This We Believe

2007 Award Submissions

Presented at the 2007 STFM:NorthEast Region Meeting by the:

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This We Believe

Family Medicine Style

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Modeled on the successful "This I Believe" project as heard on National Public Radio, the FMEC offers physicians, physicians-in-training, and medical students engaged in Family Medicine organizations, the opportunity to express their core beliefs about serving others. We believe that sharing our passion for being healers will not only strengthen our ability to serve others but also will connect us to one another and strengthen our mission in Family Medicine. We invite students, residents, faculty, and practitioners to submit statements of their beliefs.Separate awards will be offered for each group. The submissions will be reviewed and those selected as "best of" within each group will be invited to share their statement from the podium during the 2007 STFM: NorthEast Region meeting. The "best of" statements will be collated and shared in print with all conference attenders and will be distributed through the FMEC web site following the meeting.

We seek expressions of the core attitudes and beliefs - the personal philosophies - about caring for others. Authors should write up to a few hundred words expressing the core principles that guide your approach to caring for others. Feel free to use any format that helps you to convey your beliefs: a story, an anecdotal experience or you may use discursive writing. We seek that personal, inner vision that drives your passion to serve, to teach, and to be with those who need your service.

We know that those engaged in Family Medicine have a broad range of interests; from full scope Family Medicine; to international health; to care of seniors, adolescents; children; maternity care and women's health; end of life and palliative care; care of underserved, rural and inner city populations; research; education; practice improvement and health care leadership to name just a few areas of special interest. Statements of belief that share the passion that led you to your special interest are welcome as well.

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THIS I BELIEVE

I am a Family Physician. My generalist eyes can see only the big picture. It is beautiful, boundless, peaceful. All the little frustrations and hassles I encounter each day are just the sharp, shiny fragments that make up the mosaic of my life and create a grand design that I cannot even see yet. The unit of my life is a single day. My job is to make each one as full and magical and mysterious as possible. Forget about plans, and final destinations, and bills, and deadlines, and legal matters, and the rest. How's this day? How am I in it? Am I with the people I want to be with? Am I right with them? In my business, people is the medium of healing, the currency of my business, the stars of my stories. You gotta love 'em—warts and all. And I do.

The marvel of my career in Family Medicine is that I can be any thing that I want to be, anywhere, full-time or part-time, a practitioner, a school or public health official, entrepreneur, author, artist, or philosopher. I become these roles as they need me.

I deal with the stuff of life. People. Lots of them. Births. Deaths. Illness. Employment. Summer camp. Trauma. Divorce. Addictions. Abuse. I take care of the heroes who survive these traumas, and who honor me by sharing their stories and their trust. I help just by making them strong enough in body or spirit, one way or another, to show up for another day in an attempt to make their lives right. What they need from me is not the Encyclopedia Medicana, nor any particular pills, certainly not any particular tests, not even a right diagnosis. You don't have to be an Einstein to do this. Something quite other is required. What my partners in healing need is just a commitment from me to be there for them, whatever their need, whatever sorry shape they're in, to help them get through one more day and to have one more chance to make it right, as they understand it. This job is about helping two sets of lives to be lived to the fullest—mine and theirs.

I can only hold this blessing if I learn to be gentle with myself. I expect far more of myself than my patients do. I started off very afraid of making mistakes. Why? Do I think I have the option of not making them? Do I think I am not eligible for forgiveness either by myself or my patients. Sigh. I am an ordinary mortal. That's what's required for this job.

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THIS I BELIEVE

In the early dawn of her 38th week a pool of warm fluid signaled the beginning of a process that raised a pervasive fear she could only thinly suppress. Her sister in Guatemala died of a post partum hemorrhage in spite of her midwife's attempt to quell the deadly flow. Today, as the pink tentacles of a Southwestern sunrise made their way across the horizon, it was irrevocable. She was starting a family with her American husband, a thousand miles away from her family of origin trying to suppress the memory her beloved sister that had gnawed at her from the moment she learned she was pregnant.

I personally saw her for every prenatal visit contrary to our usual practice policy. Her husband, who was also my patient, accompanied her each time to supplement my ten word Spanish vocabulary. In spite of our linguistic distance, I felt her fear mounting with each step toward term and we developed a beautiful little folk dance of shared concern. Every ache and pain was magnified, the harbinger of impending disaster that I washed away with a confident reassurance she became addicted to like an opium-induced vision. The weekly visits became every other day until I went to a two- day conference during her 38th week.

The nurses informed my partner, Rob, when she reached the hospital. Moderate contractions five to ten minutes apart, clear fluid, but they were concerned about the unexplained blood pressure elevation, and a pain response that seemed out of proportion to the mild, barely palpable contractions. HELLP labs and the ultrasound were normal but she had not progressed beyond two centimeters after four hours, a clearly dysfunctional labor pattern with worrisome elevated pressures.

I landed about midnight, wearily made my way home and listened to my voice mail. "Angelica's water broke" was the first message. I could hear the strain in Tom's voice. " I hope to God you are home from your meeting" was his final irritated plea. Spurred on with an intrinsic shot of adrenaline, I was on my way to the hospital without a confirmatory phone call.

When I arrived the look of relief on Angelica's face said everything. "Thank God you're back," she gasped as tears welled up in her weary eyes, " Thank God you're back."

I could see her body relax and the contractions became more and more effective. Her blood pressure normalized and within a few hours she delivered a beautiful baby boy without complication.

I believe everyone deserves a personal physician. Something happens in that relationship that can move mountains and change physiology. In times of terror, expertise and diagnostic acumen just may not be enough. I believe individual caring unleashes a neurohumoral response that conjures up an ancient spirit to walk with us in times of distress. It coaxes out the inner strength from the depths of our soul that bridges the gap between what can and what will.

