CAFP FRESNO KINGS MADERA

4TH EDITION 2025

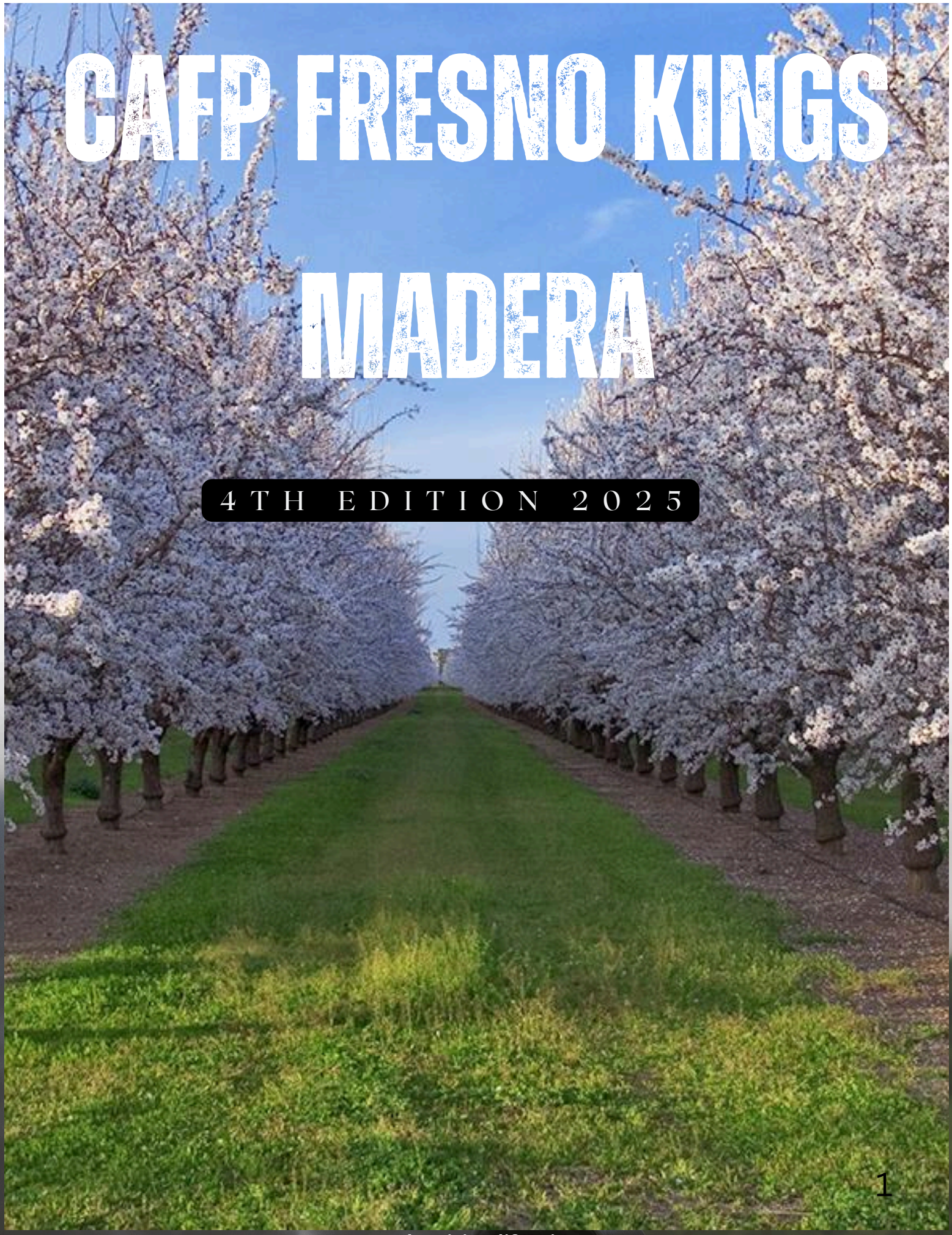


Image: by visitcalifornia.com

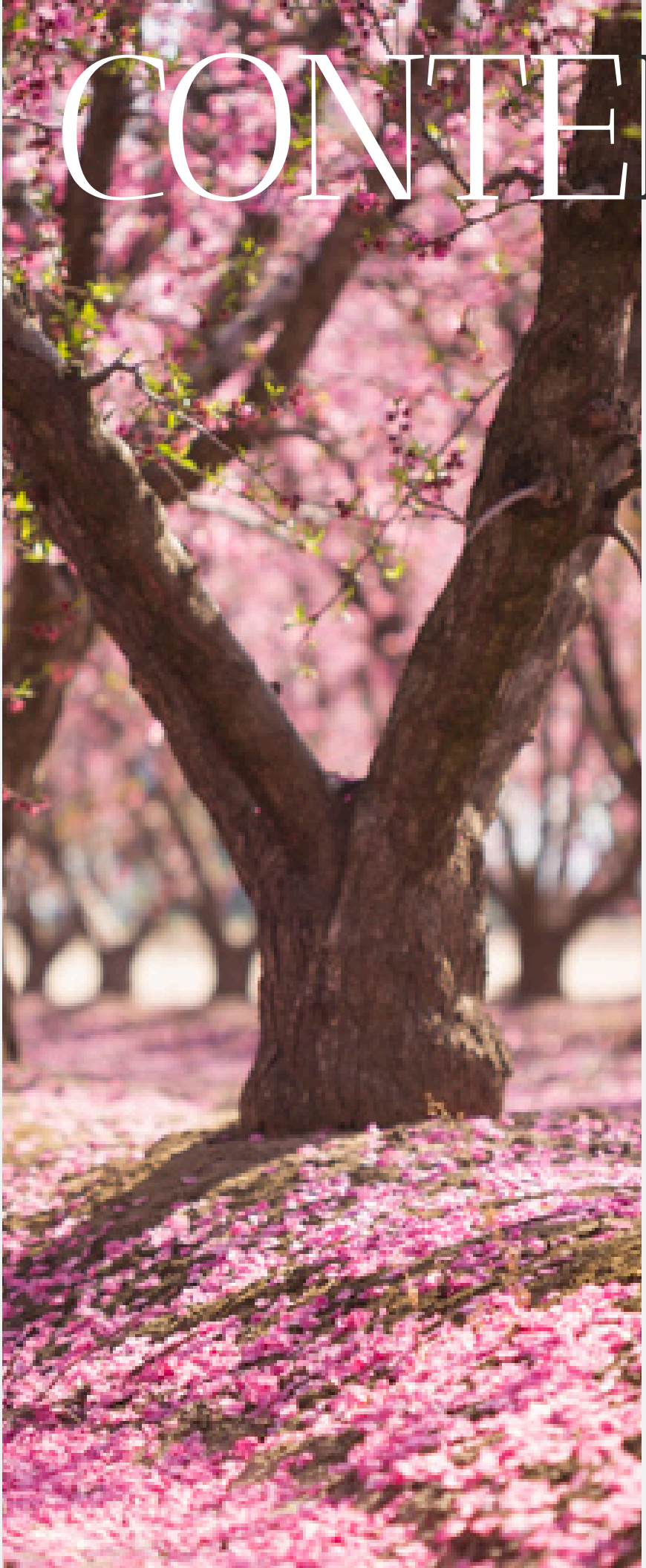
FROM THE EDITOR

The past few months have been pivotal for family medicine. In 2025, we've seen just how essential it is for us, as physicians, to advocate—not only for our patients, but for ourselves. Engaging in advocacy and understanding health legislation during this critical time is not optional; it's necessary. Policymakers shape the systems we work within, and if we don't speak up, decisions may be made without the voices of those on the frontlines of care.

I'm incredibly grateful for the opportunity to attend the National Conference of Constituency Leaders (NCCL) 2025 and the All Members Advocacy Meeting (AMAM) 2025 with CAFP. These experiences reaffirmed that when family physicians show up, we protect access to healthcare and influence the future of our profession.

I'm also inspired by the growing number of family medicine physicians eager to contribute to this magazine—to share their stories, expertise, and advocacy efforts. Together, we can uplift the full scope of family medicine and make sure our work is seen, heard, and valued

Diana Howarad



CONTENTS

Image: Suzette Barnett

VACCINE MISINFORMATION, PSEUDOSCIENCE, AND THE FRAILTY OF COMMUNITY HEALTH

How Misinformation Threatens Public Health

ALEX MCDONALD MD, CASQM, FAAFP

KAISER PERMANENTE

As a family physician, my days are filled with caring for individuals and families across the life pan and in multiple different healthcare settings.

I witness firsthand the joy of well child visits, the challenges and resilience of patients struggling to control their diabetes, and Medicare annual wellness visit all of which represent the collective effort to safeguard individual and community well-being. I spend other days meeting with legislators or advocacy groups discussing policy and how it may impact patient's health as well as physicians ability to care for them. It is with this perspective and connection to our community's health that I feel compelled to address a growing danger: the insidious impact of misinformation, the allure of pseudoscience, and the concerning trend of delayed or declined vaccinations. These forces are not just impacting individual choices; they are eroding the very foundation of our collective health, trust in career scientists, institutions and the scientific process.

