PROFESSIONAL ENTRY EXPERIENCES OF PRIMARY CARE PHYSICIANS:

A NARRATIVE INQUIRY

A Dissertation in
Adult Education

by

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ABSTRACT

This qualitative study used narrative inquiry to capture the experiences of nine Primary Care Physicians as they entered professional practice as employees of established organizations. The study, informed by social constructivism and adult development theory, focused on how their professional entry experiences informed their understanding of themselves, their profession, and their practice. Of specific interest was how they grew and developed both personally and professionally during this life transition. Narratives were co-constructed by the participants and research. Data were analyzed both as individual narratives and for collective themes. The nine participants offered a range of perspectives on their medical training, their entry into the profession, managing work and family, and their understanding of and beliefs about the profession of medicine.

The findings of this study suggest that despite strong professional socialization, beginning primary care physicians construct their medical practices to meet both their professional and personal aspirations. The findings also support the dominantly held belief in medical education that this generation of physicians is seeking balance in their lives. They are not willing to sacrifice their personal life for their profession, but they are still serious professionals. Implications for medical education, adult education and organizational socialization are discussed.
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I want to thank the many people who have supported me during my graduate studies. After my first weekend of classes, I knew that my doctoral studies would not only be academically challenging but would stretch me personally as well. Through interactions in the classroom, I have learned so much from my fellow students and developed wonderful friendships. During the past four years, I have had the opportunity to learn from and work with Adult Education faculty at Penn State Harrisburg as a graduate assistant. This experience provided opportunities that I could not have imagined when I entered the program.

Each faculty member has affected my learning and my life in his or her own special way. Daniele Flannery challenged me to think like a scholar and dig beneath the surface in my understanding and analysis. She was always there to listen about the difficulties associated with being a student and raising a family. Libby Tisdell provided many opportunities for me to do research, to write and to present my work. She sparked my interest in pop culture and critical media literacy and taught me that learning truly can be fun. Through my work with the AEQ, Ed Taylor has become part of my everyday life. As we worked together, he has always treated me like a colleague. He shared his office with me (and often my children) and has become a role model for my son.

My deepest gratitude goes to Patricia Cranton, my advisor and committee chair. She was always available to listen and guide me through this process. She challenged me to question my assumptions about teaching and learning, and to see my work as my own.
No matter where I was in my love/hate relationship with this project, she provided support, perspective and great conversations.

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Special thanks are due to the residency directors that assisted in recruiting participants, especially John Bertolino. His support and advice prior to starting this research was invaluable. In many ways, this project would never have come to fruition if it were not for him. Finally, I have the utmost gratitude and respect for the nine physicians who took the time to share their lives with me. This project is as much theirs as it is mine.
DEDICATION

This thesis is dedicated to the memory of Margaret G. Thompson who was born on October 3, 1921 and passed away on July 16, 2006. Margaret was an independent woman; who in the 1940’s pursued a career rather than as she put it, “Settling down and baking bread for the rest of my life.” She had a keen sense of adventure and a thirst for knowledge that could not be quenched. She inspired everyone with whom she came in contact.

From the day that I told her that I was going back to graduate school, she provided consistent support and encouragement. Even when it meant that I was writing rather than attending family gatherings which were so important to her. A week before she died, my husband and I visited her in the hospital. She was intubated and could not speak, but she had so many questions that she wanted answered. We gave her a pen and she wrote her first question on the back of a tissue box: “So, how are your studies, Patti?” While she will is not here to celebrate with us, I know that she is pleased.
CHAPTER ONE

Chapter One provides an introduction and summary of my study. This chapter includes the background to the problem and the problem statement that guided the study. This is followed by the purpose and guiding research questions for the study. A summary of both the theoretical framework and methodology used in the study are then presented. The final sections of this chapter include: definitions of terms, the assumptions of the study and the significance of the study.

Background to the Problem

As I was sitting eating lunch at a busy café on a large university campus, I started listening (eavesdropping is probably a better description) to two undergraduate biology students discussing their post-commencement plans. They both had been accepted to medical school and were excited that their hard work in the classroom and laboratory had paid off. As they chatted about their future careers, one stated that he wanted to be a radiologist so he could have a flexible schedule and work from home. The other stated that he was interested in emergency medicine because he heard that ER physicians have fixed schedules and lots of time off. Intrigued, I decided to hang around a bit longer and listen. Not once did either young man mention helping others, serving his community, or even the intrigue and scientific challenge of medicine as motivating his career path. Instead, it was about control; having the flexibility to enjoy life outside of work and pursue other interests.

In another venue, a researcher was doing interviews to complete her dissertation (Murphy, 1999). She describes her discussion with Matt, a 40 year old family physician as follows:
Matt is a 40 year [old] family physician practicing close to eleven years in a hospital-owned clinic in the metro area. He is married, and has four children ages nine and under. In the interview, Matt expressed frustration that, to some extent, medicine hasn’t turned out to be what he thought. Medical school did not prepare him for the managed care environment that he now practices in. In addition to his normal clinical practice, Matt is one of a small number of family physicians who still deliver babies. While he enjoys his patients, he feels the continual stress of trying to balance the demands of his busy practice with his family life. He is particularly frustrated by the fact, that while at work, he must function within all sorts of guidelines telling him how to treat his patients, what medications he can prescribe and when they can be referred to a specialist. Matt verbalized that if he could go into another career, he might think about it. But since his medical school training and residency program have taken up seven years of his life-post college, he doesn’t see that as an option. He feels caught up in the bureaucracy, and feels powerless over his own destiny. (p. 59)

The Changing World of Work

Work? Job? Career? Vocation? Profession? Across the United States, adults’ relationships with work are changing from a stable source of identity to a shifting and dynamic developmental process (Pink, 2001). The ideals once believed to be part of the American Dream such as career stability, employer and employee loyalty and community have significantly changed. (Fraser, 2002; Tulgan, 2004). Prior to this cultural shift, generations of Americans, strongly influenced by the Protestant Work Ethic, the belief that hard work is intrinsically moral (Beder, 2000), and the belief that loyalty and
commitment to an organization or a profession paid off. Even baby boomers, who revolted against authority in the 60s, were strongly socialized to value career advancement and organizational loyalty (Geroy & Venneberg, 2003). Work seems to be the cornerstone of our society.

Historically, careers or vocations were built around societal needs and particular life goals or callings, providing individuals with a singular identity. “For a person who has achieved a sense of vocation, person and work are united. A person could not change his or her work without a change in being” (Cochran, 1990, p.3). This may no longer be the case. In the contemporary world, identity, especially vocational identity, has become more dynamic. Actual industries, such as Adult and Continuing Education, exist for “identity production” (Gergen, 1991, p. 184) in order for adults to take on a variety of identities, especially career identities, throughout the life course. Gergen (2001) argues that in contemporary society, “the concept of ‘intrinsic’ interest is virtually lost from view” (p. 185); nowadays what people do for work is no longer a calling, but a construction of skills and experiences to meet a particular niche (Gergen, 2001).

Another societal shift that has influenced the understanding of work and career in our society is the demographic changes in the workplace.

One of the most dramatic sociological changes this century has been the participation of women (age 16 and over) in the nation's workforce: the proportion of women in the workplace tripled from 19 percent in 1900 to 60 percent in 1998. The rate for men, meanwhile, dipped from 80 percent to 75 percent (U.S. Census Bureau, 1999, p. 1).
In addition, the percentage of women who are raising children and working outside of the home grew from 21% in 1965 to over 80% in 2000 with nearly all women entering the workforce at some point in their lives (Purmal & Bennett, 2001).

The cumulative effects of these changes have created the need for work-life balance, an idea that was not discussed in professions or organizations less than thirty years ago. In a random survey of employees in new positions reported in Work and Family Managers’ Quarterly Newsbrief (2000), 87% of participants indicated that they sought companies with flexibility and work-life balance programs, suggesting that organizations cannot ignore work-life balance issues. It seems that no profession is exempt from these societal pressures. Even the medical profession, often described as the archetypical profession (Freidson, 1970), has experienced major changes.

*The Medical Profession in Contemporary Society*

In 1961, an ethnographic sociological study of the medical profession entitled *Boys in White: Student Culture in Medical School* (Becker 1961), provided an inside perspective on physician training in the United States. At the time, often referred to as *The Golden Age of Medicine*, the medical profession was at its peak in terms of prestige and professional autonomy (Scott, Ruef, Mendel, & Caronna, 2000), and, as Becker’s title suggests, the profession also was dominated by men. Starting in the late 1970’s this began to change and more women entered medical school (Hoff, 1998). Currently, the percentage of White men applying to medical school is on the decline while the number of women and minorities is modestly increasing (Association for American Medical Colleges (AAMC), 2005). In 2002, there was the lowest number of medical school applicants (33,625) in two decades (Pugno, McPherson, Schmittling, Fetter, & Kahn,
Even with increases reported from 2003 to 2007, there still has been a significant decrease in the number of applicants (46,965 in 1996 to 31,946 in 2007) (AAMC Data Warehouse: Applicants and Matriculants File, 2007).

The demographic changes are quite visible in primary care (family medicine, internal medicine and pediatrics) where more than half (52.5%) of the resident physicians in training programs are women (Brotherton, Rockey, & Etzel, 2005), and an increasing number of international medical graduates (IMGs) are coming to the United States for their training (Institute for the Future, 2003). It also is the specialty area with the highest concentration of physicians from different racial, economic, and cultural backgrounds training to be doctors (The Diversity Research Forum, 2007). The number of physicians choosing primary care has decreased as medical students move toward higher paying, more flexible areas of specialty care (Giovino, 2002). While this trend has seemed to level out over the past few years (2005-2007) the number of U.S. seniors (those graduating from U.S. medical schools) entering primary care has dropped considerably in the last ten years: in 1996 it was 2996 and in 2007 it was 1602 (AAFP, 2007).

These demographic issues have elicited a number of issues that the medical students of the 1960’s described by Becker’s (1961) book did not have to face. First, many primary care physicians entering practices today are in dual career families, which was not the case less than twenty five years ago (Jagsi, Tarbell & Weinsteem, 2007). Also, approximately half of married female physicians are in dual physician families (Schrager, Kolan & Dottl, 2007). This presents time constraints that the prior generation of physicians, most of whom were men with wives who worked inside the home, did not have to face.
Second, physicians entering the profession in the 21st century have incurred large amounts of medical school debt, estimated between $140,000 to $225,000 (Morrison, 2005; AAMC, 2007). As a result, many young physicians are willing to forsake long term financial gains and the professional autonomy of solo practice or partnership in a group practice for the fixed salary, scheduling flexibility, and reduced work hours associated with practicing medicine as employees of group practices (Giovino, 2002; Kirch, 2007). “The world in which the independent, solo practitioner in combination with the independent, voluntary hospital were the dominant forms of service provision as ‘gone with the wind’” (Scott, 1993, p.271 as cited by Scott, Ruef, Mendel, & Caronna, 2000, p.1). Within the medical education community and the healthcare industry, this “new face of medicine” is getting a lot of attention. There is a concern of a looming physician shortage as older “more productive physicians” retire and are replaced by younger physicians who have different practice patterns (specifically part-time and fewer hours) (Salsberg, 2006).

Whether or not this is advantageous for individual physicians or the profession at large is frequently debated. Briscoe (2003) found that despite lower salaries, being an employee of a large organization was attractive to entering physicians because it provides career flexibility, more predictable hours, and accommodation for work-life issues. He argues that the changing climate of medicine and the shifting demographics of the physician workforce “could be increasing heterogeneity in the career values and interests within the physician workforce, and over time reshaping the core values shared among physicians of younger generations” (p. 17). His argument, in part, is supported by research suggesting the Generation X physicians are more interested, than any past
generational cohort in quality of life issues and not wanting their career to be their main source of identity (Giovino, 2002; Moody, 2002).

While the idea of *physician as worker* is being supported and contested in the literature, droves of young physicians are graduating from their residency programs and joining organizations as employees. Due to this trend, it is projected that by 2010, 62-67% of patient-care physicians will be practicing as employees of group practices and this number is even higher for primary care where it is predicted that almost 85-90% of physicians entering the labor market will join groups (Institute for the Future, 2003).

Physicians practicing in contemporary society not only face the demands of the profession, they also are balancing family responsibilities, organizational expectations and personal financial concerns. Beginning primary care physicians no longer enter the profession with a single focus of developing relationships within the community and building a vibrant practice. They now are pondering how they will pay their medical school debt, who is caring for the children, and whether or not they are meeting organizational goals and objectives. Also, patient-physician relationships are changing, even in primary care. A 2005 Kaiser Health poll survey found that almost fifty percent of adults reported that they attain information about health and health care from the media while only twenty percent felt that their doctor was their primary source of information (Kaiser Health, 2005). As a result, patients are more likely to shop around for a doctor if they feel that their physician is not meeting their needs. Thus, along with practicing good medicine, beginning physicians need to practice some good public relations.

May (2000), in his book, *The Physician’s Covenant*, recognized as the preeminent work on physician professionalism (Kennedy, 2002), contends that physicians face
conflicting demands, many of which cannot be resolved but instead are mediated by the individual. As physicians enter practices they develop their own personal ways of managing the expectations of the profession in which they have been socialized during their training, along with their personal expectations and the expectations of other stakeholders (organizations, families, patients). This is somewhat seen in Mizrahi’s (1986) work, *Getting Rid of Patients*. In her study and subsequent book she found that interns and residents see patients as cases to either get rid of or learn from. But, the same people interviewed five years after their training were more humanistic and saw patients as people. So, how does that happen? How do beginning physicians move from the strong control of residency to making their own way in their practices and their lives?

Statement of the Problem

Knowing that the majority of new physicians leaving residency programs will begin their medical career as employees, their professional entry experience includes learning how to navigate the organizational terrain as well as developing an understanding of their profession and themselves. The experiences of individuals entering the profession of medicine after residency have received very little scholarly attention. Also, most physicians and organizations do not recognize the importance of professional entry on individuals’ careers. Physicians are usually expected to orient themselves and become productive healthcare providers very quickly. After some time in practice, new physicians may be provided with performance related feedback such as revenue generated, patient comments, and other data driven feedback. How they acclimated to their practice, whether they feel like they fit the organization and whether
or not they agree with the goals and objectives of the organization are rarely discussed. This is reflected in the following scenario of physician entry:

In the traditional model of physician orientation, the established physician introduces the eager, young physician to his or her nurse, points out the new physician's three exam rooms and lets him or her know about the established physician's upcoming two-week vacation in Europe. The hope is that when the established physician returns, the new physician will know how to find the emergency room, be familiar with the local specialists and understand the peculiarities of the office staff. (Grimshaw, 2001, p. 2 ¶ 1)

The effect of this lack of orientation is that many entering physicians never find their place within their employing organization. Over sixty percent of new physicians leave their first practice within four years and over fifty percent of those who leave attribute it to their inability to fit the organizational culture (Weeks & Priddy, 2003).

“Most organizational socialization theorists and researchers agree that the entry point, or what is typically referred to as the encounter stage, is a key moment for people as they construct their relationship with an organization” (Barge & Schlueter, 2004, p.1). Empirical literature supports that new employees construct their understanding of the organization and their roles through relationships (Anakwe & Greenhaus, 1999), information seeking (Morrison, 1993, 2002; Morrison, Chen, & Salgado, 2004), and role modeling (Filstad, 2004; Morrison, 1993). A criticism of the organizational socialization literature is that the socialization process is often studied from the perspective of the organization, and does not take into account that much of what occurs during organizational socialization is constructed by the individual (Smith & Turner, 1995).
This is why it is important to recognize that there are many factors both within and outside the organization that impact the organizational entry process, such as prior professional socialization, the employee’s life experiences and commitments, and an individual’s general development as an adult.

In addition to previous professional socialization and experience, new professionals have experiences outside of the organization that affect how they understand their work, organization, and profession. Though it is not recognized in the organizational socialization theoretical literature, new employees do not cease to live outside the organization once they become employed. Issues outside of the workplace, such as housing, family issues, and finances, have an impact on employment experiences and the organizational entry experience (Polach, 2004). The work-life balance literature describes how these family-to-work spillovers affect careers (Keene & Reynolds, 2005; Mennino & Brayfield, 2002) but does not specifically look at how these spillovers affect professional entry experiences, nor does it delve into how all of this blends together in a developing professional.

Physicians beginning their careers are faced with multiple challenges and expectations that they need to negotiate and eventually balance. There is literature addressing the work-life balance issues of physicians, and as well as literature that focuses on the tension between organizational constraints and professional values; but how individuals manage multiple and often competing factors in their personal, professional and organizational life as they begin their professional careers has not been studied.
Purpose of the Study

The intent of this study is to learn about the experiences of physicians during their professional entry. Through the use of narratives, this study reveals how the experiences associated with moving from a trainee to a professional informed their beliefs about themselves and their profession. This is built on the assumption that their professional lives, personal lives, and organizational lives are not separate but are deeply intertwined. To understand the participants’ experiences, the context in which their professional entry is occurring needs to be recognized which is why the narratives in this study do not just reflect the professional entry experience of the physician, but also provide background information about medical school, residency and what inspired them to pursue a career in medicine. The study takes a holistic approach to understanding professional entry as a developmental process that affects the individual at a personal, professional and societal level.

As discussed in the introduction, the contemporary practice of medicine in the United States faces unprecedented changes (Scott, Ruef, Mendel, & Caronna, 2000). Medical educators and administrators recognize these changes. They are struggling to find ways to address the ever changing culture of medicine and maintain excellence within the healthcare system (Kirch, 2007). To date there is a great deal of discussion and debate about what is happening and how it affects medical education and the healthcare industry (for example Hoff, 1998, 2003; Briscoe 2003; Jin, 2005). There has been a large quantity of demographic data collected by groups, such as the Association of American Medical colleges, which indicates trends and has elicited great concern.
At the individual physician level there has been some research interest focused on how practicing physicians adapt to managed care environments (Hoff, 2003); why physicians choose to be employees rather than entrepreneurs (Briscoe, 2003; Hoff, 1998); the influence of communication on practicing physicians development of their identities within organizations (Real, 2002); physician professional satisfaction in HMOs and other employment settings (Chehab et al., 2001; Hueston, 1998); and how physicians adjust to taking on managerial and administrative roles within organizations (Hallier & Forbes, 2005; Hoff, 1997; Murphy, 1999). But, these studies focus on physicians who already are in practice, not those entering the profession. The majority of the research concerning the medical profession and the relationship between physicians and organizations originates from studies in sociology, medicine, and management. But, there is little investigation into what is occurring as individual physicians begin their careers. This study looks beyond the demographics and provides names and faces to the “new face of medicine.”

Guiding Research Questions

1. What do beginning physicians experience as they transition from residency to practice?
2. How do they interpret their entry experience?
3. How do these experiences reflect their pre-conceived beliefs about medicine and their expectations?
4. How do these experiences shape their personal and professional expectations, their understanding of their profession, and how they practice medicine?
Theoretical Framework

This study was informed by social constructivism and adult development theory. In order to understand the experiences of physicians entering the workplace for the first time, it is important to understand the influence of socio-cultural factors. Social constructivists specifically focus on the interaction between the individual and the socio-culturally informed environment (Phillips, 1995). In relationship to this study, a social constructivist perspective suggests that individuals’ professional, organizational, and personal identities and values are learned in a social context. “Identity – whether individual or group – is not derived from the nature of the world. Rather, “identity is a relational achievement” (Gergen, 2001, p. 188). This study investigates physicians’ experiences and their interpretation of those experiences, both of which are inherently social. Their beliefs have been informed by socio-historical events. They interpret the events of their lives informed by their past experiences. They build their understanding of their profession and themselves as people in community with others not in isolation.

Social Constructivism

As with many terms in the social sciences, constructivism has multiple meanings and is used rather loosely in the literature. A basic foundation, that undergirds most definitions is that constructivism is based upon the belief that social sciences and the human world are very different from the natural or physical world studied in the hard sciences, thus the methodology for studying them should be different as well (Guba & Lincoln, 1990). Over the past 20 years constructivism has become popular in academic research and social practices such as therapy, organizational development and education (Brinkmann, 2006).
Social constructivism and social constructionism are often used synonymously in the literature. For the purpose of this study, I differentiate between the two as suggested by Patton (2002) who describes constructivism as occurring within the individual and constructionism as the “collective generation [and transmission] of meaning” (p.97). “Constructivists study the multiple realities constructed by people and the implications of those constructions for their lives and interactions with others…and social constructionism refers to constructing knowledge about reality, not constructing reality itself” (Patton, 2002, p. 96). This study focuses on the meaning making of the individual in society not societal realities, thus it is informed more by the work of social constructivists and socio-cultural psychology than social constructionists. But, because of my interest in the whole person and not just the career or organizational experiences of the physicians, this study also has a developmental component, specifically from a socio-cultural perspective. An in-depth discussion of social constructivism, social constructionism, and their relationship to the study is included in Chapter Two.

**Adult Development**

This study is also informed by the adult development literature that specifically looks at adult development from a social constructivist or socio-cultural perspective. While there are many developmental theories, there are four that inform this study. First is the work of Barbara Rogoff (1995). Rogoff (1995) frames development from a socio-cultural perspective emphasizing the significance of the personal, interpersonal, and communal influences on development. Since this study is taking a holistic approach to development, recognizing these multiple influences is important.
Next is the work of Robert Kegan (1982; 1994; 2000). His neo-Piagetian theory of development as meaning making provides insight as to how adults move from a place where they identify with the values and expectations of others, to a place where they develop their own values and beliefs that ground their lives (Kegan, 2000). His theory is explained fully in Chapter Two, but what is most relevant to this study are the stages of development that he labels as the *socialized mind* and the *self-authored mind* which is often seen as the movement from late adolescence to adulthood.

Kegan’s theory ties into the work of Jeffrey Jensen Arnett (2004) on *emerging adulthood*, a new developmental stage between adolescence and adulthood based upon Erikson’s work. Arnett’s theory provides a developmental stage in what is chronologically thought of as early adulthood (late teens to mid-twenties) which corresponds with Kegan’s idea of moving from the *socialized mind* to the *self-authoring mind*. While Arnett’s work and Kegan’s work have not been seen together in the literature, and come from very different philosophical perspectives, there are parallels in their theories.

Arnett’s *emerging adulthood* is a time when young adults are vacillating between adhering to their socialized beliefs and values and developing their own beliefs and values. Also, of the idea of *emerging adulthood* was conceived to address the contemporary socio-political climate of our society (Arnett, 2004; 2006). Because of the structure and length of medical education and training, physicians are not in a place of establishing their own lives and belief systems until way into their late twenties or early thirties. These two developmental theories provide insight into their experiences as they move into their adult roles after residency.
Finally, the work of Marsha Rossiter (1999), who suggests that adult development should be understood through narrative, also informs my study. She posits that development should not be understood as phases or stages but as lived experiences. Her work fits nicely with narrative analysis, which is the methodology used in this study and it adds a developmental perspectives to the participants’ narratives.

Methodology

This study falls into the interpretive research paradigm. Habermas’s (1971) theory of knowledge-constitutive interests posits that three distinct types of human interest—technical, practical, and emancipatory—lead us to acquire three kinds of knowledge, each of which is obtained in different ways. Since this study is about practical knowledge, which is defined as “the norms that form the common tradition underlying society” (Ewert, 1991, p. 251), the interpretive research paradigm, used to develop understanding about “how actions are interpreted and understood” (Ewert, 1991, p. 250), is appropriate.

Qualitative Methodology

Qualitative methodologies are interpretive because of the emphasis on understanding the individual and social meaning of actions. Patton (2002) argues that researchers “use qualitative methods to describe and explain phenomena as accurately and completely as possible so that their descriptions and explanations correspond as closely as possible to the way the world is and actually operates” (p. 546). Lincoln and Guba (1985) describe qualitative research as naturalistic, taking place in the real world and not manipulated by the researcher. Qualitative research is a discovery process with the researcher working to develop an understanding of the day to day experiences of
participants (Lincoln & Guba, 1985); it is inductive in that the researcher is not trying to prove something, but instead, the researcher is trying to understand a phenomenon in its truest form (Patton, 2002).

Much of the research on professional and organizational entry is based upon rational empiricism and presents this social phenomenon as cause-and-effect instrumental knowledge. This has made it very difficult for researchers and practitioners to gain any practical understanding of the learning and experiences that occur during organizational entry. There have been a few studies that have diverged from the scientific psychological paradigm and those studies have provided deeper understanding (Pollach, 2004; Filstad, 2004; Bartge, 2004). Understanding how individuals construct meaning and develop as they begin their professional lives is challenging because it requires noticing, reflecting upon, and interpreting life events that seem like everyday experiences of which the significance often is unrecognized. One way to uncover the underlying developmental themes and how everyday experiences influence the understanding of self, profession, and organization is through stories. Patton (2002) suggests that, “qualitative inquiry can be used to discover, capture, present, and preserve the stories of organizations, programs, communities and families” (p. 196). A specific method of capturing these stories is narrative analysis, which is the method used in this study.

**Narrative Analysis**

Narrative analysis is becoming a popular qualitative methodology in the social sciences. It is historically grounded in the fields of sociology and anthropology (Chase, 2005). The idea that we live our lives and understand our being by constructing stories is the keystone to this method of research. “Stories order experience, give coherence and
meaning to events and provide a sense of history and of the future” (Rappaport, 1993, p. 74). Patton (2002) states that “narrative [inquiry]…honors people’s stories as data that can stand on their own as pure description of experience” (pp. 115-116). Specifically, in the context of the medical profession, Johnson (1983) recommends the use of life stories to better understand how physicians arrange the subjective elements of their careers and identities.

Chase (2005) presents five lenses or assumptions that distinguish narrative analysis from other forms of qualitative research. First, narrative retrospectively presents the narrator’s point of view. Next, it focuses on how the narrator made meaning out experience and interpreted the experience. Third, researchers view narrative as “verbal action” (p. 656) where the narrator’s voice is recognized. Fourth, narratives exist in a social context which is both enabling and constraining. Finally, narrative researchers are narrators themselves as they interpret and present their studies. Thus, narrative analysis is an active process of storytelling and meaning making for both the participants of a study and the researcher.

Narratives also provide a depth of understanding of personal and organizational experiences. For example, employees entering an organization often use stories to understand the emotional, social, and cultural sides of work (Brown, 1985). Narratives carry and disseminate organizational values, norms and codes of behavior; they help people develop a sense of organizational reality (Meyer, 1995). Narrative analysis was used in this study because it afforded the physicians entering practices the opportunity to reflect upon and to communicate their stories of professional entry. Constructing narratives that were filled with stories of their experiences was a valuable learning
experience for them and it will hopefully inform others who follow as to what these physicians experienced when they began their professional practices.

Data Collection and Analysis

There are a variety of approaches to narrative analysis and researchers’ specific approaches “tend to be shaped by interests and assumptions embedded in the researchers’ discipline” (Chase, 2005, p. 658). The manner in which data are collected and analyzed is dependent upon the purpose of the research. This study focused on how individuals develop both inside and outside of the workplace as they begin their careers in organizations. Thus data were collected through participant interviews and on-going dialogue throughout the process of constructing stories.

After the participants volunteered for the study they were sent a biographical data sheet and a list of questions. The purpose of the questions was to prepare them for telling their stories and constructing narratives. They were asked to think about, talk about and journal about the questions prior to their interviews. The interviews began with reviewing background and demographic information. By the time we got to the questions, the participants took charge of the direction of the interview. I became a facilitator, asking questions for clarity rather than content. In facilitating their narratives, it was important to pay close attention to how they told their stories. I needed to recognize what types of events anchored their stories and how they developed an understanding of their experiences. The goal was to understand how the whole person was affected by professional and organizational entry.

“There is no canonical approach in interpretive work, no recipes and formulas, and different validation procedures may be better suited to some research problems than
to others” (Riessman, 1993, p. 69). While there are no recipes, those who write about narrative analysis, do provide some suggestions. Riessman (1993) suggests that data analysis begins during transcription. She describes transcription as an iterative process where stories are eventually given form by organizing the data to reflect the elements of story or poetry. I transcribed all of the participant interviews in order to do this. The attention to details such as voice, expression and word usage was important in the construction of their stories. I also conferred with the participants when I thought that I needed additional information and perspective about events they shared during the interviews.

It is important for researchers to recognize voice, both of themselves as researchers and of the narrators (Chase, 2005). Data can be collected and analyzed from multiple perspectives: authoritative, supportive, or interactive. Each of these strategies connect and separate the researcher’s voice from the narrator’s voice in specific ways. For this study, I chose to use a supportive voice. Chase (2005) describes supportive voice as one “that pushes the narrator’s voice into the limelight” (p. 665). I wanted their stories to be the focus of the study, not my interpretation of their stories. This was very important to me. I do not live their lives, they do; and I wanted their stories to reflect that. It would be presumptive of me to believe that I can present their stories better than they can, so we constructed the narratives together, using many of their actual words from interviews. The narratives of each of the nine participants are presented in Chapter Four.

Part of what makes narrative analysis a unique research methodology is the power of the individual narratives. I wanted the findings of this study to reflect both the
individual voices of the participants and the collective themes that appeared across their narratives. In order to do this, I analyzed each narrative individually paying specific attention to the stories within the narratives and the individual meaning making that occurred for each person as they entered their profession. Next, I looked for themes across the narratives; the common experiences, concerns and conflicts that most of them seemed to experience as they began practicing. The findings of these analyses are reported in Chapter Five.

In order to have a strong narrative study, measures are put into place to determine the value of a study. Since the measures of “rigor” do not apply to qualitative work and the criteria for evaluating trustworthiness of qualitative research: credibility, applicability/transferability, dependability, and confirmability are not directly relevant to narrative inquiry, alternative criteria are used. These validation criteria, as described by Reissman (1993), are: persuasiveness, correspondence, coherence, and pragmatic use. The narratives were read and evaluated against these criteria. Each of these criteria is described in detail in Chapter Three.

To ensure a strong study, it was important that I communicate and interact with my dissertation chair on a regular basis. She provided support and guidance throughout the data collection and analysis process. Because there are so many ways to analyze narratives, I worked closely with my dissertation chair both in determining how I was going to do this and in the analysis process. I also kept a personal journal to reflect my experiences during this process. This was very beneficial for me, especially when events occurred in my life that affected my work. Keeping a journal helped me recognize when my personal views and experiences were getting in the way of my work. This
recognition allowed me to step back, regroup and start over at times. I think that process strengthened the research and provided a valuable learning experience for me as a researcher.

Definitions of Terms

Primary care – primary care is a medical specialty that provides general care to patients. Primary care physicians are from the fields of internal medicine, family practice, and pediatrics.

Group practice – a group practice is any situation where all physicians within the practice are employees of management organizations. Examples of these types of organizations are: HMOs, large for profit and not for profit hospitals, small or large groups of various medical specialties and subspecialties that are managed by one healthcare management organization or a group of managing partners.

Deprofessionalization – is the process by which a profession is stripped of its uniqueness and becomes a job or employment rather than a profession. It is when a profession experiences a weakening, or perceived weakening of the profession’s ability to possess “altruism, autonomy, authority over clients, general systematic knowledge, distinctive occupation culture, and community and legal recognition” (Ritzer & Walczak, 1998, p. 6).

Resident – a resident is a physician in training who has completed four years of medical school and has earned the degree of M.D. (Medical Doctor) or D.O. (Doctor of Osteopathy).

Post-resident physician – a physician who has completed residency training.
Organizational socialization – the process by which new employees (organizational newcomers) learn the norms, values and processes of the employing organization.

Newcomer – newcomer is the word often used in the organizational socialization literature to represent the person who is new to the organization.

Agency – an individual’s control over his/her responses to situations or power structures.

Generation X – Generation X is the age cohort born in the mid-1960’s to late 1970’s.

Narrative – A complete literary process including a beginning, middle and end.

Story – A vignette within a narrative that gives meaning to a particular event or series of events.

Grand Narrative – A narrative, belief system or way of thinking that is prevalent in a certain group or culture.

Counternarrative – A narrative, belief system or way of thinking that challenges the grandnarrative of a certain group or culture.

Assumptions

1. Physicians entering practices experience some level of organizational socialization, personal development and professional development during the entry process.

2. Organizational socialization is predominantly informal, and the informal processes and learning are often unrecognized by the new employee and the organization at large.

3. Despite a strong cultural influence within the profession, beginning physicians also have some level of intentionality and they make choices, either consciously or unconsciously, regarding what organizational and professional norms, values, and beliefs they will embrace or resist.
4. Beginning physicians are individuals guided by personal beliefs and experiences. As a result, they approach their profession in numerous ways.

5. Beginning physicians will face some level of conflict between organizational values, personal values, belief systems and professional values.

6. Even though individuals can exhibit some level of autonomy or intentionality in their actions and decisions, organizational values, professional values, and individual values are socially constructed and influenced by socio-cultural factors.

7. Entry into employment is both a socio-cultural and developmental process for individuals, especially physicians who have spent most of their life prior to employment in education and training pertaining to the profession.

Limitations of the Study

There are several limitations to this study. They are as follows:

1. This study was conducted with physicians graduating from residency programs in Northeastern United States. Because of the number of medical schools and physician penetration in this area, the experiences of these physicians may not be similar to those in other geographical regions.

2. Participants may have been more apt to share their successes and reluctant to share certain struggles or aspects of their experiences with the researcher.

3. The participants who volunteered for this study experienced some level of professional success and more willing to share their narratives because of that.

4. Physicians are extremely busy and at times they did not have the time or energy for the reflection necessary to understand the learning they experience.
5. The findings are limited to the researcher and participant’s ability to bring implicit understanding and beliefs to the surface.

6. The historic sociological tension between the ideal of a profession and professional identity and career and career identity may produce resistance from the medical field regarding this study and its findings.

Significance of the Study

This study contributes to the fields of adult education and medical education in several ways. First, the findings of the study suggest that the professional entry of physicians is a complex developmental process involving personal and professional growth. This is not new to the field. There are life transition models of development that address this (for example, Schlossberg, 1987; Bridges, 1980, 1991). But what is unique about this group is the lack of guidance and support they had in making the transition.

Life transitions are often times of learning and development, and the learning and development is often related to the timing of the event (Merriam, 2005). Though entering practice is an anticipated event after residency, the participants of this study were on their own as they moved from a highly structured educational and training environment into professional practice. They experienced a lack of career guidance and planning and most of them were not thinking about organizational fit when they chose their positions. This study provides valuable insight for medical educators and those who are responsible for medical education and professional development in healthcare organizations. If guidance and support are provided during this time of transition, it may help entering physicians find the right fit and increase physician retention in organizations.
Next, this study showed how each physician developed his or her own way of managing the multiple demands of the profession, family life and organizational expectations as they begin their careers. This gives meaning and depth to what is now thought of as the “changing face of medicine” which is a strategic interest of medical educators and healthcare organizations. There is emerging academic interest in investigating issues surrounding the physician workforce in the United States. In 2004, the Association of American Medical Colleges created a research division specifically devoted to physician workforce issues such as: diversity, physician supply, and changing workforce demographics.

For the field of adult education, this study adds to the professional development literature. We, as researchers, often try to separate professional growth from personal growth, but they are interwoven. We often still look at career development as career achievement and advancement (Sullivan & Mainiero, 2008). The results of this study suggest that advancement is not always the goal. In fact, the participants wanted balance more than money or professional advancement. This adds to the body of literature on how the next generation defines career success. While there are many seminars, popular press publications and workshops focused on Generation X employees, the empirical literature is sparse (McDonald & Hite, 2007). This study contributes to that body of research.

Through the use of narrative analysis, this study also provides a unique picture of developing professionals and how they make meaning of the events in their lives. Analyzing the narratives individually and collectively allowed me to see the differences and similarities in how they approached their professional entry. This adds to our
understanding of individual professionals in a social world. We often think of professional socialization as constituting sameness. While, these nine physicians were socialized very similarly during their medical school and residency experiences, other aspects of their lives and other social contexts also contributed to their values, goals and beliefs. This is illustrated in the nature of the themes of their individual stories and is reflected in the way they approach their profession and their lives.

Finally, this study contributes to our general knowledge of physicians’ lives. Most people do not really know their physicians. There is not much social interaction that can occur in a fifteen minute visit. So many assumptions about physicians and their lives are made through depictions in the media or brief personal encounters. This study gives a glimpse into the everyday life and practice of physicians entering the profession. It helps all of us see them as people instead of seeing them as unapproachable men and women in white coats.

Organization of the Study

Chapter One provides an introduction to the study, the background of the problem, problem statement, purpose statement and overviews of the theoretical framework of the study and research methodology. Also included in Chapter One are definitions of terms that delimit the study, assumptions and limitations of the study and a statement of the study’s significance and contribution of new knowledge to the field.

Chapter Two provides a review of the literature pertaining to the study. Included in this review is literature pertaining to the theoretical framework of the study which is social constructivism. Other areas of the literature review discuss development and identity development, work and vocation in society, the medical profession, the
relationship between physicians and organizations, and how individuals learn how to be medical professionals.

Chapter Three presents a thorough description of the research methodology. This includes a rationale for using the interpretive paradigm and a qualitative methodology, specifically narrative analysis, for the study. This chapter also describes the background of the researcher, details of participant selection, data collection, data analysis and verification of the research process.

Chapter Four presents the narratives of the nine physicians who participated in this study. Chapter Five presents the findings of the holistic, structural and collective analyses of the narratives. The Sixth and final chapter presents a discussion of the findings in relationship to the theoretical framework and current literature. Then it presents implications for the study and suggestions for further research. The chapter ends with a brief reflection of the research experience.