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The Physician-Patient

I believe in the healing power of the physician-patient relationship. In this world of technology, medical students (and patients) sometimes come to believe that only science and machines have the answers to all health problems. I have seen countless examples of the transforming power of the relationship between a doctor and his or her patient, in my own professional life and in the offices of those physicians that helped train me. While professionalism is stressed today in medical education, I believe it is more important for physicians to learn how to share the most intimate moments of life with their patients. I was trained as an actor before going to medical school. There are incredible similarities between how an actor learns how to relate to their fellow actor on stage, and how physicians should interact with patients. Making eye contact without staring. Getting physically close without getting in the other person's personal space. Learning to respond to the emotions of the person across from you. Physicians are given extraordinary opportunities to relate to their patients on a human level. One of my great mentors, Dr. Jim Nunn, a family physician in Buffalo, New York, had a sign in his waiting room that said: "Family physicians: cure sometimes, treat often, comfort always". I believe all physicians must learn the important value of providing comfort to patients, especially when patients are faced with life's uncertainties. So I believe we should touch our patients when we see them – literally. The touch of a caring physician is reassuring. I believe we should get down to the level of our hospitalized patients – by sitting on their bed (after asking for permission). I believe we should, when appropriate, ask our patients if they need a hug. Telling a patient you are proud of them can be a highlight of their lives. I believe in holding a patient's hand, and just being still, when they are crying. And I believe in laughing and crying with our patients. I believe we must all have unconditional positive regard for our patients. This means never relegating them to the status of a collection of organs. It means being respectful to the old, playful with the young, and collegial with patients our own age. Family Physicians are given rare opportunities to see so much of the human condition. We watch the miracle of life beginning and we get to sit at the bedside of the patient whose life is ebbing away. I believe that should make us humble. We physicians ultimately earn our livings based on the misfortune of others. I believe that no matter how advanced the science of medicine gets, ultimately the exam room door closes, and you are face to face with another human being that happens to be your patient. I believe what happens at those moments is what makes medicine the healing Art that it is. And I believe we should all learn to be great artists.

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Introspection

I believe introspection is an exercise that should be a daily requirement. I have had the recent pleasure of going through the process of a gut-wrenching decision regarding the balance of family, job, church, and community. I have been examining my perspective on life, my goals and dreams. I do not think I take on this process enough. I am sure I do not. How many of us really know what we want to achieve and what we're supposed to accomplish? What will make us fulfilled? The motivational speakers and writers of today teach us exercises in order to focus our energy on introspection. They teach us ways to achieve our long and short term goals. We learn how to deal more productively with others and to get what we want out of life. We learn to seek happiness in the day and the importance of delaying gratification in education, work, and relationships. We have a five year plan, think that's a really long time to wait and tell ourselves it will all work out. The focus of our work in life should be us. In order to find that which we seek, we must first discover all that we have. What a magnificent under taking this has been to start a new year. I have had the pleasure of having my amazing wife give me guidance and provide me with thought provoking questions pertaining to my hopes and dreams. I have begun to realize how smart my wife really is. I have been able to sit back and really admire my children and I am beginning to understand what it means to see and hear God in their eyes and voices. I have terrifically supportive family and friends, people who say they will have me in their thoughts and prayers and mean it. I've developed a relationship with a thoughtful spiritual leader who studies people and knows which buttons to push. How wonderful it is to have so many people that are really looking out for my best interests. There were days when I would feel alone and uncared for. Not anymore. I need to remember the people in my life who are interested in me and all the help and support that they provide. I have realized that no matter what I decide, I have already achieved so much. I may be the most blessed person on the planet. All this from introspection? You bet. I am going to do this a lot more often.

(Submitted By: Robert A. Barnabei, MD, UPMC McKeesport, McKeesport, PA)

People Not Technology

I chose medicine as a career in high school when I watched patients arrive at Doc Shapiro's office as I weeded his gardens. No matter how hard he worked as the only doctor in our small town, his efforts could never meet the community's needs. His efforts were disconnected from the rest of the medical community. I realized I would have to connect to that community better or I would get Doc Shapiro's results. I got an insight into the power of computer technology to transform my world a week after we upgraded our home computer from an educational "toy" to a "real" computer. On our "big" 15-inch monitor was a sticky note from David, our third grade son, "I love my computer!" What could there be in this inanimate object that could inspire human emotions? I grew up watching Art Linkletter feeding punch cards into a huge UNIVAC computer on House Party. In college we were still feeding punch cards into a building filled with "Fat Albert," the university's only computer, who deservedly won the Meanest Man on Campus contest. I made it through medical school and two years of residency before my teaching hospital bought a computer for printing labs at night. I was finally getting something useful from the machine's servants, but nothing I controlled. Ten years later at a Society of Teachers of Family Medicine meeting, I first saw a demonstration of an "Electronic Medical Record" using MS-DOS and vapor ware of what it would look like in the Windows that David had fallen in love with two years earlier. I have many memories of setbacks for which Fat Albert earned his reputation, but the successes have been so numerous that I am still pursuing that vision fourteen years later! So, have I come to believe in computers? No! They are still merely inanimate objects. What makes them "loving" or "mean" is the work that countless people have dedicated their lives to – enabling a vision we have. I believe in the ability of people to finish the job we have just begun. I believe it takes a combination of two world views a generation apart. Working together – vendors, customers, patients, payers, and the government – working on many aspects in parallel – we can create a tool set we all love. We will love it because it enables us to heal better than Doc Shapiro's work ethic alone.

