Family Medicine and Community Health

Storylines of family medicine I: framing family medicine – history, values and perspectives

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To cite: Ventres WB, Stone LA, Rowland KT, *et al*. Storylines of family medicine I: framing family medicine – history, values and perspectives. *Fam Med Com Health* 2024;**12**:e002788. doi:10.1136/fmch-2024-002788

Received 12 February 2024
Accepted 20 February 2024

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ABSTRACT

Storylines of Family Medicine is a 12-part series of thematically linked mini-essays with accompanying illustrations that explore the many dimensions of family medicine, as interpreted by individual family physicians and medical educators in the USA and elsewhere around the world. In 'I: framing family medicine—history, values, and perspectives', the authors address the following themes: 'Notes on *Storylines of Family Medicine*', 'Family medicine—the generalist specialty', 'Family medicine's achievements—a *glass half full* assessment', 'Family medicine's next 50 years—toward filling our glasses', 'Four enduring truths of family medicine', 'Names matter', 'Family medicine at its core' and 'The ecology of medical care.' May readers find much food for thought in these essays.

INTRODUCTION

Storylines of Family Medicine is a series of 99 illustrated mini-essays, written by over 100 authors, collected in 12 thematically linked articles. The essays in this article speak to the purpose of the series, the foundational history of the discipline and some of the key values and rationales that support the activities of family physicians in their day-to-day work. In that these articles examine the paths family medicine has taken in the past to arrive at the present, they offer a point of departure for students and residents beginning to learn the 'ins and outs' of family medicine. They also set the stage for the future of family medicine, one many readers of this series will likely help shape.

NOTES ON *STORYLINES OF FAMILY MEDICINE*

Bill Ventres and Leslie Stone

> *Any collection of this sort—a series of short, illustrated essays written by a variety of authors—needs some explanation. Please consider these points when reading and reflecting on* Storylines of Family Medicine.

The inspiration for *Storylines of Family Medicine* arose out of a clerkship course for all third-year College of Medicine students at the University of Arkansas for Medical Sciences (UAMS). The purpose of the course has been to inform students how scholars in family medicine have, since the discipline's 1969 establishment as an Accreditation Council for Graduate Medical Education (ACGME) board-certified medical specialty, introduced to medicine theories of practice and approaches to patients that are patient, community and relationship-centred.[1]

We note *theories* and *approaches* because there is no one philosophy, organ system, age range or institutional function that defines family medicine—it is truly a generalist discipline. As well, family medicine is highly personal, dependent on the people on both sides of the stethoscope—physicians and patients. Although the medicine family physicians practice is relatively standardised in nature, the manner by which they practise it varies considerably, based on underlying motivations, individual interests, personal values and particular contexts of care.

Indeed, as a community-based family physician colleague of ours from Arkansas once mentioned in passing, 'If you have seen one family practice, you have seen one family practice. If you have seen 100 family practices, you have seen 100 family practices. Family medicine is conditioned by the people practicing it, the patients who present for care, and the places they are located.'

As a result of the clerkship course and our colleague's comment, we approached leaders of family medicine from the USA and locations around the world and asked them as authors to contribute short essays describing the motivations, interests, values and contexts of care that inform their work. We also requested they add an illustration—remember the dictum,

Honor all humanity through your work.

Learn, reflect and grow
in both ability and awareness.

Practise wisdom. Practise compassion.

Be well. Be thoughtful. Be kind.

Figure 1 If you forget everything else, remember these words.

'a picture is worth 1000 words'—and a few easily accessible key readings for readers interested in further study.

We requested that authors target medical students and family medicine residents as their intended audience, in hopes the essays, illustrations and readings in *Storylines of Family Medicine* might inform some, inspire others and pique interest in all. We also asked authors to be aspirational in tone and explore the best family medicine has to offer, rather than focusing on the challenges family medicine faces in today's medical environment. The essays we received were a mixture of personal stories, professional commentaries and academic critiques.

