The Joy of Family Practice

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Many family physicians have written about how they influence, nurture, and empower people in their communities of practice. In this essay, the author writes of the personal joys that family medicine has brought him. An expression of his appreciation for his work as a family doctor, it touches on 6 themes that continue to rejuvenate his practice: love, faith, mystery, place, dance, and medicine. By examining the emotional and psychological dimensions of these themes, he offers a path by which other family physicians may be able to find sustenance and joy in their daily work.

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Remember the book The Joy of Sex? I would like to write a book, The Joy of Family Practice. There is a tremendous amount of gratification and satisfaction that can come from this kind of medical practice. We as physicians have the opportunity to develop the doctor-patient relationship to an incredible degree.

It’s really an incredibly fulfilling undertaking, and it makes it worthwhile to get up in the middle of the night to go out and see somebody or to spend the time necessary and do whatever you can to help people.

It gets back to the family—it’s a way of becoming part of that person’s family. That, to me, is more important than the salary, the benefits, and the prestige of being a doctor, and I think it’s much more sustaining.”

Lynn Carmichael

INTRODUCTION

Two decades ago I had the privilege of interviewing Lynn Carmichael, one of the early leaders of the modern family medicine movement and the founder of the Society of Teachers of Family Medicine. I was new to practice, fresh out of a family medicine residency and a research fellowship. Lynn was one among many elder statesmen in the discipline. I didn’t yet know what it meant to be a family physician—it took me quite some time in community practice to figure it out—and Lynn seemed so eloquent in his deep knowledge and understanding.

For years I hoped to read Lynn’s book, the one to which he alluded to in our interview: “The Joy of Family Practice”. But it never got written. Lynn had other responsibilities, I am sure, as chair of the Department of Family Medicine and Community Health at the University of Miami. Later he was afflicted with Alzheimer’s disease and slowly, over years, lost his exuberance, his creativity, and his presence. All but a shadow of the Lynn I interviewed was gone. Then in 2009 he died.

I have hoped, too, that in the absence of Lynn’s ability to write of his joy in practice, someone else would write explicitly about the personal joy of being a family physician. To be sure, there are many who have touched on the subject. Our colleagues Lucy Candib, David Loxterkamp, John Frey, and many others in the United States have spoken to issues of relationship and community as family physicians. So have practitioners from other parts...
Love is clearly a complex and easily misunderstood word, but I still enjoy using it to describe both what I bring to my practice and what I receive in return from my patients. Many years ago I read the Mexican poet and Nobel Laureate Octavio Paz’s *The Labyrinth of Solitude*, in which he defined love as “a perpetual discovery, an immersion into the waters of reality, and an unending re-creation.” I have yet to find a definition that works better for me as I put into words what I hope to offer to patients in examination rooms or hospital suites. To be sure, it has measures of mindfulness and presence and the Rogerian concept of unconditional positive regard, but at its essence the love I speak of is filled with an awe of exploration that permeates my encounters with patients. Who is this person? Who is accompanying him or her? Why are they here? With what issues do they present, and what unsaid concerns lie behind their chief complaints? What are their struggles and where are their resiliencies?

That I am a family physician and not a psychiatrist means that this expression is not solely bound by the world of words, but has physical elements as well. Auscultating heart sounds or palpating an abdomen with compassion, not lacking of sensitivity, does as much to create avenues of communication as does opening my ears to hear my patients’ suffering and distress. That I am a family physician and not a subspecialist means that this expression is not bound by barriers of organ system, procedural domain, gender, or age, but is at once inclusive and expansive. It is a love expressed wherever the patient concern might be. That I am a family physician means, too, that this love is expressed with humility. In one sense, it is for the most part focused around everyday matters, both chronic concerns with which people walk the paths of their lives, and acute, generally short-term problems that occasionally show up on those paths as pebbles to be tripped over. In another sense, it is given in recognition that little things take on meanings much larger than they may seem. The welcoming attention I offer may be the single most important thing my patients receive that day—or that year.

In return, I am greeted with a reciprocal sense of love, a respect, a trust, and an invitation to join with my patients as they make their ways in life, with gratitude when things go well as well as when they do not. My patients know that I am not infallible—I do not represent myself as such and am ready to admit my limitations—but they know that I will be there for them as much as is possible in the context of their medical concerns. As a family physician, I am greeted with love born of the understanding that we are more alike than dissimilar, that we are more connected than alone, and that—professional role notwithstanding—we are on a common journey through illness and pain, through difficulty and infirmity as well as joy.

