Healing Communities Beyond the Bedside: Family Medicine's Foundations in Advocacy

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A patient's chart may document disease, but it cannot adequately document health. Health is not just defined by what a physician sees, but also includes the invisible weight that patients carry. This weight can only be visible through communication that is built on the trust the patient has in their physician. However, this trust is a privilege that is seen as inaccessible to many minority groups in the United States because they feel as though their physicians could be against them. While this may be in part due to a healthcare system that is overburdened and inequitable, it's also because we find ourselves at a time in history where prejudices are blatantly apparent in our day-to-day lives. In this system, we begin to see that privilege dictates not only who is heard but also who is healed. When every morning you wake up and your existence is questioned as a casual conversation topic, it is hard not to feel like every stranger is out to hurt you —even those who are trying to support you, like physicians.

One negative experience can ignite a wildfire of mistrust that can engulf communities —a common phenomenon in the United States. According to a poll conducted by Sanofi in the United States, 77% of people with disabilities, 69% of people from ethnic minority groups, and 70% of people from the LGBTQ+ community say they have had experiences that damaged their trust in the healthcare system.[1] When this trust is seen as unavailable, patients do not see their doctor. There is fear of judgment and repercussions. An example of this can be seen in migrant communities since the uptick in public ICE presence. Health care centers across the country have

shared anecdotes of patient attendance at appointments declining by almost 30% in some areas.[2] This intensifies the harm already faced by vulnerable populations. As the lines between healthcare and government slowly blur, the relationship between the patient and physician is at risk of becoming tainted.

So now the question is: how do physicians regain this trust? What do patients need right now so that they can feel safe in the presence of their doctor? They need to know that their doctor is on their side. That throughout the chaos of the current political climate, their physician will stand for what is best for them. This is not something that can be expressed behind closed doors, and I pull this from my own experiences as a minority woman in the United States. I need to know that my provider is not actively supporting the very forces that threaten my well-being.

Some might say this is not the physician's role; their place is in the hospital, nowhere beyond. But the factors that affect our patients' health do not exist only inside the hospital, so why should our role as physicians be limited? How can we practice the core ethics of medicine if we do not also work to protect them? Our patients' rights to beneficence, nonmaleficence, justice, and autonomy in healthcare are under scrutiny. Their right to be treated with dignity as much as the person next to them, regardless of who they are, is not something that can be guaranteed anymore. The family medicine specialty's foundations were uniquely made to address this problem, with a history that provides a guideline for family physicians to advocate for their communities

Family Medicine's beginnings in the United States

The family medicine movement began in the early 1900s, with a man named Bailey Barton Buritt. He was hailed as the "father of the family health movement" for advocating for

recognition of patients' overall health beyond emergency care. Recognized by Roosevelt as the "untiring champion of the underprivileged and the sick", Burritt advocated for social welfare legislation that promoted public health in ways we still benefit from today.[3] At the beginning of the 20th century, there was very little understanding of the concept of welfare, especially in the context of medicine; it was seen as a separate entity. Coming out of the Great Depression, Burritt noted the effects of the welfare for a single family could affect the health of a nation as a whole". While Roosevelt championed the concept of social security, it is essential to note that physicians also recognized its impact on public health.

Buritt noted in an essay,

"Social security approaches to these problems, supplemented by the combination of voluntary and publicly supported social services, have not only made the breakup of families unnecessary but have in addition reduced the volume of deaths, sickness, and deterioration in physical health, mental and moral life of families. Children in disadvantaged families are now better cared for, better fed, better educated, have less sickness, and fewer of them die.[4]*"*

The father of the family health movement's legacy emphasized the importance of not only understanding the outside circumstances of patients, but also the necessary action needed to advocate for policies that affect them.

