SAN FRANCISCO MARIN MEDICINE

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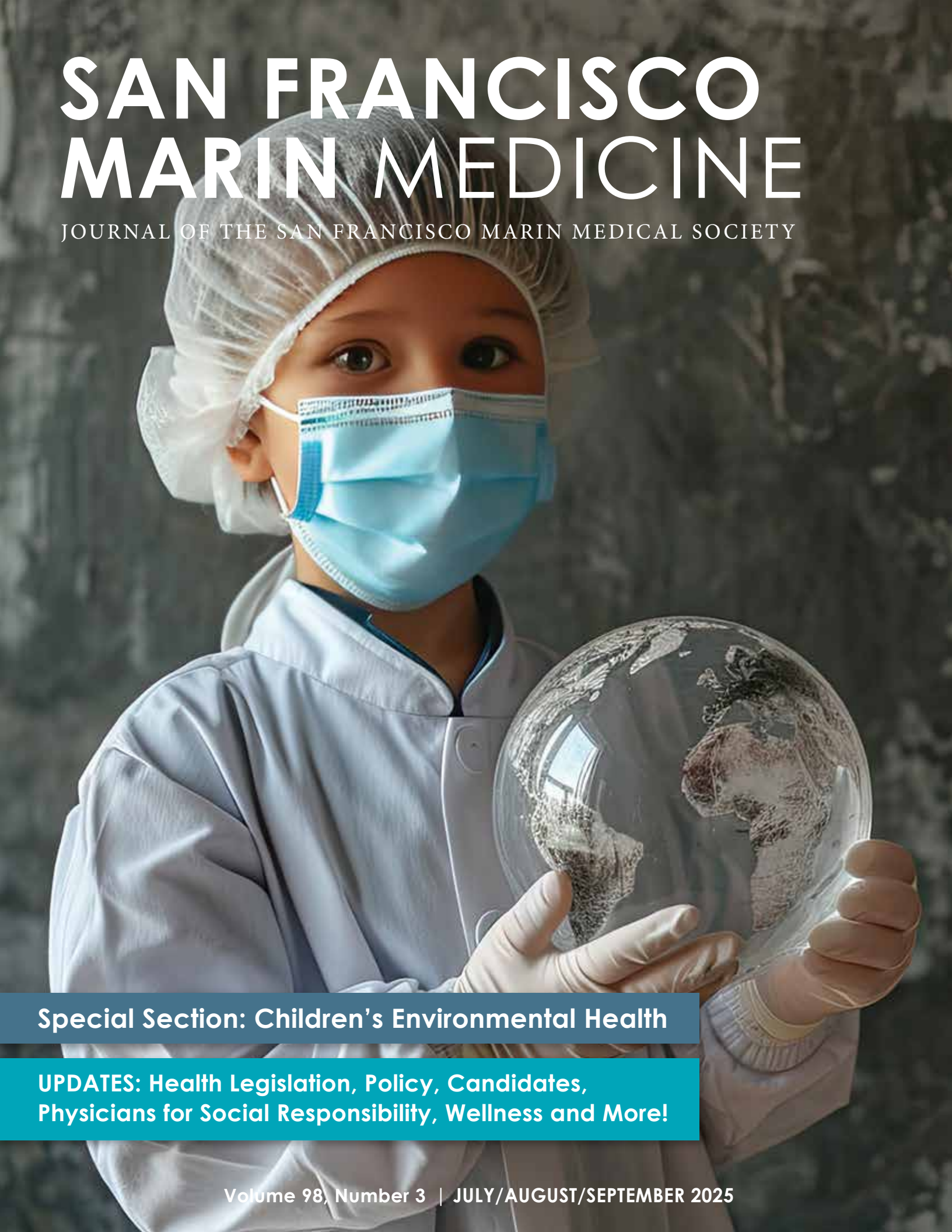

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Volume 98, Number 3 | JULY/AUGUST/SEPTEMBER 2025

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MEMBERSHIP MATTERS

SFMMS Sponsors Northern California Planned Parenthood Acts of Courage 2025 Event

SFMMS Community Foundation supports community health partners such as Planned Parenthood with donations and sponsorship. On May 30, 2025 SFMMS was a sponsor of the Planned Parenthood Acts of Courage 2025 event.

Planned Parenthood was formed 108 years ago to provide reproductive and sexual healthcare and sexual education. Planned Parenthood provides women's health including contraception, cancer screening, STI screening and treatment, abortion, gender identity counseling, and health and wellness examinations and treatment.

Jodi Hicks, the President and CEO of Planned Parenthood Affiliates of California, lamented the Dobbs decision and the current climate for reproductive health and rights. She gave an Acts of Courage Award to Gilda Gonzales, the current President and CEO of Northern California Planned Parenthood, who is stepping down.

Ms Gonzales focused on resilience, expansion of services, gender affirmation care, service to the undocumented and working with local and state politicians. She urged the audience to resist attempts to defund Planned Parenthood nationally and protect reproductive freedom.

The new CEO, Dr Nicole Barnett, was introduced and she outlined her vision for PPNorCal. The entertainment was provided by SF Gay Men's Chorus who sang "The Times They are a-Changin'." The evening festivities included a DJ and dancing.

SFMMS was represented by Board members Dr Melinda Aquino, Dr Dawn Rosenberg, and Dr Michael Schrader.

There is a current proposal within SFMMS to enhance our support for community health groups by forming a Community Health Committee. Our SFMMS Community Foundation has been doing this over the past several years by making modest grants to community health groups and the patients they serve.

Hospital board chair/SFMMS past-President Roger Eng, MD accepts the award.

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Editor Michael Schrader, MD, PhD
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For questions regarding journal, including possible submissions, contact Steve Heilig: Heilig@sfmms.org

PRESIDENT'S MESSAGE

Jason Nau, MD

DELUSIONS IN THE ER, DELUSIONS IN PUBLIC HEALTH: WHEN IDEOLOGY ENDANGERS THE PUBLIC

In the emergency department, certain patterns of behavior repeat themselves. A man in his early thirties appears dishevelled and restless. His skin is pocked with sores, which he insists are caused by tiny bugs crawling under his skin. He carries a vial of lint and dirt, which he believes contains the "specimens." I examine the vial respectfully under magnification. There are no insects, of course, just fibers and grime. This man is suffering from delusional parasitosis, a fixed false belief typically seen in the context of methamphetamine use and prolonged sleep deprivation. As an ER doctor, I have seen variations of this delusion many times, and I know there is no quick fix or magic phrase that will break the patient's conviction. The belief is real to him, no matter the evidence I present.

We accept that people in our society hold differing beliefs about religion, politics, economics, or even whether going out in the cold causes the flu. But in medicine, and especially in public health, beliefs must be tested against rigorous evidence, because they influence decisions that affect not just one person, but entire populations.

It is in this context that Robert F. Kennedy Jr.'s systematic dismantling of the Centers for Disease Control and Prevention (CDC) and the Department of Health and Human Services (HHS) demands ethical scrutiny. His embrace of discredited medical theories, particularly Béchamp's terrain theory over Pasteur's germ theory, places ideology above evidence. In doing so, he jeopardizes the public health infrastructure that Americans have relied on for generations. This is not unlike the ER patient clutching a vial of lint, convinced of his version of reality; the consequences, however, scale from individual delusion to national crisis.

In recent months, Kennedy has removed the CDC director, disbanded the Advisory Committee on Immunization Practices (ACIP), and overseen a mass resignation of senior scientists. He has described the CDC as a "cesspool of corruption," and reversed federal vaccine guidance, including for children and pregnant women. While these actions may appear as a populist rejection of bureaucratic inefficiency, their deeper foundation lies in a rejection of germ theory itself, an ideology that posits health is determined solely by internal balance, not pathogens. Kennedy's affinity for terrain theory is not just scientifically bankrupt; it is profoundly dangerous. Germ theory, validated by centuries of research, has allowed us to eradicate smallpox, control tuberculosis, and reduce the incidence of deadly diseases like Haemophilus influenzae and pneumococcal meningitis. These pathogens were once routine killers of children. The young, feverish child I evaluate today in Marin might have an illness we thought largely conquered because vaccine uptake is falling. Simultaneously, the infrastructure to track or prevent outbreaks is crumbling.

Rejecting germ theory is not a harmless intellectual exercise. It leads to policy changes that expose people, especially children, the elderly, and the immunocompromised, to real, preventable harm. As one pediatrician recently observed, it forces clinicians to re-evaluate how aggressively they must investigate common presentations. That croupy child could now have epiglottitis. That febrile toddler might be harboring meningitis. This uncertainty means more blood draws, lumbar punctures, and hospital admissions - costing families time, money, and needless suffering. These aren't theoretical harms; they're daily realities for frontline providers.

We rely on public health infrastructure the way we depend on telecommunications. I don't personally understand the inner workings of semiconductors or how my phone call reaches my daughter in Denmark, but I trust the engineers and systems that make it happen. Similarly, most people don't understand the immunologic nuances behind herd immunity or mRNA vaccines, but they depend on experts to get it right. When a policymaker insists that they know better based on "personal research" or ideology, it's like a layperson deciding to rewire the power grid based on YouTube videos. The results are predictably catastrophic.

Trust in science doesn't mean blind faith. It means acknowledging that some systems are complex and that in a functioning society, we designate experts such as epidemiologists, virologists, and clinicians to guide us using evidence. Kennedy's actions not only disregard this structure; they actively sabotage it. Over 600 CDC staffers signed a letter condemning his leadership, and nine former CDC directors issued a joint op-ed warning that his decisions are "undermining public health and endangering lives." State health departments across the country are forming regional alliances to preserve evidence-based practices in defiance of federal rollbacks.

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Editorial

ONE PRETTY UGLY BILL

Michael Schrader, MD, PhD

HR 1, the legislation that Trump calls the One Big Beautiful Bill Act will be pretty ugly for patient health and access to care. Potentially 14 million Americans could lose healthcare coverage, premiums could increase for Covered California, and state provider taxes that support Medicaid/Medi-Cal will be limited and progressively decreased. The impact of HR 1 was the major focus of the CMA Fifth Annual Medical Group Symposium covered in this issue.

Medicaid (Medi-Cal in California) was created in 1965 concurrently with Medicare by Title XIX of the Social Security Act. It provides federal funds which are administered by states for healthcare coverage to low income people. The Children's Health Insurance Program (CHIP) was signed into law in 1997 expanding coverage to children whose family income is below 200 percent of the Federal Poverty Level (FPL). In 2014, the Affordable Care Act (ACA) extended Medicaid to people under the age of 65 who make less than 133 percent of the FPL. The Basic Health Plan, a part of the ACA, enabled states to offer affordable coverage to low income people under 65 who make between 133 and 200 percent of the FPL.

HR 1 aims to save $880 billion in federal healthcare expenditures between now and 2034. While politicians talk about cutting fraud, waste and abuse, these cuts primarily focus on cutting patient access.

Many of these cuts do not occur until after the midterm elections in 2026, they are projected to cause as many as 10-14 million Americans to lose insurance by 2034. In California about 30% of our residents and 50% of our children are covered by Medi-Cal.

It also institutes work requirements for Medicaid/Medi-Cal, cuts funding to Planned Parenthood, cuts funding to the Supplemental Nutritional Assistance Program (SNAP), cuts Medicaid for certain legal immigrants, and cuts premium assistance for Affordable Care Act policies.

Many people who work and receive Medicaid/Medi-Cal will lose assistance because they will not be able to fill out onerous paperwork correctly to maintain coverage. CMA predicts that 1.4 million Californians will lose coverage this way.

Home- and community-based services (H.C.B.S.), which account for about a third of all Medicaid spending and more than half of all optional spending, would be a prime target for cuts. This would include California's In-Home Supportive Services (I.H.S.S.).

CMA predicts that over 10 years 2.5 million Californians will lose Medi-Cal and 2 million will either lose ACA coverage or have to pay substantially higher premiums.

Limits to state provider taxes, such as California's MCO tax that was recently reaffirmed by Proposition 35, will decrease state's abilities to fund Medicaid. These are state taxes on providers that are matched by the federal government and then directed to Medi-Cal.

