Family Medicine and Community Health

# Storylines of family medicine XI: professional identity formation—nurturing one's own story

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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 'XI: professional identity formation—nurturing one's own story', authors address the following themes: 'The social construction of professional identity', 'On becoming a family physician', 'What's on the test?—professionalism for family physicians', 'The ugly doc-ling', 'Teachers—the essence of who we are', 'Family medicine research—it starts in the clinic', 'Socially accountability in medical education', 'Personal philosophy and how to find it' and 'Teaching and learning with *Storylines of Family Medicine*'. May these essays encourage readers to find their own creative spark in medicine.

## INTRODUCTION

Who am I in my role as a physician? Who do I aspire to be? These are questions common to students, residents and early career clinicians in any field of medicine. These questions form the basis of professional identity formation: the process of developing one's self-image as a capable, confident and compassionate practitioner through thoughtful consideration of one's self-perceived talents, values and motives.[1] In that the practice of medicine is one of service to others, such a process also necessitates consideration of people in need, including individual patients as well as the public at large. The essays in this article explore various aspects of professional identity and its development in family medicine; they speak to some of the challenges and joys of becoming family physicians.

## THE SOCIAL CONSTRUCTION OF PROFESSIONAL IDENTITY

Hamish Wilson

*The long process of becoming a doctor can be challenging; it helps if students and residents have regular, safe and frank discussions with their colleagues to explore and process what they see and experience in clinical practice.*

Beginning the clinical phase of training represents a significant transition during early medical careers. In a process that is often complex and challenging, students and residents begin to develop a unique professional identity that is founded on their own social backgrounds and personas as well as on their formative clinical experiences.

How can medical students and residents best work to develop their professional identities while also learning the foundational biomedical aspects of medicine?

One approach is to participate in clinical reflection groups and discussion groups based on medical students' oral reports about their interactions with patients, families and staff members.[2] In such groups, discussion focuses on the thoughts and feelings of the people in each clinical situation, and the human-to-human interactions that inevitably affect the process and outcomes of medical care.

In our experience as clinical reflection group leaders, specific points of focus often arise and include several key dimensions of healthcare—what we call the *Five Fingers of Focus*: patients, learners, relationships, context and identity (figure 1). For example, participants in these groups often discuss patients' and learners' felt experiences of clinical encounters. They also explore relationships with other clinical staff and how institutional and cultural norms (ie, accepted ways of interacting and behaving) influence the development of practice style and professional identity.

Through regular peer discussions, students and residents start to make sense of their interactions with patients and the context in which these interactions occur. They begin


**Figure 1** Professional identity formation: five fingers of focus.

to incorporate their reflections on clinical medicine into their emerging sense of professional self.

Grace was a 55-year-old grandmother presenting with multiple organ system failure. Admitted to the intensive care unit, she died within 24 hours. A student named Jane described how quickly staff began to discuss organ donation with Grace's family, as it was Grace's wish to donate her organs. Although the family's grief was acknowledged by various staff, Jane was troubled by this rapid change in attention: 'One minute alive, the next dead, then her organs are being harvested.'

In group discussions, other students wondered how the senior doctors suppressed their personal responses to Grace's abrupt death and remained clinically objective. They also noted how Jane closely monitored and regulated her own feelings to 'fit in' with that particular clinical team.

This clinical incident and the resulting discussion reveal just how carefully learners in medicine observe senior staff, especially in life-or-death situations. While examples of compassionate care can prove inspirational and affirm career choices, negative role modelling, such as avoiding clinical discussions about end-of-life care, can be profoundly disquieting.[3] Similar to other methods of reflection, these discussion groups provide opportunities for students to voice their ambivalence, struggles and achievements in their journeys to becoming doctors.

By telling their own stories and by being heard and validated, students and residents can articulate the developmental challenges they face and can explore how they are building their professional identities in the service of patient care.[4 5]

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## ON BECOMING A FAMILY PHYSICIAN

Sumi Sexton

*There is no intrinsic virtue in standing in a countercultural relationship to mainstream medicine, but it is only as inequities are healed that family physicians can rejoin the mainstream as full-fledged members.*

Family medicine originated several decades ago because of the need for holistic, person-focused and community-focused care; this new specialty countered the ongoing hyperspecialisation and pathology-focused trends in medicine.[6] The specialty remains a counterculture movement to mainstream medicine as family physicians continue to hold the patient–physician relationship at the epicentre of their efforts to address health inequities.

