Health or Politics? Organizational Maintenance in the AAFP

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Abstract In recent years, the American Academy of Family Physicians (AAFP) has debated and developed organizational stances on issues as varied as nuclear disarmament, gay marriage, policing, and climate change. This article considers the relationship of "political" policies to the ongoing maintenance of this professional association over time. The author describes transitions in the organization's policies from broad, neutral statements to more explicitly politicized social policy statements and then discusses debates around the establishment of an organizational policy on *same-gender marriage*, the term for gay marriage that is used within the AAFP. Results indicate that members use concerns about the maintenance of the organization over time as a lingua franca during debates. However, while members routinely interpret policy in terms of its relationship to the maintenance of the organization, they articulate conflicting visions of maintenance, with those in favor of the policies describing maintenance primarily in terms of external legitimacy and those in opposition describing maintenance primarily in terms of internal cohesion.

Keywords organizational maintenance, symbolic politics, medical associations, family medicine, health policy

In recent years, the American Academy of Family Physicians (AAFP), like many other physicians associations, has debated and developed organizational stances on issues as varied as nuclear disarmament, gay marriage, policing, and climate change. Policies such as these indicate a broad interpretation of medical associations' presumed expertise and interests and invite questions about what—if any—rules limit the stances taken by such organizations.

Journal of Health Politics, Policy and Law, Vol. 44, No. 1, February 2019
DOI 10.1215/03616878-7206719

Other professional groups have tackled questions about what is within the purview of a professional association. For instance, the American Society for Bioethics and Humanities engaged in a public debate over "taking stands" from 1999 to 2002. This conversation began because of a dispute about whether the association should take a stance on an issue of academic freedom but erupted into a larger debate about how and when they might "issue positions on substantive moral and policy issues" (Antommaria 2004: W24; Nelson 2001; AAUP 1999). Similarly, the Modern Language Association and American Studies Association have been embroiled in debates regarding a boycott of Israeli universities (Jaschik 2014). These debates are similar in that they have successfully prompted questions about which opinions are appropriate for professional associations. Much of the debate around these issues has been about their political nature. The way that the term *political* has been deployed during these debates demonstrates the inconsistency in how organizational policies are often treated. In declaring the issues around which organization members sought to establish standards as political, some individuals used the term to designate these issues as separate from the shared concerns of organization members or to make the point that these issues were outside their authority. Others, however, seemed to use the term to label these issues as overly divisive. These arguments imply that members have responsibilities to focus on issues around which there is consensus and to respect ideological heterogeneity within the organization.

Similarly, debates about "political" topics in the AAFP have prompted significant organizational conflicts about how attention to such topics might impact external perceptions of the AAFP, internal cohesion, and the strategic capacity of the organization to address other issues. In this article, I consider the relationship of such policies to the ongoing maintenance of the organization over time. What perceived role do political policies play in organizational maintenance? How do perceptions about the responsibility to maintain the organization impact the process of policy creation?

To address these questions, I first discuss the evolution of the AAFP's social policies over time, charting shifts in policies on discrimination, guns, gay marriage, and the environment. I identify a transition from broad, neutral statements to more explicitly politicized social policy statements and from health-care-specific stances to broader social claims. I then focus on one particular debate within the AAFP: a multiyear dispute over the creation of an organizational position on same-gender marriage. The proposal of a policy on the topic sparked fierce debates within the organization about the relationship between such a policy and the long-term success of

the AAFP. I used these debates to investigate how organization members deploy arguments about the relationship between social policies and organizational maintenance. I found that, while members routinely interpreted policies in terms of their relationship to the maintenance of the organization, they articulated conflicting visions of maintenance, with those in favor of the policies describing maintenance primarily in terms of external legitimacy and those in opposition describing maintenance primarily in terms of internal cohesion.

The Project of Organizational Maintenance

A concern with organizational maintenance—that is, with the way that organizations perpetuate themselves and manage members—is apparent in parallel literatures across the social sciences (Lawrence and Suddaby 2006; Teles 2016; Wilson 1995). In particular, organizational theorists have recently given attention to the ways that members of organizations may purposively maintain, reproduce, and repair organizations and institutions through practices (Langley et al. 2013; Lok and de Rond 2013; Hussenot and Missonier 2016; Lawrence and Suddaby 2006; Lawrence, Suddaby, and Leca 2009; Dacin and Dacin 2008). In this study, I build on this literature by considering how members of the AAFP purposively work toward the preservation of the organization in policy debates. However, though organizational researchers have characterized maintenance work as reflecting intention on the part of members, it is generally not described as being explicitly theorized or debated by members. I develop new insights not only by describing the practices through which maintenance occurs but by also investigating how theories about maintenance are constructed and deployed within the organizational process.