The family medicine specialty was officially established in the United States in 1969 [5]. This did not occur in a vacuum, separate from other events. Medicare and Medicaid had been implemented 4 years before, along with regional health planning. The aftermath of World War II was still being felt, Nixon had just been elected president, the Vietnam War was ongoing, and there was the recent assassination of Martin Luther King Jr. [6]. At a time when the people were demanding reform, family medicine was born. This is not a coincidence. In 1966, the Citizens'

Commission on Graduate Medical Education released Millis' report, which called for the establishment of a primary care physician. The report emphasized that the goal of this physician needed to be "not upon individual organs and systems but upon the whole man, who lives in a complex social setting…[7]" This was a result of the aftermath of the increase in specialization of medicine after World War II. The Millis report showed that, as a result, the basic health care needs of communities were not being met.

The Millis report recognized the everyday tensions of the man that the healthcare system was not addressing. It stated that the primary care physician would be a "medical resource and counselor to an individual or a family. "

Family medicine physicians were established to build an intimate, unique relationship not only with their patients but also with the communities they serve. This is highlighted in the specialty's history. It began as a way for healthcare professionals to address the complex factors that shape who a man is and affect his health. Burritt showed that addressing these factors required not only the clinic but also a public stance..

The Principles of Family Medicine

Another key figure in family medicine was Ian McWhinney. While he was known as the "Founding Father of Medicine" in Canada, many of his teachings transcended borders. He noted nine principles of family medicine that he believes succinctly describe the specialty.

"*an open-ended commitment to patients; an understanding of the context of illness; the use of all visits for preventive purposes; the view of the practice as a population at risk; the use of a community-wide network of supports; the sharing with patients of the same habitat; the care*

of patients in office, home and hospital; a recognition of the subjective aspects of medicine; and an awareness of the need to manage resources.[8]"

The two principles that stand out to me are the "understanding of the context of illness" and "the care of the patients in office, home, and hospital". As healthcare becomes increasingly mechanical and short-fused, I wonder if we are addressing these principles in practice? McWhinney recognized that many illnesses presenting in the family medicine clinic could not be understood without addressing their social, personal, and familial contexts. In emergency situations, the context of an illness is set aside due to the pressing circumstances. Yet the ignorance of context only puts a bandage on a bigger problem.

During my inpatient rotations, I noticed many heart failure and stroke patients with the term "noncompliant" written into their charts. However, speaking to a few, I came to understand that noncompliance was not necessarily an active choice on the part of these patients, but rather the result of a series of unfortunate events in their lives. The stories I heard ranged from unemployment to the death of a family member. The patients were sullen when describing their lives, often looking defeated. In some cases, they did not want to talk at all. This is detrimental to the patient-physician relationship. Assumptions are made on both ends, and no solution is created. It can be embarrassing to describe the harsh circumstances to a stranger who you feel cannot help you beyond a moment.

Patients need to know not only that they will not be discriminated against because of their circumstances, but also that you can actually help them. Conversations can be opened if the patient understands that the family physician's role does not end at the bedside. This is shown to the patient through a family physician's open advocacy against practices that harm patients outside the hospital, which puts Ian McWhinney's principle of "care of patients of office, home,

and hospital" for family medicine into practice. What happens in a patient's home and office is dependent on the social determinants in their lives.

With the conversations surrounding the decrease in funding for SNAP and Medicaid, I wonder how adherence will be affected further. Studies have shown that food insecurity is linked to underuse of medication in working adults who suffer from chronic conditions.[9] SNAP has been documented to play a positive, integral role in the nation's health.[10] Patients should not have to choose between food and life-saving medications. The principles under which family medicine physicians serve require them to push back against disruptions to community resources, because these resources are the only means of guaranteed healing.

