spread from the intemperate and poorly nourished into the homes of Buffalo's aristocracy. Those with means fled the city, often to health spas, where they unwittingly carried the disease to new families and new

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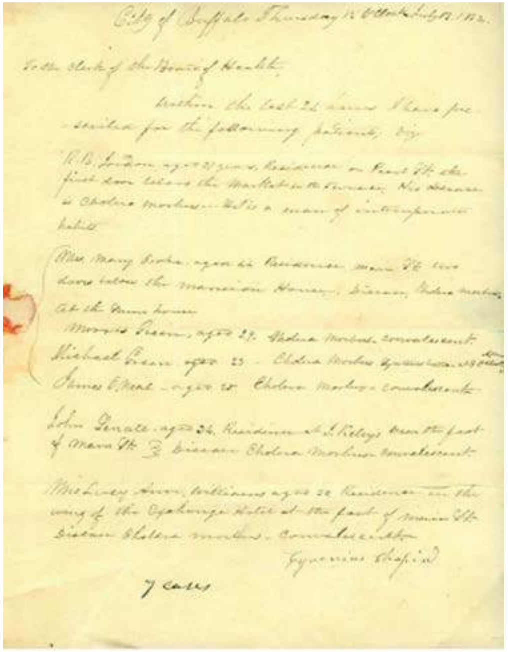
communities. Coffin makers and gravediggers worked continuously. Steamboats plying the Great Lakes and barges on the Erie Canal were intercepted until passengers and crews had passed medical inspection.[9]

The Board of Health also organized a special receiving house for destitute victims. Within days of opening, the house's chief attendant joined the body count. He was replaced by a twenty-five-year-old Irish girl named Bridget, who claimed she had no fear of cholera. Within a week, she too was carried to her grave.[9]

Mayor Johnson decided all Buffalo physicians should submit daily reports on patients they saw with dysentery-like symptoms. The senior physician practicing in Buffalo in 1832 was the curmudgeonly Cyrenius Chapin, now 63 years old. Dr. Chapin had not been appointed to the Board of Health and argued against the daily reports, saying, "Why should I report my medical cases to a set of ignoramuses who don't know the cholera from whooping cough? No: I'll see 'em hanged first."[1]

Having known Chapin for three decades, Mayor Johnson described his protest as "delightful." Visiting Chapin's home, Johnson applied charm and perseverance, soon gaining Chapin's agreement to provide daily reports. Chapin even delegated his own medical apprentice, Gorham F. Pratt, to help in the inspections demanded by the Board of Health.[13] One of Chapin's reports to the Clerk of the Board of Health from July 1832 describes seven patients with 'cholera morbus.' One patient was a 37-year-old man of intemperate habits; two were women ages 44 and 20; and four were men ages 29, 23, 25 and 24.

Figure: One of Dr. Chapin's daily cholera reports to the Board of Health in 1832. (Archives of the Buffalo and Erie County Historical Society.)



With 100 new cases a day, surviving seemed an uncertain prospect, prompting many Buffalonians to wear little bags of "gum camphor" around their necks to counteract the miasma.[12] The epidemic seemed to arrest around the onset of winter and, remarkably, no member of the Board of Health suffered an attack. Buffalo had experienced fewer deaths than many cities, with much of the credit going to the Board of Health and Mayor/Doctor Johnson's calculated guesswork about controlling the disease. Physician advocacy finally forced the establishment of permanent state and county health boards in 1866, though it would be 1883 before Robert Koch isolated the cholera bacteria, *vibrio cholerae*.[8,9,14-16]

Clearly, all levels of government confront health policy issues, from school immunizations to massive quarantines. Over the last twenty years, the US Congress has not only confirmed a series of surgeon generals, but it has also debated the Affordable Care Act, adjusted Medicaid and Medicare policies, funded and defunded health research, established COVID-19 directives, amended vaccine policy, and regulated the pharmaceutical and medical device industries. Among the ranks of legislators, physicians brought much-needed practical insights and cultural perspectives to these debates.[3]

In 2022, there were 17 federal physician-legislators, making up 3.1% of the 541 members of Congress. At the state level, 86 physicians make up 1.1% of the 7,552 state lawmakers. Given that physicians are only 0.3% of the US population, the numbers show that even today, they are overrepresented in state and federal legislatures. Congressional pay is $174,000 per year, with state legislators earning less, meaning that many physicians sacrifice income to serve in elected office.[17]

Unfortunately, there is no database tracking physicians who served in local governments. But historically, rural physicians are somewhat more likely to serve as mayors, coroners, county supervisors, and public health officers.[14] Recent data suggest that concern over the direction of the American healthcare system is intensifying physician interest in political office.[3]