The word 'counterculture' does not necessarily suggest opposition; rather, it signifies 'courage'.

It is the courage to put patients first and guide them in health decisions based on the best available evidence. It is the courage to help persons of all ages and diverse backgrounds who may have differing views and lived experiences from our own. It is the courage to practise in global, rural, urban and countless other settings. It is the courage to work in environments where family medicine is unwisely undervalued, and it is the courage to address systemic racism, to advocate for patients when others have failed them, and to chaperone our patients through a pandemic with widely disparate views on how to overcome it.

This is family medicine.

Becoming a family physician is not just a career choice; it is a path that continues to evolve over the course of a professional lifespan. Along this path are three golden circle considerations to reflect on (figure 2).[7] You might contemplate 'what' family medicine means beyond the day-to-day routine of practice and the breadth of job opportunities the discipline provides. You might consider 'how' to achieve personal goals and career aspirations, balancing such factors as family, geography and work responsibilities. Perhaps the most important question to ask is 'why?' Specifically, 'why is this important?' This question is of crucial consequence at every step along the

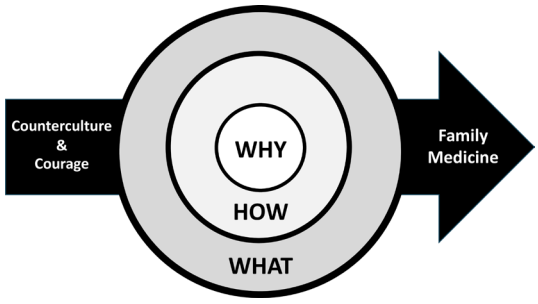


**Figure 2** Family medicine: what, how and why. Adapted with permission.[7]

path—asking it often is key to evolving into the family physician one desires to become.

As I have progressed in my career, my 'why' has become stronger and influences nearly everything I do. On the days I am overwhelmed with a busy schedule, never-ending documentation, challenging clinical cases and daunting administrative tasks, I do my best to reflect on the reason I am a family doctor: the connections that I have made with people and continue to build on energise me.

As these connections and energy have grown, so has my courage. I work to put my patients first. I advocate for those who have been abandoned by our healthcare system. I navigate shared decisions with patients who have wildly different perspectives from my own. I take actions through various leadership and teaching roles to promote our specialty. I am committed to understanding systemic racism and addressing the health inequities that currently exist.

Family medicine as counterculture? Family medicine as courage? It is all the same if we help the people who seek our care and advance along the paths we forge for ourselves.[7]

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## WHAT'S ON THE TEST?—PROFESSIONALISM FOR THE PROTO-PHYSICIAN

David Doukas

*Development of professionalism requires that learners recognize patients' vulnerability in the face of illness, develop trusting relationships in service of healing, use their knowledge and skills freely, and commit to being competent practitioners who respect all patients.*

Most medical learners have had some sort of exposure to medical ethics and humanities. This exposure, coupled with role modelling, serves as the foundation for your development as professionals in healthcare.

Prior to third-year clerkships, academic performance is self-directed, and the accrued benefit 'flows' to you as students. The pressing questions early in medical school are often 'What's on the test?' meaning 'What do I need to know *for me* to get a good grade?'

However, this focus changes when taking on clinical responsibilities in medical school and residency. Clerkship students and residents face new challenges, the most obvious of which is accepting increasing levels of responsibility for patients. The benefit flows *outward* rather than inward, as the object of professional concern shifts to the 'other' person in the healing relationship.

In addition to this shift in the caring relationship, the development of medical professionalism necessitates reflecting on how you—individually and collectively as *proto-physicians*—evolve into true professionals who maintain an awareness of how internal and external guides contribute to, or detract from, the broader professional contract physicians hold with society (figure 3).