(Submitted By: Bryan L. Goddard, MD, United Health Services, Johnson City, NY)

“As family physicians, we have a special opportunity, even obligation, to make a difference”

I have been motivated to try to make a difference since my early years in medical school some 50 years ago. After summer preceptorships with two excellent general practitioners, my mind was made up for rural general practice, where I had seen my mentors make a difference every day. After three years of graduate training, my family spent six years in Mt. Shasta, a northern California logging town. Small enough to see the problems and still make some positive changes. Beyond a busy solo practice, I got involved in setting up a two-bed coronary care unit, training the volunteer nurses, and improving the outcomes of our cardiac patients.

After six years in rural practice, Family Practice became its own specialty in 1969. The biggest need then was to start teaching programs in hospitals and medical schools. So we moved to Santa Rosa, California, to convert a general practice residency to a family practice residency affiliated with the University of California San Francisco. That launched my full-time teaching chapter, lasting 21 years. Early in those years, it was obvious that our new specialty needed its own literature of records, not just CME type review journals. So an early interest in writing led to 30 years of editing two of our journals (JFP and JABFP). Though unmet, an important mentor at that time was an English GP, Patrick Byrne at the University of Manchester, who pointed out that “unpublished research has never been undertaken as far as anybody else is concerned”. (1)

Returning to family practice on San Juan Island in 1990 after retiring from the University, I again sought out the special challenges and sense of community of our rural setting. The big need then was to stabilize our four-family physician rural practice, serving about 7,000 people on our island. The group practice had been a revolving door for physicians, facing closure on several occasions due to fiscal deficits, mostly due to unreimbursed emergency care. An ambulatory hospital district was our answer, and the practice since then has served a growing population well.

After stopping practice in 1997, these last ten years have been focused on research and writing on our health care system. This chapter has been inspired by other mentors, even unmet, such as Arnold Relman, who coined the term “medical industrial complex” in 1980 (2). It is now obvious that our market-based system is out of control, unaffordable even for middle-class families, and unsustainable without major reform. The need for fundamental reform is still being denied in many quarters (including by some of our own organizations). Again, my early interest in writing has been my way of educating myself and organizing teachable content on the issues.

1. Byrne, P.S., Why not organize your curiosity? J. Fam. Pract. 5: 188, 1977
2. Relman, A.S., The new medical-industrial complex. N Engl J Med 303: 963, 1980

(Submitted By: John P. Geyman, MD, Retired, Friday Harbor, WA)

This I Believe

Each of us is responsible for the other, whether it is the person next to you or the group in need 10, 000 miles away. I believe that this we have chosen to be part of a broad quest to provide care for all, especially the most underserved and vulnerable; train the next generation of physicians; create new knowledge that improves health and wellness; and advocate for our patients and for an equitable social agenda. I believe we must be passionate about creating a health care system that is personal, responsible, accessible, and sustainable, and creating a world that is just. The linking of individuals with passion, will, and intelligence around a virtuous quest is unstoppable.

(Submitted By: Jeffrey Borkan, MD, PhD, Brown Medical School/Memorial Hospital of RI, Pawtucket, RI)

For This I Believe – The Healing Gift of Intimacy

When I was young, my grandmother held three professions in the highest esteem. Not for their good deeds or contributions to society, but for more practical reasons. In third place was teacher. My grandmother was forced to quit school in seventh grade when her father was run over by a train. She was embarrassed by her lack of schooling and reminded of it often by her more educated sisters-in-law. In second place was lawyer. This was the profession of her only son, and generally anything done by a first-born son in an Italian family is worth boasting about. Money was always scarce for my grandmother, and too often she had to rely on the good will of her in-laws. This was the real reason that doctor headed the list of the top three professions.

In our large, extended family, one name was spoken with awe and pride, “Cousin-Charlie-The-Doctor.” My mother’s cousin was held before us as a model of what could be achieved. It had nothing to do with the level of education he attained or whether he helped anyone. My grandmother didn’t even believe in doctors. She died of breast cancer, which she hid until it was far too advanced. But Cousin-Charlie-The-Doctor was movie-star handsome, lived in a big house, drove a Mercedes and had a beautiful wife who got her hair done every week.

I didn’t even know he was a cardiologist until years later. In my family, it didn’t matter what kind of doctor you were, it was good enough just to be one. I grew up being told I was “smart enough to go to medical school.” Since I wanted to please my family and had a vague idea of wanting to help people, I went. Fortunately, there was no one to tell me what to specialize in. So I just drifted towards what felt right.

I often talk to students about being a doctor. I answer their questions about specialties, lifestyle, money. But what I really want to tell them is that I believe I was given a gift when I became a family doctor. I hold the key to a secret room. It looks like an eight by ten exam room. But when I sit in that room with a patient, I share an intimacy that sometimes catches me off guard. Mothers allow me to touch their undressed perfect children, telling them that I am not a stranger even if we’ve just met. I grieve with the couple who just lost their 24-year-old son. I listen to a mostly happily married women tell me about a brief, mistaken affair. My heart breaks as an old woman tells me she is no longer able to care for her senile husband of 65 years. I counsel teenagers about contraception as they tell me of their first stolen sexual encounters. I watch a new mother nurse. In this secret room, I am invited into people’s lives and their stories are my treasures.