The needs of patients and society's social responsibilities have been a justification for physicians playing a role in American democracy since the earliest days of the American experiment. In issues like vaccination, the country is as divided today as it was when Jenner introduced the cowpox vaccine, with endless new technologies and evolving evidence muddling patient expectations. No one debates that these issues are appropriate to the exam room, but exam room discussions are reinforced whenever the public's understanding of therapeutic potentials is strengthened. Who better than physicians possess the insights that can interject evidence-based community strategies for partisan politics. Ultimately, any collective strategy for meeting the country's healthcare needs will involve both political will and political strategy.[18]

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[i] *The term "freeman Negro used with apologies. Viewing history through the looking glass of another century requires accepting conditions and attitudes that might be considered archaic or rude. However, the discomfort we feel today reveals much about our continued attempts to improve our own culture.*

There's Power in the Union: An Exploration of the Role of Physician Unions for New York's Family Doctors

By Zelda Blair, MD

There are many reasons why it can be challenging for family doctors to engage with politics and advocacy, not the least of which include our long work hours, where packed clinic days are followed by nights of charting. One promising outlet for us to better engage with current events, while also improving our workplaces, is through unionization.

Across a broad swath of time and employment sectors, unions have coalesced worker power to shape politics and improve their own standards of living (with now taken-for-granted innovations such as weekends). The medical field, however, stands in rather stark contrast to other health professions with a relative dearth of physician unions, no less in light of the recent national story of unionized nurses in NYC having completed a 41-day strike, the longest and largest in the city's history.

The archetypal self-employed physician working in private practice does not perceive the benefits of labor organization in the same way as the contemporary physician-employee of increasingly consolidated health systems. As independent business owners, physicians in private practice do not view their leverage through the lens of collective labor power and have historically been limited by anti-trust laws in their ability to negotiate contracts.[1] Instead, physicians formed professional societies, self-described as "organized medicine." Like other industry groups, the American Medical Association (AMA) and American Academy of Family Physicians (AAFP) engage with politics and policy through hiring lobbyists and exerting leverage through high-dollar donations.

While these professional societies are generally physician-led, dues-based and engaged in democratic action on policy matters, they differ from unions in several ways. Fundamentally, labor unions are organized based on the economic reality of the employer-employee relationship, whereas professional societies are organized as an affiliation of relatively autonomous tradespeople with shared interests.

For a physician in private practice operating as an independent small business owner, such matters as contract negotiation and reimbursement are managed by each physician-entrepreneur who handles their budget, profits and expenses as they see fit. On this model, decisions about the structure of day-to-day work are made by the people doing the work, in response to their own needs and those of their patients. Membership in a professional society may therefore provide the physician-entrepreneur with adequate access to engaging with local and national policies affecting their work while the details of their work-structure are located more closely within their control.

On the other hand, the physician-employee of a large hospital system often has very little say in determining the structure of their work, from the contract options they are offered or the reimbursement models according to which they bill for services, to the budget of the hospital or academic center that employs them. The hospital-employers who manage these structural details are motivated to offer good contracts that can attract and retain physician-employees, while simultaneously working to cut costs and maintain a high profit margin (which tends to be the case regardless of for- versus non-profit status). The balance of this equation is that hospital systems make the offers and physicians decide which one to accept, creating an asymmetrical power dynamic in which physicians are unable to directly state the terms of their work but are forced to choose among options, all of which may be equally unsatisfactory.

Unions correct this asymmetry by empowering physician-employees to more directly engage with the practical structure of their work. A primary function of physician unions is representation of employee-members to interface with employers and negotiate for practice changes (including duty hours, compensation, and staffing requirements), while professional societies are less directly engaged with these details. Because physician unions acknowledge the reality of current employment models, they can more effectively protect against exploitation by hospital systems and the structural expendability of physicians as hospital employees.

Professional societies and physician unions share more apparent resemblance in the realm of political advocacy. Both serve to allow constituents with shared interests to interface with elected officials and advocate for policy changes affecting public health and professional practice, and both achieve their greatest efficacy and viability when all

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members participate fully. A cynical caricature of unions is that they become overly centralized and hierarchical, extracting dues and mandating adherence to leadership-instituted agendas to the exclusion of members' input. However, this criticism can hold equally true for professional societies. Any assembled body that functions without active and sustained member engagement runs this risk. Physician unions at their best negotiate for what their members prioritize, returning dues payments many times over when negotiations result in salary increases and reduced work hours, improved administrative support, insurance billing coverage and reimbursement models. It is through this power to negotiate with employers and to direct the course of economic activity through dictating the terms of work, that existing unions in other industries have been able to exercise political influence.