Guide to Becoming Involved

A family medicine physician, Dr. Ed Kraemer, created a formula for involvement that he calls "The Accidental Activist Algorithm." However, there is nothing accidental about it. His background in family medicine led him to become involved. The specialty calls to those who are exceptionally passionate beyond the bedside. Dr. Kraemer states he cared about an issue but did not want to be caught in controversy. However, his experiences in the family medicine setting led him to work with other physicians to create a petition that resulted in indoor spaces in his community becoming smoke-free [11]. Dr. Kraemer shows that advocacy is simply a family physician doing his job. His algorithm is simple —find an issue you are passionate about, then show up, hang around, and get it done. This algorithm is nothing unique compared to those who helped lay the foundations of family medicine. It begins simply with a passion for healing. This passion needs to be public so that patients understand that their family medicine physicians truly care for them. This is essential in establishing trust in a tumultuous time.

Call to action

This essay not only seeks to remind us of family medicine's roots in advocacy but also shows how it is possible for cynics. A physician who exemplifies this is Dr. Monna Hanna Attisha. Dr. Attisha lived in Flint, Michigan, and brought the water crisis to the national spotlight through her advocacy. She testified multiple times in front of Congress about the polluted water that was detrimentally impacting the children's health in her community [12]

Living in a time when news is accessible at my fingertips in ever-increasing quantities, it is easy to feel helpless. I am afraid for the future of the communities I will serve. Advocacy is not seen as essential in the medical school curriculum. However, current circumstances show us that we cannot sit idly by as conditions worsen. Whether it be migrant issues, genocide, climate change, or welfare benefits, each of these aspects of society effect community health. Family medicine was founded to combine the sciences of healing with the art of advocacy, and it is important to remember this now more than ever. Advocacy is how you build trust within communities and provide better care.

Bibliography

1. A Million Conversations: How we're bridging the healthcare 'trust gap' with marginalized communities. Accessed November 1, 2025. https://www.sanofi.com/en/magazine/sustainability/global-poll

2. Ali SS. Migrants aren't seeing doctors; here's why that's a public health crisis. NewsNation. March 20, 2025. Accessed November 1, 2025. https://www.newsnationnow.com/health/migrants-doctors-public-health-crisis/

3. B.B. BURRITT HONORED AS HEALTH ADVOCATE. *The New York Times*. https://www.nytimes.com/1944/10/25/archives/bb-burritt-honored-as-health-advocate.html. October 25, 1944. Accessed November 1, 2025.

4. Welfare Measures and Their Effect upon the Family. doi:10.2105/AJPH.39.2.214

5. History of ABFM. American Board of Family Medicine. Accessed November 1, 2025. https://www.theabfm.org/about/history-of-abfm/

6. History Timeline: 1969 Events. Historic Newspapers. Accessed November 1, 2025. https://www.historic-newspapers.com/blogs/article/a-year-in-history-timeline-of-1969-events

7. EARLIER DEFINITIONS OF PRIMARY CARE: A REVIEW | Defining Primary Care: An Interim Report | The National Academies Press. Accessed November 1, 2025. https://nap.nationalacademies.org/read/9153/chapter/4

8. McWhinney IR. Teaching the Principles of Family Medicine. *Can Fam Physician*. 1981;27:801-804.

9. Knight CK, Probst JC, Liese AD, Sercy E, Jones SJ. Household food insecurity and medication "scrimping" among US adults with diabetes. *Prev Med*. 2016;83:41-45. doi:10.1016/j.ypmed.2015.11.031

10. SNAP Is Linked With Improved Health Outcomes and Lower Health Care Costs | Center on Budget and Policy Priorities. December 14, 2022. Accessed November 1, 2025. https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-health-outcomes-and-lower-health-care-costs

11. Delles M. Accidental Activist Gets Stuff Done – The 2025 Vision to Action Award Winner Edwin Kraemer, MD. Center for Practical Bioethics. October 22, 2025. Accessed November 1, 2025. https://www.practicalbioethics.org/whats-new/accidental-activist-gets-stuff-done-the-2025-vision-to-action-award-winner-edwin-kraemer-md/

12. Dr. Mona. Dr. Mona. April 16, 2021. Accessed November 1, 2025. https://monahannaattisha.com