REFLECTION

Where We Belong: An Open Letter to My Colleagues in Training

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ABSTRACT

Although the American health care system seems forever in flux, the young doctors who enter it provide one constant: their desire to help others. How will this desire express itself in an evolving marketplace? This letter is a reassurance that meaning and purpose can still be found in caring for others and investing in their worthy lives.

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Dear reader, congratulations on your decision to become a family doctor. Not a little time, hard work, and treasure has gone into this project. You are wedded to a future that some speak of cynically, but like any marriage, it will return only what you invest. And the rewards—in terms of gratitude, sense of purpose, and connection to a community—are handsome indeed. You may not understand the path chosen by my generation, just as we will puzzle over yours. But it would help us both to reflect on that journey, knowing that the arc of any career follows a similar trajectory.

Long before I began my formal education, I was studying to become a family doctor. Life in our small farming community was set to the seasons and subject to the exigencies of nature. The social mores of doing one's part, extending neighborly goodwill, and practicing stewardship for the land were strengthened by their daily exercise. My father was the local GP, and I took great pride in knowing that our town depended on him. He didn't choose or invent his role. He just practiced it according to needs of his patients and the limits of his own temperament and training. There was no talk of community health in those days; health *was* community. My dad knew where he belonged—and why.

During my childhood, his practice changed before my eyes. The long car drive to the regional hospital became a 15-minute jaunt, thanks to Hill Burton funds that built our rural county hospital. He traded his half-day of house calls for scheduled office visits. Payment in cash and barter were replaced by health insurance. Solo practice gave way to groups. Yet he remained where he began. His 6-room cinderblock office stood as a symbol of security for the whole community, as was his published telephone number in the local directory and the presence of his sand-colored Chevrolet in our driveway at 808 West Elm.

For the next half-century—and my first 25 years in practice—the routines of medicine changed very little, even as the quality and cost of health care rose exponentially. Then the winds of change returned and blew hard against physicians on the front lines of care.

The past decade has seen nearly universal adoption of the electronic health record. Designed to accelerate billing and collections, the EHR would soon prove that it could generate enormous amounts of data,

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transmit it seamlessly, and facilitate care coordination among multiple providers. But it also opened the door to payers who could monitor our practices and impose external standards and incentives. Data now demands so much of our attention that we often overlook the patient sitting before us.

To meet reporting requirements, our ratio of support staff to clinicians jumped to nearly 5:1. Who can recall their names, let alone their workflows? Little wonder that our patients, too, get tangled in the web of telephone menus, front office procedures, and clinical triage options.

Just a decade ago, over 60% of US physicians owned their practices; today, less than one-third of family physicians do.[1] When I recently joined the ranks of the employed, my income rose as my workweek shrunk, but so did a sense of control over my destiny. For many of us, the supervisors who decide how we practice became increasingly removed from the work we do. But they can read our productivity reports. And know that while we lose money in direct patient care, we generate more than $2 million annually in hospital admissions, prescriptions, tests, and procedures. Some observers point to the arrival of MBAs in health system boardrooms as an inflection point in the rise of burnout among health professionals in America. More than one-third of practicing physicians report a loss of enthusiasm for their chosen profession, regard patients as objects, and feel that their work has lost its meaning.[2]

For those of us nearing the end of our careers, the renewed interest in primary care has been a source of consolation. But the new graduates are not us. You are less interested in full-time employment and broad-spectrum family medicine; you are more comfortable with being an employee than an employer; you are committed to maintaining your work-life balance. And you face an unprecedented change in the way that primary care will be delivered, including an array of value-based payment schemes and the addition of physician assistants, nurse practitioners, clinical pharmacists, and nurse educators who will care for patients in ways we once thought were the purview of the doctor.

Family physicians have long struggled with knowing where we belong. We straddle a fence between mainstream medicine and alternative healing, hospital corridors and farmhouse hallways, the therapist's couch and the surgeon's table. But we have never doubted our purpose. Our duty was simply to be there for our patients, with a desire to help; without promise of cure. With time to listen, to probe, and give comfort— if only by our presence when words and treatments fail. To strive to love something about the person in front of us, realizing that we may be the obstacle that keeps us apart.

Unlike my father and me, young graduates like yourselves sit before a banquet table of practice options. Some of you will become *urgent care* clinicians. Others will find security or accomplishment in the performance of office *procedures*. Some will become experts in illness *prevention* and the pursuit of *wellness*. Others will practice in the swath of their certified *fellowships* in geriatrics, sports medicine, integrative medicine, surgical obstetrics, or hospital-based care. And health centers will depend on your leadership to harness the talents and expertise of a burgeoning and fully-integrated of primary health care team.