In describing the construction of maintenance, I draw on recent theory about the way collectivities posit a relationship to the future. Recent sociological work has investigated how social actors' projections about the future motivate action (Brophy 2016; Jerolmack 2009, 2013; Mische 2009; Polletta 2006; Tavory and Eliasoph 2013); for instance, narratives about the threat of decline over time may motivate collectivities to develop active strategies to resist such threats (Brophy 2016). In this way, organizational maintenance can be understood as a collective project shared by organization members (Mische 2009; Schutz 1967, 1978).

However, even as members may share commitments to this project, there may be significant disagreement about how to accomplish it. To date, researchers have generally described future-oriented actions engaged in

by collectivities to be coordinated. I investigate how organization members who share the goal of perpetuating the organization over time may also work at cross-purposes, deploying conflicting narratives about organizational maintenance.

Strategically Positioning the Specialty of Family Medicine

In describing the project of organizational maintenance, I consider the particular threats faced by family physicians. Family medicine is often described as being in a state of crisis (Beaulieu et al. 2008; Green and Fryer 2002; Stein 2006; Stevens 2001), even as recent trends in US health care delivery models present increased opportunities for primary care leadership and indicate ongoing support for a primary care–driven health system (Simoens and Hurst 2006). Though there is a huge need for primary care physicians, fewer young physicians are choosing residency training in primary care (Moore and Showstack 2003). This crisis is particularly pronounced in family medicine. As distinct from the broader category of primary care physicians (which in the United States includes OB/GYN, pediatric, and internal medicine physicians), I use the term *family physician* to refer to the narrower category of physicians who act as "first respondent, coordinator, and integrator" of their patients' health care and who do not identify with other specialties (Beaulieu et al. 2008: 1158). The dearth of family physicians has been attributed to both compensation and prestige: followed only by pediatrics, family medicine is the lowest compensated physician specialty in the United States (Grisham 2017), and they are attributed less relative prestige than other specialties (Hinze 1999).

Many researchers have attributed the diminishing interest in and low prestige of family medicine to the failure of the specialty to effectively distinguish itself from other medical specialties. They have argued that (a) the breadth of the family physician's practice is unrealistic given the constant growth of medical knowledge (Green and Fryer 2002; Rosser 2002; Soulier, Grenier, and Lewkowicz 2006) and (b) the characteristics used to describe the specialty (such as their emphasis on patient care) are not unique to family physicians (Beaulieu et al. 2008). These concerns have led to concerted efforts to better define the discipline (Graham et al. 2002; Kamien 2002; Olesen, Dickinson, and Hjortdahl 2000; Wun 2002).

Scholarly interest in the identity of family physicians has, for the most part, come from family physicians themselves, intent on improving family

physicians' compensation and occupational prestige. However, instead of attempting to answer how family physicians might increase their relative power, I investigate the quality of this power (Reich 2012; Timmermans and Kolker 2004), exploring how family physicians construct arguments about their collective action in light of the threats facing their specialty. Recent reexaminations of professional associations have attended to the important cultural functions performed by these organizations (Aldrich 2018; Spillman 2012, 2018; Spillman and Brophy 2018). Professional associations are sites of meaning making, which "routinely produce cognitive categories and practices" for members (Spillman 2012: 135). The production of cognitive categories is of particular importance for an occupational group that perceives itself to be under threat. Further research is necessary to explain how family physicians translate narratives about the threats facing their specialty into strategies for action.

Case and Methods

The AAFP is the largest organization of family physicians in the United States, with about 121,000 members, and the third largest physician association in the country. Throughout its history, the AAFP has been oriented by concerns about family physicians' status in an evolving health care system. The organization arose in response to the growing subspecialization of medicine in the mid-twentieth century, particularly following World War II (FFM 2004). Beginning in the 1940s, generalist physicians sought to establish that they had equal training and rank as other physicians and should, as a result, be considered a "specialty." In 1946, the American Medical Association (AMA) established a section to address concerns related to the decreasing number of generalist physicians. The next year, this section developed into the American Academy of General Practice (Dennis n.d.). In 1969, the American Board of Medical Specialties approved family practice as a new specialty, and in 1971, the American Academy of General Practice became the AAFP (Gutierrez and Scheid 2002).