Because of the nature of how patients commonly present in family medicine, many of the concepts outlined in *Storylines of Family Medicine* have become core tenets of practice. However, these tenets of family medicine are not the exclusive property of family physicians. Nowadays, very few ideas stem from the unique contribution of one person or field of study. Instead, they arise from the efforts of numerous scholars, from a variety of disciplines, working simultaneously on similar issues. Indeed, not all concepts discussed in this series originated in family medicine. We in family medicine are indebted to all who have enriched our work.

The concepts noted here are universally applicable by all learners. The extent to which they apply these concepts will differ according to the situation. Family physicians, for example, are more likely than surgeons to rely on their relational presence with patients, just as surgeons are more likely than family physicians to rely on their procedural abilities.[2]

We recognise that some students, residents and practicing physicians (including some family medicine residents and practicing family physicians) will prefer to disregard the concepts outlined in *Storylines of Family Medicine*. We also acknowledge that many forces minimise their importance in the current culture of medical education and practice.

However, physicians of any ilk or stage of professional development who ignore the concepts described in these essays do so at their own risk and that of their patients. We suggest all readers consider the words widely attributed to the Arkansas poet Maya Angelou[3]: 'People will forget what you said, people will forget what you did, but people will never forget how you made them feel.'

We hope all readers find within these essays opportunities to take ownership of their professional growth and acknowledge their call to service for patients in need (figure 1).

Readings

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FAMILY MEDICINE—THE GENERALIST SPECIALTY

Kate Rowland

Over 50 years ago, the discipline of family medicine defined itself as an academic specialty with scientific backing, one that cared for individuals in the context of their families, communities and society while staying grounded in its generalist roots.

When the goal is health and healing, expertise in human beings is often more valuable than expertise in human bodies. US family medicine as a discipline emerged in the 1960s when the imbalance between expertise in human beings and expertise in human bodies became obvious. Medicine increasingly focused on pathologies of the body, and many people were left without a personal physician (a role previously fulfilled by general practitioners, commonly physicians who had completed a one-year rotating hospital internship before entering practice).

The seeds of this crisis were sown decades earlier as the physician-scientist paradigm rose to prominence and medical training moved exclusively to university settings.[4] After centuries of doctors functioning as generalists, within a generation, the perception that only specialty care was inherently scientific took hold. The population of general practitioners aged and dwindled as students followed available incentives to specialise and subspecialise.

Generalist physicians had always been around. They were in neighbourhoods close to their patients, attending to their patients' ailments, providing them with preventive care and listening to their life concerns. In the post-World War II era, generalist physicians rapidly disappeared, and specialists were ill-equipped to fill in. The value of generalist knowledge and skill grew more apparent as communities struggled to recruit general practitioners to help cure disease and keep the healthy well.[5] People still needed person-centred care.[6 7]

Thus, general practitioners in the 1960s designed and implemented a new specialty—family medicine—to address the need for providing personalised care for people in communities. The biomedical sciences served

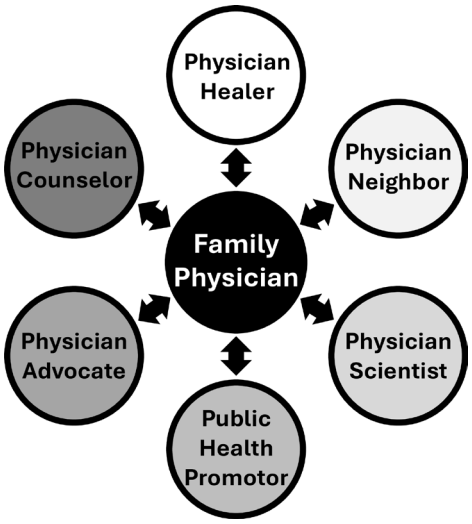

Figure 2 The family physician: historical roles.

as the foundation for this new specialty and for the care that this specialty offered. Still, it also incorporated the wisdom of many other fields, including public health, the behavioural sciences, hospital practice, systems theory and community medicine, among others.