The digital age, while offering incredible access to information, has also become an incubator for the spread of partial truths, facts taken out of context or just fake information. The terms misinformation, disinformation and misinformation are often used interchangeably, however, they are different. Misinformation is defined as false or inaccurate information that is shared without the intent to deceive. Disinformation is also false information, but it is deliberately created and spread with the intention to mislead, harm, or manipulate people for political, economic, or other gains. Malinformation refers to information that is based on truth but is used out of context to mislead, harm, or manipulate.

Measles, vaccines and the science and perception about vaccines is a perfect example of how the information/disinfor-mation ecosystem has the potential to truly hurt people and, in this case, cause death. Vaccines rumors and falsehoods are not new, but recently it has taken on new meaning. False vaccines narratives are often rooted in fear and lacking any scientific basis, can circulate rapidly through social media and online forums.

LACK OF TRUTH IS BECOMING A GREAT PROBLEM AT LARGE OUR SOCIETY AND THE ELEVATION AND SPREAD OF PSEUDOSCIENCE IS BECOMING INCREASINGLY PROBLEMATIC WITHIN THE SCIENCE AND HEALTHCARE FIELD.

For instance, the long-debunked claim linking the measles, mumps, and rubella (MMR) vaccine to autism continues to resurface, despite overwhelming scientific evidence to the contrary. A seminal study published in The Lancet in 1999, which first proposed this link, was later retracted due to ethical violations and scientific misconduct and the author has lost his medical license (Godlee et al., 2011). Subsequent, large-scale epidemiological studies have consistently found no association between the MMR vaccine and autism spectrum disorder (Taylor et al., 2014; Madsen et al., 2002). Yet, the echo of this falsehood persists, creating undue anxiety and leading parents to delay or refuse vaccination for their children. Furthermore, elected and appointed vaccine skeptics have now been given a megaphone to further promote and validate pseudoscience or definitively disproven theories.

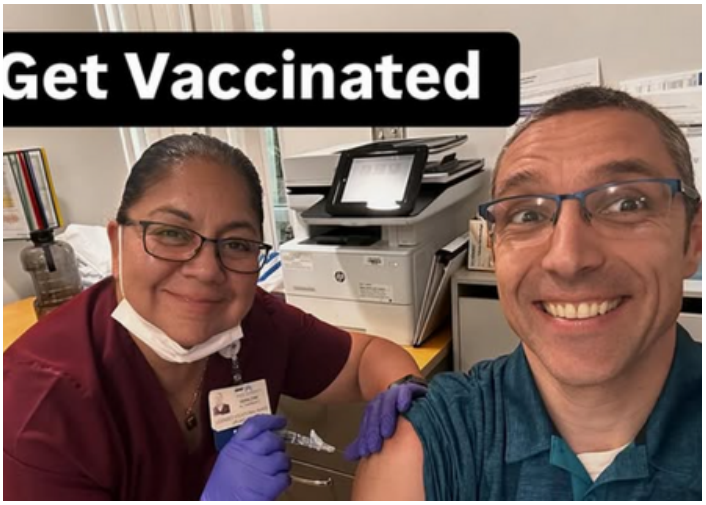
Lack of truth is becoming a great problem at large our society and the elevation and spread of pseudoscience is becoming increasingly problematic within the science and healthcare field.

Superficially pseudoscience resembles scientific inquiry but lacks rigorous methodology, peer review, bias mitigation and evidence and this further complicating the landscape and muddies the water allowing people to cherry pick “data” or “science” to fit their own narrative or agenda. It often preys on anxieties and offers simplistic solutions that bypass the complexities of human biology and disease while making blanket statements often ignoring individual factors or considering how it might apply to a specific population.

We see this in the promotion of unproven “detox” therapies to supposedly cleanse the body of vaccine ingredients or the assertion that natural immunity is always superior and without risk. While natural infection can indeed lead to immunity, it comes at the cost of potentially severe illness, complications, and even death. Vaccines, on the other hand, offer a way to develop immunity without suffering the disease itself. They undergo extensive testing and monitoring to ensure their safety and efficacy. The most current rhetoric involves needing placebo control for vaccines, which at it’s surface sounds like a good idea.

However, any new vaccine already undergoes vigorous testing with initial placebo controls and once we know vaccines are safe and effective it is unethical and immoral to then withhold a treatment which we know is effective to compare it to another potential treatment. That is not how science works and not ethical.

The consequence of vaccine misinformation and the embrace of pseudoscience often manifests in delayed or declined vaccination schedules. In my practice, often parents worry that the current vaccine schedule has “too many shots at once” and understandably they worry about their child or any short-term side effects. This might make sense intuitively to a new parent and desire to protect their child, but this false narrative prey’s on people fears. Fortunately, there is a substantial body of peer-reviewed scientific research that has consistently demonstrated that the recommended childhood vaccine schedule is safe and does not overload a child's immune system. While some parents may intend to vaccinate eventually, the delay itself leaves their children vulnerable during critical periods of development.

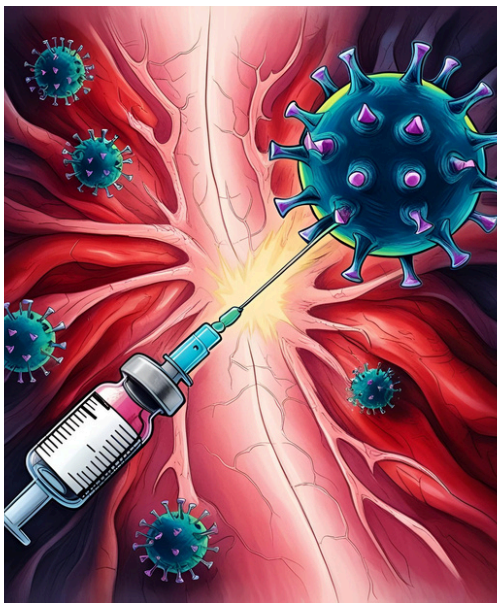


"Protect Yourself. Protect Others. Get Vaccinated"

" VACCINES ARE ONE OF THE MOST SIGNIFICANT PUBLIC HEALTH ACHIEVEMENTS OF OUR TIME, DRAMATICALLY REDUCING THE INCIDENCE OF ONCE-COMMON AND DEVASTATING DISEASES."

Furthermore, it chips away at herd immunity, particularly in young children, which increase the risk of illness and community disease transmission.
Herd immunity, also known as community immunity, occurs when a sufficiently high percentage of a population is immune to a contagious disease – through vaccination or prior infection – making the spread of that disease unlikely. This protects individuals who cannot be vaccinated, such as infants too young to receive certain vaccines, individuals with compromised immune systems, and those with severe allergies to vaccine components. The threshold for herd immunity varies depending on the disease; for highly contagious diseases like measles, it can be as high as 95% (Fine et al., 2011). When vaccination rates fall below these critical thresholds, such as in the West Texas Mennonite community, the protective shield of herd immunity weakens, and outbreaks become more likely and disease spreads more easily. We have seen tragic examples of this recently and several deaths from measles, which is a disease that was nearly eradicated in the US 2000 according to the CDC.

These outbreaks not only endanger the unvaccinated but also put vulnerable individuals at risk who rely on the immunity of the community for protection. The current vaccine rhetoric and implications extend beyond individual diseases. A decline in overall vaccination rates can erode public trust in established medical practices and institutions, making it harder to respond effectively to future public health crises. Misinformation and Disinformation normalizes the spread of unverified information and creates an environment where fear and conjecture can outweigh evidence-based recommendations. Furthermore the market for naturopathic or alternative treatment options, many of which are not based in any high quality evidenced information is estimated to be around $35 billion annual (Straights, 2024). As physicians and other healthcare workers, we have a responsibility to counter this tide of misinformation with clear, accurate, and empathetic communication. We must take the time to build trust, listen to parents' concerns, address their questions with our expertise and medical training through open dialogue.



It is crucial to emphasize that vaccines are one of the most significant public health achievements of our time, dramatically reducing the incidence of once-common and devastating diseases. In fact vaccines have been so successful that they have become a victim of their own success, as very few people remember the scourge of illness which as polio or diphtheria, as just two examples of many.

The health of our community is a shared responsibility. By embracing evidence-based medicine, prioritizing vaccination conversation, and critically evaluating the information we encounter, we can strengthen the shield of herd immunity and protect ourselves and future generations from preventable diseases. Let us choose facts over fear, science over pseudoscience, and collective well-being over the whispers that weaken us all.