Chapter Summary

This introductory chapter provides the background and summary of methodology for the study. It includes a statement of the problem that is addressed in the research and the guiding research questions. Also included are a summary of the theoretical framework, a list of definitions and assumptions that were present in the study. Along with this, the limitations and significance of the study were provided. This chapter ends with a brief overview of how this study is organized and presented. The next chapter, Chapter Two presents a summary and analysis of the literature relevant to this study.
CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this study is to capture the entry experiences of primary care physicians beginning their medical careers after residency. Recognizing that professional entry does not occur in a vacuum, this study focuses on the personal and professional events and experiences that occurred during the participants’ professional entry and how they interpreted those events. By reflecting upon the experiences embedded in the narratives of the participants, a goal of this study is to reveal how early professional, personal, and organizational experiences shape young physicians.

This chapter reviews the literature relevant to the study. Merriam and Simpson (2000) state that the literature review for a research study provides: (1) a foundation for building knowledge; (2) support for the study and how it advances the field; (3) a process to conceptualize the study; (4) support for methodology and instrumentation; and (5) a point of reference to understand and interpret the results of the study. This review will meet those objectives by presenting the relevant literature in four sections.

The first section of this review focuses on the literature regarding social constructivism and adult development. This serves as the theoretical framework of the study and situates the study in the field of adult education. Next the literature regarding work and the medical profession are presented, specifically focusing on the relationship between work, vocation, and profession and the practice of medicine in the United States. The third section provides an overview of the literature on the relationship between physicians and organizations. This includes the literature on organizational socialization, professional employees, and the issues professionals face as members of work
organizations. The fourth section moves from the collective perspective of the profession and organization to the individual physician by discussing the developmental themes found in the memoirs and biographical accounts written by medical students and residents.

**Theoretical Framework**

This section presents the literature on social constructivism and social constructionism, and their relationship to adult development which serve as the theoretical framework of the study. Social context is an important consideration in investigating professional entry experiences. A foundational premise of this study is that professional development and personal development cannot be separated, and all aspects of our lives are influenced by socio-cultural and socio-political climate. As individuals begin their professional career, the way that they go about making sense of, or constructing, their beliefs about their lives and their professions is influenced by multiple factors inside and outside of the workplace. These socio-cultural influences are often recognized in the career development literature (Brown, 1995, 2002). But, they are rarely voiced in the organizational socialization literature, or the professional development literature, outside of the teaching profession (Singer, 1982). To better understand how the social and cultural context affects individual development, it is important to understand social constructivism.

**Social Constructivism**

As with many terms in the social sciences, *constructivism* has multiple meanings and is used rather loosely in the literature. In some ways constructivism has become the social science mantra of the 21 century similar to the way behaviorism informed the field...
of psychology in the 1920s to 1950s (Simon, 2001). Constructivism is that it is based on the assumption that the social world of human beings needs to be understood in a different manner than we understand the physical world (Lincoln & Guba, 1985). Constructivist theories seem to cluster into three distinctive groups: cognitive constructivists, those who focus on the individual’s construction of knowledge (such as Piaget); social constructivists who recognize both internal cognitive processes and the socio-cultural, socio-political, and socio-historical constructions of knowledge as interactive in constructing knowledge (such as von Glasserfield, Vygotsky, Bruner, Lave, Rogoff); and social constructionists (such as Berger & Luckman, Gergen K.J., Gergen, M.M.) who do not separate the individual from the social and tend to focus on discourse, narratives, and conjoint meaning making (Gergen, 2001). Within these groupings there are subgroups (such as radical constructivists, critical constructivists) identified in the literature as well.

Constructivism, is rooted in the cognitive development theory of psychologist, Jean Piaget who theorized that human cognition is built upon a series of developmental phases in which an individual learns how to make sense of his or her environment through interpreting experiences. These interpretations become schemas or maps for understanding concepts. As the individual grows and matures into adulthood, the cognitive development becomes increasingly complex (Travers, 1982). While constructivists, such as Piaget, consider knowledge as something that is created within a person through experiences, social constructivists specifically focus on the interaction between the individual and the socio-culturally informed environment (Merriam & Cafferella, 1999).
Lev Vygotsky (1978), a Russian social psychologist, is recognized as the early social constructivist theorist. He agreed with Piaget that individuals construct meaning through experiences and interactions with the environment, but he argued that development occurs in a social context. Within the social context, learning and development occur through language which gives knowledge a culturally defined meaning (Vygotsky, 1978). Vygotsky argued that cognitive development occurs in stages. Individuals have an actual level of development (what can be done independently) and a potential level of development (what can be done with assistance.) He called the area between the two, the zone of proximal development (Vygotsky, 1978) which is the site for learning and growth. He believed that through social interaction, individuals develop by being challenged to problem solve within the zone of proximal development.

Rogoff (1995), whose was informed by Vygotsky, took this work to the next level by focusing not only on children but adults as well. She also conceptualized the socio-cultural environments in which we learn. She suggests that adult learning and development occur at three levels of interaction: the personal, the interpersonal or social, and the community or institutional. Each of these interactional levels or planes contains certain attributes. The personal level includes personal attributes, both psychological and cognitive. The interpersonal level represents the individual’s ability to communicate and interact in a social context. Finally, the community or institutional level represents communal values of a specific group. Rogoff (1995) saw each of these levels interacting with each other as a complex process which she described as intersubjectivity, the shared meaning and understanding that occurs among individuals with common interests,
assumptions, and beliefs that ground how they communicate and relate with each other and the world outside of their community.

Recognizing the interconnectedness of the individual, interpersonal, and organizational/communal planes of development is important for understanding the experiences of professionals entering practice. This is why social constructivism grounds this study. New physicians are simultaneously developing as adults, professionals, and organizational members. As Rogoff’s (1995) theory suggests, what is happening in one context of an individual’s life affects other aspects of his or her life. What is occurring interpersonally in the context of home, or other social support network, influences how an individual constructs meaning in his or her profession.

*Social Constructionism*

From a sociological perspective, discussing the construction of meaning for communities and/or society, Berger and Luckmann (1966) argued that individuals construct meaning and understanding as they develop through human activity in a particular social context. Ways of thinking and doing are habituated, and become *common knowledge* which eventually leads certain knowledge to become institutionalized, a tradition, or part of the culture. They argue that every institution or group has both a history and culture that frame reality. For those within the institution, this institutionalized reality is perceived as objective, but it is subjectively constructed through complex human interactions (Berger & Luckmann, 1966). Thus, in part, reality and knowledge are constructions of the history and culture of any given group or society.

More recently, Gergen (2001) argued that the influences of the globalization process and the information age are stretching the boundaries of social construction.
because the context is constantly changing. Due to this constant change the common knowledge discussed by Berger and Luckmann (1966) is dynamic and shifting. Gergen contends that the amount of information and multiple realities individuals experience creates constantly shifting identities, a loss of authenticity, and the commodification of self. Since he sees truth and reality as socially constructed, his concern is that the lack of “coherent community” (p. 189) is resulting in lack of personal depth and commitment. The world of work and vocation is one area that is affected by this lack of depth and commitment. According to Gergen, the meaning of work, and the depth in which work or profession defines identity, is shifting as communities and society becomes more disengaged and individualistic. This calls into question the idea of professional identity.

**Summary of the Social Constructivist and Constructionist Literature**

For the purpose of this study, the separation of social constructivism and social constructionism is not as important as the basic tenet that binds both, which is that knowledge is constructed by people attempting to make meaning of experience and it is developed, transmitted, and shared within a social context (Crotty, 1998). This knowledge is shaped by the interactions and negotiations which occur within the group or culture. Thus, personal meaning of experience is affected by the community or group and the individual affects the group’s collective meaning as well (Kim, 2001).

**Adult Development**

The adult development literature provides theoretical ways to understand how individuals grow, learn, and cognitively and psychologically develop over the life course. The relationship between work and development is inherent in most adult development models. “Implicit in the concept of development is recognition that it is a process, a
coming to be” (Reeves, 1999, p. 19). Adult educators, for the most part, agree that human development is a process, but there are numerous development theories that attempt to conceptualize this idea of “coming to be.”

The first theorist who recognized that development does not stop when individuals reach adulthood, framing adulthood as a time of continual growth and development was Erik Erikson. Recognized as the most influential theorist on development, especially identity development, it has been said that he was the “first to illustrate how the social world exists in the psychosocial apparatus of each person” (Hoare, 2002, p. 4). While Erikson’s theory is still popular and has influenced many contemporary adult development theorists, many other models or theories of adult development have emerged. Most of these developmental theories fall into one of four categories: biological or stage/phase, psychological, socio-cultural and integrative (Imel, 2001; Merriam & Caffarella, 1999; Reeves, 1999)

This study is informed by four theories of adult development. Specifically addressing the interaction between the individual self, the interpersonal self and the organizational self, Rogoff’s (1995) socio-cultural theory of development (presented in the discussion of constructivism), provides a holistic view of development from a socio-cultural perspective. Another developmental theory undergirding this study is Kegan’s (1982) theory of constructive development which examines individual meaning making and the cognitive development of individuals. A key element of his theory, in terms of the development of young adults entering a career or profession is that of self-authorship, how individuals construct their identity. The third theory of development that informs this study is Arnett’s theory of emerging adulthood. While Arnett’s theory is based upon
Erikson’s work and is not a socio-cultural view of development, it provides insight to the study because it addresses the socio-cultural and societal influences effecting adult development in contemporary society and how these factors are changing how adulthood and adult development are viewed. The final discussion of adult development in this literature review is Rossiter’s (1999) model of adult development as narrative. This theory combines both developmental theories and the perspective taking of individuals, arguing that constructing life stories is a developmental process.

*Kegan’s Theory of Constructive Development*

The grounding premise of Kegan’s (1982, 1998) theory of meaning making or constructive development is that “construction directs us to the activity that underlies and generates the form … development directs us to the origins and processes by which the form came to be and by which it will pass into a new form” (Kegan, 1982, p. 13). He posits that development is a meaning making process in which individuals construct knowledge of themselves and their environment through interaction and experience. Though Kegan is a self-proclaimed cognitive constructivist, he recognizes the importance of socio-historical context in relationship to development. In fact, he argues that the demands of contemporary society are affecting individual development and many adults are not developmentally prepared to cope with these demands (Kegan, 1998).

Kegan proposes that development takes place in five stages. Generally speaking, the latter three stages are related to adult development. These three stages associated with adulthood are: the interpersonal stage which focuses on the *socialized self*, often occurring in late adolescence or early adulthood; the institutional phase which focuses on the *self-authorized self*, often occurring in early adulthood, and the inter-individual which
focuses on the *self-transformed self*, which often never occurs, or occurs in late adulthood. What is most informative to this study is the transition from the *socialized self to the self-authored self*. In the socialized self phase meaning making is informed by the values and ideals of others; while in the self-authorized self phase meaning making is an internal process characterized by self-regulation and autonomous decision making (though the influence of social context is still recognized).

Informed by Kegan’s work, a longitudinal study of individuals aged 19 to 30 suggests that the process of moving from socialization to self-authorship often occurs in increments as an individual moves from listening to others and following a general script of life; to listening to self, or an internal voice, and creating his/her own script for life (Baxter-Magdola, 2001). For the participants of Baxter-Magolda’s study, this process occurred during their early college years into their adult years as they developed more confidence and competence in what they believed to be their adult roles. It emphasizes the personal development that occurs as individuals are beginning their careers.

While self-authorship is believed to occur during young adulthood, social context may cause variation in when stages begin and end. For example, a study of West Point Cadets found that most of them were functioning at the second level of Kegan’s model imperial or role-taking which is believed to occur in late childhood. This finding demonstrates a significant delay from what normally would be expected of young adults of their chronological age which would be the interpersonal stage based upon interpersonal versus authoritative relationships (Lewis et al., 2005). One explanation posited by the investigators is that the structure and demands for conformity in academy life did not provide an environment for individual development. Another study of adult
literacy and English as a Second Language (ESOL) participants suggests that even though this group was struggling with assimilation into a new culture, the still were moving toward self-authorship as described by Kegan’s theory (Popp & Portnow, 2001).

The variation in development in different environments illustrates the importance of understanding the contextual nature of development. Kegan recognizes the importance of context by emphasizing the influence of holding environments, the psychosocial context in which development occurs. A good holding environment is where the individual is both challenged and supported to develop meaning systems. Holding environments can be work, family, social groups, peers or a combination of contexts where the person learns and grows. While this study is not informed by transformative learning theory, it is recognized that the movement from the socialized self to the self-authorized self is often associated with Mezirow’s theory of transformative learning (Kegan, 2004; Erikson, 2007).

Emerging Adulthood

Building on both the work of Erikson and Levinson, Arnett (2004; 2006) theorized that a new phase of development has surfaced. He refers to this stage as emerging adulthood, to address the changing social environment in which adults are developing in contemporary society. In his theory, Arnett suggests that this stage begins at the age of eighteen and ends in the mid to late twenties and has five main features. First, it is a time of identity exploration, especially in love and work. Second, it is a time of personal instability and often geographic movement. Third, it is a time when young adults are self-focused. Fourth, it is a time of being between adolescence and adulthood and not feeling part of either. Finally, it is a time of endless possibility and hope.
Arnett’s theory is the culmination of extensive research, interviewing both college and non-college emerging adults from diverse ethnic and racial backgrounds (Arnett, 2004). His study suggested that the concept of adulthood has changed for college aged students and young adults. No longer is adulthood defined in terms of life events such as career, marriage and parenthood. “Instead of the sociological transitions, the most important criteria for adulthood in the minds of these college students were more intangible and psychological: accepting responsibility for one’s actions, making independent decisions, and becoming financially independent” (p.vi). Empirical studies also have suggested that this generation of emerging adults is more individualistic in their value and belief systems (Arnett & Jensen, 2002).

Arnett’s theory has been challenged with empirical research suggesting that emerging adulthood needs to be reconceptualized to include factors such as socio-political climate, community expectations, and the availability of such things as jobs and affordable housing. Molgat (2007) and Bynner (2005) argue that both institutional (how the transition from school to work is managed within a culture) and structural (class, gender, race and locality) factors have a tremendous effect on the transition from adolescence to adulthood and these socio-cultural factors need to be taken into account when theorizing about this time in individuals’ lives. For example, in Molgat’s (2007) study, he found that factors such as lack of employment opportunities and low wage jobs were the reasons given by young adults in Canada explaining why they were still living with their parents. Pursuing advanced education (beyond undergraduate degrees) was another reason that young adults chose to live at home. In addition, Bynner (2005) argues that the contemporary socio-political climate makes it necessary to accumulate
human capital (education and skills for the workforce) and social capital (social networks) to a greater extent than ever before. Thus, the individualism observed by Arnett is not necessarily a focus on self as much as it is a socially developed norm.

The individualism that appears to be a characteristic of emerging adults and the development of individualism is reinforced and rewarded in industrial societies (Gergen, 2000). Swartz, Côté, and Arnett (2005) investigated what they termed individualism. They propose that it takes two different forms: developmental individualism, where the person uses agency to navigate life and make decisions; and default individualism, where the individual allows others or circumstances to guide decisions. In a study investigating the relationship between agency and identity development in emerging adults (Schwartz, Côté, & Arnett, 2005), those who exhibit agency developed stronger individual identities. This study also found that there were no gender, racial, and cultural differences in the relationship between agency and identity. Finally, the study showed that due to the unstructured, exploratory nature of emerging adulthood, those who exhibited agency developed personal goals and ideals, while those who utilized default individualization strategies seemed to move aimlessly through this period of life.

While this finding provides valuable insight into how individuals can influence their own path, the focus on individualism is problematic in relationship to social constructivism and some of the general assumptions of Arnett’s work. The most obvious question is, “If individuals can exercise this level of agency, why are the cultural-historical influences of contemporary society requiring the development of another stage of adult development?” It is important to understand that what Swartz, Côté, and Arnett (2005) are discussing is psychological agency not sociological agency. Wandrei (2001)
argues that individual self-directed activities, or their intentional actions that may be seen as psychological agency, intimately interact with social processes and constructs. Jarvis (1992) contends that while there are philosophical debates as to the existence of free will and autonomy, because of strong socio-cultural influences and experiences, the free will that is exercised is often motivated by conformity rather than individuality. Thus, this concept of individuality (either developmental or default) as theorized by Swartz, Côté, and Arnett (2005) seems to better termed as active intentionality (seeking opportunity and understanding) or passive acceptance (allowing others to make decisions or doing what others feel is appropriate.) In this light, their theory parallels the tension between the socialized self and the self-authorized self in Kegan’s (1994, 1998) theory.

**Adult Development as Narrative**

The literature evidences many factors that influence the development of adults throughout the life course. These theories provide insight as to the complexity of studying identities, and how they are developed, challenged, and nurtured during adulthood. The complexity of life in 21st century challenges the boundaries of developmental theories. Both Gergen (1991; 2000) and Arnett (2000, 2006) argue that complexity of adult development processes is exacerbated by the pace of life in contemporary society and the changes in technology and communication have challenged more traditional views of identity and identity formation. Now, identity development appears to be more of a fluid on-going process than an end goal or the result of becoming an adult.

Constructing a meaningful picture of how any individual transitions from one phase of life to another in this complex world is very difficult to do in the framework of
one developmental theory. The purpose of most developmental theories is to explain human behavior and the human experience and to be able to predict or anticipate what may happen in the future. Rossiter (1999) argues that adult development should be understood by attempting “to describe development from the inside as it is lived rather than from the outside as it is observed. The focus is on subjective meaning—how people make sense of the events of their lives over the life course” (p. 78). To do this, she suggests viewing adult development as narrative consisting of four dimensions: contextual, interpretive, retrospective, and temporal.

The contextual dimension is how life events fit together as a coherent story. “Events of one’s life mean something in relation to other events and in relation to the valued ends toward which a person is striving” (p. 80). The interpretive dimension is the recognition that development is not just a series of events or a prediction of future events. It is an interpretation, embedded in values, preferences, personal beliefs, and purposes. The retrospective dimension looks at development as what has happened previously instead of predicting what will happen in the future. “Development is a fundamentally retrospective concept…It is only after one has arrived at what is arguably or demonstrably a better psychological place than where one was before that development can be said to have occurred” (Freeman, 1991, p. 99, as cited by Rossiter, 1999, p. 82). The temporal dimension of narrative development means that “an understanding of past and future is continually evolving in the present” (p. 82).

Viewing adult development as narrative is beneficial for adult educators for numerous reasons (Rossiter, 1999). First, doing so recognizes that adults are the constructors of their own development and the story of how they learn and grow should
be told from their perspective. Second, storytelling or narrative helps individuals deal with change. “When something happens that is outside the canon of our habitual patterns of thought and belief, we tell stories about it to tame it, so to speak, to understand it” (p. 83). Third, the reflection associated with telling developmental stories leads to development. As theorized by Kegan (1994) and discussed by Baxter-Magdola (2001), the ideal of self-authorship and personal understanding is key to adult development. Finally, telling and re-telling developmental stories can be transformational. As an individual reflects and interprets the events of life, he or she may begin to question beliefs and values.

Theoretical Framework Summary

This section reviewed the literature on social constructivism, social constructionism and adult development, all of which inform this study. Understanding the social construction of work and identity in contemporary society is fundamental to understanding the experiences of physicians entering organizations in the 21st Century. Gergen’s (2001) observations of the shifting relevance of occupation and career are important to recognize when studying professionals. Social constructivists recognize that adult development occurs in a socio-historical context. This study is bound by context: organizational, personal, professional, and societal. Rogoff’s (1995) theory of adult development attends to the influences of multiple contexts.

Aspects of the developmental theories of Kegan (1982, 1998) and Arnett (2004) are relevant to the participants in this study, young adults entering careers, while Rossiter’s (1999) theory of adult development as narrative supports the proposed methodology of this study. The belief that young adults starting careers begin to “self-
author” is a grounding premise of this study. The emerging adulthood literature, though contentious in light of the social constructivist lens used in the study, is an important element in the study because it emphasizes the socio-cultural climate in which these entering physicians are beginning their professional life. Chronologically, most of the participants were entering their thirties, and their lives to this point seem to mirror the description of emerging adulthood. Because of the focused nature of medical education, many young physicians have delayed the sociological markers of adulthood. Finally, Rossiter’s (1999) understanding of development as narrative ties nicely to the proposed methodology of this study, narrative analysis.

Work and the Medical Profession

The literature indicates that societal status and the general impression that society has of a profession influences the salience of an individual’s professional identity (Feather & Rauter, 2004; Stets & Harrod, 2004). Work in contemporary society is situated in the era of free agency (Pink, 2001) and independent workforce theory (Beck, 2000), both of which have been criticized for commodifying occupations and professions. This results in the importance of work and career being reduced in the minds of individuals and in society. While this is occurring to some extent, work is still an integral part of adult life and identity. This section of the review discusses the literature concerning work, initially from a broad perspective, then moves into a discussion of the literature regarding the medical profession.
Work, Vocation, and Identity

“Work and life have a strange reciprocal relationship: only if man works can he live, but only if the work he does seems productive and meaningful can he bear the life that his work makes possible” (Gilkey, 1966, as cited in Meilaender, 2000, p. 1).

The notion of work has been around since the beginning of time. Work and its relevance to humankind is discussed throughout the Bible, in the classical writings of the Greeks, and it is a cornerstone of Western thought (Meilaender, 2000). Generations of Americans saw work as an instrumental part of their being (Beder, 2000). Throughout history, careers were built around societal needs and particular life goals. An individual’s career provided a singular identity (Gergen, 1991). Vocation and work are integral elements of both the research and practice of adult education (Dawson, 2005).

Participation in adult education in the late 1960’s was distributed evenly between work and non-work related learning but this changed at the end of the 20th century with more than ninety percent of those participating in adult education being there in relation to their work or career (Merriam & Cafferella, 1999).

Within the adult education literature, work is often referred to as a vocation. Tied to the term vocation, a Latin derivative of the word voca or calling, many argue that what an individual does in terms of career or life’s work should be a calling. Finding ones’ vocation has been described as: “a sojourn of Soul during which work/life choices seem to be driven by psychic shifts in meaning, being, and doing” (Brewer, 2001, p. 84). This is differentiated from the concepts of: job, which may be defined as “labor for money” (p. 86); occupation, defined as a way to provide financial support that provides some level of identity but most of the person’s identity is from non-work
endeavors; and career, which is described as a dedication to work, profession, or an institution. Palmer (2000) contends that vocation should be understood “not as a goal to be achieved but as a gift to be received. Discovering vocation does not mean scrambling toward some prize just beyond my reach but accepting the treasure of true self I already possess” (p. 10). Cochran (1990) explains that for a person who is called or has a vocation, “The relationship is not contingent but personally necessary, a relationship of being and doing, potential and actualized” (p.3). In theory, a calling is not what we do, but who we are. Also, when meaning, being and doing are in equilibrium individuals usually experience self-knowledge, contentment and a feeling of purpose (Brewer, 2001).

Due to technology and globalization, society is facing a huge macroeconomic shift which has resulted in a high risk, high stress, and erratic marketplace (Tulgan, 2004). The relationship between employee and employer is no longer seen as a long-term relationship or career path based on loyalty and commitment; instead it is a “contract like economic exchange” (Tsui & Wu, 2005, p. 115) in which the employee provides a service to meet the ever changing demands of the market. As a result, the most common characteristic of employees in the knowledge economy is their commitment to the growth of their knowledge and skills (Melchionno, 1999).

This does not mean growth in a particular career or pursuing a vocation, but instead it means gaining the knowledge and skills necessary to meet the needs of a rapidly changing marketplace. Employees in the new economy no longer look for career security but instead they look to increase their passive capacity. Passive capacity is learning and skill acquisition that may not be directly associated with completing the task
at hand or a specific position, but preparation to remain competitive and be equipped for future opportunities, which increases marketability (Geroy & Venneberg, 2003).

An individual’s career no longer provides a singular identity. Instead there seems to be an intense commodity exchange mindset regarding employment relationships (Adkins, 2005). Today, society looks toward education and training to assist people in “identity production” (p. 184) in order for individuals to take on a variety of identities, especially career identities, throughout the life course (Gergen, 1991). This causes many to question whether or not people make career choices because they see a particular occupation or profession as a calling or if they see their careers as the packaging of skills and experiences in an attractive format to meet a particular market demand or niche. This seems like a contemporary issue, yet, in the 1930’s José Ortega y Gasset, a 20th century Spanish philosopher, wrote: "Strictly, a person's vocation must be his vocation for a perfectly concrete, individual, and integral life, not for the social schema of a career” (Gasset, as cited by Marty, 2001, p. 1556), which suggests that this may be a tension present in society for some time, but more recognized today.

Though the knowledge economy and globalization have changed the way many look at work, there are still individuals who see their work as a calling. Physicians are often seen as being called to their profession; some even argue that a profession in itself is a calling. When describing the moral and ethical obligation of physicians, Marty (2001) relies on the words of Louis Brandeis who stated that a profession is

An occupation for which the necessary preliminary training is intellectual in character, involving knowledge and to some extent learning, as distinguished from mere skill; which is pursued largely for others, and not merely for one's own
self; and in which the financial return is not the accepted measure of success (p.1557).

There seems to still be some sense of calling involved in the emotional dimension of the helping professions such as teaching and medicine (Dirkx, 2006). To support this, the majority of physicians interviewed for a study of the influence of managed care on the medical profession, reported that they were called to the profession (Hoff, 1997). Though there are people who are definitely committed to their calling, the question still lingers as to how calling is defined and whether or not the ideal of a calling is dissipating in contemporary society, specifically in the profession of medicine.

Those who have been in the medical profession for some time lament what they see in the new breed of physician. Beginning physicians are becoming more focused on quality of life issues and are perceived as seeing their profession more as a career than a calling (Real, 2002; Kirch, 2007). An indication of this is the continual decline in the numbers of medical students choosing to pursue primary care. “The perception among medical students is that primary care physicians work too hard for too many hours and don’t make enough to cover loan payments and support a reasonable life” (Giovino, 2002, ¶ 6). In 2007 the number of applicants to medical school increased by eight percent, which is a positive sign to the medical education community that there is a revitalization of interest in the profession. But, the increase interest is attributed to the recognition of a future physician shortage, a desire to improve society (not necessarily to help others) and the economy (Croasdale, 2007). The American Medical Association (AMA) reports, “When it [the economy] is growing the medical profession sees strong
competition from law and business. Medicine attracts people when the economy is soft because it is considered more recession-proof than other fields” (p. 1, ¶ 7).

To understand the origins of these differing points of view of the medical profession, it is important to understand the sociological and historical factors that have influenced medicine and the healthcare industry in the United States. The next two sections discuss the profession of medicine from a sociological and historical perspective.

Sociological Perspectives of the Medical Profession

There is a significant amount of discussion and debate related to the changes occurring in the medical profession. To understand the context in which the profession is situated it is important to recognize the varying sociological perspectives of medicine. Medical sociology is predominantly applied, meaning its purpose is to solve clinical problems or policy issues rather than theory development. This is attributed to its origins being tied to the realization, post World War II, that social factors were important to health. Thus, government funding opportunities focused on practical utility and application began to emerge (Cockerham, 2005). Sociology scholars have conceptualized professions in a variety of ways. Due to the power and prestige of the medical profession, most studies and theoretical explanations of “the professions” focus on physicians, which provides a wealth of theoretical and empirical literature on the topic (Ritzer & Walczak, 1988). A number of scholars have traced the historical roots of the medical profession and professionalization and presented various paradigms to explain the phenomenon of the profession of medicine (Abbott, 1988; Freidson, 1970; Gilmour, Kelner, & Wellman, 2002; Hafferty & Light, 1995; Light, 1987; Prechel & Gupman, 1995; Starr, 1982).
The three basic explanations of what distinguishes a profession from an occupation are the structural-functional perspective and the process perspective, and a third perspective, the power or professional dominance perspective, emerging later as a critique of the former perspectives. The structural-functional perspective proposes that professions exist when there is a large body of knowledge and expertise along with a collective orientation which is valued by and meets a functional need of society (Goode 1957; 1960).

Talcott Parsons (1951) and his school of sociological thought are credited with the inception of this theory which lead the scholarly defining of profession and professional. From Parsons’ (1951) theoretical perspective the practice of medicine has a specific societal function: dealing with and/or preventing illness. Parson argues that professional self-regulation occurs because physicians, unlike businessmen [sic], are collectively oriented and more motivated by collegial acceptance and approval than by external factors such as gaining wealth. Parsons (1951) contends that physicians have a responsibility to patients. This responsibility drives the profession to continually expand its knowledge base in order to deal with complex patient problems. Because this theory is based upon functional characteristics of profession such as value consensus, order, stability, and functionality at the macro-level rather than moral premises, it opened itself up to criticisms of professional self interest (Wynia, Latham, Kao, Berg, & Emanuel, 1999).

The second perspective, the process perspective (Caplow, 1953; Wilensky, 1964) proposes that a profession exists when there are certain training requirements, specific associations, professional processes, practices and ethical standards that guide and
constrain the professional practice. This paradigm also suggests that professionals should not be constrained by organizations, arguing that: “The salaried professional often has neither exclusive nor final responsibility for his work; he must accept the ultimate authority of non-professionals in the assessment of both process and product” (Wilensky, 1964, p. 146). Those who subscribe to this school of thought argue that not every occupation can or should be professionalized and professional sovereignty should be protected.

The third perspective, the professional dominance perspective, emerged in the 1970s as a critique of both structural-functionalism and process perspectives with the argument that professions gain dominance and control not because of any specific trait or skill but because of power, and maintaining this power is in the self interest of the profession (Freidson, 1970). Freidson argues that professional education institutions, credentialing boards and licensing requirements allow a profession to keep its power. To date, the professional dominance perspective has remained a prevailing influence in the sociological literature on the medical profession. In fact, at some point in the academic careers of most medical students and students of health administration, future health care professionals are required to read Paul Starr’s (1982), The Social Transformation of American Medicine, which provides a historical account of the medical profession in the United States, and is written from a power perspective.

*The History of the Medical Profession in the United States*

In order to understand the present, we often need to look at the past. This section provides a brief overview of the history of the medical profession in the United States as presented by those who hold the dominance perspective of medicine as the archetypical
autonomous profession (Freidson, 1970, 2001). This section provides a chronological account of the profession concluding with the context in which medicine is practiced in contemporary society.

Since there are multiple definitions of profession, for the purpose of this study I use the definition that Starr (1982) presents: “An occupation that regulates itself through systemic, required training, and collegial discipline; that has a base in technical, specialized knowledge; and has a service rather than a profit orientation, enshrined in its code of ethics” (p. 15). At first glance this definition appears to fit the structural-functional paradigm, but, Starr (1982) cautions that there is more to professions than what is reflected in that definition. He states that professional status also encourages the profession to continually legitimate itself through credentialing, ethical codes, and other gate keeping tactics which support both professional autonomy and authority while creating conditions that support a monopoly. It also creates “a kind of solidarity, a source of meaning in work, and a system of regulating belief in modern societies” (p. 16).

Osler, Flexner, and the bio-medical model of medicine. Historical accounts suggest that the medical profession gained its professional sovereignty and economic dominance in the late nineteenth and early twentieth century with the marriage of medicine to science (or the biomedical model), the increased power of the American Medical Association (AMA), and the infamous Flexner Report, an investigation of medical schools commissioned by the Carnegie Foundation (Starr, 1982). After visiting medical schools across the country, Flexner concluded that many medical schools needed to be overhauled to meet the demands of the profession. Specifically, Flexner reported that medical schools needed to adhere to the biomedical model of medicine prescribed by
Osler, and Johns Hopkins Medical School, the preeminent leader in this teaching model. A short time after Flexner’s report was issued, it was determined that schools that did not follow the Hopkin’s model needed to be closed and those that remained open needed to be strengthened in biomedical methodologies (Baer, 2001; Starr, 1982). Medical sociologists suggest that the influence of large philanthropic organizations run by the Carnegies, Rockefellers, and others created the professional dominance of biomedicine in the United States. This dominance continues today, but has been challenged at the inception of the “healthcare crisis” of the late 1960s and early 1970s. (Baer, 2001; Starr, 1982).

Three eras of the medical profession. Specifically focusing on the past 60 years, Scott et al. (2000) suggests that the institution of the medical profession had three distinct eras post World War II. They categorized these phases as: The Era of Professional Dominance (1945-1965), a time where physicians experienced economic prosperity and professional autonomy which also was referred to as the “Golden Age of Medicine;” The Era of Federal Involvement (1966-1982), which began with the inception of Medicare and Medicaid resulting in increased government intervention, regulation, and control; and The Era of Managerial Control and Market Mechanisms (1983-present), in which healthcare moved from being referred to as a “system” and began being described as an “industry” (Shortell, Morrison & Robbins, 1985, as cited by Scott et al., 2000).

This Era of Managerial Control and Market Mechanisms, provides the backdrop for contemporary medicine and a context for understanding the rapid change witnessed in physicians’ professional careers. This era began in the early 1980s when Congress passed bills that allowed managed care contractors to become involved with Medicare
and Medicaid, thus creating both strong governmental control of the medical reimbursement system and encouraging competition (Scott et al., 2000). As mentioned previously, even the discourse reflects the influence of management and corporate control. Physicians became *providers*; medical schools started offering courses that focused on business, economics, and organizations; Terms such as: cost conscious, cost control, efficiency, and productivity became commonplace in medical journals and across medical establishments (Scott et al., 2000). Supporting this change in the discourse are current trends such as: physicians being recruited into management and MBA programs; organizations requiring physicians to attend customer service seminars; and trade journal articles counseling physicians to become more democratic, gain social awareness and relationship management skills, and develop emotional intelligence (Serio & Epperly, 2006)– the same advice that managers and executives in the private sector have been hearing for years.

Faced with skyrocketing costs, managed care, corporatization, and governmental intervention, the medical profession has faced dramatic changes in the past two decades. These changes are in many ways similar to what is seen in large publicly traded corporations. There is a strong emphasis on productivity, cost control, and in some cases, where insurance companies have shareholders, shareholder equity (Jin, 2005; Murphy, 1999). As a result, it appears that “The organization of professional work and conceptualization of professional work is evolving with the underlying social and cultural institutions” (Jin, 2005, p.126); thus, much of what we see in the medical profession is a reflection of society in general. There are a variety of theories or perspectives which attempt to explain what is occurring. They are explained in the next section.
Perspectives on the Changes in Medicine

Those who study the medical profession provide multiple sociological perspectives explaining the underlying reasons that the medical profession is moving from an autonomous profession to one governed by institutional control. The section discusses the five prevalent perspectives: professional dominance, proletariat, deprofessionalization, rationalization, and physician as worker.

Freidson (1984, 2001) is one of the most recognized theorists regarding the medical profession. He maintains that professional dominance affords medical professionals unprecedented autonomy and control over their work (Freidson, 1984, 2001). Despite what looks like increasing external control, proponents of the professional dominance paradigm argue that even though there has been change, “there has been no perceptible movement toward actually eliminating the quasi-monopolies or cartels provided by licensing, accreditation, and registration practices” (Freidson, 1984, p. 7). From this perspective, the structures already in place perpetuate the profession, its autonomy, and its impenetrable position and power in society.

A second perspective is the proletariat perspective (McKinlay & Arches, 1985). Taken from Marx, the underlying theme is that physicians have become dependent upon selling their labor to large organizations and have no control over their work. The empirical literature regarding primary care physician satisfaction tends to support this thesis. Studies suggest that physicians are less content now than they were ten years ago (Murray et al., 2001); they have less control over their schedules and the pace of their work (Gask, 2004); and they have less time to interact with patients because of organizational demands (Murray et al., 2001; Sturm, 2002). In the same respect,
physicians also report that they still practice medicine the way they choose (Hueston, 1998). Critics of the proletariat perspective argue that even though the economic control of the profession may have shifted, physicians still have control over how they practice and what they deem important in their practice, thus, making their roles in society much stronger than just selling labor (Freidson, 2001).

A third perspective on the changing medical industry is that of *deprofessionalization* (Haug, 1973; Haug & Lavin, 1983). Deprofessionalization is when a profession experiences a weakening, or perceived weakening of the profession’s ability to possess “altruism, autonomy, authority over clients, general systematic knowledge, distinctive occupation culture, and community and legal recognition” (Ritzer & Walczak, 1988, p. 4). The basic premise behind this argument is that the same society that can grant power and prestige to a profession or group, can take it away as well. Many of the theorists who support the deprofessionalization thesis do so from a Weberian perspective. Positing that much of what is happening within the medical profession is due to the societal powers that support *formal rationality* conflicting with the profession that is guided by *substantive rationality*. Weber (1992) describes *substantive rationality* as holding on to values, ideals and traditions as a way of determining the most rational means to ends; and *formal rationality* as determining the most efficient methods and procedures to realize goals through regulations, rules, laws and structures.

The empirical literature does suggest that there is increased public cynicism and decreased public confidence in the medical profession though generally public perception of the profession is still rated as very high (Pescosolido, Tuch, & Martin, 2001). In addition, the strong interest in patient satisfaction and customer service (Grembowski et
al., 2003) suggests that medical care is being reduced to a commodity which reflects formal rationality. The extent to which this is happening is reflected in the literature. At the extreme, physicians working in urgent care, no appointment walk-in clinics are often referred to as “McDoctors” reflecting the similarities to the fast food industry (Murphy, 1999; Ritzer & Walczak, 1988).

