Archival & Historical Committee

November 13, 2023

Interview with

Bruce R. Williams, DO, FACOFP *dist.*

(ACOFP President March 2022 – March 2023)

Committee Chair: Thank you, Dr. Williams, for being with us tonight. We want to go ahead and record some points about your presidency to be a part of the Osteopathic President Profile. As a tradition, we have some questions that have sort of been carried on down through other presidents, so we'll go ahead and members of the group can kind of work down through that list. And then if we don't hit something that you feel is important as we go down through here, just go ahead and interject it. We can certainly do it. The only reason we had the canned questions is so we can kind of keep in an order that way, but we don't have to necessarily follow those questions.

Dr. Williams: Good.

Committee Chair: So what was the theme of your presidential year?

Dr. Williams: So the theme was actually *family reunion*. It was not only getting back together after the pandemic, like in not being a get together in person for a

couple years, so it was our first convention back in person, but it was also an opportunity to get back out to visit state meetings and visit the members more on a personal level and also do what we could do to hopefully build interest and engagement back in ACOFP after everybody had been locked down so long, so that's kind of where our theme was for that year.

Committee Chair: Right, so it was COVID that sort of drove the theme then, right?

Dr. Williams: Yeah. Yes, it really was.

Committee Chair: Dr. Misra, I think you had your hand up.

Committee Member: Yeah, actually I think you kind of lead into the next question, which was: What was the driving force behind that theme? And that makes a lot of sense, Dr. Williams. I'll ask the next question. Obviously, it's always challenging, I think, especially when you're just outgoing, but what do you see as your biggest accomplishment or accomplishments during this past year?

Dr. Williams: Well, for what was driving me and what I hope were accomplishments is some renewal on the importance of family medicine, so there was lots of effort, not only in advocacy, but -- and that's an ongoing thing -- to try to have family medicine as a specialty recognized for the importance that it is, not only that it deserves more resources, obviously physician compensation, but more resources for our practices so that we can take care of our patients the way we really need to. So infrastructure needs to be developed, that costs money. You just don't go out and buy an EMR. There's lots of things that go into it. And now we need to include continuity to care, telemedicine, etc., and that demands resources to be able to put that together. And especially ~~some of~~ for our rural practices, that's very difficult to do, so… Alston and Bird was all

over that during the year, and again that's ongoing, but hopefully the advocacy efforts in those areas, as well as just messaging to the membership, is driving that to some extent. I focused a lot on osteopathic distinctiveness and how that benefits the specialty of family medicine, and also the importance of utilizing OMT because it's helpful to our patients, and it's also helpful to our practices. It's disappointing to me to see this gift that we're all given is underutilized to the extent that it is; and our patients are ones that are really not getting the benefit of it. I always tell the students and I tell my colleagues, "If you can do it, you can document it, you can code for it, you can bill for it, you'll get paid for it." I regularly hear that they don't have time to do OMT as a procedure. If you treat it like every other procedure, you've got plenty of time to do it, so I think that was some of the messaging that I tried to promote. And as far as an accomplishment, I think, hopefully, that was raising awareness of that. It's unfortunate that we had to raise awareness of it, but that's kind of what my focus was on. I think the other accomplishment was just the successful sale of our building and finding a new office and getting that secured. That was a pretty big effort throughout the year, and we were able to get that accomplished, our membership has remained stable and even continues to grow, so I think that that's good to see as well; and we're financially stable also.

Committee Chair: Just to follow-up on that, Bruce, were you involved in some of the decisions to sell the building? And just real quick, you don't have to do a lot, but just what were the driving factors that figured that we needed to move out of Arlington Heights and closer to Chicago?

