As a medical student, do you ever wonder what it's like to specialize in family medicine? Meet Christopher Garofalo, MD, a family medicine specialist and a featured physician in the AMA’s “Shadow Me” Specialty Series, which offers advice directly from physicians about life in their specialties. Check out his insights to help determine whether a career in family medicine might be a good fit for you.

The AMA’s Specialty Guide simplifies medical students’ specialty selection process by highlighting major specialties, detailing training information and providing access to related association information. It is produced by FREIDA™, the AMA Residency & Fellowship Database®.
"Shadowing" Dr. Garofalo

Specialty: Family medicine with obstetrics.

Practice setting: Outpatient practice.

Employment type: Private, independently owned.

Years in practice: >20.

A typical day and week in my practice: My schedule is a little different each day, which affords me flexibility to attend to my family’s needs. One of things you understand when choosing medicine is that it is not a 9-to-5, punch-in and punch-out career.

If I have a newborn and postpartum dyad to see at the hospital, I start my day at the hospital and then head to the office. I attend to portal messages from patients, sending out letters and even calling with results. I don’t want patients to feel like every call from their physician is doom and gloom! Then I have a short huddle with my medical assistant to review and prepare for what our patients need for their visits.

The schedule is as varied as our community—a newborn weight check, a Medicare annual wellness visit, a follow-up on depression, a newly pregnant woman, a patient with chest pain and a worrisome EKG, a follow-up COPD with abdominal pain for three days, an adolescent well visit, talking to the EMTs who transported a patient with chest pain, discussing a new blood sugar of 350, or doing pre-op for a shoulder surgery.

In between patients, I open mail, complete notes, review labs and imaging, and provide guidance for my staff on how to handle issues with patients. That is just in the morning. The only constant in family medicine is seeing something different every day.

Lunch is time to chat with my physician colleagues, bouncing patient questions off each other, calling specialists, triaging and answering messages. The afternoon is just as varied as the morning, and after I’ve seen patients, I answer more messages and thank my medical assistants. I cannot do what I do without them!

Then it’s time to go home for a kickboxing class and dinner with my family. I do spend some “pajama time,” prepping patient charts for the next day, sending portal messages and lab results and looking up medical conundrums that need more thinking.

On Mondays and Fridays, I start patient sessions at 1 p.m., which allows me to have lunch with my wife. On Mondays, I also have evening hours, until 6 p.m. On the other days, I start at 8 a.m., and on Tuesdays, I finish at noon, with the afternoons’ being administrative time at home, allowing me to
schedule appointments for the dentist, car servicing, etc. On Wednesdays and Thursdays, I see patients 8 a.m.–4 p.m.

During a typical week, I have several meetings. Some are at my hospital or with my partners or office staff, and others are in support of my local advocacy efforts—with the Massachusetts Medical Society (MMS), as a member of the House of Delegates, chair of the Committee on the Sustainability of Private Practice or chair of my caucus to the AMA House of Delegates.

My other advocacy focuses on the national level as a delegate from the MMS to our AMA delegation and a member of the AMA Organized Medical Staff Section and its education committee, and the new AMA Private Practice Physician Section.

Weekends are family time, unless I am on call for my group, which is in the office on Saturdays. We take call for a week at a time every two to three months. Of course, one of my prenatal patients could go into labor at any time, and I promise them that I will be at their delivery, on call or not, as long as I am not out of town. I have delivered babies on Christmas Day and New Year’s Eve.

The most rewarding aspects of family medicine: Seeing patients across decades. We watch newborns grow up to have their own babies, parents become grandparents and all sorts of people manage mild to severe medical issues. We also get to see multiple generations and branches of a family and their friends and their families.

How life in family medicine has been affected by the global pandemic: We have embraced telehealth for urgent, routine and chronic care issues. Some issues lend themselves more easily to telehealth, such as mood issues and blood pressure follow-up, as long as patients have a BP monitor at home. Also, patients are appreciative that we can provide safe care, either in person or online.

Physicians have, in general, and particularly in primary care fields, such as family medicine, become more active in advocacy efforts—in other words, advocating for adequate PPE so we can see patients safely and reimbursement for telehealth is on par with inpatient visits. This has been energizing for many of us.

The long-term impact the pandemic will have on family medicine: Telehealth is here to stay, which will be particularly beneficial to specialties whose focus is on cognitive skills, such as family medicine. The slashing of regulatory and financial barriers has allowed telehealth to ramp up to a level that, without the pandemic, would have taken years to manifest. In some states, insurers were mandated to pay physicians for a virtual visit at the same level as an in-office visit and visits were not subject to cost-sharing. But in one fell swoop the disincentives to patients and physicians were removed and telehealth flourished. I believe many of these incentives will survive because patients, employers, insurers and physicians all benefit when visits are done virtually.
Three adjectives to describe the typical family medicine specialist: Curious, empathetic and holistic thinking.

How my lifestyle matches, or differs from, what I had envisioned: It is actually pretty close to what I hoped to have. I am an owner of a private practice, so I have autonomy. I have maintained a cradle-to-grave practice, which actually is even pre-cradle, since I do prenatal care and deliveries.

The first patient I ever saw as an attending lived to 101 years. I see all ages, all genders, three generations of families and extended families and friends of families. I am part of the community, as I live in the town where I practice. I love seeing patients when I am out shopping, at a school event or at a baseball game. When I was growing up, I always wanted to be a physician in my hometown.

Skills every physician in training should have for family medicine but won’t be tested for on the board exam: First, empathy. Patients need and want this, and it is as therapeutic as any prescription I can write. Second, listening. There is a reason my medical school taught communication skills from day one. Third, learning to let the patient talk and pause, even when it’s uncomfortable. Patients will tell you what their diagnoses are, if you just listen to them.

Asking the right question is important too. “What do you think is wrong?” gives remarkable insights into what the patient is thinking and is worried about.

Also, addressing worry is hugely therapeutic. Being able to say “I don’t know, but we are going to figure it out” can make a huge difference.

Books every medical student interested in family medicine should be reading:

- *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, by Anne Fadiman. It is an excellent read, focusing on the critical issue of understanding and respecting unfamiliar cultures.
- *What Matters in Medicine: Lessons from a life in Primary Care*, by David Loxtercamp, MD. Dr. Loxtercamp is a family medicine physician and a gifted author who writes about a variety of topics in primary care medicine, often using anecdotes from his practice, in coastal Belfast, Maine. It is a great read about the history of primary care.
- *Being Mortal*, by Atul Gawande, MD, MPH. This talented surgeon and writer uses anecdotes from real life to look at how we think about the end of life and provides glimpses into ways to think about this phase of life.
- Any doctor joke book. We all need to laugh at ourselves and be able to make others laugh.
The online resource students interested in family medicine should follow: The American Academy of Family Physicians website provides a wealth of information about this diverse specialty.

Quick insights I would give students who are considering family medicine: Be flexible and follow your heart. You will be healthier and happier for both.