Many hospitals are in a tenuous financial condition, especially those in rural areas. CMA estimates a $9.5 billion increase in uncompensated care over ten years. This could cause bankruptcy for hospitals. A late addition to HR 1, the Rural Health Transformation Fund dedicates $50 billion in grants for states to use between fiscal years 2026 and 2030 to cover certain costs for rural health care. This is estimated to offset about one third of the lost revenue that rural hospitals will incur.

The law does increase Medicare physician payment by 2.5% but only for one year, starting Jan. 1, 2026. It is possible that the growth of the deficit will trigger 4% sequestration cuts to Medicare under the Statutory Pay-As-You-Go Act of 2010.

Do we let HR 1 become the new normal or do we oppose this? Organized medicine can try to influence the federal rulemaking process, advocate for legislative corrections, and back judicial challenges.

At the CMA Medical Group Symposium in August, CMA President Dustin Corcoran suggested forming a super PAC to lobby for Medicaid. In addition CMA proposed that we aid our patients in filling out the forms to document work hours. One participant in the meeting (our own Dr. John Maa) suggested additional sources of revenue earmarked for Medi-Cal such as taxes on sugary beverages and vapes.

What can individual physicians do? We can familiarize ourselves with the specifics of HR 1 and educate our patients and colleagues about the threat to Medicaid/Medi-Cal. We must continue to advocate for patient access.

For more in depth analysis of HR 1, KFF, an independent charitable organization, produces independent analyses of healthcare policy and has produced an analysis of HR 1: *https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/#2ca666ac-5d15-4454-8973-241566e22bb5*

Dr. Schrader, an internist at Dignity Health, is former Chair of the SFMMS delegation to the CMA and a past-president of the SFMMS.

EXECUTIVE MEMO

Conrad Amenta, SFMMS Executive Director

SFMMS' NEW STRATEGIC PLAN, AND WHAT IT MEANS FOR YOU

The San Francisco Marin Medical Society (SFMMS) has unveiled a bold new strategic plan designed to strengthen its role as a vital resource for physicians and their patients. With a renewed focus on member engagement, advocacy, and community partnerships, the plan lays out a roadmap for how SFMMS will evolve to meet the changing needs of healthcare professionals and the populations they serve.

Whether you're a long-time member, a new physician in the region, or someone considering joining, this strategic plan has direct implications for how SFMMS will support your professional journey and amplify your voice in shaping the future of medicine in San Francisco and Marin.

Member Engagement: Supporting and Connecting Our Physician Community

At the heart of the strategic plan is a commitment to deepen connections within the physician community. SFMMS recognizes that meaningful engagement starts with effective communication. To that end, the organization will attain consistent, timely, and tailored messaging to inform and connect both members and non-members.

SFMMS will prioritize engagement opportunities based on what members want. A comprehensive and representative membership survey is in the works to better understand preferences, needs, and expectations. This data-driven approach will help SFMMS design events, resources, and initiatives that are truly relevant to its diverse membership.

Diversity and representation are also key pillars of the engagement strategy. SFMMS is taking a hard look at its membership demographics—examining representation by specialty, practice type, medical group affiliation, career phase, ethnicity, and more. By identifying underrepresented segments, SFMMS aims to foster a more inclusive environment and ensure that its governance reflects the full spectrum of the physician community.

What this means for you: Expect more personalized communication, opportunities that align with your interests, and a stronger sense of belonging—regardless of your background or career stage.

Advocacy: Advancing Policy, Services, and Initiatives

SFMMS has long been a voice for physicians in policy and public health discussions, and the new strategic plan doubles down on that commitment. One major goal is to enhance the sustainability of medical practices, especially small and solo operations that often face unique challenges. By working directly with these practices and medical groups, SFMMS will identify pain points and advocate for solutions that make day-to-day operations more manageable.

Improving patient and community health is another cornerstone of the advocacy strategy. SFMMS plans to identify the most pressing public health issues in San Francisco and Marin and mobilize resources to address them. This could include anything from tackling chronic disease to responding to emerging health threats.

To be more effective in the political arena, SFMMS is also working to increase its influence with local government leaders and agencies. A key tactic will be forming responsive subgroups of physicians based on specialty interests, allowing the organization to quickly gather feedback and provide expert input to decision-makers.

What this means for you: Your practice concerns will be heard and addressed, your expertise will help shape public health initiatives, and your voice will carry more weight in local policy discussions.

Community Partnerships: Collaborating for Health Equity

Recognizing that health doesn't exist in a vacuum, SFMMS is expanding its efforts to collaborate with local community benefit organizations. A new Community Partnerships Committee will be established to strengthen these relationships and ensure that SFMMS is a proactive partner in addressing local health needs. To guide these efforts, the organization will conduct research to better understand the health challenges facing San Francisco and Marin residents. This will inform targeted interventions and help SFMMS align its resources with the most impactful organizations and opportunities.

The strategic plan also calls for expanding the reach and capacity of the SFMMS Community Service Foundation. By studying best practices and outcomes from other successful foundations, SFMMS aims to build a more robust infrastructure for community service and philanthropy.

What this means for you: You'll have more opportunities to engage in meaningful community work, contribute to health equity, and be part of a broader movement to improve lives beyond the clinic walls.

Looking Ahead

SFMMS' new strategic plan is more than a set of goals—it's a reflection of the organization's values and its commitment to evolving alongside the physicians it serves. By focusing on engagement, advocacy, and partnerships, SFMMS is positioning itself as a dynamic force in local healthcare.

As a member, you can expect more relevant communication, greater representation, stronger advocacy, and deeper community impact. And if you're not yet a member, there's never been a better time to join and help shape the future of medicine in San Francisco and Marin.

Your voice matters. Your work matters. And with this strategic plan, SFMMS is making sure both are heard loud and clear.

TEN SFMMS-SUPPORTED BILLS AWAIT GOVERNOR'S DECISION

Adam Francis, CAE

Every year, SFMMS's Advocacy and Policy Committee meets to review, analyze, and make recommendations on state legislative positions and priorities to the SFMMS Board. Given limited staff resources and time, the APC reviews hundreds of pieces of state legislation and narrow down its recommendations to a maximum of 20 bills. Many factors go in to deciding whether SFMMS should prioritize a piece of legislation. Does the bill affect health care issues specific to San Francisco or Marin? Would it affect issues SFMMS prioritizes, such as public health, physician practice, substance use, etc.? Is it sponsored by CMA or has CMA taken a position on it? Is it authored by a local San Francisco or Marin legislator? Does it align with CMA and SFMMS policy?

Throughout the year, successive legislative and political hurdles must be overcome for a bill to make it all the way through the legislative process and land on the Governor's desk for his signature or veto. Hundreds of bills fall to the wayside, particularly those that would cost the State money, are opposed by large monied interests (e.g., tech companies, health plans, labor, etc.), or are politically controversial.

After overcoming these obstacles, they face the final challenge of winning the Governor's support. SFMMS has already notched one victory this year—SFMMS-supported bill AB 544 (Davies) was signed into law, requiring a person under the age of 18 to take an electric bicycle (e-bike) safety course if they receive a violation for failing to wear a proper helmet and want the court to not impose a fee. It also requires e-bikes to have red reflectors at all hours of the day instead of just at night.

As of this writing, ten other SFMMS-supported bills await the Governor's decision:

- **AB 255 (Haney)** – This bill will allow state funding for supportive-recovery residences that emphasize substance use abstinence. It would also prohibit eviction based on relapse. If a tenant is no longer interested in living in a supportive-recovery residence or is at risk of eviction, the bill requires that the supportive-recovery residence help in accessing housing operated with harm-reduction principles that is also permanent housing.
- **AB 489 (Bonta)** – This CMA-sponsored bill will prohibit the use of terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession, enforceable against an entity who develops or deploys artificial intelligence technology that uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI to indicate or imply that the advice or care being provided through AI is being provided by a natural person with the appropriate health care license or certificate.
- **AB 512 (Harabedian)** – This CMA-sponsored bill will change the timeline for prior or concurrent authorization requests to no more than three business days from the plan's or insurer's receipt via electronic submission, or five business days from receipt via submission that is not electronic, of the information reasonably necessary and requested by the plan or insurer to make the determination. The bill would require a utilization review decision to be made within 24 hours from receipt of a prior or concurrent authorization request via electronic submission, or 48 hours from receipt via submission that is not electronic, if the enrollee or insured faces an imminent and serious threat to their health or the normal timeframe would be detrimental to their life or health.
- **AB 1363 (Stefani)** – This bill, which will be known as Wyland's Law, authorizes the State Department of Justice to establish an automated protected person information and notification system to provide a petitioner or a protected person in a protective order case with automated access to information about their case. It will ensure protective orders are properly transmitted and verifiable, with clear records accessible to families, survivors, and law enforcement.
- **SB 40 (Wiener)** – This bill will prohibit health plans from imposing a co-pay of more than $35 for a 30-day supply of insulin or imposing a deductible, coinsurance, or any other cost-sharing on insulin. It will also prohibit a health plan from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin.
- **SB 41 (Wiener)** – This bill will place various restrictions on the practices of a pharmacy benefit manager (PBM), including how the PBM pays pharmacies and how the PBM is compensated. The bill will also prohibit health plans from charging enrollees more than the actual cost of prescription drugs.
- **SB 306 (Becker)** – This CMA-sponsored bill will require health plans and insurers to report statistics regarding covered health care services subject to prior authorization and the percentage rate at which they are approved or modified. The State would then identify and publish a list of the most frequently approved services and require a plan or insurer to cease prior authorization for them.
- **SB 351 (Cabaldon)** – This CMA-sponsored bill will empower the California Attorney General's office to investigate and intervene in cases where private equity firms unduly influence medical care.

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CMA HOUSE OF DELEGATES 2025

Michael Schrader, MD, PhD

HATE SPEECH IS A PUBLIC HEALTH CONCERN

The resolution I wrote about hate speech was adopted by the AMA as policy this summer after being adopted by the CMA and then being forwarded to the AMA. I wrote this resolution because I believe that hatred spreads like a disease and hate speech is the vector that spreads it.

Sometimes I can write a resolution to the CMA in half an hour. Most of them take me several hours. This one took me seven years.

This resolution was the culmination of many years and influences. It started with an anti-racism resolution I wrote in 2017 after the anti-semitic march in Charlottesville, Virginia that resulted in mayhem and murder. President Trump said there were fine people on both sides.

My resolution against racism was passionate but it did not have clear "Resolved" clauses. I took it to the SFMMS District VIII Delegation meeting in late 2017. I remember the Delegation's decision was that the resolution wasn't ready and wasn't complete. But I remember our Delegation Chair, Dr. Lawrence Cheung saying that he had also tried to write an anti-racism resolution. And that he would help me write that resolution. That encouragement was the inspiration that stayed with me.

I went to the shrine that had been created at the Emanuel African Methodist Episcopal Church in Charleston in 2017. A white supremacist murdered nine people at a bible study group in 2015.

In 2019 I visited the shrine created at the Tree of Life Synagogue in Pittsburgh, Pennsylvania. In 2018, a right wing extremist killed eleven people at a religious service.

And recently I visited the University of Virginia Campus in Charlottesville, Virginia where the white supremacists marched in 2017 in a deliberate provocation that ended with a murder that same weekend.

But these are only a few of the places where racist violence driven by hatred has resulted in murder. And this hatred fuels violence that occurs around the world.

Covid-19 killed more than one million Americans. The origin of the virus was thought to be in Wuhan, China. Racism against Asian Americans increased with violence in San Francisco and across the country. In 2020, President Donald Trump called Covid-19 "Kung flu."

Dr. Joe Woo said that he didn't want this to become part of the vernacular. He organized a press conference at Chinese Hospital. This event drew SFMMS leaders, local politicians, and local press.

Over the years Dr. Woo and I engaged in discussions about hatred, racism, and racial violence and what it does to our patients and our society. My elderly Asian patients isolated themselves because they were afraid to go outside and afraid to ride the bus.

Hatred and racial violence do spread like an infectious disease. Of course most people don't act on racist impulses. There is a progression from thoughts to words to deeds. Often the violence is perpetrated by the mentally ill or others disenfranchised in our society.