Dr. Williams: There were several, Dr. Told, and I was involved in it. It was a Board discussion, so Arlington Heights as a community for healthcare organizations was not ideal. It's hard to recruit good talent into that area. It was hard to find tenants for us. We had the AOBFP upstairs for a while and they moved downtown to the AOA, so trying to secure tenants for the building was difficult. Just the structural design of the building~~, it~~ was challenging because, if you remember, it was kind of a big circle with a foyer in the middle, so being able to interact with staff regularly was challenging. So that was a lot of it. The other part of it was the value of the building was declining. So in order to get a good price for it, we kind of got lucky that a radiology group that was (I think they were losing their lease or there was a situation with a building they were in.) was looking to purchase another building and our building kind of fit the bill for them. That was obviously after we had decided to sell it, had put it up for sale, but we actually got a better price than we anticipated and were able to close on it, so it was multifactorial. Dr. Misra, am I forgetting anything? I think the ability to obtain, acquire, and sustain good employees was a big challenge because it was difficult to get to it. There wasn't really good access to transportation. So in Rosemont, where we currently are, it's right there on the on the "EL". It's right by the airport. It's fairly easy to access for employees to get there.

Committee Chair: Good. Okay, thank you.

Committee Member: I think that's an interesting point I'd just like to comment on. We've had many presidents and we've reviewed the information from many past presidents talking about: How do we make things better for our members?

How do we make things better for our members? I think this is the first time I heard a president talking specifically about things that we did to make better for the team that makes our organization run well. And I'm not suggesting that others didn't do that, but that seems to me like a unique facet that I've not seen in some of our other presidential discussions, so I appreciate you sharing that information.

Committee Chair: It was great. Thank you.

Committee Member: Dr. Williams, I think you had a lot of big challenges that many of us onboard. Can you pick one? The insurance issues, the authorizations, the paperwork, the creep *[sic]* of practice and burnout and telemedicine, just pick one maybe and tell me what you did about it besides sock it in the nose?

Dr. Williams: I think the main thing that's been kind of present for the last several years is certification. How do we get around that? I think what we're able to do this year, last year at OMED, we actually put a presentation together for Dr. Kevin Klauer and Dr. Gelb, Maura: and just we had a slide presentation that actually showed the impact that the certification issues having on our members on our specialty, the entire profession really, and how it's important to address those issues because we're losing way too many of our residents to the other board certification; and it's important. We have this initial certification grant that the foundation has put a lot of time and effort in, raised over $2 million, and we can't give the money away because the residents aren't taking advantage of it, so we don't really know what else to do. We're providing registration and travel for residents to come take our board certification exam and they're still not doing it I think we just tried to illustrate this to the AOA and Dr.

James* was there as well. So, I know after that presentation, Dr. Monka, - - I saw red in his eyes and smoke coming out from under his collar, but I think that was one of the things that led to his taskforce this year. So hopefully something along that line is having some impact, but certification has been a bur in our bonnet for many years. I know Dr. de Regnier was dealing with it when he was president, and that was the year that I came on the Board. I imagine it was being dealt with for a few years before that as well, so it's just one of those ongoing issues. I think the other issues that I felt frustrated with was just the ongoing apathy, which kind of ties into the certification issue. I think we really need to do something to develop osteopathic distinctiveness. I know the AOA is working on that, but I think whatever the ACOFP can do to have an impact on that, we need to do because I think it's important that we're able to articulate how we're different. We all know we're different. Our patients know we're different. The problem is that we really struggle to articulate how we're different. I think we really need to be able to do that. We need to be able to do it… I always say we need to be able to do it in a 30-second elevator speech. Because if a patient asked me: What's the difference between an MD and a DO and I start explaining it, you can go on for two hours, but does the patient really understand what you're talking about. So, I think what I've kind of settled on is that, and Dr. Misra actually gave me this tagline, is that MDs treat disease; we treat dysfunction. I think that seems to have taken hold a little bit. I don't know whether it's taking hold throughout the whole profession, but it works for me and my discussions that I have with people, so…

Committee Member: Thank you.

Committee Member: Bruce, you said one of your frustrations was apathy. Apathy on whose part?

