

Simple, Elegant, and Flexible: Why I Chose to be a Rural Family Doctor

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Three short years from now, I will be nearing the end of a long journey through some twenty-five years of education as I complete a residency in Family Medicine. People will call me “doctor.” I will serve an endearing group of people that I refer to as “my patients.” They will call me in the middle of the night when their newborn won’t stop crying, when their elderly mom has fallen out of bed, or when their contractions are “almost ten minutes apart.” I will offer advice over the phone for free, because it’s what a doctor is called to do. I’ll see them through hospital stays, deliver their babies, and, when the time comes, I’ll offer support and care for the dying.

Understanding the history

In this day and age, the term “physician” encompasses a huge breadth of trained medical professionals. Family Medicine became the 20th official specialty in American medicine in 1969. However, its history goes back thousands of years. The first physicians in the world were generalists who provided all of the medical care available. They diagnosed and treated illnesses, performed surgery and delivered babies. After World War II, the age of specialization began to flourish and physicians chose to limit their practices to specific, defined areas of medicine. Since then, the number of specialists and sub-specialists increased at a phenomenal rate, while the number of generalists declined dramatically. The public became increasingly vocal about the fragmentation of their care and the shortage of personal physicians who could provide initial, continuing and comprehensive care. Thus began the reorientation of medicine back to personal, primary care, and the concept of the generalist was reborn with the establishment of Family Medicine as its own field almost forty years ago. (AAFP, 2006.)

In a world where medicine is growing ever more complex, where patients are sorted based on individual disease states and organ systems, Family Medicine is unique. Family physicians diagnose and treat a huge variety of illnesses in their patients. Their approach to medicine is simple, elegant and flexible. Patients are treated by a personal physician who knows their living situation and family. In Family Medicine, the relationship between the physician and patient is at the center of the healthcare system.

Making the choice

Choosing to become a family physician was not a terribly difficult task for me. I knew that I wanted to be able to live in a rural Minnesota community and be “their doctor.” Other specialties in medicine just couldn’t fit that mold. I love to deliver babies, but OB-GYN doctors don’t see the kids they deliver until that child grows up and is pregnant with kids of her own. I enjoy pediatrics, but I also like to have adult conversation with patients. I loved emergency medicine. The thrill of knowing you might save somebody’s life “right there” is seductive, but it drove me nuts when I never found out what happened to my patient after they left the Emergency room. Cardiologists couldn’t help you if you had a broken bone or an ear infection; orthopedists couldn’t help you with your skin lesions, your headaches or your chest pain. Every specialty I learned about in medical school was interesting, but I always found myself wondering about my patient far beyond the realm of the specialty in which I was studying. In short, I felt like I was short changing patients because I knowingly left most of their issues untreated.

A profession of caring

I am studying to be a family physician because I want to be useful to people. I am a teacher at heart but I just couldn’t see myself in a classroom. Instead, my loves for medicine, learning, and teaching directed my medical career into the epicenter of primary care: rural family medicine. In my opinion, Minnesota’s rural family doctors are science teachers who take individual appointments. They are also skilled workers, performing surgery, office procedures, and emergency care depending on the needs of their community. Just as a teacher finds gratification in filling young minds with wisdom, the family physician can save a life by educating that teacher about the need to take her blood pressure medication to prevent a stroke. The family doctor is there to take care of a whole community. The part of their job that keeps them coming back to work in the morning is

the gratification that they are able to truly help people during their greatest times of need.

The lure of Lake Wobegon

After I finish my official training in Family Medicine, my husband and I will move to a small town in Minnesota to practice medicine. I think the attributes of rural living ensure my ability to treat patients successfully. Small towns are more intimately connected than big cities. Neighbors know each other. Life is less likely to be complicated by a preoccupation with material goods because there aren't numerous shopping malls nearby. Schools are the pride of a community, family-run businesses are still around, and churches stand proudly at the center of town. Although a city man himself, Garrison Keillor knows how to describe rural Minnesota when he repeats the ever-familiar phrase at the end of his radio program: "Where the women are strong, the men are good-looking, and all the children are above-average." Rural communities are among Minnesota's richest treasures.