Another common concern about unions is that they create an external third party that complicates employer-employee relations. This criticism is somewhat related to the previous one regarding unions' potential disregard for members' concerns. Unions are composed of the employees themselves: they are no more nor less than their members. Unions provide the benefits of allowing employees to negotiate with the employer collectively rather than individually, which ensures that no colleague ends up worse off than another, and helps to secure additional legal protections while negotiating with employers. Rather than creating antagonism between employees and employers, labor unions can be a way to bridge it. Ideally, physicians and their employers do share the same goals, these being to care for patients while earning a reasonable living for themselves.

A final important issue for unions is their portrayal as being unprofessional for physicians or as negatively impacting patient care. While unions are most notoriously associated with conducting strikes, this type of concerted action creates significant disruption not only to workplaces but also to employees own livelihoods and only ever arises as a tactic of last resort in the face of complete, persistently fruitless breakdown of negotiations.

The ethics of striking in healthcare are complex, and physician unions may look to nurses' unions for ways this may be effectively and responsibly navigated. Ultimately, if physicians do choose to strike it is invariably in response to untenable work conditions and moral injury from being asked to do increasingly more (forms, prior authorizations, peer-to-peers) with less (clinic funding, compensation, staffing), which negatively impacts patient care. Unions serve their physician members as a powerful outlet to highlight how negotiating for improved working conditions in turn improves patient care.

Some important legal ramifications or potential challenges for physician unions include the role of state versus federal labor laws, and the impact of prevailing political winds on unionization efforts. In general, federal policy as enacted by the National Labor Relations Board (NLRB) has a greater impact on unionization efforts than state or local laws and policies. The current federal administration's hostility to labor organizing has significantly slowed down new union formation; however, once unions have been established, they tend to endure based on the sustained benefits that their members enjoy.

In the face of sweeping changes to medical practice patterns and encroachment of corporate health systems upon US healthcare, physician unions have seen continued growth, such as with Doctors' Council, an NYC-based physician union. Medical residency programs in particular have seen a wave of unionization efforts, such as the Committee of Interns and Residents, which doubled its membership in 2 years from 15,000 in 2021 to over 30,000 in 2023.[2] For those who feel that we live and work in a dysfunctional and unjust system that exploits both physicians and our patients, unionizing presents one potentially powerful tool for combating this cynicism. Family doctors should consider unionization as an effective strategy to strengthen our voices in the health systems that employ us, to advocate for ourselves and our patients, and to expand our influence on the local and national policies which directly impact our daily work.

In closing, some questions for consideration: What would you change about your work and how do you see that happening? What is your current capacity to engage with issues in your practice that you'd like to see change? How do you think the administration at your institution or practice would react to unionization efforts? What avenues do you currently have for voicing your perspective and concerns to your employers? To your local and national representatives? What would you like to see change in the local and national policies that affect your work? What is your current capacity to engage with the policies that affect your practice?

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Physicians and Social Media Use: Navigating the Digital Landscape

By Sarin Itty, DO; Ann Mathew, DO and Jincy Cherian, DO

Introduction

Social media use has skyrocketed in use over the past decade, with an increasing physician presence on social media. Within the online world, there is a significant degree of misinformation, which threatens public health.[1] Physicians can help address health misinformation by proactively engaging with the public regarding health misinformation, using media platforms to share accurate information and partnering with community groups to prevent and address health misinformation.[2,3] As health misinformation spreads rapidly on social media platforms, physicians play a critical role in countering it, by using their online presence to strengthen public health education and understanding.

Family medicine physicians serve as educators and role models for patients, not only in clinical settings but through their online behavior as well. Key takeaways from this article include strategies for maintaining professionalism, navigating boundaries with patients, mitigating risk, and leveraging social media as a tool for education and advocacy. By outlining best practices and potential pitfalls, this article will equip family physicians with guidance on engaging social media with professionalism and responsibility while having a potential impact on improving public health.