Policies developed by large physician associations such as the AMA, the American College of Physicians, and the American Academy of Pediatrics, are often adopted as federal and state laws and instituted as policy by health care organizations. This form of symbolic power allows physicians to police the boundaries of their profession and to advance physician-oriented frameworks of health care (Blackstone 1977). Given the perception of the crisis faced by family medicine, the policing of the boundaries of the specialty has been a particular priority of the AAFP. Attention to this crisis can be credited with the growth of the specialty in

the second half of the twentieth century. However, beginning in the 1990s, family physicians began to express frustrations about their position as gatekeepers to a "fragmented and wasteful system" (FFM 2004: S5). In 1996, a report released by the Institute of Medicine demonstrated that the public had a poor understanding of primary care (Donaldson et al. 1996). Following the release of the report, the growth of physicians opting to specialize in family medicine and other primary care specialties has lagged significantly behind that of other specialties (FFM 2004; Pugno et al. 2002). In recent years, the AAFP has attempted to use its policy to renegotiate its position within the health care system. In particular, the organization has sought to frame the task of the family physician as proactively integrating, rather than simply coordinating, patient care (FFM 2004).

The AAFP, like many other organized medicine associations, creates much of its policy through a parliamentary democratic structure. Much of the work done by the organization is focused around a three-day annual meeting of the AAFP's policy-making body, the Congress of Delegates (COD). Membership in the COD is made up of delegates and alternates selected by constituent chapters. These delegates represent geographic or interest-based constituencies (e.g., women physicians, racial and ethnic minorities, and LGBT physicians). Delegates are able to submit potential policies (resolutions) for consideration at the COD meeting. During the COD meeting, delegates debate resolutions at reference committee hearings, elect AAFP officers, and vote on organizational policies.

In discussing social policies created by the AAFP, I first review policies created by the organization in four categories: discrimination, guns, same-gender marriage, and the environment. To chart the evolution of these policies over time, I rely on the policy statements themselves, as well as the amendments submitted and edited at the annual COD meeting. I then focus on one policy debate that took place from 2010 though 2014 around the creation of an organizational stance on same-gender marriage. To chart this debate, I rely on (a) AAFP policy statements, position papers, and discussion papers adopted through 2014; (b) the 2010–14 Congress of Delegates Transactions, the official AAFP record of the annual meeting; (c) my own participant-observation field notes of the annual AAFP COD meetings in 2012 and 2014; and (d) reports produced about the meetings by the AAFP and Medscape.

Social Policies over Time

As of April 2017, the AAFP had 396 policies. Though most AAFP policies cover such topics as payment and clinical practice, about 10% can be

described as social or cultural policies. Among these policies, I identified four topic areas with multiple policies: discrimination, guns, same-gender marriage, and the environment (fourteen policies in total).[1] To chart the evolution of organizational stances on these topics, I examined changes in the text of the policies themselves over time. I also make use of reports written by the AAFP and Medscape about the policies, and the COD Transactions to provide insights into the ways that members framed the stakes of these policies.

Same-Gender Marriage at the AAFP

I detail the process of developing an organizational stance on same-gender marriage. Between 2010 and 2014, AAFP members debated eight separate proposals on same-gender marriage in reference committee hearings and the official business meeting of the annual COD conference. I draw on my participant-observation field notes (2012 and 2014) of the annual meeting, the COD Transactions, and reports produced about the meetings to reconstruct these debates, to examine some of the important fault lines within the organization, and to investigate the significance of such policies to professional identity.

Data Analysis

To analyze this material, I draw on insights of grounded theory (Glaser and Strauss 1967; Myers 2009; Strauss and Corbin 1998) and abductive analysis (Timmermans and Tavory 2012). I made use of iterative coding to categorize field notes, the Transactions, and meeting reports using the qualitative coding program Nvivo. I used an open coding scheme to identify themes. This process made apparent the frequency with which organization members framed arguments about the organizational statement on same-gender marriage in terms of how the policy would be interpreted in the future, as well as about the ways that social policies impacted the strategic capacity of the organization. I then engaged in secondary coding to explore connections between these themes and existing theory about organizational maintenance.

1. I have excluded one area of recent policy attention: those identified as part of the AAFP's strategic focus on diversity. While the discussions around policies designated as being about diversity provide important insights, I have not included them here because several of these policy debates had not concluded by April 2017.

Social Policies in the AAFP

While most AAFP policies concern topics directly related to primary care practice and reimbursement, about 10% of the policies address broader social and cultural issues. In general, these policies are proposed as important for family physicians because of their broad interest in "overall health" and their investment in patients. A few of these policies do specify the unique investment of family physicians; for instance, a 2015 policy on hydraulic fracturing (fracking) argues that family physicians have a special interest in fracking because they must treat patients who present with exposure to the chemicals used in fracking. As a result, family physicians must be able to access proprietary information about the chemical makeup of fracking solutions. However, most social issues addressed by the AAFP do not provide such rationales and present only a broad concern with health, safety, or patients. For instance, a 2016 "Discriminatory Policing" policy provides only the justification that the excessive use of force by police officers "pose[s] health and safety hazards" to communities of color (COD 2016). Likewise, the 2012 AAFP statement in support of civil marriage for same-gender couples simply states the AAFP's investment in "overall health and longevity," family stability, and the benefit of children (COD 2012). Table 1 presents the rationales provided for the fourteen social policies discussed in this article.