HONORING WOMEN'S HISTORY MONTH

SAKSHI JOSHI MD

KAISER PERMANENTE

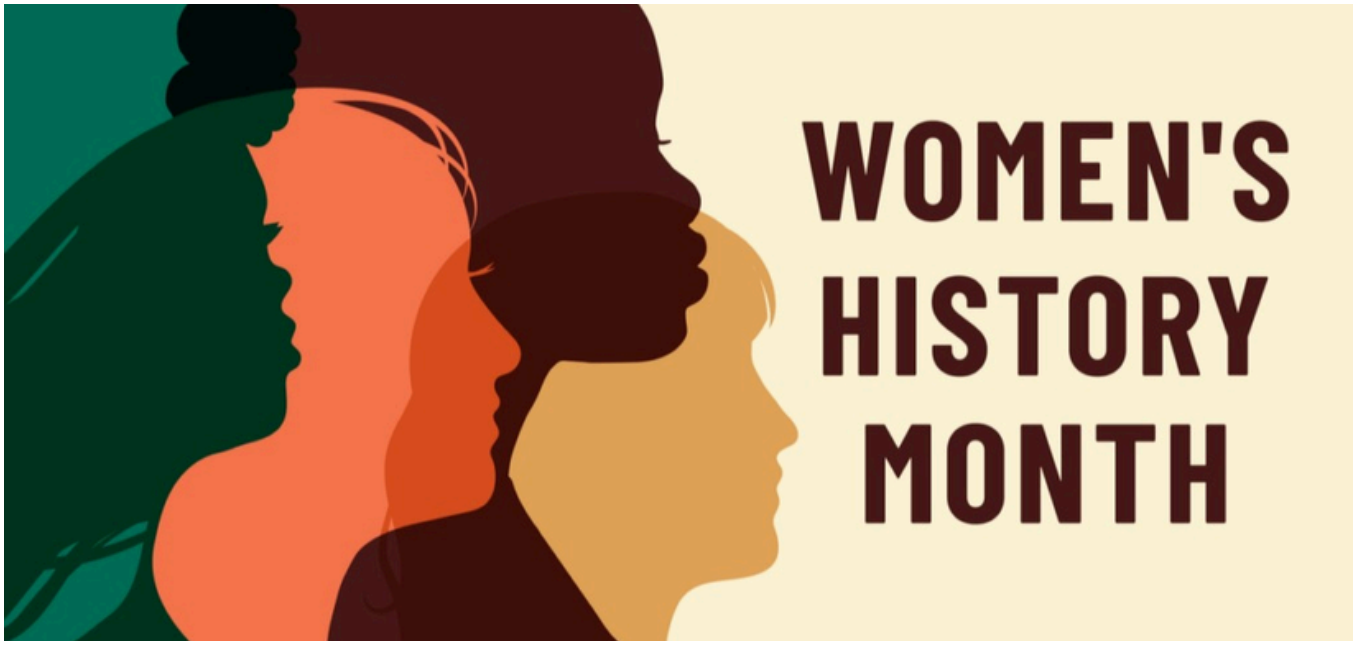
Most evenings, after seeing my last patient and finishing the day's charting, I step out into the evening still ruminating on patients I'm worried about, lab or imaging results that are pending, patient calls/emails to return. Like so many physicians, I've learned that the work doesn't end when I leave the clinic. We carry it with us in our bodies, in our hearts, and in our minds. Being a woman in medicine is a complex and deeply personal experience. We move through a system that wasn't always built for us, often while serving communities that rely on us to both provide care and create change. For me, that experience is further shaped by my identity as an Indian woman, a daughter, a sister, and someone rooted in a rich cultural tradition of caretaking and resilience.

I've witnessed firsthand how gender impacts health systematically. We've all heard that women are more likely to have their pain dismissed, their symptoms minimized, and their health concerns delayed. I've had female patients come to me after months or even years of being told their symptoms were "just stress" or "nothing to worry about." I've seen how cultural expectations and fear of judgment keep many women from seeking care at all.

That's why representation in medicine matters. When patients see someone who looks like them, someone who understands their language and their cultural references, it creates a sense of safety. They tell you things they've never told anyone else. They open up about things like their mental health, issues with weight and self-image, domestic violence, the emotional toll of caregiving, or menopausal symptoms. They ask for help —sometimes for the first time.

Sakshi Joshi

“AM I WORKING IN ALIGNMENT WITH MY VALUES? AM I SHOWING UP IN A WAY THAT REFLECTS THE KIND OF PHYSICIAN, WOMAN, AND ADVOCATE I WANT TO BE?”



As women physicians, we have a unique ability and responsibility to advocate for our patients in meaningful ways. In today’s political climate, where access to reproductive health care is increasingly uncertain, where maternal health disparities by race persist, and where mental health remains stigmatized, especially among women of color, our voices are more important than ever. We help protect autonomy, dignity, and choice.

This advocacy doesn’t always come with a megaphone. Sometimes it’s in quietly pushing back against a protocol that doesn't serve the patient. Sometimes it's in making space in your schedule for someone in crisis. Other times, it's mentoring the next generation, or challenging bias in your own workplace.

The idea that we can “do it all” is a comforting illusion. Some days, I feel grounded. Other days, I feel like I’m walking a tightrope, balancing care for my patients, care for my loved ones, and care for myself. But over time, I’ve learned that the goal isn’t perfect balance. Am I working in alignment with my values? Am I showing up in a way that reflects the kind of physician, woman, and advocate I want to be? There are days when I fall short and I’m not quite my best self; but even then I remind myself that showing up still matters.

What do Medical students tell us

Advocacy in medical school

CONGRATULATIONS TO OUR OUTSTANDING MEDICAL STUDENT WHO MATCH IN FAMILY MEDICINE

We're thrilled to celebrate Mandy Helle, who actively participated at the 2025 CAFP All Members Advocacy Meeting (AMAM).

Her passion for advocacy and dedication to primary care have now led to another exciting milestone—matching into Kaiser Napa- Solano Family Medicine Residency Program! We are so proud of you and can't wait to see the impact you'll make as a future family physician.

Image L: Mandy Helle at AMAM Lobby Day
R: Mandy Helle MS, Dr. Raul Ayala, Assembly Member Dr. Joaquin Arabula , Dr. Linscheid and Dr. Howard

Fueling the Future: Empowering Young Athletes in Underserved Communities

One player excitedly said, "I've never had someone break this down for me before—I actually know what to eat now to get stronger."

GOBINDER PANDHER
UCSF SJV PRIME CLASS OF 2026

Growing up in the Central Valley, I witnessed firsthand the health disparities that plague our underserved communities. Access to proper nutrition and health education is often overlooked in areas where socio economic struggles take center stage. As a medical student committed to bridging these gaps, I saw an opportunity to make a tangible difference—starting with our youth.

Last summer, I led a community project at Caruthers High School and Sunnyside High School, where I spoke with student-athletes about optimal muscle building, proper nutrition for athletic performance, and injury prevention. These schools, like many in the Valley, lack funding for robust athletic programs or comprehensive health education. Many of the students I worked with had never been taught how to fuel their bodies effectively, often relying on convenience over quality, impacting their long-term health.

To provide accurate and practical information, I conducted an extensive review of meta-analyses and systematic studies on muscle growth, nutrition, and injury prevention. My goal was to translate complex, science-backed data into a clear, actionable guide for student-athletes. Through engaging workshops, I broke down macronutrient intake, explained how to calculate basal metabolic rate, and emphasized hydration's role in muscle recovery and performance.

Beyond education, I aimed to equip these athletes with tangible tools for long-term success, including methods to track nutrient intake, assess metabolic needs, and incorporate dynamic stretches to reduce injury risk. I also addressed common misconceptions about supplementation and strength training, offering evidence-based recommendations to help them train smarter and more effectively.

Enhancing Athletic Performance Through Nutrition and Muscle Hypertrophy

High School Edition

The impact was immediate. Students asked insightful questions, rethinking their approach to food and training. Coaches expressed gratitude, acknowledging how this would benefit their athletes beyond just one season. One student remarked, “I didn’t know eating more protein could actually help me recover faster—I always just ate whatever was around.” That moment stuck with me. After the workshop, football players lined up for one-on-one guidance. I helped them calculate their macros and create personalized meal plans paired with training regimens to boost performance. One player excitedly said, “I’ve never had someone break this down for me before—I actually know what to eat now to get stronger.” Seeing their enthusiasm reinforced the importance of this project and how access to the right knowledge can be a game-changer.

This project reinforced a crucial lesson: education is one of the most powerful tools in addressing health disparities. Providing knowledge, especially in resource-limited areas, can be transformative. It’s not just about sports—it’s about fostering lifelong habits that combat chronic disease and build healthier communities.

As I continue my journey in medicine, I carry these lessons with me. A single initiative can spark change, and I’m committed to ensuring that underserved communities receive the health education they deserve. Because when we equip our youth with the right tools, we’re not just improving individual lives—we’re fueling the future of an entire community.

OUR RESIDENTS PERSPECTIVE

We are excited to showcase the dedication of our residents as they advocate passionately for their patients and shape the future of medical practice.

Honoring Excellence: Dr. Salcedo Named 2025 National Hispanic Medical Association Resident of the Year

FROM THE CAFP FRESNO KINGS MADERA CHAPTER TO THE NATIONAL STAGE

The National Hispanic Medical Association (NHMA) has honored Dr. Emanuel Salcedo, a Family Medicine resident at Valley Health Team in Fresno, California, with the prestigious Resident of the Year Award, recognizing his exemplary dedication to underserved populations and global health outreach.

Dr. Salcedo, originally from Peru, has emerged as a passionate advocate for health equity, cultural inclusivity, and service to vulnerable communities. His work bridges clinical excellence with a commitment to addressing systemic disparities in healthcare delivery.

In addition to his residency training, Dr. Salcedo co-founded the American Association of Peruvian Physicians (AAPP Health), a national nonprofit organization devoted to supporting the advancement and integration of Peruvian and Latin American physicians in the United States. Through this initiative, Dr. Salcedo has been instrumental in creating mentorship opportunities, educational programming, and advocacy platforms for international medical graduates.

Dr. Salcedo's commitment to service transcends borders. He has participated in and led medical missions to the Amazon jungle and rural Nicaragua, providing bilingual care to underserved populations. In these settings, he has delivered primary care, conducted point-of-care ultrasound evaluations, and helped coordinate fundraising to supply essential medications.

