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Family Medicine

PRESIDENT'S COLUMN

Why Family Medicine? Timing, Relationships, and Opportunity

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If we all were to share stories that have shaped our lives and our careers, we would likely find commonality in the themes of timing, relationships, and opportunities.

My journey to family medicine was anything but linear. I wish I could describe it as intentional. A psychologist by training, I found my way to family medicine during my residency at the University of Missouri–Columbia, where I worked in consultation with family physicians in a student health clinic. When the time came for me to find a fellowship, after living apart from my husband during training, the right opportunity appeared at the University of Mississippi Medical Center in the Department of Family Medicine. I never imagined that I would one day return to lead that same fellowship program and join the family medicine faculty. It was there that one of my fellows told me about an organization called the Society of Teachers of Family Medicine—and about the Behavioral Science and Family Systems Educator Fellowship (BFEF).

The BFEF was highly competitive; it was my final year of eligibility to apply, and it was Dr Deborah Taylor's last year as director. What timing, what relationships, and what opportunity! When I asked Deb for some quick mentorship, her advice was simple: "Always be willing to say yes." I did. I said yes to opportunities that emerged at the right time and began to forge relationships along the way—relationships that led to opportunities.

I could end the story here, but like a classic doorknob complaint, there is a little more. I cannot fully answer "*Why family medicine, why me, and why now?*" without also sharing about a patient. In family medicine, our meaning often lives in the stories of our patients and their families. This is a story I cannot let go.

He was 38 years old, married, and a father of two. He was young, relatively healthy, and worked as both a farmer and a security officer—strong, dependable, a provider in every sense of the word. True to the stereotype, he didn't come to the doctor often. When he finally did, his chief complaint was simple: "I'm just tired, doc." His family physician listened and ordered routine labs. Nothing dramatic, nothing rushed. When the results returned, they showed exactly what no one ever wants to see.

Here is a detail that matters: his family physician asked him to come back. They sat with him. They explained the labs. They offered what reassurance they could, even when reassurance felt thin. Then, they referred him to oncology.

The oncologist was optimistic. MD Anderson had a new experimental therapy with a reported 90% remission rate. For most patients, those odds were fantastic. For him, they weren't. He was in the 10% for whom it didn't work. Over the next year, his cancer didn't dramatically worsen, but something else did. He lost an enormous amount of weight, going from 280 pounds to 120. When he brought his new symptoms and concerns to his oncologist, the response, delivered with little emotion, was brief: "You have cancer. I'll see you again in three months." That was it.

He returned home with his faith in medicine shattered. He told his teenage daughter something that should stop all of us cold: "You might be better off if I wasn't here anymore."

It was his daughter—the teenager—who pleaded with him, "Go back to your family doctor. Ask if there's anything else."

When he returned, his family physician's intervention was powerful. He took the time and listened, really listened. He did not dismiss his despair, or assume someone else had it handled, or say that the specialist knows best. He offered

encouragement, hope, and he remained curious. By the end of that visit, there was enough reassurance to try again, to see a new oncologist.

What we will never fully know is whether that family physician recognized passive suicidal ideation in that moment. We will never know whether he realized the hopes of a teenage daughter were balanced on that encounter—the hope that her father might see her graduate, marry, or have children. It turned out his symptoms were not due to cancer progression at all. They were due to histoplasmosis in an immunocompromised patient who worked on a farm with chickens. It was a diagnosis that required curiosity and relationship.

Because of that family medicine visit, he lived to see his daughter graduate high school, college, and to give her away at her wedding. He lived long enough to hold his grandchildren—my children. Family medicine did not merely extend his life; it returned meaning to it and changed our family forever.

Would this still happen today?

Would we bring a patient back to discuss devastating results—or release them through the electronic health record with a follow-up call from a scheduler? Would we notice dramatic weight loss amid fragmented care? And if we did, would we assume the specialist was managing it? Would we have time to see despair reflected in a patient's eyes or would we move on because the inbox is full and the schedule already behind?

These are not accusations. They are pressures.

Nearly a decade ago, John Frey, MD, articulated the challenges facing the specialty: the need for educational and practice reform, concerns about technology's impact on care delivery, preservation of the doctor–patient relationship, the economics of education, social responsibility to marginalized populations, and the persistent struggle to build the physician workforce our country needs.[1]

Nearly 10 years later, we are still naming the same challenges. This means the problem is not awareness. It is action.

Family medicine was founded by people who refused to give up—who were strategic and tenacious. They understood something that has never been more relevant: family medicine is not defined by what we know. It is defined by how we relate. By whether we listen and remain curious, and by whether we stay present when it would be easier to move on.

Each of us brings a gift to this work—some more than one. But like a symphony, progress requires unity. Without it, our message is lost in the noise. We need clear, actionable goals to shape the next generation of educators and attract learners who share the core values of family medicine: empathy as a practice, technology as a tool and not a substitute for presence, and protected time for listening, even when the system emphasizes speed.

We need models that allow family physicians to practice family medicine; models that sustain joy, recruit value-aligned learners, and strengthen relationships between patients, communities and physicians.

This is why a Louisiana farm girl from humble beginnings is here at the right time, with an opportunity, and with awesome relationships. I look forward to working alongside all of you to strengthen the family medicine faculty workforce and the student pipeline.

We know relationships.

We have opportunity.

And now, it is time.

Thank you for allowing me to serve as the 54th president of STFM.

REFERENCES

1. Frey JJ. A creation story. *Family Medicine*. 2017;49(4):270–274.