In general, the AAFP's social policies either provide no rationale at all for family physicians' specific engagement with these topics (in four of the policies) or simply note that the issue has implications for "health" and/or "safety." In part, the broad language of these organizational policies is a function of democratic process. Often, detailed justifications provided by the authors of the initial resolutions are objected to and removed during debates, leaving only broad language in the resulting policy. However, the broad nature of these social policies also indicates a perception that family physicians should demonstrate their investment in the lives of patients by creating policies on the frontiers of public health and the social determinants of health (SDH). These popular health discourses play an important role in shaping how social issues are conceptualized within the association (see Avni, Filc, and Davidovitch 2015).

They also act as "discourse[s] of power," providing tools for professional authority (Geltzer 2009: 527). In advocating for social policies, AAFP members frame public health and SDH discourses as resources that can increase the relative power of family physicians. For instance, in arguing on behalf of the organization's "Discriminatory Policing" policy at the annual COD meeting in 2015, one attendee contended that "this resolution puts

Table 1 AAFP social policies: rationales for family physician engagement

Topic, policy	Rationale for engagement
Discrimination	
Patient discrimination	—
Physician discrimination	Professional skill; value of diversity
Hate crimes	Health risks to patient
Discriminatory policing	"Health and safety hazards"
Guns	
Firearms and safety issues	Public health
Preventing gun violence	—
Same-gender marriage	
Domestic partner benefits	Elimination of health inequalities
Equality for same-gender families	"Overall health and longevity," family stability, children
Civil marriage for same-gender couples	"Overall health and longevity," family stability, children
Environment	
Climate change and air pollution	Adverse health consequences
Nuclear, biological, and chemical warfare	—
Nuclear waste disposal	Safety
Nuclear disarmament	—
Fracking	Proper diagnosis

[the AAFP] on the map and says, 'No other medical associations are bold enough to do this, but as family physicians we will not take injustice . . . any longer'" (Crawford 2015). Similarly, at the same meeting, a proponent of a resolution on gentrification described the issue in this way: "Gentrification is a social determinant and we anecdotally know it impacts health, but there is little research on the topic. . . . As a result, there haven't been policies put into place to protect our most vulnerable populations in our inner cities. I am hoping the Academy will recognize that with its unique position at the intersection of primary care and public health, it could take the lead on this issue" (Crawford 2015). In both of these instances, social policies are framed as strategies that will enable the AAFP to claim broader jurisdiction for family medicine.

The Evolution of Social Policies over Time

The social policies enacted by the AAFP can be described as transitioning from broader, more neutral statements to more explicitly politicized social

policy statements and from health-care-specific stances to broader social claims. Table 2 outlines the evolution of social policies on discrimination, guns, same-gender marriage, and the environment.

From More Neutral to More Politicized Statements. AAFP social policies have gradually transitioned from more neutral to more politicized statements. For instance, the organization's policies on discrimination have over time come to be more explicitly framed in terms of progressive social values. While earlier policies on patient and physician discrimination use more neutral language (and, in the case of the physician discrimination statement, advocate for hiring and credentialing decisions to be "based solely on verifiable professional criteria") (COD 1996), later policies, such as the 2016 discriminatory policing statement, attempt to position the AAFP as being at the forefront of social policy on behalf of marginalized persons. This transition is reflected in recent organizational campaigns to demonstrate leadership on diversity (an organizational priority identified by the AAFP's 2016 strategic plan) and has led to the proposal of several new antidiscrimination policies, such as a statement in support of transgender individuals being able to use public bathrooms of the gender with which they identify. Similarly, the AAFP's environmental and gun violence policies have been amended to oppose federal policies that deny funding to research on gun control and climate change.

AAFP members often make reference to the relationship between these more political statements and the long-term success of the AAFP during debates over policy. Advocates for these political policies argue that higher-profile declarations will benefit the AAFP by positioning it as a leader in social policy. In recent debates about expanding the categories of discrimination mentioned in the patient discrimination policy, advocates who pushed for the inclusion of additional categories have built their case around the public legitimacy that will be afforded to the AAFP as a result.