A fourth perspective on how the change in medicine is affecting the profession is that of rationalization. Also based on the work of the well known sociologist, Max Weber (1992), proponents of the rationalization thesis argue that the focus on evidenced based medicine, and the substitution of human technology for the problem solving art of the physician, with statistics, measurements, productivity goals, external reviews and pay for performance systems has drastically changed the profession (Jin, 2005; Ritzer & Walczak, 1988). They are not as concerned with the societal dynamics that those who support the deprofessionalization thesis contend. The rationalization school of thought is focused on the daily working of the healthcare profession instead of the relationship of the profession to society. Jin (2005) states that, “as [the medical profession’s] institutional environment changed from granting autonomy to demanding accountability, it is experiencing a transformation from vesting authority and objectivity in individual experts to rationalized scientific evidence and organizational rules” (p.6). Though many physicians applaud the accountability associated with review and measures, pressure from external organizations, such as insurance providers, to quantity things that may not be quantifiable and to hold physicians accountable for the behaviors of patients has been met with skepticism (Hoff, 2001b; Jin, 2005).
A final perspective on how the medical profession is changing is the *physician as worker perspective*. This is a relatively new theoretical premise recognized in the literature. The grounding argument of the *physician as worker perspective* is that the evolution of contemporary society facilitates physicians becoming employees of organizations and there are positive aspects to viewing physicians in this manner (Hoff, 1998, 2001a, 2001b). Hoff argues that the scholarly discussion regarding professions, specifically the medical profession, is focused on the profession as an institution or collective and does not take into consideration the individuals who comprise the profession (this is the opposite of Freidson’s view that a profession is not a collection of individuals but an institution in itself). He contends that focusing on “traditional” values, specifically autonomy and self-employment which are the focus of both the deprofessionalization and proletariat paradigms, does not account for the fact that these values were constructed at a time when the profession was dominated by White males usually from upper class backgrounds who had the luxury to make the profession a top priority due to societal support (Starr, 1982).

*Physicians as Workers*

As discussed in Chapter One, the demographics of the medical profession continue to change with medical schools having more women applicants than men and increasing numbers of ethnic and racial minorities entering the field (AAMC Data Warehouse: Applicant and Matriculant File, 2007). Hoff (1998) argues that these groups are not as interested in being entrepreneurs and independent practitioners. Many female physicians, especially those with young children, are more likely to want salaried positions with set, controlled hours due to responsibilities outside of work (Briscoe,
Practice pattern statistics suggest that racial and ethnic minorities often lack financial capital to invest in a practice, tend to practice in underserved areas and with disadvantaged groups that may not have the resources to pay for medical care, and often lack community support and the business training and exposure necessary to be entrepreneurial, thus they tend to choose to be employees of healthcare organizations (Hoff, 1998).

These arguments are substantiated by a wealth of empirical and anecdotal data appearing in medical journals regarding the demographical and attitudinal differences between those entering the medical profession and groups prior. A physician’s trade journal ran, *A New Era of Leaders: Younger Physicians are Changing the Practice of Medicine* (Odle, 2006) as a cover story. The article began with, “Value systems, work ethics, and expectations can clash when younger physicians join a practice headed up by ‘mature’ doctors” (p. 15). Practicing physicians interested in recruiting new physicians to their practice are encouraged to realize that beginning physicians do not want to be on call as much as their predecessors were, are willing to take less money for a more balanced life, and are interested in financial stability versus entrepreneurial success (Giovino, 2002; Kirch, 2007).

What is not apparent is how this change manifests itself in an individual’s professional beliefs, expectations and experiences. The literature does not report whether or not salaried physicians and/or those working in large groups perceive their positions as callings or good jobs that pay the bills. Seasoned professionals speculate that it is the latter, but there is no empirical evidence to support their claims.
One dissertation study did investigate how individual physicians perceived their positions as organizational employees. The study consisted of a nationwide survey (n=2881) and qualitative interviews of thirty seven physicians. Four career values or career themes surfaced. These career values were described as pragmatists, balancers, advancers, and ambivalents (Briscoe, 2003). Pragmatists were those who chose to work as an employee of an organization because of job security and the freedom associated with not having to deal with managing a small business as well as providing patient care. Balancers were those who specifically focused on defined workload and schedule predictability as well as adequate time to pursue other interests, even though work-life balance was deemed important to most physicians surveyed. Advancers were those who were interested in status, advancement, and administrative and leadership positions. Members of this group saw working for an organization as a way to attain those career goals. Finally, ambivalents demonstrated a high level of organizational ambivalence. Basically, the organization was just a place where they happened to be practicing medicine at the time of the survey. Ambivalents were not interested in organizational advancement though they were not necessarily negative toward the organization. Instead they perceived their employment with the organization “with a healthy dose of cynicism regarding whose interests are being served” (Briscoe, 2003, p. 116).

Women had stronger representation in the balancer category, while men had a stronger representation in the advancer category. Also, women held significantly higher representation in the ambivalent category, specifically unmarried physicians. The researcher speculated that it seemed as though many unmarried female physicians surveyed and interviewed saw their current position as a holding environment or
temporary space until they started their real lives. A final significant finding was that physicians with children demonstrated a stronger commitment to the organization than those without children. This suggests that the financial obligations associated with parenthood helped them appreciate the economic stability that existed for them as employees. Briscoe (2003) concluded that despite the perceived loss of autonomy, physicians employed by organizations experienced higher life control because the organization buffered them from the responsibilities associated with private practice. The empirical literature regarding physician satisfaction mirrors these findings. (for example: Chehab, E.L., et al., 2001; Huetson, W.J., 1998; Freeborn, D.K., Hooker, R.S. & Pope, C.R., 2002).

Since the trend toward physicians being employed by organizations is continuing, and may even be beneficial for new physicians, issues and concerns that were not pertinent to the profession less than twenty years ago need to be addressed. Physicians are now members of business organizations. They work in organizational cultures, and some take on managerial roles. All are expected, to varying degrees, to be organizational citizens and follow the written and unwritten codes and beliefs of the organization.

While all of these factors create a very different practice and employment environment, physician education and training is astonishingly the same as it was for many years (Apker & Eggly, 2004). There are forces moving toward curriculum change (Finucane, Allery, & Hayes, 1995; Woolliscroft, 2002). One recent change is the institution of six general competencies required by the Accreditation Council for Graduate Medical Education (ACGME) which occurred in 2006 and is continually being reevaluated in the medical education community.
The new ACGME requirements not only expect residency programs to facilitate the mastery of the competencies, but data-driven and measured improvements consistent with the movement toward evidence based medicine (EBE) are also expected (Derstine, 2006). The competencies that residents must master before graduation are: (1) Patient care – The demonstrated ability to provide compassionate appropriate care for the treatment of health problems and general health promotion; (2) Medical knowledge – The demonstration and application of established and evolving biomedical clinical, epidemiological and social-behavioral science knowledge; (3) Practice-based Learning and Improvement (PBL) – The demonstrated ability to self-evaluate and engage in learning and self-improvement while incorporating quality improvement into everyday practice; (4) Interpersonal and communication skills – The ability to communicate with and relate to peers, allied health professionals, and patients from a broad range of socioeconomic and cultural backgrounds along with keeping comprehensive medical records; (5) Professionalism – The demonstrated ability to display compassion, integrity, respect, responsiveness to patients, respect for privacy, personal and professional accountability, and sensitivity to diverse populations; (6) Systems-based practice - demonstrated awareness and responsiveness to the larger context and system of health care, such as being aware of organizational parameters, cost awareness and risk-benefit analysis and ability to identify system errors (ACGME Common Program Requirements, 2007).

Because training programs that facilitate the development of these competencies are only beginning to surface, it will be some time before they have an impact on graduating residents. A review of the literature since the competencies have gone into
effect indicates that residencies are working to implement the competencies and include reflection (Leach, 2006), journal writing (Cayley, Schilling & Suechting, 2007), journal clubs (Lee, 2006) and various screening and evaluation techniques for assessing the potential of incoming residents (for example, Metro & Talarico, 2006, Bandiera, 2006).

An issue that has been empirically addressed is the subjectivity of evaluation of skills such as communication and professionalism. Haurani, et al., (2007) found that a halo effect occurred with more affable residents and this resulted in higher evaluations in their technical competencies as well. The competencies focus on professional development, but there is no mention to the personal issues and growth important in developing physicians nor is there any discussion of career counseling to prepare physicians for entering practice and the healthcare marketplace.

When new physicians begin their careers as physicians in organizations, not only are they moving out of the safety and security of the training environment of residency, they are entering organizations where they are expected to learn the organization’s culture, values, written and unwritten rules. The next section reviews the literature on organizational socialization, the process in which employees learn how to work and live in an organization, and the relationships between physicians and organizations.

Professionals and Organizations

Understanding the relationships between organizations and individuals has been an area of interest for scholars since early civilization. Contemporary studies on the topic date back to the classic work of Chris Argyris (1957), entitled *Personality and Organization* (Porter, 1996). How employees enter and acclimate to an organization is an important aspect of organization life. Interestingly, the magnitude of the
organizational entry experience is often not recognized by organizations or the individuals they employ (Holton & Russell, 1997).

**Organizational Socialization**

Social science scholars often use the term *organizational socialization* when discussing the process by which individuals become acclimated to the organization. Organizational socialization is consistently defined as the process in which organizations perpetuate their culture by instilling values, beliefs, and work processes in new employees (Anakwe & Greenhaus, 1999). It is evident that the first few months in a new organization are a time of tremendous learning and development for individuals (Ashforth & Saks, 1996). Unfortunately, prior to 1990 the organizational socialization literature was described as being “theoretically sophisticated and empirically underdeveloped” (Saks & Ashforth, 1997, p. 235). Despite the lack of research on the topic, organizations recognize the importance of employees taking on the values and beliefs of the organization. Popular management literature consistently points to the importance of value congruency between the organization and those who comprise the organization (employees) (Covey, 1999; Senge, 1990; Wilson & Wilson, 1998). This sentiment is articulated in the scholarly literature as well (Ashforth & Saks, 1998; Holton, 2000).

Fogarty and Dirsmith (2001) argue that socialization should be studied through an institutional theory lens. Institutional theorists argue that there is a separation between the institutionally espoused values and practices and the values and practices that are used on a day to day basis in the actual work environment (Fogarty & Dirsmith, 2001). These authors contend that three factors influencing the process should be investigated.
These factors are normative forces (often those associated with the norms of a specific profession), coercive forces (financial and status rewards) and mimetic forces (social modeling). Currently, there is no empirical support for using institutional theory to understand organizational socialization, but studying the context in which socialization occurs from multiple perspectives may produce a depth of understanding not evident in the current literature. This is especially true when studying professionals who often are versed in the espoused values of the profession whether or not they are internalized. Also, framing the socialization process in this way allows researchers the opportunity to recognize the influence of outside factors, such as prior professional socialization, on the organizational socialization process.

**Professionals and Organizational Socialization**

The implicit objective of organizational socialization is that the person entering the organization becomes a highly functioning part of the organizational whole (Holton, 1996). Even so, dependent upon the organizational culture, there is a varying range of expected behavioral conformity. Early empirical research on organizational socialization focused on the effectiveness of the tactics employed by organizations to assimilate employees (Saks & Ashforth, 1997), but there is an element of the socialization process which is reflective of the individual. For example, the level of behavioral conformity for those entering the armed forces is usually quite high and the individuals who enter those organizations experience an intense early socialization process. This was not the case of Riddick Bowe, a successful professional boxer who enlisted in the Marines. The socialization process that worked so well with young recruits was unsuccessful with him.
He developed values through prior life experiences that actually incited resistance to the Marine’s socialization process (Baker & Jennings, 2000).

On the other side of the scale, in organizations that encourage individualism, that norm can become institutionalized and part of the culture. Then individualism is no longer individual choice but an expectation (Goethe, 2004; Honneth, 2004). This makes sustaining self-realization within organizations very difficult, which was evidenced in the way that Microsoft had to recruit outsiders and house them in a separate location in order to keep their creative edge. Known in its early days for being a humanistic, employee-centered, creativity-focused organization, the organization grew into a large company steeped in tradition and beliefs. The socialization of norms and values became so strong that to develop the newest gaming products, the employees involved in the project had to sever ties with the organization in order to not have the culture constrain their thinking (Grossman, 2005).

This is how values, beliefs, and cultures become so entrenched in organizations (Fogarty & Dirsmith, 2001), but it also is how values and beliefs become entrenched in professions. Entering into a pluralistic organization and being socialized to the organizational values and belief systems may influence how physicians perceive and interpret their profession and how they identify with their role as an employed professional. Socializing professionals into an organization is more of an integration of two organizations (the profession and the organization) than it is the individual’s assimilation into the organization (Bunderson, 2001). Therefore individual (or professional) belief systems, knowledge, and identity are influenced by the community’s
collective identity, belief systems, and knowledge (Lave & Wenger, 1991; Wenger, 1998; Wenger et al., 2002) and the community is influenced by the profession.

Professional Employees

As described in the discussion of the physician as worker paradigm, “The traditional ideal in which professionals alone or in small groups serve their patients and clients in accord with a public-spirited goal has moved more toward practices in which professionals serve in organizations that value mainly their expertise and expect them to act in accord with the organization’s goals” (Thompson, 2005, p. 274). The trend toward professionals, specifically physicians, becoming employees of organizations means that they need to follow organizational rules and work toward organizational goals that are decided by someone else, probably someone from outside of the profession.

This can present physicians with a variety of ethical and professional dilemmas tied to both representation and authority. First, to whom or what is the physician loyal—the patients, personal ethics and morals, or the ethics and morals of the employing organization? Second, who does the physician represent when acting for the institution? Does the physician’s level of professional expertise provide a position to influence the organization or does the physician become so bound to the organizational goals that the professional identity held is tied more to the organization than it is to the profession? Third, who holds the ultimate authority to make the final decision? Thompson (2005) explains that “some division of moral labor is necessary in any complex institution. The doctor at the bedside should not have cost containment uppermost in his[her] mind, and the CEO of the HMO (even if he/she is a doctor) cannot give absolute priority to the individual welfare of each patient” (p. 275).
As mentioned previously, there is concern that as more physicians become employees, medicine is becoming deprofessionalized and the profession is becoming a trade (Ellis, 2004). But what does this mean? In general, physicians working for organizations are reported to have higher professional satisfaction (Freeborn, 2001; Freeborn, Hooker, & Pope, 2002), increased career opportunities (Sturm, 2002), and less difficulty balancing their life with work (Briscoe, 2003). The issues that create dissatisfaction such as lack of control, not enough time with patients, and increased volume of patients are attributed to external factors such as insurance companies (Grembowski et al., 2005; Jin, 2005).

This in part may be due to the type of organizations in which physicians are working. There are different types of organizational structures that support or reinforce organizational goals. Burns and Stalker (1994) theorize that organizations have different forms to fit their organizational needs, values and expectations. They theorize that organizations fall on a continuum between *mechanistic organization* which features a rigid structure, horizontal chain of command and bureaucratic organization; and *organic organization* which features more of a networked organization with a vertical organizational structure and less formalized rules and routines. In healthcare an example of a mechanistic organization would be a large university health system and a more organic structure would be a small office or limited partnership. It is possible that physicians’ offices, even if they are in large organizations, do not take on the attributes of large bureaucratic structures, but instead feel like smaller practices without the frustrations associated with running a small business.
While there is debate as to the direction of the medical profession, it appears, at least on the surface, that younger physicians are content with positions that allow them to pursue multiple interests and not be consumed by work. These findings reflect what has been discussed in the literature regarding Generation X employees, those born in the mid-1960’s to late 1970’s, in the workforce at large. Since this is the age cohort of most of the participants in this study, and the themes of the physician as worker literature seem to reflect those of the Gen X literature, it is important to briefly discuss the literature regarding this age cohort and their relationship to work.

*Generation X Employees*

Generation X is the name given to the generation, born in the mid-1960s to the late 1970s, which followed the baby boomers. Gen Xers received a fair amount of media attention in the mid to late 1990’s as they were leaving college and entering the job market. This group has been stereotyped as being very individualistic, self-serving and unmotivated, especially when it comes to going the extra mile for a work organization (Straus & Howe, 1991, 1993). Other commonly held beliefs about this age cohort are that they are less likely to put work ahead of family and friends and are more likely to leave positions when they feel they are not challenged (Hall, 2001; Karp, Fuller, & Sirias, 2003; Zemke, Raines, & Filipczak, 2000). McDonald and Hite (2008) argue that much of the information that has significantly influenced how this cohort of adults think, feel and act, especially when it comes to work is a result of the popular press, presentations and workshops, not empirical research. Interestingly, an empirical study conducted by McDonald and Hite (2008) supported the following themes found in a review of the previous literature.
Three main issues surfaced in the empirical literature on differences between Gen Xers and other generations with regard to work. These issues are tied to deeply held, often tacit, values, beliefs, and identity. The first difference with this generation and preceding generations is that of career identity. The second is the need and desire for work-life balance. The final is the ideal of organizational commitment.

**Career Identity.** For the past decade college graduates have been counseled that they will probably change careers six to eight times over the course of their life time (Pelsma & Arnett, 2002). This theme is beginning to surface in the literature regarding physicians as well, as many baby boomer physicians are opting for early retirement and the pursuit of a second career (Schofield & Beard, 2005; Haig, 2007). Concepts such as McJob, a term that became a popular description of a job that covers the bills until one with meaning can be found (Coupland, 1991), along with casual dress codes, and casual work attitudes are often attributed to Generation X employees in the workplace. It first was presented in the popular press as a bothersome change in the culture of work, but now scholars are arguing that these attitudes are responses to changes in the psychological contracts between employer and employee that affect employees of all ages (Tulgan, 2004).

**Work Life Balance.** One of the strongest themes in the literature regarding Generation X and work is that work-life balance is very important; this age cohort does not live to work but works to live (Moen & Roehling, 2005). This has been attributed to a number of factors ranging from this generation being raised as “latch key kids” (Straus & Howe, 1993) to increased household and family demands as a result of dual-career families (Catalyst, 2001). Work-life balance greatly affects beginning physicians as more women
enter the profession that was dominated by males (Briscoe, 2003). The literature specifically focused on physicians and work-life balance will be presented in more depth in a subsequent section.

Organizational Commitment. Both the theoretical and empirical literature suggests that the members of the Generation X cohort value individuality (Arnett, 2000; Karp et al., 2003). As a result, Generation X employees tend to be more committed to the actual work or project and less concerned with organizational identification or even professional identification (Mir & Mosca, 2002). Employees in the 21st Century tend to be committed to increasing their individual knowledge and skills to remain attractive to employers in a volatile job market (Melchionno, 1999). There is an implicit agreement between employees and employers that the psychological contract assuring long term employment in exchange for commitment no longer exists (Pink, 2001). This is being witnessed in the medical profession where organizations may displace physicians due to downsizing and physicians find themselves unemployed (Loyttyniemi, 2001). Ironically, while the number of people in the general workforce who decide to be self-employed and market their skills as service professionals is on the rise, the opposite is occurring with physicians.

Physician Identity in Organizations

Both the theoretical and empirical explanations of the relationship between the professional and organizational identities of “employee-physicians” can be categorized into three themes: professional versus organizational identity salience, organizational connections to the profession, and managing multiple identities. Because this study focuses on primary care physicians who predominantly work in office based practices,
the majority of this literature in this review is based specifically on these specialties. It should be recognized that different technical and social environments associated with other physician groups may produce different identities (Kumpusalo et al., 1994).

Professional versus Organizational Identity

The complex relationship between the professional roles of physicians and the administrative roles of both the organization as a whole and the professionals employed by organizations is recognized in the literature as problematic (Bunderson, 2001). This is especially true when physicians are making patient care decisions such as referrals. Do they refer to someone within the organization or to someone outside of the organization that they believe to be more capable? Do they utilize the organization’s diagnostic facilities or allow the patient to go to the most convenient diagnostic center? When having to make a choice between the interests of the patient, interest of the profession or self-interest, what do physicians choose? The answers to these questions depend upon a variety of factors. Medical ethicists argue that the health care workers (physicians, nurses, etc.) have professional codes of ethics and personal ethical standards that need to guide their decision making in such matters (The Park Ridge Center for Health, 2002), but the empirical literature suggests that multiple factors influence these decisions.

The first factor identified in the literature as influencing professional decision making is with which group does the decision maker identify: the profession or the organization? This was especially true when physicians moved into leadership and administrative roles. Those who identified with the profession tended to see their role as the spokespeople for the working physician and sometimes the patient to the organization; those who identified with the organization saw their role as the
spokesperson for the organization to the physician workers (Hallier & Forbes, 2005; Hoff, 1999). One of the most significant reasons that a physician identifies with the organization is that his or her career goals are organizationally driven (Briscoe, 2003; Hoff, 1999). Whether or not the tendency to orient with the organization is what drives the career goals or vice versa is not clear in the literature, but it is clear that career and leadership focused physicians tend to be men, educated in some of the best medical schools in the country (Briscoe, 2003; Hoff, 1997). Other reasons, suggested in the empirical literature, that a physician may identify more strongly with the organization than the profession are: the external image and perceived attractiveness of being an organizational member, the level to which the physician is actively involved in the organization, and the level of cooperative behavior the physician displayed in the workplace (Dukerich, Golden, & Shortell, 2002).

The second factor influencing the relationship between physicians and organizations is from the individual physician’s expectations of the organization. The relationship between an employee and the employing organization is said to be guided by a psychological contract which is an unwritten set of rules of behavior and reciprocity. A study of psychological contracts of physicians and their employing organizations found that physicians’ reactions to administrative breaches of the psychological contract (the employer not living up to its business obligations to the physician) elicit more discontentment and turnover than when the breach is professional (the employer not providing the professional environment necessary for practice). It should be noted that both administrative and professional breaches reduced employee satisfaction, increased employee frustration and decreased employee productivity (Bunderson, 2001). Other
studies suggest that the psychological contract between the physicians and the organization is dependent upon whether or not the physicians perceive that they are being treated fairly (this includes being compensated fairly) (Hueston, 1998), the level of freedom that exists to practice medicine as they desire (Freeborn, 2001; Hueston, 1998; Warren, Weitz, & Kulíš, 1998), and whether they perceive that they can provide quality care for patients within the constraints of the organization (Chehab et al., 2001).

A third factor that influences the relationship between physicians and the organization and to what extent they identify with the profession or organization is the physicians’ ability to enact their individual agency and personal experiences (Dukerich et al., 2002; Hoff, 2003). If employee-physicians enter the employment relationship with a positive attitude and believing that they do have agency, the ability to make choices and have control over their lives, they tend to have a more positive view of their work and be more willing to support the organization. In the same respect, this agency may be a detriment at times for the organization. This same study that identified agency as a positive factor for physician-organization relationships also recognized that having this agency results in physicians often not recognizing organizational goals and objectives and not adapting, or adapting slowly, to organizational change even when they are not actively resistent (Hoff, 2003).

Managing Multiple Aspects of Life

Most of the literature on organizational commitment, organizational identity, and organizational citizenship does not address the issue that employees have lives outside of the organization that may directly interfere or compete with the needs and goals of the organization. This absence is evident in the literature regarding physicians. Most of the
literature that recognizes multiple competing interests is situated in the work life balance literature (Bartley, 2005; Gibson, 2005) or literature which looks at the relationship of social identities, such as race and gender, with professional identities (Settles, 2001).

The empirical research suggests that physicians do recognize the influences of the multiple demands on their lives at various levels and as a result, manage their careers in many ways. In a qualitative study of how male and female physicians manage the demands of the organization, the profession and family life, three distinct processes emerged: *Career dominant physicians*, those who put their career identity above all others to the extent that they did not have any interests outside of the profession. *Segregators* were those physicians that had families and or interests outside of medicine, but managed their outside lives around their careers. The final group identified in the study was the *accommodators*. These physicians managed their careers around their other identities, which often meant working reduced hours and taking more time off (Dumelow, Littlejohns, & Griffiths, 2000).

Another investigation found that physicians manage their multiple roles in a variety of ways, but a distinguishing factor was whether they were influenced and driven by external factors (those factors external to the profession) or internal factors (those associated with the practice of medicine) (Real, 2002). Within these categories were multiple perspectives on the profession. For example, the group of externally focused physicians tended to recognize how influences such as time pressures, economic changes, family expectations, malpractice, and so forth, influenced their identity both as a physician and as a person. Many of the physicians that Real (2002) categorized as having “external identities” clearly expressed that they have multiple priorities outside of
medicine. Yet, they did not manage their lives in the same way, with some taking a positive, proactive perspective, and others taking on the role of a victim controlled by outside forces.

There also were multiple ways in which those categorized as having “internal identities” managed their identities. The physicians who fell into this category tended to be driven by work relationships both with patients and the practice or employing organization. When interviewed, this group of physicians recognized either no or only one external influence on their lives. They did not see themselves as having multiple demands on their lives, though many of them had families, children, and many outside interests. The key element of their identity was their profession. They gained personal meaning and satisfaction through patient interaction and bonds with patients. With their profession meaning so much to them, some of these physicians reported being disillusioned, having high levels of frustration when patients did not follow their recommendations, personally attacked by the threat of malpractice, and highly motivated by the satisfaction of patient care (Real, 2002).

These studies suggest that the manner in which physicians manage their multiple aspects of their lives and the demands that go along with them may be as diverse as the identities they possess and roles they play. There are a plethora of factors that influence how individuals, and specifically physicians, manage their lives. Also, what may work at one point in their life or career may be very different just a few years later. An interesting aspect of Real’s (2002) study was the influence of memorable messages on physician’s identities. These messages may have been heard in medical school, residency
or practice, but they had a lasting impact on how physicians perceived their profession and their understanding of self.

*Work-Life Balance of Physicians*

The literature regarding work-life balance issues for physicians recognizes that many of today’s doctors are seeking to have balanced lives. The standard is no longer that medicine is above everything else (Laster, 1996). Though the ideal of work life balance is compelling, and our society and work have changed dramatically over the past 50 years, the idea of career success has not changed (Moen & Roehling, 2005). Most of the books related to career growth and management still emphasize the importance of positive work attitudes, drive and commitment as important for success (Buckingham & Coffman, 1999), which translates to putting work first. This is especially true of physicians who have been entrenched in a “medicine above all culture” from the time they entered medical school (Gerber, 1983).

*Changing Demographics of the Workplace*

With over 80% of U.S. women currently in the paid labor force and nearly all women being employed outside the home at some point in their lives, there no longer is the “spouse at home” which allows the “spouse at work” to devote most of his or her time and energy to work. Also, many younger workers are choosing not to marry or to marry much later in life. Singles are trying to manage it by themselves, and married or partnered workers are both trying to have successful careers without home support. Thus, the concept of work-life balance and work motivation may be more an issue related to societal change and the increased necessity of both genders having to juggle the
responsibilities of the home domain than it is related to internal attitudes and preferences (Moen & Roehling, 2005).

These trends are especially noticeable in medicine which, as recently as 1970, was dominated by white males (Starr, 1982). With the changing demographics in the profession came changing priorities, such as the importance of work-life balance. But as briefly discussed in the section of this literature review on the concept of physician as worker, this is creating dissonance in the field. Similar to the general workplace, more experienced baby boomer physicians, who are often in charge, hold the traditional values of the profession, and specifically the belief that younger employees need to display commitment and pay their dues. Here is an example of events occurring when recruiting physicians:

A solo physician in his 50s hired a new physician. The solo physician planned to slow down, cut his schedule and eventually make the new physician a partner…[the new physician] hadn’t planned on working that hard. She wanted a schedule like the solo physician’s. They clashed and within six months she left.” (Capko, 2000¶ 2).

Another example provided by Capko (2000) is the story of a highly skilled male physician who graduated at the top of his class. Due to his family’s unhappiness with the geographical location, he left a dream position. These behaviors are often incomprehensible to established physicians who were professionally socialized in a different era.
Work-life Balance and Gender

In order to deal with the demands of family life, women are still more likely than men to put career behind family and men vice versa, though this may be changing slightly with women focusing more on career (Greene & DeBacker, 2004). Societal norms propagate this to the extent that men believe that they will be penalized for taking time off from work for familial commitments (Levine, 2000), and both women and men are hesitant to take advantage of work life programs in fear of not being perceived as serious about their career (Gibson, 2005). Research also indicates that many women with college degrees are willing to accept lower paying, gender stereotypical jobs (such as waitresses, checkout clerks and domestic work) in order to have flexible hours and time for family demands (Arbona, 2000) or chose part-time work risking being perceived as not serious about their career (Akande, 1994; Glass, 2004; Rogier & Padgett, 2004). Men, on the other hand, are discouraged from taking paternity leave, time off to deal with family responsibilities, and part-time work. This culture does not support an egalitarian family life which puts a tremendous strain on families and especially women’s careers (Levine, 2000).

This is exacerbated for female physicians who are at risk of not being taken seriously if they opt to work less hours or part-time, but still have most of the responsibilities at home and, similar to the research on women in the general workforce, tend to sacrifice career for family (Hinze, 2000), especially in a two physician families. Research indicates that women in medicine work fewer hours than male physicians (Hawkins, 2005; Hinze, 2000) and are more relationship oriented with patients resulting in longer patient visits and less patient visits per day (Kumpusalo et al., 1994). In
addition, women are affected to a much larger degree by family to work spillover, or when family demands interfere with work responsibilities (Keene & Reynolds, 2005). As a result, female physicians tend to make less money and are often perceived as less career minded than male physicians.

Medicine tends to be inflexible and driven by schedules that cannot be easily altered. It is very difficult to cancel a day of patients at the last minute without frustrating the medical staff and patients. Research suggests that factors that limit both family to work spillover and psychological distress are not the number of hours worked but the flexibility of those hours (Gareis & Barnett, 2002; Keene & Reynolds, 2005). Unfortunately, that type of flexibility is not very common in medicine. Another interesting finding in the work-life balance literature regarding physicians is that single female physicians’ salaries are comparable to male physicians’ salaries while the salaries of female physicians with children drop to below 60% of the average male physician’s salary (Mennino & Brayfield, 2002). Also, male physicians who are married to physicians have lower salaries and work less hours than male physicians with stay-at-home spouses (Mennino & Brayfield, 2002). This suggests that even with over half of medical school applicants being women and women constituting over fifty percent of primary care physicians, the work norms and cultures of are changing slowly.

Physicians’ Expectations of Work-Life Balance

What is changing is how individual physicians deal with work-life balance and what future physicians expect. Prior to entering the field, medical students are discussing the importance of work life balance, how family and lifestyle will affect their career decisions, the need for time away from medicine and limited work hours (Tolhurst &
Stewart, 2004).  In general, younger men (those often referred to as Gen Xers) are more likely than men in previous age cohorts to adjust work schedules for family responsibilities while still maintaining their self-esteem (Carr, 2002).  Part-time medical practice is becoming more accepted for both men and women who want more balance to their lives (Maresh, 2004); this is especially true for salaried physicians working in large groups or for organizations that can provide substitute coverage and flexible scheduling.

There is a significant body of research regarding dual physician couples and the effect of dual physician marriages/partnerships (Kermode-Scott, 2004; Myers, 1994; Schrager, Kolan & Dottl, 2007); the effects of work-family interference on physicians (Montgomery, Panagopolou, & Benos, 2006); and general dual-career family work-life balance (for example: Bird & Schnurman-Crook, 2005, Hochschild 1989, 2001).  All of these bodies of research suggest that life outside of medicine or work in general does have an effect on individuals’ performance and satisfaction with a job.  Empirical research suggests that this added dimension of family life puts strain on the physician and it ultimately affects the physician’s performance and focus on the job (Kermode-Scott, 2004; Montgomery, et al., 2006).

While the tides are changing, they are changing slowly.  Still following the sage advice of Osler, known as the father of medicine and medical education in the United States, “heavy as are your responsibilities to those nearest and dearest, they are outweighed by the responsibilities to yourself, to the profession and to the public” (Dumelow et al., 2000, p.1437), both the medical profession and hospitals are steeped in a culture that does not accommodate for families or life outside of work creating
tremendous stress for physicians and their families (Gerber, 1983; Hinze, 2000; Meyers, 1994).

How progressive an organization is in terms of work life balance is often dependent upon the organizational leadership (Chalofsky & Griffin, 2005), and as mentioned previously, most medical practices are heavily influenced by the prior generation of physicians who still live by Osler’s motto and have never experienced the family demands faced by this generation of physicians. This was evidenced in Real’s (2002) study regarding managing multiple identities. Though he did not make a generational connection in his conclusions, he mentioned that the majority of the physicians in his study that were internally focused and content had been practicing for 14-17 years, which in most cases would place them in the baby boomer category. This group of physicians reported that they are not affected by outside influences such as family demands, and they were strongly motivated and committed to the relational aspects of their work both with patients and the organization. Those with less tenure were more focused on being good practicing physicians and maintaining skills, rarely mentioning the relational aspect of the profession. This group often discussed the importance of endeavors and interests outside of medicine.

Similar to the literature reviewed previously about Generation Xers, and the literature reflecting the trend toward physicians as workers, the work-life balance literature suggests that beginning physicians are less likely to put their profession above all else. Also, they more likely to make decisions to work less hours in order to have a fulfilling life outside of work or to provide opportunities for their partners to be involved in career pursuits. While this is clearly the expectation, meeting that expectation may be
difficult, especially in medical institutions that have strong professional cultures. When reviewing the literature regarding work life balance for physicians, certain unanswered questions emerge such as: Has medicine become a good white collar job versus a calling? Does having a calling mean that a professional needs to be unidimensionally committed to his/her profession or can an individual be called to a profession and live a balanced life? Is the need for work-life balance the same throughout the life course or is there an ebb and flow during different phases of adult development?

The next section of this review discusses the developmental process of becoming a physician. There are a number of milestones that individuals experience on the road to becoming a residency trained, board certified physician. As mentioned previously in this review, though there is a movement toward competency based education in residency, medical school and residency training have not changed much since the early 1900’s (Apker & Eggly, 2004; Pellegrini, Warshaw, & Debas, 2004). Aspiring physicians usually begin the journey as an undergraduate, competing for high grades and opportunities to shine in order to get into medical school. Once they are accepted, they begin medical school with two years of intense classes and two years of clinical experience. At the end of medical school, they attain the title of Doctor but move quickly into the role as an intern. Finally, they move through residency learning their specialty and leave their training programs to begin their first position. For many the journey began in high school or early in their college career when they decided they wanted to be a doctor—twelve years later they begin their careers. While individuals are being trained as physicians, they also are developing as adults. This section summarizes the
themes in the stories of how individuals develop personally and professionally as they learn to be doctors.

Becoming a Physician

Pories (2006), a physician and medical school professor at Harvard, shares that there is a rich tradition in medicine of novels and memoirs about medical training and the experiences of physicians, but unfortunately this is rarely incorporated into medical curricula. In this section I review the themes of many of these literary works to illustrate what we learn about the medical profession through the eyes of those who live it every day. A host of books and sociological studies have been written that present the culture and experiences of medical education and training. When looking at these studies and stories of medical school and residency a developmental theme begins to emerge. Since this study is a narrative inquiry of physicians’ experiences as they begin their careers, this portion of the literature review also serves as a reminder of what can be learned from personal narratives.

_The Experience of Medical School_

Most students entering medical school have little expectation or anticipation of what it will be like. Getting accepted to medical school often is an _ends_ rather than a _means_ at that point in their life, but when retrospectively asked about the experience physicians consistently say it was awful (Takakuwa, Rubashskin, & Herzig, 2004). Most medical students enter school with a basic science background and the expectation that they will leave as doctors. The process of socialization in medical school has been studied by sociologists. _Boys in White_ (Becker, Geer, Hughes, & Straus, 1961) is probably the best known study of the medical school experience. The medical school
culture is very similar to we see today (Beagan, 2001). This description of medical students from 1961 book is a good example:

Young people who are—physically and in most social respects—fully adult. They may be married and have children; they may have served in the armed services; and they may have worked at various jobs...Yet in their chosen professions, they still have ahead of them a long period of a sort of adolescence during which they are asked to show adult competence and learning, without being given full adult responsibility. (Becker, et al., 1961, p. 5)

The theoretical and empirical literature explaining the socialization process of medical school recognizes certain developmental steps or common experiences of medical students that change their thinking and their identities (Beagan, 2001; Becker et al., 1961; Mizrahi, 1986). These studies rely on short retrospective interviews or surveys which provide valuable information for understanding the socialization process. Consistent themes were: learning the language of medicine; learning a professional persona and how to present oneself as a physician to both colleagues and patients; relating to patients and normalizing physical contact; letting go of an old identity and claiming a new one. While this is important information for educators and future medical students to learn and understand, it seems quite impersonal and homogeneous. As the demographics of the medical profession become increasingly diverse, a more personal understanding is needed.

One way to gain this understanding is through reading about the experience of medical school in the stories of those who experienced it, and there are many. Some are retrospective accounts and some are published journals of the medical students as they
experience their learning; they all are valuable resources for understanding the professional development of medical students. When I analyzed the various stories presented by medical students, themes emerged. These studies provided deeper descriptions of the development which occurred in medical school; they gave those who are traditionally unrecognized a voice; they illuminated the interrelationship between personal and professional development; and they illuminated the individualistic nature of medical school. Following are detailed descriptions of how these themes surfaced in the literature.

Reading the actual accounts and experiences of medical students provides more than just a cognitive understanding of the experience, it goes much deeper. Hearing the experience as told by the medical student gives it new meaning. For example, the literature consistently reports that transition from the classroom during the first two years of medical school into the clinical setting during the third year, is a defining moment in most medical students’ careers. While that provides the reader with an awareness of the importance of the experience, hearing it from the perspective of the student may sound like this:

The process of identification with them [referring to the house officer, or resident physician responsible for training medical students] takes over the soul of the student not merely because what they can do is so prodigiously impressive, but because the immediate goal is not to become a physician in some general sense, but to become a house officer and to master as quickly as possible their strategies for survival under the inhuman regimes to which house officers are subjected and subject themselves. (Konner, 1987, p. xiii)
This description presents a different picture, one of short term survival rather than long term professionalism, thus providing a deeper understanding of the socialization process and the emotional aspects of it as well.

The biographical literature presenting the actual stories of medical students is important in the understanding of the physician’s development and socialization process. It gives those who are traditionally underrepresented a voice. As mentioned quite a few times in this literature review, many of the current norms and values of the medical profession have been based upon the archetypical physician of the 1950s to 1970s. These physicians were predominantly upper middle class white males (Starr, 1982; Takakuwa et al., 2004). As the profession becomes more diverse, it is important that the socialization experiences of this diverse population be understood. For example, one of the themes of the literature on the socialization process of medical students was that they learn how to present themselves as physicians, but the manner in which a white man, a woman, or a person of color may do this are very different. The white male does not have to worry about patients and colleagues attaching gendered, racial, or ethnic stereotypes to his professional identity. These issues make the identity management process for people of color more complex than how it is described in the dominant literature (Morgan, 2002).