(Submitted By: Carla Jardim, MD, Hunterdon Medical Center, Milford NJ)

I Believe In Patient Respect

I believe that the main value in the practice of Medicine is the respect for our patients. I have had many opportunities where I have been able to explain and talk to my patients in a clear and concise way by showing my respect to them. For example, I had a patient who had a difficult time taking her Coumadin. I sat with her and gave her my reasons for prescribing the medication, the side effects, the consequences, and the importance of the medication for her health. She mentioned that it had been the first time a doctor had talked to her in a way that showed compassion, treated her like an equal and gave her the opportunity to ask questions, express her fears, and receive all the answers needed. I believe if we all treated our patients with respect and were able to give them the explanations and reasonings for our treatments, we will improve our patient-physician relations. Let's all try to work on this as one of our main values in Medicine

(Submitted By: Adriana C. Linares, MF, DrPH, The Brooklyn Hospital Center, Rochester, NY)

Health Is A Right Not A Commodity

“Please don’t take offense, but can you tell me why you chose to go into family medicine?" A nurse at the community hospital asked us new interns this question on our first day of residency. Her tone was dismissive, implying "You could have chosen anything, but here you are, throwing away your career, community standing and income to do primary care." We took turns answering her question. I went into family medicine to keep people healthy instead of patching them up when they got sick. To care for the whole person instead of an organ system. To care for patients in the context of the families and communities they live in. I thought of the dusty roadside villages in Central Africa where I had weighed and vaccinated babies while providing prenatal care for young mothers, conducting clinics in which every fever was invariably malaria, dispensing quinine and medical advice for a pittance. Health needs were palpable, from the scrofulous lump on the spine in untreated TB to the grossly swollen liver and spleen of advanced schistosomiasis. Villagers needed basic primary care services to prevent disease, treat illness, and promote reproductive health, starting with clean water and good food, with access to nurses and doctors and the magic medicines waiting to cure on the shelves of the dispensary. Though I had chosen to become a doctor so my signature could allow me to dispense lifesaving therapies to people who might otherwise die, I began to resent my drug-pushing role. I was a pez dispenser in a white coat spitting out prescriptions, the middle man in the lucrative practice of getting drugs to the highest bidders. Patients without insurance struggled to be seen. People without money didn’t get their meds. Our health system is designed to maximize profits, not health. In Africa, and in America, children die of preventable and treatable illnesses that are neither prevented nor treated for wont of financial incentives. Diseases that affect millions are considered orphan diseases because there is no paying market for the drugs. Eflornithine, the only medication effective against arsenical-resistant sleeping sickness, was taken off the market in Africa (lifesaving, but no buyers) while being repackaged as a depilatory in the states (frivolous, but lucrative). Lives are at stake and money wins. Why did I do family medicine? I believe health is a human right and not a commodity, I began. And we need to do everything we can to make sure everyone gets the care they need. We need prenatal visits for all pregnant women, vaccines for all children, yearly visits for everyone. We need to make it easy for people to see their doctors so they can treat earaches before ear drums burst, high blood pressure before they have heart attacks, or control diabetes before they lose their kidneys and their sight. To do this, we need more primary care doctors. I am here so we can change the system so health is no longer a luxury, but a fundamental human right.

(Submitted By: Kohar Jones, MD, Brown Family Medicine Residency, Providence, RI)

This I Believe

I believe a powerful gift we bring to our patients is the power of witnessing. As witnesses we allow our patients and ourselves the opportunity to reach more deeply into our shared humanity.

The power of the witness became clear to me with a “challenging” patient I had been seeing for a variety of complaints. The patient is a young woman, about 24 years old, who had visited my office on several occasions, each time with a new concern. There were the pounding headaches, painful joints, upset stomach, insomnia.

I had concluded that she was depressed, but I hesitated to write an anti-depressant. I sensed her symptoms were the result of an unresolved issue and not a clinical condition. I encouraged her to visit frequently and provided counseling about diet, exercise, sleep enhancement and sources for self care, including relaxation techniques. But she continued to report a variety of new symptoms with each visit.

I probed more deeply about her insomnia. I asked when it started: “several years ago.” What happened a few years ago? “My best friend died.” Really, how? “She committed suicide.” Is that so? “Yes. She had called me the night before to come over, but I didn’t go. There wasn’t a particular reason, I just didn’t.” Yes? “And then she was found dead by her brother who is also my friend.” And you?

Then came the tears that turned to sobs.

I was astounded. I went home that evening very somber, wondering how many opportunities I miss to connect with the patients that I see on a day-to-day basis. And yet, at the same time, I saw the power of the witness, the power to provide the safety for another person to unfold and turn their grief manifesting as bodily pain and dysfunction into health and well being.

A few weeks later she returned to the office. I had never seen her so relaxed. She said she was now able to sleep and the headaches were better.

It’s more than listening. It’s encouraging, protecting, probing, connecting, and providing a safe place of trust. We all have this power in us. It’s a matter of accessing and using it not just for patients, but for ourselves.

(Submitted By: Kathleen A. Klink, MD, NY-Columbia-Presbyterian FPRP, New York, NY)

This I Believe

I was a generic doctor. After a one year rotating internship, I started solo practice as a general practitioner, not that I was specially trained for that role, it just happened. It was what I could do.

I loved the practice of medicine, and I decided that my vocational goal was to serve my chosen profession, Medicine.

Then I met Pesky.

One of my early patients was a young woman who I will call Gertrude, with many problems. She was a county woman, uneducated, crude in her language, outspoken, and simple in many ways. Her husband had died, leaving her with a five year old daughter, and no money. They were living with another man and seemed to have a good relationship.

Gertrude had an inexhaustible list of physical symptoms, but each of them disappeared, or at least subsided, after an examination and reassurance. I saw her infrequently, but know that she would have come much more often if she were able to manage the $2 office fee. So between visits, she called almost daily to talk to one of us, our office nurse, my wife, or me. She always began the call with “This is Pesky.”