How then could the value of family medicine be codified and communicated to the medical establishment, medical schools and medical students? Family medicine needed uniform training that, like other medical specialties, would lead to board certification; it needed three-year residencies for training and innovative models through which training could be provided.[8] By the last third of the 20th century, family medicine in the USA had agreed on core knowledge base and skill set, a specialty organisation, a nationally recognised certifying board and residency programmes in all 50 states.[9]

Family medicine has never been less rigorous or easier than any other specialty. Nor has the training and practice of family medicine ever looked like those of other specialties. Family medicine has different, broader problems to identify and address. Family physicians have built their discipline on the care of patients in the context of family, social and structural circumstances.

General practice was rooted in the paradigms of physician-healer and physician-neighbour. Its extension—family medicine—has added rigorous academic and scientific dimensions to generalist care (figure 2). Family medicine has evolved in a way that allows practitioners to take a holistic approach in which they attend to the concerns of human beings in addition to the ailments suffered by human bodies. Through it all, family physicians have continued to do the same job in the same places where generalist practitioners have always been, providing whole-person, whole-family and whole-community medicine wherever people live, grow, learn, play, work and age.

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FAMILY MEDICINE'S ACHIEVEMENTS—A *GLASS HALF FULL* ASSESSMENT

Rick Streiffer

> *Family medicine's historical promise in the USA has been to 'rescue a fragmented healthcare system, put it together again, and return it to the people…by being inclusive rather than exclusive in the care provided.'*[10]

The establishment of family practice—the 20th major US specialty—emerged in 1969 because of rising concern that the USA would confront a lack of generalist physicians in the face of post-World War II subspecialisation.[11] Ten years later, many considered family medicine successful in addressing this concern, although it was clear even then that much more attention to primary care would be needed for the US healthcare system to function appropriately.[12]

Now, a half-century later, much more is still needed in the discipline's *glass half full* status (figure 3). Few would say that family medicine has succeeded in rescuing the US healthcare system; nonetheless, much has been accomplished:

- **Family medicine as a public good**—The discipline has consistently advocated for creating a larger, more appropriately diverse and representative primary care workforce that is geographically distributed to allow people access to the care they need. Robust primary care is a public good that should be community-based, patient-centred and universally accessible.[13] Family medicine works to address the need for social accountability in its programmes and policies, advance a broad and holistic model of care and embrace a multidisciplinary team-based approach to care.
- **Integration into medical education**—Academic family medicine departments and required clerkship experiences flourish in all but a small handful of US medical schools. Numerous family physicians have served as deans, associate deans and course directors within a variety of academic health centres.
- **Residency development**—In 1969, family medicine arose when a handful of 2-year general practice residencies transitioned to 3-year family medicine residencies; today over 700 accredited family medicine residencies exist—more programmes than in any other specialty!
- **Organisational growth**—Family medicine's professional organisation, the American Academy of Family Physicians, boasts some 130 000 members. The professional home for family medicine educators, the Society of Teachers of Family Medicine, serves a membership of over 5000.

Figure 3 History of family medicine: key achievements to date.

- **Primary care scholarship**—Family medicine has created robust primary care research initiatives, including practice-based research networks. The specialty has created novel advancements in medical education, faculty development and applied scholarship, and has promoted evidence-based clinical tools, publications and skill development. Finally, policy research has demonstrated the benefits of robust primary care to health systems and populations.
- **Recertification**—Family medicine created the concept of recertification in 1970; today, this concept—Maintenance of Certification—is used by all major specialties. The American Board of Family Medicine has become the third largest of the 24 specialty boards of the American Board of Medical Specialties, with over 100 000 diplomats in its ranks.

Family medicine's path has been neither easy nor linear. Like long-term doctor-patient relationships—characterised by fits and starts, riddled with uncertainty and ambiguity, and marked by efforts both successful and less so—the development of family medicine in the USA has had a serpiginous path. Now, however, family medicine finds itself the only medical discipline in the USA that remains focused exclusively on primary care as a social good that is essential to the health of the public.