I don't think we can stop people from having racist or hateful thoughts. But we should do what we can to stop them from voicing them. And transmitting them to others. And influencing those who might act hurtfully.

I found that the United Nations had a very well-crafted definition of hate speech. The CMA and the AMA both had existing policy about hate crimes. There is clear evidence that hate crimes are increasing. And the internet has amplified hate speech and increased the audience for hate speech.

I only hope this policy makes a difference.

Dr. Schrader, an internist at Dignity Health, is former chair of the SFMMS delegation to the CMA and a past-president of the SFMMS.

Resolution: (Subject: Hate Speech is a Public Health Concern Referred to: Reference Committee (Assigned by HOD)

Whereas, the United Nations Strategy and Plan of Action on Hate Speech defines hate speech as "any kind of communication in speech, writing or behavior that attacks or uses pejorative or discriminatory language with reference to a person or a group on the basis of who they are, in other words, based on their religion, ethnicity, nationality, race, color, descent, gender or other identity factor," and

Whereas, hate speech is in general protected by law under the First Amendment unless it rises to the level of incitement, and

Whereas, hate speech has been recently amplified by internet social media platforms, and

Whereas, hate spreads like a communicable disease and hate speech is the vector for spread, and

Whereas, the progression from racist or prejudicial thoughts to words and violent actions can be slowed by discouraging and countering hate speech, and

Whereas, hatred is a public health threat and hate crimes have been recognized as a public health issue, and

Whereas, hate speech is a public health concern because it causes emotional, mental, social, and physical harm to our patients, therefore, be it

RESOLVED, that our American Medical Association declare hate speech a public health concern; and be it further

RESOLVED, that our AMA support public and professional campaigns to educate against hate speech and its detrimental effects on the mental and physical well-being of the public; and be it further

RESOLVED, that our AMA encourage internet social media and search engines to establish and enforce meaningful content moderation to protect against the spread of hate speech on their platforms.

STANDING STRONG: THE CALIFORNIA MEDICAL ASSOCIATION'S FIGHT FOR HEALTHCARE VALUES AND PATIENT PROTECTION

Brian Grady, MD

The California Medical Association's recent Medical Group Advocacy Symposium illuminated a critical truth: in today's rapidly evolving healthcare landscape, physician advocacy isn't just important—it's essential for protecting both patients and the practice of medicine itself. As federal policies increasingly threaten California's progressive healthcare values, medical professionals must unite to defend access, equity, and the fundamental principles that guide quality care.

The San Francisco Marin Medical Society was well represented, by Drs. John Maa, Man-kit Leung, Roger Eng, Michael Schrader, and myself, as well as CMA President Shannon Udovic-Constant and CMA Vice Speaker George Fouras.

The Federal Challenge to California Healthcare

The symposium's opening session, "When Federal Policy Falls Short: Safeguarding California's Values in Health Care," set the tone for urgent discussions about protecting state-level healthcare innovations from federal interference. With Dustin Corcoran, CEO of CMA, leading the conversation, participants explored how California's leadership in healthcare policy often conflicts with federal directives that may not serve the best interests of patients or providers. This tension becomes particularly evident when examining the impact of federal actions on insurance markets and patient access. The session on "CalPERS and Covered California: Impacts of Federal Actions on Premiums and Market Stability" highlighted how federal policy decisions ripple through state insurance programs, potentially destabilizing coverage for millions of Californians. Jessica Altman, CEO of Covered California, provided crucial insights into how state programs must navigate federal constraints while maintaining their commitment to accessible, affordable healthcare.

Legal Battles as Healthcare Advocacy

Perhaps no figure embodied the spirit of medical advocacy more powerfully than California Attorney General Rob Bonta, whose presentation on "The AG's Legal Battles Against Federal Attacks" demonstrated the intersection of law and medicine in protecting patient rights. Bonta's inspiring and energetic approach to defending California healthcare values through litigation represents a model for how legal advocacy can serve medical priorities. His commitment to protecting access and privacy through lawsuits against federal overreach exemplifies the multi-faceted nature of modern healthcare advocacy. From defending California's protection of gender affirmation and reproductive rights to preventing the Trump administration's injection of politics into medical examination rooms, Bonta's work illustrates how legal advocacy serves as a crucial shield for medical practice integrity.

The Attorney General's efforts to protect the Affordable Care Act, prevent sharing of health data with ICE, and push back against healthcare disinformation demonstrate that effective medical advocacy requires partnerships between healthcare professionals and legal experts. His collaboration with CMA represents a powerful model for physician-attorney cooperation in defending healthcare values.

Economic Realities and Physician Sustainability

The symposium didn't shy away from addressing the economic pressures facing medical practices. The afternoon session "Care, Costs, and Capacity: Can AI Deliver?" brought together experts including Dr. Keisuke Nakagawa from UC San Diego Health and leaders from Kaiser Permanente and VerityMD to explore how artificial intelligence might address healthcare's capacity challenges while controlling costs.

However, advocacy extends beyond embracing new technologies. The legislative updates revealed concerning trends, including prior authorization reforms and efforts to control AI applications in healthcare settings. Of particular note was the discussion of limiting private equity involvement in healthcare and addressing hospital closures—issues that directly impact physician practice sustainability and patient access.

The SEIU-UHW initiative to limit healthcare executive compensation to $450,000 total represents another front in healthcare advocacy, raising questions about resource allocation and organizational priorities within healthcare systems.

Medicaid Leadership and Rural Healthcare

Caprice Knapp, PhD, serving as acting Deputy Administrator and Director of the Center for Medicaid and CHIP Services, brought crucial federal perspective to state-level healthcare challenges. Her expertise as a Medicaid economist proved invaluable in discussions about California's unique healthcare landscape, particularly regarding rural health relief funds and the disproportionately higher number of Medi-Cal patients in rural areas.

These discussions highlighted how effective advocacy must address healthcare disparities and ensure that policy solutions work for all Californians, regardless of geographic location or economic status.

The Path Forward: Unified Advocacy

The symposium's emphasis on "increasing physician voice" through a suggested $200 million super PAC funded by health groups represents a recognition that effective healthcare advocacy requires significant resources and coordinated effort. This proposal acknowledges that defending healthcare values and patient interests requires the same level of organization and funding that other industries bring to policy advocacy.

The discussions revealed both challenges and opportunities. While participants noted "lots of jargon and nebulous answers" and "no clear answer about timeline for uniformity," the commitment to advocacy remained strong. The evasive responses to questions about monitoring human consequences of healthcare cuts only underscore the importance of physician-led advocacy in ensuring that policy decisions consider patient impact.

Moving Forward

The CMA's Medical Group Advocacy Symposium demonstrated that effective healthcare advocacy requires multiple approaches: legal challenges, legislative engagement, economic analysis, and grassroots physician involvement. As federal policies continue to challenge California's healthcare values, the medical community must maintain its commitment to advocacy that protects patient access, preserves practice integrity, and ensures that healthcare policy serves healing rather than politics.

The path forward requires sustained engagement, strategic partnerships, and unwavering commitment to the principle that healthcare decisions should be made by patients and their physicians, not by distant bureaucrats or political interests. Through continued advocacy, California's medical community can protect the values that make quality healthcare possible.-||

Brian Grady, MD is an SFMMS past-president and a urologist with Sutter Health, Vice Chair, CMA - Organized Medical Staff Section, Board Member, CALPAC, member, CMA Council on Legislation and past Chief of Staff, Seton Medical Medical.

President's Message

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What we are witnessing is the institutional equivalent of delusional parasitosis, decisions based on fixed, unshakable false beliefs, enacted by someone in power, with no regard for contrary evidence. In the ER, I can manage such delusions with antipsychotic medications and psychiatric referrals. On the national stage, it's not so easy. There is no pill to counteract misinformation at scale. No injection can restore lost trust or resurrect a gutted health agency.

Ethically, Kennedy's actions violate multiple principles. They compromise beneficence by putting the public at greater risk. They violate non-maleficence by inflicting avoidable harm through the rollback of proven interventions. They trample justice by disproportionately harming vulnerable populations who rely on public health programs. And they betray the principle of fidelity: the promise that those entrusted with public power will act in good faith and uphold the public's welfare.

In the emergency room, we meet the consequences of failed public policy face to face. The child with a disease we thought was extinct. The parent afraid of vaccines because of misinformation. The psychotic patient convinced of a fantasy. All are reminders of how fragile the boundary between order and chaos can be.

The difference between clinical delusion and ideological delusion is that the former is usually confined to one person. The latter, when embraced by those in power, becomes policy, and policies built on denialism and distrust do not end in health or liberty, but in suffering.

We cannot afford to let ideology dismantle infrastructure. We cannot allow the rejection of science to become a political movement. And we must protect the systems that, however imperfect, have allowed Americans to live longer, healthier lives. Because unlike a vial of lint, the consequences of Kennedy's delusion are all too real.-||

Jason Nau, MD, is an emergency physician at Kaiser Permanente in San Rafael, CA, where he's been caring for his community for 26 years. A self-proclaimed serial hobbyist and amateur philosopher, he's driven by curiosity, always eager to explore new ideas, and unafraid to have his beliefs challenged—and occasionally overturned.

Policy Report

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- **SB 418 (Menjivar)** – This bill will prohibit health plans and insurers in California from discriminating against individuals based on race, color, national origin, age, disability, or sex. The bill will also prohibit health plans from actions like canceling, limiting, or refusing coverage, denying claims, or imposing extra costs based on protected characteristics. The bill also requires a health plan to cover up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy and the necessary supplies for self-administration.
- **SB 497 (Wiener)** – This bill will expand California shields law by prohibiting provider, health plans, and other entities from complying with out-of-state or federal subpoenas that require them to disclose medical records or information that would disclose person is seeking or undergoing gender-affirming care, including mental health services.

To learn more about state and local legislation, and how you can be involved, please consider joining the SFMMS Advocacy and Policy Committee: https://tinyurl.com/SFMMS-APC-||

Bringing back Juul is a bitter defeat for California — and the health of America's youth

THE TRUMP ADMINISTRATION IS USHERING IN GOOD TIMES FOR BIG TOBACCO

John Maa, MD and Steve Heilig, MPH

The public health battle against tobacco addiction and the suffering and death that result from smoking is now decades old. Thanks in part to the efforts by lawmakers and citizens of San Francisco and California to curtail tobacco use among younger people, the proportion of Americans who smoke has dropped by three-quarters since the 1950s. But Big Tobacco never gave up trying to find new ways to addict new smokers, especially young ones, and this summer they were handed a significant — and tragic — victory.

In July, the U.S. Food and Drug Administration authorized Juul's Virginia tobacco and menthol flavor pods with 3% and 5% nicotine concentration for sale as a new tobacco product. This is a huge step backward, and it's hard to understand the scientific rationale behind this decision because it will negatively impact the health of children.

San Franciscans should be proud of the role they played to stop Juul, an e-cigarette company once based in the city. Founded in 2015, Juul gained widespread popularity due to its variety of flavors, at one point becoming the leading e-cigarette brand on the market, leading tobacco giant Altria to make a $12.8 billion investment in the company.

Research soon showed that vaping was a path to nicotine addiction and tobacco smoking for youth. In 2017, to address rising youth addiction to e-cigarettes, then-San Francisco Mayor Ed Lee signed a ban on menthol cigarettes and flavored tobacco products. Marin County and several Bay Area cities followed suit. The following year, R.J. Reynolds unsuccessfully spent almost $13 million to overturn San Francisco's ban. In 2019, Juul spent $16 million on a second failed effort to rewrite vaping laws, which San Francisco voters overwhelmingly defeated.The city's supervisors, in coordination with the San Francisco Medical Society, led the fight to force Juul to stop selling its products without Food and Drug Administration authorization. Juul's products were subsequently banned in multiple countries, and the company neared bankruptcy, but not before millions of youth had become addicted to nicotine.

In 2020, Gov. Gavin Newsom signed Senate Bill 793 into law, expanding San Francisco's flavored tobacco products and menthol ban to the entire state. But the tobacco industry filed a statewide referendum that earned them two extra years to sell nearly $830 million in menthol cigarettes, while costing California $800 million in tobacco-related health care costs until that referendum was overwhelmingly defeated.

