

SPECIAL COMMUNICATION

Can Family Medicine's Counterculture History Help Shape an Anti-Racist Future?

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Family medicine prides itself on community engagement and has embraced its counterculture roots. After the racial and social reckoning of 2020, including the COVID-19 pandemic and the Black Lives Matters movement, family medicine, as a specialty, must embrace anti-racism as a core value to meet community needs. This article reflects on the foundational tenets of family medicine's origin. It highlights the current disparities regarding professional representation while offering equitable, intentional, and collaborative approaches to move toward and achieve anti-racism within the specialty, medical education, and the community. (J Am Board Fam Med 2022;35:169–172.)

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Introduction

While many family physicians have trumpeted the progressive tone of our specialty, G. Gayle Stephens, MD's 1979 presentation and publication of "Family Medicine as Counterculture" are considered by many to be a rallying call for the specialty of family medicine.^{1,2} In his comments, Dr. Stephens highlighted the "social reform ethos" of family medicine.¹ Recognizing that being on the side of change is often seen as counterculture, he named several mid-20th century reforms whose values he believed to be echoed by family medicine, including love of the land and rural areas (agrarianism), that "the well-being of the individual [should not be] subverted by class, religion, race, or poverty" (utopianism), transparency, quality control, patient advocacy (consumerism), and feminism.¹

Dr. Stephens acknowledged some foils to these ideals. For example, the unwillingness of family

medicine "to listen to the deeper issues of women's liberation, or to modify our residencies to allow a woman to be a mother and a resident simultaneously" demonstrated an ambiguity about feminism.¹

Counterculture (or not), family medicine prides itself on serving communities, particularly underserved ones: 46% of physicians in Federally Qualified Health Centers (FQHCs) are family physicians, double the proportion of the next best represented specialty (pediatrics, 22%),³ and family medicine is the only primary care specialty whose concentration increases with rurality.⁴ Family medicine residencies were designed with an eye to training doctors to serve rural and underserved communities.⁵ While Dr. Stephens hints at racism as a thwart to utopianism, the 2020 murder of George Floyd in the context of glaring health disparities laid bare by the COVID-19 pandemic revealed how structural racism harms the health of people and communities. This historic moment has raised awareness among many of us that we must amplify past efforts against discrimination. While we invite individuals to examine their own biases, implicit or explicit, the purpose of this piece is to address structural racism. We present information about the state of efforts within family medicine to address disparities and strategies to address structural racism.

Professional Representation Disparities

While many point to "social justice as the moral core of family medicine,"⁶ and our specialty has

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embraced caring for underserved and marginalized patients, we continue to fall short at equitable racial and ethnic representation in our ranks.

Compared with United States (US) Census estimates from 2019, Black, Hispanic, and Native American communities continue to be brutally underrepresented in medicine (URM) as a whole and in family medicine specifically.^{7,8,9} Among all practicing physicians, only 6% are Black, while Black People represent just over 13% of the US population.^{7,8} Of the 34 physician specialties assessed by the Association of American Medical Colleges, family medicine has the seventh-highest proportion of Black practitioners (7%), approximately equivalent to physical medicine and rehabilitation, geriatric medicine, and pediatrics, while internal medicine (8%), preventive medicine (10%), and obstetrics and gynecology (11%) come closer to reflecting the general population.⁸ Understanding why some specialties attract more diverse membership is important to our specialty's mission. While the demographic breakdown of initial certifications and recertification examinees from the American Board of Family Medicine demonstrates slow progress toward more racial and ethnic diversity, the proportion of Black and Hispanic diplomates was still far less than half that in the U.S.⁹ Among health professional colleagues, including physician assistants (PAs) and nurse practitioners (NPs) who practice primary care, the statistics are similar.^{10,11}

These statistics represent a threat to health equity in our specialty. The cause lies with biases and discriminatory practices that permeate the medical system.^{12,13} The family medicine specialty was built to consider family and community as intrinsic to the individual patient experience, but we are not immune to the effects of personal and systemic racism. Dr. Stephens said, "the emergence of family practice was a response to ideas whose time had come."¹ Once again, we must mobilize resources to achieve a common goal.

Equity

Teaching about health equity and structural racism can lead to increased cultural humility and awareness among future providers. These should be required curricula. However, only half of the family medicine departments surveyed in 2020 incorporated anti-racism and health equity in the

curriculum.¹⁴ Standing on our counterculture foundation, it is important to dismantle racism by offering student and faculty opportunities to engage with issues of health equity and social determinants of health.^{14,15} The prioritization of equity in medical education can elevate family medicine by welcoming diverse perspectives, attitudes, practices, and knowledge reflective of the communities we serve.¹⁵ Addressing equity can make the learning environment more inclusive and advance health equity for our patients.