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FAMILY MEDICINE'S NEXT 50 YEARS—TOWARD FILLING OUR GLASSES

Rick Streiffer

The discipline of family medicine has made significant contributions since its establishment in 1969. There remains much for family physicians to accomplish in the future.

The first half-century of family medicine in the USA brought tremendous growth and success, including a coordinated effort by eight 'family medicine organisations to strategically align work to improve practice models, payment, technology, workforce development, education, and research to support the Triple Aim for optimising health system performance.'[14] Still, the discipline of family medicine has much to achieve. In the words of Marie Curie, 'The way of progress is neither swift nor easy.'[15]

Experiences from past decades inform family medicine's current agenda, which aims to fill our half-empty glasses (figure 4). This agenda focuses on the following:

- **Hold medical schools accountable**—Without the will to hold medical schools accountable for their use of vast public dollars, we will continue to experience the inadequate production of a primary care workforce.[16 17] By changing admissions policies, providing early medical school exposure to community-based experiences and family medicine role models and ameliorating student debt load, we can promote family medicine and primary care as an excellent and satisfying career choice.[18 19]
- **Partner with public health**—Perhaps family medicine's most strategic partner is the public health sector. Both aim to address the falling US life expectancy, improve the status of expectant mothers and their babies, and improve clinical prevention, community health, patient trust, health literacy and disparities in health outcomes. Already, other countries have demonstrated how we too would benefit from a vigorous alliance between family medicine and public health.[20]

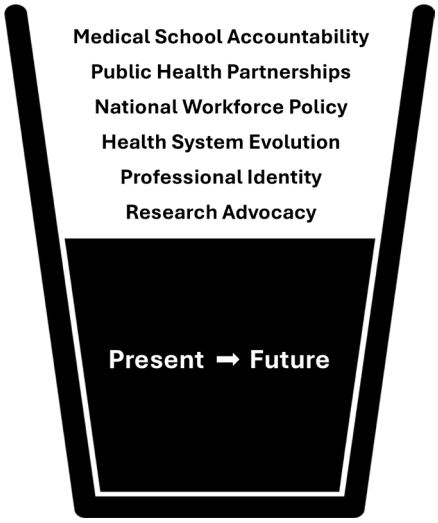

Figure 4 Family medicine's future: key areas for attention.

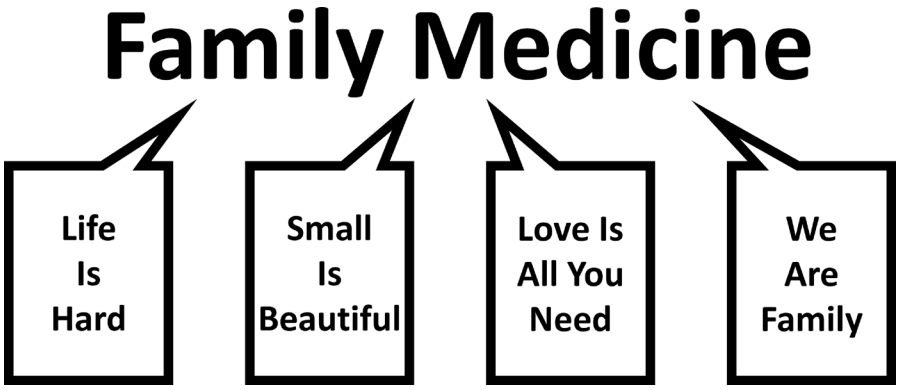

Figure 5 Four enduring truths.