As I learned to know her, I realized that her symptoms were due to an overwhelming sense of guilt. She was not a religious woman, but she had strong beliefs in what was right what was wrong, and living as she did, unmarried, she considered wrong. I asked the obvious question, and her man was quite willing, but Gertrude said that she could not afford to get married because they would lose her daughter’s social security payments. One day I confronted her with the issue and urged her to get married anyway. She finally said “Yes – but you have to make the arrangements.” “Oh no” said I, “see the justice of the peace.” “No way” said she, “marriage is much too important – it must be in church. I don’t know no church, so you make the arrangements.”

So I did. They were married by our Episcopal priest, with my wife and I as witnesses and our daughter playing the organ.

Thankfully, Gertrude’s symptoms nearly disappeared.

With her I learned that;
- clinical problems do not always have clinical solutions;
- learning to know a person, or a family, is essential to understand their problems;
- mutual understanding makes patients more likely to follow the advice offered;
- understanding meant that I can learn to love all of my patients, even those “unlovable” ones.

I also learned that this kind of practice brought me great joy. I was serving people I cared about and knew that I was providing the very best possible care for each one. I did not have a name for this kind of practice, but it was the very essence of Family Medicine.

My ultimate goal really is to serve my patients in every way that I can.

I believe Family Practice makes this possible.

Thank you, Pesky.

(Submitted By: Thomas L. Leaman, MD, Retired Penn State College of Medicine, Hershey, PA)

This We Believe

I believe that relationships are the stock and trade of family medicine. They ground us, affirm us, challenge us, nourish us, reveal us and- we can only hope- change us.

We are trained to haul a doubling fund of knowledge, armamentarium of drugs, and basket of services across a shifting economic landscape. Our technology has become cooler, the standards stricter. A ticking clock has invaded the curative calm. Yet during my twenty-three years in medicine there has been one constant: patients who refuse to remain mere clients, consumers, or subscribers.

It is no mystery how to please them; they will happily tell you. They have come for a test, a drug, a note, or a little piece of mind. For patients who already have their answer, any midlevel practitioner or case manager will do, and do it better for less money. But when they can no longer hide their suffering, doubt, fear or loneliness, when all they can muster is the unspoken question, a doctor is required. They might have consulted a therapist, a priest, or an advisor. They might have gone on-line, scoured the self-help bookshelf or drained relief from a bottle. In the patients' moment of self-disclosure, in that instant of wonder and grace, we see what the physician-poet William Carlos Williams spent two careers unveiling. "They're in trouble," he once wrote, "and that's when you're eager to look into things deep, real deep. I wouldn't walk away from those kind of talks for anything; I come away from them so damn stirred myself- I've needed to walk around the block once or twice to settle down."

Would Williams have been less passionate about disease registries or health maintenance checklists? We will never know. But he and others who created the literature of medicine built it on the power of relationships. This literature- from novel down to anecdote- begins with an appreciation of people that flows into relationships that are populated by stories we are compelled to tell. I am not urging us to establish more fellowships in Literature & Medicine. Only that we keep the doctor-patient relationship central to the enterprise. The appreciation of people, our love of patients- even by our researchers and instructors- must never take a back seat.

Last week a new patient informed me that I passed his three-item test: he liked me, liked where I worked, and sensed that I liked him, too. Somehow, in my hurry and preoccupation, I conveyed the joy of caring for him. W.H. Auden once said that "A doctor cannot be a scientist; he is either, like the surgeon, a craftsman, or, like the physician and the psychologist, an artist." Auden understood the unique importance of patients to family medicine. He knew what we know best. What our patients, all patients, need most. They need a doctor who is willing to inch his way with them toward happiness and fullness of life. They need relationship.

(Submitted By: David Loxterkamp, MD, Seaport Family Practice, PA, Belfast, ME)

Precious Stone

I believe that family doctors learn everyday, a little from every patient, journal and colleague we encounter for no greater purpose than to share that accumulated wisdom with the next patient who asks.

While traveling in the mountains a meditative monk happened across a precious stone. He admired it and placed it in his pack. Later that day he met another mountain traveler. The traveler was hungry so the monk opened his pack and shared his food. Admiring the precious stone in the monk's pack, the hungry traveler asked the monk to give it to him. Without hesitation the monk did so.

The traveler left, incredulous about his good fortune. The jewel, he knew, was worth enough to give him financial security for the rest of his life.

The sun rose only once more before the traveler re-entered the mountains searching for the monk. Upon finding the monk, he returned the stone declaring, "Being so close to wealth has set me thinking. This stone is very valuable but I must return it to you with the hope that you can give me something much more precious. If you can, give me what you have within you that enabled you to give me this stone."

Virtually every family doctor would proudly fill the shoes of the meditative monk. They have a secret for which most wise travelers would forfeit a ransom. Whether they practice in rural, urban or suburban America they trade in commodities other than precious stones. They learn from each patient they befriend, then process, polish and resculpt this wisdom to share with the next.

(Submitted By: Thomas C. Rosenthal, MD, University of Buffalo, Buffalo, NY)

It Is Hard To Catch A Flea

Having grown up with dogs I know it is hard to catch a dead flea and almost impossible to catch a living one. So when I hear the medical students being invited to see a flea under the microscope that a patient had brought to the office, I was surprised. I had trouble envisioning a patient transporting a flea to our office on a bus or a train. The organism under the scope had been found on a hair covered area of the patient. When I went to look, however, rather than a flea, I found the fat body and short legs of a pubic louse. What had intrigued me was the certainty with which wrong information was being given.