Action Opportunities:

- Create and implement anti-racism educational interventions. Many toolkits are available, including an education-focused anti-racism toolkit from the Society of Teachers of Family Medicine,¹⁶ a community health-oriented toolkit from the American Academy of Family Physicians (the EveryONE toolkit),¹⁷ and an interprofessional diversity, equity, and inclusion (DEI) toolkit from the Physician Assistant Education Association.¹⁵
- Move beyond what is comfortable and implement anti-racism pedagogy that allows learners to offer critical reflections regarding oppressive power structures and how they affect their personal lives and the lives of their colleagues, community, and patients.¹⁸ This pedagogy does not allow for the notion of neutrality; therefore, learners and faculty must recognize, assess, and address implicit and explicit biases.¹⁸
- Move beyond cultural competency to incorporate "structural competency," which asks learners to recognize complex social, environmental, and economic structural factors leading to decreased health.¹⁸

Through actions like these, family medicine has a pivotal opportunity to renew its social contract with our target communities.¹⁹

Intention

An intentional and action-oriented approach is necessary to dismantle systemic racism. This includes decisions and actions by the top tier of departmental or institutional leadership to support and include faculty who are URM. The 2020 Association of Departments of Family Medicine survey demonstrated that two-thirds of departments reported a working infrastructure for diversity and inclusion in their institutions.¹⁴ While 74.4% of departments

had a plan for supporting diversity during the faculty hiring process and 66% supported diversity during residency recruitment, only about half had a values statement or a mission statement that included diversity, or a plan for supporting diversity in the staff hiring process.¹⁴ Fewer than half of the departments had a diversity/inclusion officer charged with taking reports of adverse events; fewer than half of these positions were funded.¹⁴

Action Opportunities:

- Family medicine programs should create policy statements and deploy admissions practices demonstrating their commitment to anti-racism, justice, and DEI.^{15,18}
- Systems can and must be put into place to retain and promote URM faculty:
 - Structured education to prepare leaders to support underrepresented faculty;
 - Providing time, funding, and expectations around mentorship for new URM faculty members; and
 - Support for local and national funding opportunities targeted to URM faculty.²⁰

Collaboration

A collaborative approach to dismantle systemic racism is paramount. Family medicine can serve as an exemplar in this charge. Like our leadership among the medical specialties in caring for marginalized communities, we must be leaders in medicine in the effort to address systemic racism. Family medicine can leverage the interprofessional team dynamic to pursue anti-racism and health care equity and justice by partnering with our PA and NP colleagues. The Interprofessional Education Collaborative offers four core competencies for interprofessional collaborative practice, with two of them aligning with the proposed trajectory to address racism in the profession, patient care, and health outcomes.²¹ The interprofessional team should create and preserve mutual respect and shared values (in this case, advancing anti-racism) and work together to deliver safe, efficient, competent, and equitable health care.²¹

Conclusion

In 1979, Dr. Stephens claimed not only that “the family practice movement has succeeded ... because we were identified with reforms that are

more pervasive and powerful than ourselves,”¹ but that our “continued success is dependent on our ability to identify what they are, and to facilitate their expression, not to manage, control, or own them.”¹ We hold the public trust in our hands and must continually consider biases and structures that influence provider-patient interactions, medical decision-making, uptake of health behaviors, and health outcomes.²² We should “recognize the relationship between culture and medicine, and consider the external circumstances of humanity and welcome new and ever-changing awareness concerning race in America.”²² This type of introspection should manifest in practice to dismantle structural violence in family medicine, which is intimately associated with societal injustices and oppression.²³

There is no ignoring racism as a pervasive societal ill; our current experience with a deadly pandemic that has disproportionately affected communities of color, triggering a racial reckoning in the United States, makes that all too clear. As a clinical specialty, we must recognize the deep, firm roots of racism in our nation and develop a sustainable way forward in medicine while diversifying the workforce and applying cultural humility to address community health.¹⁹ Now is the moment for family medicine to reconnect with its counterculture roots and identify itself clearly with anti-racism as a value and a reform that is desperately needed within our own specialty and country.

To see this article online, please go to: <http://jabfm.org/content/35/1/169.full>.