- **Create a national workforce policy**—The compelling benefits of a robust primary care infrastructure will remain unfulfilled without a 'public good' system of advocacy and implementation that directs funding for programme implementation to family medicine and other specialties prioritising primary care.
- **Contribute to the evolution of the healthcare system**—Recent models of accessible, interprofessional and person-centred practice have demonstrated that primary care has a vital role in efficient and effective systems.[12] New practice models must be cultivated, including those that integrate behavioural healthcare, expand and refine telehealth, encourage outcomes over volume, reward coordination and respond to community needs.
- **Clarify our name, identity, role and scope**—Despite major efforts by various family medicine organisations, confusion remains about what defines a family doctor, who can and should be doing primary care and why primary care matters.
- **Advocate for the value of research that originates from family medicine and other primary care settings**—Although current findings suggest that most medical care takes place in the community, office and primary care settings, most medical research still originates from a strict biophysical, overtly mechanistic and tertiary-care emphasis of medicine. To change this means including family medicine, along with other primary care disciplines, in the institution that funds and prioritises health research: the National Institutes of Health.

Family physicians are genuinely proud of family medicine's achievements. Many are, however, dissatisfied that family medicine has not yet fulfilled its potential. Yet, as Thomas Edison wisely noted, 'Discontent is the first necessity of progress.'[21] Future family physicians must build on family medicine's remarkable successes by facing current and future challenges as they arise, thus creating a bright future for our discipline and for the people we serve.

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FOUR ENDURING TRUTHS OF FAMILY MEDICINE

Bill Ventres

Family medicine as a process of care has four guiding truths.

Family medicine got its start as an outgrowth of general practice. It developed because of the realisation that medicine was becoming increasingly fragmented. In many ways, this fragmentation was antithetical to the individual care of patients and to the health of the public.[22]

Similar concerns still exist, and the discipline of family medicine continues to work toward fulfilling its potential as a bedrock of robust primary care that is embedded in rural, suburban and urban communities, attendant to the medical needs of patients and cognisant of how factors such as culture, class and history affect people's health and well-being.

Family medicine has introduced many approaches to care that clinicians in a variety of disciplines now employ. These approaches include systems-oriented care, patient-centred and family-centred care, and community-oriented primary care, among many others.

These approaches all share four truths that have withstood the test of time. Despite our ever-changing world, these four truths will likely continue to form the foundation for whatever dynamic new family medicine philosophies lie in future's wait.

These four enduring truths include (figure 5):

- **Life is hard**—In the context of family medicine, this truth represents the reality that human beings often struggle to adapt and overcome health challenges. They need someone—a knowledgeable professional, a trusted guide, a thoughtfully wise counsellor—to help them through these challenges and, in turn, prevent future disease, lessen pain and suffering, feel cared for and avoid premature death.[23]

- **Small is beautiful**—Espoused initially as an economic premise,[24] this truth suggests that people—*regular* people—are the end goal of all medical care, not institutions or technology and certainly not the 3P's of power, prestige and profit.[25] It also suggests that the beauty of family medicine lies in the attention its practitioners give to those same *regular* people, routinely measured in small amounts doled out over time, such that the sum of their efforts as family doctors is a potent and therapeutic healing force.
- **Love is all you need (almost!)**—Clearly, family medicine is medicine. It entails all the professional knowledge, procedural skills and clinical wisdom family physicians need to attend to patients in ambulatory and hospital settings. When practised faithfully with appreciation for the power of continuity, comprehensiveness, coordination and access to care, family medicine is a work of love, in which one person helps another move toward health and well-being.
- **We are family**—Family is a metaphor for all that does not exist in the reductionist model of biomedicine that currently dominates the US healthcare system.[26] It is also a touchstone for understanding that we exist in an interdependent world. No one lives or works in isolation from others.

Applying these four truths as key principles of the discipline and whether inspired by indignation, hope or some other motivation, family physicians have laboured in opposition to the depersonalisation of medicine. These principles have and will continue to shine a guiding light on the power of interpersonal connection and compassion in medicine.

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NAMES MATTER

Michael Macechko, Julie Roulier and Leslie Stone

A name is a 'word or phrase that constitutes the distinctive designation of a person or thing.'[27] Family doctors, the first contact in the healthcare system, provide continuity and coordination of care. They are skillful physicians who walk the complex journey of illness and health with each patient.

We are family physicians, family doctors (figure 6).

We once called ourselves family practitioners. We no longer do.