**Internal guides**—All enter medicine with a variety of experiences, beliefs and biases. The religious, philosophical and humanistic underpinnings of who you are as an individual influence the physician you will become. These beliefs and biases are often sorely tested when you are charged with the responsibility for another person's health and life. It is important to explore how these internal touchstones can assist you in your work with patients and to acknowledge that some internal guides may negatively influence your ability to provide care.

**External guides**—Medicine is grounded in a social contract. This contract lays out the profession's duties to society at large and directs that physicians' efforts benefit the patients in their charge, taking care to prevent harm to third parties or society when doing so.[8] As to your future in medicine, the underlying premises of this contract are threefold[9]:

**Figure 3** Finding our professional way. Adapted with permission.[11]

**Figure 4** Taking flight in family medicine. Copyright 2021 Nora Rodriguez. Reproduced with permission.[13]

- The humbling nature of illness requires the establishment of trust between you and your patients. Illness places patients in vulnerable positions and creates power imbalances that only trust can mitigate.
- The knowledge of healing is non-proprietary. It is entrusted to you as a professional in order to benefit others and train learners.
- Through the expression of your professional oath, you publicly commit to competence, service that benefits patients and respect for individual rights.

Fundamentally, professionalism means striving to heal the vulnerable with knowledge and skill, offered with respect, accounting for both internal and external guides within your moral compass.

The purpose of professionalism is to recognise that our aim as physicians is not to help ourselves, but rather to help others feel better. When seeing patients in medical school and residency, your teachers will evaluate your competence, respectfulness and devotion to the benefit of patients and society.[10]

Remember, however, these evaluations are not the endpoint. In the end, the 'tests' themselves do not matter—*only the patient does.*[11]

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## THE UGLY DOC-LING

Jes Cerdeña

*Becoming a family physicians means relying on the insights of others—patients and colleagues alike—to develop the essential traits of wisdom, humility and gratitude.*

I am not ready for my intern year. As everyone says, no amount of reading, observed clinical assessments or simulations can prepare you for the challenges that lie ahead in residency. I will likely enter my first order incorrectly, tangle myself in the cord of the wall-tethered otoscope in an unfamiliar examination room, fumble with my patient lists on morning rounds and spill coffee on my last pair of clean scrubs midway through a long shift. Even so, I am ready to smile, laugh and give thanks for every day I get to do what I love—and learn to do it better.

Family medicine is a tough specialty. Rather than magnifying the retina or a cross-section of a coronary artery, we, as family physicians, take a panoramic view of our patients as complex, dynamic people across their lifespans. We learn the medicine for each organ system and every stage of life. We train in relevant technology, community awareness and health psychology. We are bound to make mistakes, just as we can cherish our successes and grow in community with those around us.

As a new family medicine resident, I plan to embrace humility as I recognise the wisdom of those around me. I know my pharmacist colleagues will rescue my patients by dosing their anticoagulants and antibiotics more quickly and appropriately than I ever will. I will turn to nurses and medical assistants to help find the supplies—and warm blankets—needed to ensure my patients receive quick and compassionate care. When I inevitably find myself lost in the hospital, I will appeal to the good humour of the custodial and transport staff who always know the shortest routes around our labyrinthine healthcare buildings.

Above all, I recognise the wisdom of my patients and look forward to learning from them. Though I spent years in school learning medicine, my patients have spent their lives learning how their bodies work. Listening to patients' heartbeats or inhalations is not sufficient; I must listen as patients explain what it feels like to live in their bodies, for they are the true experts in the clinical encounter, not me.

In medical school, I joked that I was an 'ugly doc-ling' waiting to become a long-white-coated swan (figure 4). In the classic fairy tale, a misfit duckling suffers criticism from his fellow hatchlings for his odd attributes. He sets off alone, seeking refuge with charitable countryfolk along his journey. As the duckling grows, his strange features fashion into elegance, and he finds his identity and companionship among a bank of swans.[12]

As an ugly doc-ling, I will stumble and fall out of place. I will rely on the kindness of my friends for support and insight. With humility and gratitude, I will grow into my place in family medicine, taking flight among the graceful—and gracious—peers who have shown me the way.[13]

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## TEACHERS—THE ESSENCE OF WHO WE ARE

David Kelley

*Teaching is the superpower of family medicine. We as family physicians can't help but teach. It is our nature.*

As family physicians, we teach patients about the complicated words of medicine and about the complex process of working within a healthcare system. We teach them how to do home exercises, what to expect from consultations and even how to get to them. We teach them how to get a laboratory test or a study, why a test or study is important and, once completed, when to come back for a follow-up visit. We teach our patients how to interact with medicine as a whole and how to interact with our clinic staff. We teach about medications, about nutrition and health, about feelings and thoughts and about expectations and fears. We teach about life and the loss of life.