Social Media Use Among Physicians and Public Perception

Social media has experienced exponential growth over the past 20 years. An estimated 90% of physicians are on social media.[4] Social media presence can come with benefits and drawbacks, expanded upon in *Figure 1*. A survey of healthcare workers (nurses and physicians) in Texas demonstrated that the healthcare workers encouraged patients to research their conditions on social media ($p<0.05$), although less than 50% of respondents believed that online information on disease was reliable.[5]

A study published by Sun et al. in *Frontiers in Public Health* found that doctors posting professional knowledge content improved patient adherence and treatment effectiveness; however, doctors sharing personal content resulted in lower patient adherence and poorer treatment outcome.[6] In the same study, female doctors had a weaker impact on patient adherence when posting professional knowledge but a stronger negative impact when sharing personal content on social media, which is consistent with gender stereotypes despite having similar social media behavior.[6]

However, while social media presence brings visibility, it comes with the cost of privacy loss, which can spill into crossing professional boundaries. In a survey of Australian doctors, nearly one in five physicians had received a "friend request" from a patient. 60% of survey respondents reported "being uncomfortable" in interacting with patients who had accessed personal information about them online, prior to consultation.[7] Sixty-five percent of physicians surveyed displayed hesitation regarding social media immersion and online communication due to concerns regarding privacy and legal concerns.[7] The more consistent predictors of physicians who used social media were being younger, being male and having teaching hospital privileges.[8]

Combatting Health Misinformation

Social media has users seeking trustworthy sources of information; however, when there is a lack of health and digital literacy, misinformation can spread.[9] A research article published in *Social Sciences* describes how misinformation is spread; due to the reward structure of social media that encourages users to form habits, users will automatically respond to cues and develop insensitivity to the consequences of sharing.[10] Health misinformation is prevalent on social media; a systematic review by Suarez-Lledo & Alvarez-Galvez found that the main principal categories affected were vaccines (32%), drugs or smoking (22%), noncommunicable diseases (19%), pandemics (10%), eating disorders (9%), and medical treatments (7%).[11] Due to targeted marketing, health misinformation on social media disproportionately harms female adolescents, racial and ethnic minority youth, LGBQT+ youth, and other marginalized groups.[12]

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As per an article published in *BMC Public Health*, strategies to combat health misinformation involve improving communication from community leaders, scientists and community-based organizations.[13] Younger adults often rely on social media for news. Technology based strategies could be considered such as fact-checking/deleting false posts, and other multimedia strategies such as games or videos; prerequisites for combating health misinformation involves needs assessment (encouraging people to report misconceptions, assessing community needs and having a social demand for fact-checking).[13] Another category discussed by Keikha et al. was combatting health misinformation by educating community leaders such as influencers, peer leaders, religious leaders and other public leaders.[13] It is important to have reliable sources, well-structured content which fits cultural norms, and incorporates the native language of the target audience.

Healthcare professionals can "meet people where they are" by having a social media presence that disseminates important health information and debunks health misinformation. The "debunking" strategy can help counter health misinformation and consists of 4 steps: state the facts, follow this with a warning about the myth, explain the fallacy, and then finish by reinforcing the facts.[14] Being more focused on medical aspects rather than commenting on political issues helped Hofstra & Gommers increase their impact while avoiding trouble (receiving direct threats).[14] It is also important to recognize that social determinants of health have an effect on information-seeking behaviors; as per Forgie et al., the physician-patient relationship should evolve to accommodate the increasing role of social media in health and how best to use social media as a tool to improve health outcomes.[15]

Benefits of Social Media

Eighty percent of internet users seek health information online.[15] A research study completed in China that examined the various communication forms on social media with doctors and their impact on the consumer's e-health literacy and healthy behaviors found that following doctors' accounts, responding to doctors' posts, and recommending doctors to others was significantly associated with e-health literacy ($p<0.01$); following doctors' social media accounts, liking doctors' posts, and recommending doctors was significantly associated with healthy behaviors ($p<0.01$).[16]

There are other benefits in the realm of public health from social media which include health promotion, emphasis on disease prevention, community building, peer support groups (addiction support, suicide prevention), direct access to the latest information, facilitating relationships between patients and physicians/organizations, allowing for rapid dissemination regarding disease outbreaks or other health emergencies and building connections for global perspectives on health.[17]

Role with Learners

Social media can be an especially valuable tool for learners including medical students, residents and current family medicine physicians. In a study of 485 physicians, nearly 25% of survey respondents report using social media daily or multiple times daily to scan for or explore medical information.[18] In the same survey, 57.4% of participants reported that social media allowed them to deliver more effective care and 60% answered that it improved the quality of patient care delivered.[18] Social media also can help physicians stay up to date on the latest medical knowledge.

In addition to the educational benefits, social media offers the opportunity to collaborate and network. In a review article published in *Cureus*, networking via digital platforms (LinkedIn, ResearchGate, Twitter) helps expand one's network beyond face-to-face opportunities.[19] These online venues help expand visibility, allowing connections with other professionals and allowing for the dissemination of research findings, showcasing achievements, and engaging with content which may attract opportunities.[19] Within the past few years, medical students and residents are using social media pages to scout and connect with residency programs as well.