During my relatively long career in medicine I have been surprised at how bright and well-respected people have given information or predictions that later turned out to be wrong. When I was interviewing for medical school in 1972, one of my interviewers confidently told me that we would have nationalized health insurance before I completed medical school. A professor in medical school told me once with great assurance that a patient with a Foley catheter could never get a urinary tract infection. Patients and medical students often seem to prefer hearing confident predictions or pronouncements made with great certainty to more honest discussions dealing with uncertainty. The older I get the less certain I have become about many things.

My natural skepticism has been a train that has served me well through the years and helped to keep me out of trouble. When I conduct a seminar series with medical students on the interactions between physicians and pharmaceutical companies, I'm skeptical when some students assure me that free lunches, free pens, sponsored CME and talks paid for by the pharmaceutical companies don't influence physician prescribing habits. Many well done studies point out how susceptible we are to being influenced by even small gifts. When a colleague told me that a patient had a high fever because of a urinary tract infection, but had a urinalysis with only a few white blood cells and no bacteria, my skepticism made me go to examine the patient myself only to find a large pneumonia as the cause of the fever.

As a professor at a medical school I firmly believe we must nurture a healthy skepticism in our students. Much of what they are taught will later turn out to be incorrect regardless of how confident the presenter is. Much of what they confidently believe now will turn out to be wrong in the future. They must learn to listen carefully to what is being told to them, while at the same time realizing that if what they are being told doesn't make sense in terms of their own experiences, they should be careful. I believe that we owe it to our patients to thoughtfully question many of our firmly held assumptions and think about the conclusions we are reaching. We need to be skeptical.

(Submitted By: Fred W. Markham, MD, Jefferson Medical College and Community Medicine, Philadelphia, PA)

(Untitled)

I make lists. Before embarking on the path to medicine, I made a list of the attributes that attracted me. I was too naïve to know the negatives.

Here, in no order of rank is my list:

1. My parents would be pleased.
2. I would have an ample, secure income.
3. I like science.
4. Medicine is a prestigious profession.
5. The accomplishments are significant.

My joy in medicine is that the items listed have been fulfilled!

Of course, I already knew that my parents would be proud. In a single generation our family had vaulted from the ranks of semiliterate sweatshop workers and produce peddlers to the upper middle class.

As a child of the great depression, security was my goal. I succeeded. The mortgage and credit card were paid on time, cash was paid for my mid-priced cars, and the children went to summer camp and attended the colleges of their choice.

I chose Family Practice so that I could apply as much of the science of medicine as possible. I estimate that I have made almost 400 thousand medical decisions to date. Most were routine, and almost automatic, but problems occurred often enough to activate my intellect, and sometimes to scare the hell out of me. Some days were boring, but I always eagerly anticipated the new day.

Since my first clerkship in 1953, physicians have been telling me that the prestige of our profession has been waning. To be sure our well-earned authority is more often challenged as western civilization moves from authoritarianism to equality. We practice better medicine when we educate and convince our patients of the validity of our advice. Public opinion polls rank physicians near the top of desirable professions, and I still hear awe in the listeners when I am introduced as a physician.

So my expectations have been fulfilled, but there is more. I could not foresee the privilege of being witness at birth and death, the kick of caring for four generations, the trust with which my patients share their innermost feelings, the unique experience of seeing life in a time-compressed capsule as it parades through my office daily, and using that knowledge as a guide for my own life.

(Submitted By: Leon N. Zoghlin, MD, Hilton, NY)

Shadows Into Light

I believe that open discussions with regards to end-of-life-care are imperative. Many patients in long-term nursing facilities with poor prognoses suffer daily from diseases, organ failure, pain and infection. To further complicate matters, these unfortunate souls may also be bed-ridden with limited responsiveness. Working with chronically ill patients, their families and nursing-home facilities, I question if merely existing is truly living. A 60 year-old African-American woman with VDRF, chronic tracheostomy secondary to advancing multiple sclerosis and aphasia was admitted from a nursing-home with pneumonia, grade-IV sacral ulcer and bacteremia. Mrs. Smith* also had numerous comorbidities: PVD, anemia, pain, osteomyelitis, blood clots and CHF. With consults/care from a comprehensive team of specialists, Mrs. Smith received antibiotics, pain control and wound care. Ultimately, comfort care was recommended, because the risks involved with extensive treatment could only yield limited benefits. And, whether Mrs. Smith qualified for hospice was unclear. During the last 20 years, Mrs. Smith spent her life divided between being bedridden at a nursing-facility and being in the hospital. We are taught to treat patients with compassionate, evidence-based medicine, but first and foremost, are we not responsible to do no harm? Prolonging one's natural life with medical/surgical treatment, only to suffer from future, repeated complications, seems cruel and tortuous. For the chronically ill patient, each day equals 24-hours, 1440-minutes, 86,400-seconds of pain and suffering. Mrs. Smith's husband, her power-of-attorney, was adamant about keeping his dying wife full code. Even with her pain and ultimate prognosis, the family had hesitations to change her code status stating that there must be a divine reason why she was still alive. I empathized with the family's desire to keep their loved one alive. I also knew that Mrs. Smith's demise was inevitable and more than divine intervention, it was the ventilator that kept her breathing, but clinically removed from the situation, it was easier for me to realize this. In addition, though easier said than done, I knew that the POA should strictly speak on the patient's behalf. What anyone else thinks or wants is irrelevant, but when these issues are not discussed beforehand and emotions (positive and negative) are involved, inevitably, POAs may hold onto time, fate or divine intervention to help make these important decisions for them. These ethical issues can be discussed and debated. There is not one right answer. I believe that the "best" solution is to encourage continuous dialogue between medical professionals, patients, family and friends. Death and dying is a morbid topic, but one's mortality is absolute. We cannot avoid it. We can, however, empower one another by bringing such dark discussions into the light and educate patients with regards to news stories, urban legends and anecdotes of medical miracles/debates. These should not be the basis for end-of-life decisions. I believe that via discussion, education and communication can a person's wishes be truly honored. In conclusion, I believe that physically existing, but having no spirit to interact with the world around me is not truly living. How about you?

