

mon guidance that can be provided by ACGME and ABMS Boards.

The ABFM Board of Directors and executive leadership are committed to a change in policy related to training standards for board certification that will provide for a more supportive approach to changes in the lives of residents and their family members. We hope to share this with the community before the 2020-2021 academic year. Our approach will be inclusive and permissive, while at the same time remaining consistent with our duty to the public to assure that a board-eligible or board-certified physician completing residency training is worthy of entrusting their care. We will work to support residency programs in understanding and implementing these new guidelines, cognizant of some of the challenges this will present to managing both educational and coverage needs. The ACGME will play a corresponding role in policy development and resources. It is the right time and the right thing to do. We look forward to the transition ahead and working together to promote healthy residents and healthy families.

Elizabeth G. Baxley, MD (corresponding author, [ebaxley@theabfm.org](mailto:ebaxley@theabfm.org))<sup>1</sup>; Deborah S. Clements, MD<sup>2</sup>; Warren P. Newton, MD, MPH<sup>1</sup>; Aimee Eden, PhD<sup>1</sup>; Kathy Botner<sup>1</sup>  
<sup>1</sup>American Board of Family Medicine,  
<sup>2</sup>Northwestern University Feinberg School of Medicine

## References

- Magudia K, Bick A, Cohen J, et al. Childbearing and family leave policies for resident physicians at top training institutions. *JAMA*. 2018;320(22):2372-2374.
- Willett L, Wellons M, Hartig J et al. Do women residents delay childbearing due to perceived career threats. *Acad Med*. 2010; 85: 640-646
- Humphries LS, Lyon S, Garza R, Butz DR, Lemelman B, Park JE. Parental leave policies in graduate medical education: a systematic review. *Am J Surg*. 2017 Oct;214(4):634-639.
- Webb AMB, Hasty BN, Andolsek KM, et al. A timely problem: parental leave during medical training. *Acad Med*. 2019 Nov;94(11): 1631-1634.
- Stack SW<sup>1</sup>, Eurich KE, Kaplan EA, Ball AL, Mookherjee S, Best JA. Parenthood during graduate medical education: a scoping review. *Acad Med*. 2019 Nov;94(11):1814-1824.
- Gottenborg E, Rock L, Sheridan A. Parental leave for residents at programs affiliated with the top 50 medical schools. *J Grad Med Educ*. 2019 Aug;11(4):472-474.
- Weinstein DF, Mangurian C, Jagsi R. Parenting during graduate medical training - practical policy solutions to promote change. *N Engl J Med* 2019; 381:995-997.
- Varda BK, Glover M. Specialty board leave policies for resident physicians requesting parental leave. *JAMA*. 2018;320(22):2374-2377.
- Stack SW, Jagsi R, Biermann JS, et al. Maternity leave in residency: a multicenter study of determinants and wellness outcomes. *Acad Med*. 2019;94(11):1738-1745.
- Wendling A, Paladine H, Hustedde C, Kovar-Gough I, Tarn D, Phillips J. Parental leave policies and practices of US family medicine residency programs. *Fam Med*. 2019;51(9):742-749.
- Rangel EL, Smink DS, Castillo-Angeles M, et al. Pregnancy and motherhood during surgical training. *JAMA Surg*. 2018;153(7): 644-652.
- Worthington RO, Feld LD, Volerman A. Supporting new physicians and new parents: a call to create a standard parental leave policy for residents. *Acad Med*. 2019;94(11):1654-1657.



*Ann Fam Med* 2020;18:282-284. <https://doi.org/10.1370/afm.2546>.

## AAFP TAPS VETERAN FAMILY MEDICINE ADVOCATE AS NEXT CEO/EVP

When longtime AAFP CEO and EVP Douglas Henley, MD, announced last year that he planned to retire this summer, the Academy launched an exhaustive national search for his successor. That intensive 11-month process came to a close on March 11, 2020, when veteran family medicine advocate Shawn Martin was formally named the next CEO/EVP.

Martin, the Academy's senior vice president for advocacy, practice advancement, and policy, is already familiar to many AAFP staff members and family physicians, having served in that role since 2012. Before joining the Academy, Martin served more than a decade as director of government relations for the American Osteopathic Association.