Juul struggled during this period. They settled nearly 10,000 lawsuits, paying over $3 billion to public entities, starting with $40 million to North Carolina in 2021, continuing with $462 million to multiple states in 2023, among many others. But the recent FDA decision has brought them back from the brink of extinction. Times are once again good for Big Tobacco. Global industry revenue estimates for 2025 are close to $1 trillion. A tobacco industry giant was the largest corporate donor to Trump's presidential campaign, and the return on investment has been strong. Susie Wiles, a former lobbyist who represented the tobacco industry, is now White House chief of staff, and much of the infrastructure for federal tobacco control has been dismantled following the firing of the Centers for Disease Control and Prevention staff at the Office on Smoking and Health. A previous Surgeon General's report on tobacco-related disparities was removed from the CDC website. On the campaign trail, Trump promised to "save vaping," and four days after his second inauguration, a proposed FDA rule to prohibit menthol cigarette sales was withdrawn by the White House.

The FDA's July ruling designated Juul's pods as a new tobacco product. The question of whether vaping unflavored products may help some smokers cut down or quit, as the makers of Juul assert, merits further research, the agency said.

As public health advocates, we understand targeted "harm reduction" as part of a comprehensive smoking cessation program, and are not prohibitionists. But making e-cigarettes available to smokers does not require allowing the mass marketing to youth. E-cigarettes are banned in 37 nations, while Australia requires that e-cigarettes be sold only in pharmacies.

A legal challenge to the FDA ruling is possible, and further scientific review of the health harm to young people could overturn the authorization. Legislators across America should take proactive action to end the sales and advertising of flavored

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PHYSICIANS FOR SOCIAL RESPONSIBILITY

SFMMS Interview: Robert Gould, MD

Steve Heilig, MPH

Pathologist Robert Gould, MD has long been interested in countering not only biological and clinical pathologies but also public health and political ones. As President of the long-time medical advocacy group Physicians for Social Responsibility, whose international affiliate was awarded a Nobel Peace Prize, he has long worked on anti-nuclear war and environmental health efforts via those organizations and also as a member of the CMA House of Delegates, often working closely with the SFMMS delegation as well.

Where did you grow up, go to undergrad and medical school and other training practice, teaching, and so on?

I grew up in the Bronx, close to Montefiore Hospital, where my family received healthcare through the Health Insurance Plan (HIP) available to working people. After Bronx High School of Science, I attended the State University of New York (SUNY) Buffalo, where I graduated with a BA in Chemistry. Back home to Alfred Einstein College of Medicine, and then I did a Pathology Residency at San Francisco Kaiser. Then until 2012 worked as a Pathologist at San Jose (Santa Teresa) Kaiser, whereby I joined the Santa Clara County Medical Association (SCCMA) in 1995. I remain very active in its Environmental Health Committee which has been a source of many important CMA resolutions adopted as policy addressing global warming and diverse public and environmental health issues, some of which informed "upstream" incorporation into AMA policies

In 2012 I joined the UCSF Program on Reproductive Health and the Environment where I continue as an Adjunct Assistant Professor. Through this role I've been able to engage with educational efforts among health professional students at UCSF and at UC Berkeley School of Public Health. This has included working with student and faculty leaders to develop elective courses covering diverse environmental and public health issues, including incorporation of the impacts of nuclear weapons and militarism.

This has connected with concurrent organizational roles. I was on the Board of National Physicians for Social Responsibility (PSR) from 1993 through 2022, serving as President in 2003 and 2014. I've also served as President of SF Bay PSR since 1989, and have been a long-time member of the International Physicians for the Prevention of Nuclear War (IPPNW), serving on the Board since 2017, currently North American regional Co-Vice President. Since 1986 I have been a leader of the Peace Caucus in Affiliation with the American Public Health Association (APHA), currently serving as co-Chairperson. Over four decades, the Peace Caucus has been instrumental in developing programs for annual meetings involving approximately 10,000 public health professionals, and policies adopted by APHA addressing health and environmental impacts posed by nuclear weapons, and militarism in general.

How did you first become an advocate/activist on health issues?

I grew up in a progressive family steeped in a commitment to social and economic justice. I had a very early understanding of the horrors of the Holocaust, including the death and suffering of many members of my own family in Eastern Europe, and with an early sensibility that the "Never Again" lesson was not specifically applicable to those of Jewish background, but to all human beings generally confronted through the centuries with unspeakable crimes and pogroms. This informed my involvement in the anti-Vietnam war movement in high school and college, opposition to Reagan-era brutal counter-insurgency wars, and through my current strong opposition to what I believe is horrific ongoing genocide in Gaza. When I was 12, viewing "Failsafe" and "Dr. Strangelove" strongly influenced my lifelong opposition to nuclear weapons, and underscored my subsequent activism.

Upon entering medical school in 1973, I had the privilege of attending the "Community Medicine" course led by Dr. Victor Sidel. Vic served as a dear friend and mentor to me in providing a model of prioritizing public health principles in the practice of medicine, and I worked with him closely in PSR and APHA Peace Caucus work. Vic, in his well-known lectures covering militarism and nuclear weapons issues to generations of medical and public health students, infused with a powerful social justice message, greatly influenced my own thinking and practice on broad public and environmental health issues throughout my life.

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How did you first get involved with PSR and on what main issues?

I had been acquainted with PSR's work through knowing the work of Vic Sidel and another co-founder Jack Geiger. I went to my first PSR National meeting in 1985, where I supported initiatives calling for connecting PSR's anti-nuclear work with the broader movement against militarism, agreeing with Dan Ellsberg that the dangers of nuclear war were greatly increased by "conventional" military confrontations involving nuclear superpowers. I still believe this remains a major concern in wars in Ukraine, Mideast, and growing geopolitical conflicts with China.

My commitment to abolishing nuclear weapons has remained a central aspect of my PSR work to date. In the early 1990's, PSR expanded its work to "existential" dangers posed by global warming and other profound environmental health threats. I also embraced this work, which has constituted much of my subsequent work within PSR. This has included work on "Green Team" sustainability issues in my tenure at Kaiser and UCSF, multiple PSR climate initiatives (electrification, etc.) over the decades, as well as educational/advocacy work in SCCMA/CMA.

You've long been part of the CMA House of Delegates - how did that start for you and what have been the main things keeping you involved there?

I became a delegate representing SCCMA starting in 1997, and worked to get CMA to pass a resolution to eliminate all weapons of mass destruction. This preceded later work in collaboration with Dr. Robert Lull, a past-president of the San Francisco Medical Society to develop a stronger nuclear abolition policy that was blocked by CMA leadership at multiple HOD meetings.

Through decades of close collaboration among colleagues in SCCMA, we've gotten many important environmental/public health policies passed since the late 1990s, many specifically supporting sustainability initiatives of Health Care Without Harm/Practice Green Health. These included reducing health facility generated pollution such as mercury, or dioxin from medical waste incineration, as well as promoting healthy food in hospitals, etc. Starting in this century we passed many resolutions addressing climate change and associated air and other pollution, that predated and anticipated more comprehensive climate policies adopted by CMA in 2021.

In the aggregate, these efforts supported primary prevention of disease and other threats to our patients and communities, and inspired similar activities over the last two decades, in other state medical associations and the AMA, and many health specialty societies represented within the Medical Society Consortium on Climate and Health. We now have a vibrant nationwide health professional movement for climate health and justice reflected by the strong turnout of health providers in opposition to the EPA plans for abandoning the "Endangerment Finding" that has provided the basis for strong climate-protective regulations and government actions.

Of course, our patients, particularly those who are poor or of communities of color who bear the brunt of the disease burden of accelerating climate change, are now subject to the massive cuts to Medicare, Medicaid and other supportive social programs heralded in the "Big Beautiful Budget Bill." Countering this, CMA has demonstrated extraordinary leadership in organizing our members to fight these cuts here in California and through national efforts, and I'm looking forward to our upcoming House of Delegates meeting to learn how we can move forward further in this direction most effectively, in tandem with ongoing oppositional work within our PSR network.

How else might busy clinicians become involved with such issues as part of their lives w/o becoming overwhelmed?

I think we need to do what we can to get involved, to speak up courageously at times like these. CMA has developed texting networks and the like to make it relatively easy for busy clinicians to plug-in and voice their defense of fundamental health programs, opposition to vaccine mandates now being threatened by RFK Jr. and his minions at HHS, etc. We at PSR provide background information, and related talking points to make it easier for busy health professionals to testify virtually at meetings of regulatory agencies such as the California Air Resources Board (CARB) or EPA to defend our communities most at risk from global warming and pollution of all sorts. At SF Bay PSR we have regular virtual meetings of our Environmental Health Committee bringing together wonderful health professionals representing many health systems and specialties throughout the SF Bay Area that's provided a very supportive space for supporting our collective engagement on these issues.

We're in a rough time of backlash, retrenchment and outright attack on medicine, public health, environmental health, research and more - how do you see the professions best resisting and reversing these assaults?

Thinking back to what my own family experienced in Europe, the bottom-line is we need to avail ourselves of every opportunity we have to use our credible voices as trusted health professionals to speak-out in the various public fora we still have available. At a minimum we can provide the scientific evidentiary base to strengthen current and future legal challenges to the wholesale dismantling of fundamental science and health programs we see going down. CMA, PSR and various coalitions-in-formation are providing us the community and tools to fight back, and we need to have the courage and fortitude to support the broader social movements that will be necessary to reverse the authoritarian threats to our basic liberties and possibilities for human survival.

Steve Heilig is an editor, ethicist, epidemiologist, environmentalist and educator based at the San Francisco Marin Medical Society, and co-editor of the Cambridge Quarterly of Healthcare Ethics.

SION ROY

John Maa, MD

Dr. Sion Roy, an Indian American physician and education advocate, has been endorsed by the California Medical Association (CMA) in his campaign for California State Senate District 24. The CMA highlighted Dr. Roy's dedication to public health and his extensive contributions to the medical and educational fields.

Dr. Roy is a cardiologist and Associate Professor of Medicine at Harbor-UCLA. He was born in Austin, Texas, earned his BA at Johns Hopkins University, and his MD at the Virginia Commonwealth University School of Medicine. He completed his Internal Medicine residency at Georgetown University Hospital and Cardiology Fellowship at Harbor UCLA, where he serves as the Associate Program Director of the Cardiology and Advanced Cardiac Imaging fellowships. He is a cardiologist at a public hospital serving South Los Angeles and is committed to strengthening the Medi-Cal system, which provides care for nearly half of California's children. He is the Past President of the Los Angeles County Medical Association, Past Chair of CALPAC, and a former member of the AMPAC Board.

Dr. Roy was the first major candidate to announce a run in the 2026 California State Senate race to succeed Sen. Ben Allen, who will term out in 2026.He has twice been elected to the Santa Monica College Board of Trustees, where he currently serves as the Vice-Chair. A Malibu resident, he draws on his personal experience with recent wildfires to guide his campaign. "Like so many other residents of Malibu and the surrounding communities, our family lost our home in the devastating Palisades fire. In Sacramento, I will fight to bring resources back to the district to help us quickly, safely, and affordably rebuild our communities."

Former Assemblymember Richard Bloom was among the first to endorse Dr. Roy. He stated "Sion Roy is an accomplished public servant. On the Santa Monica College Board he expanded educational opportunities, championed new programs, and worked with state legislators on behalf of SMC…I look forward to his leadership in Sacramento."

CMA President Dr. Shannon Udovic-Constant added "In both his professional and personal capacities, Dr. Sion Roy has been a tireless and passionate advocate for the health and well-being of his community. As a distinguished cardiologist, dedicated professor, and tireless public health champion, Dr. Roy's commitment to improving the lives of others is unparalleled, and his leadership has had a profound impact on countless individuals." You can follow Dr. Roy'scampaign at Instagram, Facebook, and Twitter/X.