(Submitted By: Cecillia Shim, DO, Mercy Suburban Hospital, East Norriton, PA)

What We Believe

"I swear by the oath that I have taken to be a good physician, to care for my patients with a loving heart, and try to the best of my abilities to:

Maintain my medical competence through diligence and continuing medical education;

Be gentle, patient, friendly, cheerful, polite, and kind, and be forever helpful to my patients as well as to others, who depend on me;

Be trustworthy and honest in my personal conduct, tell the truth at all times, and treat others as I myself would want to be treated;

Meet my obligations willingly, even when I am not expected to be compensated;

Seek to understand rather than be understood, and be respectful to all, even to those whose ideas and customs are different than my own;

Be obedient to the rules and regulations that govern my practice and obey all laws;

Muster the courage to take positions to correct injustice, especially to assist those who entrust their lives to my care, even if it causes me inconvenience or discomfort;

Practice in an efficient and effective manner and do what I can to lower the cost of medical care for my patients, but do no harm;

Be true to my family, my teachers and to all those who depend on me;

Be true to myself by being a good example of good health through regular exercise, good nutrition, adequate rest, avoidance of toxic substances, and maintaining a neat appearance;

Remain observant to what is reverent, read good books, speak well of others, use no foul language, and practice inner peace with a grateful attitude;

Be faithful to the above stated time-honored principles that bring respect to my profession."

(Submitted By: Nikitas Zervanos, MD, Retired, Lancaster, PA)

This I Believe

Our destiny as general practitioners is to save from collapse the health care systems of the western world. I use the term general practitioner because it is only by being generalists that our discipline can survive. Our discipline is unique in medicine. All the other fields describe themselves in terms of technologies or disease entities. We describe ourselves in terms of relationships – especially the doctor-patient relationship. It is customary for patients to join our practice before we know what illnesses and problems they will have. Our commitment to patients is to care for them whatever illness they bring to us. That is why we must be generalists. If we allow our discipline to break up into a hundred pieces, it will die.

It follows that whenever we sit down in our consulting room, we know that we are going to be face to face with the unknown. We will usually know the patient, but with a new visit we will not know what their problem will be. Our special skill is the assessment of undifferentiated clinical problems and we do this day in day out. To face the unknown takes courage. Very often we are face to face with suffering and we are all at times tempted to flinch – to withdraw emotionally from the patient. It takes courage to face suffering without flinching.

A number of patients will be referred to specialists, while we remain available to them if they need us. But most of our patients are cared for without my referral to the secondary or tertiary sectors. We have a much broader experience of illness than any other branch of medicine. Because we are generalists, we take a wholistic view of our patients. We are the only field of medicine that transcends the fault line between mind and body.

All these factors, together with our long-term relationships can give us deep knowledge of our patients' lives. Medicine's orthodoxy draws a straight line between a patient's disease and his life story. Our experience teaches us differently. Yet we seem to make very little use of this knowledge. Perhaps we are too intimidated by the weight of orthodoxy which dominates our medical schools. Sooner or later the present paradigm will change. When it does, we must be there to lead the way.

(Submitted By: Ian R. McWhinney, MD, University of Toronto, London, Ontario)

Ownership

Being a family doctor is about ownership. As a resident, I was reluctant to say "my patient," or "my nurse." It implied a degree of importance – and responsibility – that I didn't feel ready for. But as I began my practice, I was faced over and over with situations that required someone to step up and take charge. "Wow, I can't believe you're doing this," the ER nurse would say as I babysat a patient's three-year old while she was being evaluated for appendicitis, waiting for her husband to come from work. "Well, if I don't do it, who will?" I would usually say. Who else will, really? You're the doctor. You're the one with the skills to fix the problem. While I think it's healthy to remember that we can't fix everyone, I believe we should be at least trying to fix most everyone – identifying problems and barriers and solving them, or finding people who can. It makes our lives easier in the long run, and it's the right thing to do. Training programs are more humane now than they used to be. In my faculty position, I work with trainees who are blessed with the "work hour rules" and can sign out their patients and go home after a night on call. While this is unquestionably safer for residents, it can lead to a lack of ownership. If you don't take care of something, the next guy will do it. I miss the sense I had when I was in practice alone: If I don't do this, then nobody will. Last week, I took care of a patient who has been admitted more than ten times for congestive heart failure. Each admission, the cardiologists change her meds a little bit, she gets higher doses of diuretics, and everyone mumbles behind her back that she is "non-compliant." When I went in the room to talk to her, I realized that she has been treated by something like forty different physicians in the past six months, none of them trying to figure out why she can't take the meds. Each visit, more pills are added to her regimen; she's supposed to take thirty-three pills a day. We agreed that ten or fifteen pills that you would actually take would be more effective than thirty-three, of which you could take none. I asked her why she hadn't given her suggestions, which were good ones, to the cardiologists. "I don't like to complain," she said. I believe that a family physician can, and should, speak up and say: This is my patient. Let's do what is best for her. I will sort through the specialists' recommendations; I will review the list of pills and talk about them with her; I will find out which ones make her nauseated, and remove them. I am the doctor. This is my problem now; I own it, and I will take care of it. This is what I believe.