In a collection of narratives of medical students from various backgrounds ranging from a Black woman who was a teenage mother to a Vietnamese boat refugee; or from a recovering alcoholic, to individuals dealing with mental or chronic illness; Takakuwa, Rubashkin, and Herzig (2004) attempt to portray the uniqueness of individuals in the medical profession rather than paint a homogeneous picture of professional identity. When finding themes to organize the stories, these editors found
that the themes of the individuals’ stories emphasized their diversity not the sameness as was seen in the sociological studies of the 1960s. They were based upon the medical students’ backgrounds more than their common experiences in medical school or characteristics of the profession that they were attaining, which is how many sociological studies are organized. Another book of medical student stories focused on events that changed the students’ perspective on life, medicine and their role in the world (Pories, Jain and Harper, 2006). The very well publicized memoirs of Danielle Ofri’s learning to be a doctor at Bellevue Hospital in New York City provide an intimate portrait of the complex issues with which she grappled during her time as a medical student (Ofri, 2003).

Another theme of this literature is that personal development and professional development are intertwined in the medical students’ stories. This is not how these issues are studied in the empirical literature on professional socialization or medical school training. The narratives of medical students include their personal struggles as well as their professional learning. Many times the stories are a result of the struggle to understand how the experiences of medical school are shaping their lives as individuals (Konner, 1987).

How the personal and professional threads are woven together can be seen vividly in the story of Linda, a recovering alcoholic. The difficult experiences of her past (sexual abuse and alcoholism) are intertwined in her professional development as a physician. Initially, she tried to hide her involvement in alcoholics anonymous while in medical school but later realizes that it is part of who she is, stating: “I don’t believe that medical school is more difficult for sober alcoholics than it is for anyone else. In some ways, it
might be easier. With everything I’ve been through, the opportunity to do work I love is a gift, not a burden” (Palafox, 2004, p. 86).

A final theme from my reading of the medical students’ stories is that they describe their lives as lived alone. It is not that they do not have social experiences or exposure to others. Some were married and had families, but they were making sense of their worlds in a very individualistic manner. Their stories are very individualistic; they portray medical students as “in limbo.” They clearly suggest that many medical students, even though they are in their mid-20s, and often older, have received a college degree, and may have children and significant others, often do not consider themselves adults because they are entrenched in a training environment that is all consuming and they are never exactly sure what is next (Laster, 1996). Thus, while they are developing professionally and personally, they often do not see it until years later when they reflected upon the experience.

*The Residency Experience*

Similar to the literature regarding medical school, how professional values and identities are shaped during residency training has not changed much in the last century. The hierarchical power structures of residency programs reinforce the traditional biomedical model and discourage dissenting voice (Apker & Eggly, 2004). While the socialization processes remain the same, certain aspects of residency have changed. In 2003, the American Council for Graduate Medical Education (ACGME) limited the residents’ work week to 80 hours per week. Programs that did not uphold the standard were subject to significant penalties. Another factor influencing residency programs is advancing technology. Information is available to patients and physicians just by turning
on a PDA (Pellegrini et al., 2004). Finally, the ACGME competencies that have been initiated in residency programs across the country are having some effect on residency programs, but it still is too early to be evaluated.

The milestone of medical school graduation officially awards the title of “Doctor” but the title is not internalized when new physicians show up for their internship year beginning in early July. It takes awhile to get used to the title and the responsibility that goes along with it, but physicians do not have that kind of time. They begin their internships full steam ahead. Describing her first day as an intern, Emily Transue (2004), shares this experience:

I had woken up that morning having never seen a death, and by lunchtime I had been part of one. Nothing in medical school or in life had prepared me for that moment. Amid the jumble of predictable emotions—sadness, fear, confusion, a certain excitement—I felt wrenchingly and terribly alone. (p.1)

She goes on to explain that this experience began her socialization process into the medical profession, but it also disconnected her from those she cared for and was closest to because they lived outside of the profession.

The stories of interns and residents provide similar depth of understanding as the stories of medical students do, but it seems that the tone and purpose of the stories are a bit different. Unlike the narratives of medical students, which were often focused on their individual meaning making and how they were understanding their experiences, the interns and residents shared their stories so that others could understand their experiences. Robert Marion (1989), author of *Intern Blues* stated that reading his book may scare a future physician. His purpose in communicating his experiences was so his
parents could understand his world. He suggests that family members of future interns should read his book because “that is the only way they will truly understand what hell their loved ones’ life is likely to become” (p. xvi). Similarly, Transue (2004), after the experience mentioned previously, began to write her experiences so that her family members could relate to her life. At this point they had survived medical school and they wanted to connect with the outside world and share their experiences of suffering.

The themes of the stories of interns and residents are different as well. First, they seem to move from the ideal to the real. They go from wanting to help patients to learning how to get rid of undesirable patients (referred to as GROP) (Mizahri, 1986). Their stories no longer reflect their sentiment of people in need of help, instead the stories sound like problems that need to be solved. A seasoned physician explains it this way:

What is particularly shocking to a new doctor is the discovery that the patient has become part of the problem. In traditional training settings, patients mean more hard work and longer hours. Each new admission, especially a complex one, requires time and energy that the house staff may not have to give, so that at some point to patient becomes part of the problem as opposed to part of the reason for the doctor being there in the first place. (Laster, 1996, p. 18)

The stories tend to be outward focused, describing patient cases and what they learn from the cases (in contrast to the medical students whose stories were about their interactions with patients and how they grew out of those experiences.) They also focus on what their colleagues are learning, the influence of the house staff, their residency community, and their experiences. This in contrast to the medical student narratives tended to be more focused on understanding self. Another difference between the two
groups is that the issues of difference seem to subside; there is a collegiality in residency that did not exist in medical school. The narratives were written by men and women but the influences of their gender were not mentioned. When reading the stories there are subjective differences as well. The medical students tended to look toward and discuss the future, while the residents were steeped in the here and now. These differences in the stories suggest a personal and professional developmental process.

*Physicians in Practice*

It appears that medical professionals like to share their lives and experiences with others, often in creative ways. For example the journal, *Family Medicine*, has a section devoted to stories and poems of residents and physicians affording them the opportunity to describe their everyday professional life in creative ways. In 1980, *The Journal of the American Medical Association (JAMA)* began a column entitled, “A Piece of My Mind.” The purpose was to let doctors share moving experiences to highlight the human side of medicine. The journal received so many submissions that in 1988 a compilation was published as a book and the steady flow of articles continues (Dan & Young, 1988). The editors believe the popularity of the column “stems from the fact that doctors are given the opportunity to divulge some of their most deeply held feelings, perhaps for the first time in their lives” (p. xv).

Oscar London (1997, 2001) writes about his experiences as a physician from a satirical perspective. Often describing his essays as advice as to how to be a good doctor in modern times, Dr. London expresses his opinions on issues such as managed care, the changing face of the medical profession, doctor-patient relationships, and the joys and frustrations of his everyday medical practice. By adding humor, he presents his life and
experiences in a manner for lay readers to enjoy and physicians to relate. A theme in the stories and essays of practicing physicians is that they give advice and they tend to be more reflective than both the medical students and the residents. Also, unlike the stories of residents and interns, the practicing physicians moved back to seeing patients as individuals and not cases. This was also found in Mizrahi’s (1986) work. The same physicians who decided the worth of patients by assessing how much they could learn from the case became very humanistic caring individuals when they began professional practice. The time to reflect upon their training experiences and appreciate how far they have come, provides a very different tone and focus in the stories of practicing physicians, most of whom want to impart knowledge to those who follow.

Summary of Physician Development

One of the most fascinating results of reviewing the narratives written by or about medical students, residents, and practicing physicians is how the stories they tell take a developmental path as they learn and grow in their profession and in life. This analysis of these literary works that were never thought of as scholarly endeavors provides insight that is difficult to attain through the empirical literature. The narratives provide rich descriptions and give life to the physicians’ experiences. Johnson (1983), a proponent of using biographical methods when studying physician’s careers, critiques the current sociological literature because it is based on outdated assumptions about careers, professions and identities. He contends that researchers need to recognize that there are many ways in which individuals make sense of the careers outside of the traditional professional models. He argues that it is important to recognize that physicians are reporting “increasing concern with non-clinical and extra-professional activities as ways
of gaining greater satisfaction, rather than seeking status and money rewards offered within medicine” (p. 261). An appropriate way to study these concerns is through narratives or life stories of physicians.

Chapter Summary

What is the relationship between what we do as a profession and who we are as a person? The literature on work, the medical profession, organizations, and adult development, personal development and professional development builds a strong theoretical and empirical argument for the importance of this study to the fields of adult education and medical education. Work, its relationship to self, and the distinction between work and other aspects of life has been discussed by scholars dating back to the great philosophers of the Renaissance. St. Augustine, in his classic work, *The City of God*, wrote: “For no one ought to be so leisured as to take no thought in that leisure for the interest of his neighbour, nor so active as to feel no need for the contemplation of God” (Meilaender, 2000, p. 132). Thus, suggesting that the quest for balance in life has been part of the human experience for some time.

Evidenced in the theoretical and empirical literature presented in this chapter, contemporary discussions regarding the relationship between work and self are more complex than the binary between activity and leisure. This is especially true for physicians beginning their careers in organizations. They are faced with balancing professional, organizational, familial/personal and leisure aspects of everyday life. The literature presented on the sociological perspectives of the medical profession, provides a context; a conceptual picture of how the profession was established and the changes and challenges it currently faces.
Since the trend for new physicians’ medical practices is moving away from private practice in favor of employment in organizations, the literature concerning the relationship between organizations and employees, specifically professional employees such as physicians, offers a picture of organizational life and the relationships that exist between physicians and the organizations in which they practice. A missing element in this literature is in regard to physicians’ experiences during organizational entry, which supports the importance of this study.

There is a strong relationship between adult development and work. Almost every development theory or model presents work/career as an element of adult development. It is very interesting that the work/career literature, other than in the field of career development, does not mention adult development. This is especially surprising in the organizational socialization literature because organizational entry often coincides with other developmental issues such as the transition from college to independent living, relationships, and financial independence. Reviewing the adult development literature, especially the more recent work discussing emerging adulthood, provides a deeper understanding of the complexity of developing professional, organizational, and personal identities. This is particularly important for understanding the stories of the participants in this study.

One of the fascinating aspects of this literature review is that medical professionals, steeped in rational empiricism and the desire for concrete evidence, have produced scores of books, articles, poems, and other creative endeavors to make meaning of their personal and professional experiences and share those experiences with others.
The themes of these stories, presented in the final section of the literature review, demonstrate the relevance of using narrative in this study.
CHAPTER THREE

METHODOLOGY

The purpose of this chapter is to present the research methodology used in this study and discuss how the study was conducted. This chapter begins with a brief description of the purpose and guiding research questions for the study. Then, I explain the tenets of qualitative research and narrative analysis as a methodology. After this, the mechanics of the study including participant selection, data collection, data analysis, and the ethical treatment of participants are discussed. The next section reviews benchmarks for narrative research. This is followed by a discussion of how participants were selected. The final sections discuss how the data were collected, analyzed, and verified.

Purpose and Research Questions

“Despite a rich tradition of novels and memoirs about medical training, medical curricula have offered little systematic description of what it means to become or to be a physician.” (Harper, 2006, p.231). In this study, I address this gap by using narratives to describe the life experiences of beginning primary care physicians. Not only are these experiences captured, but the physicians’ narratives also reveal how the experiences affect their understanding of themselves, their profession and the organization in which they work. Their narratives reflect their personal and professional journey into practice after years of very structured education and training.

The research questions that guided this study are:

1. What do beginning physicians experience as they transition from residency to practice?
2. How do they interpret their entry experience?
3. How do these experiences reflect their pre-conceived beliefs about medicine and their expectations?

4. How do these experiences shape their personal and professional expectations, their understanding of their profession, and how they practice medicine?

It is my hope and the hope of the individual participants of this study that their narratives provide insight into what new physicians face as they begin practicing medicine.

Research Methodology

This section includes an explanation of why qualitative research is used to address the research questions which undergird this study. Next, a description of narrative analysis and the rationale for using narrative analysis for this study are presented. This section concludes with a discussion of the role of the researcher in qualitative research and the subjective nature of qualitative research.

Qualitative Research

In order to determine what type of research methodology best fits a study, it is important to think about how the methodology reflects the philosophical framework. This study is informed by social constructivism. Merriam (2002) contends “The key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world” (p. 3). From a social constructivist perspective researchers are interested in understanding how people construct and interpret experiences realizing that these experiences are both temporal and contextual.
It is also important to determine what type of knowledge a study is attempting to acquire. Habermas (1971) differentiates three human interests which lead to acquiring different types of knowledge. Each of these knowledge paradigms fits a specific type of research. The purpose of this study is to acquire what Habermas refers to as *practical* knowledge. Unlike acquiring *technical* knowledge to understand cause and effect, *practical* knowledge is the understanding of meanings and social interaction. This type of knowledge is interpretive, and qualitative methodologies fall into the interpretive paradigm. Researchers interested in uncovering how people learn and grow through experiences face an interesting dilemma because development is not a conscious activity; it happens as a by-product of life experiences and events. It requires reflection in order to be recognized and understood. This understanding is interpretive in nature.

Finally, this study is about understanding and interpreting individuals’ unique experiences as they entered their professional careers in medicine and how these experiences affect not just their careers, but their whole lives. When people begin their professional careers they do not leave every other part of their lives at the door. It is important that the experience is seen as a “complex system that is more than the sum of its parts” (Patton, 2002, p. 41) and not broken down into discrete variables and/or cause and effect relationships. In order to do this data must be “soft” according to Bogdan and Biklen (2003). Soft data includes richly and thickly descriptive data which is often presented in words or pictures. This type of data provides the depth and meaning needed to understand the experiences of others.

Lincoln and Guba (1985) describe qualitative research as naturalistic, taking place in the real world and not manipulated by the researcher. Qualitative research is a
discovery process with the researcher actually serving as a human instrument in the data collection process. While collecting data, the researcher must rely on tacit knowledge (that which is unconscious) as well as propositional knowledge (conscious and instrumental) in order to glean information regarding a phenomenon through multiple means such as interviews, observations, and analysis of artifacts and documents (Lincoln & Guba, 1985). This practice provides a holistic description of the social fabric of the lives of the participants. “Qualitative researchers share in common the core belief that interpretation of social life is valued highly and valued more than explanation or prediction” (Riehl, 2001, p. 117). The researcher is not trying to prove; he or she is trying to understand (Patton, 2002). This understanding is built through an inductive process of gathering data to build concepts and theories from themes or categories that emerge in the data.

Narrative Inquiry

The idea that we live our lives and understand our being by constructing stories is the keystone to this method of research. “Stories order experience, give coherence and meaning to events and provide a sense of history and of the future” (Rappaport, 1993, p. 240). Patton (2002) states that “narrative [inquiry]…honors people’s stories as data that can stand on their own as pure description of experience” (pp. 115-116). The use of narratives, creative writing, and journals is beginning to surface in medical education as well (Hatem & Ferrera, 2001; Pories, 2006). “Narrative probes the depths of medical experience, allows for greater understanding of [doctors’] patients, work and selves” (Hatem & Ferrera, 2001, p. 14).
But, narrative analysis is not just about collecting biographical data. According to Elliot (2005), narratives have three key features. First, they are chronological meaning they represent a sequence of events. Second, they are meaningful in that they do not just report events, they give meaning to events. Finally, they are inherently social meaning they are produced for an audience.

As with any methodology there is debate and disagreement as to what does and should constitute narrative. For example, Boje (2000) argues that using this type of narrative form overlooks the “storytelling spaces outside of the plot” (p. 2 ¶ 3). Others argue about the discrepancies between fact and fiction within narratives (Barone, 2007). What this study attempts to do is recognize both the stories that are told within the narrative and the overall narrative of the participants in order to gain a richer understanding of their experiences. Thus, the narratives, while having narrative form, are comprised of numerous stories told in the participants’ own words. Barone (2007) reminds us that the word fiction comes from the Latin derivative “fictio” meaning something fashioned. Thus, while we strive toward truth and integrity in our narrative research, truth is not something that can ever be attained.

Foundations of Narrative Research

While narrative analysis seems to be flourishing in education research over the past fifteen years, it is historically grounded in the fields of sociology and anthropology. Chase (2005) suggests that contemporary narrative analysis is rooted in the collection of life histories, and three major influences have framed what we now consider to be narrative analysis. First, she attributes the early use of life histories to the sociological researchers of the 1920s and 1930s in the Chicago School describing them as the
“predecessors of today’s narrative researchers” (p. 653). She posits that Thomas and Znaniecki’s (1918/1927) book *The Polish Peasant* is the first endeavor to use life history for sociological understanding. Second, she suggests that the field of anthropology significantly influenced the use of life history, a form of narrative analysis, in studying cultures. Finally, she presents the argument that movements such as the feminist movement and the civil rights movement renewed interest in using life histories or narratives for understanding a social phenomenon.

Johnson (1983) specifically discusses the use of biography or life story in understanding the careers of physicians. He felt that the early sociological studies of physicians in training that used life histories (such as Merton’s (1957) *The Student Physician* and Becker’s (1961) *Boys in White*) to understand the depth of their professional socialization experiences elicited great scholarly and public interest in how physicians are trained. This has continued today with numerous memoirs and books being published by physicians conveying the challenges of medical school, residency training, and professional practice (Pories, 2006). Johnson (1983) posits that life stories are useful in studying careers because the holistic nature of biography helps researchers understand career patterns and career progression. He explains that careers are often seen through two lenses. The individual *objective career* or how the career is seen by self and other, and the *subjective career*—the individual’s interpretation of the career and its importance. This argument has been made recently by West (2007) following his experiences with using life stories in his longitudinal study of primary care physicians working in inner city clinics (West, 2001).
As with many theories and methodologies that try to make sense of a subjective world, writers and theorists discussing narrative analysis have different ways of presenting this methodology. They do seem to agree with the importance of “having research strategies that can work with the narratives people use to understand the human world” (Polkinghorne, p. xi, as cited by Clandinin and Connelley, 2000, p. 15). There are a number of assumptions regarding narrative and use of stories in research that guide the researcher.

**Guiding Assumptions of Narrative Research**

Chase (2005) presents five lenses or assumptions that distinguish narrative analysis from other forms of qualitative research. The first assumption is that narrative retrospectively presents the narrator’s point of view and how he or she made meaning out of experience. The second assumption is that researchers view narrative as “verbal action” (p. 656). This means that story telling or narrative is an active process where the narrator’s voice is recognized. The third assumption is that narratives exist in a social context which both enables and constrains the story and the narrator. The fourth assumption is that narratives are flexible. They are “interactive performances – as produced in this particular setting, for this particular audience, for these particular purposes” (p. 657). The same story may be presented in very different ways depending upon audience, setting and purpose. The final assumption is that narrative researchers are narrators themselves as they interpret and present their studies, thus recognizing that narrative researchers’ interpretation and understanding of stories have the same filters as the story-teller does.
Rationale for Narrative Inquiry

There are multiple reasons why narrative analysis was chosen as the research methodology of this study. First, is the belief that individuals’ stories reveal the multiple dimensions of their experiences. Merriam (2002) points out that that the same story can reveal the influences of culture on learning, the relationship between development and identity, and the influence of language on meaning making and understanding of experiences. Clandinin and Connelly (2000) describe the multiple dimensions and continuity of individuals’ lives as narrative unity. When discussing their own research, they state that “narrative unity gave us a way to think in a more detailed and informative way about the general construct of continuity in individuals’ lives” (p.3). This depth and continuity endemic with narrative is conducive for understanding the professional entry experiences of physicians and how they interpret those experiences.

The second reason is that stories illuminate culture. Durrance (1997) writes that:

The story is our oldest, proven motivational tool, and it’s now being used in corporations large and small to motivate and educate employees and to consolidate corporate culture…A story… carries the shared culture, beliefs, and history of a group. Moreover, it is a means of experiencing our lives. (p. 26)

The participants in this study are influenced by a number of cultures in which they were educated and trained, work, and live. Their narratives reflect those cultures and give perspective as to how those cultures affect their interpretations of their experiences.

A third reason for using narrative analysis in studying physicians’ entry into organizational life is that narratives are a way to carry and disseminate organizational or professional values, norms and codes of behavior; they help people develop a sense of
their organizational and professional reality (Meyer, 1995). Often employees entering an organization use stories to understand the emotional, social, and cultural sides of work (Brown, 1985). Affording new physicians the opportunity to reflect upon and to communicate their stories of professional entry can provide a valuable insight for them as well as those who follow.

In order to create narratives rich with meaning, this study provided opportunities for participants to reflect before and after the narratives were written. As mentioned previously, much of the learning and development that occurs during professional and organizational entry often goes unrecognized by individuals or organizations. It just happens. New employees “learn the ropes” and adapt and accommodate to their new work environment and life. This process occurs unintentionally and often unconsciously. Bringing this learning to a conscious level is a crucial facet of this study. Clandinin and Connelly (2000) point out the effectiveness of uncovering learning through narrative as they describe the work of Mary Catherine Bateson. In her book, *Peripheral Visions* (1994) she recounts her experiences as an anthropologist. Clandinin and Connelly (2000) posit that the narrative she constructs allowed her to learn about her growth through experience and allows all who read her work to learn as well.

*Interpreting Narratives*

Even with the power of stories being well established, interpretation is another matter. Narratives are constructions based upon individual experiences and interpretations. Mishler (1995) reminds us that,

> We do not find stories; we make stories…we retell our respondents’ accounts through our analytic redescriptions… In this sense the story is always co-
authored, either directly in the process of an interviewer eliciting an account or indirectly through our representing and thus transforming others’ texts and discourses. (p. 117)

“Transcribing discourse, like photographing reality, is an interpretive practice” (Reissman, 1993, p. 13). Qualitative research is subjective; subjectivity presents itself throughout the research process. There is subjectivity in what is attended to by the narrator; that which is attended to is subjectively told by the narrator. Meaning also shifts again during transcription and analysis as the researcher cannot attend to every nuance and detail that occurred. Finally, subjective meaning is made by readers of the research as they interpret the stories (Reissman, 1993). Narrative researchers need to recognize, reflect upon, and articulate how their frame of reference may influence the study.

Conducting narrative research requires a certain mindset and focus on truly listening to the stories of others. For me this was a learning process and paradigm shift in my thinking. Bochner (2001) provides a compelling argument for the use of narrative in scholarly research. His argument guided my thinking throughout this project:

The narrative turn moves away from a singular, monolithic conception of social science toward a pluralism that promotes multiple forms of representation and research; away from facts and toward meanings; away from master narratives and toward local stories; away from idolizing categorical thought and abstracted theory and toward embracing the values of irony, emotionality, and activism; away from assuming the stance of the disinterested spectator and toward assuming the posture of a feeling, embodied, and vulnerable observer; away from writing essays and toward telling stories. (p. 135)
I saw the participants’ narratives as more than data to be interpreted. They are stories that need to be shared. I struggled with interpreting the narratives of others.  

Bochner (2001) remarks on the subjectivity of analysis:

It’s not as if the analyst can transcribe a story’s meanings, is it? When I first sit down to analyze a story, there’s the story, and there’s me. The meaning of the story is not immanent [sic] in the text…If the storyteller is a cultural production, well, then so is the analyst. (p. 136).

Thus, I thought it was very important to include the individual narratives in this dissertation. My interpretations also are included, but they are just that, my interpretations of other people’s stories.

My Position as a Researcher

My interest in the experiences associated with beginning a career or profession, specifically for new physicians, is rooted in my life experience. As an organizational development professional, I have always been intrigued by the effects that starting a job or entering a new organization have on individual’s values and belief systems. The focus on primary care physicians stems from my observations of my husband, who is a primary care physician, and his colleagues as they began their professional careers after residency. A few of them started in positions that fit them personally and professional, but most did not. Over the past thirteen years, I have heard their stories and watched them struggle, my husband included, to find organizations and practices that “fit.”

I also chose to study this particular group because beginning physicians are entering a profession that has faced monumental changes in the past ten years. Considering that the time a physicians spends in education and training ranges from
eleven to fifteen years, these changes have resulted in the profession being very different from what it was when these new physicians decided to enter the field. Also, as discussed in Chapter 2, the demographics of the profession have dramatically changed. These changes have created economic and work-life balance issues that did not exist for physicians of previous generations.

My interest also stems from the years I have spent interacting with physicians as a parent of a child with a chronic illness. The experience of spending weeks in neonatal and pediatric intensive care units, making multiple ambulance trips to the emergency rooms, sleeping in the general pediatrics ward, and consenting to my child undergoing multiple surgeries, including three brain surgeries, has given me a quite different perspective of the profession than that of most physicians’ spouses or life partners. In both my personal and professional relationships, I have noticed an increased level of frustration regarding the current trends in medicine and the influence of organizations on physicians’ practices. As a researcher, I need to be aware of how these experiences influence my understanding and interpretation of the participants’ stories.

Participant Subjectivity

The subjectivity of the participants needs to be recognized as well. When individuals present their stories or personal narratives they interpret their lives and present their story as they see it. Often they present what they feel is socially appropriate and confirming of their own view of “self” (Markham Shaw, 1997). Personal narratives are memories shaped into stories. They are personal reflections of events that occurred in the past. Researchers need to recognize that “time separates the happening of the event from the telling of the event. This separation in time creates a distance between the self
being told about and the self telling” (Markham Shaw, 1997, p. 303). This study is about understanding the meaning people make during this time of transition. Thus, participant subjectivity does not reduce the value of the story; it enhances it. How events are disclosed and interpreted by an individual gives depth to the story.

Bloom (2002) suggests that recognizing how the depth of the participant’s story changes as he or she becomes more familiar with the researcher and research format, becomes data in itself. I noticed this in the participants of this study. When they first began sharing their experiences, they were very tentative. They discussed series of events and any time they began talking about how they felt about the events they would apologize for digressing. As time went on and I encouraged these “digressions” they began to share interpretive stories instead of just events. They not only talked about events but also their perspective on the events. As a result, each of the participants’ narratives is uniquely written to provide a verbal portrait of their life at that point in time.

Bloom (2002) suggests that researchers should be ethically responsive and maintain humility. She warns that, “maintaining humility means not taking ourselves or our research so seriously that we forget that those we research have other, more important things going on in their lives” (p. 313). This message strikes a chord with me because of complexity of the lives of the physicians in this study. They were so busy with their lives and their practices that I did not want to burden them. I tried my best to create a positive learning experience for them rather than having the conversations be a task or a chore.

This was important because the participants of this study were serious and competitive people. They would not have gotten through medical school and residency if that was not the case. They are accustomed to being objective, so the subjective nature of
this study was a very different experience for them. For example, many of them asked if their narratives were “consistent” to what I was learning from others. Bloom (2002) recommends that researchers are self-reflexive and never put the research ahead of the person, and I tried to heed that advice. She concludes by stating that, “when done with integrity…narrative research leaves us, and I hope, our respondents forever changed in the best possible ways” (Bloom, 2002, p. 313). In the end, the subjective nature of narrative research was a learning experience for all of us, and we all learned from the study.

Participants

Marshall and Rossman (1999) describe a realistic site for research as one where entry is possible, there is a rich representative mix of participants, the researcher can build trust and cooperation, and data quality is reasonably assured. The key of this for me was “were entry is possible.” Since the medical profession tends to be closed to outsiders, networking with friends and acquaintances that I have met through the years was the easiest way to gain access. I used various networks to contact residency directors and program coordinators from five different residency programs. The residency directors were supportive and they allowed me access to residents and graduates of their programs. Despite their support, none of the physicians from three of the programs were interested in participating. Many contacted me to let me know that they were too busy and others did not respond in any way.

The initial participants who volunteered for the study came from predominantly one residency program. This was probably due to the residency director sending a letter to residents and graduates explaining why he felt the research was valuable and why their
voices needed to be heard. The rest of the participants who volunteered came to me through referrals. Fifteen physicians volunteered for the study. Four did not meet the selection criteria and two dropped out because of changes in their employment. All of the participants in the study had either attended medical school or trained in Family Practice, Internal Medicine or Pediatrics in Pennsylvania.

Pilot Interviews

Two pilot interviews were conducted. These interviews provided insight in a number of ways. First, in terms of developing narratives, the pilot interviews provided an opportunity to use different interview questions and techniques. During the pilot interviews I recognized that the data best suited for narrative analysis was attained when the interview was less structured and participant driven instead of researcher driven. As a result of this, I provided the interview questions (see Appendix D) to the participants of the study in advance of their initial interviews. I encouraged the participants to reflect upon the questions, write about them and discuss them with others. Most of them had not thought much about what their entry into the profession meant to them. It was just another step in a very long journey. Having the questions in advance gave them a time to reflect and think about how their lives had changed during their entry into professional practice.

The pilot interviews also gave me an opportunity to think about selection criteria. I interviewed one physician who was out of residency for about three months and another physician who had been practicing for four years. The physician who recently graduated gave me great descriptions of what she was experiencing but she did not have enough time to make any sense of it. She was still trying to figure things out and find her way.
There were many tactical skills that she had to learn such as billing, time management and dealing with being on call in a new system. She was still in the process of mastering these things and did not think much beyond that. The other physician gave me rich examples of how his entry into practice and specifically the organization where he was employed affected his practice style, his beliefs about patients and his life. He was very philosophical about it. He did not remember the events at all; he could just recall how the experience affected who he is today. As a result of these experiences, I decided that one of my selection criteria would be that the physicians needed to be in practice between three months and three years. Hoping that this time range would allow the participants to discuss both the events associated with entry and their interpretation of those events.

Criteria for Participation

The purposeful sampling criteria used to choose participants were as follows:

1. Participants were in practice as primary care physicians for at least three months and no more than three years. This includes: Family Practice, Internal Medicine, and Pediatrics.

2. Participants were graduates from U.S. medical schools.

3. The sample needed to be representative of those in primary care. This meant that it needed to include both men and women and be racially diverse.

4. Participants had to be willing to be interviewed three times: an initial interview to discuss the study and their interest in the study and to go over the focus of the study, a second interview to share their entry experiences, and a final meeting to review the transcripts and construct their stories. Due to geographical constraints these interviews were a combination of face to face
and telephone interviews. Email played an important role when writing and discussing narratives.

5. The participants had to be willing to share their stories. Since the purpose of this study was to create knowledge which will help those who follow; ideally, the participants’ stories will be shared in the future with third year residents preparing to enter the workforce. Pseudonyms were used to protect participants’ identities.

6. Participants had to be beginning their medical careers as “employees” of group practices, HMO, or hospital run practices.

Rationale for Criteria

The first and second criteria for participation were that all participants are primary care physicians and graduates of U.S. medical schools. Currently, primary care is drawing almost 50% of its residents from international medical schools (Institute for the Future, 2003). While understanding the experiences of international medical graduate (IMGs) is important, it does not inform this study because cultural differences will influence how a profession is perceived and a key element of this study is how the profession is changing. Due to high debt incurred during medical school and the general negative view of primary care in the medical community, more U.S. trained physicians are opting for high prestige, high income specialties (Hawkins, 2005) or specialties such as radiology, dermatology and anesthesiology which are deemed as “life friendly” because of the predictable hours (Giovino, 2002). Learning about the experiences of those who opt for primary care may provide important information for residency directors and healthcare organizations.
A purposeful sampling (Patton, 2000) strategy was used in choosing participants. There were eleven participants in the study. Six were women and five were men. There were three White men, two Latino men, five White women and one African American woman. One White man and one Latino man withdrew from the study. This reflects the current demographics of primary care. Approximately 52% of primary care physicians are women (Brotherton et al., 2005). Two of the nine participants who completed the study were racial minorities. They were not chosen because of their race or ethnicity. Statistics suggest that medicine still lags behind other professions in terms of acceptance and admittance of people of color but this is changing rapidly, especially in primary care because of the substantial decrease of white men choosing these specialties.

Participants could be single or partnered; either way their lives outside of the workplace were as important to this study as their work lives. Physicians entering practice are not just beginning a job or joining an organization. Often they are starting out in a new community, moving into their first home with their first mortgage, receiving the first paychecks that cover more than the basic essentials, and trying to build a practice reputation. They also, for the first time, are working outside of a formal training environment. All of this can be exciting and stressful for everyone involved, not only the physician. In addition, since the focus of this study was on intangibles such as values, professional beliefs, and life balance, it required reflections and discussion. These discussions often occur in the home. New physicians are not constructing their professional and organizational lives in a vacuum; instead it is all part of system of a developing self which includes the personal and familial as well.
Participants had to commit to engaging in reflection and discussing their narratives. The quality of this study rested on the level of commitment of the participants. It is about their stories, their learning and growing, and their lives. In order to ensure that participants understood what they were embarking upon, a document listing all of the possible data collection techniques was be included in the informed consent packet. It should be recognized that the participants in this study were eager to share and actively participate. In this respect, they may not be representative of many of their peers. As mentioned previously, the graduates of a number of residency programs chose not to participate. If they did give a reason, it was time constraints and busy lives. But, it may also be that they were not interested in sharing about their experiences, for whatever reason.

This study focused not only on the participants’ professional entry, but their experiences as employees of organizations, thus the participants needed to be employees. This took many forms, from one employee being employed by her father to others working for large organizations. The key was that they did not have ownership of the practice where they were working. Situating the study in employing organizations is relevant to the contemporary practice of medicine, considering approximately 80% of entering primary care physicians are employees and plan to stay as employees instead of becoming practice partners or solo practitioners (Institute for the Future, 2003). The participants in this study reflected this statistic. One of them wants to eventually become a solo practitioner; but the rest do not even want to become partners in their practices. They like being employees.
Data Collection

Patton (2002) suggests that “a naturalistic design unfolds or emerges as fieldwork unfolds” (p.44). Since qualitative research relies on an emergent design, the data collection process was adapted for each individual participant. While they all were presented with the same questions and were informed as to the purpose of the study, the participants were encouraged to tell their stories and construct their narratives as they saw fit. They did not all address the same events or experiences; they focused on the events and experiences that were relevant and important to them as they entered the profession.

Data Collection Methods

Chase (2005) suggests that there are a variety of approaches to narrative analysis and researchers’ specific approaches “tend to be shaped by interests and assumptions embedded in the researchers’ discipline” (p. 658). The manner in which data are collected and analyzed is dependent upon the purpose of the research. Since narrative analysis is about the collection of stories, each of these approaches focuses on different aspects of an individual’s life story. Thus, interviews are conducted and data are collected through a specific lens.

Chase (2005) describes five of the more prevalent ways in which contemporary narrative inquiry is conducted. The first approach she discusses is the psychological approach which concentrates on the individual’s psychosocial development by finding relationships between life stories and quality of life. The second approach is sociological and focuses on identity work within contextual constraints such as an organization, institution or culture. The third approach, also sociological, and centers on specific aspects or events in individuals’ lives. The fourth approach is ethnographical. This
approach combines ethnography and life stories to illuminate the life of one or a few members of the culture being studied and include the relationship between the participants and researcher. The fifth and final approach is autoethnographic where the researcher tells his/her own story of an experience.

This study is focused on how individuals develop both inside and outside of the workplace as they begin their professional careers: how they make sense of their personal experiences, how they tell their stories, and what their stories are about. I chose to take more of a psychological approach to narrative. With that, because the study is informed by social constructivism, the entire data collection process focused on understanding how the participants created meaning in relation to the social structures and communities in which they participated.

Data Collection Process

An initial interview took place with each participant. During that interview we discussed the demographic information they shared when they volunteered for the study. A brief demographic survey was included in the informed consent packet (see Appendix C). The purpose of this meeting was to establish rapport and to determine if the participant met the selections criteria. Participants were given a list of questions to reflect upon for their interviews. Interviews were then scheduled, giving the participants at least three weeks to review the questions.

During the initial interview, participants were asked about their preferred methods of making sense of their lives and recounting their stories. Most of them had no idea what I was asking. They did not ever think about this. Once we talked about it for a bit, many said that they like to share with family or friends. One mentioned that he had
strong relationships within his church and he confides in people from his church to make sense of things. They all discussed making sense of their world in conversation and relationship with others. So I decided that interviews with a conversational tone would be the best approach to collecting data.

One thing I think is key to successfully using narrative inquiry as a research methodology is to view myself as not only a researcher but a facilitator. Ultimately, narrative research is about their stories and how they interpret those stories. Empowering participants during interviews and throughout the process to become narrators rather than interviewees is pivotal to a successful narrative study (Chase, 2005). One aspect of narrative analysis that I had to learn early in the data collection process is that the focus of my time with the participants was not to get the story “right” but to allow them to their stories the way that they wanted to tell them. Hendry (2007) cautions that, “Research is still seen as representation. We invest our trust in our methods not in our relationships” (p. 493). This turned out to be difficult to implement in practice. As a researcher, I had expectations that I needed to constantly keep in check while working with the participants on their narratives. Many times they did not tell me what I expected to hear. Other times they told me more than I ever really wanted to know. I had to learn to listen well relying on the skills I learned as a counselor, and I hope the narratives reflect that.

Data Analysis

“There is no canonical approach in interpretive work, no recipes and formulas, and different validation procedures may be better suited to some research problems than to others” (Reissman, 1993, p. 69). I collected data through interviews and other oral and
written communications. I conducted, recorded and transcribed the interviews. The individual participants and I co-constructed the narratives.