I grew up a happily curious kid. Being raised by physician-parents, I was exposed to medical books from the get-go, like *Netter's Atlas of Human Anatomy*, which directed my desire to learn about the human body. I made it a point to discover for myself how things work. In elementary school, my curiosity prompted me to embark on self-directed research endeavors, such as feeding hormone pills to my mom's African violets or tracking people's blood pressure readings as they listened to a tape of kids making a mess of the house. I also loved to "help" anybody in medical distress. Instead of playing "house" with my Barbies, I played "doctor." One morning, I discovered that Hollywood Hair Barbie had fallen into the paws of my destructive puppy dog, who inflicted some near-fatal injuries on my innocent doll. To Barbie's benefit, I happily spent the day repairing her lacerations with medical tape and Silly Putty skin grafts.

Genetic predisposition

When I was little, I remember being up late at the hospital nurses' station while Mom delivered babies. I knew about forceps, labor, and pitocin, and I think I've always been familiar with the consequences of "the birds and the bees." Over the years, I have come to realize how much I learned about medicine from being raised in my family. Making the decision to spend the rest of my life as a physician was not difficult. I haven't ever wavered from that goal. My genuine desire to take care of people has been with me since I was very small. I was raised in a household that taught me

to hold the service of others in high regard. In my mind, there is no greater satisfaction than knowing that you've helped someone feel better.

My journey into rural medicine didn't begin in the town of Population-Less-Than-Five-Thousand, Minnesota, where the majority of my classmates at the University of Minnesota Medical School -- Duluth Campus grew up. I grew up in St. Cloud, which has, in the past ten years, become the latest sprawling, traffic-laden suburb of "The Cities." However, that phenomenon did not prevent my growing up under the care of a group of excellent family physicians who took care of our whole family. They did our sports physicals, delivered my siblings, and took care of me in the hospital when I had pneumonia as a 6-year-old. They really cared about us and it showed. We didn't really need to see anybody else unless it was for something weird, like when my mom came down with Guillain Barre syndrome. Our family doctor sent her to a neurologist for care, and when she recovered, it was back to the family doctor again. In my mind, this was the way medicine was supposed to be.

Testing the waters

During the summers between years of college, I found myself working at a Lutheran Bible camp in northwestern Minnesota. This was where I first encountered a rural family physician. One of my diabetic campers had forgotten to take her insulin and became very ill. It was a Sunday evening and the clinic in town was closed, of course. I thought we would need an ambulance to come from the nearest hospital, 30 miles away. Instead, the camp director took out the phone book and called the family doctor who lived just a mile down the road. He came at once and saw my camper, gave her a shot of insulin, and accompanied us to the local hospital. Once there, he wrote orders for her admission and saw her through her illness. I was impressed at how knowledgeable he was, but more importantly, I saw how he gave up his Sunday night when he wasn't on call because somebody really needed him.

The very next week, I had a camper who somehow lodged a fishing lure through his eyebrow. I took him to the hospital (I knew where it was after the incident with my previous camper), and a very familiar face was there in the emergency room. It was the same physician who had taken care of my diabetic camper the week prior! He skillfully removed the lure and stitched my camper's eyebrow back together. When he was done stitching, he excused himself rather quickly. I asked the nurse what the rush was for. "He's delivering a baby in the next room," was her reply. I was enamored

with his line of work. This man was needed by so many people, and he handled his responsibilities with humility, skill and grace.

High-contrast experiences

I began to learn about what made family medicine different from other specialties after college when I got a job as a medical assistant in a busy metro area ear, nose, and throat (ENT) clinic. The physicians I worked with were nice people, but they ran on a completely different wavelength from the family physicians I had grown up with. They saw 40 patients a day -- sometimes more than that. Appointments were very brief. Services were performed, ears canals were cleaned, sinuses were irrigated, and vocal cords were visualized using the long spaghetti-like flexible endoscopes. Patients came and went like snowflakes on a June afternoon. It took five medical assistants to keep all the patients moving.