Dr. Williams: On the part of the membership. What does it mean to be an osteopathic physician? This group excluded because obviously we're very passionate about it, but, as Dr. Misra and I know and those of you who have students and students out on rotation, that it's pulling teeth to try getting to work with a physician. DO students work with a DO that really truly embraces the osteopathic philosophy, does OMT, and is going to give them skills that they're going to be able to take into their career, that really shows that they're treating their patients, utilizing the osteopathic philosophy? Anybody can write a prescription for a pill, but are they taking into consideration the social determinants of health that affect their lives in general? So, I think that's one of the things that frustrates me.

Committee Chair: Did you have any issues or any pearls about communications to the membership? Did you have anything that was particularly successful?

Dr. Williams: Well, I always joke with the staff when they wanted me to do something with media that I have a face for radio and a voice for newspaper, so I think my most effective communication was probably in articles for the OFP and just communication that we would send out to the members periodically, blogs, that type. I did a few blogs with the students and that type of thing, so I think that was… I got more feedback from the members about that than I did with either my appearances at state meetings or other addresses, those types of things, but I think just because I was able to sit down and think about it more clearly.

Committee Member: Bruce, you mentioned students a couple of times. What do you think was your most successful interaction with the students? What did you find most rewarding?

Dr. Williams: Well, one of my biggest disappointments is that I didn't get to interact with the students as much as I would have liked. Really the only student visits I got to make where I got to visit, obviously, two campuses in Kansas City and in Kirksville. I was supposed to go to Iowa and that fell through. We tried to make some arrangements with others, just never really could get it fixed up, but the visit I had in Kirksville was amazing. The students were all very engaged. They were all very welcoming. They insisted that I go through the museum. I actually got to go over to A. T. Still's gravesite, but just their interest in family medicine and their engagement was actually very heartwarming. Like I said, I wish I… I know my - - Dr. Park will make up for what I haven't been able to do, but the few visits I was able to make were rewarding.

Committee Member: Good. That's good. What about osteopathic recognition? When we wrote the chapter, osteopathic recognition is really owned by family medicine. I don't know whether the AOA is really trying to push that as much, but I think there's more than 250 family medicine programs that have osteopathic recognition. Only about 200, 220 or something like that. Maybe Dr. Misra, you know better, but… And then we've only just got a trickle in all of the other subspecialties, but by far and away it's family medicine that runs the osteopathic recognition; and it was actually the need for family medicine that brought ACGME to the table. And I don't know whether a lot of - - because we

now - - we eclipse the MDs in joining family medicine, so… have you had any experience with interaction with the AOA on how we try to push osteopathic recognition to programs?

Dr. Williams: Well, I think part of the discussion that we had at OMED last year included that and the need to try to promote osteopathic recognition more. As ACOFP, we have what we call a HUB structure where our Board is divided up into regions of the country and they all are given responsibility for the residency programs in that region. So, for example, a couple of years ago when it got started, I had the southwest. They called it the Southwest Division. It was basically Oklahoma, Texas, so the idea was I connected with all the residency program directors and just explained to them: I'm a governor for ACOFP and I'm actually your contact on the Board, so if you have questions or issues, please feel free to contact me. In return, we ask them for contact information for the residents so that we could make sure that we have our database current as well as an ability to reach out to the residents with information about the early entry initial certification pathway as well as the initial certification grant information and just trying to make sure that they were up to date because we were finding a lot of the residents didn't know that that was available. So, if you don't know it's there, it's going to be difficult to apply for it. So, I think that's something that was done. That was actually done under Dr. DeLuca's presidency, but it's kind of carried forward and now I think we're hoping to include the past presidents in that structure. So, I think the more touch points that the residents have with the ACOFP leadership, the

more impact it'll likely have and just getting that experience from people who've been there, done that.

Committee Chair: The feedback I get from some of the residency programs here in the west, in Colorado, is that they don't have good resources. They (Inaudible) the AOA and then they get gigged on mostly bookkeeping things and then they don't have any way - - they don't have anything to follow up with. I wonder if ACOFP chapters ought to provide that for some of the residency programs. The schools tried to, but you can't get the faculty to go travel out to a residency program or at least it's difficult to do that. I wonder if that would be something we need to do.