The SFMMS PAC supported his campaign, which the CMA has identified as a top priority for 2026. I had the opportunity to first meet Dr. Roy through CALPAC and understand his vision through our mutual friend Dr. Lawrence Cheung, who highlighted Dr. Roy's success in fundraising and service on the AMPAC Board of Directors. Dr. Cheung identified Dr. Roy's eloquence, leadership, and career trajectory in government as a model for medical trainees and practicing physicians to emulate.

I was grateful for the opportunity to speak with Dr. Roy about his vision and goals:

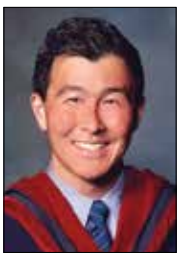
What legislation do you hope to pass your first year in the Senate?

In the first year in the Senate my focus will be to fight for resources in the state budget to stabilize our Medi-Cal safety net system, as federal policies have targeted our most vulnerable communities in California. I will work to help build a sustainable Medi-Cal system that California families can count on. The Palisades fire had a huge impact on our family personally, and also a huge part of the Senate district—our Communities will be rebuilding for the next few years. I will be pushing to bring resources back to our community that will allow us to rebuild safely, quickly, and affordably. These include focusing on fire risk mitigation tactics, supporting our firefighters, making fire-safe building more affordable, and insurance market stabilization.

What do you believe are the best responses to the Medi-Cal challenges at the state and federal level?

Our healthcare system is broken in so many ways, and I think it's critical that physicians and healthcare workers familiar with day-to-day healthcare delivery lead the effort to build a system where all Californians have access to quality healthcare. This election cycle, we will lose our only two physicians in the state Assembly—Dr. Arambula is termed out, and Dr. Bains will be running for Congress to fight for Medicaid funding at the Federal level. That will leave Senator Dr. Weber as the only physician legislator. As the only physician running for State Legislature this cycle, I hope to join her with the help of your members so that we can lead based on our backgrounds as clinicians spending our careers directly taking care of patients.

The SFMMS PAC strongly encourages SFMMS members to support Dr. Roy's campaign. If you are interested in making a contribution or volunteering, more information is available at: *https://drsionroyforsenate.com/?fbclid=PAZXh0bgNhZW0CMTEAAadMrzQpnx1x53ACTuixHOkgEDK77aqxB2y7sigTFy8Wqedd3NHPh6tXRy5JUA_aem_cNt0_T2GytLQlQ-XYr0pmg-*



John Maa, MD, an SFMMS past-President, serves on the board of directors of the American Heart Association Western States Affiliate. He was appointed by Governor Gavin Newsom to the California Tobacco Education and Research Oversight Committee and serves ex-officio on the University of California Office of the President Tobacco Related Disease Research Program.

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OPERATION ACCESS

REFERRAL PROCESS

1 SEND REFERRAL TO OPERATION ACCESS

Filling out our referral form is now **optional but recommended** to ensure we have a complete referral. If more convenient, send referral via fax or email through your Electronic Health Records system along with a patient demographics page.

- Include specific procedure requested and referral coordinator information.
- Attach relevant chart notes—including the medical need for the procedure.
- Include radiology reports (e.g. ultrasound, CT scan, X-Rays), lab results, or other necessary items indicated on the referral guidelines.

2 OPERATION ACCESS SCREENS THE PATIENT

We contact the patient to screen for eligibility by phone. Patients are generally contacted within 10 days of referral receipt. An appointment will not be scheduled in this call.

3 ELIGIBLE PATIENTS

We send a text to eligible patients to explain the program and outline the process. The referring clinic is notified of the eligibility status of all referrals in the semi-monthly Referral Status Notification, requesting action on incomplete and unreachable referrals.

***Eligibility**: Uninsured and not covered by Medi-Cal, Medicare, and Workers Comp; Earn up to 400% of FPL; In need of outpatient procedure but not ongoing care.

4 WAIT TIMES

Eligible patients are scheduled with a participating specialist. Most referrals can be sent to a specialist within 1 month. The average wait from referral to appointment is 1-3 months.

5 SCHEDULING AN APPOINTMENT

- When a specialist is available, an Operation Access case manager contacts the patient to confirm the appointment.
  - Our case managers try to coordinate appointments close to where the patient resides, but patients may need to travel to a specialist in another county.
- We notify clinics when cases are completed and provide information about the outcomes, where the patient was served, and how to obtain the medical records

Send referrals by fax to (415) 733-0019 or by email to referrals@operationaccess.org.
Call us with any questions at (415) 733-0052 or visit www.operationaccess.org.
Direct address (within EMRs): operationaccess@direct.sacvalleymedshare.org

Welcome to our collection of articles from leaders in the field of children's environmental health. From the latest science on chemicals and autism risk to policy recommendations for protecting children from harmful toxicants, this compilation captures the urgency of the task before us.

As these pieces show, practical solutions are within reach if we choose to pursue them.

We can provide pediatric oncologists with information on environmental drivers of childhood cancer. We can train health care providers about the dangers of hormone disrupting ingredients in personal care products — especially during pregnancy and early childhood. And we can adopt "unflashy but high-return" population-wide strategies like enforcing clean air rules, banning pesticides that harm children's developing brains, and incorporating environmental health training into medical school programs.

We can also celebrate progress as we go. This October marks the 10th anniversary of Children's Environmental Day, a national day of action organized by the Children's Environmental Health Network (CEHN) to lift up success stories and call for continued action to protect future generations. As CEHN's director Nsedu Obot Witherspoon notes:

"Now more than ever, we need child health champions to stand up, have courage, and raise their voice. If not us, then who?"

Kristin Schafer, Director
Collaborative for Health & Environment

Kristin Schafer, MA has been working in the environmental health field for over three decades, including at US EPA, World Resources Institute, and Pesticide Action Network. She holds a Masters in Social Change and Development from Johns Hopkins University School of Advanced International Studies. In 2021 she received the national Child Health Policy Award.

RETHINKING AUTISM'S ORIGINS: BEYOND THE GENOME

Bruce Lanphear, MD, MPH

We've been searching for triggers of autism with a microscope; we need a wider lens.

The rise of autism has sent scientists deep into the genome, searching for answers in DNA sequence. Yet the harder they look, the clearer it becomes that the answer isn't hidden in the genome. Rare mutations account for only a fraction of cases, and the common variants we keep cataloging are—by definition—common. If they alone dictated destiny, nearly everyone would meet the diagnostic checklist. Something outside the genome is nudging children's brains off course.

That "something" is not a single villain but a web of factors. Prenatal air pollution impairs the fetal brain; organophosphate pesticides sabotage synapse formation; and phthalates disrupt hormones just when they should choreograph growth. Combine pesticide exposure with inadequate folate, Bisphenol A with the aromatase gene, or air pollution and the MET gene, and risk increases substantially. These findings don't cancel genetics; they reveal its contingency.

We have been slow to accept this because toxic chemicals and pollutants are messy and political. Genes are tidy: you can sequence them in a lab and implicate no one. Pollution points to factories, zoning laws, and weak regulation. That invites accountability. Yet evidence is evidence: children downwind of highways or born near pesticide-treated fields reveal dose-related increases in autistic traits. By contrast, folic-acid supplementation—cheap, safe, and proven—cuts risk for some children.

The pattern echoes an older story. Lead once lurked in paint and gasoline. Industry insisted low doses were harmless until researchers widened the frame—tracking IQ, attention, and crime. We phased lead out, and children's blood levels plummeted. Autism research stands at a similar crossroads: cling to genetic determinism or chart the exposome—the sum of lifetime environmental exposures—and act on what we learn.

Action doesn't demand certainty. We already know how to reduce exposures: enforce clean-air rules, ban neurotoxic pesticides, replace hormone-disrupting plastics, and fortify diets with folate. These are population strategies—unflashy but high-return—like the sanitation and vaccination drives that once tamed infectious killers.

Across autism, ADHD, and learning disorders, studies converge on a core insight: brain development lies on a spectrum shaped by many influences—genetic coding, nutrient supply, and an ever-changing mix of environmental chemicals. Some exposures adjust the melody; others throw the orchestra out of tune. When the discord grows, a child's developmental path can shift in ways we are only beginning to map. What we do know is that toxic chemicals and synthetic chemicals exert a powerful pull on that trajectory. Understanding this interplay is no longer optional; it is central to preventing disability and promoting lifelong health.

Contact the author for references at blanphear@sfu.ca

Bruce Lanphear, MD, MPH, is a preventive medicine physician and professor at Simon Fraser University in Vancouver. For over 30 years, he's studied how toxic chemicals—like lead, fluoride, and pesticides—impact human health, especially children. To reach a wider audience, Bruce launched Little Things Matter, *and shares the stories behind the science on his Substack platform.*

AUTISM SPECTRUM DISORDER: ENVIRONMENTAL FACTORS AND EMERGING RESEARCH METHODOLOGIES

Anne-Louise Ponsonby, PhD

Recent data from the Centers for Disease Control and Prevention confirms that autism diagnoses in this country are on the rise. We should not assume that these increasing rates reflect only changes in diagnostic criteria and improved detection.

Current scientific evidence supports that autism is fundamentally a multifactorial disorder. We and others in the field are moving to studying multiple genetic and environmental factors and how they may act in concert. Research consistently demonstrates that environmental factors influence individual autism onset and severity risk. Manufactured chemicals could contribute to autism etiology via multiple mechanisms (PMID: 32479765, 39418383).

Aspects of the modern environment require serious consideration in autism research. One critical area is the increasing exposure to manufactured plastic chemicals (PMID 39183960). Plastics are the most utilised manufactured material in daily life; global production (460 M metric tons in 2019) is projected to triple by 2060. A range of chemicals including plastic additives (e.g. bisphenols, phthalates) should be investigated, not only a focus on microplastics. There is no precautionary principle; plastics are assumed safe unless proven otherwise.

Our work published in *Nature Communications* in 2024 demonstrated that prenatal exposure to bisphenol A (BPA) is associated with autism risk in boys through a mechanism involving aromatase suppression (PMID: 39112449). Boys with low aromatase activity and high prenatal BPA exposure were six times more likely to receive an autism diagnosis by age 11 years. This research revealed that BPA suppresses the aromatase enzyme and is associated with anatomical, neurological, and behavioral changes in male mice consistent with autism. This represents the first identification of a specific biological pathway that might explain the connection between autism and BPA exposure (PMID: 39112449).

Environmental factors such as BPA rarely act in isolation. There is growing recognition that prenatal exposure to neurotoxic mixtures of environmental chemicals—including endocrine disruptors (e.g. bisphenols, phthalates), pharmaceuticals, pesticides, and food additives—may contribute to neurodevelopmental outcomes such as autism. Yet chemical mixtures have rarely been investigated in autism.

Chemical co-exposures through shared pathways can contribute to cumulative chemical effects. However, current exposure science has been constrained by targeted approaches. This limited scope fails to reflect the complexity of real-world exposures: >4,600 chemicals with high production volume (>1,000 tons/yr). A key technical advance is that we can now accurately quantify low-abundance environmental chemicals in human serum.

Research demonstrates significant synergistic interactions between commonly used chemicals, with combinations showing greater neurotoxicity than individual substances alone. A 2024 Science report found that almost all pregnant women have multiple chemicals detectable in their blood, with 90% having more than 38 chemicals, including many with known neurotoxic effects (PMID: 39418383). The top-ranked chemical for inducing cellular neurotoxic effects was a food additive, demonstrating the value of comprehensive untargeted toxicological approaches.

New machine learning techniques are revolutionizing our capacity to comprehensively measure and understand complex pathways and mechanisms underlying autism development and the multifactorial nature of autism. The convergence of epidemiological evidence, mechanistic research, and advanced computational approaches is opening new frontiers in autism research, providing hope for both improved outcomes for individuals with autism and prevention strategies.

Dr. Anne-Louise Ponsonby is an epidemiologist and public health physician. She has extensive experience in the design, conduct, and analysis of population-based studies, and public health translation. Ponsonby has 427 publications, has contributed to three patents, and is on the research committee for the International Paediatric Multiple Sclerosis Study Group.

CHILDHOOD CANCER AND THE ENVIRONMENT: OPPORTUNITIES FOR PREVENTION

Mark Miller, MD, MPH and Maria Valenti

When children are diagnosed with cancer, parents often ask their doctors, "Did the environment have something to do with it?"