Teaching is about better health for our patients, helping them imagine and become the best version of themselves they can be. Ideally, teaching is how we help other people get out of their own way and accomplish something healthful, something healing and something they want to change for the better. Teaching is how we transform people so that they need us less. Our goal through teaching is not to provide more services and make more money but to encourage people—our patients—that they have the capacity to move toward health of their own accord, now and in the future.

Teaching moments are special snippets of time during which we can communicate information in ways that are meaningful and respectful so that patients can hear and understand what we are sharing. Such moments can change people forever.

This applies as much to our learners in medicine as it does to our patients.

Teaching is about our future and the future of family medicine. Teaching is how we pass on to the next generation of clinicians how to listen and be with patients—how to provide person-centred and people-centred care. In teaching students and residents how to be the best doctors they can be, we not only teach the science and art of our discipline but also the foundation of humanistic care in any field. It is about ensuring, as well, that patients have access to the kind of personalised care they cherish and need.

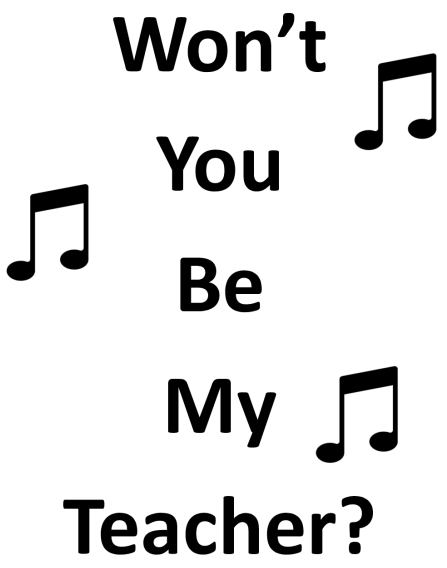


**Figure 5** Teaching: the song that keeps the beat going.

Day in and day out, we are being taught and learning how to teach. Our patients, our colleagues, our staff members and our learners—they are all our teachers, as are the structures of medical school, residency training and society. How we translate to others all we have learnt and are learning, how we package the thousands of lessons, big and small, in support of others—that is our task in return.

Being a teacher is a constant process of humility and growth so that we can give the best we have to our learners at each juncture. It is learning new methods and being open to learning new words, new ways and new futures—and given the current circumstances around the world of medicine, change is about the only thing teachers can bank on. By teaching, we will never be alone, we will never be stagnant. Teaching is a way to be alive and active, always learning, as much at the end of our careers as at the beginning (figure 5).


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## FAMILY MEDICINE RESEARCH—IT STARTS IN THE CLINIC

Mike Fetters

*Great research questions arise daily in clinical practice—they are just waiting to be recognized and explored.*

Back when I was a family medicine resident, I was scheduled to see a 52-year-old woman for a gynaecological examination, which included a Pap smear. Her medical

history mentioned obesity and hypertension. It also indicated that she had undergone a hysterectomy due to the presence of fibroids. I was trained to collect cells from the squamocolumnar junction to ensure an accurate Pap smear, but given the patient did not have a cervix, I was baffled as to what to do. I asked my preceptor for advice. She replied, 'That's a good question!'

The prevailing wisdom at the time was to scrape the surgical cuff. When I went to perform the Pap smear with an Ayres spatula, I struggled to find my patient's surgical cuff. Afterwards, I wondered how she could even get cervical cancer. After all, she had no cervix! When I tried to look up an answer, I found contradictions between multiple specialty guidelines and acknowledgement of uncertainty in the US Preventive Services Task Force (USPSTF) recommendations.