As for me, now in the last leg of my career, I have become a *chronic care coordinator*. After giving up obstetrics and closing my practice to new patients, my patients are aging as fast as their doctor. I have become their travel agent, managing referrals from specialist to specialist and minding the revolving door between the hospital, rehab, and home. Much of my work now is an unvarying routine, and tinged with the melancholy task saying good-bye to so many old friends. But even here, I find hope in the eyes of my patients, their families, and all who care for them, for they understand what holds a community together. They know where they belong.

All of your options will provide a good income, if not by comparison to your surgical classmates, then certainly in relation to those you care for. You can still choose to know something of your patients' lives: the depth of their suffering; the unfairness of their circumstance; the steps that led them there, for which are only partially responsible; the sources of their despair. For one's calling is not defined by the job description. Vocation is equally about the commitments you will make and keep. It is often about edging away from a place of safety, privilege, and relative comfort. It is about listening to what others are asking of you, and about your heartfelt response.

A quarter-century ago I wrote a paper called "Being There: On the Place of the Family Physician."[3] It was only the third of my long-winded career, but it captured what would become an urgent and recurring theme. I told stories of patients for whom my sole redeeming act was to bear witness to their sorrows—to be there for them when they called and needed me. Until then, I didn't know how something so little could matter so much. Nor can you, until you experience it for yourself—on the hospice wing, in an after-hours phone call, or during a work-in that disrupts your plans. A patient's smile, hug, or simple expression of

gratitude goes a long way to shore up a beaten-down day. As your schedule becomes increasingly compact, it will take courage, vision, and personal sacrifice to make space for the unexpected—a space fiercely contested but critically important to your identity as a family physician.

Surprisingly, such proud moments can lead to practice redesign. Twelve years ago, we began caring for patients with opioid use disorder because. Why? Because to ignore them would have broken our hearts. We began to offer medication-assisted treatment in the form of buprenorphine, weekly recovery groups of 10 to 12 patients, and an integrated behavioral health approach where therapist and doctor became the group's co-facilitators. We introduced them to coping skills, goal-setting, self-reflection, and insight into their disease. We offered them the kind of support that other people might receive from their family, employers, and sober friends. We created a receive community where they could connect with peers and receive honest feedback. We insisted that their lives are worth something, and offered them hope of achievement. In exchange, they gave us a role in their recovery beyond the mere prescription of a pill.

With the success of our recovery program, we began to apply the principles of group therapy and inter-disciplinary collaboration to other chronic diseases, elder isolation, and care management. None of us were trained for this; it was just the right thing to do. It relieved the gnawing frustration of having nothing else, or at least nothing useful, to offer. Patients benefited from their newfound sense of community and so did the entire practice. The lesson here is not that we all should treat addiction. Rather, that we should remain open to the unexpected. Be watchful for ways in which your desire to help can strengthening communities.

Of all my past teachers, none contributed more to my professional formation than the late Gayle Stephens. He not only taught me how to write, but what was worth writing about. It was once said of him, and his most famous essay, "Family Medicine as Counter-Culture:"

"[Dr] Stephens taught a generation of personal doctors to hold their patients in a state of grace. To locate primary care practices in the context of where people live, work, and play was not countercultural because it went against the grain; it was counter because it ruptured thought. It located health and healing in communities, in people, and in relationships."[4]

I have only an inkling of what awaits you, the new heirs of family medicine. Likely, there will be territorial skirmishes, threats to your income, and conflicts around the rules of practice. Much lies outside your control. Yet you have entered primary care at a high and heavy tide; the challenge is to own the crest of the wave. You grew up with computers and social media; the challenge is to master them and not be their slave. You understand the role of social determinants in health and disease; the challenge is to share the burden so as not to be devoured by it. You promised to build a life for yourself outside of work; the challenge is to remain fully alive inside it.

Though our words may differ, I see that we are vowed to the same profession and speak of a mutual desire to help others. You are learning that health resides in the community and flourishes where purpose and connection co-exist. You will find creative and compassionate ways to invest in, perhaps even live in, the neighborhoods and communities you serve. This gives me unbridled optimism for a future we must all learn to live in.

Where do we belong? It is not a logical decision, nor ours alone. We are tugged by an allegiance to place of origin. We must honor financial obligations and family commitments. We have made choices narrowed by the scope of our training. And then, enter our patients. It has long been the legacy of family medicine to let them speak, and to listen carefully to their every word.

Old travelers like me can guide you, but this is your moment. Your opportunity and challenge is to be there for your patients, on their terms and yours, in communities you both will call home.

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