*Transcribing and Analyzing Stories*

Riessman (1993) suggests that data analysis begins during transcription. She describes transcription as an iterative process. She emphasizes the importance of transcribing interviews as accurately as possible, recognizing nuances in language such as pauses that may be dismissed. This is why I transcribed each interview myself. After the interviews were transcribed and data were collected, narratives were developed using narrative form. There was a beginning and an end. Each narrative contained a plot and complicating actions that required resolution. While there was narrative structure placed on the individual narratives, they took their own form and were dependent upon the participants’ lives, experiences and the stories they told within the overall narrative. Once the narratives were constructed and agreed upon, decisions needed to be made regarding how the narratives would be analyzed and interpreted. Interpretation of narrative data is a complex process:

As our work progresses and as we fall in love with our participants, the field, and then our field texts, we may tend to lose sight of questions of significance, meaning, and purpose. But as we make the transition from field texts to research texts, questions (such as who cares? And so what?) reemerge. How do we know that our inquiry interest is anything more than personal or anything more than trivial? How do we know that anyone will be interested? Will our inquiry make a difference? (Clandinin & Connelley, 2000, pp. 120-121)
Taking field texts and interpreting them into research texts is how we take the personal meaning presented in the stories of participants and construct a social meaning. A key element of data analysis and interpretation for narrative research is the ability to take the personal stories, interests and experiences of participants and tie them to larger social concerns and the stories of others (Clandinin & Connelly, 2000) in such a manner that it becomes relevant to the academic field (in this case adult education and medical education) and society in general.

One way of doing this is to present the full narratives, which I have done in Chapter Four. Since the narratives are not data but an interpretation of the data by both the narrator and me, the narratives are in effect an analysis of the participants’ experiences. What may resonate with one reader may not resonate with another reader or me, and I wanted to keep the participants’ individual voices first and foremost in this study. Another reason to present the full narratives as analysis is to open readership to include people outside of the scholarly world of education. Most social science research is written for an intended audience of scholars in the field with the purpose of being informative and persuasive to professional colleagues (Barone, 2007). Presenting the full narratives provides people outside of the field including other physicians, health administrators, patients or anyone with a general interest in the lives of physicians, an opportunity to understand and interpret the study without the filters of my analysis. The final reason that the full narratives are presented is so that the participants’ individual voices are recognized.

Each of the individual narratives was analyzed for structure and themes within the narrative. The structural analysis of individual narratives was completed using Labov
and Waletzky’s (1997) structural model of narrative form. The purpose of this type of analysis is to delve into the meaning making processes that the participants disclosed in their stories. Labov and Waletsky propose that narratives have six elements: The 
\textit{abstract} which summaries the story; the \textit{orientation} which gives the background and setting; the \textit{complicating action} which is the event that happened; the \textit{evaluation} which is what the event meant to the participant; the \textit{resolution} or how it ended, and the \textit{coda} which brings the narration back to the present. These structural components were used to analyze each of the individual narratives. There was also a collective analysis performed. This analysis was informed by the work of Clandinin and Connelley (2000), but the purpose of finding general themes was to accentuate the holistic analysis. The themes alone do not present an accurate picture of the findings of the research.

\textit{Recognizing Voice}

Researchers need to be in tune with the relationships between the narrator and the researcher and how each of their voices is portrayed. Chase (2005) suggests that “rather than locating distinct themes across interviews, narrative researchers listen first to the voices within each narrative” (p. 663). Also, she suggests that researchers have specific voices as well which guide the interpretation of data. Depending upon the purpose and context of the study, researchers can take an authoritative voice, supportive voice or interactive voice. Each of these strategies connects and separates the researcher’s voice from the narrator’s voice in specific ways.

For this study I leaned toward a supportive voice. Chase (2005) describes supportive voice as one “that pushes the narrator’s voice into the limelight” (p. 665). This is my preferred way of understanding other’s lives, and I believe that an important
aspect of my study is that it gives new physicians an opportunity to tell *their own* personal stories of their professional entry experience. One of the criticisms of this method of analysis is the researchers may “romanticize the narrator’s voice as ‘authentic’” (Atkinson & Silverman, 1997, as cited by Chase, 2005). Chase (2005) disputes this claim by arguing that narrative researchers who use a supportive voice are not trying to establish authenticity but allow the narrator to be self-reflective and create his or her own story. Throughout the process I encouraged self-reflection for the participants, and I spent time in reflection as well.

**Validation**

In order to have a strong narrative study, measures are put into place to determine the value of a study. The validation criteria as described by Reissman (1993) are: persuasiveness, correspondence, coherence, and pragmatic use.

*Persuasiveness*

Narrative researchers need to ask themselves, “Is the interpretation reasonable and convincing?” (Reissman, 1993, p. 65). Narrative researchers need to recognize that the meaning of narrative texts is not stable and the persuasiveness of a narrative is historically and socially dependent. With this understanding it is the responsibility of the researcher to present the stories with the best of literary style. The success of a narrative study depends on “the analyst’s capacity to invite, compel, stimulate or delight the audience…not on criteria of veracity” (Gergen, 1985, p. 272 as cited by Reissman, 1993).

*Correspondence*

Qualitative researchers are encouraged to conduct member checks which involves having the participants involved in the data and checking their perceptions of the
transcripts and interpretations (Lincoln & Guba, 1985). Due to the dynamic nature of stories, member checks may not validate narrative research. While it is important to have participants review transcripts and data and provide feedback and insight throughout the research process, there are times that participants may not be able to agree with the researcher’s interpretations. Also, individual participants do not have the perspective to evaluate themes across multiple narratives. This is why it is very important for narrative researchers to clearly distinguish their narrative interpretations from those of the participants. Reissman (1993) counsels narrative researchers that “in the final analysis, the work is ours. We have to take responsibility for its truths” (p. 67).

Coherence

Three criteria for coherence posited by Agar and Hobbs (1982 as cited by Reissman, 1993) are: global, local and thermal. Global coherence is how the narrative or study reflects the overall goal or purpose of the narrator. When individuals tell stories, they usually have a reason for why they tell the story the way they do. It is important for narrative researchers to recognize and reflect this in their analysis. Local coherence is how the narrator presents the story and what literary devices such as comparison and contrast, metaphor, analogy, he/she used to connect events. Themal coherence focuses on the specific themes that are repeated and important to the story. Pragmatic use is how the particular study is used for future studies.

The criteria for validation and trustworthiness of narrative research hold the researcher responsible for being mindful of the narrator’s intent and the researcher’s intent and clearly delineating the two. While this is imperative to the research process, Reissman (1993) also suggests that researchers need to compile and provide detailed
information about the research process. Similar to the audit trail that Lincoln and Guba (1985) suggest for qualitative research in general, narrative researchers need to explicate how interpretations were formed, how they conducted the research, and how they transformed the data into narrative. Finally, they need to be deliberate in record keeping and make data available to other researchers and full transcriptions available.

Ultimately narrative researchers need to balance the art of crafting stories with the criteria of trustworthiness in order to produce research that is both substantive and compelling. Though I followed the criteria set forth by Reissman (1993) for narrative validity and rigor, I also took the advice of Hendry (2007) who argues:

As researchers we often bring our preconceived notions and understandings and want our data to fit what we already know and want to believe…My concerns with rigor and validity have to do with staying true to our informants’ stories and not imposing our narratives on them.

Fortunately for me, I had committee members and a few participants who held me to that. Also, including the narratives provided another form of validity because the reader can decide whether or not to accept my analysis or provide his or her own analysis of the narratives.

Chapter Summary

In this chapter, I discuss the use of qualitative research, specifically narrative analysis, in exploring the professional entry experiences of primary care physicians. I provide an explanation of the processes and procedures associated with a strong qualitative study and I discuss how I conducted my study. This included explanations of how participants were selected, how data were collected, and how narratives were
constructed. I then explained how the narratives were analyzed and presented in this dissertation. Finally, I discuss the importance of trustworthiness and validation to the study and describe the measures I took to ensure that the narratives meet the criteria of good narrative research.
CHAPTER FOUR

THE PHYSICIANS’ NARRATIVES

The purpose of this study was to learn about the experiences of beginning primary care physicians as they enter the profession, their interpretation of those experiences, how the experiences compared to what they expected, and how the experiences informed their lives and practices. The nine narratives presented are not reports of biographical data collected during an interview. They are narratives; co-constructions of the researcher and each individual participant presented in a sequential or chronological order, connecting events in a meaningful way in order to resonate with the reader or audience (Elliot, 2005).

Because context is so important when analyzing data through a social constructivist lens, how the primary care physicians got to the point of professional entry was as important in understanding their experiences as the actual events that occurred as they began their careers. Also, shortly after I began working with the participants to write their narratives I realized that it is virtually impossible and a disservice to the participants to put their experiences into categories labeled “personal,” “professional,” and “organizational.” These categories are intertwined and inseparable. Thus, in their narratives, we (the participants and me as the researcher) tried to paint a picture of who they are today and how they got there, rather than just reporting their professional entry experience.

During the data collection process, I internalized the meaning of the researcher serving as a human instrument. Using multiple forms of data collection including interviews, reviewing participant notes and journals, and immersing myself in the world
of medicine by observing doctors, nurses, and patients in practice settings and hospitals, I realized the importance of my relationship with the participants and the data. For me, part of analyzing the participants’ narratives was the process of understanding my own narrative in relationship to theirs.

I recognize that their narratives are influenced by mine. I made contact with most of these participants through relationships developed through my husband’s position as a primary care physician or through meeting people during stays at the hospital with my son. I have interacted with physicians as a patient, as a mother of a chronically ill child, as a wife, and as a friend. Also, critiquing the healthcare industry is part of the public discourse in the United States in which I participate. The media, politicians, and the general public all have ideas on what is wrong with the system and how to solve it. I, too, come with those ideas.

As explained in depth in Chapter Three, there are numerous ways to construct and analyze narratives. The narratives presented in this chapter reflect the values and interpretations of the individual participants. They are narratives in form, meaning they are structured to have a beginning, middle and end. I worked with the participants to construct this form. Within the narrative are, what I call, stories. The stories are told by the participants and are in their own words. The stories within the narratives were collected during participant interviews, they were presented in the participants’ writing and other communications the participants shared with me. One participant emailed me a speech that he gave when he graduated from residency. Another shared some writing she had done. In the end, I saw myself as a facilitator assisting them in creating their narratives.
The Participants

Table 1 gives an overview of the participants’ background and experiences.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Specialty</th>
<th>Employer</th>
<th>Months in Practice</th>
<th>Marital Status</th>
<th>Children</th>
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<tr>
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<td>Family Practice/ER</td>
<td>Community Hospital System</td>
<td>26</td>
<td>Married</td>
<td>Stepson in college, baby on the way</td>
</tr>
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<td>Small Practice</td>
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<td>Single</td>
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<td>Large Physician Group</td>
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<td>Married</td>
<td>Six year old daughter, one yr. old son</td>
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<td>Married</td>
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<td>Internal Med</td>
<td>University Hospital System</td>
<td>4</td>
<td>Single</td>
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<td>Married</td>
<td>None</td>
</tr>
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<td>Robert</td>
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<td>Community Hospital Group</td>
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<td>Community Hospital Group</td>
<td>13 total /3 in current position</td>
<td>Married</td>
<td>Children grown, one grandchild, one stepdaughter in HS</td>
</tr>
</tbody>
</table>
Introduction to the Participants’ Narratives

This section presents the narratives of the participants. Each narrative was co-constructed by the participant with my assistance. As mentioned previously, the narratives are co-constructions of the participants and me. At the beginning of each narrative is a brief biographical sketch of the participant at the time the narrative was written.

I Just Want to Make a Difference

Chris

*Chris is a 43 year old physician board certified in Family Practice. He currently is employed in a small community hospital as an emergency room doctor. He also practices inpatient medicine at this hospital and another small community hospital in the area. At the time of the interview, he was beginning his third year of practice after residency and expecting his first child. During his first three years of practice, he has tried to develop a niche for himself in both inpatient and emergency medicine. By choice, he practices outpatient medicine on a very limited basis.*

Background

Chris did not take a traditional path to a career in medicine. He began his undergraduate career with full intention to study science and attend medical school, but changed his mind his freshman year. He recalls,

I went to X University thinking I was going to study science and go to medical school, but my first chemistry professor ended that. He so turned me off from the sciences that I ran away! I refused to take another science course! He was terrible and I knew that I would never survive four years of professors like him.

So, he decided that he would become a Navy fighter pilot because his father was in the Navy and he was always interested in flying. He met with the Navy recruiter at his university in order to get advice on what major to pursue. He explains,
Well, the recruiter said that my undergraduate major didn’t really have much of an effect on my potential career as a fighter pilot, but he thought that either engineering or accounting were good degrees to pursue because the Navy always needed accountants and engineers.

Chris decided to study accounting in order to avoid the science professors at the university.

Unfortunately, Chris’s career path took a different turn. During his junior year of college, he tore his ACL (anterior cruciate ligament) which required surgery. The surgery restored normal knee function but that was not enough to pass the flight physical required to be a Navy pilot. As Chris relays, “As if it wasn’t bad enough to know have the door closed on being a pilot, I was going to be graduating with a degree in a field that I strongly did not like!”

Chris finished his degree program and graduated from X University with a degree in Accounting. Because he did well in his educational pursuits, he was recruited to work for a large company in New England, which for most accounting majors would have been a dream come true, but it was a disappointment for Chris. He was very successful in his business career. He received good assignments, was well compensated, participated in programs for “high-potential” employees and pursued an MBA. But, he was not happy. He recalls,

Gosh, when I left the company in 1991, not that money defines you, but, I was making $75,000 a year. My father almost had a stroke when I told him that I decided to leave my job and go to graduate school – you know, he was an old fighter pilot, engineer type guy. He was like, “Are you crazy?” Because he was a depression kid that grew up with the philosophy of “If you have a good job, you
NEVER leave a good job.” But I did it anyway. I hated accounting. I just hated it. I never really intended to do it. I had planned on flying and then probably attending law school because I was so turned off from science and medicine by that professor my freshman year. I thought, well, I’ll do the military pilot thing for five years, go to law school, be a military lawyer and retire from the military. But, well it is funny how things change.”

At the time his life was not as he planned. But, with all of the career twists, turns and disappointments, he never forgot about his interest in medicine. He tells this story:

The way I got back to medicine (pause), well you know it was funny…I was in the library one day with a good friend of mine, when we were finishing our fourth year of undergraduate school and there was a little advertisement in the New Yorker magazine. I can still remember. We were sitting at the library that day and he knew that I was going to work for Company Y at that point, and that I was just very unhappy with the way things were going. My friend tore the ad out of the magazine (which you weren’t allowed to do- he says under his breath), handed it over to me and said, “You want to be a doctor!” (Chris laughs). It was an advertisement for a post-baccalaureate program to prepare students for medical school.

I had saved that ad all of those years in a folder and I found it again! One day, shortly after that, I was finishing up work and I said to myself, “God, if I do this for the rest of my life, I am going to blow my brains out in the parking lot in my BMW!” I said, “This is so freaken boring!” (He gets quiet and changes his tone.) Now, keep in mind that I did some fun stuff in accounting. I did mergers
and acquisitions, which I guess is never a good thing for people going through it, but it was fun for me. You know, it was like when I showed up the grim reaper was at your doorstep. You were either being bought or sold when I showed up – neither of which was particularly popular.

Getting back to my story, so, I decided to do it. I decided to try medical school. I looked into the program that was advertised in the *New Yorker*, but that meant that I would have to move, and at the time the program seemed very expensive. So, I decided to apply to a Master’s program in biochemistry at a prestigious university in New England which also provided the prerequisite courses for medical school. One the first day of classes the professor told us that of the 600 people who were starting the program, only twenty would get into medical school. I was fortunate to be one of the twenty.

Medical School and Residency

Chris’s experiences in medical school were influenced by his being a non-traditional student in a medical school that he felt was geared toward traditional students, right out of undergraduate programs. He attended a competitive program and did quite well. He recalls,

Attending medical school after working for eight years was a real experience. I wasn’t making any money and I often felt like the “old guy”. But, at times that gave me an advantage. Oddly enough, I enjoyed it. I was learning and it was hard, but I enjoyed the challenge. While I was in medical school, I was mentored by surgeons and I planned on pursuing plastic surgery, specifically hand surgery. I thought it would be great. Unfortunately, my father got sick and I needed to go
back home. So I had two choices. One was to postpone residency until my father was stabilized, and the other was to find a residency program near home and try to take care of my father and do residency.

Since I was already pretty old (he says in a sarcastic tone of voice) and I was acquiring debt in medical school that needed to be paid off, I decided to find a residency program back home and give up on being a plastic surgeon. This just seemed to be the story of my life, make a plan and not be able to follow through with it, but I needed to be closer to home to help out and I am happy that I did it. The residency program had a great reputation and I felt right at home when I went there to interview. I think the big thing is that it was a Family Practice residency program that was very internal med focused, so, I got to do everything I wanted to do. I wanted to get all of the emergency medicine and pulmonary/critical care experience that I could, and this program allowed me the flexibility to do that.

Dr. T. (the program director) was great in that respect. The program prepared me to be a good doctor.

Chris continued to express his gratitude to the program director for allowing him to pursue his interests rather than a set residency program. He was quite enthusiastic about his training experience. He continued,

I knew that I didn’t want to do Family Practice and I was interested in Emergency Room Medicine. I moonlighted in the ER as much as I could to get experience and I did an elective rotation at the hospital where I am working now. It was great to be able to tailor my training to my interests.
Even though he enjoyed his years in training, he paints an interesting picture of his experiences. He explains his perspective,

So, the thing is this. Looking back on it, if you took college students and had them go into a week of residency, they would run screaming from the room for the most part. The process of learning to practice medicine is just successive years of increasing torture (he laughs). Seriously, you just become used to it. You can become acclimatized to anything if you gradually do it over a span of time. The problems that occur, those that make people crack or go crazy, are when people are dumped into a system with drastic changes immediately. I mean, if you think about it, when you are in college you work at one level. Then when I went to work at my job in business I worked at a certain level, then I added graduate school, then medical school and residency. By the time I got to residency, I was used to working all of the time. Also, I wanted to learn as much as I could so I worked. I worked and worked and worked.

Entering Practice

Chris started practicing as soon as he graduated. As mentioned previously, he started his career as an Emergency Room physician at the hospital where he completed an elective rotation during residency. He found life after residency to be a bit different than he expected. This is how he described it.

When I got out of residency my first job in the Emergency Room was one 24 hour shift a week! My wife was afraid when she would come home, what I would do in a given day. I had so much time on my hands that I was LOOKING for WORK! She would be driving home at the end of a day and think to herself,
“Oh my God, I wonder what he has torn up today and what he has built today?”
And she would be afraid to see what I had done. She was actually quite happy when I decided to take more jobs because it left me much less time at home to destroy and build things. So, she was much happier to come home and not have this, that or the other things destroyed. (He gets more animated.) I mean, she would come home and never know what to expect. One day I would have every cabinet in the house cleaned out. Another time I tore out the tile floor and put a different floor in.

I knew how to work. That is what I did. I was so used to working 100 tough hours a week, that I was bored out of my mind! I mean I went from residency to the ER where I was working, gosh, maybe 1500 hours a year. Granted, I was making about five times, well maybe four times, the amount of money that I was making in residency. That was what the pathetic part was! So, you know, I was making $32,000 a year in residency, and then with moonlighting I could make more but I had to work the hours to do it. But, I was working a quarter or a third of the time and making two to three times the amount of money that I made during residency with moonlighting! So, I finally said to myself, “Okay, I am going to have to go and get another job.” Then I just kept getting more and more jobs until I ended up where I am at now, working three jobs!

I have decided that it is worth it. You know, probably unlike most of the people that you are talking to, I am a boomer, I am the last year of the baby boomers and I want it all! I grew up in that generation, we wrecked the environment and now we have to fix it. My wife and I, we are both baby
boomers. She is a few years older than I am and we grew up with, well, we want to be out of all of our debt except our house in the next year.

I try to save around $75,000 every year. That may sound like a lot, but you have to remember that to be a physician and change careers, I pissed away twelve of my best earning potential years in graduate school, medical school and then residency. Now, I need to make up for it. And that is how I approach it. I will make it up by working hard and saving. It sounds crazy, but that is what I am doing and I am hoping to retire by the time I am 52!

Finding His Way

Because Chris took this eclectic approach to building a medical career, he has experienced a variety of practice settings. At the time of his interview, he was working in Emergency Rooms in two different hospital systems. He also was practicing inpatient medicine and dabbling in outpatient work (which is where most family physicians practice.) He articulates his beliefs about medical careers and the future of medicine.

Personally, I think medicine is changing and I am not sure if it is for the best. What I mean is, well, more and more people are working part-time and personally, I think that the way you become good at medicine is to do medicine. I mean, I think you have to do a lot of it. Maybe not as much as I do, but you have to keep up with things. I really wonder if you can work part-time and say current, but anyway, a lot of people are doing it and I think that the attitude starts in residency because of the new work rules. The culture has really changed.

I think I have always realized that medicine is a tough field, but the more I am in it, the more I realize that is true. I mean, I really went into the field because
people still respected the profession at the time that I was making the decision and I wanted to be able to look at my life and to be able to say that I make a difference. Now, I am not that ego maniacal or that materialistic. But, I really wanted to make a difference and right or wrong, I felt that medicine was that area where I could make that difference. And most of the days, I hit grounders where I get tagged out at first base, but every once in a while, I do something really good or I catch something really good and it reaffirms that I made the right decision.

It is just so tough sometimes because you need to be able to, well, take emergency medicine. You have to be able to take a potentially difficult situation for somebody and well, I try to find some humor in just about everything, well unless, of course it is not a humorable situation, if that is even a word, but you know what I mean. Anyway, I think that we always have to think about the patient and how to help the patient in the specific situation and it can be different for different people. When I think about it, well you know the word Doctorate is from Latin and it means “to teach.” I think that sometimes people forget that. I mean, in the process of “doing” medicine we forget to teach! So, I try to use every opportunity and every patient encountered as an opportunity to try and teach something and it is not always easy.

For example, outpatient medicine; I hate, well, it is my least favorite thing about being a doctor because you have the least amount of control. I mean with inpatient medicine, you probably have the most amount of control because they (the patient) are basically a prisoner! You order their tests, and they do it. You restrict their diet and they follow it. Well, within reason because you know
sometimes, no matter what you do the family brings in cupcakes or crap like that, but for the most part they have to follow your rules and do what needs to be done to get better and get out of there.

But, as a general rule, outpatient medicine is frustrating because there are insurance issues like when you prescribe the medicines that work the best and the insurance company won’t approve it or worse yet is when the patients don’t want to take it or they don’t want to be responsible for themselves. In this day of “delayed gratification is boring” people want to take a pill and correct a problem. It’s like this, “Hi, I am diabetic, I want to eat too much and have the lifestyle I want, but I want you to correct my problems with a pill or something, I’m not going to change or do what needs to be done to help myself.”

That is why I got out of doing outpatient, or at least why I do it as minimally as possible. I just felt like people didn’t care about doing the right thing or what they needed to do to help themselves. They didn’t want to be responsible for their own lives and health and that was incredibly frustrating for me. And the worst thing is they really aren’t held accountable for being responsible. Everyone is telling them, they don’t have to be responsible; it is someone else’s fault or problem!

For example, it is really hard for me to get excited about a hemoglobin A1C of 7.3 versus 7.0 and for me to feign indifference or pretend to be excited when I feel indifference, is well, it doesn’t work for me. So, the guideline is 7.0 and I am held accountable for that patient staying at 7.0, but really, why? What difference does it really make?
Then, what made matters worse; I always had to make 20 or more phone calls a day that I could not bill for. My partner was an “old time” doctor, he was about twelve years older than me, and well, he just accepted it as part of the job. When I was like, “Hell, I need to have these people come in and talk to me about their labs and what they need to do, not just talk to them over the phone. At least then I can bill for it.” It was just ridiculous, everyone wants you to practice phone medicine for free! That is what I like about inpatient and emergency room work. I don’t have to worry about what gets billed and what doesn’t, I just do my job and the CFO, or whomever takes care of the rest. They are always asking me to get involved in that stuff, you know because of my accounting background, but I just say no. I don’t want to do that.

But, back to frustrating patient expectations. I will never forget one time I was in Florida at my son’s college football game and I just assumed that people wouldn’t call me on my cell phone when I wasn’t on call. Well, I was wrong, because my cell number showed up on people’s register and they saved it. I had patients call me when I wasn’t on call! Yeah, I was sitting at the game and someone called. When I explained that I wasn’t the doctor on call that weekend and I was at my son’s game I got, “Well, I know that you are not on call, but, I don’t like the doctor who is, so I saved your number. Can you help me out?” I got off the phone and I went CRAZY!!

I guess I can be pretty cold sometimes when it comes to those things. My code is that I am not here to make love to these people. I am here to help them get better. I’m not a doctor to please people, I need to practice good medicine by
getting them in, getting them better and getting them out. I don’t prescribe pain medicines unless people have a pain generator… I mean, I really feel like, “I am sorry that life sucks and you’ve gotten hooked on narcs, but I am not going to give them to you. Maybe someone has in the past, but I’m not him or her and I’m not going to do it.”

It is absolutely HORRID. Everything is CYA. Now people will sue you if you don’t address their issues but then they get mad at you if you do address their issues. There is no winning! For instance, every time I see somebody, if I see that their weight has gone up, I have to say, “Hey, I am concerned that I see that your weight’s up.” And they usually reply, “Why do you keep harping on me about this, every time I see you, doctor?” And I say, “Well, because, if I don’t keep harping on you, ten years from now when you have your heart attack, you are going to look back in my records and say, “Well, Dr. S. never said that my weight was a problem; therefore, he is responsible for my heart attack.” BOOM – No way – you are responsible for your behavior and YOU are responsible for your heart attack!”

Knowing He Made the Right Choice

Despite his frustrations, Chris can’t imagine doing anything else with his life. He says, “It is short and sweet. I am a doctor because I want to make a difference and I want to have fun doing it.” Chris vividly reminisces about residency and recounts an experience he had during residency that cemented his desire to serve others through practicing medicine. He shares,
I had a lady once, your average 60 year old lady who smoked was a little bit obese and a bit hypertensive. She came in and she was, well, she had three children and she took care of three grandchildren every day. She was at the hairdressers and she stopped moving her entire left side. She couldn’t walk, couldn’t get out of a chair. So, we got her to the hospital and I found out that she was a little short of breath with exertion. I listened to her heart and she was in A-fib and she had probably thrown a clot to her brain. We agonized for an hour about what we should do and I said, “Look, if she stays like this, she will never go home; she will be in a nursing home. I can’t promise you that things will work out, but we should probably get her evaluated at a stroke center.”

So, we sent her to a medical center in a large metropolitan area that had a stroke center and they were doing arterial TPA at the site of the thrombus. She came out of the hospital two or three days later walking and talking! She actually got another four or five years of good quality life out of it. I look at that as one of my granslams because I took a lady that was going to a nursing home, and even though I did not do the procedure, I got her to somewhere where they could do it and that was very gratifying to me. It was one of those moments where you can always look back and go, “Wow! That was really pretty fun.” It was a very good moment.

Work-Life Balance

Chris sees work-life balance as much more than how he uses his time. Not saying that how he allocates time isn’t important to him, but he also sees how his career in
medicine affects his life in other ways. Throughout the discussion he gives examples of how his medical career affects his life.

*Being an “Insider”*

Chris sees the medical culture as exclusive, meaning that there are “insiders” and “outsiders.” Also, he recognizes how the privilege of being on the inside helps him and his family. He explains:

Another thing I realized while I was in residency and dealing with my father and his illness, was that it nice to be there and know what is going on and be able to explain it to others. It is nice to have the insight to know what is going on. Then my family knew and I knew…With medicine, you are either on the inside looking out or the outside looking in. It is still one of those old clubs where when you are on the inside, it is so much better than being on the outside.

In the same respect, he recognizes how his medical training and experiences have influenced the way he lives his life. This has been especially true for him during his wife’s pregnancy. He describes it this way:

My wife, she wants me to be happy about our pregnancy. Finally, I said to her, “Marie, I have a very skewed view of pregnant families. NOBODY ever comes to see me in the ER because they are doing well. And, so, I refuse to get excited about this.”

He goes on to explain his point of view:

Even though we are at 24 or 25 weeks now, I’m still anxious. When we get to 32 weeks and there is total viability and lung maturity, I will have a better attitude. We’ve lived through five miscarriages and other problems like that already. So,
with what I know and what I have seen it is hard for me to not be pragmatic. I come at it from a very pragmatic view – bad things happen. And you know, then you do a lot of second guessing. I mean, when I am working with the general public, I always assure them that they have done the right thing. Because, as a general rule, I never tell someone that they should have done something different or that maybe they may have made a poor decision. I figure, what is done, is done, I need to help them move forward. But, I don’t follow that same rule with myself. I know too much.

*Physician Heal Thy Self*

Chris realizes that being a patient and following doctor’s orders is not always easy. He believes that as a physician, he has a responsibility to practice what he preaches. He tells this story,

Here was a little test from two years ago. I was about 170 pounds and I was as indifferent as anyone else. I remember that I finished up residency at 164 pounds and I felt pretty happy. I had been that weight forever, so I thought I had this under control. Well, I got out of residency and I started going to a doctor, who is a very good doctor, the best around. If he were in New York City he would probably be making 7 digits a year. Anyway, I had gone up in my weight from 164 to 172 and he addressed it. Just like any other good patient, what did I do when my next appointment came up and I was still heavy and probably heavier? I CANCELLED my appointment because I didn’t want to get yelled at! (He says while laughing.)
But then I realized that is hypocritical! So, I had to do something at that point. What I did was say to myself, “Ok. You drink a can of pop a day and you eat a bunch of crap.” So, over the next six months, which actually ended up being over two years, I gave up the pop and went to water. I gave up eating all the crap and went to five servings of fruits and vegetables. When I showed up at my check up six months later, I was down from 178 to 160! My point being, my doctor said I was fat and that I needed to lose some weight. I ignored it and didn’t take it seriously until it was time for my appointment (which I cancelled.) But, then I took it seriously and did what I had to do. I wish my patients would do that but most people don’t think about it or don’t want to put the hard work into it. I know it is work, but I also showed that it can be done. I try to tell my patients this, but most don’t listen; they would rather take a pill.

*Life Beyond Medicine*

Chris works a lot! Three jobs and many sleepless nights are part of his weekly routine. But, he feels that his profession does not provide his identity. He explains, Medicine is not my life. I do not want to be defined as a doctor. When I am gone, I don’t want people to define my life as a physician. I want to be defined as a person who happened to do medicine. I think that a lot of doctors, particularly those who are at my age group or older, they define their life by medicine. Everything in their life had to fit around their medical career. Their wives took care of things at home and they were not involved with their children or things at home.

His goes on,
I like being home; I like being involved with things outside of medicine. I have a ton of hobbies. I am not a doctor, or one of those doctors, who won’t know what to do with themselves when they retire. I love woodworking. I love working around the house. I love to go out and being with my dogs. I love doing a hundred different things!

Plus, if all goes well, I will hopefully have my daughter, who is going to be born soon. And I have our son (his wife’s son through her first marriage) who is talking about going to the NFL. We’ll have to see about that, but he will be doing something and I want to be involved.

I mean, really, I could do hundreds of things! Now, many of the things I like to do don’t pay very well. I have an old BMW motorcycle that I rebuilt. I think I could be a motorcycle mechanic. I really have a bunch of interests. But, you have to kind of balance the reality of what we do for a living by figuring out what you enjoy doing and then understanding the reality of what you can get paid to do. I guess that is why I like medicine. I know doctors don’t make the money they used to make, but it is a comfortable living and for the most part, it is enjoyable.

You know it is actually funny thinking about this because I have friends at my old company who are making as much, maybe more money, well probably not more because I am working three jobs, and very close to retirement or early retirement because they have been with the company for a long time and their numbers are getting up there. I would probably be retired right now if I had stayed in accounting. My first early retirement break came two years ago and I
would have taken it and moved to something else. But, I wanted to make a
difference and I don’t regret it. I don’t want medicine to define who I am, but I
think that I’m probably happier with who I am because I decided to pursue a
career in medicine.

Reflections

Chris is a very energetic individual. During his interview he replaced light bulbs,
tightened screws in his cupboards, fed the dogs and did a load of laundry. He manages
three jobs and a busy life outside of work. This does not leave much time for reflection
and self-analysis. After he volunteered to participate in this study, it took four months to
connect with him due to his schedule and general busyness. He speaks and processes
information quite quickly. His interview lasted a bit over an hour, but it was an
information packed hour and that was the case with the follow up as well.

When Chris reflected upon telling his narrative he felt that his narrative is a
expression of a generation past in medicine. He reiterated his concern about the future of
the profession. He wasn’t concerned about the profession losing prestige and respect, he
sees that as a given. What he was most concerned about is how these changes may affect
new physicians’ commitment to and professionalism in practice. He clearly believes that
there medicine requires a high level of intensity and that intensity is at the individual
level; it should transcend organizations, personal expectations and frustrations about the
profession. Out of everything he shared about his experiences as a physician, he felt that
this was the message that he most wanted to convey. He believes that being a physician
is a privilege and a responsibility that needs to be taken seriously. It cannot be
appraoched as just a job because if that is how it is approached now, that is what it will become for future generations.

There is Something Good for the Soul

Ellie

Ellie is a 31 year old single White female family practitioner. She attended medical school in an urban setting. She completed her residency training at a community hospital. Currently, she is employed by her father, the owner and manager of a solo practice in a small town. She was employed at her current position for approximately fifteen months when she was first interviewed.

Background

Ellie wanted to be a pediatrician from the time she was in junior high school. She grew up with medicine. Her father is a solo practice family doctor who mainly saw geriatric patients. She recalls that as soon as she was old enough to work in his office after school and during the summers she thought, “These old people are always complaining. You never can do anything right for them. They take so many medicines. And I could never, never work with them.” She knew that she was fascinated with medicine, but she didn’t want the same type of patients that her father saw, so she decided to pursue pediatrics.

She recalls that her father’s friends were very discouraging when she decided to become a doctor. She gives her perception,

Medicine is very different from when he [my father] started. But it wasn’t enough to keep ME out of it. His friends were quite serious when they said to him, “Why would you let your daughter go to medical school. What is wrong with you?” He said, “Well it is what she really wants to do. What am I supposed
to do, tell her no?” And they said, “Yeah, do you really want her involved in this? You know the law suits and the….” They just had a very negative view of it and they just couldn’t believe that he would allow me to go to medical school. But, he LOVES what he does and he always did. I grew up with that and it was contagious. So here I am.

Medical School

Ellie chose to attend medical school in a large metropolitan area. During her first three years of medical school, she was following a path to become a pediatrician. That changed when she met with her advisor to choose her fourth year electives. She describes the conversation,

He asked me, “Now, tell me again why you are not doing Family Practice?” And I said, “I know it sounds rude, but it is the old people. I can’t stand having to see nothing but complaining people who have all of these medical problems that I can’t fix!” He said, “I will tell you, you might get a different view if you are seeing a different population, like the population we have here”

So I spent four weeks of elective time doing Family Practice for my very first rotation of my fourth year. And, sure enough, about a week into it, I called home and I said, “Guess what Dad, you were right. I am a Family Practice person!” (She laughs.)

Though her experiences in her father’s office gave her a skewed view of Family Medicine, they did instill a desire to be part of people’s lives. She wanted to get to know people and take care of them throughout their lives. She recalls,
My dad’s patients are not people who saw him a couple of times in their life. They, for the most part, knew him well, and he knew their kids and their extended family. I saw that as such an amazing opportunity, to be part of people’s lives in such an important way. That is why I picked primary care.

**Residency**

She proceeds to explain how she chose her residency. She recalls that she interviewed at ten places. She was convinced from her experiences in medical school and especially during her fourth year rotations that she wanted to stay in the city. But, when she visited the program at the community hospital about one hour from her home, she felt that it was the right program for her. She reflects back on that time,

There was something about the people at Program C that drew me to that program. Within 30 minutes of being there, I felt like they were the kind of people, who, at 3:00 in the morning, when I was sick of the ER paging me, I could look across the table at them and feel like they really understood where I was coming from. And they would just be, I guess, down to earth kind of people. I guess that is the best way to describe it. So many other programs gave me the sense that they had to tout the importance of Family Medicine because they were training hospitals that had surgeons, and internal medicine residents. So, I think that they started to think that “Hey we’re low man on the totem pole here, and so if we act really elitist, and we say that education is our number one priority then”… I don’t know.

I just really got that sense from so many programs. That they were focused on academics, research and sitting in lecture. Whereas, the attitude at
Program C was, “Hey, you are only going to learn how to take care of people by taking care of people.” It is funny, I went to the interview thinking, and “This is kind of a waste. I don’t want to be in the middle of nowhere.” And I wasn’t there very long when I knew, “This is where I am going.”

She shares that becoming comfortable with where you are and knowing it is the right place for you is truly a process. She explains how she finally knew that her residency program was right for her.

I knew when I was at Program C as an intern that it was where I was meant to be. I wasn’t supposed to be at a big hospital fighting with the surgical interns about who can do the central line. At Program C, you could do as much as you wanted to do and I thought that was really cool.

She attributes the leadership and guidance that she received during residency as to why she is able to keep work in perspective and be able to leave things at the office. She explains,

To me, once I leave work, I am leaving work. If I get into a journal article and I look something up online about a particular case, than I can do that and turn it off. I think I actually learned how to do that at the end of my residency.

As an intern, you can’t. You live, sleep, breathe and eat residency, and so it is really hard to keep yourself grounded in other things. But, Program C does a great job of encouraging residents to be human beings and family members first and residents second. That is something that the residency director always emphasized to us and it really came through in our training.
Beginning a Professional Career

Ellie went from wanting to train and practice in an urban setting, to training in a community hospital and beginning her career working for her father in his solo practice. She explains,

I knew that I wanted to TRY working with him. At the same time, I sort of felt like, “Well, I am sure your patient population hasn’t suddenly lost years and they are all young now.” At the same time I knew that I couldn’t live with myself if I hadn’t at least tried it. I wanted to avoid the awkward feeling of, “Well Dad, it is not working out, I’ve got to leave.” So early in my third year of residency, he and I sat down and I outlined for him some principles that were important to me.