Early on, 'family medicine' referred to the education and study of the work of family physicians. Family medicine now refers to the discipline as a whole, as conducted in both academic and practice settings.[28]

Family medicine is one of the primary care disciplines together with general internal medicine and general paediatrics.[29] Family physicians work alongside and in collaboration with professionals in each of these areas, as well as with family nurse practitioners and physicians' associates/assistants in generalist practice.

We are not 'general practitioners'. In the USA, general practitioner refers to those physicians who have only completed an internship. Nevertheless, in most of the countries of the British Commonwealth and Europe, family physicians call themselves general practitioners.

We are also not 'providers'.[30 31] This term originated years ago but has become popular due to the increasingly corporate nature of medicine. The word 'provider' misrepresents the work of all healthcare professionals, suggesting that their work is nothing but labour to be bought and sold, another commodity on the healthcare market.

We are, like others attending to patients, healthcare professionals. Like others who attend to the diagnosis and treatment of patients' illnesses, we are clinicians. Specific to the nature of our work, we are primary care professionals or primary care clinicians.

We are generalists. The principles of generalist practice include the 7C's: first contact, continuity, comprehensiveness, coordination, community engagement, patient-centredness and complexity.[32] We add context as an eighth. The constellation of these principles distinguishes the robust work of family physicians and other generalists from that of subspecialists and leads to distinctly different ways of approaching patient concerns.

Figure 6 Call us by our name.

Both perspectives are vitally important to the care of patients.

Family physicians are made up of both allopathic and osteopathic physicians, medical doctors (MDs) and doctors of osteopathy (DOs) alike. The similarities between these types of physicians are numerous: both must attend and complete four years of medical school, take and pass licensing examinations, complete a 3-year residency and meet the same requirements for board certification. Osteopathic physicians are, notably, more likely to employ osteopathic manipulative medicine.

As physicians, we hold the biological bases and medical/surgical treatment of disease as foundational elements of our practice. In addition, however, we believe the addition of 'family' to 'physician' enhances our therapeutic potential as generalist clinicians, acknowledging that 'family' has many meanings.

We make our mark on our patients' health and well-being by knowing their names and, sometimes, even the names of their dogs. We know their dreams and aspirations. We know their family members and often see them as our patients, too. We are there for them in health and in sickness. We are there when traditional medicine has reached it limits, when caring—simple, decent caring—is what we offer.

We are proud of our work. It is engaging, dignified and challenging. It is crucial to the well-being of individual patients, the health of the public and the common good.

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FAMILY MEDICINE AT ITS CORE

Jeff Borkan

Family physicians have a powerful story to tell. Though their voices are sometimes muted by political context, cultural forces and the hesitancy of its practitioners, telling family medicine's story is critical to the health of the nation and the world.

Family physicians are the heirs of general practice. Their roots extend back before recorded time to shamans and indigenous healers. Early European immigrant forebears had to combine medicine, surgery and apothecary skills into general practice as they adapted to the New World, and generalist clinicians have been a prominent feature of healthcare since colonial times. General practitioners and their modern descendants, family physicians, have benefitted the people and communities that they have served for centuries, and they continue to do so even as generalist practice adapts to ever changing social developments and scientific advancements.

Strangely, family medicine is considered both mainstream and marginal. Family medicine is the largest primary care discipline, present in hamlets, towns and cities across the USA. Yet as a discipline, it often leads a marginal existence in terms of power, authority and finance.

Primary care accounts for 5% or less of the healthcare dollar in most states, dwarfed by the amounts of money going to other specialties, hospitals and even insurance companies' administrative costs.[33] The practice-based philosophies of family medicine sometimes run counter to the dominant industrial and profit-oriented model of medicine in the USA.

However, family physicians' focus on patients, families, communities and populations is a constant source of personal and professional renewal. With its broad conceptual foundations and comprehensive scope of practice, family medicine has prospered as a medical specialty that merges a systems approach with care of individuals. Accordingly, family physicians work to observe and listen in a holistic manner, develop

Figure 7 The many dimensions of family medicine.

relationships and apply insights and evidence to their encounters with patients.