Dr. Williams: Well, I think the thought, right now, is to try and get that feedback and see what we can do. Is it to involve the states more? What can ACOFP do directly? All that type of thing, so I think it's: How do we get that feedback? And I think this is the start of that.

George, did you have a question for me? I saw your hand up a minute ago.

Committee Member: Oh, yes. Hello, Dr. Williams. You've done amazing job advocating for the osteopathic profession and all of our students and residents know who as we become leaders, we'll become the future of ACOFP when we get into family medicine. So, from your opinion and your foresight, what is the biggest challenge you see facing ACOFP in the coming years?

Dr. Williams: I think it's our identity crisis. I think there needs to be a stronger focus on osteopathic family medicine and what does that mean. I know that there's the current discussion about we need to serve the members. But if we don't have any osteopathic family physicians practicing osteopathic family medicine, we

won’t have a membership to serve, so I think it's very important to promote osteopathic distinctiveness. I think it's very important to promote OMT. That's obviously an important element of osteopathic medicine and it's something we're depriving our patients of. They're not getting the benefit of OMT and therefore those conditions are becoming more chronic, more cost. It costs more, so providing OMT is a service to healthcare all the way around; and I think it's something that we really need to do, so. And family medicine is the ones that do it. We're not the only ones who do OMT, but we can certainly take a leadership role in that; and I think that family medicine needs the recognition. So as far as the specialty, we do the preventive care. We do a lot of the chronic care management. We do a lot of the behavioral health management and all that kind of thing, and we are the important instrument of healthcare savings as far as trying to control healthcare costs, so I think the resources need to be provided for our specialty and the recognition needs to be provided for our specialty. Yes, compensation. I don’t think any of us here would disagree that family physicians are very under compensated for what we do, but it's also the resources that we need to treat our patients.

Committee Chair: But did you have any budgetary challenges, Dr. Williams? Were you having to do more with less?

Dr. Williams: Fortunately, if there was any good thing that happened with the pandemic is that we're able to maintain our stability and actually come out a little bit ahead financially, so we had everything we needed financially and were able to try to put some efforts forward. We're still very cautious because we know that that's not going to last forever and everything's getting more expensive,

so we do have to kind of keep an eye on what services we're providing, what our annual operating plan is, and how effective that is, whether we have the budgetary resources to do it, and you also have to prioritize what we're doing and is this something that we're going to continue to - - we're going to see a benefit from continuing to do or is it something that we should pause or step back from because other things are higher priority and they really need to have the funds for that. Right now some of our biggest financial outlays are we have to update our association management system, our website, all that kind of thing; and that's proving to be a pretty hefty expense. And every time we turn around, it gets bigger, so we're trying to keep the beat on that, trying to… Actually, Bob has gotten in some just about knockdown drag outs with the company that we're dealing with to try to maintain the costs where they said they would originally be, so that's probably one of our biggest financial hurdles right now. Fortunately, during my term, we were actually in a pretty good space as far as that's concerned.

Committee Chair: Good.

Committee Member: Dr. Williams, you have a great smile. We have to make you laugh a little bit. Something fun, something memorable, something you'll always remember about your term?

Dr. Williams: Well, I think the convention was probably the thing that I'll always remember, just being able to have a convention and see all my colleagues and friends and everybody. I thought the venue was, I won't say great, but it was nice, in Dallas. I mean it was special for me because my family was there and the

school made a big deal about it and all that, so my head got kind of swelled, but I think the convention itself was probably a highlight.

Committee Chair: Good. That's good.

Committee Member: I've got a question for Bruce. Was there any particular projects or I guess objectives from the Board that you had to hand over to the next president, things that were sort of on the hot plate that just needed to be finished or maybe even started that just didn't come in a timely fashion when you were trying to do it in your presidency?