**FAITH**

Family medicine and family practice used to be considered 2 different sides of the same coin. Family medicine was the academic discipline, the research and teaching. Family practice was what one did in offices and hospitals, the daily work of attending to patients. For marketing and political reasons, more than anything else, “practice” was dropped and the work of family physicians was subsumed under family medicine. Yet I consider my work still a practice. It is a studied practice, one with knowledge and skills and scientific acumen. It is also a practice of faith.

The faith I refer to is not some dogmatic adherence to a set of beliefs or unquestioning surrender to someone else’s authority, both of which seem to have created “turf” mentalities that divide people. It is a faith that by being open to patients as people in the context of medical encounters, something more therapeutic happens than is possible when strictly biomedical necessities are attended to. There exists a shared sense of possibility, a shared potential, and a shared understanding that leads us to go forward even when life is difficult or uncertain. It is a practiced faith in that, as a family physician, I must constantly be aware of looking...
for that potential, wherever it may exist in context of
my patients' lives. It is a practiced faith, too, in that this
abiding understanding helps support me in a work that
is often challenging and occasionally baffling.

My work is a practice of faith because it draws on a
worldview that is interdependent and inexplicable, much
more complex than the reductionistic biomedical model
that I was taught in medical school and residency. So
many factors influence the health of my patients—dis-
esases, behaviors, family dynamics, race, sex, geography,
political climate, and money are but some of them. It
is my job to sift through these with patients and, with
intelligence, discernment, and heart, assist them in see-
ing the possibilities latent within change and help them
move forward. Even when lives are not tidy and man-
ageable or predictable—and they rarely are in the face
of illness—I am there to observe, to recognize, to bear
wit ness to, and to offer a path amidst the unknown.

MYSTERY

Among other reasons, family medicine is challenging
because it deals with uncertainty, and I often think that
it is my tolerance for uncertainty that sets me apart
from my subspecialist colleagues. I deal with uncer-
tainty, first, because my patients present with what are
commonly poorly defined, undifferentiated problems,
and these problems reflect a variety of possibly related
or unrelated causal forces or events. Second, like most
family physicians, I generally see patients in short
blocks of time. Any sense of increasing certainty rarely
comes to me instantaneously but rather over repeated
visits with my patients. This sense is enhanced by an
awareness of the communities in which my patients live,
as well as by our understanding of how my patients live
in those communities. Third, because I am a true gen-
eralist, there will always be an overabundance of infor-
mation for me as a family physician to assimilate.

I was trained to look for and see information in
objectified bits and pieces as a means to lessen doubt—
and I should add that this created within me an oppres-
sive feeling of anxiety—but over time I have come to
see uncertainty as something to be accepted as part of
my work. It is not as though I have abandoned compul-
siveness as a strategy to cope with uncertainty—physi-
cians for the most part share this characteristic to some
extent—but I have learned that uncertainty is less to
be feared and avoided than to be creatively engaged as
a mystery to be explored.16 It is as though I lean into
the vague ambiguities that are inherent in the work I
do, expecting there to be stories behind the pain and
suffering my patients present with, knowing that I will
not hear them all, believing that it is through time and
trust and respect and insight—appreciating my own
abilities as a family physician to listen in context—that
they will become evident, as is needed, as is important,
and as is clinically relevant.

PLACE

The way I conceptualize my work as a family physi-
cian probably puts me on the periphery of allopathic
medicine, where the hegemony of biomedical thinking
reigns. Medical schools overwhelmingly teach their
students from a Flexnerian foundation that priori-
tizes particularized knowledge at the expense of an
integrated understanding of disease and health across
the biopsychosocial spectrum.17,18 For the most part
even family medicine residencies train their residents
in such manners and settings that suggest that family
practice is but the compilation of sets of knowledge,
mostly modeled after subspecialty practice and mostly
taught in hospitals or their associated clinics. Ironically,
it has been some community-based subspecialists who
have best understood my work. I suspect that while
they recognize my limitations of knowledge among
the patients I refer to them for consultation, they also
recognize their own limitations in understanding the
complexities of patient care outside the boundaries of
conventional medicine—where my expertise lies.