Currently completing his training in California's Central Valley, Dr. Salcedo plans to remain in the region to practice full-spectrum family medicine. His long-term vision includes expanding the reach of AAPP Health, continuing global health outreach, and mentoring future Latino healthcare leaders.

> *"As a physician, I believe it's our duty not only to heal, but to listen, empower, and serve—especially where resources are most limited," said Dr. Salcedo. "This award from NHMA is not just a recognition of my journey, but a call to continue uplifting communities that have long been left behind."*

BRIDGING THE GAP: DEPRESSION, PSYCHIATRIC CRISES, AND THE ROLE OF PRIMARY CARE

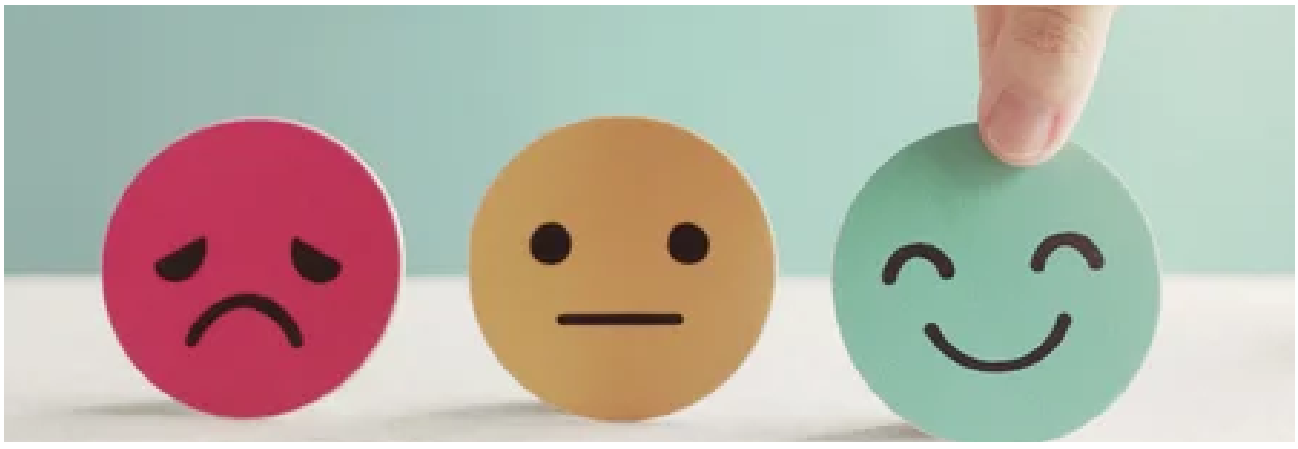
> "The sobering reality is that many individuals who die by suicide had seen a primary care provider within the month prior. "

GABRIEL ALLAF , DO
PGY-1
SAMC

In the ever-evolving landscape of primary care, one reality remains constant: the growing mental health crisis. Depression, one of the most common and debilitating conditions seen in clinical practice, continues to demand nuanced, interdisciplinary care. With its complex biological, psychological, and social roots, it challenges clinicians to not only screen but also intervene, guide, and advocate.

As of recent estimates, over 5.5 million adults in California are living with a mental health condition, including more than 1.2 million adults with a serious mental illness. Depression ranks among the most prevalent of these conditions and is now recognized as one of the leading causes of disability worldwide. Despite increased awareness, the challenges surrounding access and equity remain substantial. In recent years, more than 35% of Californians who needed mental health care were unable to access it due to cost barriers. More than 9 million Californians reside in areas deemed to have an inadequate supply of mental health professionals. Within these statistics are the patients we see every day—those who may come in for chronic disease management or routine checkups but are quietly enduring fatigue, hopelessness, and emotional distress.

Primary care providers often serve as the first point of contact for individuals facing depression or acute psychiatric crises. Tools like the PHQ-9 are useful for screening, but the responsibility goes far beyond scoring a questionnaire. Moderate to severe depression often coexists with chronic medical conditions such as diabetes, hypertension, and chronic pain and is frequently underdiagnosed in these settings. Furthermore, depression remains a major risk factor for suicide. The sobering reality is that many individuals who die by suicide had seen a primary care provider within the month prior.



"We must advocate for systemic improvements in access and funding, particularly for underserved and rural communities in California, where mental health needs are high but infrastructure remains underdeveloped".

Depression's rising incidence further compounds this challenge. According to UpToDate, adults aged 18–25 are experiencing the steepest increase in major depressive episodes, with adolescents and young adults facing new stressors post-pandemic. In California, the UCLA Center for Health Policy Research found that 36.7% of teenagers needed help for emotional or mental health problems in 2021—nearly double the percentage from just five years earlier. This is a crisis that spans developmental stages and demands long-term solutions.

In managing these patients, especially those in active distress, clinicians are often tasked with simultaneously addressing safety concerns, initiating treatment, coordinating follow-up, and mobilizing social support. These challenges are intensified by long wait times for psychiatric services, fragmented community resources, and a shortage of behavioral health integration in many outpatient settings.

To meet this moment, primary care clinicians can adopt several proactive strategies. First, we can normalize conversations about mental health, approaching depression as we would any chronic illness—through regular assessment, thoughtful follow-up, and longitudinal care. Incorporating mental health check-ins into routine visits not only destigmatizes the topic but also builds trust. Second, collaborative care models and telepsychiatry should be championed as scalable ways to bridge the access gap. Engaging behavioral health consultants and social workers when available can significantly improve outcomes. In moments of acute crisis, familiarity with local resources—including mobile crisis teams, 24-hour hotlines, and county-funded crisis stabilization units—can offer crucial, timely alternatives to emergency department visits. Just as importantly, we must advocate for systemic improvements in access and funding, particularly for underserved and rural communities in California, where mental health needs are high but infrastructure remains underdeveloped.

Addressing these challenges requires time, training, and emotional investment—but it is deeply meaningful work. Depression is not a silent diagnosis—it walks through our doors daily, woven into the fabric of chronic illness, trauma, and unmet social needs. As clinicians, we are often the first to recognize the quiet signals of distress beneath routine complaints; thus, our responsibility extends far beyond screening. With that awareness comes both the opportunity and the responsibility to act. By remaining vigilant, compassionate, and engaged, we can bridge the gaps in care, especially for those who might otherwise fall through the cracks. In doing so, we not only treat an illness—we affirm the humanity and resilience of every patient we serve.

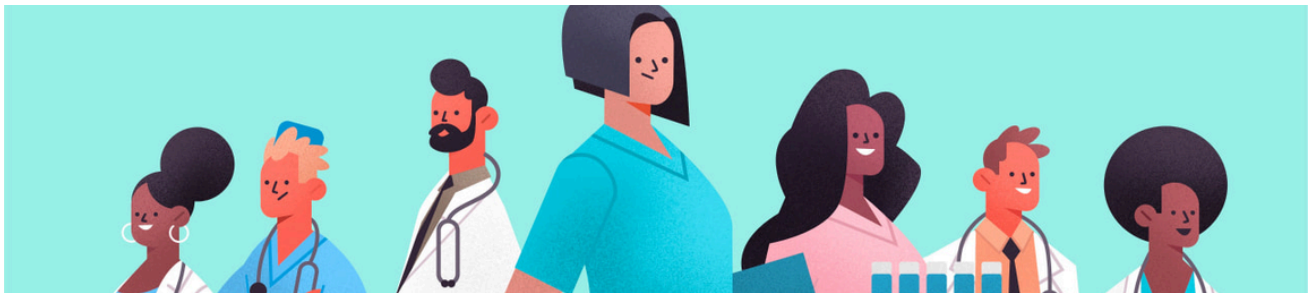
"FAMILY MEDICINE FRONTIERS: CARING ACROSS THE SPECTRUM"

IMAGE:

The Power of Family Medicine for Foreign Medical Graduates in Specialty Clinics

ZHOOBIN BATENI, MD
COMMUNITY
HEALTH PARTNERS

Dr. Zhoobin Bateni is a family physician working in a specialty urology group in Fresno, California, with a clinical focus on men's health, urologic cancer care, urinary incontinence, and outpatient procedures. A former urologist in his home country, he immigrated to the U.S. with his family, pursued research at academic institutions in Texas and California, and ultimately matched into family medicine. He is a proud member of the California Academy of Family Physicians.



In the evolving landscape of American healthcare, family medicine stands at a unique and powerful intersection: broad in scope, deeply rooted in patient-centered care, and increasingly adaptable to specialty settings. For foreign medical graduates (FMGs), family medicine offers more than just a route into the U.S. healthcare system—it provides a vibrant, achievable, and rewarding career path that marries comprehensive primary care with focused specialty practice.

A Gateway to Meaningful Practice

Many FMGs arrive in the U.S. with rich clinical experience in surgery, obstetrics, urology, psychiatry, or internal medicine. While the transition into U.S. medical practice is challenging, family medicine offers a uniquely inclusive and flexible training pathway. FMGs bring with them not just knowledge, but global perspectives, cultural sensitivity, and a commitment forged through perseverance. Training in family medicine enables these physicians to re-enter clinical care with a robust foundation, while also opening doors to subspecialty-focused environments where their prior experience can shine.

