Table 1. Vision, Voice, and Leadership

Vision	• Improve the health and healthcare of the American public and the health care system
	• Improve FM departments, academic FM, and AHCs
Voice	• Articulate a coordinated, unified voice for family medicine in academic health centers and legislative bodies
	• Speak for the future of the discipline within the evolving health care system
Leadership	• Find, prepare, coach, & support future FM leaders to be effective chairs and FM advocates
	• Offer leadership to the "family" of family medicine in areas of strength for departments

FM = family medicine; AHC = academic health center.

ration in Washington, DC ADFM's early years were typified by commiseration, support, and golf meetings of Generation One leaders, many of whom were clinician-educators thrust into leadership roles in an emerging clinical field.

Generation 2: Chair Education

A major turning point came through a Strategic Planning exercise in 1999. This process galvanized ADFM's move to become a more organized and productive organization characterized by organizational expansion, a growing sense of focus and purpose , and the finding of a voice for ADFM and its members within academic medicine. It paralleled the transition to Generation Two leaders who came from more academic roots and who aspired to be triple/quadruple threats (clinical care, education, research, and advocacy). ADFM added professional management with the appointment of Ardis K. Davis, MSW, as Executive Director in October 2004. ADFM annual meetings intensified, with chairs teaching chairs how to improve their departments. Leadership cycles were shortened, member participation increased dramatically, and Board committees addressed specific areas of departmental efforts, such as residency, predoctoral education, clinical practice, research, and legislative action. ADFM expanded participation by departmental senior administrators, began mentoring future chairs and developing senior leaders, and opened dialogue with academic and health care leaders from in- and outside of family medicine. In addition, ADFM helped advance a common voice for academic family medicine through the establishment of the Council of Academic Family Medicine (CAFM) and via coordination with the AAFP and ABFM.

Generation 3: Leadership

With the maturation of ADFM's administrative operation, in October 2008 the ADFM Board recognized it can now shift its attention from internal organizational topics to better address issues of critical importance to Departments, the discipline, academic medicine, and the healthcare system. These sentiments led to a vision and mission process with the ADFM Board, facilitated by the outgoing and incoming presidents, with presentation and discussion with members at the February, 2009, Annual Meeting. This process led to ADFM's new tagline summarizing ADFM's purpose: "Vision, Voice, Leadership," and described in Table 1.

ADFM is stepping up to the plate to address critical issues for family medicine including:

- chair leadership pipeline
- primary care workforce
- patient-centered medical homes
- practice redesign
- RRC residency requirement revisions
- student interest in family medicine
- pre-doctoral education core curriculum project (C4)
- family medicine research including clinical and translational science awards (CTSAs)
- academic health centers
- health of communities
- advocacy

As chairs of Departments of Family Medicine, we are passionate about joining with our colleagues across the family of family medicine in improving the health and well-being of individuals, families, and communities through clinical care, medical education, research, and advocacy. We must and will succeed in the "Generation Three" mission to ensure improvements in health and the future success of Departments of Family Medicine through Vision, Voice, and Leadership.

Written by the ADFM Executive Committee following the 2/09 Board meeting where the tag-line Vision/Voice/Leadership was conceived.

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Michael Magill, MD, Immediate Past President,
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From the Association of Family Medicine Residency Directors

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ADVOCACY: THE TIME IS NOW

Listening to Dr Joe Scherger[1] recently, one understands that personal responsibility is required to create a functional health care system. "Creating" seems better than "reforming", for instance, because the function-

ality of the current system is in dire straits. Consider a restaurant where the patrons and the workers are dissatisfied, ratings are bad and the books show red ink for almost 60 years in a row. Any sensible owner would have started over years ago (getting out of the business not being an option). Dr Scherger describes some success rising from the ashes, however: "Idealized micro-practices" where physicians have increased career satisfaction and patients are so pleased they are actually paying out of pocket to belong! Proactive care delivered to "activated" patients who are empowered to have an impact on their own health care. The family medicine physician is employing (and perhaps is actually an agent of) what he describes as "disruptive technology," turning the tides of woe into currents of hope for frustrated patients and doctors.

So perhaps, with apologies to Ronald Reagan, it is morning in family medicine--optimism awakens. The alarm clocks of the powers that be are playing a tune written by the nation's primary care physicians and their patients. Perry Pugno's "paralysis of inaction"[2] could well dissolve in the face of many such success stories.

The Clinton administration failed to focus on "systemic problems in funding, organization, and delivery of care,"[3] and saw good ideas and well-intentioned initiative fall short of success. The Obama administration is taking aim at health care reform, and is listening to the family of family medicine. We cannot merely complain to legislators about "Big Pharma" and physician reimbursement, although these are undoubtedly important topics. Now is the time to get actively involved in legislative advocacy. We must rise to more effective tactics. Frontline private and academic physicians should learn to feel comfortable bringing issues to legislators and our patients. Those that we serve can become our biggest advocates. We must forge ahead and DO the things that have been shown to improve quality and reduce cost.

Even office design now has evidence-based literature showing cost savings.[4] We must be familiar with TransforMED's findings and new models such as Idealized Micro-Practices, but our key talking points with legislators should be based upon our own personal or program's experiences in trying to achieve patient-centered care. We need to identify current barriers to improving the quality of care and ask for help to eliminate them. We should discuss why the almost 45-year old hospital-based graduate medical education reimbursement system is particularly problematic for adequately financing primary care residencies and that it needs an overhaul. Legislators need to hear stories of how our local innovations are working to improve patient satisfaction and reduce cost, while also training future family doctors. These tales will resonate with lawmakers, and be more tangible than promises based on dreams of what could be done "if only we had more money."

Advocacy in family medicine, like a planetary nebula, is beginning to coalesce into some well organized efforts from the haze of the national-level health care issues. The focus tends to remain at a national, rather than state or local level, since ideas traded across listserves now understandably concern the Obama administration. We need to meet with our state and national legislators, and carry our message to our home residency communities at medical staff meetings and county medical society gatherings to develop key physician contacts for local and state as well as federal legislators. We must implement advocacy curricula to educate all family medicine residents as an opportunity for familiarity and comfort with the necessary topics and strategies, and to encourage development of relationships with legislators. Patient-centered medical home (PCMH) strategies are buzzwords in Washington now; staffers need to be aware that we are using tools such as open-access scheduling, health care teams, and patient registries to improve and document outcomes. It is imperative that we are giving more than lip service to the PCMH if we expect more than that out of legislation.

Of all health care costs, 50% are consumed by 5 diagnoses: asthma, diabetes, hypertension, coronary disease, and depression. This sounds like the afternoon schedule of every family physician in America! How can Washington or anyone else deny that the practicing family physician is equipped to lead the change? We are already doing it. The time is now to beat a drum in our state and nation's capitals to create the rhythm of change.

T. Edwin Evans, MD; Elissa Palmer, MD; Stoney Abercrombie, MD; Peter Carek, MD, MS; Sandra Carr, MD; Gretchen Dickson, MD, MBA; Joseph Gravel, Jr, MD; Karen Hall, MD; Stanley Kozakowski, MD; Mark Robinson, MD; Martin Wieschhaus, MD

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