SPECIAL COMMUNICATION

An Exploration of Professionalism in Everyday Practice

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Professionalism is what professionals do to connect, contribute, and give back to their profession. We often picture it on a grand and spot-lit stage: the white coat ceremony, graduation oath, diplomas on the wall, and resumes on file. But it is in the crucible of everyday practice that a different image emerges. The icon of the heroic and duty-bound physician morphs into a kind of family portrait. Here we stand on a stage built by our forebears, lean against our colleagues, and look to the community where our work is fulfilled. (J Am Board Fam Med 2023;36:515–519.)

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There is no such thing as a solitary polar explorer, fine as the conception is.

Annie Dillard

Introduction

One hears grumblings that medicine has become less professional. What could that mean? Some point to a loss of control over the workplace. Indeed, the majority of current graduates in family medicine choose to be employed—some 89% in a recent survey.[1] But professionalism is not about ownership, even if the lack of it constrains some of our choices. The poet Robert Frost once defined freedom as feeling a little loose in one's harness.[2] There is still plenty of wiggle room in the harness of medicine to reach for our ideals.

Some worry that part-time physicians, walking the tightrope of work-life balance, are less committed to their patients than we old-timers. I never felt that I came close to meeting the needs of my patients, no matter how many hours I put in. Had I worked harder, I might have earned a doctor-of-the-year award but received it posthumously.

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Some describe professionalism as a "contract with society," by which, metaphorically speaking, doctors are given the right to train and certify their membership, sanction the unscrupulous, define what is true, and set the standards of care. In exchange, medicine promises to satisfy the health care needs of the nation. If that were true, there would be far less inequity in the salaries we earn, the specialties we enter, and the places we choose to practice.

Metaphor, nevertheless, can help us understand what professionalism is all about. As we will see, it has more to do with the collective than the individual. It is always aspirational and never contractual. It is less a tally of rights and responsibilities than the stuff of memory, tradition, honor, community, and love of neighbor. It asks us to put the needs of others before our own.

Trish

She was, as she often said, born under an unlucky star. A congenital heart defect led to multiple surgeries and an early exposure to opioid pain medication. In her teens she became asthmatic, which worsened during her parents' divorce. Symptoms of anxiety and bipolar disease soon surfaced. Her young adulthood saw a series of ups and downs: she was hired for good teaching positions but could not hold them; she was given a new car by her parents but quickly totaled it; her marriage to the man of her dreams ended in failure but not before the birth

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of 2 beautiful daughters whom she never ceased to love and praise.

Everyone remembers Trish. She was among the first to enter our medication-assisted treatment program and the first to join a recovery support group. The groups were led by a therapist and clinician who thought we were teaching accountability and impulse control, facing one's anger, and avoiding triggers. But it was we who were learning what lies beyond the bridges they burned: jobs denied to the felon; children held in foster care; the narrow edge between freedom and incarceration. Trish was our mother hen: jubilant when the group did well and despondent when members drifted away. She spilled her tears with every turn of fate.

Golden Age

When I first entered practice, doctors spoke to one another. Of necessity. There were call group meetings, medical staff meetings, and county medical society meetings. We ran into each other on hospital rounds, in the doctors' lounge, and at the emergency department (ED) late at night. We depended on the general surgeons for our C-sections, and they needed us to first-assist. Offering "professional courtesy" was the norm, and we rarely took our patients to small claims court over bad debt, knowing even before we saw them that they could not pay. We volunteered for vaccine clinics, sports physical clinics, and talks before the Hospital Auxiliary or Rotary Club. Gradually our charity was replaced by billable time.

Nowadays I help out at the practice I cofounded but no longer own. Like my younger, busier colleagues, I forfeited my privileges at the hospital, ED, and nursing home. We see "continuity" patients, mostly without the continuity. In our building there is a clinical pharmacist, behavioral therapist, and walk-in clinician, and while they are only a few steps away, I almost never see them. Even my physician colleagues are scattered about the office, and staff come and go before I learn their first names. From the administrative offices an hour away, one of us is chosen to be an "employee of the year," and all us are treated to the annual appreciation barbecue. But none of us feels appreciated, much less connected.

To say that I felt more professional in the early days would only be true in the narrowest sense: I knew my colleagues and they knew me. We judged each other's strengths and weaknesses, successes and failures; we knew the demands of the job. Some in my call group worried that I was stealing their patients. Some felt that I encroached on their professional prerogative. Some wanted to keep me at the bottom of the pecking order. But over time, and in the end, we recognized the good in each other's intentions and did our best to compensate when 1 of us fell short. We often fell short.

The modern clinic is not designed to be collegial. It is too easy to practice with blinders on. Too easy to curse the flooded inbox instead of blessing those who help bail it out. Too easy to work one's shift and escape out the back door. But it is not impossible to find redemption here; it shines in the lives of those we care for—so much less advantaged than our own—and in the goodwill of those we work alongside.