One of them was that I wanted to work for one year and THAT WAS ALL. I wanted it to be a one year contract and at the end of that year, if, for whatever reason, things didn’t work out, I didn’t want there to be hard feelings or hostility when I leave. I wanted there to be an understanding that I really have to do where ever is best for me, and I didn’t know at the time where that was, but I wanted to at least start here.

A Rough Start

Ellie was fairly frustrated when she started her job. She said that “Initially I was seeing people who were his patients already. I was siphoning off of his patient population.” She stated that within a few months she was certain that she was going to look for another job. In fact, her New Year’s resolution was to start sending out resumes. She explained,
I learned that real world medicine is a scary place. As a resident, by my third year, I was doing a lot of moonlighting and we were in the office four afternoons a week, functioning fairly independently and it created, as I look back on it now, what turned out to be this false sense of security. I thought, “Oh man all it is are sinus infections and kids with ear infections. I can handle this. Medicine is not nearly as difficult as it seems.” Then, all it takes is one person who comes in with a rash that I can’t make any sense of or abdominal pain that despite multiple visits and multiple medicines and tests, I can’t figure out what it is. It was a very humbling experience. And that was combined with being BORED. I was only seeing like three patients because there wasn’t the volume.

She goes on to explain how they set up the practice when she started and why she was bored.

The way we set it up is we allowed patients to choose who they were going to see and so a lot of them were choosing my dad because they KNEW him and they were comfortable with him. And, so there were some mornings that from 8:00 am to 12:00 pm, I just felt like, well, I couldn’t focus enough to read journal articles and so I wasn’t making good use of the time. I was bored, and I was frustrated! I thought, “I would be so much better off if I was in a group where you have set hours and set patients and the patients don’t care who they see, they are just there to see a doctor.”

I also was frustrated because since it was just me and Dad, we would trade call every other week. So, I would be on call 24 hours a day, seven days a week and then he would take the next week. I knew that the very next week I was on
again. None of my friends were doing that. My friends were every fifth week or
something like that. I thought, “This is not worth it.” I am in the office for long
hours, but I am not doing any work! I mean, I could be at the mall from 10:00 am
to 12:00 pm and just see patients from 2:00 pm to 4:00 pm and pack them all in! I
realize now that I had to be there, but at the time, ugh.

She recalls that her father sensed her frustration and tried to encourage her. He
explained to her that it was important for her to be there, for exposure, and so that people
could catch up with what has been going on in her life. This did not give much solace.

She explains,

We had this running joke that I was kind of like a politician running for office
because that is what it felt like. I wasn’t really busy with patients, but I was doing
a lot of, you know, “I want you to meet Mrs. So and So’s grandmother, who you
went to school with” (she begins to laugh). I enjoy interacting with patients one
on one, but I am NOT a group meet and greet and wave kind of person. It just
sort of, it wore me out. I felt like I was not really doing what I love doing, which
was talking to patients and trying to help patients. Instead, I was being a
GREETER for all of the people that my DAD got to see!

A Fortuitous Event

Just about the time that Ellie committed herself to finding a new job, the local
pediatrician retired. She recalls, “Suddenly, the office was just flooded with phone calls.
‘Will you see kids?’ ‘Are you seeing newborns?’ And it just turned my attitude around
180 degrees.” She explains, “All of the sudden, I liked being here. I liked being in a
small practice. It made a world of difference.”
Not only did she get all of the pediatrician’s patients, he was so happy that someone was going to fill the void that he left when he retired, that he gave her thousands of dollars worth of children’s office furniture and equipment. She describes his generosity.

It was so cool. He called me and said, “I am getting rid of some things in my office unless you want them.” He literally GAVE me office furniture, pediatric scales and chairs. I mean, just all sorts of things. I said to him, “This is awesome, I don’t know how to repay you!” And he said, “Oh, I am so glad for you. It is so good to have you coming back here to practice.” It was just an amazing feeling because the whole idea of the Hippocratic Oath and how we pass on the art to the next generation. I felt like he really embodied that. He was GIVING ME – I mean thousands of dollars worth of furniture. It had to be probably 20-30 years old, but everything is sturdy and works. They look great and that touched me in such an amazing way.

A New Job and a New Practice

The pediatrician’s retirement changed Ellie’s attitude and it also completely changed the practice. She explains,

I expected that I would mostly be taking care of patients that were my dad’s. I did not expect to be bringing new patients. I thought that I would be doing his 50 year old ladies’ annual gyne exams or their breast exams and that is what I would be doing all day long. I just had these visions of not doing anything very exciting and not having too many patients of my own.
I went from having a very slow practice with people who weren’t very complicated to newborns and new moms who have 8000 questions and the need them answered TODAY. You cannot put them off until the next visit. It was a huge adjustment for me. I had to learn how to manage my time because I tend to take more time with parents and kids than I do with, for example, someone my age with bronchitis. I don’t want them to feel like I am rushing them out of here.

Initially, I did a lot of apologizing. I did a lot of, “Sorry you guys have been waiting. I know you have been here for a long time.” Then, it was really important to me that those people who waited so patiently had the time that they needed which just perpetuated my running behind issue, but it was just out of principle.

As time passed, I got used to seeing these kids and I got used to the questions that the parents were asking…I trained my office staff on how to handle the kids differently from the adults…but I loved my NEW job so much that the being busy, running behind, and sometimes feeling like I would NEVER catch up, it never got too overwhelming because I loved it so much. I think if I were over run with old ladies, I would still not be here.

While Ellie was ecstatic about her new job, having the patient population of the practice change so drastically was an adjustment for her father, his patients, and the office staff. It seemed like she did not have to learn the organization or practice, but the practice had to adjust to her! She explains,

I think sometimes his patients are a little bit scared because sometimes my little patients are running around hacking on everyone in the waiting room. His
patients are like, “Ah, What are they doing?” I think they view them as carrier monkeys or something and they have to get out of the waiting room as soon as possible! It is funny, because every once in a while, he [her dad] will say, “So and so was in today and she was very upset by all of the commotion in the waiting room.” We get a chuckle out of it. They were so accustomed to this waiting room being very quite with classical music playing in the background. So for all of these older people sitting in their rocking chairs just waiting their turn, well, the classical music is still there (she laughs) but there is a bunch of screaming monkeys out there too!

Much to her surprise, her employer, her father, has been very supportive of all the changes. She says,

If you had asked me five years ago, ‘How is your dad going to react to it when you are there?’ I would have said “Oh, it is going to be tough. I am probably going to have to follow all of his rules and I am going to have to work his hours and he is probably not going to be happy with all of these kids that I’m going to bring to the practice because a lot of these kids are on Medicaid and he didn’t even TAKE Medicaid until I joined because so many kids are on CHIP [a government subsidized program for children who do not have health insurance.]

That changed the face of this practice too and he has done great with it. Occasionally he will say, “One of your animals was carving his name into my desk!” And it does happen. You have parents who aren’t paying attention, or don’t care. It is amazing the destruction that can be done in five minutes in a room and he never had to deal with that before...His patients were a little bit more
respectful than my patients tend to be. It is quite a different population (she says as she begins to laugh.)…I mean manners are the LAST thing that they are concerned about! But, there is such a personal satisfaction in knowing that actually I am HELPING people.

She proceeds to discuss how happy she is with her job, and how aware she is that her father is making concessions to make it work.

I am very satisfied with my job. In fact, I am so much happier than I ever thought I would be. A huge part of that is how flexible my dad has been with my patients.

If I were truly a partner and had to pull my weight, with seeing this much Medicaid, there is just no way. Quite honestly, I am probably costing him money! But, he is allowing me to be able to do that. I look forward to getting out of bed and doing this everyday.

Having to Manage Her Time, Set Priorities, and Get Through the Day

Ellie is responsible for both inpatient and outpatient duties. As a result, she has to manage her time very efficiently or she will be working day and night. She explains that when she first started working for her father, she “mirrored his hours” working in the office from 8:00 am until noon and 2:00 pm until 6:00 pm in the evening, with Mondays being a late day, ending the patient schedule at 8:00 pm. Along with this, they have to fit in rounding in the hospital, hospital admissions, and phone calls. She explains,

My dad works these hours and he loves it. It is fine with him! He fits in rounding at lunch and in the morning. I did that for a while, but then, once I was actually busy in the spring and seeing lots of patients, I needed some time off. I felt like I came home from the office and I was so tired. I didn’t even want to make dinner,
let alone get on the treadmill and walk! There was just no way that was going to happen! I didn’t even want to check my email! So, I decided to talk to my dad. I said, “I don’t know what I am going to do. I still like this job, and I like being here, but I hate the way things are turning out. I am exhausted!” And he replied with, “Well, why don’t you take some time off?” I told him that wouldn’t work. I said, “Well, I don’t think a vacation will work. I mean, I would just come back and it would be more of the same.” And he said, “No, no, I mean, maybe an afternoon a week or a morning a week, or even a morning and an afternoon, however you want to do it!” His only request was that I did not take off on Monday or Friday because they were the busiest days in the office.

The discussion continued. Her father told her, “I want you to be happy here. I want you to work here because you enjoy working here, not because you think you have to or I would be mad if you didn’t.” She explains that this was a true break through in their relationship and the way that she looked at her job. When she started working, she felt like she had to be dedicated and work a lot of hours because that is what her dad did and that is what she thought he expected of her. She did not want to disappoint him or have him think she was lazy.

She recalls her shock when he first suggested that she take some time off, saying, “My first reaction was, “Who are you? My dad would never say that!” She shares that they both have learned how differently men and women look at work. She explains, I don’t have any kids, so in my mind there was no reason for me to want any time off. If I had kids, then I should want time off, but because I have nothing at home that demands my attention, I should want to work.
She reports that her father did not see it like that at all. So, she decided to take off Tuesday afternoons. She exclaims,

It has done amazing things for my sanity! I just enjoy being in the office more because I know that I have that time. I don’t have to come back to the office, do charts or make phone calls. I am really off and I will take care of everything the next day. Sometimes, I just go home and nap. Sometimes, I just go to the mall. It is neat to be able to look forward to that time off and to know that Dad is not upset that I am doing it. That he is actually glad that he can offer that to me!

She admits that she still feels guilty about taking time off, but she is working on it. She shares,

There are still times that I am at the mall and I am thinking, “Oh my gosh, I am walking around with all of these people who should be at their jobs. We are all lazy! Honestly, it is just part of the way I was raised. Both of my parents were very hard working individuals who believed that a big part of your self esteem and self respect was a result of the hard work you put into life. And, I still believe that, but, I also recognize, that in order to keep my sanity, I have to have time where I get to do things that I want to do. The guilt is lessening as time goes on. When I first took Tuesday afternoons off, I actually just sat in our back office where we have our desk and bookshelves. I sat back there and did charting and reading on-line articles. It was 2:00 in the afternoon, I just couldn’t leave work. Having some time off helped her morale, but as a primary care provider, she sees a need to be organized and streamlined and she is working at it both in the office and at
the hospital. She explains that if she doesn’t work efficiently, she ends up working all kinds of hours.

Our census [the number of people from the practice who are in the hospital] is usually three or four in the summer. But, as pneumonia season approaches, there are times that there are ten to fifteen people in the hospital and that tends to wear on me. As a resident, when you have fifteen people on your census, you are in the hospital all morning and you have from 6:00 am until noon to finish. We don’t do it that way. Some practices do, but we don’t. We still have regular office hours and we just fit in seeing the patients in the hospital somewhere in the midst of all of that.

That was another surprise from my dad to me. There have been times, days that I was rounding and there would be nine people in and I just wasn’t finished at lunch time, but I had to come back to the office to see patients. So, we finish for the evening at 6:30 pm, and I am usually still writing charts. My dad says, “What are your plans for tonight?” and I respond with, “Well, I have got to go back over there, there are still four people I didn’t see!” There are a number of times that he would say, “Well, I’m done my work, let’s go see them.” Or, “Why don’t we go together, we can do it in half the time.”

That has been a huge surprise and a really uplifting surprise for me, because that was another area where I felt a lot of guilt. I remember arguing with him, “No, Dad, it is my week, I can do it!” The issue in my mind was, “I don’t want him to think that I can’t handle the work,” or, to think that I am not pulling my weight. So, I would argue with him, “No, no, I want to go see them!” Well,
who REALLY WANTS to go see somebody in the hospital at 7:00 at night, but it was really important to me, just for my own sort of dignity issues, that I was doing it myself. But, he was really encouraging. He would say, “Really, I know that you are capable of doing it, it has nothing to do with you. So, look, I have nothing else to do. Five years ago, I was doing this all on my own, so let me help you!”

I don’t know how long it will last, maybe in a couple of years he will not be offering anymore, but how things are going now, it is awesome, just awesome…It is so cool that we can still do inpatient care, but I am not so overwhelmed that at the end of the day, I am just able to start crying. And there were some days that I felt like that. I just wasn’t able to keep up! Part of it is because I tend to spend more time with patients. So it just takes me longer in the office and when I am rounding. But also, Dad has been doing this longer and so he is so much more efficient in managing his time, and also, it doesn’t take him as long to figure things out. Sometimes, I’m asking all kinds of questions and taking this thorough history and he would have known it sooner. So, it is the combination of factors that makes him a lot faster than I am. And occasionally it gets me into trouble.

Later she discusses how in general, she is learning to manage her time in the office. Here is how she describes it.

I just tend to spend more time with patients. I always did, even as a resident. The other residents would always make fun of me. They would be like, “Why are you
ALWAYS the last one out of the office?” I tend to be more chatty and I also want to make sure that the patient feels like we covered everything.

I am learning how to say, “Boy, you’ve got a lot to talk about here. How about when you come back and we recheck your blood pressure, let’s address the osteoporosis and whatever again.” I used to feel bad saying that because I felt that they were leaving and not having everything addressed. But, now I am addressing it. I am not saying, “Yeah, yeah, whatever, get out of here.” I’m saying, “I realize you have these other things that you want to talk about, but, in order to give you the time you need, let’s discuss this at the next appointment.” That was hard to learn, but I am getting there.

Accepting that I am Not Going to Please Everyone

One aspect of Ellie’s job that she is still working on accepting is what she often referred to as “the role of politician,”

Aside from kissing babies, I do a lot of things and I feel like, every time I am out in public I see someone. At the gas station, the grocery store, the post office, I don’t think I EVER go out that I don’t see somebody that I know. Even people I don’t know know me! Someone will say, “Hi Ellie!” And I am thinking, “Who are you?” I am getting used to it, but it took a while because I always thought that I was going to live in a big city and not come back here to a small town. It took me a while to adjust to being noticed and having to have a public face.

Though she sees herself adjusting to practicing in a small town, she still finds it hard to deal with disgruntled patients. She shares her thoughts on this.
Yeah, there are still those patients who, even after my long explanation [as to why they do not need an antibiotic for a cold], they will call the office three hours later and ask to speak with my dad and tell him that they needed an antibiotic and I REFUSED to give it to them! We just get a laugh out of it. It is like, “Boy, people are something else.” Occasionally, I have to deal with hurt feelings and I will ask my dad, “Don’t they trust me? I mean, it is like, Yeah, I want their kid to have an ear infection and be miserable, come on!” Because he has been doing this long enough, he is the combination of a little bit thicker skinned and a lot more wisdom. He will say, “Listen, you can’t make everybody happy, no matter what you do. It is not your job to make them happy. It is your job to do the principled thing. And, if they get mad, fine, let them find a new doctor.”

That is hard for me. As a new doctor, it is kind of a popularity contest. You think, “If they leave, then I am not cool and no one is going to like me and word will get out that I am MEAN” and so on and so on. He has to talk me through this. He says, “Look, if they go out there and say that you are mean and you have one person saying you are mean and ten who like you and think you are really great with their kids, people are going to believe what they want to believe. In a small town, word gets around, so don’t worry about it. Things have a way of working out and don’t let the grumpy people make YOU grumpy and don’t let it ruin your day.” He is very encouraging and encourages me not to get stuck on, “Look at me, I am a bad doctor and I should not be here.” All the things that happen, I tend to through them all together and then all of the sudden I start
thinking that I should not even be working! He always focuses me by saying,

“Whoa, whoa, let’s step back and look at the facts.”

Balancing Life and Work

Both Ellie and her father recognize that medicine is changing and the attitudes of new physicians are changing as well. She shares that

Even the guys that I trained with, only a handful of them went into a super busy practice and had the attitude of “Oh Yeah, I love working all of those crazy hours.” The majority of us, both men and women, like what we are doing but also, really relish our time off and knowing that we have something else in our lives besides work.

Being an Employee

One thing that is very important to Ellie is that she is an employee and not a partner. In a large group practice, this is understandable, but she is practicing in a two physician practice with her father. She sees this as essential to keeping her life balanced. She explains,

I am an employee and that is the way I want it to be. First of all, because I didn’t think that I would be staying (she laughs) quite honestly. I thought it was just easier to say, “Let’s negotiate a salary and health benefits and then I am out of here.” But then, as I stayed on and realized everything that is involved in running a solo practice, I honestly didn’t want to be a partner. I didn’t want to have to do the billing and making sure that we got paid for all of the visits and what to do when the bills come back. We don’t have an office manager. We have someone who does the billing and we have a lady who answers the phones and files and
that sort of thing, but we don’t have an office manager, per se, so a lot this “business end” of things, my dad takes care of. Making sure we have envelopes and stamps and taking the deposit to the bank.

I told him upfront, I don’t want any part of that! It was one of the biggest reasons that I was going to join a group. I don’t want to have to deal with all of that. There is enough paperwork and documentation and all this other stuff in medicine, I don’t want to add on this!...He treats me like a partner, but I don’t have all of the headaches. The extra salary is not worth all of those headaches!

And the truth is, I hope that one day I have a family of my own. And then I would even be less likely to want to do all of the other stuff…At hospital staff meetings, people say to my dad, kind of jokingly, “Hey, shouldn’t you be out on the golf course (she states in a deep masculine voice) and let her take over?” And he has said, “Hey, I like what I am doing.” So he is planning to continue working and the truth is, if for whatever reason he would have to quit or cut way back, I would probably leave the practice, I DO NOT want to run it myself and I have told him that.

The Loss of Professional Respect

Ellie explains that the reason that she went into medicine is because she truly wanted to help people. She really wanted to make a difference. She explains,

I am doing a lot more for people than I thought I would and I am helping a lot more people than I thought I would. That is a big reason why I went into medicine. I mean, that is what we all say at our interviews, “Oh, I want to help people.” But it is true. You can’t go into medicine to make money or be famous,
unless you are a specialist working with a professional football team or something like that. Honestly, we are not respected anymore. (She says with a chuckle.) I’ll be in a store or . . . well I think that at least a third of my patients call me by my first name instead of Dr. P., and that is very upsetting to my dad. I always say to him, “Look, as long as they are not calling me names. First of all, our culture as a whole is not very respectful and then you add on top of that my particular patient demographics and I am not surprised that they call me by my first name!”

My dad and I have talked about how different medicine is today than when he started out. His candid opinion is that a generation from now, the smart kids won’t be going into medicine. I guess of friend of his told him that is the way it is in England now. Because of socialized medicine, the bright kids go to be engineers and businessmen and other things like that. It is not the best and the brightest that are going into medicine and that is the way it is going to be here. Look at the cost of medical education alone. Then add on liability issues and the demands of patients. The demands are going up and the reimbursements are going down. For all of these other reasons, you are not going to get too many kids, who are in their right mind (She laughs.) who will want to be a medical doctor.

As far as doctors my generation, there aren’t too many of us on staff that are recent graduates. There are a few of us that interviewed at the same time and my dad was on the credentialing committee when we interviewed. He said, “This has really given me hope about this generation of physicians. I had thought that they were not that interested in their work.” I think his generation tends to view
us as lazy people who want banker’s hours and no responsibility and that we don’t
care about our patients they way they do. Some of that can be well founded, but
there are certainly plenty of young physicians out there who are as dedicated,
motivated and hard working as my Dad’s generation was.

My dad does say, “You know I feel sorry for you kids, because you are
not going to see the reimbursements you deserve, the respect you deserve, or the
quality of life that you deserve.” I think it is probably true; especially since I had
the vantage point of growing up in a household with a family physician and
seeing the differences that he has gone through in 20 or so years. He is right.

Loving the Job

Now that she has ironed out the kinks in her schedule and has a patient population
that she really enjoys serving, Ellie clearly loves her job. She exudes with enthusiasm
while she explains:

It is amazing. I couldn’t have designed it any better if I had called God myself
and said, “This is my patient population please!” (She chuckles.) He couldn’t
have done it any better.

She continues by explaining how happy she is with her life,

My life is awesome. I wouldn’t want to be anywhere else. Though, occasionally,
when I see a classmate with her kids, there is a part of me that thinks, “I could
really get used to being a mom, too.” But, far and away, I love what I am doing
and I love where I am. After all of those years of hard work and training, and all
of the delayed gratification. First you are putting off the things you want to do
thinking, “I have to make the grades to get into med school” and then once you
are there, you work really hard to learn everything so that you can be a good
resident. And then in residency, you just work. So, it is awesome, to not have to
look ahead and say, “I have to do all of this so I can do that.” Instead, now I am
just enjoying doing what I spent all of these years training to do.

It is an awesome feeling. It was a discipline to live for the future, and so
is has been fairly easy for me to sort of put on the brakes and say, “Hey, woe, I
don’t have to plan for “How am I going to get to that point in five years?” and
convince myself, “Oh well, I have to make these sacrifices now.” Right now I am
in an apartment and I am happy here. I am not even house hunting! I have
ABSOLUTELY no future that I am particularly planning for, and that is pretty
cool. (She smiles.) I can get used to this coasting through my future planning
status!

She goes on to explain that even though there are many long hours, and she had to delay
gratification, it was worth it. She says,

The long hours that you put in are worth it in the end. Because there were so
many days that I thought, “Ah, this is ridiculous, I don’t want to be here this
long.” But, there is something good for the soul about doing what you were made
to do and that is how I feel. More than I ever felt at any other point in my
training, I feel like I am really doing what God made me to do and that is an
awesome feeling. You can’t top that one.

Interestingly, though she shares how pleased she is with her life, she would trade it in for
a family.
If at some point I have a family of my own and I am unable to balance in what I
determine to be a healthy way, my family and my career, then I would have to,
well, that would be a deal breaker. My mom was a stay at home mom when we
were kids and I think that made a huge impact on us. So, if I felt that my kids
would rather be with the nanny than be with me; that would be a deal breaker. I
would be done. It would be fairly easy for me to leave medicine for that reason.

Reflections

Ellie is happy, very happy. She loves her practice and the patients that she gets to
help. Though she never thought that she would go back to the small town where she
grew up and practice medicine with her father, it really has worked out great for her. She
attributes much of that to her father. He is her mentor and employer. She recognizes that
his flexibility and support is allowing her to provide a service to the community and to
people who really need healthcare. She feels that this opportunity and the control she has
over her life strongly contribute to her contentment.

She sees her life situation as very unique. She is an employee, but employed by
her father. For the first time in her life, she is at a place where she does not have to plan
for the future but can revel in the present. She is living in an apartment and she shared
quite contentedly that her only responsibility outside of work is her cat. As satisfied as
she is at this time, she also shares that she wants more. Eventually, she wants to have a
family and wants to be an integral part of her family’s life. She recognizes that this may
cause some internal conflict for her, but she is strong in her belief that she will always put
her family first.
Having grown up around medicine, she sees how the profession has changed. Yet, her father still practices the way that he has for the past 30 years. He lives and breathes medicine and she recognizes that it works for him, but not for her. She sees this as both a gender difference and a generational difference. While she knows that she will never want to work the hours that her father works, she is very thankful that he is the archetypical family practitioner. His work style affords her the opportunity to have her work style and still have the intimacy and community connections associated at working in a small practice in a small town rather than a large group practice in the city, which is what she always expected to do.

While she sees that medicine is not the profession it once was and doctors do not have the respect or financial rewards that were once associated with the profession, she truly feels called to the profession and feels that it is a noble field. In fact, she shares that her 26 year old sister has left her “meaningless job” and is taking post baccalaureate courses to prepare for medical school! She credits much of this to her father’s influence on the family and his passion for his work.

What Was I Thinking?

Jacki

Jacki is a 31 year old White female family practitioner. She is married and has two young children. She attended medical school in an urban setting. She completed her residency training at a community hospital, in the town where she grew up. Currently, she is employed by a large group practice as a salaried employee. She was employed at her current position for approximately fifteen months when she was first interviewed.

Background

Jacki recalls that she decided to go into medicine when she was a freshman in High School. The combination of her love a science and her experiences with a
compassionate physician when her grandfather was diagnosed with cancer, led her toward the field. She attended a small liberal arts college that had a good reputation for getting students into medical school, and chose a medical school in an urban area approximately an hour away from where she grew up. She always intended on going into primary care and training at the residency program at the hospital in her hometown. That is exactly what she did.

On the personal side, Jacki got married during the summer between college and medical school. She had her first child while she was in medical school. She believes that she has a different perspective on things because of this. She recalls a discussion she had with her father on the way to her medical school interview.

I was getting out of the car and my dad said, “Do you think you ought to wear your engagement ring there?” I was a bit shocked and asked why. He said, “I don’t know. Don’t you think that they are going to think that you are less of a serious candidate when they see that you are engaged?”

I had never thought of that before. But, I replied, “No, you know this is what I am, this is who I am. I am going to be married when I come here whether they like it or not, so they will have to deal with it.” But, that has always been in the back of my head, that my dad thought that. Or that people would see me as less of a serious person if they knew I intended to have a family and do all of those things.
Medical School

Jacki describes medical school as a blur. She explains,

I can’t remember things that happened in medical school. I think that I was so nervous about everything then. I was so much in overdrive and trying to study all of the time that I really forgot. So when I look back and try to remember how I felt about something, or anything like that, it is hard to remember because I was totally burned out.

She does recall being optimistic, or as she calls it “delusional,” about the future.

She shares her medical school experience.

When I was in medical school being sent out to different hospitals and doing rotations, I always sought out the people who kind of looked like they were in the same situation I was in. Then, I would try to find out what their life was like. Sometimes, I would do that, and I wouldn’t want to know anymore because I would find out that they were really frustrated and they were struggling with the same things that I am struggling with right now. I think, in my head, I was always thinking that I was going to do better (stated with emphasis.)

She begins to laugh a bit, then, she continues,

I think I was a little bit delusional. I just remember getting into medical school and having a lot of people, well, let me go back. When you begin medical school, you start getting exposed to residents. The residents are all a little bit disgruntled. But, I was really surprised at how many people would say, “Oh, if I had it to do over again, I wouldn’t go into medicine.” And I would always think, “Well, that is a really mean thing to say to somebody who has just put down $25,000 for their
first year’s tuition. You are being so negative. You could at least PRETEND to be positive!”

She shares that during this time, she would talk herself into a positive attitude.

I just remember trying to block a lot of that out because you go to school on day one and you are already in so much debt that you have GOT to go through this career. As much as somebody might be negative with you about his or her life, you think, “Oh, I don’t want to be like that.” I think I always have this drive to say to myself, “It is not going to be like that. That is unique to this person.”

That is the reason that I have never wanted to leave this area because a lot of the people that I remember juggling a career and family where living in an area where they had no family support. They were trying to build a career in City X when their whole family was somewhere else in the country. They didn’t have Grandma or Grandpa to go to for help with babysitting.

Residency

Because family support was so important to Jacki she applied to the residency program in her hometown. She explains,

I just decided that I was going to do what it takes to make sure that things worked more smoothly for me. I was going to be HERE. My mom lives five miles from the hospital and so, if I need something and my baby sitter can’t come through for me, or if some emergency comes up, and I can’t do anything about it, my mom helps, my dad helps, my brothers or my sisters-in-law will help. If I was somewhere else, displaced from everybody I wouldn’t feel like I had that extra sort of buffer.
Even with family support Jacki found it difficult to juggle family and medicine during residency. She shares her frustrations with having a demanding schedule for residency and having her daughter in day care. This is the way she remembers it.

I went through my last couple years of residency racing to get out of the hospital, and I would ALWAYS feel bad about that. If something happened at one minute after 5:00, I couldn’t help. I had to run. I had to leave because my day care provider was 25 minutes away and closed at 5:30. Other residents, who lived across the street from the hospital and didn’t have kids, could stay and chat for an hour. It didn’t matter because they had no place to go. They had no one depending on them. So, then you end up feeling bad because you are dumping things on your peers all of the time. I hate to use my family as an excuse. I think it is the BEST excuse you can have, if you are going to use and excuse, but I hate to be always doing that.

She also recalls her frustration and guilt.

There were lots of times when I got to her school when I was supposed to get there to pick her up and she was STILL the last one there! I would get out of the car feeling confident that I got there on time and I hadn’t killed anybody with the car on the way. Then, she would say, “I’m the last person here!” and I would feel bad about it. It was a SUCCESS and she still made it into something for me to feel bad about!

Beginning a Professional Career

Jacki decided to be an employee of a large group practice. The group has a number of doctors in various locations. Her particular office has two physicians, herself
and one other woman who had been at the office for quite some time. Jacki was hired to
work as both a hospitalist, providing inpatient coverage for the group, and an outpatient
clinic provider.

*Choosing a Practice and Starting the Job*

Jacki committed to her position during her second year of residency. In hindsight
she expresses that she probably was impulsive in taking the position, but she was
desperate to stay in the area and so she took what was available. She explains her
feelings when she started at the job,

> When I joined this group it was kind of disappointing because there was a lot of
demands. I mean it was a very heavy call burden, and I just jumped into it and
took what they offered me, assuming that it was the best thing for me. Once I got
into it and started talking to other people, they would say, “Wow, you are on call
that much!” And I would say, “Yeah.” So, I started doing a lot of complaining
and I have continued doing it.

She explains a bit more about how difficult it was for her when she first started. She
explains that she felt different than the rest of the physicians in the practice in terms of
her lifestyle and priorities,

> Most people in this group have been in the group for a long time. I think that
before I started, the last time that they brought a new employee into the group was
eight years ago! And, it is A LOT of MEN. Seriously, that has made a big
difference. There is the one woman that I told you about, but she only works part-
time because she has five kids and severe arthritis, so she has a special schedule.
My partner [the other doctor in the office] is the only other female aside from the
part-time person and she is not married. Well, she is married but has no kids and she is in her mid-forties, so, it is just a very different life style.

When Jacki thinks about her future with this organization she is pretty clear that she does not want to become a partner. She shares her rationale for this decision.

I am not terribly interested in getting involved in the business end of all of it and the partnership thing is a lot of business. I mean, it is not salaried. If you are a partner, you are bringing home what you, well, what you work. You bring home money based on the work you do and you have to worry about it all of the time. And then, our group has certain business ventures that they are involved in all of the time to bring more money into the group. The group members divide that stuff up…that is just the kind of stuff that I don’t want to worry about. It would be nice to have that extra bonus money coming in, but, the way I look at it is that my husband is going to get out of school sooner or later and when he does, he will have a job that will be at least partially descent. Then, I would cut back on my work schedule. If anything, I don’t want to get more involved in the group than I already am.

Learning How to Work Within the Organization

After a short time in the organization, Jacki realized that she needed to express her feelings and concerns. She recognized that she was only an employee and did not have a vote or the same voice as a partner in the group, but she wanted to be heard. She explains how she did it.

I kind of whined a lot (she stated while laughing)! Seriously, for example, if I had to rearrange my work schedule to go and see a play or something like that at my
daughter’s preschool, and I would have to get someone from the group to cover me, I made a point always, right or wrong, of not hiding what I needed time for (she stated emphatically.) You know, I was very purposeful about saying, “I really have to make it to this play at my daughter’s school and I need someone to cover this for me.” I just talked to, well, I kind of felt out who was receptive in the group and I talked to them A LOT about what goes on in my house (she begins to laugh again.)…I did complain a lot!

I told people that I thought I was on call too much and I thought that the amount of call that they wanted me to take was not conducive to have a family lifestyle. At the time they kind of acted like, “Well this is the call schedule we made up for the year, and we are planning to hire somebody else, so hopefully next year when we hire somebody else it will get better.” And the first year ran as the schedule was made on day one. Nothing changed. But, there were people in the group who were very receptive to switching a call with me or even taking a call for me and not asking for anything in return if I had some kind of family obligation.

I think it just got to the point were I brought it up enough that other people were bringing it up for me! Yes, at the meetings, I don’t have a vote, but other people do and they were saying, “We have to look at this schedule. Not because Jacki is unhappy, but because we are NEVER going to get any new people into this group if Jacki is unhappy! If people look at her schedule and see that she is trying to manage a family and she can’t do it because of what we are demanding
and doing to her, then we are never going to be able to refresh this group and it is all going to end. We will retire and it will be done.

While she was learning how to navigate the organization and trying to get the ear of the managing partners, she also had to learn how to work in her office. Her office consists of two physicians (herself and another woman who has been there for a long time), two front desk people, and two nurses. She goes on to explain that because she decided to take a job at this practice, she did a rotation there during her residency training, just to make sure she liked the office.

She recalls, “When I was there I was just totally amazed at how nice everybody was and how well they all got along…but when I got there, I found out that nobody likes the other doctor!” She laughs as she explains further, “There was a much different dynamic going on there once I started working than there was when I was a resident. They were trying to impress me when I went in as a resident. They told me the truth later.” She goes on to further explain the climate of the office. She clearly articulates that the other doctor is very nice and patients always comment about how nice she is, but she adds,

She is a pain in the butt to work with because she is real particular about things, she is real anal retentive, everything has to be just so and she also has this kind of prima donna attitude about being the DOCTOR in the office.”

She tells a story to explain what she means and how she and her partner are different.

If the toilet paper in the bathroom is empty, she is not going to put a new roll on. She is going to come out and tell one of the nurses that the toilet paper in the bathroom is empty. She is not going to pick up a paper clip off of the floor in the
exam room. She is going to tell the nurse that there is a paper clip on the floor in the exam room. (She pauses.) That was funny for me to walk into because I was so used to being the mom, trying to multi-task and do 200 things at one in my own house. So, I would come out of the bathroom and there would be a new roll of toilet paper on that I put on when I was in there, and the nurses would go in after me and say, “Oh we just went in there to put on a new roll of toilet paper and you did it!” (She sounds surprised and amazed as she continues.) “Well, yeah I did it, what did you expect me to do!”

She goes on to explain that the office staff definitely gave her messages about what they did NOT want her to become. She explained that she is who she is. She is the same person at home, at work or any where else and even though she is the doctor, she has become so accustomed to multi-tasking and doing it all, that she doesn’t really think about it.

One thing that she does find surprising is how little feedback she gets about what the group (managing partners) expects of her and how they think she is doing. She gives an example of how uninvolved and uninformed the leaders of the group are about her work.

A good example of that is, when I started with this group I was trying to get here [the hospital] by 6:30 or 7:00 in the morning to start rounds because when I started a couple of the partners would come in every morning to help me with rounds. Well, I didn’t want them to see me coming in an hour later than they did. I was trying to get in early to get started and pull my weight. But, since we hired a new person, another employee, she and I are on equal footing as far as the group
is concerned. We are both employees and she and I handle the bulk of the rounds…(she explains the details of her rounding schedule).

So, now it is much more convenient for me at home, to get up and get my daughter ready for school and make sure she has everything she needs. But, if I do all of that, I don’t get here until quarter ‘til eight or eight o’clock. Now, that I am not working with a partner, per se, directly, and I am working with another employee, it has been really easy to do that. I can come in here late because nobody knows that I am coming into the hospital late. The partners don’t seem to have a thing to say about it (she sounds surprised.)

She goes on to explain that,

I really do not receive any direct or indirect clues from them to tell me what they expect. They just let me play the role, they just let me make up and job! And they ask me, “How many people is it reasonable to expect you to see in a morning because none of us have ever done this [meaning work as a hospitalist and round on all of the group’s patients]?” They didn’t know. So, I kind of set my own expectations that way. It didn’t make a whole lot of sense for me to say that I could see 15 people in a morning, when I knew that I couldn’t see 15 in the morning and come in later, so it was much better form me to say that I could see 10-12 which was much more realistic. Do you know what I mean?...It doesn’t make a lot of sense for me to have expectations set so high for myself that I have to be stressed out about getting in here and doing an unreasonable amount of work in the period of time that I have before I go to the office.
Developing a Professional Identity of Her Own

She was initially frustrated with what the managing partners of the organization expected from her in terms of work hours and call. She explains her perceptions:

People going into medicine now, I think, have different expectations. More and more people going into medicine are looking to have the whole enchilada, you know, they want to take the vacations, and have the family time. They don’t want to be on call all of the time and they don’t want to work twelve hour days. I think they [meaning the leaders of the organization/group] realize, or I hope they realize, that my concerns are more about the changing face of medicine than a lack of dedication to my career.

But, I do think that in the grand scheme of things, when you compare me to other people in this, I mean to other people who do what I do, I do feel like I am a little less serious about it than other people are. I mean, if somebody offered me the opportunity to not do this, I would not do it. I know people who will say, “You know, if I won the lottery, I would still do my job, because I love my job.”

But, if I won the lottery, I would QUIT (she begins to laugh.) I would give it up.

She also shares how difficult it is for her to work in a group of predominantly men who are in very traditional family structures and depict the archetype of the family physician.

Work Life Balance

Jacki discusses how much she values work life balance and how difficult it is to achieve. She feels that the organization she works for is beginning to hear the message that the priorities of many practicing medicine today is not the same as it was twenty-five
years ago. She shares a pivotal experience that helped her define what was important to her and how to manage life along with her career.

Setting Priorities

Jacki describes a pivotal point early in her career that has influenced the way that she looks at work and balances her life.

What made a big difference for me is that I came into this job with a very intense call schedule and I just thought, “Okay, that is what these people want me to do and this is what they think is a reasonable amount of call for me to do. This workload is what they expect to be a reasonable work load. So, even though I think that it is kind of excessive, I’m just going to get it done. You know, I am going to do it because this is the way life is.”