From Health-Care-Specific Stances to Broader Social Claims. AAFP social policies have also transitioned from health care–specific stances to broader social claims. For instance, the organization's first successfully established policy on same-gender marriage simply stated that "the AAFP supports the legal recognition of domestic partnership benefits regarding health care in an effort to eliminate health care inequities" (COD 2007). This policy addressed only the issue of health care benefits. However, policies in 2011 and 2012 argued on behalf of full legal equality for same-gender couples and eventually marriage. Similarly, the organization's discrimination policies have broadened from those that address discrimination in health care settings to broader examples of societal discrimination, and

Table 2 AAFP social policies: evolution over time

Topic, policies	Year	Change over time
Discrimination		Transition to proactive priority: Initial policies in opposition to patient and physician discrimination (1996) were later amended to incorporate additional categories of discrimination. The 2003 hate crimes policy was later reframed in terms of public health. Both the 2014 amendment to the hate crimes policy and the 2016 discriminatory policing policy indicate that antidiscrimination is a central concern of the AAFP.
Patient discrimination	1996 (amend 2015)	
Physician discrimination	1996 (amend 2015)	
Hate crimes	2003 (amend 2014)	
"Discriminatory Policing"	2016	
Guns		From broad statement about safety to more aggressive policy intervention: The 1995 "Firearms and Safety Issues" policy was created in the wake of the federal assault weapons ban and supports research about and enforcement of existing gun laws. The 2013 policy advocates for more aggressive policy intervention, advocating for specific restrictions on gun sales and background checks. The 2014 amendment reframes earlier policy in terms of public health. These two policies were also followed in 2015 by a "call to action" statement from the AAFP, along with seven other medical associations and the American Bar Association (Weinberger et al. 2015).
Firearms and safety issues	1995 (amend 2014)	
Preventing gun violence	2013	
Same-gender marriage		From health-care-specific engagement to broader social stance: the 2007 policy advocates for health care access only, while later policies advocate for "equality" (2011) and eventually marriage (2012).
Domestic partner benefits	2007	
Equality for same-gender families	2011	
Civil marriage for same-gender couples	2012	
Environment		Staking a claim in contemporary environmental policy: Environmental policies are updated to reflect contemporary discourse (e.g., 2015 addition of "climate change" to 1969 air pollution policy). Recent policies also stake a claim in issues such as fracking and disaster preparedness.
Climate change and air pollution	1969 (amend 2015)	
Nuclear, biological, and chemical warfare	1987 (amend 2016)	
Nuclear waste disposal	2003	
Fracking	2015	
Nuclear disarmament	2015	

its recently established policies on nuclear warfare and nuclear disarmament simply assert the AAFP's position rather than discussing the relationship between these policies and health care.

The Declaration of Support for Civil Marriage

The most divisive policy addressed by the AAFP in recent years has been an organizational stance on same-gender marriage. In 2007, members established a policy supporting domestic partners' access to health care benefits. Following the success of this policy, some members pushed for a stronger organizational statement explicitly expressing support for same-gender marriage. As table 3 shows, in both 2010 and 2011 members proposed policy statements about the health benefits of same-gender marriage, asserting that marriage equality is "not just a social issue." The 2010 resolution proposed that the AAFP publicly support "full civil marriage equality for same gender families to contribute to overall health and longevity, improved family stability and to benefit children of Gay, Lesbian, Bisexual, Transgender (GLBT) families" (COD Transactions 2010: 340). Following the nonadoption of this statement, the resolution was resubmitted in 2011. An almost identical resolution proposing that the AAFP support "marriage equality" (rather than "full civil marriage equality") was also introduced (COD Transactions 2011: 263). After open testimony, the reference committee assigned to the issue recommended a substitute resolution supporting "full legal equality" rather than an explicit mention of marriage (COD Transactions 2011: 340). This substitute was accepted by the COD and became AAFP policy.

In 2012, following the partial success of the previous year's resolution, both the medical student section and the resident section of the AAFP submitted resolutions declaring the AAFP's support for civil marriage for same-gender couples. Much of the testimony in support of the student and resident resolutions relied on personal anecdotes about gay friends, family, and patients and argued that not voting for the resolution would result in the AAFP being perceived as backward because of its failure to support civil rights. Physicians who did not support the resolution primarily focused on the fact that the debate was "no longer about health" and had become politicized. These physicians described the "Declaration of Support for Civil Marriage" as detracting from the AAFP's ability to address shared member concerns, such as health care funding problems and the viability of small family medicine practices. However, in spite of this testimony, the declaration was voted in as AAFP policy.