Patients didn't depend on the ENT physicians for comprehensive medical care. Our clinic sorted patients based on the pathology of an organ system. The competent physicians knew everything there was to know about ear canals and sinus cavities; they even performed complicated head and neck surgical cases. I would bring my daughter to see one of them in a second if she needed tubes placed in her ears. However, they were not like family physicians. If they had been family physicians, our patients would have had an entirely different relationship with us. Patients would have had a personal physician who knew them, answered their questions, and addressed all of their medical needs.

Launching an education

In the fall of 2003, after one year with the ENT physicians, I started medical school at the University of Minnesota Medicine School – Duluth Campus. Compared to the large Twin Cities campus, the smaller, more family-oriented Duluth campus prides itself on how many family physicians it generates for rural Minnesota. Together with fifty classmates, I navigated the rigorous academic curriculum of the first two years. Medical school surprised me. As difficult as it was, it was also more fun than I have ever had in an academic setting. The people I met made all the difference. My classmates and professors were the most wonderful people I think I will ever know.

Many of my professors have been teaching medical students in Duluth since my parents went to medical school there thirty years ago. Clearly these professionals have dedicated their lives to

providing Minnesota with good quality family physicians. Instead of merely tolerating students who might take away from their time in a research lab, our professors actually liked to teach. Our histology professor would be covered in chalk dust at the end of an hour's lecture because he illustrated the intricacies of cell adhesion molecules with a dozen different colors of chalk. Our pathology professor likened the intrinsic and extrinsic coagulation cascades to pairs of stiletto heels. Oftentimes, on the day before the "killer" exams, our professors would subject themselves to interrogation in front of our class until all questions were answered. I think we drilled one poor professor for four hours before we released him. He will be back next year to be interrogated by the next class.

Our lectures were all in the same classroom; the professors came downstairs from their labs to lecture. It was like a one-room schoolhouse. This added to the already-strong camaraderie I had with my classmates. Some days we would get to school before the sun came up and went home after dark. If a classmate was absent, everybody knew, and if you were gone two days, you could expect your classmates to come to your door and find you. When somebody got engaged, the whole class celebrated. When somebody's grandparent died, the class sent flowers, and twelve people would offer you their notes from lecture. The whole environment of Duluth's medical school exemplifies family practice. It is a fantastic model for learning how medicine can be practiced both personally and efficiently.

Experiential learning

We spent time with community family physicians from the third week of class. The first year we followed local physicians in the hospital and clinic, the second year we were sent out to small towns all over Minnesota to spend a few days with a family physician and his or her family. I spent some time in Moose Lake, Minn., a little town on Interstate 35 between Duluth and the Cities. I enjoyed my experience so much that I asked to spend some time there during the summer.

One of my professors set up a summer internship for me in Moose Lake, where I spent time with clinicians, pharmacists, law enforcement officers, nurses, and a dentist. Overall, the experience was fascinating. The hospital happily provided lodging for me in a little house across the parking lot so I could see late-night deliveries and E.R. patients. During my short three-week stay, I saw family doctors delivering babies and performing C-sections, colonoscopies, endoscopies, tubal ligations, circumcisions, and vasectomies. In

the E.R., I learned valuable skills such as how to question people presenting with chest pain, how to suture, and what to look for in a domestic abuse situation. The pharmacists taught me how to calculate creatinine clearance for the ICU patients. The social workers in the nursing home allowed me to sit in on a family meeting for a new resident admission. I watched a family dentist use hundreds of tools to construct a new incisor for a 16-year-old. I followed the nurse anesthetist who walked me through how to give miraculous pain relief to a woman in labor. In the clinic, my preceptor showed me how to find fetal heart tones. I watched as he carefully removed skin cancers. I found that I was already able to apply the history and physical skills that I'd just learned in my first year of medical school.