(Submitted By: Joanne Wilkinson, MD, MSc,
Boston University Medical School, Boston, MA)

Using the Truth

I believe in using the truth. Truth is the best weapon in my arsenal. To encourage, to motivate, to communicate, even to scare, I use the truth to effect change. I tell Althea's parents that the school is right, she is obese. I tell them that if, heaven forbid, she had cancer, they would do anything, change anything in the world to save her life. I tell them that obesity is just as deadly as cancer, and then I tell them the best truth of all – it's 100% curable. They have the power, but they don't have it without the truth.

(Submitted By: Deborah Gilboa, MD,
Squirrel Hill Health Center, Pittsburgh, PA)

With Open Arms

I was on call for the hospital when I received a page from the former chair of our Department. He asked if I would be willing to take his father-in-law on to my service. His father-in-law was in an emergency room in a small town about 2 hours from Rochester and had just been diagnosed with an apparent brain tumor. To complicate matters, his father-in-law's physician had just died two weeks ago so he was without a primary care physician. Jay thought that perhaps a surgical specialist could be consulted and his father-in-law's problem could be taken care of expeditiously. Of course, I agreed to admit him and consulted the surgeon. Sadly, after several consultations, it became clear that Mr. Szwagiel's condition was terminal and there was really nothing that could be done in terms of cure. Over the next 5 weeks I came to know Mr. Szwagiel, to some extent directly, but mostly through his wife Joyce, and his daughter Sophie.

Francis Szwagiel was from Poland, but during WWII, managed to escape Poland for England where he eventually fought in a Polish division of the Royal Air Force. While there, he met Joyce, who was the equivalent of a WAC, at a dance party for the service men, fell in love, and married. They immigrated to the United States with little to their name, but with hard work and perseverance eventually made a nice life for themselves. He was known to be a hard working, responsible, devoted Catholic, who was family-oriented and loved his gardens. He died peacefully on November 18th.

Several months later, I received a card from Joyce Szwagiel. The card ended with "In wishing you and yours the best of the great feast of Easter, I hope that the enclosed will, in a way, offset some of the pain we have all shared. God bless." Enclosed in the card was a personal check made out to me.

I thought long and hard about what to do with the check, eventually deciding to use the money to make a bench -- a place for people to sit and rest -- a bench with flowers, especially given his interest in flowers. I wanted the design of the bench to somehow reflect the nature of our practice -- who we are, and who the patients are. The fact that Mr. Szwagiel was Polish and immigrated to this country was an obvious similarity to our many immigrants and refugees. I reflected on all the stories I have heard of heroic struggles and an image of Ulysses came to mind. Yet, I also wanted to acknowledge that all people, near and far, are engaged in their own heroic struggles. I wanted to communicate a sense of welcoming, a place to feel safe and secure. So, I designed the back of the bench to represent open arms and inscribed the following on a plaque:

With open arms, we welcome the
sick, the tired, the poor, those
Ulyssian travelers from near and far.

(Submitted By: Alan Lorenz, MD, University of Rochester, Rochester, NY)

This We Believe

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Family Medicine Style

Sponsored by the Family Medicine Education Consortium
www.fmec.net

We invite students, residents, faculty, and practitioners to submit statements of their beliefs. Separate awards will be offered for each group. The submissions will be reviewed and those selected as "best of" within each group will be invited to share their statement from the podium during the 2007 STFM: NorthEast Region meeting. The "best of" statements will be collated and shared in print with all conference attenders and will be distributed through the FMEC web site following the meeting.

We seek expressions of the core attitudes and beliefs - the personal philosophies - about caring for others. Authors should write up to a few hundred words expressing the core principles that guide your approach to caring for others. Feel free to use any format that helps you to convey your beliefs: a story, an anecdotal experience or you may use discursive writing. We seek that personal, inner vision that drives your passion to serve, to teach, and to be with those who need your service.

We know that those engaged in Family Medicine have a broad range of interests; from full scope Family Medicine; to international health; to care of seniors, adolescents; children; maternity care and women's health; end of life and palliative care; care of underserved, rural and inner city populations; research; education; practice improvement and health care leadership to name just a few areas of special interest. Statements of belief that share the passion that led you to your special interest are welcome as well.

We invite you to contribute to this project by writing and submitting your own statement of personal belief. We offer these suggestions:
Tell a story: Be specific. Take your belief out of the ether and ground it in the events of your life. Your story need not be heart warming or gut wrenching. It can even be funny, but it should be real. Tie your story to the essence of your life philosophy and to the shaping of your beliefs.
Be brief: Your statement should be no more than 500 words. The shorter length forces you to focus on the belief that is central to you. Essays longer than 500 words will not be accepted. The winning essays should be short enough to be presented verbally in no more than three minutes.
Name your belief: If you can't name it in a sentence or two, your essay might not be about belief. Rather than writing a list, consider focusing on one core belief.
Be positive: Say what you do believe, not what you don't believe. Avoid statements of religious dogma, preaching or editorializing.
Be personal: Make your essay about you. Speak in the first person.

Please submit your essay to Ms. Nicole Day Nicole.day@fmec.net or go to www.fmec.net to submit on-line.
Deadline: May 21, 2008
For questions, please contact Laurence Bauer, MSW, Med, 937 428-7866 or Laurence.bauer@sbcglobal.net

Rules
Submissions will be accepted from those associated with FMEC Member organizations. A list of current member organizations is available at www.fmec.net. The authors of the winning submissions will receive a complementary registration to the 2008 STFM NorthEast Region meeting in October, 2008 in the Baltimore/Washington D.C. area. Authors will be responsible for their own travel expenses.

Attribution: This project and its description quotes heavily from "This I Believe: The Personal Philosophies of Remarkable Men and Women", published by Henry Holt, NY, NY. 2006 ISBN 13: 978-0-8050-8087-2