I was intrigued and pondered the mismatch between standard practice and common sense. With faculty encouragement, I applied and received a small research grant from the American Academy of Family Physicians Foundation. I conducted a literature review framed by the USPSTF criteria for effective screening tests. With input from colleagues, I published an article in *JAMA* concluding that there was no evidence for conducting Pap smears after a hysterectomy for benign disease.[14] Additional research studies started appearing in the literature, and the USPSTF subsequently recommended against doing Pap smears in women who had undergone a total hysterectomy.

Because of an observation I made as a resident physician, the encouragement I received from a faculty member, and my determination to find an answer that made clinical sense, I was able to expand my medical knowledge. That small discovery eventually influenced a policy change affecting hundreds of thousands of women and their medical practitioners.

What a concept (figure 6)! Although well-intentioned and firmly engrained in practice, Pap testing after total hysterectomy for benign conditions was unnecessary. Family physicians, obstetricians/gynaecologists, internists, nurse practitioners and other healthcare professionals were wasting efforts on testing that were not only often uncomfortable for patients but also did not work, took time away from effective preventive services and contributed to unnecessary costs.

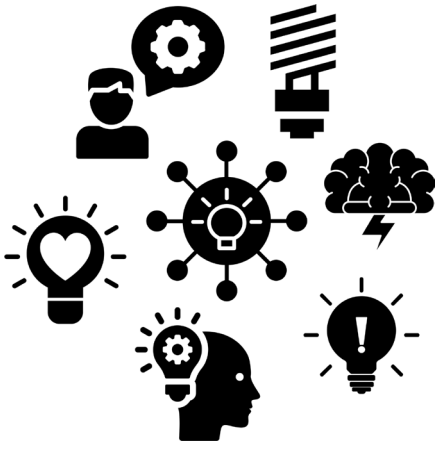

**Figure 6** Family medicine research: following up on *lightbulb moments.*

Doing good research in family medicine means being inquisitive. It means focusing on clinical brainteasers in day-to-day practice and considering clinical questions as they arise during routine care.[15 16] Doing good research in any field of medicine means being curious, observant and thoughtful in the everyday work of caring for patients in the context of the communities in which they live.

When you hear someone say, 'That's a good question,' pay attention! You never know where such a question can lead.

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## SOCIAL ACCOUNTABILITY IN MEDICAL EDUCATION

Jeff Haney

*What is the purpose of a medical education? What responsibilities come with the title of physician? The answers to these questions demand we build socially accountable systems of medical education and practice.*

**From individual to social**—As prospective students, residents or family physicians we have a recurring shared experience. Whether consciously acknowledged or not, we regularly ask ourselves, 'Why do I want to be a doctor?' With every standardised examination, personal statement and cover letter we reflect on that question. The answer differs for each of us, but at the heart, it is our unstated commitment to our patients, communities, and society at large.

Recently much scholarship has been devoted to moving that implicit understanding to an explicit statement of our social contract, a contract that defines the expectation of the profession.[17] Though this concept of an explicit social contract lays the groundwork for forward movement, it leaves us with a very important professional challenge. A contract, by its nature, is individual, necessitating the fulfilment of individual roles and responsibilities rather than social ones.

**From social contract to social responsibility**—The individualisation of a social contract has left the health of our patients and communities wanting.[18] Various health systems and organisations have identified the need to