Then, in November of my first year, I got pregnant. Whereas, my pregnancy with my daughter was a breeze with absolutely no problems at all, I had a lot of problems with my second pregnancy with my son. I had all sorts of unexpected issues, like I would wake up in the morning and have some type of crisis, and I ended up having to not go to work. One time I went to my routine doctor appointment to get checked and the doctor told me that he wanted me to be on bed rest for five days and just see how things go.

That doesn’t go over well in this kind of job, when you have to have somebody covering you all of the time. But, my partners were very receptive to that…they were very helpful. I never had to worry about getting somebody to cover me and it was usually a matter of just calling my office and telling the other
doctor that I was having a problem and she would find a way to get everything covered.

So, I think that having to go through a difficult pregnancy in the face of a very difficult job really changed my perspective of the way that I approach the job. I really went into the job putting the job first and trying to impress people in the job. And with the pregnancy, and having to really back off and take time for myself, having to follow doctor’s orders and behave, I think I switched. The pregnancy was the defining moment. That was really what made me put the family aspect of things first, and kind of have the job fit the family.

*Expectations and Frustrations*

Jacki had to learn how to change her expectations and learn how to juggle multiple priorities. As she reflects upon where she is today and what she has learned she states,

Time management wise, I am sometimes amazed at how many things I find myself doing at the same time. I have had four or five things going on at one time and I am amazed that I reached a point in my life where I can juggle like that, but I have had to. It seems almost like a scatter brained thing, but it is not. It is organized multi-tasking.

And I also have learned that I have to give in. I have to give up some things. Like, I don’t like everything that my babysitter does. I don’t like every little thing that she does with my kids and there are things that I would do differently if I were there all the time. But, I am not, and I am never going to be.
So, I have given up control of certain things because it is easier to give up control than to fuss over every little thing.

She continues to explain how difficult it is to let go of things.

It is the same thing with the cleaning lady. I really don’t like having a cleaning lady. I would rather do the stuff myself. I would rather have the time to do that myself, but I had to give that up. I had to just expect that if I was going to do all of this other stuff that I committed myself to, then, I have to pay somebody to come to my house and do this stupid housework. In the grand scheme of things, if I have to choose between spending time with the baby and cleaning the shower, I’m going to give up cleaning the shower.

**Survival**

Jacki explains that she is both the primary bread winner of the family because her husband is a law student, and she is responsible for running the household. She shares her daily routine and how she feels about it.

Thanks to the way my schedule is, I am home most days by 5:30 pm, but then it is just one thing after another. I mean, I get home and check my daughter’s backpack to see what she needs to take to school. I try to spend some time with the baby and get dinner for everybody and get everybody baths, and try to spend some quality time with the kids, and then everybody is in bed.

It has been hard this year, since my daughter has started kindergarten, because she had been going to bed at 9:00 or 9:30 pm when she was in preschool because the curriculum part didn’t really start until noon. So, it didn’t really matter when she went to bed and it didn’t matter when she woke up. If she got to
bed late because we were goofing off, spending quality time together, then she just woke up late. But, now she is up at 7:00 am every day to go to kindergarten and so her bedtime has gotten backed up to 7:30 pm. I am getting home at 5:30 pm and trying to cram all of this kid time in really quickly so that she can get to bed at 7:30, and I can still feel like I had a part in her day. It is just tough.

I don’t think that my husband sees it the say that I do. I don’t think ANYBODY else sees it the way that I do, except other mothers who have to do it. The way I see it, my babysitter is with my son from 7:30 in the morning until 5:30. You know, she gets ten hours with him and I get two. And, this is how I see it every day. . .I would like to do what I do, but I would like to do it less. I really wouldn’t want to change what I do at my job because I like the content of my job, but I would like at least one more afternoon off so I could be there in the afternoon when my daughter is coming home from school or I would volunteer when things happen at her school. . .I just think having more free time is going to be the key.

She goes on to explain how she guards what little family time that she does have. She explains that “I take my job seriously and I don’t slack off, but, at the same time, if I have to be somewhere for my family, I am going to change the job, not the family commitment.” She gives this example.

There was an organizational meeting for the Daisy Girl Scouts. So, here we are at this meeting and I thought they were going to tell us, “Your meetings are on Thursday nights and here is Jane your leader.” I got there and there were about eight other mothers there with their daughters. This lady came out and said, “Hi, I
am the regional manager of the Girl Scouts, who is going to be the troop leader?
Since this group does not have a leader one of you needs to come forth, probably
two of you need to come forth, and be leaders or co-leaders for the group.”

So, I am sitting there thinking, I am probably the busiest person in this
group, why is everyone looking at me?(she laughs) Before the night was over, I
had volunteered to do this and I had been talked into the fact that it wasn’t going
to be a major time commitment. So, not a WEEK later, I get an email saying that
I have to go to TRAINING TO BE A LEADER! I had a choice of two evenings
from 6:15 to 9:00 pm or two days from 10:00 am to 1:00 pm. The other co-leader
chose to go in the evening and I wouldn’t go.

She was kind of upset with me, but I would have had to go straight from
work to Girl Scout training and I would have not been home to put my kids to
bed. I would have not been home to make everybody dinner and I wouldn’t have
been there to talk to my daughter about school. It was just a REALLY big deal to
me that somebody wanted me to take TWO evenings like that and WASTE
them…So, I actually changed my work schedule to make sure that I had the time
in the middle of the day to go and do this girl scout training, because I would
rather inconvenience the people at work than inconvenience my family.

The Medical Profession

Jacki faced some discrepancies between what she expected of the profession
versus the reality of the profession. Outside of her concerns about juggling work and
family, she also found the lack of flexibility and the financial sacrifices as surprises.
The Demands of the Profession

She explains that she was not prepared for the lifestyle and constraints that are inherent in her profession. When she was in medical school and she saw people struggling with the demands of the profession she chalked it up to their chosen specialty. She shares,

I always kind of thought, “Well, I am not going to have a problem, because I am going to be a Family Practice doctor. That person is a surgeon; so of course, they are going to have problems.” I don’t know, I think that I always thought that is was going to be (she hesitates) a more forgiving lifestyle. But that’s a joke (she says as she laughs.) It doesn’t make any sense at all because the demands in Family Practice, time wise, are just as bad. Any medical profession, you are looking at having somebody on duty 24 hours a day. Somebody has got to be there.

And it is not only the day to day stuff, but even, if you want to go on vacation three months from now. You can’t even say, “Hey I am going on vacation in January, because…” My husband always fails to notice this. He always fails to recognize how complex this is, because when he was working he would say, “I’m going on vacation and January,” and they would say, “okay.” Somebody would take over his duties while he was gone, but it wasn’t any big deal. But, when I am not going to be around, it is like, “Who is going to cover the office and who is going to do this and who is going to do that and who is going to be on call, and so on.”
Just in the last few years, our practices have gotten electronic medical records, so now all of the doctors are connected by email and I am ALWAYS sending out emails saying, “I’m going to be doing this or that, can you cover the office, or hospital for me?” You always have to worry about who is going to take care of your patients and who is going to cover for you.

She goes on to express her feelings about the time constraints of the profession.

It always amazes me when I would bend over backwards to get somebody to cover me so I could go to a Christmas play, and I would get there and the place would be PACKED at 2:00 in the afternoon! I would always be like, “What is wrong with me? Why did it take so much effort to get here when there are a hundred other people here? What is everybody else doing all day?”

Here is another example, this afternoon I am on call for the hospital, but I am going to have to duck out of here later to go buy a birthday present for a girl whose birthday party is tonight and my daughter is going to it. I am going to go into Walmart and there are going to be 200 people there and I am just going to wander around, gawking at these people and wondering WHO they are. I always feel that; like I am the only person who has to squeeze in these little shopping trips between the hospital and the office.

*The Financial Reality of a Primary Care Career*

Jacki never expected to face financial challenges as a physician. She knew that she wouldn’t have an extravagant life style, but expected to be relatively comfortable. She explains her financial situation.
It has been hard because my husband is not working. For the first year that I had this job, it was the first time ever that I had a good salary and he had a job. You know, we were living on his salary since we got married and he was a journalist and didn’t make very much money. So, when I was a resident and he was working, we had two crumby salaries and we made due with two crumby salaries. The first year that I was working, we were pretty financially comfortable because we had two decent salaries coming in, but this year has been hard. Since he started law school, it has been difficult and the same kind of think we faced before. It is exactly like time. You know, there is never enough to go around. Everybody wants a little bit of your time. It is the same thing with money. Even if you are not living extravagantly, even if you are not spending money on a lot of stupid things, the money just disappears. You start paying back student loans and his school expenses, and then the books, and because he is a law student he needs to have professional clothes. The suits and stupid things like that end up costing a fortune. It is just like, the money comes and the money goes.

Reflections

With Jacki’s busy schedule, she does not take much time, or have much time to reflect upon her life. She sees that as both good and bad. As she reflects upon this process, she recognizes how demanding her life is and how that can be frustrating. But, she also is proud of her accomplishments and her ability to manage everything that goes on in her life. She sees this as temporary and hopes that once her husband finishes law school, it will slow down. Yet, she is still concerned that as her children’s schedules become more demanding, managing dual careers may even get more difficult. She shares
that during her training, she occasionally thought, “I am going to have a hard time getting everything I want out of life,” but she quickly dismissed it.

What was most enlightening for her was realizing that she really didn’t think about how she was going to accomplish everything she wanted in life, she just assumed that she would and could. The other thing that she realized is that, despite the frustrations and the times that she wishes that she hadn’t gotten into this “whole thing,” she recognizes that she can’t imagine doing anything else. She explains that she thinks that her conflicts come from looking at her nuclear family (her mother, father and siblings) and thinking, “I am going to have a family just like theirs.” In hindsight, she recognizes that that expectation does not make any sense, but she never “pieced it all together and thought about how it all had to fit.”

The other thing that she recognized is how she successfully moved from the role of a resident and medical student, always trying to prove that she was committed and willing to do everything, to the role of a mother, wife, and professional who has to set priorities. She believes that having her second child, helped her put it into perspective; but she also is confidence and comfortable with her decision to put family first.

I Found My Niche

Jessica

Jessica is a 31 year old White female physician. She is currently married and has a young daughter. She attended medical school in a large metropolitan area, and completed her residency at a community hospital where she served as chief resident during her final year. She completed a fellowship in primary care Sports Medicine at a prestigious academic medical center. She was employed at her current position for four months when she was first interviewed.
Background

Jessica began thinking of a career in medicine when she was in High School. She explains, “You come to the point in life that you have to pick what you want to do, it is like, I couldn’t think of anything else.” She was driven by her love of science, and her interest in understanding how the human body works, but she also was intrigued by what she saw as the endless possibilities of a career in medicine. The career path that she followed is indicative of the flexibility in the profession. Throughout medical school, she was thoroughly convinced that she would return to her hometown and complete a residency in Family Practice. She did just that. But, shortly before she started her residency, she was exposed to primary care Sports Medicine and fell in love with it. She finished her Family Practice residency and went on for a fellowship in Sports Medicine. She considers herself a primary care physician in a niche area, since she predominantly sees athletes.

The Flexibility of a Medical Career

Many physicians see themselves pigeon holed into a certain career path. There is a decade of training which is often combined with a large amount of debt. While Jessica spent nine years of her life in postgraduate training and incurred quite a bit of debt, she has a different opinion of a medical career. As she reflects upon what she termed as “the time in her life that she needed to make a career decision” (which was High School) she recalls that she vacillated between teaching and medicine, but just didn’t seem to be as passionate about learning about teaching as she was about learning about medicine.
She was finally convinced that medicine was what she wanted to do when a physician visited her High School and spoke to her about a career in medicine. Though it was years ago, her excitement about the conversation is still evident. She recalls,

He sat down with me one day, because I had questions, and he said that the interesting thing about medicine is that with your medical degree you really can do anything. Like you can get into government work, you can get into academics, you can do research, you can do clinical work. There was this whole sort of slew of things you could do with that education and the idea of that was something that was very attractive to me. I thought it was unique to that field. I mean, I think there are fields where you could do a lot of things but not really like medicine. I mean, you can apply to be the physician for the space program!

_A Little Bit of Luck_

Jessica had limited exposure to the different medical specialties prior to attending medical school. So, when she began medical school and she was asked, “What do you think you want to do?” She replied, “Family Medicine,” without giving it much thought. She explained,

At the time, I think it was because it was what I knew. I mean it was kind of, you know, the doctors that I had exposure to at that point were all Family Medicine doctors. So, that was why. It seemed like they were all good people, and they seemed to make a good living and like what they were doing, so it seemed reasonable.

As with many medical students, as she began her third and fourth year rotations through the various specialties, she changed her mind a number of times, but, she always
returned to Family Medicine. First, because of the variety inherent in the specialty, but, also because she knew that there was an excellent Family Practice residency in her hometown and she was very drawn to return home and work with people that she knew. She went through the residency interview process and matched with the residency in her hometown, but she still needed to finish her fourth year rotations. In her last elective rotation that she needed to complete prior to graduation, she was advised by a classmate that she should think about doing a Sports Medicine rotation. She recalls,

- It was spring and a friend of mine was like, “Yeah, I went to University Y and did a Sports Medicine rotation. It was really easy.” So I thought, “I can do easy.” (She says with a smile.) So, I signed up for easy, and it was so interesting and I was so interested, I thought, “This is great. It is just what I would want to do.” I ended up working weekends, and doing a research project. This would not have been looked upon by my classmates as easy, per se, but I had such a great time.

Residency

The rotation in Sports Medicine had such an effect on Jessica that she tailored her Family Practice residency, as much as possible, in order to get Sports Medicine experience. She recalls,

- I knew that I had this Sports Medicine bent, and I started trying to get experience. Like anytime I could do some extra sideline coverage or work with an orthopedist, I would jump at the chance. My second year of residency, I actually did a rotation with the University of X and ended up really clicking with everyone at here.
But, even though Jessica enjoyed Sports Medicine, in order to become a board certified Family Practice physician, she had to be trained as a primary care doctor, which meant dealing with a variety of patients in the hospital and in the clinic. Her stories of residency reveal her frustrations with primary care Family Practice and validate her decision to pursue a career in primary care Sports Medicine. She explains,

There were many times in residency that I thought that I made the absolute wrong decision. You have frustrating days and frustrating patients, and you know, there is not a lot of gratitude in Family Medicine. . .I mean people just expect you, in Family Medicine, to just do for them and then it is very, very rare that a patient is grateful for the service that you render to them. (Her tone gets edgy.) I mean, at times it got to be very frustrating, I mean you do all of this work and you bend over backwards for people and instead of them saying, “Thank you’ or“Geez that is really nice of you to stay late and get all of my test results,” it is like, ”You should have done this; or you should have that.” They just want to say that you should have done more! And truthfully, at the end of the day, I think that for all that you do in Family Medicine, there is just not very good, (she hesitates) you know, you don’t get reciprocated in any way for it. Not from the patients, not monetarily and um, not usually from where you work!

She goes on to give examples of what she has experienced during her short time in practice. She describes how the university with which she is affiliated has parties for the specialists at prestigious clubs and restaurants while, (and she admits that this is a bit of an exaggeration) Family Medicine gets to go to the local pizza shop. She gives a very telling description of the differences in the patient populations. She explains,
It is ironic in a way, and I think about that. It is like, in Family Medicine, you are treating people for life threatening conditions, I mean diabetes, hypertension, heart conditions and other serious diseases and they really don’t care. Now, I am fixing people’s knees so they don’t hurt when they run marathons and they are SO happy. I mean, I am not treating them for anything that will kill them, for the most part; it is just things that will allow them to have a better quality of life.

As she continues to talk about what she perceives as a lack of respect for Family Medicine doctors, she becomes increasingly animated. She laughs at the irony as if she is still trying to make sense of it all. Also, her descriptions reflect the frustration she has about society’s view of medicine. She shares a critical incident that occurred during residency. One of the most memorable experiences of her residency training had nothing to do with patients or medicine. Instead, it was a human resources/management decision to have employee contributions to their medical insurance costs. Her description of the experience was filled with emotion; it was as if this managerial decision, which did not even affect her directly, took all of the wind out of her sails.

She explains,

I think at the time that I truly thought that I made a big mistake going into medicine …It is kind of funny because it didn’t even effect me; but when I was a resident, the hospital changed their benefits program and, well, I wasn’t even part of this. I mean, my husband has a state job, so we had his benefits; but I just remember being so upset because they went to this benefits program where it was almost, and I hate to say this, but it was like, communist, because they said, “Well, you know, even though everyone is getting the same benefits, we are going to
base how much you pay on your salary bracket. So, if you make over $100,000, then you are going to pay this much or this percentage, but if you are someone who makes $40,000 you only have to pay this percentage.” I was upset because, you know, you work so hard, you go through all of this, we have all of these loans, and you go through all of this education. This is when, I think, I realized that you don’t get ahead, because there is always someone who says, “Well, you are making more and so you are going to have to pay more.” It is kind of like, I mean it is the same with the government and taxes right?

She goes on to explain how she was so frustrated that a hospital, a medical institution none the less, would do this. It was clear that this was a defining moment. She shared that the emotion lingered, not for a day, or a week, but almost a month. It seemed that she felt like she was on a treadmill, exerting energy but not moving forward, and this incident convinced her that she never was going to reach a finish line and finally “Make it and get ahead.”

Joining the Organization and Learning How to Survive in It

Jessica completed her fellowship at the organization where she is now employed. During fellowship she developed the skills and insight that she uses today to work within the confines of a large university medical system. Her role changed slightly when she left her fellowship and moved into a professional position, but she had learned the keys to organizational success while she was a trainee.

_Fellowship: Learning to be a Sports Doctor and Learning the Institution_

Since Jessica wanted to specialize in primary care Sports Medicine, she needed to apply for a fellowship. She admits,
When I applied for a fellowship, since I am married, I have a child and my husband has a job in this state. I did not want to leave. So, I ended up doing the very unthinkable thing of applying to just one fellowship program and, as luck would have it, they liked me as much as I liked them. I matched with them. I got into the fellowship program!

She expresses her sentiment about her fellowship like this,

You know when you are a fellow, and no one tells you this, well, fellow is equivalent with the word slave. I mean I just worked so much. I was traveling with teams, all over the place and doing whatever I was told.

She goes on to say that her dedication and persistence seemed to pay off because she did well in her fellowship, at least well enough that they offered her a job. She attributes much of success to her interest in medicine but also her being a “team player.” She remarks.

Any organization has a lot of politicking and I think that the best way to learn the ins and outs is, you observe and figure out who is important and well received, then you show interest in what they are doing, get to know them, and emulate them.

Jessica was very astute in knowing that in order to succeed she had to be a good organizational member as well as a good physician. She shares about her fellowship experience,

Maybe the reason that I looked so good was because the other fellow looked so bad. He wasn’t going to have any part of the system, He didn’t want to. He just wanted to be a doctor, and it ATE him, I’m serious, it did. When he left here, he
asked people for letters of reference and the told him NO! He literally moved across the country to start over and I know he left under bad terms.

She goes on to share about other stories she has heard about faculty, and others who came before her in the organization. She states, “I think you have to realize your place.” She explains that you have to understand who is in charge, and you have to be sensitive to people’s positions in the organization. She expresses that she learned to be very cognizant of how she refers patients for surgery, making sure that she equally divides them among the surgeons. She states that in the end, “You have to keep everyone happy.” It seems like this is how she survived fellowship and how she positions herself to be successful now that she is in practice.

Choosing a Position

When Jessica completed her fellowship, she had to decide between three positions. One was part-time with a doctor who works with an NFL football team, the second was with the community hospital where she did her residency and one was with the academic medical center where she did her fellowship. She decided to stay with the medical center where she completed her fellowship. She states, “When we weighed the pros and cons, it was the best decision for my family and my career.”

But, what made it the best decision? From her point of view, it was what she was going to do on a day to day basis, not the organization where she was going to do it. As she evaluated the jobs, she visioned what her life would be like in each of the positions. She was concerned that if she worked for the team physician, she would have to supplement her income by working somewhere in Family Practice. At the community hospital she felt that her role would be as a physician who primarily practiced Family
Medicine and knew a little about sports. At the University hospital, she saw her role as a sports doctor who knew a bit about Family Practice. In the end, that is how she identified herself. She explains,

The thought having to admit nursing home patients for urosepsis makes me shutter. It was not what I ever enjoyed doing. I mean it is not that those people do not need care and attention, but it wasn’t the thing that got me excited every day…When I see athletes or I am on the sidelines at football games, you know they are the things that I am really happy about.

This decision reflected her reason for pursuing a career in medicine. She explained that she saw it as a flexible career with many possibilities. In the university system, she has the opportunity to teach, work with medical students and residents, see patients, work on the sidelines at football games, and treat nationally recognized ballerinas!

When she describes what she does, it is clear that she is passionate about her work and very serious about being a physician, but she also enjoys the environment, and recognizes the organization’s influence and prestige. One of her frustrations about medicine is the lack of respect that the profession receives in the general public. It seems that this organization and her particular position insulate her from that. She gave many examples of this. She has a beautiful office and her own administrative assistant. She is invited to special events and meets all kinds of interesting people. She has access to a number of specialists who can advise her regarding acute patient care (such as on the football field). Even when it comes to patient care, she finds that patients are willing to accept her being behind schedule because of the reputation of the organization. While
this doesn’t make her job any easier, it does alleviate some of the frustrations she experienced during her Family Practice residency.

Identifying with Profession and the Organization

Since Jessica trained at her employing organization, she understood what she was getting into when she started her career. But, she still had to move from a trainee position to a professional position at the same organization. She talks about this transition and when she realizes she finally made it.

There was one point where I traveling with the university and a very esteemed colleague of mine, who I respect very highly, introduced me as his colleague and he said, “This is my colleague” and I was like, “Wow!” I felt like I had finally made it… I was treated more like a peer rather than a fellow or the resident… I was given respect and I started to get invited to things. Now that I am in the department, I get invited to things that you wouldn’t ordinarily be invited to.

Recently we [meaning her family] were invited to a very formal event where they presented the new company of the ballet for the year. I take care of some of the ballerinas. It is nice when they recognize you and say something like, “Hey, you know, my foot is feeling better” or “Hey, I am the lead in Swan Lake this year, you have to come and bring your daughter because she can come back stage and see all of us warming up.” I mean, imagine being a little girl and going back stage at the ballet and meeting them!

It was at this point, after all of the education and training along with a number of years of second guessing herself, that Jessica felt comfortable with her decision to pursue medicine and comfortable with her career. She explains,
This is when I realized, “Oh, look at all of the opportunities I have created!” Not that I have created all of them. Some of them I created, but some of them presented themselves. Anyway, I think it all started to pay off, and that sort of feeling that I wasn’t going to get ahead or not have any gratitude, it all started to (she hesitates) well the tide changed and I felt like, “I am getting ahead” and I am, I mean, in a lot of different ways and I am finally feeling appreciated for what I do.

The Financial Reality of a Career in Primary Care

Despite the fact that she loves her job, Jessica recognizes that she was not informed or prepared for all of the hurdles she would have to face and overcome to get where she is today. She expressed that there were so many times that she wished that people would have told her what it was going to be like, but, then she thinks about it and recants, stating,

If someone would tell you the frustrations that lie ahead as part of the process, I mean people don’t tell you that because they think, “Oh, here is this excited young person and they want to go into medicine.” No one wants to squash them and say, “Just so you know what you are getting yourself into, because you are going to have a lot of loans and you are going to have to pay back a lot of money and there are definitely going to be some days, sometimes weeks or even months when you are going to hate what you are doing.”

Even more frustrating than the loans and sacrifices that she faced to finally be where she is today, is the societal perception that doctors have a lot of money. She admits that she is comfortable, and feels guilty about complaining, but she also
recognizes that it is very difficult, in primary care, to, as she calls it, “get ahead” because of the enormous amount of debt incurred during medical school and the relatively low (in comparison to other medical specialties) salaries. As reality set in, and she realized that her school loan is larger than her mortgage (and it is a 30 year loan.). She seems to be quite very torn about this. She explains,

It is just something that isn’t told to you, and that makes sense. I mean, why would you tell some bright, young, aspiring physician in Family Medicine – I think it would be a deterrent to going into the field – and you don’t want to lead people away but, at the same time, when you are deep in the trenches you think, “Gosh, someone should have told me this.”

Lessons Learned

Though she has only been in her position for a short time, she feels compelled to help those who are following her in the profession. It is one of the reasons that she volunteered for this study. She wants to get information out to those who are thinking about a medical career in order for them to make an informed decision. Also, whenever she is asked to talk to medical students or residents, she takes some time to give what she feels is sage advice. It usually sounds something like this,

Look, no one ever tells you this, but whatever you pick as your career, you have to think about life because it happens whether you want it to or not. So, you just make it work, and don’t wait for the best time to do stuff [referring to getting married and having children] because it will never come.

She believes that “You need to plan life and then your career will work its way around it.”
Managing Work and Family

Jessica is married and has a young daughter. She admits that she was attracted to her current position because she had no inpatient responsibilities and did not have to take hospital call. She explains, “I have my cell phone on all the time at home for athletes who have problems…but, there is never something that I actually have to move from where I am sitting to address it.” She enjoys her position because unlike in residency, she now has some control over her life and schedule. She explains,

I have planned busyness in my life now, which is very good for me. During football season, every Friday night and every Saturday I am on a football field somewhere and that is okay with me, I don’t mind that, but I never have overnight call and I am not going in and rounding early on patients in a hospital somewhere.

She attributes some of her family’s success in managing both work and family to teamwork between her and her husband. She explains, “Over the eight years we sort of devised a pretty good system of figuring out who does what, and I usually end up falling on the short end of the doing stuff scale because I work longer hours for the most part.”

As she continued to talk about her work life and home life, it became clear that she and her husband had become quite masterful at multi-tasking and setting realistic expectations.

Unlike Family Practice, which has seen tremendous growth in the number of women physicians, Jessica works out of an orthopedic surgery office at a large, prestigious hospital. Her department is predominantly men. Also, the married men in her practice, for the most part, have wives who work in the home. She explains that sometimes it gets very frustrating because her colleagues have wives at home who “Don’t
work, and can make their dinner for them and do their laundry.” She said that sometimes she gets frustrated because both she and her husband work. She paints this scene, “Yeah, I go home at night and someone has to make dinner in our house. We both work and I didn’t see my daughter all day and the dog needs to be fed and the laundry is backed up because nobody has had time to do it.”

While she recognizes her own frustration, it is very clear that she has difficulty relating to the lives of her colleagues and their spouses. She goes on to say, “Yeah, they all have a wife at home, and they will say, ‘Oh, once a month I give my wife a break and she goes to card club with her girlfriends,’ or they will give their wives a break with from the kids.”

Once she gets started on the topic, it is easy to see that it is one of her frustrations with her career. She goes on to explain how difficult it is for her husband because most of the events for spouses are still geared toward women (for example, the “spouse’s tea”). But, what is incredibly difficult for her is when she has to listen to the wives talk about their difficult lives. She explains,

You go out with these couples and the wife tells you she had such a hard day. She went to the gym, but was disappointed that she only was able to work out twice this week; she went to the grocery store and then had to make it to the dinner. And I am thinking, really? I mean, I haven’t had time to work out in over a month and our milk is past dated. I smell it every morning to make sure that it will be okay! . . . I mean, they complain that their lives are so full; their lives are full, but full of nothing in particular.
She is very happy with the work-life balance climate in her office. There are times that she brings her daughter in for weekend duty. She is excited that her two and one half year old daughter’s presence does not ruffle anyone’s feathers and she clearly sees her organization as family friendly. It is clear that, despite her stories of being frazzled and not having much time for herself, her lifestyle works for her and her family. Unlike when she was a resident, she feels like her work schedule and her life are manageable. She never mentioned a desire to work part-time or be less involved with career. She doesn’t mention any avocational interests or how she uses her free time, since she really does not have much. Still, she is content; she has found her niche and she seems to be happy being where she is.

Reflections

Going through this process and being interviewed about her career solidified Jessica’s positive feelings about her career choices. She explains that she thinks that she would be miserable if she had continued as a primary care Family Practice doctor and probably would have tried to move into some type of administrative position. As she thinks about the reflective process that she went through while participating in this study, she feels the need to talk about the future of Family Practice and primary care.

She takes her personal experiences and ties it to policy, saying,

Even for the really good programs, it is harder to recruit people and I think that medical students who are looking to go into the field are seeing the frustration, the time constraints, the lack of appreciation. Less and less American medical school graduates want to go into the field and I don’t know if I blame them.
As she looks back on her feelings about Family Practice, she considers it to be a dead end job where you will be doing the same frustrating work for less and less pay. On the flip side, she is thrilled about where she is, and quite pleased with her career, organization life, and family life.

While entrenched in medical school, residency, and fellowship, she really did not have much time to think about what she was doing. She just did it. As she looks back on her decisions and how she acclimated to the profession, she recognizes that similar to her idea of “Don’t plan your life around your career, make your career fit around your life,” she can also say, “Make your career work for you, your passions and interests rather than pigeon holing yourself.” She went into medicine because of the possibilities, now she is in a non-traditional career track for a family physician, demonstrating the flexibility of the field.

Making a Difference in People’s Lives

Lily

Lily is a 31 year old White female pediatrician. She is married to a pediatrician, who is a participant in this study as well. She attended medical school in an urban setting. She completed her residency training at an academic training hospital in a mid-sized community. Currently, she is employed by a large pediatric group in a large metropolitan area. She was employed at her current position for approximately fifteen months when she was first interviewed.

Background

Lily does not recall exactly when she decided that she wanted to be a physician. She explains,

I don’t know when, the exact time that I got interested in medicine, but I have always been the sort of person that is interested in science. So, I would be at home in eighth grade watching the Discovery Channel, or whatever it was at the
time and it had Ophthalmology update and Cardiology update and I loved it! My parents would laugh at me because I was only thirteen years old and only had half a clue about what I was watching, but it was really something that I sort of always wanted to do.

When I was really little I thought, “Oh, I am going to be a nurse.” But, then I thought, “You know what, I want to be the one who will ultimately make the decisions.” Because I am more of a strong willed person, more of a leader than a follower, I thought, “Forget that! I want to be the one to make the decisions!” (She laughs.)

Medical School

Lily choice of college and medical school were influenced by her desire to minimize her educational debt. She describes her decision making process for choosing a medical school and a medical specialty.

I really didn’t pick the college that I went to. I mean, I got a full scholarship to the college, so I decided to go there. From there, I applied to different medical schools, but knowing already that I was going to come out of medical school with a fair amount of debt, I didn’t want it to be overburdening. I chose to go to University of X, a state school, because I knew it was a fine school, it would give me the education I needed, and not overburden me with debt. In medical school I took a year off in the middle, basically so my husband could catch up and would be on the same schedule that I was on. I did research for the department of medicine that year.
I hadn’t really set myself on any particular specialty when I started medical school. One of my first rotations was ob/gyn and it was very exciting. It was great to see pregnant moms. But, as soon as the baby came out, all I wanted to do was to see what was going on with the baby! (She begins to laugh.) I didn’t really want to go back and finish the c-section or do anything with the mother. That was sort of cluing me in that the draw of spending time with children was something that I was interested in.

Then, when I did pediatrics, I realized that, and I think of it in a purely selfish manner, at the end of the day, kids gave back enough to me to make me feel like it was a worthy day, a redeeming day. When kids are sick, no matter how well or sick they are, they are still kids and you still see that in them. There are still smiles. There are still hugs. There is still that part of it. And, the way that they weather illness is just so inspiring to me.

As far as treating adults, I just really have a hard time with people, who, and unfortunately a lot of internal medicine is a lot of lifestyle factors or things that people have done like smoking, carrying around extra weight, you know, adults do things that aren’t sometimes the best. Or they don’t follow Doctor’s directions. In the geriatric population it was very nice. I enjoyed spending time with them. But, I had a really hard time with the hypertensives, the diabetics, and all of those people who just really weren’t compliant. And I never got, well, you never get that feeling with a kid because no matter what, except for adolescents, they usually don’t do things to themselves.
Residency

Lily and her husband decided to “couples match” for residency. They interviewed together and took a very methodical approach to the decision.

We rank listed the residency programs. Basically, we went together and we when we left the programs that day, we talked about what we thought about them. When we went to Residency Y, we left and we both thought, “You know we really like this place. It has what we need.” What I was looking for in a residency was a program that was big enough to handle two people. You know; a program that has enough specialty exposure, and enough primary care exposure. One where the work schedule is tolerable and we would be able to see each other for the next three years of our lives. The program we chose was excellent for that. We were, well I am, very proactive about setting schedules. We maximized our time together which helped my sanity and my husband’s sanity throughout residency. Maintaining that time together helped us maintain our relationship.

Beginning a Professional Career

Lily and her husband approached their job search in a very similar fashion to how they chose residency. They were methodical and worked together. Because they wanted to practice in a large metropolitan area, they knew that finding jobs would be difficult and very competitive.

Searching for Jobs

She explains how her personality influenced the way they approached their job search,
Throughout my life I have been one of these planner people. You know, I planned where I wanted to go to medical school and then I planned the residency that we wanted. Then, two years into residency, actually the second fall of residency, we knew that we wanted to go back to where our family was and we knew that it was a very competitive area. There are lots of providers here. So, we knew that we had to begin early and that we really had to work hard to find places in the same geographic area where we could work, have schedules that we liked, had benefits that we felt were comfortable and where our job would be tolerable. So, we started the process early. Some of the other residents joked with us, because they didn’t start as early. But we wanted choices.

There was one job opening in the area where we wanted to live and that is the one that my husband applied for and got. He started looking at it about eighteen months before we finished residency. This was before anyone was actually considering it. He just kept in contact with them and that is what happened. We mass mailed resumes; sending them out to every practice that had more than three or four physicians in it. Because, again, in the smaller practices, you are going to be on call every other night and it is more difficult to take vacations and stuff like that. We didn’t want to, well (she paused), we thought about working in the same organization, but again, because we wanted to have the freedom to take vacation at the same time, to coordinate our schedules, we decided to focus on different practices.

So we sent out a mass of resumes and my husband called back half of the places and I called the other half, saying, “Are you planning on looking for
anybody? Did you get my resume? What do you think? And all of that stuff. At this particular practice, the one that I am working at now, when I called I spoke with the chief, the CEO of the organization and he said that they weren’t really looking for anyone. BUT, then he noticed that I speak Spanish and asked if I was fluent. When I told him I was, then he became interested. So, it was kind of a random occurrence that got me here. I had a few interviews for jobs with a couple of physicians that I didn’t get which is fortunate because this was the first but it was the best overall fit for me.

Starting Her Career in a Group Practice

Lily and her husband chose to work as employees of group practices. By coincidence, their offices are across the street from one another! She shares her feelings about her practice and explains how different it is from residency.

My position is optimal for me. It is really the best of both worlds. Mostly, I do what I want to do. I get to see a mix of patients, it is not one hundred percent healthy kids all day long, which tends to get monotonous – I mean, any field has monotony in it, but it is nice that every so often something interesting comes in the door and you get to share stories with colleagues and work through it. My practice is part of a larger group, so there is not so much pressure on each individual provider to, well, you know, hearing, “Oh, we can’t make budget this month, we can’t do this or that.” It is much more of a centralized organization, but, that being said, it is not Kaiser or some of these other large organizations where you feel like you are just an employee. Instead, I feel like I am part of the practice or the group, even thought I am a salaried employee.
Things are vastly different from residency to practice, of course – the lifestyle, the schedule. Coming from taking call every fourth night and being up all night. When you are working as a resident, you are constantly running around to get everything done! Now, I work a four day work week! Yeah, I work one evening from 12:45 pm to 7:00 pm, but on most days it is fairly 9:00 am to 5:00 pm. My day starts at 8:40 am; it takes me about 10 minutes to get to work. I see patients until noon. Usually, it is a mix of physicals and sick patients, or an occasional consult—behavioral consult, problem with eating, stuff like that. My office then has a lunch break until 1:30 pm and then it starts up again until 5:00 pm. Now, if it has been a particularly busy morning, a higher proportion of sick patients to well patients, I have to finish some of my charts at lunch. But, with an hour and a half, I have plenty of time to finish charts, make phone calls and even eat! I usually get out of the office between 5:30 and 6:00 pm. Then I just GO HOME!

Now, of course, I am on call one evening a week and one weekend a month, and I have to do Saturday morning office hours that weekend. Also, I have to go to see newborns and babies in the hospital in the morning. But, I work a four day week! I have Tuesdays off; so no matter how you do it, it evens out to less than a 40 hour work week. That is half of the hours that I was working in residency! And on my call nights, well, last night I was on call and I got one or two calls around 9:00 pm and that was it! We have a nurse triage system that takes over at 11:00 pm, so, after that I don’t get called unless there is an admission!
I was really surprised at how I got into the flow of this pretty quickly and how quickly I re-accustomed myself to a different pace of life. I was surprised just so surprised! I mean, within a couple of months I was like, “Remember what it was like..?” I also was surprised at how I was pretty much well prepared for practice. I figured there would be more times when I would be sitting there going, “You know, I have no idea – I am not sure AT ALL what this rash is!” And at the beginning, occasionally I would ask people, you know I would ask other physicians, and they would come up with the same thing that I would! Or, they would so, “I don’t know either.” So, that was a bit surprising that even people with years and years of experience would be as unsure as I was!

Learning How to Manage Time in the Office

Lily is not only amazed about the differences between residency and practice in terms of lifestyle and schedule; she also is surprised in terms of the organization and co-workers.