The physicians I met in Moose Lake reminded me of the family doctors I had known and loved growing up. They were the type of physicians who would have taken care of my diabetic camper on a Sunday night. My clinical skills were miles ahead of where I thought I'd be by the end of my second year because these doctors had been so generous with their time. I wanted to spend as much time as I could learning from them.

Immersion learning

Traditionally, medical students who finish two years in Duluth transfer to the Twin Cities campus for the latter half of medical school, the clinical years. Instead of going directly to the big-city hospitals, medical students at both campuses, thankfully, have the option of spending nine months in a small town learning medicine from small-town doctors. This unique program is affectionately referred to as "R-PAP," which stands for "Rural Physician Associate Program." I was sent back to Moose Lake.

The physician who took me under his wing in Moose Lake treated me as an equal. At first, the learning curve was steep. He sent me in to see his patients right away and then asked me for my treatment recommendations. Being fresh out of the books and rather raw in practical patient care knowledge, I quickly learned how junior I was. After just a few weeks, however, I felt much more confident. He always saw my patients after I did, asked me what I thought, and explained the intricacies of each disease state. I read textbooks in a different way than I had ever read them before. When I had a patient in heart failure, I saw her swollen ankles and I read to understand it. If my patient was wondering if her unborn child could hear, I dug out my embryology textbook and read until I knew the answer. My preceptor physician sent me over to the hospital to admit new patients from the clinic. I ordered labs, looked at CT scans, and

dictated. We worked in the emergency room, where I learned how to intubate and treat trauma patients. I admitted patients to rule out heart attacks and strokes, learned how to treat electrolyte disorders, and delivered almost fifty babies. By the end of the experience I had seen more than a thousand patients.

Big city, big difference

The last year of medical school involved moving away from Duluth and taking some rotations at bigger medical centers in the Twin Cities. I did a few of these at Hennepin County Medical Center, a gigantic health care facility in downtown Minneapolis. The ICU at HCMC held more patients than the entire hospital in Moose Lake. At first, I felt like a fish out of water. There were seven buildings with seven floors each. Once I was able to find my patient, however, I found that the medicine was much the same as it had been in Moose Lake. The diseases were the same: people still had depression and heart disease and kidney failure. The drugs and therapies were the same. The biggest difference was in how many specialists were around. No matter what disease your patient had, there was a physician who specialized in the treatment of it, and he or she would come and consult on your patient.

My time at Hennepin sealed my decision to become a rural family doctor. The medicine floor was a sea of consulting sub-specialists. My job was to navigate the waters for my patient. I had to pick and choose among all the specialists and their procedures to treat my patient appropriately. It was difficult and frustrating because my patients never had just one disease. They were complicated individuals with compounding chronic and acute medical and psychosocial pathologies. No single specialist could treat my patient as well as I could because I was treating a whole person instead of an organ system or a disease. Another interesting phenomenon: many of the specialty procedures provided to my patient were simple, logical treatments that I could have done myself. I started to understand why primary care makes sense as a cost-saving and personal way to deliver excellent health care. Within the walls of a county hospital, I learned how our sophisticated medical system can over-treat a patient without listening to their story. I missed the elegant simplicity of rural family medicine, where my patients wouldn't fall through the cracks and get lost in the shuffle.

I am privileged to have the opportunity in life to pursue my dream career. Becoming a physician takes a huge investment of time and money, more than I originally anticipated. Today, if I had

the choice, I would do it all over again, and I don't think I would change much. It is hard for me to believe that I have only a few years remaining before I can find that rural community that needs a physician. As the future of medicine is sure to change, I can't be sure how my future practice will turn out. However, I am sure of one thing. No matter what, once the exam room door closes and it is just me and my patient, I will still be able to talk to and take care of people, and I will be their doctor.

Reference

American Academy of Family Physicians: [Family Medicine: Scope, Philosophical Statement](http://www.aafp.org/online/en/home/policy/policies/f/familymedicine.html). Website. 2006.

URL: <http://www.aafp.org/online/en/home/policy/policies/f/familymedicine.html>