The announcement capped a busy few weeks for Martin, who—in addition to accepting this promotion—recently turned 50 and completed his master's degree in health care delivery science from Dartmouth College in Hanover, New Hampshire. Now he'll move from the Academy's Washington, DC, government relations office to its Leawood, Kansas, headquarters.

He will continue serving in his senior vice president's role until June 1, 2020 and then will work alongside Henley as CEO designee during a transition period until Henley's retirement on August 1, 2020.

*AAFP News* sat down with Martin to discuss his new role, his vision for the Academy, and the challenges ahead.

**Q:** You grew up in rural Oklahoma as the son of a family physician. How did your father's medical career shape your understanding of primary care and your interest in health policy?

**A:** I saw at a young age the impact that a single physician, or a group of physicians, can have on individual patients and on a community. The burden on primary care was real even in the 1970s and '80s. We were

isolated, far from the big health care centers in Oklahoma City or Tulsa. People relied on my father and the other primary care physicians in our county for the majority of their health care. I saw the capability that existed in family medicine to be comprehensive and deliver care in the traditional cradle-to-grave sense. I also learned the importance of access to health care in ensuring a thriving and sustainable community. Beyond that, as thousands of our members tell us, it is not easy to go into an underserved rural community and practice family medicine. Seeing my father dedicating his life to that every day for years made a lasting impression on me.

**Q:** You've been focused primarily on governmental advocacy for more than 20 years in leadership roles with both the AOA and the AAFP. What motivated you to take on this broader role?

**A:** I've spent all my adult professional career working in and around health care policy at the convergence of policy and politics. But I've always had other responsibilities in both of the organizations I've worked for. I've described it as being kind of a public brand ambassador for the organizations because I've played a role in communicating or collaborating with other people in the health care sector—employer groups, insurance companies, etc. I've come to those responsibilities through a government relations or health policy position, but I've had the opportunity to engage in a broader set of activities around the organization and its mission inside and outside of the political arena. The mission of the AAFP and working with our members are 2 things that really motivated me over the past 8 years and will continue to motivate me in the future. There is an incredible amount of opportunity that exists for family medicine. Our future—as a discipline—can be whatever we want it to be.

**Q:** What are your short- and long-term priorities in your new role?

**A:** There are 3 things I spend a lot of time thinking about: being strategically focused, organizationally disciplined, and structurally aligned with the first 2 issues. We have a good strategic plan. We have good strategic objectives. That will allow us to create value for members, create a health care system that is foundational in family medicine and primary care, and allow patients to gain access to the benefit of comprehensive, continuous, coordinated family medicine and primary care. We're developing an operational plan that will help us be disciplined and align our human and financial resources to that strategic plan. That's an important endeavor we have started in the past year. It will be a point of emphasis moving forward.

**Q:** The Academy has advocated for increasing the percentage of health care dollars invested in primary care. How can your experience in Washington help family medicine move the needle in that direction?

**A:** My experiences in Washington are part of me. My view of the world is shaped by the reality I've existed in for the past 20 years. I understand that audacious goals meet political reality and financial reality pretty quickly—sometimes in a really rude introduction. That doesn't mean there's not work we should do or there's not work that's worthy of pursuing. When we think about payment and investment in primary care, one of the things people are going to hear from me a lot is that our product is family medicine, and we need to be talking about the value of family medicine more aggressively. Part of that is paying family medicine more, and part of that is putting family medicine in a better position to be successful. We need to remove barriers from family physicians and allow them to do what they're best at, which is providing care to patients. We also need to make sure purchasers and payers are prioritizing family medicine and that government agencies understand the value of family medicine. We need to talk about the value of family medicine more and in different ways. My Washington experience will help us do that.

**Q:** Administrative burden is another area members are asking for help with. What are your plans to keep fighting against prior authorization and other barriers that are encroaching on the time family physicians spend with their patients?

**A:** Members identify administrative burden as their top frustration and their top priority for the Academy. We've initiated a lot of efforts aimed at reducing and eliminating administrative burden in its various forms. I've been pretty vocal in my blog and elsewhere that there was a failure in health care policy with respect to electronic health records and the HITECH (Health Information Technology for Economic and Clinical Health) Act. It's one of the few places in any industry where tech hasn't created efficiency. It's actually decreased efficiency in health care in many respects. It's a tragedy of policy-making that needs to be corrected. I don't think it means we get rid of electronic health records. I believe the digital collection, aggregation, and distribution of medical information is an essential tenet of a 21st-century health care system. But we have to find a way to do this in a manner that doesn't detract from physicians' core function. We've all seen and heard stories that physicians are distracted and doing a lot of things besides actually listening and providing care to the patients in their exam room. Again, it's a real failure of health care policy that we are where we are today.