References

1. Stephens GG. Family medicine as counterculture. *Fam Med* 1989;21:103–9.
2. Waters RC, Stoltenberg M, Hughes LS. A counterculture heritage: rediscovering the relationship-centered and social justice needs of family medicine - a perspective from the Keystone IV Conference. *J Am Board Fam Med* 2016;29:S45–S48.
3. National Association of Community Health Centers. Community health center chartbook. 2021. Available at: <https://www.nach.org/research-and-data/research-fact-sheets-and-infographics/2021-community-health-center-chartbook/>. Accessed July 7, 2021.
4. Larson EH, Andrilla CHA, Garberson LA. Supply and Distribution of the Primary Care Workforce in Rural America: 2019. Policy Brief #167. WWAMI Rural Health Research Center, University of Washington; 2020. Available at: <https://family>

- medicine.uw.edu/rhrc/wp-content/uploads/sites/4/2020/06/RHRC_PB167_Larson_revised.pdf. Accessed June 28, 2021.
5. Rodgers DV, Wendling AL, Saba GW, Mahoney MR, Brown Speights JS. Preparing family physicians to care for underserved populations: a historical perspective. *Fam Med* 2017;49:304–10.
 6. Schroeder SA. Social justice as the moral core of family medicine: a perspective from the keystone IV conference. *J Am Board Fam Med* 2016;29:S69–S71.
 7. United States Census Bureau. Quick facts United States. 2019. Available at: <https://www.census.gov/quickfacts/fact/table/US/PST045219>. Accessed June 20, 2021.
 8. American Association of Medical Colleges. Diversity in medicine facts and figures 2019. Available at: <https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019>. Accessed July 7, 2021.
 9. Peterson LE, Fang B, Phillips RL, Avant R, Puffer JC. The American Board of Family Medicine's data collection method for tracking their specialty. *J Am Board Fam Med* 2019;32:89–95.
 10. American Academy of Physician Assistants (AAPA). AAPA salary report. 2021. Available at: <https://www.aapa.org/shop/salary-report/summary-of-national-findings/>. Accessed June 28, 2021.
 11. American Association of Nurse Practitioners. The state of the nurse practitioner profession. 2021. Available at: <https://www.aanp.org/practice/practice-related-research/research-reports>. Accessed September 2, 2021.
 12. Mateo CM, Williams DR. Addressing bias and reducing discrimination: the professional responsibility of health care providers. *Acad Med* 2020;95:S5–S10.
 13. Rodriguez JE, Campbell KM, Adelson WJ. Poor representation of Blacks, Latinos, and Native Americans in medicine. *Fam Med* 2015;47:259–63.
 14. Association of Departments of Family Medicine (ADFM). ADFM annual survey. 2020. Available at: <https://www.adfm.org/resources/adfm-data-reports/>. Accessed June 30, 2021.
 15. Physician Assistant Education Association (PAEA). Diversity, equity, and inclusion toolkit. PAEA Learning. 2020. Available at: <https://paea.edcast.com/pathways/diversity-equity-and-inclusion-toolkit/cards/7075182>. Accessed June 28, 2021.
 16. Society of Teachers of Family Medicine. Toolkit for teaching about racism in the context of persistent health and healthcare disparities. 2017. Available at: <https://resourceibrary.stfm.org/view/document/toolkit-for-teaching-about-racism-i>. Accessed September 2, 2021.
 17. American Academy of Family Physicians. The everyONE project toolkit. 2021. Available at: <https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/html>. Accessed September 9, 2021.
 18. Wear D, Zarconi J, Aultman JM, Chyatte MR, Kumagai AK. Remembering Freddie Gray: medical education for social justice. *Acad Med* 2017;92:312–7.
 19. Boatright D, Berg D, Genao I. A roadmap for diversity in medicine during the age of COVID-19 and George Floyd. *J Gen Intern Med* 2021;36:1089–91.
 20. Doll KM, Thomas CT. Structural solutions for the rarest of the rare — underrepresented-minority faculty in medical subspecialties. *N Engl J Med* 2020;383:283–5.
 21. Interprofessional Education Collaborative. Core competencies for interprofessional collaborative practice: 2016 update. Available at: <https://ipec.memberclicks.net/assets/2016-Update.pdf>. Accessed June 28, 2021.
 22. Sturges D. Race matters in physician assistant education and clinical practice. *J Physician Assist Educ* 2017;28:109–12.
 23. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med* 2006;3:e449.