As a result, family medicine is one of the rare fields that both improves health and saves money. Its presence in communities extends life expectancy (whereas an increased presence of subspecialists negatively affects community-based mortality and health outcomes).[34] Despite family medicine's impressive ability to improve health outcomes in a cost-effective manner, however, one question often remains. Is anyone listening?[35] The US healthcare industry has a long history of being disinclined to change, even in the face of overwhelming data.

Though an abundance of previous studies, manifestos, programmes and initiatives have tried to increase primary care in general and family medicine in particular, the USA remains in need of a robust primary care system grounded in the principles of family medicine. The path to making high-quality primary care available to everyone living in the USA is clear, and we would all do well to heed these objectives[13]:

- Pay for primary care teams to care for people, not for doctors to deliver distinct services.
- Train primary care teams in the communities where people live and work.
- Support patient, community and relationship-centred approaches to care.
- Design information technology that serves patients, families, populations and interprofessional care teams.
- Provide specialist support to high-quality primary care clinicians embedded in communities of practice.
- Ensure that high-quality primary care is available to every individual and family in every community.

May family physicians, now and in the future, work to lead in the development and redevelopment of robust primary care in the USA and around the world, and may they join with other generalist colleagues and concerned patients to promote fundamental change in healthcare systems for the sake of all people (figure 7).

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THE ECOLOGY OF MEDICAL CARE

Larry Green

The ecology of medical care exposes the desired scope of practice for family physicians. It also reveals opportunities to implement proper healthcare for individuals, families and communities.

Ecology is the study of relationships between living organisms and their environments. It is a science that helps us understand the world we live in. The ecology of medical care focuses on the relationship between people and the environment of medical care.

Understanding this relationship is foundational to medical education, research and practice. A breakthrough study from 1961 showed how, during any typical month in the USA, most people had some sort of medical symptoms. Only a fraction of those people sought medical care, however, and that care rarely involved hospitals.[36] The study pointed out that although the overwhelming burden of people's health concerns and suffering

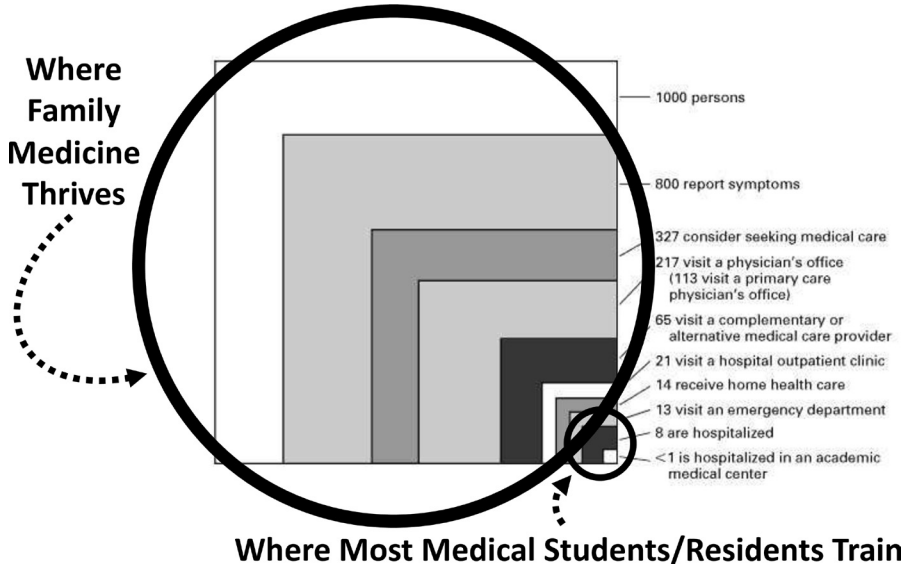

Figure 8 Medical education and the ecology of medical care. Monthly prevalence estimates of illness in the community and the roles of physicians, hospitals and university medical centres in the provision of healthcare. Adapted with permission.[36]

occurred in communities, the problems seen in hospitals dominated medical education and research.