The Best of Both Worlds: Breadth and Depth

A striking advantage of family medicine is the ability to practice broadly or with focus. For FMGs who have prior exposure to surgical disciplines, urology, orthopedics, or obstetrics and gynecology, the specialty offers a space to remain clinically active in those fields through outpatient procedural care, chronic disease management, and diagnostic evaluation.

Working in a specialty clinic doesn't limit the role of a family physician—it enhances it. FMGs trained in family medicine and working in urology or orthopedic practices, for example, provide preventive care, manage comorbidities, perform office-based procedures (like vasectomies, joint injections, or minor excisions), and serve as a patient's primary point of contact. This hybrid role allows for focused clinical mastery within a specialty setting while preserving the holistic, long-term view that defines primary care.

The Best of Both Worlds: Breadth and Depth

A striking advantage of family medicine is the ability to practice broadly or with focus. For FMGs who have prior exposure to surgical disciplines, urology, orthopedics, or obstetrics and gynecology, the specialty offers a space to remain clinically active in those fields through outpatient procedural care, chronic disease management, and diagnostic evaluation.
Working in a specialty clinic doesn't limit the role of a family physician—it enhances it.

FMGs trained in family medicine and working in urology or orthopedic practices, for example, provide preventive care, manage comorbidities, perform office-based procedures (like vasectomies, joint injections, or minor excisions), and serve as a patient's primary point of contact. This hybrid role allows for focused clinical mastery within a specialty setting while preserving the holistic, long-term view that defines primary care.

A Solution for Underserved Areas

In regions with significant shortages of specialists, especially in rural or underserved urban areas, family physicians with specialty-focused skills offer an elegant solution. They reduce referral bottlenecks, provide timely interventions, and offer continuity of care that spans both general and specialty domains.

The healthcare system gains a dual benefit: a clinician who understands the patient's full medical history and can also manage focused conditions or procedures in-house. This model enhances access, improves care coordination, and reduces costs. More importantly, it strengthens the doctor-patient relationship—an anchor of quality care.

FAMILY MEDICINE IS NOT A FALLBACK– IT'S A LAUNCHING PAD

Achievable Dream

For FMGs, this journey is not only possible—it is happening. Across the country, more and more FMGs are training in family medicine and finding fulfilling roles in subspecialty clinics. The pathway is achievable with dedication, mentorship, and a willingness to adapt. Residency programs increasingly recognize the value FMGs bring, and the healthcare system urgently needs their talents.

Conclusion

Family medicine is not a fallback—it's a launching pad. For foreign medical graduates, it offers a powerful route to re-engage in clinical care, focus on areas of passion, and provide high-value service in specialty clinics. It's a path where comprehensive knowledge meets focused impact, where the generalist becomes the trusted specialist, and where patients receive the best of both worlds.
In embracing this model, we not only support the careers of FMGs —we build a more flexible, responsive, and equitable healthcare system for everyone.

The Role of Minor Procedures and Preventive Care

In a time when healthcare is shifting toward value-based models, family physicians trained in office procedures are a tremendous asset. From dermatologic interventions to musculoskeletal injections, bladder catheterizations, contraceptive insertions, or vasectomies, these skills elevate the scope of outpatient care. For FMGs who often trained in hands-on environments abroad, this is a natural extension of their abilities.

Moreover, the preventive medicine mindset of family medicine complements specialty clinics perfectly. Whether it's counseling on cancer screening, managing diabetes in a patient with BPH, or addressing mental health in a chronic pain patient, the family physician in a specialty setting enhances outcomes through comprehensive, proactive care.

Where Advocacy Meets Obstetrics: The Power of Full-Spectrum Family Medicine

Inspired early on by mentors in family medicine and a commitment to social justice, I pursued full-spectrum care to serve vulnerable communities.

CAROL'S MONTES CASTELLON, MD
SAN JOAQUIN GENERAL HOSPITAL

What inspired you to pursue a fellowship in obstetrics, and how did your training shape your commitment to full-spectrum family medicine, including delivering babies and performing C-sections?

Much like the decision to fulfill my dream of becoming a physician, full spectrum Family Medicine was an early calling to serve the most vulnerable communities. As a pre-med, my mentors were Family Medicine physicians, Dr. Puvvula and Dr. Granados' Summer Urban Health Fellowship was instrumental in my journey to medical school. Showcasing how mentorship, community empowerment, social justice and advocacy are as integral to family medicine as are addressing the social determinants of health that lead to the myrrhiad of chronic conditions disproportionately affecting our communities.

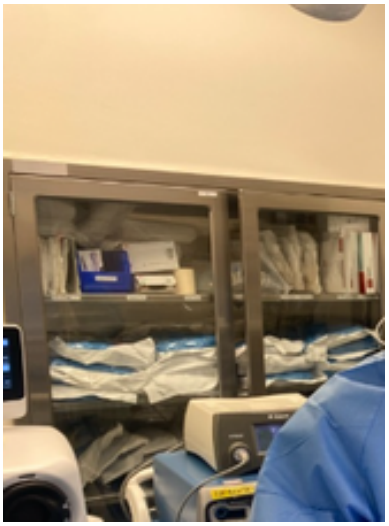
During medical school, I delivered my first baby guided by the hands of midwives at San Joaquin General Hospital where I now work as a FM/OB. It was here that I fell in love with caring for pregnant people at all stages of their journey. I felt torn as my roots were sown in family medicine. However, a peer recommended I look into unopposed and full-spectrum family medicine programs to see the breadth and medical scope of Family Medicine. This led me to an acting internship at Contra Costa Regional Medical Center.

I was inspired by the family medicine physicians who were leaders in all the departments, both in the hospital and in ambulatory care settings. I saw firsthand how family medicine led the labor and delivery units, the internal medicine units, and the ICU.

> *My heart was reconnected to my roots in family medicine, knowing that there were spaces where we could be a voice for our patients, and provide the highest level of care in all phases of their lives.*

How did your path from residency to fellowship support your commitment to full-spectrum care, and how has harm reduction shaped your approach to caring for pregnant patients?

On my first day on labor and delivery, I thought it would be the usual: triage patients, write notes, and continue to improve technical skills I learned in medical school. All was true, and also, in my first case, a breech twin delivery by primary cesarean section, I was handed the scalpel and guided through my first surgery as an intern by none other than a family medicine physician, Dr. Rodelo.



She became one of my role models for the kind of family doctor I wanted to grow up to be like. Patient with her residents, kind to her peers, and an advocate for her pregnant patients in all walks of life, especially those facing tough life addictions. She was one of the few physicians in the area providing substance use disorder prenatal care. At the time, this was quite unheard of, as physicians were still deciding whether it was within their comfort and practice to apply for X-Waivers to provide substance use disorder treatment for everyday adults. This modeling taught me the fearlessness family medicine physicians have, stepping up when there is a need, and providing necessary care in spaces where other specialties are hesitant to do so.

A FAMILY MEDICINE PHYSICIAN'S JOURNEY IN FULL-SPECTRUM CARE

Because of these experiences, alongside the robust inpatient and ambulatory care training I received, it was a clear decision as a first year resident that I would seek further training through an advanced surgical obstetrics fellowship.

I trained in Chicago at the PCC Wellness Parent Child Health Fellowship, where I furthered my skills in high risk surgical obstetrics, managing complex patients with high medical and social morbidities. Part of this training included addiction medicine, where we cared for pregnant patients who were often unhoused and with severe opiate addictions.

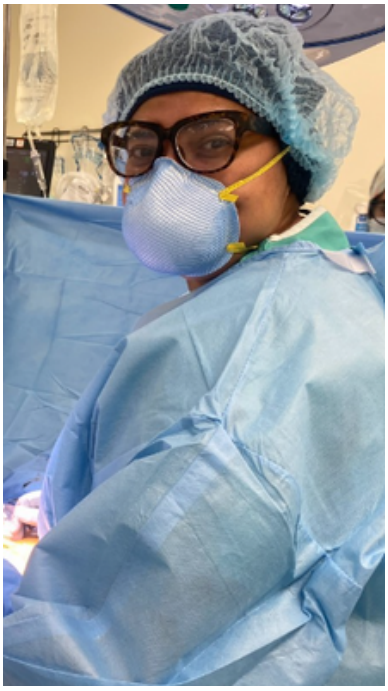


Image: Dr. Montes Castellon and her family medicine fellow during one of her first C-section cases as an attending.

I worked closely with the inpatient addiction team and would routinely have patients admitted for induction of treatment for opiate use disorders on labor and delivery. When infants were delivered, I worked closely with neonatologists and NICU nurses, and social work to keep infants and parents together.

Part of the training was management of infants who had neonatal abstinence syndrome from parental substance use. The goal was caring for the infant and parent, and ensuring they had the best opportunity to stay together as a family.

How Family Medicine Physicians Are Bridging OB Care and Primary Care

Because of the broad scope and training we receive, primary care doctors, especially those with advanced training in high-risk obstetrics, are part of the solution to solving "maternity care deserts"

What are some common misconceptions about full-spectrum family medicine, and how do you counter them in your work and mentorship?

One of the common misconceptions of family medicine is that you are an outpatient physician who only cares for overall healthy people and provides basic health screenings.

Image: Dr. Montes Castellon receiving her long white coat on her first day as an intern

The beauty of family medicine is that there are very few limitations to the patients you can treat, the health conditions you can manage, the procedures, and the scope of practice you can undertake, so long as you have the training and willingness to do so. As a specialty, family medicine physicians are not just primary care physicians.