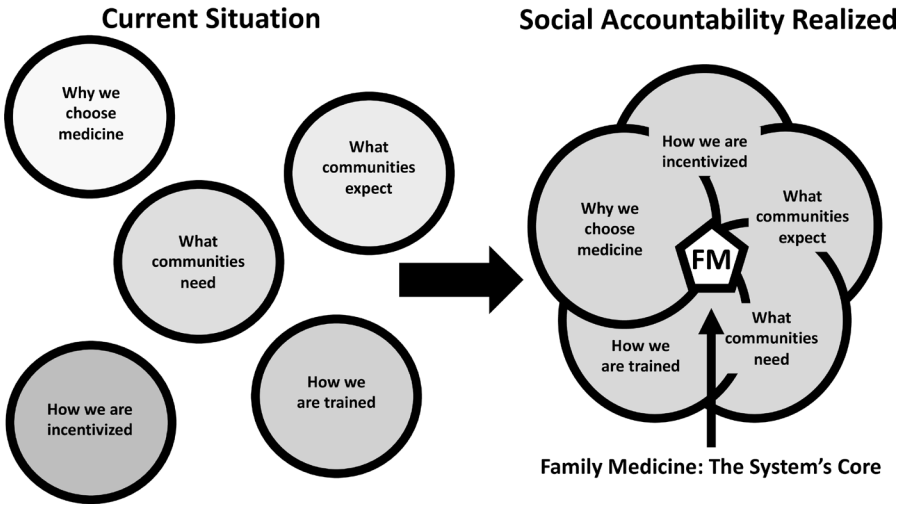


**Figure 7** Transitioning to socially accountable medical education and practice. FM, Family Medicine.

close gaps, to serve communities and—essentially—be socially responsible.[19] We need to ask ourselves: 'Why do we want to be doctors?'

Frequently, the attributes of socially responsible medicine are linked directly to the key tenants of primary care and family medicine, in that they provide 'comprehensive, person-centred, relationship-based care that considers the needs and preferences of individuals, families and communities… People in countries and health systems with high-quality primary care enjoy better health outcomes and more health equity.'[20]

**From social responsibility to social accountability**—At present, social responsibility has not resulted in healthier communities. Medical schools and healthcare institutions voluntarily can, and should be, socially responsible. In addition, however, they should be held to account by society for what they do. Although there are plenty of arguments for social accountability at multiple levels of medicine,[21–23] individual efforts are not enough—moving our health system to a framework of social accountability is a collective task. It is central to the most important question that we ask ourselves almost daily, 'How can we best serve our communities' and patients' needs?'

**Toward socially accountable medical education**—Our final question to consider: 'How can we train the physicians of tomorrow to meet the needs of *all* patients in *all* communities?' To be accountable, we must collectively act across the continuum of medical education (figure 7). The evidence is clear in support of holistic approaches to medical school admissions[24]; recruiting based on diverse backgrounds, geographical areas of need and stated interests; training in rural and underserved environments; early exposure to primary care; aligning economic incentives[25]; and embracing community-engaged medical education.[26] The guidebook for social accountability already exists. The challenge before us is the collective advocacy, persistence, and will to assure we are accountable to our patients and communities.

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## PERSONAL PHILOSOPHY AND HOW TO FIND IT

John Frey

*Five recommendations for finding one's personal philosophy of family medicine.*

For decades, I have advised senior residents, as they enter their final year, to write 'the letter'. I ask them to list in this letter the principles of family medicine that will guide them in their search for a practice position. I tell them to keep a copy for themselves.

I wrote my letter in 1972 and still have it today. I wanted to work with low-income communities—or whatever term was used back then—and I wanted to teach. For the subsequent 50 years, I have worked in community health centres and have been a teacher. While I have done other things along the way, my practice and my teaching have been the central themes of my career in medicine. I go back to my letter and feel happy about all I have accomplished in my career. (I also wrote that I wanted to be a small-town doctor. I almost took my first job in a rural clinic as a resident teacher, but I did not. The rest, as they say, is history.)

All the writers, clinicians and teachers who have inspired me over the years were driven by values made clear in their work. William Carlos Williams, the American physician–writer, said this about the relationship between poetry and medicine: 'One rests the man when the other exhausts him.'[27] Like Williams, my teachers

- Everything is about relationships—learn from them
- Find people who are willing to try new things with you
- Push to do things you are reluctant to try
- Teachers are everywhere—find them
- Find meaning in generalism—it's worth it!

**Figure 8** Finding your philosophy: recommendations for young family physicians.

found a balance between acting and reflecting that sustained them. They thought about their daily work of caring for patients and teaching, put their thoughts into words, and shared them with patients, students, residents and colleagues.