Dr. Williams: Nothing specific. I think you're always handing things over, so one of the reasons I didn't have a big agenda for my year as president is because we were involved in a lot of things that had been started by other presidents. So, we were still in the process of streamlining our governance structure, and evaluating our committees. That was really started under Dr. Koehler to some degree. Dr. DeLuca probably took the biggest bite of it. And then, of course, Dr. Bixler got caught up in COVID and DEI and all the social changes that took place and had to develop policies and processes for, so there was a lot of that still ongoing when I took over as president. I think pretty much during the year I had aligned the governance issue and resolved that for the most part. So as far as what I had to transition to Dr. Park, I don't think there was really that much.

Committee Chair: Good.

Dr. Williams: I don't know. Dr. Misra, can you think of anything that was really kind of a hot topic that I kind of dumped in his lap?

Committee Member: I honestly don't. I feel like, and I think you said this very well, you were sort of the end cap to three to four years of initiatives that had really, as you mentioned, been started all the way back with Dr. Koehler, moving through Dr. DeLuca, Dr. Bixler and I feel like I think it's interesting because Dr. Park's theme was of course Legacy, but I think a lot of the initiatives that Dr. Park has been working on are really newer initiatives. I don't think you dumped anything in his lap.

Committee Member: Bruce, you mentioned a couple of times the AOA. Can you talk a little bit about how you see the relationship between ACOFP and AOA under your time as president and maybe what were one or two of the major issues you had to navigate there?

Dr. Williams: Well, I think the relationship overall is a good relationship. I mean we were able to collaborate and communicate regularly, with Dr. Klauer and Dr. Gelb. I was always bumping into Dr. Gelb and Dr. Giamo at state meetings, so there was always a lot of communication and messaging, which was very similar at those meetings. I think the certification issue was an issue we talked to the AOBFP about even in Dallas and just continue to try to have that discussion. I think since Kathleen Creason and Dr. Monka have come onboard, that's starting to get a little bit more attention. It's obviously a pretty major work in progress, but I think it's starting to develop that we might actually be able to make some headway on it. It's our certification and AAFP is coming after us. They want to our members and now they're even talking about wanting to do something as far as osteopathic medicine in their boards; and I think we really need to kind of dig our heels in the ground and resist that. It may be an easy

conduit for us, but I really don't think it's going to benefit our members. It's not going to benefit our patients. It's not going to benefit our profession becoming part of AAFP, so I think that's something that ACOFP needs to be very focused on and AOA needs to be very focused on. Because if our boards become part of the ABFM, who's going to be accountable for making sure that osteopathic physicians are doing OMT correctly? And that's something that scares me. We're looking to train MDs to do OMT. We're looking to have ~~you~~ more DOs do OMT. But if you're not doing it correctly, who's going to be accountable for that? And then pretty soon, everybody's going to claim they can do osteopathic manipulation. But if they're not held accountable to doing it correctly, it's not only going to hurt our credibility more, but the patients are going to be the ones that are suffering because they're not having a procedure performed correctly. So I think it's important for our certification to be maintained for that reason, for the sake of our patients.

Committee Chair: Agreed.

Committee Member: Thank you.

Committee Chair: Well thank you. Anybody have any other questions? I think we've done a good… We really appreciate you taking your time tonight. I think that's important. As part of Dr. Park's legacy, we like to see how the legacy is playing out and continues on and we really appreciate that, appreciate the time you gave us.

Dr. Williams: Thank you.

Committee Chair: We'll go ahead and we'll have one of our members, once we get the full recording, which won't have any inaudible(s) on it, I don't think will it, and

we'll go ahead and then summarize that, give you a chance to review that, to edit it, and then we'll go ahead and place that as part of that chain of leadership as the bios on each one of the presidents. And most of all, we appreciate the legacy, how you guys kept things move during some pretty difficult times and certainly through this great transition. And as medical education sort of transitions, we got to make sure we don't lose our identity through all of that process. So, yeah, thanks for your sure guidance that way.

Dr. Williams: Well, thank you; and I had I great predecessors and great mentors to help me through it.

Committee Chair: Well, good.

Committee Member: Dr. Williams, thank you.

Committee Chair: Well, thank you and we wish you a good evening.