Altruism

Taking the oath of service is a right of passage for most medical students. This is the most tangible and overt expression of their membership in a profession. But what makes it so, a profession rather than a trade or guild? A plumber, too, lays claim to an expert body of knowledge, commits to excellence, belongs to a self-regulating trade group or union, and is paid well enough to avoid needing a second job. Why is plumbing not a profession?

In a word, altruism. It was coined by the 19th-century French philosopher Auguste Comte, who was searching for an antonym to egoism—the exclusive concern for oneself.[3] Altruism comes from the Latin word for "other," *alter*, and expresses a desire to put the good of others before one's own. You could argue that not all in the profession still abide by it. But as Gayle Stephens points out, whether *we* believe in it or not, others do,[4] which is why patients are able to trust us in times of crisis.

Altruism remains one of the few things in medicine that is optional. We are expected to provide a billable diagnosis and procedure code for every encounter. We are required to keep patients safe, as prescribed in the code of ethics and clinical standards of care. But to actually help them, whatever their request or need, no matter the limits of our training or the resources at our

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disposal, is left to our discretion—albeit influenced by those around us.

The Job and the Work

Stephens elsewhere likened the work of medicine to the sighting of a snow leopard in its natural habitat. It is impossible to do without spending strenuous days and frigid nights along the migratory path of Himalayan blue sheep, the great cat's principal prey. The snow leopard is so well camouflaged that when you spot it, if you *ever* spot it, it will occur in a flash "over your shoulder and out of the corner of your eye."[5]

The job of medicine trudges behind the blue sheep. It is what we are trained to do, paid to do, and expected to do. It fills our days and gives structure to our lives. We know how to keep our distance, stick to facts, and stay the familiar path. But once in a while, in the course of suturing a wound, reshuffling a medication list, or simply pausing at the door, we catch a glimpse of something more. An opportunity opens up and we are swallowed whole. The patient hints at a life-altering disappointment, some forgotten grievance, the grace of an unexpected kindness, or an irrepressible joy. Did we sense or imagine it? Should we circle back and risk falling further behind? Or realize that this is why we had become a doctor: to participate in moments of self-revelation, mystery, intimacy, and vulnerability. This vision of humanity is distinct from the job. "It happens of its own accord. But it comes only in the very process of attending to the job, with all its aching drudgery."[5]

The doctor-poet William Carlos Williams described it this way: "They are in trouble; and that is when you are eager to look into things deep, real deep. I would not walk away from those kind of talks for anything; I come away so damn stirred myself, I've needed to walk around the block once or twice to settle down."[6]

Baseball and Polar Exploration

Baseball, America's pastime, is still played in sandlots, on local diamonds, and at corporate stadiums across the country. Those who come to the game—players, coaches, families, and fans—know that it is more than a box score, individual statistics, and the rules and regulations that hold it together. There is a palpable love of the game, the thrill of a well-executed play, the unfolding drama between pitcher and catcher, the beauty of a manicured field under the lights, memories of heroes and the events that made them so.

From Little League to the Majors, what it means to be a ballplayer is also being defined and modeled, tested and contested. He or she is not just a technician, an athlete, but someone who loves and respects the game and its traditions, wins and loses graciously, strives to improve, puts team before self, helps struggling players, holds teammates to the high standards of the sport, honors the game on and off the field, mentors younger players, and volunteers in the community.

One can argue that the atmospheric salaries in today's professional sports have destroyed the game. That it is all about solo performances and a winning record. But watch young players and their coaches. Most can list their heroes; many share the sentiments of Mets pitcher Tom Seaver. In his Hall of Fame movie, he was asked about how he controlled his emotions when a game was on the line and 50,000 fans were screaming his name:

> For me, it was very simple. I loved what I was doing. I was like an artist, a physical and mental artist. I would take those emotions, whatever they were, and focus them on what I had to do out there. I loved all of it. I loved 60 feet, 6 inches. [The distance between the pitcher's mound and home plate.] I loved the history of the game. Sandy Koufax. Christy Mathewson. Walter Johnson. I loved them. . .In my heart and brain I knew them. They were artists and I was an artist, and I loved being part of that history.[7]

The end of the 19th and beginning of the 20th century is often referred to as the "Heroic Age of Antarctic Exploration." No fewer than 17 major expeditions set out from 10 different countries, each intent on advancing science, mapping unexplored territory, and planting a flag at a geographic pole. The journeys were exhausting, perilous, and often fatal: 19 expedition members died of such causes as falls (through the ice, from a mast, into a crevasse), disease (beri beri and syphilis), starvation, and exposure.