This is particularly true in spaces with high needs of all medical providers, such as rural and underserved areas. Because of the broad scope and training we receive, primary care doctors, especially those with advanced training in high-risk obstetrics, are part of the solution to solving "maternity care deserts", where there are not enough physicians to care for pregnant patients. In this same manner, family physicians step up where medical care is limited, like providing HIV care, gender affirming care, options counseling, family planning services, and addiction medicine, as some examples.

How can residency programs, mentors, and physician leaders better support trainees in choosing and sustaining a career in full-spectrum family medicine, especially in underserved or rural communities?

Currently, I serve as core faculty for San Joaquin General Hospital, as well as Director of the Advanced Obstetrics Fellowship for Family Medicine. One thing I often teach my residents and fellows is that as family medicine physicians, we have to be curious about all aspects of our patients' lives.

Is the reason the patient has new-onset urticaria because she lives in the Central Valley, or is it because she has recently moved from Southeast Asia and has developed severe anxiety? Is the patient's diabetes uncontrolled because they aren't taking their medication, or is it because they lost their job, have been under severe stress, and have not been able to afford it? Curiosity gifts us insight into our patients' lives, and medicine allots us the opportunity to create solutions to some of their conditions.

Whether it's caring for the newborn infant and parent after you have delivered their newborn, holding your patient's hand during their last breath in the ICU, adjusting diabetes and hypertension medications, or providing relief for their OA with a joint injection, we have the privilege to walk with our patients in each and every one of these spaces. I don't know of any other medical specialty that can say that!

Gender Affirming belongs to Primary Care

Metaverse, A New World Under Construction

The Metaverse and Its Impact on the Physical World: Challenges and Opportunities

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Nunc consectetur pellentesque velit quis dapibus. Nullam eu nulla vitae massa imperdiet fringilla. Nullam mi mauris, aliquet id consectetur quis, pharetra et lorem. Aenean dapibus neque fringilla magna feugiat, eu sollicitudin diam viverra. Proin sodales est ut elit consectetur, semper aliquet ex elementum. Morbi porta eget nunc sed aliquam. In nec convallis ligula, in tincidunt est.

Lorem ipsum dolor sit amet, consectetur adipiscing elit. Nunc consectetur pellentesque velit quis dapibus. Nullam eu nulla vitae massa imperdiet fringilla. Nullam mi mauris, aliquet id consectetur quis, pharetra et lorem. Aenean dapibus neque fringilla magna feugiat, eu sollicitudin diam viverra.

On the Frontlines: A Family Physician's Fight Against HIV in the Central Valley

ROGER MORTIMER, MD

UCSF FRESNO
FAMILY AND COMMUNITY MEDICINE

Dr. Mortimer received his Doctor of Medicine from the University of Sherbooke, Quebec, Canada. He holds a bachelor's degree in psychology and biology from UC Berkely. He completed his residency in family medicine at UCSF Fresno. Dr. Mortimer is the Assistant Dean for Academic Affairs at UCSF Fresno. He provides primary and specialty HIV care at the CMC Special Services clinic. He does research in HIV and wilderness medicine. He is an instructor for the National Cave Rescue Commission and is the assistant training officer of the Fresno County Sheriff's Search and Rescue Mountaineering Team.

What inspired you to specialize in HIV care as a family medicine physician?

As a resident, long ago, it irked me that my patients knew more about HIV than I did. I worked to learn more, but found that I soon knew more than my attendings. I added a small amount of elective HIV time during my 2nd year working with Dr Robert Libke, who was very supportive of getting this population the care that it needed, and Dr. Michael Reyes, a family physician who had completed a fellowship in HIV care through a Song-Brown grant. Back then, there was not as much to learn. There was only AZT when I started. When DDI came along, we were happy about the option, but didn't really know what to do with it. Most of the early work was in the prevention and treatment of opportunistic infections, with more exposure to what would eventually be termed palliative care than anyone could want. As an early attending, I got to work under the recently passed Ryan-White Care Act to do consults on patients in primary care. With time, HIV medicine made great strides, to the point that we had to change models to one of integrated primary and specialist care. Now it has become more of a chronic disease, with a lot more people getting their care in primary care settings. It's really gratifying to see how the pendulum has swung on that.

ON THE FRONTLINES: A FAMILY PHYSICIAN'S FIGHT AGAINST HIV IN THE CENTRAL VALLEY

How does your background in family medicine uniquely support your work with patients living with or at risk for HIV?

Family Medicine is a great base upon which to add HIV care. We are well trained in care of chronic diseases. HIV affects men, women, and children, with specific HIV needs different for each. In Fresno County, it was family physicians like Ivan Gomez who started managing antiretrovirals in pregnant women and cared for the HIV exposed and infected children alongside pediatric consultants. We are used to talking about drug use, sex, and contraception. We are not afraid to get the occasional biopsy trying to sort out opportunistic infections and cancers. Our minds go naturally to prevention with vaccinations. As the HIV infected population ages, training in geriatric care helps us treat and prevent HIV-unrelated problems in the older population.

Healing in the Heartland: HIV Care from a Family Medicine Perspective

ANDREW SEE, MD
COMMUNITY HEALTH PARTNERS

Andrew See, MD, FAAFP, is a family medicine physician passionate about HIV prevention, treatment, and gender-affirming care. Dr. See was an active-duty physician and the EMS medical director at the Naval Air Station in Lemoore, taking care of active-duty service members, dependents and retirees. He leads HIV prevention initiatives within his organization and works to create welcoming, affirming spaces for LGBTQ+ patients in primary care. Outside of clinic, he's involved in provider education and community outreach to expand access to PrEP and HIV services.

What inspired you to specialize in HIV care as a family medicine physician?

I've always believed healthcare should be a place where people feel safe, seen, and cared for — especially for communities that have historically faced barriers. Early in my training, I realized how much stigma and misunderstanding still surround HIV, and I knew I wanted to be part of changing that. Family medicine gave me the perfect foundation to build long-term, trusting relationships with patients, and HIV care lets me combine science, advocacy, and connection in a really meaningful way.

> *"You can help people that has been forgotten or have been marginalized , you can make sure they can have a safe space to take care of them"*

HIV Care in primary Care

Article by Andrew See MD

What barriers do your patients face when accessing HIV prevention (like PrEP/PEP) or treatment, and how do you advocate for them?

For a lot of my patients, it's not just about getting a prescription — it's about navigating stigma, insurance hurdles, transportation issues, and finding providers they can trust. I try to make prevention and treatment a natural, normal part of primary care, and advocate for systems that make it easier for people to get what they need. Whether it's helping someone enroll in patient assistance programs or pushing for clinic-level changes, I'm always thinking about how we can remove the extra hurdles and meet people where they are.

Bridging Gaps: Providing HIV Care in California's Central Valley

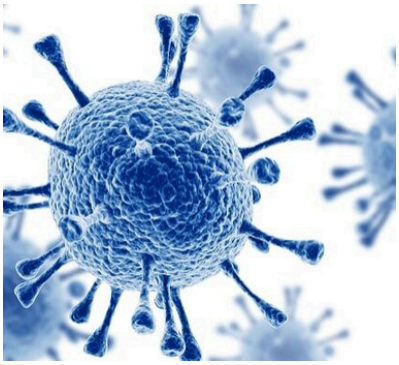


IMAGE TURNBRIDGE.COM

ALEXANDRIA MEYERS, MD

UCSF FRESNO
FAMILY AND COMMUNITY MEDICINE

Dr. Meyers received her medical degree at University of Connecticut School of Medicine and completed her residency at Sutter Sacramento Family Medicine Residency where she learned HIV medicine under Dr. Dineen Greer, family medicine physician and HIV specialist. Dr. Meyers serves as assistant clinical professor at UCSF Fresno Family Medicine Residency for several years providing full spectrum care for all ages and HIV care at a Ryan White funded office in Fresno, CA. Starting in June she will be joining the new Sutter Memorial Medical Center Family Medicine Residency in Modesto as core faculty. She is passionate about providing patient centered care and mentoring the future generation of physicians. Dr. Meyers is married with two children and enjoys spending time with her family, reading, and hiking.

What inspired you to specialize in HIV care as a family medicine physician?

As a child, I remember hearing about HIV/AIDS, a new disease that was killing people, including young people. At the time, there was little knowledge on how it was transmitted and there were limited treatment options. People were losing their jobs due to the fear and stigma with the classic example of Magic Johnson ending his basketball career. I remember seeing TV interviews of people living with HIV, who were talking about the new lifesaving medications available. HIV was no longer a death sentence, but the medications came at a price not only financial, but also with side effects that impacted the individual's quality of life. Then, within a matter of years, new medications were developed allowing for viral suppression with fewer side effects. I thought that was so exciting. During residency, I had the privilege of learning HIV medicine from my program director, who is an HIV specialist and provided HIV care in her primary care office. Despite the many advances in HIV care, there is still a residual stigma that my patients have expressed to me. I am happy to have the privilege of providing HIV care to people where the individual feels comfortable, be it in a specialty office or a primary care setting, and helping to de-stigmatize HIV.

How does your background in family medicine uniquely support your work with patients living with or at risk for HIV?