The Childhood Cancer & the Environment Project (CCEP) of the Pediatric Environmental Health Specialty Units (PEHSU) Network, led by the Western States PEHSU, has been helping pediatric health care providers and caregivers answer this and similar questions for three years.

Research in the last 25 years has greatly expanded our understanding of environmental risk factors for childhood cancer. Exposures before and during pregnancy and in early childhood to pesticides, tobacco, air pollution, and solvents have been found to increase the risk of childhood cancers. In Shakeel et al., the authors determine that environmental exposures to air pollutants and tobacco smoke can also negatively affect the survival of childhood cancer patients.[1]

We also know more about protective factors. Evidence shows that both attending a large daycare and early exposure to animals help protect children from developing childhood cancers. Why? Researchers believe the answer is in the modulation and calming of the immune system as it reacts to early, common infections in childhood.

Surveyed clinicians report that although they regularly get questions about environmental exposures, they have little or no training about this (only 6% said that they had been trained to take an environmental history). They are uncomfortable answering questions, want to know more, and want clear action items that they can implement. For example, learning how to provide guidance on the use of the air quality index and home air filtration helps clinicians translate research on air pollution and respiratory illnesses in childhood cancer survivors into daily practice.

The CCEP is working with pediatric oncologists at two major childhood cancer centers to develop environmental health consulting services within their programs. Surveys at these institutions indicate broad support for these programs.

We have developed a suite of innovative educational materials and conducted a range of in-person and virtual events for many audiences, from health care professionals to *promotores de salud*. Three months after in-person workshops were held for pediatric oncology providers, 86% said their perceptions regarding environmental risks and childhood cancer changed due to the workshop, and 80% said they had made changes to their clinical practice.

One attendee said, "For newly diagnosed patients, I do a more thorough history to look for environmental exposures and possible correlations between patients in similar areas."

Community workers are a vital audience. New materials for them include a "flip book" to use with families. We also partnered with others to organize *Childhood Cancer Prevention Symposia* in 2024 and 2025 to bring together scientists, families, media, and the public.

For More Information: The *Childhood Cancer & the Environment* web page has a wealth of free materials, including a free Continuing Education course for health professionals offered by the CDC (*A Story of Health*). You can also sign up there for our free bimonthly newsletter.

Dr. Mark Miller, MD, MPH is an Associate Clinical Professor in the Division of Occupational and Environmental Medicine at the University of California San Francisco. He is also the Director Emeritus of the Western States Pediatric Environmental Health Specialty Unit and the past director of the Children's Environmental Health Center at California's Environmental Protection Agency.

Maria Valenti has been an environmental health education leader for over three decades. She has co-authored several environmental health publications including Story of Health, Generations at Risk: Reproductive Health & the Environment, *and* In Harm's Way*:* Toxic Threats to Child Development*. She consults with the Western States Pediatric Environmental Health Specialty Unit on the Childhood Cancer & the Environment project.*

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1. Shakeel O, Wood NM, Thompson HM, Scheurer ME, Miller MD. Environmental Exposures Increase Health Risks in Childhood Cancer Survivors. Cancers. 2025; 17(13):2223. https://www.mdpi.com/2072-6694/17/13/2223

NOT SKIN DEEP: CHILDREN'S HEALTH & CHEMICALS OF CONCERN IN PERSONAL CARE PRODUCTS

Marissa Chan, PhD

In the United States (US) only 11 ingredients are banned or restricted from use in personal care products. In comparison, more than 2,500 are banned or restricted in the European Union and more than 500 in Canada.

This underregulated marketplace allows for chemicals of concern to be in products that individuals use every day. These chemicals include carcinogens and endocrine disrupting chemicals (EDCs) that can interfere with the body's hormone system. These exposures can have consequences for fetal development and harm the health of both children and adults.

Exposure to EDCs in personal care products is inequitably distributed in the US. Studies have found higher exposure to phthalate metabolites and parabens among individuals of color, notably Black populations. These inequities in exposure may be driven by differences in personal care product use patterns—specifically hair products, including certain leave-in products (hair gels, oils, pomades) and chemical hair relaxers. These products are disproportionately marketed to and used by Black consumers compared to other racial/ethnic groups.

Importantly, exposure to EDCs and use of hair products have been linked with a variety of adverse health outcomes, including birth outcomes (e.g., low birth weight, preterm birth) and children's health (e.g., precocious puberty, obesity, allergies and asthma, and neurodevelopment).

Personal care product use is driven by a complex combination of factors at multiple levels. While research has previously considered personal care product use an individual-level behavior, scientists are now considering upstream factors including structural and neighborhood/community-level drivers of product purchasing and use patterns. For example, my previous work in Boston, MA reported differences in access to safer hair products between sociodemographically distinct neighborhoods—highlighting how where one lives can influence product use patterns.[1]

While understanding drivers of inequities in EDC exposure is important, we already know who is most impacted. It's now time to focus on interventions and solutions. Pregnancy and childhood are sensitive windows of development, so healthcare professionals working with these populations can play an important role educating their patients about EDCs in personal care products and how to reduce exposure.[2]

For patients:

- Avoid products with any synthetic fragrance.
- Avoid essential oils that have known endocrine disrupting properties (tea tree and lavender).
- Use publicly available consumer databases and apps to shop safer (Environmental Working Group's Skin Deep database, Clearya, Campaign for Safe Cosmetics' Non-Toxic Black Beauty Product Database, Silent Spring's Detox Me app)

For healthcare providers:

- Seek out resources and education to increase your knowledge about EDCs in personal care products.
- Share information with your patients on how they can protect themselves from toxic chemicals in personal care products.
- Advocate for environmental health training in medical school and continuing education credits.

The recommendations noted above are rooted in individual-level behavior change. Individuals can take steps to make a difference, but solutions at the business and policy level are also essential to address upstream barriers to safer hair product purchasing and use. A multi-level approach to solutions will be necessary to ensure access to safer personal care products for everyone.

Marissa Chan, PhD is a Research Scientist at Columbia University Mailman School of Public Health. Her research interests focus on the intersection of place-based environmental hazards and product-based exposure to endocrine disrupting chemicals (EDCs) in personal care products. She received her MS and PhD from Harvard T.H. Chan School of Public Health.

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RECONSIDERING CHILDREN'S HEALTH POLICY

Ken Geiser, PhD

There is a crisis in children's health in the United States. While rates of disability and death due to cardiovascular disease, stroke, and many cancers among adults have been decreasing over the past half century, the incidence of serious pediatric diseases has been increasing. A recent paper published in the *New England Journal of Medicine* and written by a diverse selection of science and policy experts — including myself — reviewed the evidence.

Over the past 50 years the incidence of childhood cancer has increased by 35 percent. The prevalence of pediatric asthma has tripled, while childhood obesity has nearly quadrupled and trends in type 2 diabetes have shown a sharp increase. The frequency of reproductive birth defects in boys has doubled. One in six children now show neurodevelopmental disorders and one in 36 are now diagnosed with autism spectrum disorders. Such trends should be of national concern; these non-communicable diseases cause the nation's largest share of childhood illness and deaths.[1]

A growing body of clinical and epidemiological research has linked these health conditions with exposure to a broad array of manufactured synthetic chemicals, including heavy metals, halogenated hydrocarbons, and plastic additives. Many of these chemicals are recognized as carcinogens, mutagens, neurotoxicants, endocrine disrupters, and substances hazardous to reproduction. Many others are simply untested.

Hazardous chemicals are now ubiquitous in the global environment. Children everywhere today grow up in a world contaminated with low levels of these chemicals.[2] Even children privileged to live in high income communities often breathe polluted air, drink water with limited health standards, eat untested foods, and play with consumer products assumed to be safe simply because they are on the market. Children in lower income communities and economically developing countries are at even greater risk.

A precautious children's health policy would strive to reduce or eliminate the use of these hazardous chemicals across the economy. Past experience in reducing the use of harmful chemicals in occupational settings, in gasoline, in schools, and in consumer products has demonstrated measurable effectiveness in reducing specific health effects.

The paper was written in 2024 to call national attention to the chemical threats to children's health. It reviews the relevant pediatric health science and then moves on to critically assess the inadequate federal laws and regulations regarding hazardous chemicals. It closes with a set of ambitious recommendations including new laws, a new international chemical treaty, increased corporate responsibilities for public transparency, and the transition of the chemical manufacturing industry to safer chemistries. The paper was published in January of 2025 and widely covered in the national media.

January 2025 also marked the inauguration of a new federal administration. In the months since, much has changed in federal policy. Wide swaths of federal environmental regulations have been waived or weakened, agency staff have been cut, on-going safety programs have been terminated, and budgets for health and environmental research have been eliminated.

Instead, the administration is focused on voluntary agreements with industries and negotiated deals with food companies. These initiatives are not insignificant, but they do not reflect the ambitious, science-based policy recommendations laid out in our paper.

Ken Geiser is Professor Emeritus of Work Environment and Distinguished University Professor at the University of Massachusetts Lowell. One of the authors of the Massachusetts Toxics Use Reduction Act, he was Director of the Massachusetts Toxics Use Reduction Institute for thirteen years. As founder and past Codirector of the Lowell Center for Sustainable Production, he is also the author of Materials Matter: Toward a Sustainable Materials Policy *and* Chemicals without Harm: Policies for a Sustainable World.

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OUR CHILDREN ARE NOT OK

Nsedu Obot Witherspoon, MPH

Ten years ago the Children's Environmental Health Network (CEHN), a national non-profit with the mission to protect all children from environmental hazards, launched Children's Environmental Health Day (CEH Day). This is a day of action for and with our youth on the second Thursday of every October, which is Child Health Month.

CEHN and partners network, engage, and share resources, tools, and best practices, while lifting our collective voices among elected officials and influencers around various protections that are still necessary for current and future generations to thrive. As of 2025, there are officially over 200 CEH Day partners, and the number continues to grow.

Awareness is growing among the general public on the impacts environmental exposures have on public health. Between 1999 and 2021, the percentage of children in the U.S. living in areas with pollutant concentrations above national standards decreased, as did the number of days with unhealthy air quality.

However, the percentage of children served by community drinking water systems with monitoring and reporting violations has fluctuated during this period. And for children ages 6-10, higher median levels of phthalate metabolites were found in their urine between 2015-2018.[1]

When it comes to chronic child health outcomes, childhood asthma rates increased to 9.4% and then decreased to 6.5% in 2021. Disparities in childhood asthma rates continue, with Black children at 12.3% in 2021 compared to White children at 5.6%. Childhood cancer incidence, learning disabilities, and obesity rates continue to rise. Environmental exposures are linked to 25-40% of these negative health outcomes.

While infant mortality rates overall have declined, a concerning and persistent disparity exists with Black infants dying at a rate of 10.8 per 1,000 live births.[2]

Climate change is increasingly exacerbating air, water, and soil pollution while contributing to physical and mental health concerns, especially among children. Increased wildfires contribute to air pollution, increasing respiratory illness. Increased flooding and extreme storms are contributing to contamination of waterways. The rising heat index is contributing to dehydration, increased allergies, and heat stroke.

The Trump Administration's proposed rollbacks on vehicle emission standards, deregulation of coal burning power plants, and EPA's overall mission to protect the public's health add additional stress and challenges for all communities, particularly those most marginalized and disinvested in.

The stakes could not be higher for the health, safety, and well-being of all children. The lessons from decades of peer-reviewed science and lived experiences demand a much different sense of urgency. During this 10th Anniversary of Children's Environmental Health Day, CEHN's Call to Action is for community, business, public health, health professional, youth, and science leaders to engage and work with elected officials and influential leaders to ensure that the health and well-being of all children is at the core of all policy making. We invite all to utilize the resources, toolkits, and technical assistance available through all CEH Day partners that position the needs of children first.

Now more than ever, we need child health champions to stand up, have courage, and raise their voice. If not us, then who?