The author Anne Dillard tells us that Sir John Franklin set sail from England with 138 officers and men for an expedition to the North Pole. Instead of storing sufficient coal for the auxiliary engines, he brought along a 1200-volume library, china place settings, cut-glass goblets, and sterling

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silver flatware. Their bodies were never recovered. Sir Robert Falcon Scott could not bring himself to use sled dogs, let alone feed them to each other. Instead, he employed English ponies, for whom he carried hay. Scott felt that eating dogs was inhumane; he also felt, as he himself wrote, that "when men reach a Pole unaided, their journey has 'a fine conception' and 'the conquest is more nobly and splendidly won.' It is this loftiness of sentiment, this purity, this dignity and self-control, that makes Scott's farewell letters—found under his body—such moving documents."[8]

On the other hand, Roald Amundsen—the first person to reach the South Pole—made haste using sled dogs and feeding them to each other on a regular schedule. Robert Peary and Matthew Henson reached the North Pole in the company of 4 Inuit guides who drove the dog teams, built igloos, and supplied seal and walrus clothing. They improvised and adapted their way through the frozen wilderness, at great sacrifice, for no greater cause than to meet a challenge, advance science, and answer the call of duty. They were no more heroic than Franklin or Scott, but they knew that their "professional" community extended to those who knew the territory and the means to survive it.

Local Professionalism

Two years before I met Trish, my partner and I stumbled on an opioid epidemic at our doorstep. Fortunately, a new treatment had just been approved. As we began to prescribe Suboxone, we were deluged by patients who requested our help. We cobbled together a treatment program. Agreed to treat Trish and many others—from 27 different zip codes—who never officially enrolled in our practice. The flow quickened. We were overwhelmed not only by the numbers but by the complexity of their mental illness and social liabilities. What they needed most, we finally realized, was a recovery community, so we formed groups that were cofacilitated by a therapist and a clinician. And when we ran out of group leaders, we required every colleague to attend at least 1 session. The stories they heard convinced them all to stay.

As the number of prescribers and therapists grew, so did our differences—in basic knowledge about addiction, preferences for dosing, and patience with relapse. So we committed ourselves to meet. Weekly. And flesh out guidelines that could accommodate our differences yet maintain the program's coherency. When an effective and nontoxic treatment for hepatitis C came along, we the care team expanded once more to include a clinical pharmacist and care manager.

One evening as my wife and I dined at the local pub, a customer fell off a bar stool. While I attended her and waited for the ambulance to arrive, a policeman dropped by. And a light bulb went on: the only way to save an overdose victim would be to put naloxone in the hands of every patrolman. My partner and I approached the police chief a few days later. "How can I say no," he shrugged, "when 2 busy doctors have taken the time to educate me?" But not everyone in the community was happy. Many, including Trish's sister, complained that medication-assisted treatment merely substituted 1 addictive substance for another. Indeed, few tapered off and many relapsed. Nevertheless, they survived, and Trish—the mother hen of our group—cheered us on.

Trish

I still remember the snowy Sunday morning when she was found. Her children had been sent away for a weekend with their father. Now her sister was on the phone with the news. "No autopsy," she instructed me, for we all knew what it would find. "But please join us next Saturday for a celebration of her life."

Years ago, my partner and I agreed to help a clinic north of town when it lost its physician. One day a week, we listened to stories, swabbed throats, bandaged wounds, and slowly got to know—even became a part of—the tightly knit community that Trish called home. Though decades had passed, I was now greeted by old friends, many of whom approached me, hugged me, thanked and consoled me. We were, of course, just like Trish—each of us struggling with the guilt of our failure to prevent her death. And each finding consolation and support from those who had gathered in her memory.

Conclusions

Much of what we do in medicine, good or bad, is a solo performance behind closed doors in the rush of the day, our heads down and eyes fixed on the keyboard. No one tracks the unreturned phone

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calls, the notes of condolence left unwritten, or courtesy visits we might have made. The only ones who would notice, who could save us from ourselves, are those with whom we share the load. For the business of medicine hurries on.

Once in a while a practice is asked to rise above itself. Trish and her recovery community offered us that invitation. They insisted that we care for them, treat them as more than their addiction, and concern ourselves with problems that went beyond the receptor site. They needed a safe space to meet, cry, and rage without fear of interruption or judgment. And we? We needed to acquire new skills, teach them to one another, and talk through our differences. We discovered just how far-reaching a community can be. And as a consequence, our care team expanded until it included us all.

Local professionalism is what doctors do of their own accord, in their own locale, to maintain their integrity, honor the past, confront their failings, and elevate the profession—our collective selves. Medicine is neither polar exploration nor baseball, but like them, it is buoyed by the love, honor, and teamwork we bring to it. We labor for the money; we are comforted by status and praise. But as we pull against the harness, we keep looking, looking for the snow leopard among the Himalayan sheep. Professionalism is not about the stand-alone physician, no matter how capable and committed he or she has proven to be. For as Annie Dillard reminds us, "There is no such thing as a solitary polar explorer, fine as the conception is."

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