As a family medicine physician, I am able to provide comprehensive health care to individual all ages and on a daily basis I treat hypertension, diabetes, high cholesterol, anxiety, depression among a myriad of other medical conditions. With my primary care expertise I am able to utilize this knowledge to provide primary care to people living with HIV. I am not limited to taking care of people living with HIV at specialty office as I can manage their HIV along with their other medical conditions in my primary care office

Management of HIV by Family Medicine

Alexandria Meyers MD

What role do you think family physicians play in ending the HIV epidemic—especially in underserved or rural communities?

Primary care physicians play an important role in preventing, screening and treating HIV by providing increased access especially in rural and unserved communities. The PCP has the opportunity to screen for HIV as part of routine care and to offer PreP to individuals at increased risk. If newly diagnosed with HIV, then the PCP can start combined antiretroviral treatment.

How can other family medicine physicians get involved in HIV care or advocacy, even if they don't specialize in it?

Screen for HIV yearly and more often in individuals with higher risk. Learn the basics about HIV treatment and/or have a working relationship with colleagues, who specialize in HIV from whom they can ask professional advise. Learn PreP treatment and start prescribing as indicated.

What advice do you have for medical students or residents interested in HIV care within the field of family medicine?

Seek out mentors who practice HIV in the primary care setting and/or who provide primary care services along with HIV care. Explore the American Academy of HIV Medicine, which has learning modules, advocacy information, and information to become a member and an HIV specialist. Another great resource to utilize is the National HIV Curriculum.

REDEFINING THE SCOPE: A FAMILY PHYSICIAN'S LEAP INTO AESTHETIC MEDICINE AND HAIR RESTORATION

NADIA PAYAN, MD
INSIDE OUT

OSCAR HERNANDEZ SANDOVAL, MD
INSIDE OUT

What inspired Dr. Payan and Dr. Hernandez to open Inside Out Medical Center and specialize in esthetics, primary care, and hair restoration?

Inside Out Medical Center was founded by both of us—Dr. Nidia Payan and Dr. Hernandez—family medicine physicians who wanted to reimagine what a medical practice could look like. We were inspired by the idea of blending our strong foundation in primary care with advanced training in esthetics and hair restoration. Our goal was to create a space where health and beauty come together in a holistic way. With international training from Mexico to Europe, we've built a practice that offers highly personalized care, combining medical expertise with innovative aesthetic solutions. For us, it's about treating the whole person—helping patients feel confident and well, from the inside out.

> *Our mission is to merge beauty and health, guiding patients through their journey to improved well-being from the inside out.*

What advice would you give to other family medicine physicians interested in esthetics or starting a specialized practice?

Get properly trained and certified—preparation is key. Find mentors in the field who can guide you, stay passionate about the work, and be patient with the process. Building something meaningful takes time, but it's incredibly rewarding.

What is the scope of services offered at Inside Out Medical Center?

Our center is the first of its kind in the Central Valley, offering comprehensive hair transplant and restoration services using advanced techniques like FUE and DHI, supported by AI-driven technology like HairMetrix. We also provide a full range of aesthetic treatments, including fillers, neurotoxins, microneedling with radiofrequency, and medical-grade skincare. Importantly, we haven't abandoned our roots—we continue to provide primary care services, making Inside Out a truly integrated medical and aesthetic practice that supports total patient wellness

Healing with Pride: Family Medicine Physicians Providing Gender-Affirming Care in the Central Valley

DIANA HOWARD, MD AAHIVS (SHE/HER)

UCSF FRESNO
FAMILY AND COMMUNITY MEDICINE

What inspired you to provide gender-affirming care clinic within your Family Medicine practice?

As a family medicine physician committed to health equity, I recognized a deep gap in access to gender-affirming care in the Central Valley of California—an area where many transgender and nonbinary patients had never had access to affirming, comprehensive care. Founding the Gender-Affirming Care Clinic at UCSF Fresno was a step toward addressing that disparity. I wanted to create a safe space where patients could access primary care, preventive health, and gender-affirming services all in one place.

My inspiration was also deeply personal. During residency, I was mentored by Dr. Julie Nicole (OB/Gyn), who was later my WPATH mentor, who showed me just how rewarding and impactful it is to provide evidence-based gender-affirming care. Her mentorship, along with the support of many other physicians at UCSF, affirmed my commitment to expanding access, training the next generation of physicians, and building a sustainable network of affirming care.

How does the Gender Affirming Care Clinic support education and training for future physicians?

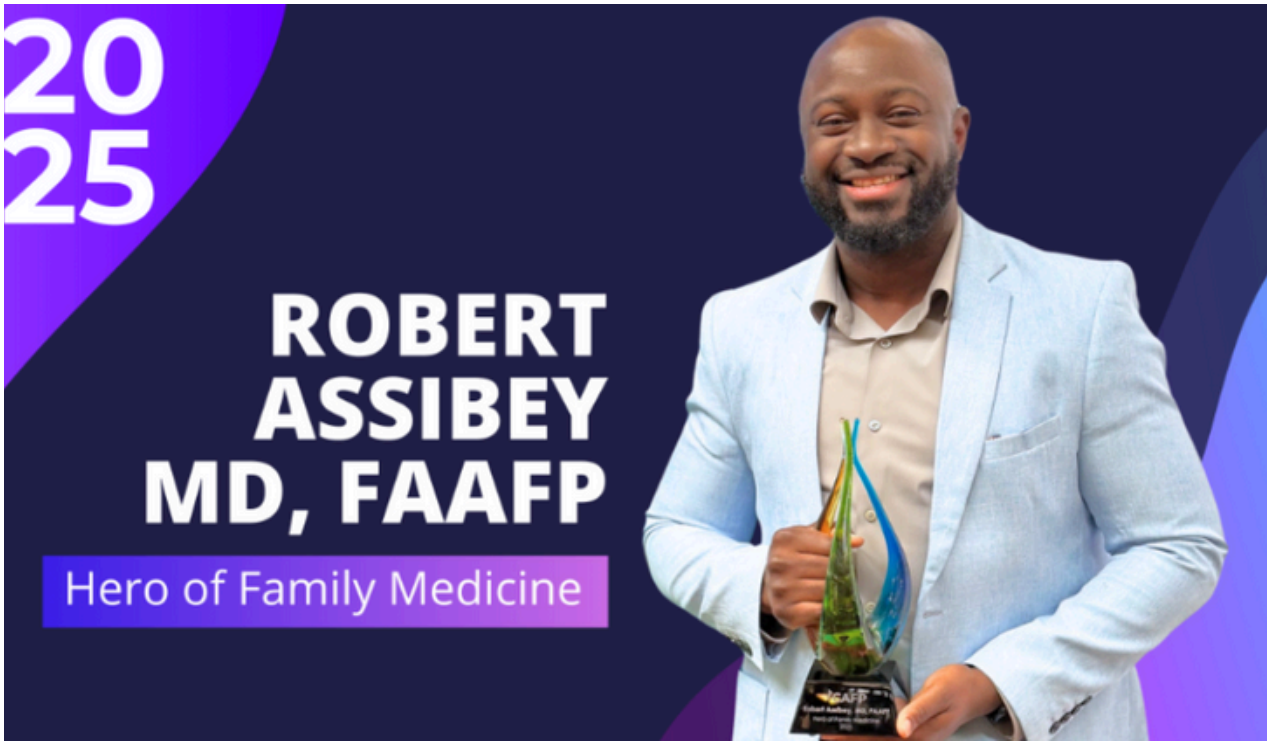
Our clinic has become a valuable training site for family medicine and pediatric residents, as well as medical students rotating through UCSF Fresno. We offer hands-on clinical experience, emphasizing evidence-based, compassionate care. I'm proud that we're not only caring for patients but also helping shape the next generation of physicians who are ready to deliver gender-affirming care with confidence and humility.

IMAGE: Arienreed Art (local artist)

How do you motivate other residents or physicians to start providing gender-affirming care?

I always remind colleagues that gender-affirming care is fundamentally inclusive, patient-centered primary care—rooted in compassion, evidence-based practice, and respect. It is lifesaving. Many physicians are already providing elements of this care; they often just need the framework, confidence, and intentionality to do more. I encourage residents and physicians to start by learning the basics, practicing inclusive and affirming language, actively listening to their gender-diverse patients, and seeking mentorship. We urgently need more inclusive primary care physicians in the Central Valley—our patients deserve access, dignity, and providers who are ready to care for them fully.