The British/Canadian family physician and educator Ian McWhinney said that he got his ideas from three sources: talking with people, reading and clinical medicine.[28] He then used those three sources to write some of the finest explications of generalist practice that have ever been written.[29 30] He and others have continued to search for answers about what has kept them doing the work of generalist practice for a lifetime.[31 32]

Many of the people who have helped me develop my own rationale for the work of doctoring and teaching have had difficulty articulating the philosophy behind their lives. Yet the way they lived illustrated their philosophies: through service, relationships, making a difference and passing on a legacy of care.

One of the best explanations for staying with the work of medicine and service came from a small-town family doctor from California who I once met. When I asked him why he stayed to practise in his town for more than 30 years, he simply responded, 'Because they need me, and I need to feel needed.' Service and a sense of purpose are at the heart of family medicine.

Being clear about the values that were the source of my desire to be a clinician and teacher has helped tremendously over the 50 years I have been engaged in those two roles. Writing them down helped. It still does. But the other life experience that has kept me vital and excited over that time was trying things—taking chances, talking with people who inspired me and not being completely bound by protocol or history. Combining chance, caprice and opportunities with values has helped me look back and describe my career (figure 8). More is still to come.

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## TEACHING AND LEARNING WITH *STORYLINES OF FAMILY MEDICINE*

Bill Ventres and Leslie Stone

> Storylines of Family Medicine *can help learners find meaning in their work as family physicians…and we are all learners!*

The purpose of *Storylines of Family Medicine* is to inform students and residents how clinicians and scholars in family medicine have introduced to medicine distinctive theories of practice and approaches to patient care.

Each essay in the series describes a personal reflection on family medicine's history, theory of practice or approach to patient care—each represents a motivating tenet of family physicians' daily work. Each can be easily read in five minutes, and each is accompanied by an illustration and suggested key articles for further reading. Collectively, the essays in 'Storylines' represent an accumulation of practice-based wisdom culled from authors' varied experiences.

Although useful for any clinician in any specialty or subspecialty, these tenets are particularly applicable to family physicians. This is so because of the character of family medicine, one in which patients present to their family physicians first and foremost as people (rather than as a collection of concerns or a physiological process gone awry), in times of health and in times of distress, and commonly with problems that are often undifferentiated in nature.[33–35]

For teachers of family medicine, we encourage you to incorporate *Storylines of Family Medicine* into your educational endeavours. When? Where? With whom? With what intent? We leave the answers to these questions to your discretion; however, we do request you use *Storylines of Family Medicine* to promote active learning.[36–38] Whether with students or residents as part of an ongoing, small-group focused curriculum or to stimulate in-the-moment, one-on-one discussions, please allow learners to do their own work on reading the essays in this collection.[39] Give them space to create their own personal philosophies of practice, the guiding beliefs from which their own

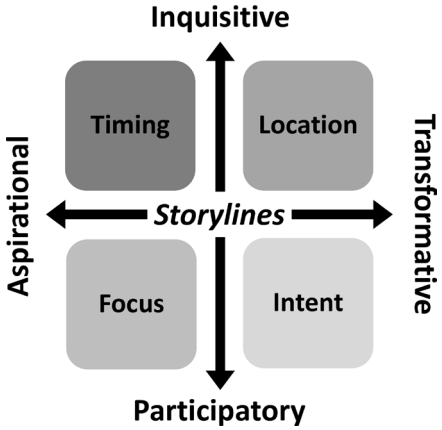


**Figure 9** Engaging learners with *Storylines of Family Medicine*.

personal therapeutic potentials can blossom (figure 9). For students, take advantage of the creative space teachers invite you to enter: be active learners!

Although we have edited these essays with medical students and family medicine residents in mind, we believe the essays in this series are applicable to any learner planning to walk the professional path of becoming a physician, whether in college, medical school, residency or fellowship. We hope readers find knowledge, wisdom and inspiration in these essays regardless of where they are on their professional paths. We hope that they will help readers grow into capable, confident and compassionate physicians, thoughtful practitioners of a kind of medicine that integrates art and science as one.

Our final hope is that all learners—and we all are learners—can make this pledge with assurance at the end of each day: 'As I am able, I am capable in the diagnosis and management of disease, confident in the practice of my chosen field, compassionate in the face of suffering and caring in my attention to patients.'

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