Table 3 AAFP same-gender marriage resolutions

Year	Policy statement	Reference committee recommendation	Outcome
2010	"AAFP Policy Statement on Healthy Benefits of Same Gender Marriage—Not Just a Social Issue"	Don't adopt	Not adopted
2011	"Equality for Same Gender Families"	Substitute	Substitute adopted
2011	"Healthy Benefits of Same Gender Marriage—Not Just a Social Issue"	Substitute	Not adopted
2012	"Declaration of Support for Civil Marriage for Same-Gender Couples"	Adopt	Adopted
2012	"Declaration of Support for Civil Marriage for Same-Gender Couples"	Adopt	Adopted
2013	"Resolutions Involving Social Issues Having Ethical, Religious and Moral Implications"	Don't adopt	Not adopted
2013	"Neutral Position on Civil Marriage for Same-Gender Couples"	Don't adopt	Not adopted
2013	"AAFP Reaffirmation of Non-discrimination"	Don't adopt	Not adopted

In 2013, discussion of civil marriage focused on the impact of the 2012 resolution on the unity of the AAFP. During the 2013 dues cycle, approximately 244 members contacted the association regarding the 2012 "Declaration of Support for Civil Marriage." Of those 244 members, 107 (44%) either allowed their membership to lapse or resigned from the AAFP (COD Transactions 2013: 194). At the 2013 annual meeting, three resolutions prompted discussion about the possibility of walking back the AAFP's stance on civil marriage. A resolution proposed by the Tennessee chapter recommended that the AAFP not accept resolutions "that have ethical, religious, and moral implications for division between members of the [AAFP]" (COD Transactions 2013: 343), and a resolution proposed by the Oklahoma chapter attempted to reverse the 2012

declaration on the basis that the AAFP had previously opted "to remain neutral on highly divisive and socio-political positions" (COD Transactions 2013: 307). The resolution pointed to the AAFP's neutral stance on abortion. Both resolutions failed, as did a reaffirmation of nondiscrimination, which proposed that "rather than target support to any specific institution," the AAFP revise its policy in opposition of discrimination to explicitly include marital preference (COD Transactions 2013: 309).

Conflicting Visions of Maintenance

Notably, the arguments made by both those organization members in favor of and those opposed to the civil marriage declaration were framed in terms of the relationship of the policy to the long-term maintenance of the AAFP. However, members representing these two different positions described organizational maintenance in different terms: those in favor of the policies described maintenance primarily in terms of external legitimacy, and those in opposition described maintenance primarily in terms of internal cohesion.

Maintenance through External Legitimacy

Many of the arguments made on behalf of the civil marriage declaration made reference to how a failure to adopt the policy would impact the AAFP's legitimacy. Several delegates made arguments about the AAFP being left behind in the national conversation on same-gender marriage. They argued that "the trend toward growing acceptance [is] both clear and unstoppable" (COD Transactions 2011: 268), citing national polls about support for same-gender marriage and a rising sentiment in society.

Testimony also made reference to policies and statements adopted by other medical associations, such as the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, and the AMA. These referents were used to justify that this issue was, in fact, a health issue (most frequently expressed as a part of SDH) and to position the AAFP as a part of a competitive ecosystem in which medical associations must take public stances to justify their ongoing legitimacy.[2]

Arguments about how the policies would impact perceptions of the AAFP were temporal in nature: delegates argued that they needed to make

2. Interestingly, statements in opposition to the policies also made reference to the policies adopted by other organizations, warning members that they should consider how these organizations' membership was affected by the adoption of these statements.

this choice in light of how it would be interpreted in the future. As one individual testified, "When looking back twenty years from now and children ask what side of this issue you were on, what do you want to be able to tell them?" (COD Transactions 2011: 268). Another argued that "by doing this, we're still arriving at the dance late as an Academy, because other major organizations have already gotten there. We have always been trendsetters, but in this particular case, we are at the back of the pack" (COD Transactions 2012: 392).

During testimony on the topic, the medical students and residents were attributed as having particular symbolic importance because they reflected the future of the academy. Residents and medical students gave testimony about how undivisive the topic of same-gender marriage was among younger physicians (separate resolutions in support of same-gender marriage had passed without difficulty at their congress meetings), and many physicians gave testimony commending these younger physicians because they represented the future of family medicine. In 2012, the reference committee charged with reviewing testimony on behalf of the same-gender marriage declaration used the support of the younger physicians as a primary justification for the policy, noting how impressed they were with how noncontroversial the issue was among the residents and students. An older physician spoke about his role as a dean of medical students, arguing that when his students see this resolution,

> they ask the question, "Why are you debating this?" These are the future leaders of our Academy and our country, and it goes back to that Wayne Gretzky thing. The reason he's so great as a hockey player is because he doesn't skate to where the puck is. He skates to where the puck is going to be. Our students and residents are rising in support of this, because they know where this is going to be at in the not-so-distant future. (COD Transactions 2012: 392)

Arguments that characterized younger physicians as visionaries appealed to concerns about organization maintenance. By crafting such arguments, organization members were able to envision a future AAFP that was oriented by commitments to SDH and social justice.