Social media also empowers physicians to be advocates. There are various forms of advocacy, including "listening to the stories of those with particular experiences, informing people of issues they were previously unaware of, organizing supporters for a specific cause, and pushing for more direct actions."[20] Even sharing day-to-day activities and stories of challenges in healthcare can be a form of advocacy.

Social Media Posting: Risks and Challenges

In a survey conducted by Surani et al., nearly 40% of healthcare workers were unaware of their institution's social media policy, which could lead to a potential privacy breach.[5] Family physicians should be aware of their institution's policies regarding social media posting, in order to not risk violation. A systemic review published in 2021 demonstrated increased use of social media among health care professionals, along with a reciprocal increase in the prevalence of unprofessional behaviors.[21] If physicians are displaying unprofessional behavior (inappropriate social media use), professional society and medical boards can impose practice restrictions or suspend/revoke physician licenses.[22] This can put a physician's job and license at risk, especially if a physician posts enough information to potentially identify a patient.

In a multi-site survey-based study published by Garg et al., emergency medicine residents and faculty were surveyed to identify the prevalence of unprofessional social media use.[23] Most of the identified unprofessional behaviors grouped as high-risk-to-professionalism events (HRTPE) were reported by residents.[23] Of the 1314 responses received, residents reported posting: identifiable patient information (26%); a radiograph, clinical picture or other image (52%); images of intoxicated colleagues (84%); inappropriate photographs (66%); and inappropriate posts (73%).[23] The study concluded that such events pose substantial threats to the healthcare professionals and their associated institutions.

Social media can make maintaining work-personal life boundaries difficult, with a survey by the AOA finding that 65% of millennials and 43% of all adults feel that it is appropriate to contact physicians about a health issue through social media by either posting on their page or directly messaging them.[24] Understandably, physicians are hesitant to respond and should avoid interacting with their patients on social media since it could

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violate a professional boundary, even if patients are the ones initiating the contact. Organizational policy statements often discourage personal online communication with patients.

Figure 1: Best Practices and Pitfalls of Social Media Use for Physicians[20,22,25,26]

Best Practices:

- ➔ Be professional[20]
- ➔ Follow institutional policies[20]
- ➔ Obtain informed consent if sharing patient information[20]
- ➔ Reference trials and publications when qualifying statements and recommendations[25]
- ➔ Maintain patient privacy[25]
- ➔ Remain authentic[25]
- ➔ Refer patients for an official medical evaluation and avoid practicing medicine online[26]
- ➔ Potential positive impact on medical care[26]
- ➔ Potential positive impact on medical care[26]

Challenges/Pitfalls:

- ➔ Limit screen time[20]
- ➔ Avoid conflicts of interest[20]
- ➔ Avoid reputation damaging information[22]
- ➔ Avoid false or misleading information[22]
- ➔ Avoid patient-identifying information[22]
- ➔ Avoid sponsored information[22]
- ➔ Avoid copyrighted information[22]
- ➔ Risk of burnout, anxiety, and/or depression[25]
- ➔ Risk of being misunderstood[25]
- ➔ Avoid direct patient engagement[25]
- ➔ Avoid direct patient engagement[25]

Mitigating Risk: Best Practices as per the American Medical Association

The Code of Medical Ethics published by the *American Medical Association* said that while social media can "foster collegiality and camaraderie within the profession and [used for public health messages]"; however, social media use by medical professionals can "potentially undermine trust and damage the integrity of the patient-physician relationships and the profession as a whole, especially [when used to] promote personal interests."[27] Furthermore, the AMA states that "physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly."[27] An abbreviated version of "Professionalism in the Use of Social Media" is displayed in *Figure 2*.

Conclusion

In the 21st century, social media has not just become a conduit for personal connections but an opportunity for professional engagement. Health misinformation poses a risk to public health promotion. Social media can be utilized as an effective tool in combating health misinformation and sharing important medical information. Family practice doctors should also consider utilizing social media as a tool for education, collaboration, and advocacy.

Figure 2: AMA Recommendations for Physicians on Social Media[27]

Social Media Guidelines for Physicians

Protect Your Reputation • Protect Your Patients • Protect the Profession

1. Every Post Has Consequences
Any personal post can damage professional reputation and reduce the integrity of the profession.

2. Protect Patient Privacy
Respect patient privacy and confidentiality at all times.

3. Maintain Professional Boundaries
Uphold ethical patient–physician relationship standards online.

4. Manage Your Digital Footprint
Use privacy settings, monitor your presence, and remember the internet is permanent.

5. Disclose Financial Relationships
Publicly disclose paid partnerships, sponsorships, and financial interests.

6. Share Accurate Medical Information
Ensure medical information posted is useful, evidence-based, and accurate.

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