Nsedu Obot Witherspoon, MPH, serves as Executive Director for the Children's Environmental Health Network (CEHN). She serves on the External Science Board for the Environmental Influences on Child Health Outcomes (ECHO) NIH Research work. She is a Co-Leader for the Health/Science initiative of the Cancer Free Economy Network. For the past 25 years, she has served as a key spokesperson for children's vulnerabilities and the need for their protection, conducting presentations and lectures across the country.

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Editors' note: The brief articles in this special section come from esteemed members of the Collaborative for Healthcare & Environment (CHE), a network founded at the SFMMS, UCSF, and Commonweal in Marin in 2002. For more see: https://www.healthandenvironment.org/

GOVERNMENT POLICY CHANGES 2025 AND BEYOND: HOW WILL THIS AFFECT MDS AND MANAGERS?

Debra Phairas

The healthcare landscape in 2025 and beyond is being reshaped by sweeping policy changes, political turmoil, and corporate consolidation. Physicians and practice managers face mounting challenges as government actions, market forces, and public trust issues converge.

Political and Regulatory Shifts

The appointment of Robert F. Kennedy Jr. as Secretary of Health and Human Services has sparked nationwide controversy. His clashes with the CDC, warnings about liability for physicians who deviate from official vaccine guidance, and the dismissal of expert advisory panels have created uncertainty around vaccine policy. Several major medical associations—including the American Academy of Pediatrics, The American College of Physicians and the Infectious Diseases Society of America—are suing HHS over actions they say undermine vaccine safety.

Simultaneously, the president signed into law major Medicaid reforms that could see up to 13.7 million people lose coverage by 2034. Rural and underserved communities are expected to suffer the most, with reduced access to essential care. Hospitals warn of service cutbacks, staff reductions, and potential closures if uncompensated care rises.

Medicare faces ongoing payment disputes and reductions in reimbursement. While a modest 2.25% increase is planned for 2026, cuts in other areas continue to threaten physician reimbursements. CMS, under new leadership, is tightening oversight on Medicare Advantage plans while delaying decisions on GLP-1 weight-loss drugs and AI regulation.

Corporate Expansion and Market Pressures

The rise of payer-owned and corporate-operated practices is accelerating. UnitedHealth's Optum now employs or affiliates with nearly 90,000 physicians—10% of the U.S. workforce. Payer-owned practices provided nearly 6% of Medicare Advantage primary care services in 2023, a number expected to grow. While this promises efficiency and access, it raises concerns about physician autonomy, patient care quality, and aggressive billing practices such as upcoding.

Private equity (PE) firms continue acquiring physician groups, driving workforce turnover but often leaving practices saddled with debt. Critics argue PE involvement increases patient costs and reduces quality, while states like California and Minnesota are advancing legislation to restrict non-clinical ownership of medical practices.

The tide may be turning however as I, and many of my practice management colleagues nationwide, are assisting physicians to start new private practices.

Patient Trust, Safety, and Misinformation

Doctors increasingly battle misinformation from social media. Patients are proudly presenting anti-vaccination videos with their babies and children on social media such as TikTok, Instagram and Facebook. Nearly two-thirds of physicians report that online misinformation complicates patient care, leading to longer visits, impacts physician productivity, reducing revenue and strained trust.[1] Effective strategies include empathetic listening, plain-language communication, sharing reputable resources, and using the "teach-back" method to confirm patient understanding. Physicians are speaking out on social media to correct this misinformation and present evidence-based, scientific medicine. I compliment every physician I see on these media and thank them for educating patients.

It is recommended to include patient resources on your website and handouts such as:

- Mayo Clinic
- MedlinePlus
- American Cancer Society (ACS)
- American Heart Association (AHA)
- American Medical Association – YouTube videos
- Your medical specialty specific organization information

Immigration and Legal Concerns

Healthcare facilities face new legal challenges following policy reversals that allow ICE operations in medical settings. Clinics are advised to:

- Designate a point of contact for ICE agents.
- Require valid judicial warrants before disclosing information.
- Protect patient privacy by avoiding unnecessary immigration status documentation.
- Inform patients of their right to remain silent and offer support to contact legal aid if needed.

- Contact legal counsel immediately when uncertain.
- Record details of the ICE visit, including the names and badge numbers of agents, the time, and any warrants presented.

Technology and AI in Healthcare

Artificial intelligence is rapidly being integrated into practice operations. A recent AMA survey found 38% of physicians already use AI, primarily for documentation and care planning. Successful adoption requires designating an "AI champion," testing one use case at a time, provide staff education on using AI, and educating patients about the role of AI to maintain trust.

Virtual assistants, AI scribes, and automated scheduling are becoming essential tools to improve efficiency and reduce administrative burdens. It is imperative to educate patients on how to use these tools.

Key Takeaways for Physicians and Managers

- Stay compliant: Keep up with OSHA, HIPAA, and Medicare regulations.
- Prepare for policy impacts: Medicaid cuts, Medicare adjustments, and payer dominance will affect revenue streams.
- Support patients: Combat misinformation with empathy and evidence-based resources.
- Safeguard privacy: Have clear policies for responding to ICE and legal challenges.
- Leverage technology: AI, virtual care, and automation can improve efficiency when adopted thoughtfully.
- Monitor corporate influence: Understand the implications of payer-owned and PE-backed practices on independence and care quality.

Conclusion

2025 has brought unprecedented uncertainty to U.S. healthcare. Physicians and managers must balance patient care with policy shifts, corporate consolidation, and new technologies. By staying informed, advocating for evidence-based medicine, and maintaining patient trust, healthcare leaders can navigate these challenges while protecting both patients and practice sustainability.

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WELLNESS IN ACTION

Jessie Mahoney, MD

Over the past five years, I've had the privilege of helping shape our SFMMS wellness and member engagement work—both in conversations on these pages and in shared experiences out in the world. Wellness, as I've come to see it, is not simply a program, an initiative, or a feel-good event. It is a living culture we create together—one that is built, moment by moment, in how we lead, how we work, and how we care for one another. This summer, that culture came alive in three ways: a rejuvenating hike through the Marin Headlands; a Women in Medicine luncheon; and an afternoon at an art gallery. These gatherings were intentional spaces to restore, inspire, and strengthen our capacity to care.

In this issue, I'm honored to share three articles that speak to the deeper work of physician wellness:

The Science of Burnout explores what actually works—evidence-based, structural, and cultural solutions that go far beyond surface fixes.

The Missing Link in Physician Wellness highlights the essential role of leadership that heals and models sustainable ways of working.

Medicalizing Burnout Misses the Point challenges us to resist turning wellness into yet another metric, and to instead commit to authentic cultural healing.

I invite you to see wellness not as one more box to check or party to attend but as a shared responsibility—an active, evolving practice that belongs to all of us. The evidence is clear: meaningful change is possible when we combine structural reform, personal responsibility, and cultural evolution. Our SFMMS wellness efforts will continue to create space for connection, growth, and joy—and, perhaps most importantly, to offer opportunities for each of us to step forward as leaders in this essential work.

The Science of Burnout: Physician wellness isn't a mystery—it's a matter of enacting the evidence.

Recently a local emergency physician preparing a talk on wellness asked me for help. She knew I had been working on physician wellness for two decades. She wanted to know what actually works—what is rooted in evidence, not simply what is available, convenient, or appealing. This was what I shared with her:

Structural Solutions, Not Surface Fixes

The most powerful remedies for burnout are structural, not personal. Systemic change is not a luxury; it is the evidence-based intervention we continue to delay. Reasonable patient volumes, thoughtful schedules, responsive and compassionate leadership, and reduced clerical burden are not extravagant wishes. Financial constraints, staffing shortages, and political pressures are often cited as reasons for postponing meaningful reform. In truth, they are reasons to move faster. The longer we delay, the more costly—in human and financial terms—the problem becomes. The resilience of the medical workforce is already stretched to its limits. Addressing the structural drivers of burnout is not just the right thing to do; it is the most pragmatic way to ensure the viability of our health systems. Wellness activities such as yoga classes or gratitude initiatives can offer moments of respite. They have value in the right context, but without supportive structures, their impact is limited. Sustainable change requires addressing the environment in which physicians work, not just the symptoms of that environment.

The Overlooked Role of Lifestyle Medicine

There is another essential layer: lifestyle medicine. We know that sleep, movement, nutrition, mindfulness, and meaningful connection are fundamental to optimal brain function, sound decision-making, and long-term health. We prescribe these with conviction to our patients, yet in the culture of medicine they are often treated as optional for physicians themselves.

A profession that demands peak performance under high stakes should be the first to ensure its members have the physiological foundation for that performance. Chronic sleep deprivation, physical stagnation, and professional isolation undermine not only physician well-being but also patient care.

Mindfulness and Coaching: Proven and Underutilized

Mindfulness and coaching are often seen as "extras," yet both have been validated in randomized controlled trials as effective interventions for reducing burnout, strengthening purpose, and improving quality of life. They are not fringe tools—they are practical, evidence-based strategies that help physicians align decisions with values, set healthy boundaries, and maintain clarity under pressure. When physicians shift away from patterns of self-sacrifice, toxic independence, and over-responsibility, the culture begins to shift as well.

Cultural change is not a secondary benefit—it is as essential as system reform. A culture that values presence, compassion, and shared responsibility makes structural solutions more effective and sustainable. In my experience, a blend of mindfulness and coaching is the most effective way to create and sustain healthy personal and culture change.

Moving Beyond Optics

What does not work is mistaking optics for impact. Wellness dashboards, one-off retreats, and symbolic gestures may signal awareness, but they do not change the lived reality of medical practice. Nor should we "medicalize" burnout, treating it solely as an individual condition rather than recognizing it as a collective cultural distress signal.

A Layered Approach to Sustainable Wellness

Sustainable wellness requires three interdependent commitments:

1. Institutional accountability – Building systems that make wellness possible.

2. Personal responsibility – Engaging in practices that sustain our own health and capacity.
3. Cultural evolution – Creating professional norms that respect human limits and value connection.

Physician burnout is not a crisis of knowledge—it is a crisis of action.

External challenges—financial pressures, political headwinds, staffing constraints—should be catalysts for institutional change, not obstacles. The greater the pressure, the more urgent the need for structural change and cultural renewal. Institutions may not move quickly, but that does not mean we as physicians are powerless. Personal development and shifted mindsets and expectations are critical first steps. The evidence is clear, and the opportunity before us is real.

By choosing to act—together—we can create a future where the practice of medicine is sustainable, meaningful, and deeply human.

The Missing Link in Physician Wellness: Leadership That Heals

Leadership is the most overlooked factor in physician wellness—and the most powerful lever for change. Intentional heart-centered leaders who are committed to healing are needed to actively heal the culture of medicine, sustain those who care, and create a future where the practice of medicine remains meaningful and human. The culture of medicine is shaped in quiet ways—the way meetings begin, the pauses before responses, even the energy transmitted in emails sent and received. These seemingly small moments ripple outward, setting the tone for entire teams, influencing what is spoken and what remains unsaid, and defining what feels possible and what feels unsafe.

The culture of medicine is not an abstract force. It is built moment by moment, including—and perhaps especially—in silences. Every decision, every glance, every unspoken expectation from our leaders shapes the emotional climate of our institutions and of medicine as a whole.

In the ongoing search for solutions to burnout, leadership remains the missing link—the most powerful lever for change, yet one we too often overlook.

For years, we have offered physicians wellness apps, burnout surveys, conferences, lunchtime yoga, and holiday gatherings. We have created wellness dashboards and appointed chief wellness officers to analyze the data. While these efforts have value, they miss a key truth—physician wellness rises and falls with the way we are led and the way we lead.

I first spoke about "leading with a lens to wellness" in 2018. In the years since, our understanding of burnout has grown, but our leadership culture has evolved much more slowly.
Until leaders make decisions with the human well-being of caregivers at the center, little will change.

This shift is not complex, but it does require training—and often retraining—our leaders to attend to the health and human needs of physicians. Financial pressures, staffing shortages, and political headwinds are sometimes used to justify delaying this shift. In reality, they are reasons to accelerate it. When resources are stretched, the quality of leadership becomes even more critical to maintaining morale, engagement, and retention.