Since then, medicine has changed drastically with explosions in knowledge and advances in technology. Surely the ecology of medical care has changed just as drastically. Not so! Forty years later, the ecology of medical care had hardly changed at all.[37] Similar patterns of participation in healthcare persist today.[38]

Why does this ecology matter so much to family medicine? From an organisational perspective, it reveals the crucial role family doctors play as personal physicians who sustain relationships with their patients over time and place, remaining geographically close to where their patients live.

From an educational perspective, the ecology of medical care highlights the breadth of scope, including knowledge, attitudes, experience and professional relationships, needed to prepare expert family physicians (figure 8). Such training must include hospital care, but it must also extend well beyond hospital settings. It must extend deep into communities where people live their lives as they see fit. Family physicians—indeed, all generalists—must learn how to establish and sustain trusting personal relationships that transcend any particular problem or setting of care. They must advance patient-centred, personalised goals and care plans across all the environments in which their patients participate.

From a research perspective, the ecology demonstrates how family physicians are perfectly positioned to study the origins of diseases and illnesses, the complexity of patients with multiple problems, the prognoses of various signs and symptoms and the meanings of health, illness and recovery. Research in family medicine has, as a unifying focus, whole people in the context of their families, communities and systems of healthcare.

From a practice perspective, the ecology confirms the responsibility of family physicians to accept any presenting concerns people bring to their attention. They make sense of these concerns in the context of their patients' particular circumstances. They collaborate with their patients to determine which concerns need attention, in what settings and with what urgency; they provide direct care as indicated and coordinate care when appropriate. Waiting for people to become patients is not sufficient for family physicians. Their presence in communities helps prevent problems, promotes health while people are asymptomatic and aids in addressing social determinants of health.

Ultimately, the ecology of medical care is important because it helps family physicians and others understand the world of medical practice and reveals how and where people participate in the management of their own healthcare needs.

Readings

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Acknowledgements We thank: (1) all those who have helped make *Storylines of Family Medicine* a reality, including our loved ones; (2) the essays' authors for their diligence and patience, particularly during the COVID-19 pandemic; (3) several key people at the University of Arkansas for Medical Sciences—specifically, the medical writer Emily Hunter for her skillful editing, the medical librarian Lindsay Blake for her project oversight, and our entire UAMS family medicine team for their support; (4) our patients—we have learned much from them along the course of our professional paths; and (5) those who peer-reviewed the *Storylines of Family Medicine* manuscripts—Cathleen Morrow, Sarah Strasser, and 3 anonymous peers reviewed the entire series; Agata Dunsmore, Scott Fields, Elizabeth Fleming, Lauren Ng, and Kieran Sweeney reviewed selected manuscripts within the series. In honor of his encouragement and support, we dedicate *Storylines of Family Medicine* to Michael D. Fetters. Dr. Fetters was a family medicine colleague and friend from the Department of Family Medicine at the University of Michigan Medical School. Unfortunately, Dr. Fetters was unable to see *Storylines of Family Medicine* published. He passed away on July 16, 2023, from pancreatic cancer.

Contributors WBV and LAS conceived of the *Storylines of Family Medicine* series. WBV, KTR, RHS, MDM, JMB and LAG wrote the first drafts of their respective essays or sections of the manuscript. All authors contributed to the conception and editing of their respective essays or sections of the manuscript. Essay first authors reviewed and approved the final version of their contributions. WBV is the guarantor of this work and, as such, had full access to all the components of the manuscript and takes responsibility for the integrity of and accuracy of the information contained within. Except as noted, authors designed the initial illustrations associated with their essays, and WBV created the final published images. All graphic icons originated from the Noun Project (https://thenounproject.com/).

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no datasets generated and/or analysed for this study.

Author note All patient names are pseudonyms. Identifying data have been changed to protect patient anonymity.

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