I also believe that rapidly transitioning away from fee-for-service and into new alternative payment models is important. Our health care delivery system is built around episodes, and those episodes each have complicated documentation and auditing requirements. Alternative payment models (APMs) offer an escape from these legacy approaches to delivery and payment. The AAFP has been a national leader in the development, implementation, and advancement of APMs, ranging from the Primary Care First and accountable care organizations programs to direct primary care. Each of these, while different from each other, is built on a new approach to delivery and payment that moves away from fee-for-service as the foundation. We have a lot of work to do in this area, but the AAFP leadership in this area is well established.

**Q:** Other thoughts?

**A:** I really look forward to working collaboratively with our staff in DC, Leawood, and around the country to ensure they have the direction needed and they feel empowered to do the good work we, as an organization, do every day. I'm also excited to work with our state chapter executives, who are dynamic leaders and partners, and the 7 other family medicine organizations. It's a team sport.

David Mitchell  
AAFP News



*Ann Fam Med* 2020;18:284-285. <https://doi.org/10.1370/afm.2547>.

## CLOSING THE GAP: OUR CHALLENGE, OUR OPPORTUNITY

### A Review of ADFM's Annual Conference, February 12–15, 2020

2020 was a year of firsts for ADFM's Annual Conference in New Orleans. The first with a new name ("Annual Conference" replacing the legacy name "Winter Meeting"), the first with Amanda Weidner, MPH, as Executive Director, the first with over 250 attendees, and the first with a keynote "Heritage Fund Speaker," Professor Sir Michael Marmot, Director of the UCL Institute of Health Equity.

Professor Marmot's eminent career of over 40 years researching health inequalities and inequities directed the title and theme of this year's conference, with his

book, *The Health Gap: The Challenge of an Unequal World*, selected as the One Book, One ADFM title. His presentation started with the baseline question, "Why treat people and send them back to the conditions that made them sick?" followed by data on life expectancy trends for men and women, the steady decline of children earning more than their parents, and the impact changes in well-being had on inequalities. Professor Marmot also shared data and details related to the 6 objectives of his Fair Society, Healthy Lives policy, evidence-based strategies to address fairness and social justice which also reduce health disparities: (1) Give every child the best start in life; (2) Enable all children, young people, and adults to maximize their capabilities and have control over their lives; (3) Create fair employment and good work for all; (4) Ensure healthy standard of living for all; (5) Create and develop healthy and sustainable places and communities; (6) Strengthen the role and impact of ill health prevention.

The theme of "closing the gap" in health inequalities was also covered in a variety of other sessions:

- ADFM President Allen Perkins, MD, MPH, shared his personal experience, as a physician and Chair of the Department of Family Medicine at South Alabama University, of slowly moving the health equity needle forward when in a "red state."
- ADFM's Diversity, Inclusion, and Health Equity committee organized 6 action-oriented breakout discussion sessions on: (1) recruitment of faculty staff; (2) retention and recruitment strategies for students and leadership development; (3) coming together in action for inclusion, equity, and diversity; (4) inclusion of those with disabilities; (5) diversity and inclusion training (including implicit bias and others); and (6) intentional management throughout the system.
- Topic tables during breakfast sessions on Thursday and Saturday mornings included content on ways to address social determinants of health and recruiting medical students to family medicine.
- ADFM's 5 strategic committees (Diversity, Inclusion, & Health Equity, Education Transformation, Health-care Delivery Transformation, Leader Development, and Research Development) met over lunch on Thursday (open to all attendees). New in the 2-year strategic plan are diversity, health equity, and inclusion goals unique to each committee's focus.

Steven Waldren, MD, Vice-President and Chief Medical Informatics Officer of AAFP, was also a keynote speaker, with a plenary that explored the emerging "4th Industrial Revolution" of artificial intelligence and its potential impact on family medicine. Understanding the differences between artificial intelligence and machine learning, identifying opportunities and challenges in AI/ML, and noting key issues that will