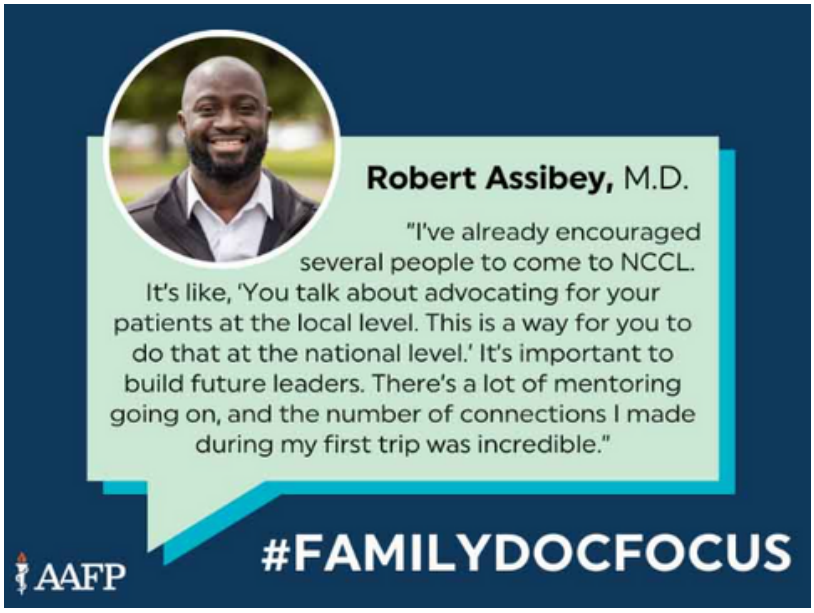
CONGRATULATIONS TO OUR HERO OF FAMILY MEDICINE



ROBERT ASSIBEY MD, FAAFP

WOUNDS R US

Dr. Assibey graduated from medical school at Ross University, in Dominica, West Indies. He completed his Family Medicine Residency at San Joaquin General Hospital. He is board Certified by ABFM - American Board of Family Medicine. Dr. Assibey currently serves on the CAFP Board as the District 8 Director and San Joaquin Chapter President. His professional interests include preventative medicine, advocacy, chronic disease management, geriatrics, medication assisted treatment, gender affirming care and procedures. He enjoys academic medicine and working with aspiring medical students. Currently working on his entrepreneurial skills and taking care of his 2 wonderful children.



"MY MOTTO IS, 'MEET PATIENTS WHERE THEY ARE, AND TREAT THEM WHERE THEY ARE,'" HE SAID. "THAT'S TRUE WHETHER IT'S MY ADDICTION MEDICINE PRACTICE, OUR HOMELESS OUTREACH OR GERIATRIC HOMEBOUND PATIENTS. IF THEY CAN'T COME TO US, WE'VE GOT TO GO TO THEM.

AAFP FEB 25TH 2025

What message would you like to share with our medical students, residents, and recent family medicine graduates?

As a family medicine physician, educator, and clinic leader, I've had the privilege of working alongside students, residents, and early-career physicians committed to making a difference. Whether you're just starting your journey or transitioning into independent practice, know that your voice matters and your growth never stops. Embrace each patient interaction as a chance to learn, each challenge as an opportunity to lead, and each day as a step closer to the physician you're becoming. I'm here to remind you: you belong in this field — and our communities need you more than ever

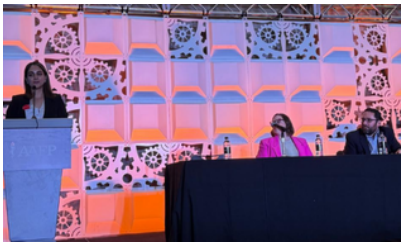
Why are you passionate about advocacy?

My passion for advocacy is rooted in a simple, guiding principle: meet patients where they are. That means recognizing the social, emotional, and structural barriers that affect their health and showing up with compassion and action. Whether through street medicine, addiction care, or community partnerships, I believe family physicians are uniquely positioned to champion change from the clinic to the Capitol. Advocacy isn't just policy work — it's how we show up for people, especially the ones most often left behind.

NCCL 2025

DIANA HOWARD, MD

UCSF FRESNO
FAMILY AND COMMUNITY MEDICINE



"NCCL reminded me that our voices as underrepresented physicians matter and that we can shape the future of our specialty by showing up, speaking out, and lifting each other up. "

Attending the National Conference of Constituency Leaders (NCCL) for the first time was an incredible and energizing experience. As a family medicine physician representing the LGBTQ+ constituency, I felt both proud and inspired to be part of a space where underrepresented voices are not only heard—but empowered.

The California delegation was phenomenal—supportive, collaborative, and full of passionate advocates. One of the most exciting parts was the adrenaline of writing resolutions together—brainstorming ideas late into the night, crafting language that captured our shared values, and learning in real time about the legislative process behind AAFP advocacy. We weren't just talking—we were actively shaping the future of our specialty.

We also had the chance to vote on the resolutions we believe the AAFP should take forward. It was powerful to see how our collective voices could turn real issues into national priorities.

Beyond the policy work, NCCL was about connection. I met so many inspiring mentors and leaders—people I genuinely look up to—who reminded me that showing up and being visible in these spaces matters. I left the conference feeling recharged, supported, and ready to keep pushing for more inclusive, equitable care in family medicine.


2025 NATIONAL CONFERENCE OF CONSTITUENCY LEADERS (NCCL) DELEGATES AND ALTERNATES
CAFP

A message from our NCCL Convener 2026 Dr. Anna Askari

"That initial leap of faith sparked a now more than decade-long commitment to leadership and advocacy in family medicine that continues to shape my career and purpose today."

ANNA ASKARI, MD
ONE HEALTH

Can you share with us how your journey in advocacy began and what inspired you to get involved with organized medicine?

My journey in advocacy began as a first-year medical student at The Ohio State University College of Medicine when I was elected president of our Family Medicine Interest Group. I was passionate about raising awareness of family medicine as a vital specialty and wanted to encourage others to consider its importance. That role led me to my first state chapter meeting with the Ohio Academy of Family Physicians, where I met Dr. Sarah Sams, a remarkable mentor who introduced me to the work of the AAFP's commissions. Attending that meeting opened my eyes to the impact that organized medicine could have on health policy, education, and patient care. Thanks to a scholarship from Dr. Sams, I attended my first AAFP National Conference (now FUTURE), where I served as a student delegate to Ohio, then AMA MSS Delegate and eventually became the Resident Chair of the conference.

These early opportunities not only helped me develop leadership and public speaking skills but also gave me the confidence to step into advocacy roles I hadn't imagined for myself. That initial leap of faith sparked a now more than decade-long commitment to leadership and advocacy in family medicine that continues to shape my career and purpose today.

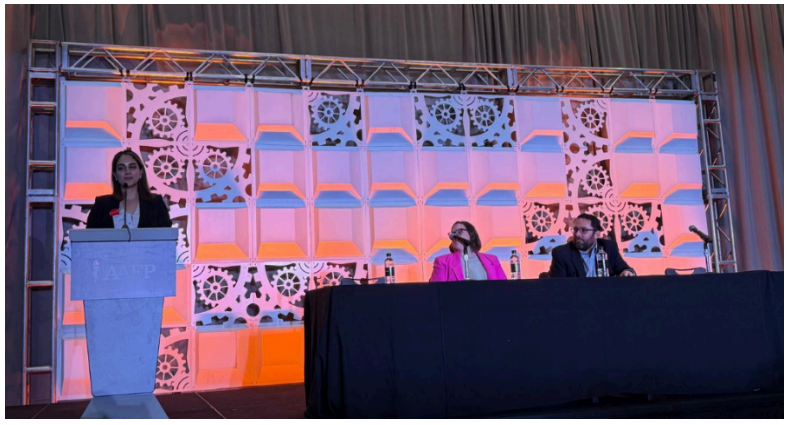
As the New Physician delegate to the AMA YPS and now the NCCL Convener, you've had a significant leadership role. What have been some pivotal moments or challenges in your advocacy work that helped shape your perspective as a family physician leader?

One of the most pivotal moments in my advocacy journey was serving on the AAFP's Board of Directors as the resident member. It was an amazing experience to work with the AAFP executive leadership as well as the other Board of Directors.

It was there that I truly found my voice—representing residents during critical discussions about our specialty's future and the AAFP's strategic priorities. Navigating complex topics, working to build consensus, and seeing my recommendations lead to real change and adding perspective showed me the power of this work.

Many residents and medical students look for mentors and role models in advocacy. What advice do you have for early-career physicians who want to get involved in health policy, leadership, or organized medicine but aren't sure where to start?

Start small, start local, and don't wait to feel "ready." Whether it's joining your local academy chapter, submitting a resolution for AMAM, or attending a meeting like POP, those first steps matter. Reach out to someone you admire and ask how they got started—most of us are more than happy to share. Also, look for leadership programs like NCCL, which are designed to help newer voices grow. And most importantly, let your lived experiences and values guide your advocacy. You don't need to know everything about policy—you just need to care deeply and be willing to learn and speak up.



You've become a strong voice for family medicine on both state and national levels. How do you see your role as a model for emerging physician leaders, especially those from underrepresented communities?

Representation truly matters. When I first got involved, I didn't always see people who looked like me or shared my lived experience in leadership roles. That's why I'm intentional about showing up authentically and making space for others to rise. I want early-career physicians—especially those from underrepresented communities—to know that their voices are needed now, not just someday. Leadership isn't about having a title—it's about standing up for your patients and your peers. If I can be a mirror or a door-opener for someone else's journey, then I see that as one of the most meaningful parts of this work.

What keeps you passionate about advocacy? In the face of burnout and competing demands, how do you stay energized and hopeful about making change?

What keeps me going is the reminder that advocacy is an extension of care. Every policy we influence has the power to impact not just one patient, but entire communities. Yes, burnout is real—especially in primary care—but advocacy gives me a sense of agency and purpose beyond the day-to-day grind. I stay energized by connecting with like-minded colleagues, mentoring others, and celebrating even small wins. And when it gets hard, I think about the patients who inspired me to start this journey in the first place. Their stories are what keep me hopeful and committed to change.

Dr. Anna Askari