Maintenance through Cohesion

Arguments in opposition to the resolutions were largely pragmatic; these arguments tended to focus on the divisiveness of the issue. Opponents argued that the AAFP should refrain from taking a position on the issue

because of its potential to create discord within the COD and prevent the AAFP from being able to address shared priorities. Some opponents urged the COD to think of the potential attrition that the AAFP would face because some members would feel alienated by the policy. Others made reference to the issues they might be unable to address because of the attention they were giving to same-gender marriage, such as payment reform, board certification, and primary care physicians' scope of practice. A 2010 delegate, speaking on behalf of the Texas delegation, argued that addressing this issue would cause the Congress "to take our eyes off goals that are so critical right now" (COD Transactions 2010: 342). In 2012, another delegate placed another organizational priority in conflict with this resolution by referring to health care funding problems in the South, suggesting that the same-gender marriage declaration "derails" attempts to address these pressing issues (COD Transactions 2012: 395). Another Texas delegate made a similar argument, reporting that the physicians in her state do not understand why the association continues to debate this issue. She explained that her delegation supports families and is "absolutely against discrimination" but that to focus on such a politically polarizing issue takes away from other issues (COD Transactions 2012: 397).

This argument about the divisiveness of the issue drove the 2013 resolution "Neutral Position on Civil Marriage for Same-Gender Couples":

> WHEREAS, The mission of the American Academy of Family Physicians (AAFP) is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity, and
>
> WHEREAS, in the midst of tumultuous changes in healthcare and its financing the AAFP needs to remain true to its mission, united in purpose, and strong in numbers, and
>
> WHEREAS, in 2012 the AAFP Congress of Delegates approved a policy supporting legal marriage of same-gender couples, and
>
> WHEREAS, the AAFP has wisely decided to remain neutral on highly divisive and socio-political positions, (e.g. prochoice vs. pro-life policy), now, therefore, be it
>
> RESOLVED, That the American Academy of Family Physicians adopt a neutral position on the issue of civil marriage for same-gender couples. (COD Transactions 2013:307)

Testimony in support of this resolution argued that organizational policy should not take on divisive topics but, rather, should convey "unifying

principals [*sic*]." A neutral policy, it was argued, would "allow for members to agree to disagree" (COD Transactions 2013: 307).

The claims made by members during the debate about same-gender marriage reflect broader strategies used during policy debates within the AAFP. Arguments about the divisiveness of issues are advanced around a number of topics, for instance, ongoing debates about the AAFP's position on abortion. However, they do not reflect a universal logic by which organization members think about topics of social, moral, or political significance. As is indicated by the expansiveness of the policies proposed by members of the AAFP, members do not consistently abide by the belief that the organization should avoid social, moral, or political topics. Instead, the framing of policies in terms of their divisiveness indicates how members use concerns about the maintenance of the organization as a lingua franca during debate, even as they may voice conflicting visions of maintenance.

Discussion

The findings of this study provide insight into the strategies by which family physicians attempt to position their specialty within an evolving health care ecosystem. To date, research about family physicians' perception that they are "an endangered species" (Beaulieu et al. 2008) has primarily considered how they address their scope of practice (Beaulieu et al. 2008; Graham et al. 2002; Kamien 2002; Olesen, Dickinson, and Hjortdahl 2000; Wun 2002). In this article, I identify another way that family physicians navigate their status within medicine: through social policy creation.

By engaging social policy issues, family physicians attempt to strategically position the specialty of family medicine as future oriented and forward thinking. The framing of such policies indicates an awareness of the symbolic power of progressivism, whereby organizational actors can "exercise and contest power by advocating . . . [social] progress" (Berrey 2015: 5). The impact of the AAFP on broader nation-state policy on these topics is likely minimal; these policies function more importantly as symbolic political acts, conveying a message about the AAFP's status as a conscious and engaged health policy actor (Ovink, Ebert, and Okamato 2016; Edelman 1971, 1985; Stolz 2002, 2007).

