



Why? A Personal Reflection on Becoming a Family Physician

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(Fam Med 2011;43(3):201-2.)

I went to medical school mainly because it was the hardest course to get into and carried the greatest prestige. I entered as an intellectual snob but quickly found out that medical school in Scotland in the 1960s required taking risks, putting up with a lot of stuff, and working hard! I enjoyed all clinical courses, but the most intense competition was for the professorial surgical internships. Naturally, I became one of only two female surgical houseofficers—we really did live in the hospital! My attending forthrightly stated that my appointment was a mistake by the mysterious selection process, and a waste of a career-building opportunity for a (male) surgeon.

I was determined to impress, but the work quickly sublimated the motivation to placate distinguished but tyrannical bosses. We were the best surgical unit anywhere. We took acute and referral cases from a wide area and were regularly swamped with highly complex admissions. Houseofficers quickly became adept at assessing patients and lining up the data to present a tidy case to superiors. We were skillful negotiators with anesthetists, operating room personnel, porters, lab technicians, and multiple others in a complex and precariously balanced barter system. As soon as an attending decreed he would operate or needed a specific investigation or treatment, we could make it happen.

The work was grueling, but we were intensely proud of being part of the professorial team. We lived on caffeine and adrenaline, cocky and confident young physicians who (almost) believed our team could fix anything.

One night we admitted a man who was asymptomatic but deeply jaundiced. At laparotomy his pancreatic cancer was so advanced that the Chief only attempted a biliary drainage procedure and closed the abdomen. His silent fury and frustration left everyone depressed and helpless. I was told to “call the GP and discharge the patient home.”

The GP, an elderly doctor in a small town, was not surprised by the situation and was surprisingly pragmatic. As I poured out the details, he kept repeating “OK, I’ll deal with that.” Finally, I wailed, “But it’s hopeless, he’s going to die.” “I know,” he replied, “but my job is to ensure he dies well. I’ve been his doctor for a while, and I owe him this.” He talked calmly about pain and symptom control and the patient’s family—he knew all kinds of details, including that the patient’s daughter was planning to be married in a few months “so we should see if they can bring the wedding forward.” He was under no illusions about how demanding and difficult the task would be, but he was prepared to guide and support the patient and family through the experience. I felt foolish. In my world, the interesting patients were

prioritized by the uniqueness of their pathology or the technical challenges they presented for surgical intervention. I was jealous of the GP’s relationship with his patient and in awe of his calm determination to manage this case for which our world-class unit had “nothing more to offer.” I wanted to be someone’s doctor instead of the slickest houseofficer in the Royal Infirmary.

This experience started a process of reflection on my motivations and needs in my professional life. Being challenged, busy, and making a difference were obvious. I realized that my favorite time had become as the wards settled down for the night. Checking things with the incoming night nurses had started as a smart move to minimize calls that disrupted sleep, but late evenings provided an opportunity to talk to patients without the pressures of the day. Discussions about symptoms or plans for tests or treatments were more honest and productive in the quiet evening wards. I was increasingly interested in how patients had become aware of their conditions, what they thought was going on, and what might happen after the hospitalization. I was too curious, or too selfish, to be content with being involved

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only in the hospital snippet of their experiences.

So, I realized that I was intellectually and emotionally a family physician. I had to endure the accusations of being a wimp or strangely of being “too clever” for family medicine. (This from the attending who told me I was a mistake.) I tried to explain but realized that appreciation of primary care was going to take much more than my feeble efforts. The negative comments hurt, especially those that implied I had injured prospects for future women applying to surgery. Shallow understanding of other specialties and lack of appreciation of the contributions of colleagues in other disciplines still make me angry, no matter who makes them—patients, students, or professors.

Sadly, I still encounter the misplaced belief in a hierarchy of specialties, especially since I now predominantly care for frail elderly patients. Nevertheless, I know that what I do is challenging, demanding, and regularly humbling but consistently worthwhile. I have never outgrown the need to have complex intellectual challenges or to take care of patients when others have given up. Being “my doctor” to patients who are mostly over 80 years of age requires all my intellect, skills, tenacity, and experience but provides significant professional satisfaction.

My greatest concern is that today’s students are forced into early career decisions and have limited ability to change specialties as they mature and develop their own professional personae. They are buffeted

by stereotypes and pressures to select specific specialties. Like myself, many will be influenced by the perceived higher prestige of some types of medical practice. I hope they are more mature and reflective than I was. I hope they will encounter a patient or an attending who will encourage them to make the decisions that result in every day being intriguing and demanding after nearly 40 years of practice. Each student has to work out for her/himself how to become a specific type of doctor and to be able to answer the very personal question, “Why?”

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