Leadership That Heals

Change happens when leaders ask whether a new policy will nourish or deplete their teams. It happens when schedules are designed to allow for restoration rather than erosion, when meetings run with intention and respect for time, and when concerns are met with curiosity instead of defensiveness. Change happens when leaders model boundaries and rest, acknowledge their human limits, and invite others to do the same. It happens when mindful communication, compassion, patience, and presence are recognized as essential leadership competencies—not "soft skills." The health of physicians must matter as much as the health of patients if we are to create a sustainable, high-quality system.

Investing in Leaders Who Lead Well

Wellness is not a department or a project—it is a way of leading. One of the most transformative investments any health care system can make is to offer mindful coaching for all it's physician leaders. Chief wellness officers can set priorities and advocate for system change, but the daily lived experience of physicians is shaped most by the physician leaders they work with directly.

We do not need leaders who prove their dedication by working the longest hours, seeing the most patients, or sacrificing their own health to cover the most undesirable shifts. We do not need leaders whose success is measured in dashboard metrics. We need leaders who are grounded and present. Leaders who choose curiosity over fear. Leaders who are willing to stop glorifying exhaustion and self-sacrifice so that we no longer pass depletion to the next generation of healers. A few forward-thinking institutions are beginning to recognize that emotional intelligence, self-regulation, mindfulness, self-compassion, and attention to personal health are not optional extras—they are core competencies. Leaders must not only create psychological safety; they must understand the impact of trauma in training, the toll of vicarious trauma in practice, and the structural factors that affect wellness. It begins when leaders themselves are well enough to hold steady in storms, listen fully, and choose their words and actions with care.

When leaders choose presence over pressure, compassion over speed, and restoration over depletion, something shifts. The air in our hospitals and clinics feels lighter, and the work begins to feel human again. In this space, medicine can return to what it is meant to be: a place where healing flows in all directions.

Medicalizing Burnout Misses the Point—Wellness is not One More Box to Check

Over the past decade, medicine has attempted to address burnout by medicalizing it—treating it as an individual pathology rather than a predictable outcome of systemic and cultural dysfunction. It has become one more task. Another metric. Another domain of performance that we measure, track, and monitor—without fundamentally changing the conditions that created it. The solution to the physician burnout crisis isn't more diagnoses or interventions. The antidote isn't another module, survey, screening, or questionnaire. What's needed is cultural healing—something we have so far been unwilling, or too depleted, to attempt.

Over the past decade, physician wellness has been absorbed into the very system that contributed to its erosion. We've

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labeled burnout as pathology when, in reality, it is a predictable outcome of a culture built on perfectionism, over-functioning, and self-erasure. Physician unwellness is not a disease. It is a cultural, values, and systems problem. It won't be solved by resilience workshops, checklists, apps, more meetings, committees or even wellness conferences. Efforts to "treat" burnout using the same mindset and mechanisms that created it are destined to fail. The pressure to measure and optimize everything has turned "wellness" into yet another performance standard—stripping it of the humanity it is meant to restore.

Physicians are uniquely positioned to address this crisis because they understand the intricacies of the system. We live them. We carry the stories, the suffering, and the stakes.

For years, we were told to leave system design and workplace reform to others so we could "focus on patient care." That approach has not served us—or our patients—well. Those outside the system, however well-intentioned, do not share the same depth of understanding or lived experience of medicine's invisible wounds. True cultural healing will require physicians not only to be included but to be trusted with shaping the solutions.

When physicians are supported to live, lead, and work in alignment, they become the most powerful agents of change the health care system has ever seen. This is an encouragement to institutions to take a risk: to step beyond performative wellness offerings and invest in transformative programming. Programming that repletes, empowers, and inspires physicians.

Jessie Mahoney is a pediatrician, a certified life coach for physicians, and a yoga instructor. She is the Chair of the SFMMS Physician Wellness Task Force. She practiced pediatrics and was a Physician Wellness leader at Kaiser Permanente for 17 years.

Other Recommended Listening: Healing Medicine Podcast with Dr. Jessie Mahoney and Dr. Ni-Cheng Liang

To listen, scan the QR codes with your smartphone or visit https://www.jessiemahoneymd.com/healing-medicine-podcast

How to Be Well in Medicine—Even in Residency and Academics with Dr. Jed Wolpaw

How many conversations in medicine today focus on how hard and how broken things are? This episode is a hopeful and grounded counterpoint. Enjoy a rich and thoughtful conversation with Dr. Jed Wolpaw, an anesthesiologist, critical care physician, educator, and host of the beloved medical education podcast ACRAC (Anesthesia and Critical Care Reviews and Commentary).

It's Okay to Have Fun: The Evolution of a Happy Doctor with Dr. Beni Seballos

This episode is an invitation to allow joy, play, and fun to take their rightful place in your life—without guilt, resistance, or apology. Dr. Beni Seballos, a Bay Area family physician, mom, wife, daughter, and radiant soul shares how she went from overwhelmed and over-responsible to energized, creative, and genuinely happy. Beni transformed her from a life of self-sacrifice and exhaustion to one of trust, fun, healing, and inspired leadership.

From ER Burnout to Soulful Living: Enia Oaks on Poetry, Pause, and Healing

A heartfelt conversation with an ER physician, poet and author. From a Studio in Oakland, California: 108 Notes on Existence, is a must-read—whether you're an ER physician, a young adult navigating the uncertainty of life, or someone simply seeking meaning and alignment.

Gathering Our SFMMS Members in 2025

To learn more about our upcoming events and offerings, visit our SFMMS events page at https://www.sfmms.org/news-events/events.

SFMMS Hikes—Connect, Refresh and Gather

It was wonderful to connect with physicians across specialties and health organizations. We loved every minute of it! I'm looking for ward to the one, hopefully every month!"

– SFMMS Member

In June and in August, SFMMS gathered a group of 10 to 15 SFMMS members and their family/friends for two separate SFMMS hikes, led by SFMMS President, Dr. Jason Nau. The group gathered in June for the five mile hike to Rodeo Beach and again in August for a hike on Mount Tamalpais to enjoy stunning Bay Area views and opportunity to connect with one another in an active way, outside of the clinic setting. Hikes are planned often and you may learn more about future hikes by visiting our SFMMS website's event page.

SFMMS at the de Young

"Great event! It was fun to go to the de Young. I enjoyed chatting in the cafe with other physicians and seeing the exhibits."

– SFMMS Member

In June, SFMMS with support and coordination of Dr. Andrea Young, gathered a group of 10 SFMMS members and their family/friends to peruse the exhibits at San Francisco's de Young Museum.

SFMMS Women in Medicine Farm to Table Luncheon

"It was a glorious day. The conversations and connections were much deeper and more naturally flowing than at other venues/ events. This is always true of women in medicine events, but even more so at this one. It was particularly fantastic that it attracted several members who had never attended previous SFMMS events."

– SFMMS Member

In August, SFMMS gathered physicians, who identify as women, for a farm-to-table luncheon at Nicasio Creek Farm. Special thanks to our host SFMMS Membership Engagement Committee Chair, Dr. Jessie Mahoney and special thanks to our sponsor, the California Medical Association Alliance for their generous support of this event.

California Doctors in Retirement (CADRE) Gathers Monthly in Greenbrae

"The monthly CADRE meeting is always fun. This gathering is for special people, who have had unique lives. As retired SF and Marin physicians, we can be best understood by each other." Join your fellow retired physician colleagues for CADRE (CAlifornia Doctors in REtirement) for casual conversation, connection, & free coffee, monthly (3rd Thursday of the month) at Peet's Coffee in Greenbrae.

SF Free Clinic Seeking Physician Volunteers to Help Provide Care to the Uninsured

The San Francisco Free Clinic, founded in 1993 by Drs. Patricia and Richard Gibbs, provides free medical care to more than 2,500 uninsured patients each year—over 6,000 visits in total. We provide primary and urgent care services but we rely on the generosity of volunteer specialists for curbsides and consults.

These are unprecedented times. With policy changes expected to significantly increase the number of uninsured, and safety-net clinics already stretched thin, the need for physician volunteers has never been greater. Your contribution—whether through specialist consultations or general support—can have a direct and immediate impact on patients who have nowhere else to turn.

Colleagues who volunteer with us describe the experience as both nourishing and a powerful reminder of why they entered medicine.

To learn more or to volunteer, please see the fact sheet at right.

We would be honored to have your help!

FAQ: Volunteering at San Francisco Free Clinic

What is the San Francisco Free Clinic?

The San Francisco Free Clinic was founded in 1993 by two CPMC physicians (Drs. Patricia and Richard Gibbs) to provide free medical care to people with no health insurance. We believe that no one should suffer or die prematurely because they cannot afford medical care. Despite the advances of the Affordable Care Act, there remain tens of thousands in the Bay Area with no insurance. Each year, the clinic sees over 3500 unduplicated patients with over 7000 patient encounters. *All patients are screened for eligibility for safety net insurance programs, and those who qualify are guided to the appropriate program (Medcare, Med-Cal, Healthy San Francisco).*

The clinic is an award winning and unique model of cooperation between the medical community and private charitable contributions. We are incredibly fortunate to have a number of specialist physicians who donate consultations when needed. We are seeking additional physician volunteers who would like to help with this underserved population.

What kinds of volunteers are we looking for?

All specialties are welcome! In particular, we are seeking volunteer specialists from Dermatology, Endocrinology, Neurology and Urology.

What is it like to volunteer with the San Francisco Free Clinic?

There are a variety of ways for specialists to get involved. Examples include:

- Donating a patient consult in your own office (for example, 1 or 2 patients per month)
- Being available via email for quick curbside questions
- Seeing patients at the San Francisco Free Clinic (perhaps once per quarter)
- Donating medication samples, medical devices, or supplies
- Donating studies such as exercise tolerance tests or in-office spirometry

When volunteer specialists donate patient visits at their own offices, we make the process as seamless as possible. There is no billing or complicated paperwork. We never expect a specialist to manage a problem, but rather to advise the SFFC physicians who will carry out the care and complete all follow-up. With just 15 minutes per month, volunteers provide an uninsured patient with specialty care that would otherwise be unaffordable and out of reach.

How do I sign up or learn more?

For more information on the SFFC, please visit our website at www.sffc.org. If you would consider volunteering one or two consults per month or donating resources, please contact our Executive Director, Dr. Ian Nelligan, inelligan@sffc.org.

What current volunteer physicians have to say:

"This is why I went to medical school" - Dr. Ed Kersh, Volunteer Cardiologist.

"I can't imagine not being a part of the SF Free Clinic. The physicians, staff, and volunteers all work together to provide outstanding, compassionate, evidence-based care." - Dr. Janice Hansen, Volunteer OB/GYN.

"The SF Free Clinic is among my most rewarding experiences." - Dr. Nina Schwartz, Volunteer Rheumatologist.

THE TRUMP ADMINISTRATION IS USHERING IN GOOD TIMES FOR BIG TOBACCO

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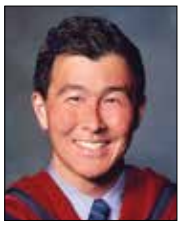
vaping liquids that target youth and implement a solid anti-vaping curriculum in schools. Californians should notify the FDA of any improper claims implying e-cigarettes are an approved smoking cessation treatment, and report any unlawful sales of Juul's menthol products in the state to the attorney general.

In a healthier regulatory world, Juul's products would have been fully evaluated by the FDA to be approved as a nicotine replacement therapy for smoking cessation, rather than allowing an extended profiteering experiment on youth. Juul instead applied to the FDA to market the newest in a host of tobacco products that lead to addiction and health problems.

The story of Juul is setting a bad example: Prey on kids, sell out to Big Tobacco, pay billions in settlements and have the White House bail you out. California once again has the opportunity to change the course of this sad story.-||



John Maa is a general surgeon and former president of the San Francisco Marin Medical Society. Steve Heilig is a veteran public health advocate, also with the society and editor emeritus of the Cambridge Quarterly of Healthcare Ethics. The opinions expressed are their own. This piece first appeared in the San Francisco Chronicle.

Steve Heilig is an editor, ethicist, epidemiologist, environmentalist and educator based at the San Francisco Marin Medical Society, and co-editor of the Cambridge Quarterly of Healthcare Ethics.

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