Debate about these symbolic policies indicates a shared concern within the organization regarding the perpetuation of the AAFP and family medicine over time. However, as described here, organization members advance conflicting strategies for organizational maintenance. This study provides insight into the ways that organizational maintenance can serve as a lingua

franca for the articulation of diverse political viewpoints. It also provides insight about organizational conflicts regarding the validity of taking political stances. The AAFP debate about same-gender marriage has initiated discussion about the extent to which it is appropriate for the organization to take stances on political topics. However, as indicated by the growing number of policies on social issues, organization members are not only comfortable with addressing political topics; they perceive the creation of these policies to be an important strategy whereby family physicians can claim authority within in a broader health field that increasingly prioritizes frameworks such as SDH and social justice. But as Nina Eliasoph (1998) has argued, group membership—even in groups that engage controversial topics in the public sphere—often nurtures a culture of political avoidance, whereby members work to disguise their political engagement. Notably, debates about whether to engage political topics in the AAFP occur around issues about which there is substantive disagreement. These same considerations are not raised around issues for which there is not contention. Scott Jaschik (2014) notes that the Modern Language Association has adopted policies on topics such as the US Patriot Act and gun control. These issues are certainly political in the scope of nation-state politics and are not clearly related to the core activities of the Modern Language Association. However, since members generally agree on these issues, these votes failed to attract much attention from the broader organization. Similarly, Alice Robb (2014) describes how former New York City mayor Michael Bloomberg's aggressive antismoking policies, such as banning the sale of cigarettes to anyone younger than twenty-one years of age, were "met with near-universal support—even though his campaigns against soda and trans fats became fodder for national debates about individual rights and personal freedom" (see also Borovoy and Roberto 2015).

Conclusion

In this article, I have investigated the symbolic function of social policies in a physician professional association. However, it is important for future research to consider how their establishment reconfigures members' identity. In the case of the AAFP, many members saw their policy statement on same-gender marriage as a part of a broader movement on behalf of civil rights for same-gender couples. However, the creation of this policy has ramifications not only (and perhaps not chiefly) for the advancement of civil rights, it also has the potential to reshape the identity and composition of the organization over time.

AAFP members' identification of particular social issues as political is strongly determined by partisan affiliations. The resistance to many of these policies is better explained by conservative members' opposition to the leftward drift of the organization than by broadly shared concerns about limiting the scope of the organization's authority. To some extent, the AAFP has attempted to address the challenge of managing partisan polarization, for instance, through a neutral organizational stance on the topic of abortion. However, as the trajectory of the debate over same-gender marriage indicates, such debates may subjugate concerns about managing ideological heterogeneity and organizational cohesion to concerns about external legitimacy.

Eric Vogelstein (2016) argues against medical associations taking stances on controversial issues not grounded in medical disputes. He contends that the taking of stances on such issues can lead to a number of adverse outcomes: (a) the foreclosure of critical thought, (b) moral distress on the part of members, and (c) alienation from professional organizations. Because professional associations are assumed to have authority, stances on such issues may be deployed in other contexts without critical consideration of the underlying issue. Members of the professional associations may also, over time, come to stop thinking critically about the issue once it becomes settled. Alternatively, those who do not agree with the position taken by the organization may experience psychological or emotional pressure to adhere to positions that they believe to be morally wrong. This pressure may result in distress or, alternatively, cause them to view the professional organization as unreliable when it comes to other ethical issues. Whether or not one agrees with Vogelstein's assessment that it is wrong for professional associations to take stances on ethically controversial issues, it is important, from an organizational perspective, to consider the effects that the taking of such stances has on the composition of the organization over time and the perception that organization members have of their relationship to the wider field within which they act. In the case of the AAFP same-gender marriage debate, the taking of a public stance has affected the organization both by alienating some conservative members and by strengthening the perceived role of frameworks such as SDH and social justice within the AAFP.

Elsewhere, I have described the way that members of organizations attempt to manage ideological fragmentation and change (Brophy 2016). In the case of the AAFP, debates about topics such as same-gender marriage have the potential to shift how members perceive the central goals and identity of the organization. They also indicate an opportunity to investigate

how physicians—and, perhaps even more important, physicians who perceive their autonomy and role within the field to be under threat—attempt to maintain a coherent vision of the organization in spite of such shifts.

The findings of this study have implications beyond the strategies employed by family physicians and, furthermore, beyond health care. I develop new insights about the ways that members of organizations purposively engage in organizational maintenance through the creation of policy, even as they may advance contradictory strategies for maintenance. Future research should continue to investigate how the status of occupations within the broader fields in which they operate shapes the maintenance strategies in which these actors engage. This approach may provide insights into variation between the ways that actors of different statuses (e.g., family physicians vs. higher-status subspecialty actors, or professional physician organizations vs. nonphysician clinical professionals) engage in policy creation.

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Acknowledgments

I am grateful for the helpful comments provided by Eric Patashnik, Eitan D. Hersh, and the participants of the *JHPPL*–Tufts "Political Beliefs and Civic Engagement of Physicians in an Era of Polarization" conference, as well as participants in the University of Pittsburgh sociology department's "Works-in-Progress Workshop." Access to the AAFP Congress of Delegates Transactions was provided courtesy of the Center for the History of Family Medicine, American Academy of Family Physicians Foundation.

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