At one and the same time, I find satisfaction know-
ing that my work positions me at the core of why
so many people entered medicine: to bring care to
people, to offer hope when possible and solace when
needed, to cure when it is a reasonable goal, to manage
and support when it is not. From an organizational per-
spective, family medicine is an eminently logical foun-
dational layer within a rational health care system, and
I am extremely proud to be a very small part of that
foundation. But we do not have a rational system of
care here in the United States,19 and it is difficult and
often lonely to avoid the strong pulls that money and
status and ideology present in our country. As for me, I
take refuge in accepting that there are more important
things in life than those that can be conferred by the
traditional accoutrements of our culture. I also know
the central role I play in my patients’ lives, as a coun-
selor, as a guide, and as their personal physician.

DANCE

It is in my role as personal physician that I sometimes
find myself figuratively dancing at work. My fashion
sense is not flashy, my moves are not fancy, and I have
been known to miss beats and step on toes occasionally.
But there is an undeniable elegance to what I am doing,
to how I am interacting, and to the knowledge and skills
and attitude that I bring to my encounters with patients.
I find myself dancing with patients when there is a give and take between us, giving space for each one of us to lead and follow when it is most appropriate. When I lead, my intent is to help my patients and their families to feel a sense of competency in the face of challenge. When I follow, it is to allow them room to express their fears as well as their own special strengths. I find myself dancing with my patients when the rhythm of their needs and my responses create some mutually resonant rapport. I find myself dancing with them when, after the 10 or 15 or 25 minutes of our visit is done and the tasks of problem list review and medication reconciliation and charting are completed and I am leaving the examination room, I can honestly say, “I’ll be thinking about you. Until our next visit.”

When we are dancing, there is a flow between my patients and me that suggests connections beyond the examination room, residual reverberations of words and movements and intents. There is a temporal connection that extends well after the office visit is over, one that I believe helps direct their welfare at the same time it nurtures my well-being. There is a human connection, too, one that extends to and is amplified by the people around us, the receptionists and nurses and laboratory technicians and social workers with whom I work. As well, there is a spatial connection that helps all our lives become more expansive, more readily willing to grow, and more conscious of kindness to self and others in the face of adversity. The art of the dance is, ultimately, about dignity and grace across dimensions of time and person and place, about sharing a generosity of spirit when the despair of illness threatens, and allowing the effects of that generosity to linger well after my patients and I part.

**MEDICINE**

The foundation of what I do as a family physician is address the medical concerns as my patients present them. I hear their stories of illness, how they understand their perceived problems. I conduct a physical examination. I recollect bits and pieces and, sometimes, entire wholes of information I have learned, of facts and theories and patterns, and reconstruct them in my own mind focusing on the specific and particular needs of the person or people before me. I diagnose. I treat. I do what physicians of whatever ilk do: I attend to my patients’ needs as best I can.

In response to those needs, I play many roles: interpreter, guide, diagnostician, advocate, and healer. In playing any one of these roles, I am supported by the structure, the knowledge, and the language I learned many years ago in medical school and residency. I am supported as well as by the titles I have earned, first as physician and later as family physician. But while my medical training continues to provide a framework for my work, it has been but a start to something more whole, more complete, and more authentic—to that which I truly treasure—my work as I see it, as a family doctor.

**CONCLUSION**

I am not oblivious to, nor have I been immune to, the difficulties that family physicians (or other primary care clinicians) face in today’s medical environment. I certainly know that there are days when my family practice is not so joyful, when things go wrong, when mistakes are made, and when people (patients and professionals alike) are difficult to reach or even refuse to join in. I am aware, too, that within family medicine there are those who will not be able to comprehend my insights into practice and may, perhaps, even be threatened by them. But in writing this, I have chosen to hold up for inspection the fulfillment that my work brings to me. Rather than focus on the challenges of my work as a family doctor, some due to a socioeconomic structure that has fostered the creation of a medical industrial complex and others to the human need for conservatism and conformity,20,21 I have chosen here to explore and appreciate the sources of that happiness and what continues to nurture it.

For it is in this exploration and appreciation that I am best able to find the gratification and satisfaction that Lynn Carmichael shared with me many years ago. It is by examining the myriad facets of my daily work, modest as they are meaningful, that I am able to sustain myself in contentment as a family physician. It is in doing this that I open myself—and my patients—to joy. So may we all.

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