When I first started, I was nervous about the flow and taking too much time, because I am a slower person than other people I knew. In the winter, we see a lot of patients. Our schedule changes from winter to summer. In the summer, it can be so slow that you might be seeing 15 patients a day. In the winter, well, yesterday I saw 38 patients. We do not change our hours. We just end up full and over booking here and there. So, I might not be finished my charts from the morning until 1:00 or I may not leave until 6:00 pm or 6:30 pm. The hours don’t drastically change; it is just the pace that changes. So, you are feeling much more like you are running around.
It is interesting because I like to linger. I enjoy spending time with patients and chatting with them. When it gets to be difficult, it isn’t because of the pace of the schedule because you have a proportion of sick people. They usually just run in and have a quick issue. The difficulty runs in when you get a patient that is quote, unquote, billed for something. You think that they are coming in for a belly pain or a rash and it turns out to be a much more extensive problem that should have been devoted a lot more time in the schedule. When you don’t have that time to devote to it, it gets difficult. So, depending upon the severity of the problem and how acute it is, you end up getting behind. Then, you end up feeling bad and apologizing to the next patient. And this happens.

I will often get behind towards the end of the shift, because parents want one stop shopping. They will want you to deal with the earache that they called and set up the appointment for, but then they want to talk about the growing pains that they have had for the last five years, the mole on the back and, “Oh, by the way,” as they are leaving. We hear that all the time. I deal with the acute issue, and then when the patient is leaving, I get, “Oh, by the way, can I ask you about the temper tantrums, or behavior?” and things like that. It is part of pediatrics, and you can’t ignore the issue at hand, but it slows us down A LOT.

Efficiency is very important in primary care practices. There is not a lot of room in the budget for additional overhead such as staff overtime. Also, billing is complicated because every insurance company approaches payment differently. Lily explains how difficult this is, and how she goes about learning and dealing with it.
Dealing with how to code and bill a patient visit, especially the types of visits that I talked about where the patient makes an appointment for one issue and then discusses a multitude of problems, is part of life, but it is one of the most difficult things in practicing. It is ironic. I mean, we are in a diverse area. We have a lot of very well off people, as far as their income is concerned, but you still get a lot of resistance as far as coming back and having to pay an additional $20 copay or something like that.

Also, in my practice I have a very large Hispanic population and many of them may not have insurance. So, as soon as they walk into the office, pretty much immediately, when they come in for an issue, they are spending $70 or $80 and they want everything dealt with. Certainly, this is a huge amount of money to pay, so I try to be as accommodating as possible. And I understand when people say, “Now, I spend this much for insurance and I have to pay a copay for every problem?” But it is the nature of our beast. When we put someone in for a ten minute slot because their child has an earache that is really all we should deal with because it is all that insurance will allow us to bill for.

Part of it is learning how to bill properly and it becomes hairier, more difficult when a kid comes in for a physical and then has four different issues. Insurance companies do not want to pay for that. When you have spent 45 minutes dealing with these issues, then you have to explain to parents that in insurance terms it as two visits, a physical and a sick visit and they need to pay two co-pays! Parents do not like this. In the mean time, I am behind because I bent over backwards to address all of their issues so they don’t have to come
back, and then I get the backlash of, “Why should I have to pay twice?” And it
bothers me because I really can’t do anything about it.

Sometimes it is really hurtful because you feel like, I am doing you a favor
here to be accommodating and now you are giving me a hassle because of the $10
co-pay or something (grr) when YOU drive your Hummer here and yeah, your
ring on your finger, I can’t even look at it, it is so shiny (she starts laughing). You
know how it is. And I think, part of that, and I don’t know how much of it is, but
there is a certain perception that people have that physicians make a certain
amount of money. They think that, well, certainly I can’t complain that there is
nothing there, but pediatrics is not cardio-thoracic surgery. So, you know, people
say, “Oh, why are you driving that car and why aren’t you driving your
Mercedes?” It is difficult when someone is complaining about paying a $20 co-
pay while her diamond is blinding you, and her Mercedes sits in the parking lot;
when you are just trying to keep your ten year old car on the road and cover your
medical school loans. It is just, well, you know, it is kind of interesting that they
still have this perception that we just make gobs and gobs of money working in
pediatric primary care. It is just not the case.

Working with the Staff

One of the big differences for Lily between residency and practice is support staff. She
explains,

Having support staff to help you get your work done faster is a real change. You
know, people are really aiming to help speed you through what you are doing
during the day. I have never had that in residency. The nurses were not (pause),
well, the nurses were too busy working on taking care of inpatients to help figure out what you needed so that you could get done faster. They didn’t think about the most efficient way to do things.

It is just a completely different mindset. In my office, they perceive ME as the person that needs to be helped. In residency, in the clinics and inpatient, you know, they saw us [referring to residents] as people who are there to do THEIR work. But, in our office, we are the people generating the revenue, so everyone is like, “Let me do this.” “Let me run this test for you.” “Let me help. I can call this person back for you.” Now, that is a big SURPRISE! I am not accustomed to this. I mean somebody who actually wants to help ME! In the beginning, actually, it was sort of interesting because they would be like, “Oh, I will go make copies.” And I would say, “I can make a copy.” Or they would say, “I will go print this up.” And I would reply with, “That’s okay, I can do it.” So, you know, I’m not used to letting other people take a lot of the responsibility away from me to do these things. I usually do them all myself. It was sort of strange for me and difficult to get used to. It sometimes made me feel a little bit bad, because I COULD do these things. And, having other people do MY work, quote, unquote, just didn’t feel right. I knew that they were there to help me, but it was very strange.

It is tough because I want to gain the trust of the staff and make sure that they feel comfortable working with me. I never want to impose myself and abuse anything like that. SO, finding the balance between letting them do the things that they need to do to help me, and making sure that they know that I really
appreciate it. Well, it took a little while. It is funny because, some of the other
people in the office warned me, “You have to be careful, because if you insist on
doing everything yourself, then when you really need someone to help you and
you are swamped, they are just going to think that you always do things yourself
and that you don’t WANT anyone to help you.” I found that kind of ironic, but it
is true. So, now I have started asking for help. I know it is important that they
know that occasionally I need help and that I don’t do everything all the time by
myself.

It is getting easier because I have already established a rapport with the
staff and they know that I certainly do not take advantage of them. If I come out
and, let’s say, I need a strep test done and they are all busy doing things, then I
well go start it myself. Whereas, if I have a giant pile of charts of patients to go
see, and they are sitting there not doing anything, I feel free to ask them, because
they know that I am not just sitting around. It has been enough time that they
know me and they know that I would not take advantage of them.

*Being an Employee or Deciding to Become a Partner*

After two full years of employment, Lily has to decide whether she wants to
continue working as an employee or “buy into” the practice and become a partner. This
is how she explains it.

There is an option to buy in after two full years of employment. They crunch the
numbers and you are put on the “partner track,” so to say. The way they do it at
this practice is that they gradually increase your income instead of directly
moving you to partner status and that is your buy-in. So, there is a whole bunch
of different calculations about your productivity and all this sort of stuff. How long it takes you to buy in is based on how much you bring in and it somewhat complicated. But, it is always an option.

The only issue would be that you have to bring in enough to make it worth your while to go through that whole process and there is some inherit financial risk. Because we are a big organization with multiple offices, there is shared risk and shared reward as well. So, it is a little bit less stressful because say, if a particular office doesn’t do well for a month, then you don’t have to be concerned about what it is going to do to your income if you are a partner. The partners make money based on their productivity and the productivity of the employed physicians in the entire organization, not just one office. It is a little bit more spread out.

The other thing that I have to consider is, is it worth it, if for whatever reason, I decide to have a child and then I back off time wise for a while. That would not be the time to be in the middle of buying into the practice. There are also more administrative issues. There are shareholder meetings and in order to make partnership status, you have to be on one of our committees. Right now I am on the vaccine committee which means that we meet by telephone three of four times a year and discuss vaccines. You know, we discuss how we are going to incorporate new vaccines into the schedule and all of that. There is a financial committee and a board of directors, and all of that, so there are people who have a lot more administrative responsibilities.
**Earning Your Keep**

Lily is a salaried employee but she knows that she needs to have a certain level of productivity in order to cover her salary. Since the other physicians in her practice are partners they are acutely aware of the practice’s productivity. She explains,

When I first started I was very concerned about it [productivity]. Then, after about nine months we sat down and they said, “Okay, you earned your keep.” And so then I sort of relaxed a bit about it. I am a salaried employee, so technically is doesn’t matter, but if they see that I don’t earn my keep then they are not going to want to keep me in the organization. So, in a way, it influences it. Of course, if we have a day when it is incredibly slow, I feel a little bad, but it evens out. As long as I sit and occasionally run the numbers (pause).

Building the practice is the thing that I have tried to do in order to improve that part to the best of my ability. There were three doctors here and then when I was added as a fourth. Well, it means that I have stolen patients from some of the other physicians. That is what happens, redistribution occurs. And in a way, I felt a little bit bad about that because that means that the other physicians might see, theoretically, less patients. So, I felt that it was my responsibility to try to get some more patients into the practice, so that it would even out in the end.

I have put a lot of effort into it and I think it is working well. But, we just moved into a new facility, so we have a much nicer office. Of course, the nicer office costs more. So you hear people going, “Oooh, we need to be more productive, we need to see more patients, we need to, you know, grow bigger in order to support ourselves now that we are in a bigger facility.” And you know,
there is only so much you can do. Obviously, you bill properly and you try to get your patients to follow up when they are supposed to. You try to get them in for their physicals and you try to grab new patients through different kinds of things. I have done that.

We set up a booth at the mall for one of these family festival days. I go to the hospital and talk to pregnant parents, well, expecting parents. I feel that I put in the effort and they see that. The difficulty is that two of the physicians are really looking toward retirement from the practice. So, they are not focused on getting new patients in, so that burden falls on the younger physicians in the practice. If all four physicians were working to try to get new patients, we would probably do better with that. But, we are not.

*Learning How to Be a Patient Advocate*

One of the roles that Lily plays is patient advocate. Because there are fewer people going into pediatric sub-specialties, she is finding it difficult to get her patients the specialty care they need. She feels that it is her role to treat patients, educate their parents and advocate for them. She feels that this is why she is a doctor. She gives an example:

I had a patient come into the office a few weeks ago who is a new diabetic. You know, he came into the office with increased urination, and thirsty and all of this stuff. And I got to be the one to help them through that process, and they are Spanish no less, which is tough, but you know, I helped them. I helped the patient and I helped the parents understand. That is what makes being a doctor rewarding.
Now, I had another diabetic patient, and it was another Spanish speaking family. Communication for them is a big issue and it can be very difficult for them to get the care they need. Anyway, I had this diabetic patient that I saw. He came in for a physical and as we were going through things I found out that he was out of school every day because his blood sugars were so high! So, I told them that they needed to call the endocrinologist and get the set up changed.

Well, it had been nine months since they saw the endocrinologist! When I asked why, she said that she had cancelled an appointment and now they won’t call her back. Then she went into all of this horrible stuff and how the school is telling her that he needs to be home schooled because he is sick all of the time.

I told her that he is NOT sick all of the time; he just needs to have his diabetes under control. So, I started advocating for the patient. The people in the endocrinologist’s office gave me all of this blah, blah, about how [the parents] they did not follow up. But, it doesn’t matter, that is no excuse when mom calls and says that his sugars are out of control! These parents need an advocate in order to get things under control. I understand that specialists are really busy, but I am the primary care pediatrician and I have to coordinate care and make sure that I am really doing what is in the best interest of the child.

The problem was that the mother didn’t understand what she needed to do and how she needed to record things. She should have had diabetes education and maybe she received it in English or maybe she didn’t understand it. But, I had to, and have to reiterate that SHE has the power. I have to empower her to advocate for her child. And it is pretty difficult because many times they don’t understand
the severity of the illness or they are in shock. It is incredibly frustrating because I don’t have the time to sit through all of the screens and paperwork and help them understand things, even like how to give medicines or what medicine to use for what. But, someone has to.

For example, if a child has asthma and has to take inhaled medicines. You know there are two different kinds that are used at different times. So that a parent doesn’t get confused and give the inhaled steroid instead of the albuterol when the child is sick, I need to make sure that they understand. I end up working with terms like, “THE ROUND ONE” and “THE LONG ONE” (she says chuckling). And some of them are asthmatics themselves and still don’t get it. So, it really takes effort to make sure that people understand what they need to do for their child.

Work Life Balance

As mentioned previously, Lily appreciates the slower pace that she has now that she is in practice. She recognizes that it could be easy for her and her husband to get consumed by medicine, but they have made a conscious effort to make sure that their relationship with family and each other is nurtured. That is one of the reasons why they chose to practice where they are practicing. She explains, “We certainly had hobbies, but coming out of residency we have to make sure we pay enough time to them and get back into others, like exercising and my husband is into sports-things like that.”

*Different Priorities for a New Generation of Physician*

Lily explains that there are “numerous layers” to the differences between older physicians and those coming out of medical school and residency today. She explains,
I am the youngest doctor in my office. There are older physicians in the practice who are in their 50s to 70s. They came from a time when you got out and you opened your own practice and you were on call all the time. And you ALWAYS had to go to the hospital. And so, they gave everything to medicine. They did not see their children, and they always had to leave home for various occasions. They spent all of their time at the office. Actually, in the practice that I am in, one of the daughters of one of those physicians works at the front desk and another one works in the central business office as the coder/biller. When I talk to them, you hear that. “Well, Dad wasn’t around very much.” And “Well, you know I cut myself and he said, wrap it and I will be home in four hours,” or something like that.

Certainly, I see in the big group, or our big organization, that the younger people that are coming in, well, they really have a different philosophy about what they want out of a career in medicine. Everybody obviously loves medicine and wouldn’t have chosen it if they didn’t want to; but, certainly the women who are in it now, entering now as opposed to the older generation of women, do not at all feel like they have to, you know, stop having children, or give up a lot of the dealing with the family. And certainly, all of my friends and colleagues that have gone out to practice feel like the option to, you know, to maintain the family, to work part-time, and to not necessarily own my own practice, or to not want to do something so auspicious like be the chairman of medicine or something like that. That is not really our thought. Our thought is more, you know, “Do some good, have a good life but still have our priorities the way we want them.”
This leaves space for a lot, well, unfortunately it means, especially in pediatrics, where the majority are women that it is hard to find people who really, really want to be those go getters and advance and be the leaders, you know, start new organizations or be the chairman.

She also speculates that this is why people of her generation are not going on for sub-specialty training.

What is interesting in pediatrics is there is a difference between the primary care specialists and the other specialist. We are seeing a great need for pediatric specialists. Few people trained in pediatrics are doing specialties within the field, and I am speculating on this, but I think it has a lot to do with the changing culture in medicine. More women in medicine, more part-time employees. People are thinking about taking care of their families and such. They are not wanting to spend the extra time to go into a specialty, which I certainly understand...It is tough, especially for the surgeons and other fields that take so many years until you quote unquote start your life and make the kind of income that you feel like, you know, you can support your family with. That, plus if you have a substantial amount of undergraduate debt and/or medical school debt, it can be overwhelming. Yeah, it really can.

Generations Work Together

As for how the older, more seasoned physicians in her group feel about this, she explains, I think that they do have a hard time dealing with the differences, well sometimes. There was a physician that was in the practice before me and she was the type of person who made it clear from the beginning that her family came first and if she
had children, she was going to stay home until she decided she didn’t want to. She wanted things her way. Like, she clearly let them know that if she was pregnant, she was not going to see patients with rashes and things like that. And she wasn’t going to do this and wasn’t going to do that. And that, OF COURSE, rubbed them the wrong way. Because that felt like a lack of commitment to medicine to them, I am assuming. And you know, there are people like that who really perceive it just as a job, for whatever hours you work and for whatever time you decide to work, not so much of a career or a calling or something like that.

I still perceive it as a calling because, nobody would go through this much trouble and there is just too much work to do in this job unless they felt like there was something more than just a paycheck at the end of the day. So, in that way, I haven’t had that many problems seeing anybody or doing anything. I guess, in some ways, that makes me different from some people coming out and that is FINE. Again, for me, I didn’t choose it because I wanted a glossy paycheck or the notoriety or respect or whatever it is that comes along with the career. And so knowing the commitment that is involved, I wouldn’t have given my ENTIRE decade of 20s to it unless I knew I would, would be willing to do what all was involved.

But, the perception is out there and it rubs people the wrong way. I know in our group, and with me being the youngest, I get SHOCK, like, “Oh, you offered to take this extra day?” Or, “You went and did this?” Or, “You decided that you want to help the practice grow?” Or “You took on this extra
responsibility?” There is just some measure of surprise that some people have with that.

Reflections

The best way to describe Lily is content. She enjoys her practice; she is happy to be home near family; and, she is pleased with her slower paced life (in comparison with residency). In hindsight, it was very exciting for her to see how quickly she became acclimated to the perils of private practice, especially billing and productivity issues.

Lily is a self-professed “planner.” Her career path shows that. She did not really get advice or direction from anyone when she and Ricardo (her husband) were making their plans. When she thought about this, she was amazed that things turned out the way they did. They were teased by their peers for being so proactive. As she looked back at her narrative she suggested that this was just so different than what is seen in the medical culture where it is about networking and finding a job through people you know. Because she and Ricardo had to actually look for a job, they thought about the process more deeply. As she looks back at this, she is pleased with their decisions. She is living and working in the location that she desired and she clearly knew what she was getting into in terms of her medical career. Her biggest surprise was that it was fairly easy to become comfortable and confident in her practice.

Though she often verbalizes that she feels called to medicine, taking the time to reflect upon her decisions and her practice has solidified that calling. She says that her life goal has always been “to try to help people in life and through
my profession. Through my personal life and through my relationships with other people, you can make a difference in people’s lives.” She was surprised at how strongly her narrative reflected her challenges and learning around the day to day issues of practicing medicine and less about how she adapted to professional life. She guesses that this is because it was so easy for her to adapt to having everything she wanted.

Stop Complaining and Start Living

Ricardo

*Ricardo is a 31 year old Latino male pediatrician. He is married to a pediatrician, who is a participant in this study as well. He attended medical school in an urban setting. He completed his residency training at an academic training hospital in a mid-sized community. Currently, he is employed by a small pediatric group with two offices in a large metropolitan area. He was employed at his current position for approximately fifteen months when he was first interviewed.*

Background

Ricardo’s interest in practicing medicine began when he was in college, at the encouragement of the woman who is now his wife. He explains,

Initially I was planning on being a researcher because I have always liked genetics and I always liked research. I used to do research at NIH during the summers when I was in high school. I always liked science and I applied to NIH for a summer program and got a position. My wife actually did this too, which I didn’t know. I got hooked up in a lab that I really liked and I continued every summer during college. Then, when I was in college, I actually met my wife. She was a pre-med and I started to take some pre-med courses. I continued to do research, but then I realized that I was too much of a people person just to do research. I wanted to kind of combine the aspects of science, but also have
interaction with people. I was halfway through college when I decided, “Maybe I should try med school.” So, I took the extra courses to do that and then I knew. I knew at that point that if I went to med school I would only want to do pediatrics. I thought about pediatric genetics because of my research. I knew that I wanted to work with kids and that I couldn’t handle working with adults because adults NEVER listen to what you say! Whereas for kids, they do. They will take your advice a little more seriously. So, that is what kind of got me into pediatrics.

Medical School

By the time that Ricardo was deciding on medical school, he was in a relationship with the woman who sparked his interest in medicine. He shares the story,

When I was applying to medical school my wife and I wanted to stay in the same area. She was actually a year ahead of me because I wasn’t sure if I wanted to go and get my PhD. or go to medical school. She got into U of X and so I only applied to the local schools. I got accepted and got a full scholarship to go to Med School Y, so I thought, “I will go there.”

I am very happy with my decision. I was initially a little tentative because I was deciding between School Y and School Z, but the difference was $20,000 per year and I thought, “Well, there is more name recognition with School Z, but it really doesn’t matter. If I go and do really well on my board scores and pass of my classes, everybody uses the same books anyway, it should be okay.” When I went to college, I had the same deliberation because I got accepted to Princeton but I had gotten a full ride to U of X. I ended up going to U of X and I loved it. I had absolutely no regrets. So I thought, “I should do the same for med school. I
will go somewhere where it is going to cost me less and if I am at the top of the class there, it is better than being at the middle of the class somewhere more competitive.” It turned out great. I got my first choice of residency and I had absolutely no problems.

Residency

Ricardo and his wife wanted to attend the same residency, so they decided to “couples match” which means that they would interview for residency positions together. This is how he explained it,

We interviewed together at eleven different residencies and initially we had thought that we wanted to stay in the area. I knew that I didn’t want to go to a place that was too demanding because neither I, nor my wife, are very gung-ho, aggressive sort of people. I wanted to go somewhere where there was a little more social interaction; more time to get to know people and enjoy yourself. We ruled out a couple of the more competitive places, but we pretty much interviewed everywhere else in this geographic area. Because there were only six programs in pediatrics locally, we thought we should branch out a little, so kind of on a whim, we started looking at adjacent states that weren’t too far away.

We wanted to stay reasonably close because her parents and my parents are both in this area. We didn’t want to go more than two hours away, so that we could come back on weekends if we wanted to. When we went to program Y, it was our tenth out of 11 interviews, and we absolutely fell in love with the place. Everyone was nice and everyone was very accommodating about us coming in together, and trying to give us call together, and trying to arrange our schedules so
we could take vacation together. Whereas, a lot of other places were like, “Oh yeah, we would love to have you both, but you know it is residency. There are no guarantee that we can put you together and this and that.” But they said, “Oh, we can try to switch this around and make it work and things like that.” I was really impressed with all of the staff and the other residents, so we ended up ranking it first because we thought that we would really fit in there and we were absolutely right. I have a lot of other friends that went to residency and had a really hard time of it. But, we thoroughly enjoyed it, well, as much as you can enjoy somewhere where you are working 80 to 90 hours a week! It was actually very enjoyable.

Beginning a Professional Career

Ricardo and his wife wanted to practice medicine in the geographical area where they grew up. It is a large metropolitan area where the physician job market is quite competitive. Still, it was very important for them to return to the area to be near family. Ricardo explains his priorities:

Family is important to us and we have made career decisions around that. It has worked pretty well. I mean, it really has not affected my career. The nice thing is that I haven’t had to sacrifice career ambitions to be close to my family. We really wanted to stay nearby so we could see our families. My brother has a house here and my parents live here. My wife’s parents, grandparents, and brother live here. We knew that we wanted to be somewhere where we could be close but if we couldn’t find jobs, we were willing to move away. Fortunately, it hasn’t really factored in. I mean, we probably could have went some place a little
bit closer for residency, but because we really liked the program that we went to and it was still close enough, it balanced out.

The same thing happened with working. We first looked in the area around where our families lived, but we ended up finding jobs here, which is about half an hour from them. So it was a nice compromise. We both found jobs that we really like and we are still close enough. So, we didn’t have to sacrifice both with residency and with getting a job. We really didn’t have to move far away.

**Choosing a Position**

Since Ricardo desired a certain geographic location to begin practicing medicine, he thought that he may have limited options, but he found a position that suits him well. He explains:

> My job is great. I had interviewed at three places. This was my first interview and I really liked. I really liked the people. One of the two partners went through residency program Y [the same residency were Ricardo trained] so we knew a lot of the same people. He is very laid back and he is a very nice guy, so we just hit it off. After I interviewed here, I interviewed at a couple of different places around the area, but I ended up choosing this one because it seemed more like my kind of place. Plus, then my wife ended up working across the street – it is literally walking distance! So, when she decided that she wanted that job, that made my decision easier because then we could be right near each other. Plus, this was my top choice anyway.

He explains further:
I am a very, very laid back person and I wanted to go somewhere where people were happy to be there. And it was kind of a, well you know, you come in, you do your job, you play with the kids; a loose atmosphere with people joking around and having fun. I didn’t want to go somewhere that was too regimented. There are a lot of doctors’ offices where people don’t really talk to each other. Everybody is just kind of there; they do their job and go home. When I went for my interview, I saw that all of the nurses and all of the front desk staff had lunch together and they are always laughing and goofing around. They are always joking with each other – and I saw that when I was interviewing. I heard them talking and getting along. So, that was actually the main thing for me. I figured anywhere I go I can practice my own way, but as long (pause) well, the most important thing for me, was that as long as there is a good staff around you and you feel that you fit in with them; you can be productive AND have a GOOD TIME! That was the most important thing for me, and it turned out to be true so far.

*Fitting a Square Peg in a Round Hole*

Ricardo recognizes that the medical profession is not very “laid back.” He talks about how he has acclimated to a professional culture which is counter to his inherit personality:

I have to tell you, there were sometimes in both residency and medical school, not so much now, but definitely during my training, that I had some troubles. Especially with some attendings and some of the professors in medical school because of the fact that, well, I just don’t worry about things. I never have.
Things don’t bother me. I just show up, do what I am supposed to do and I go home. I graduated third in my medical school class and I did perfectly fine in residency. My personality never gets in the way of my performance, but I think that some people, they just thought that I didn’t take things seriously enough.

That happened a lot in residency. I had some attendings that would get upset with me and I would say, “I did all of my work. Everything is done. You don’t have to be bitter, angry and disgruntled all of the time.” I mean you’ve got to be there. If you work from 8:00 until 6:00, you have to work from 8:00 until 6:00 whether you are happy or upset. So, if you are walking around grumpy and upset and it is 10:00 in the morning, no one is going to come to you and say, “Hey, you look like you are having a bad day, why don’t you do home?” So there is no point in being miserable. So, when I was on call, instead of saying, “Oh God, I’ve got another call!” I would say, “One more call down.” That is just how I am and you know, I think that it just rubbed some people the wrong way. Some people will find things to be upset about. But, everywhere I go, I have always been one of the most laid back people and some people just didn’t like it. I just had to say, “Oh, well, that’s life,” and move on.

Finding an Organizational Culture that Fit

Ricardo explains that the culture of his office suits him quite well. His “laid back” nature may have caused problems in residency, but it seems to suit him well in his office practice. This is how he explains it:

Now, at my job, it is a little different because we have two offices. We have one in another area about 20 minutes away and that is where the two partners are and
two of the older docs. They just opened this practice so there are actually just
three of us [providers]. There is one physician’s assistant (PA) and there is
myself and another doctor who is just out of residency two years before me. So,
you know, we have three providers under 35 and all of our staff is in their
twenties. Whereas in the other office, the providers are in their 50s and the staff
is older. So, our ENTIRE office is very laid back. We all eat lunch together; we
all have fun; we have a good time! So it [referring to his laid back attitude] hasn’t
been as much of a problem here. I think that is one of the reasons why I wanted
to work here because I thought, “WOW, this seems like a place where other
people are laid back too and I won’t stick out too much!”

Now the two offices have two REALLY different cultures and sometimes
(pause) well, the other office is bigger and sometimes, if one of our nurses is sick
or we had a nurse who was pregnant and gone for a few weeks and some of the
nurses had to come over from the other office. It takes them a few days to get
used to me. Because, well, I hop around the office! I sing! I run up and down
the halls with the kids and we throw paper airplanes at each other! There is one
nurse in the other office that is in her early 60s. She has been a nurse for about
thirty years. The first day she was here she would just sit there behind the counter
and I would be chasing the other nurses around and we’d flick rubber bands at
one another and she would just sit there and say, “I can’t believe that I am
working at a doctor’s office!” But, the funny thing is that we bring in more
revenue than the other office. I have been here less than two years and I have the
second highest number of patients after one of the partners! So, my work performance is nothing to worry about. We just have a very different culture!

The partners realize that there are two very different cultures and different feelings in both offices, but since the revenues are so close, it seems okay. Because of the growth in the area, our patients tend to be younger, between 0 and 5, while at the other office there are a lot of teenagers and patients who have been there for a while. They realize there is a difference, but I haven’t heard any problems of concerns. The partners help out at our office when we have our days off. One of the partners is a really laid back nice guy and he always, when he comes over says, “Oh, it is my day with the kids! I have to put on my roller skates because you have too much energy!”

Adjusting to Private Practice

Ricardo assumed that he would enjoy practice and knew that it would be much easier than residency, but he was surprised at how quickly he adapted. He shares his in detail how he goes about his day.

Most of pediatrics, especially general pediatrics, is pretty much bread and butter. There is not a lot of really complicated stuff. So, most of it is your typical colds, and your ear infections, so any competent doctor can diagnose those things. So, the difference between pediatricians is going to be the interaction with the children and the interaction with the parents. So, I make that my first priority.

I have 10 minute sick kid checks and 20 minute well checks and I see, on average, in the winter I usually see somewhere around 25 to 30 patients a day. We try not to overbook. The problem is that some places try to see 40 kids in a
day and it is doable, but: 1. You run behind, and 2. There can be absolutely no social interaction. I mean there are some days, like two Monday’s ago, where I saw 36, but usually, on a Monday you are around 30 to 35 in the winter and the rest of the week, well, it varies, but it is somewhere around 25. I think my average for the winter is in the 22-28 patients a day range and in the summer it is usually a little less, probably around 20. Outside of the days when I am seeing 35 or 36 patients, the most I run behind if half an hour and I never get further behind than that. Because our lunch break is from one to two and a lot of times, I will see my 12:50 at 1:15 and maybe I will end up seeing my 4:50 at, well, I think the latest I ever saw them was 5:30, but that really is unusual.

You know, you just have to budget your time. If, well, you can’t spend the same amount of time with every patient and if it is a patient that just came in for a well check two weeks ago and I spent plenty of time with them in the room during that visit and they come in now, with cold symptoms, well, I don’t need to do as much of the social interaction. I can come in and I say, “Hey, you are back!” And I check them out. If it is just a cold, I maybe spend 5-6 minutes, and if the next patient is also just a cold, but I haven’t seen them in months or I am suspicious that something else is going on, I might take those 5-6 minutes that I saved with the other patient before so I can reconnect. If you run 1-2 minutes over with every patient, then you are way behind. It is a balancing act, but it is something you have to do. You have got to stay on top of that because no matter how nice you are, and how good of a doctor you are, if it always takes an hour to see you, you know the parents are going to be like, “Yeah, I really like him, but it
takes an hour to see him, so I am going to go somewhere else.” So, you have to keep that in mind.

It is a lot to balance, but I think that it all boils down to, if people think that you are a really genuinely nice person and really, really looking out for their well being, then the time that they come in and you are really behind, well, they are probably not going to have a problem. Or, if you come in and it is a cursory 2 to 3 minute exam because you don’t want to get behind and it is just one of those days. If every other time that they come in you address their concerns and you interact with them and you play with the kids and the kids love you and know that you genuinely care, you can squeeze through those things. But, if it is like that every day, well, I know that there are practices where they squeeze 35-40 patients in every day. I don’t know how they handle that and I have chosen not to do that. There are a couple of the doctors at the other office who will double book and they will put more people in because, obviously, they are getting more revenue. I am not going to do that. And they have asked me that before, but the partner said that as long as you bring in enough revenue that you are covering your salary, above that is productivity. So, if you don’t see anybody else, you don’t get extra money. If you see more people, you get extra money. I just don’t think that it is worth it to do that and give what I think is more cursory, shoddy care to make an extra couple bucks.

Learning What is Expected

Ricardo appreciates the culture of his office, but he also has to work within a larger system. He explains how he has adjusted to that.
My first month, I split time between the two offices. They do that for people when they first come in so you can get a feel for both offices and you can work with the partners and get a feel for how they do things. And it is good to know how both offices run. But, after my second month, I felt pretty comfortable, so I told them that I was fine to go to this office and do it myself and open up my schedule more.

The office that I work in just opened a few years ago, so, it was kind of, well, I think that they observed ME and saw my style more than I observed them. They kind of fit around my style and followed my ways of doing things. But, at the other office, it was much more of, “Well, this is what happens. This is how we do this or that.” The partners were there, so I just went along with them. But, at this office, I kind of did things my way and there didn’t seem to be any problems, so I just continued. I told the office manager, “Hey, if there are things that you just don’t do, or if this isn’t the way that you do things, just TELL ME.” They were pretty comfortable with that and there wasn’t any problem because I told them right off. I said, “Hey, don’t sit there and fume over it—just say, hey, we usually don’t do that or we don’t do this and I will just figure it out.

So, it has been pretty easy going. Like I said, the nurses adapted to me and to my style pretty quickly and like I said, because I had a pretty open style and an open dialogue with them in the beginning, it works. Like one day I said, “Hey, lets draw blood on this kid.” And the nurse said, “Well, we don’t usually draw them because we don’t get reimbursed and blah, blah.” So, I had to learn little things like that, procedural things and technical things. And then there were
some things with the way that I practice that the other doctors didn’t do, but it was never an issue. They just picked up on my nuances and it was fine. For the most part, I make the decisions as to how I am going to practice medicine. I mean, I treat asthma myself.

Transitioning from Training to Practice

Ricardo surmised that he would have much more control of his life and his time when he finished residency and went into practice. He believes that he was right. He works a four day work week and is only on weekday call once in every six nights. His weekend call is every sixth weekend, so he feels that he has a very manageable schedule. He explains what it felt like, after many years of training to actually be in practice:

I knew that once I got out of residency the lifestyle would be a lot more relaxing and a lot less stressful. People kept telling me, well, the attendings kept telling me, “Oh, it is really not that much easier, it is less hours, but it is this and that.” It is really SO much easier than residency. I was really scared coming out and then after my first few months in practice, it was just, I was just surprised at how easy it was to just flow into private practice and how comfortable you get. Just after a couple months, you are just totally comfortable as a private pediatrician and a lot of the stress and angst from residency are totally gone and call is not stressful. You really get to enjoy your life outside of medicine. Whereas during residency, even when you weren’t there, you were thinking about work and thinking about when you have to go to work. Now it is the exact opposite. I’m thinking, “Oh, yeah, is tomorrow Monday? Yeah, I have got to go to work.” So, that was the
one thing that surprised me, how much of a change it was from residency and how much easier it was to be out in practice.

The main things about residency were the hours and the acuity of the care. In private practice, you might have a wheezer, you might have a kid who is seizing once in a blue moon, and so you send them over to the ER and let them take care of it. But in residency, especially on the nights that you are on call, YOU WERE IT! The attending was at home and there was always that fear, especially in the NICU [neonatal intensive care] and the PICU [pediatric intensive care], and with the sick kids on the floor. You were always scared. What if something happens and I have to do it all myself? That was constantly on your mind. When you are in private practice, you don’t really have that.

Transitioning from residency to private practice was much easier than transitioning from medical school to residency. I mean, I was expecting residency to be the worst thing that I ever went through, and so I was going in thinking that. It is like you are stepping up in intensity when you are transitioning from medical school to residency. But, then, when you move from residency to practice, you are stepping down in intensity.

Balancing Life and Work

The main reason that Ricardo chose to be a general pediatrician instead of a geneticist was because he was concerned about lifestyle. He seems to have a clear idea of what is important to him and that leads him in his career decision making. He explains his philosophy on life:
I always think of your life as a big pie and you have to have time for family, time for work and time for your own personal interests. And when any of those impedes on any of the others, it really causes problem, and that is when you start having stress in life. Like, if you are spending too much time at work, your family suffers, your personal interests suffer and you are miserable. If you are not working enough or not making enough money and spending too much time on your personal interests, then your financial status suffers. So, you always have to keep your pie balanced.

There is always that, especially in medicine, law and other professions where you are in higher echelon fields, you think that if you work a couple more hours or do a little more of this, you can make a little more money. Then the little more moves to more and before you know it, you are working 6 or 7 days a week, just so you can make a little more money and you are not really happy doing it. And, it sounds remorse, but then you die and what do you do? Do you stuff all of that in your casket? So, you know, you want to have enough to live off of and be comfortable, but the rest of your time should be spent enjoying life, and enjoying your family and enjoying what you do. And that is what I have always tried to find, somewhere in the middle. You have to work and you should like your job, but beyond that you should be with your family and doing the things you like to do.
Deciding on Partnership

Both Ricardo and his wife are in practices where they can eventually “buy in” and become partners. Ricardo explains his reticence toward buying into the practice and becoming a partner.

Usually after your second or third year you can buy into partnership. So, what happens is, well, during your first year, you are just on salary. Then in your second year, you are on salary and productivity, if you meet your salary number. Then, during your third year, you can start buying in to the practice and it is one of two ways. Either you, at the end of the third year, buy in with the whole lump sum, or you do what most people do and that is they take your productivity, the money you make above and beyond your salary, and you put that in and buy in over a couple of years.

But, because my wife and I are thinking of starting a family in the next year or two, I haven’t decided about partnership. Part of that is going to be seeing what happens there. If we decide in the next year, if she has a baby, she will stay at home for a little bit and then go back to work. I don’t know if I want to jump into partnership just yet, I may want to wait a couple of years. Or, I might, - well, we decided that we are both not going to work full time when we have a family. She is a little more of a go getter sort of person than I am, so probably one of us will go for partnership and the other will probably go back to 2.5 or three days a week to spend time with the kids. As of right now, it will probably be me. She may go back to work part-time, like three days a week for a while until the baby is
six or seven months and then she will go back full time and at that time I will cut back. So, if that were to happen, then I would not be pursuing partnership.

I made sure that the possibility of staying as an employee was in my contract. Because, even when we talked about it before, in residency, we talked about one of us working part-time and spending time with the kids and I have always wanted to do that. As I said, she is a lot more work driven than I am. I told them that when I interviewed and they said that was fine. There is one of the doctors at the other office who has been there for eight years and has no desire to do partnership either. So, it is not really the business of medicine that bothers me and doing the administrative work. It is more from a practical standpoint. I wouldn’t do it if I were to cut back to part-time and not be able to dedicate my whole self to it because partnership adds a whole other job above and beyond just coming in and seeing patients.

Perception of the Profession and its Future

Ricardo recognizes that he looks at the world a bit differently from most physicians. He attributes this to his upbringing. He explains:

I didn’t practice 20 or 30 years ago and from what I hear, it is a lot different. Doctors make a lot less than they used to and they need to see more patients than they used to. Reimbursements are going down…but, you know it is still a wonderful field. You know, there are not many other jobs that you can do and you can make a difference in people’s lives every day. People come in sick and you make them better. And no matter what doctors tell you, you could poll 100 lay people on the street and ask them what job they have the most respect for and
doctors will always be one of the ones on the top. And it always will be. And that is one of the wonderful things about being in medicine. People really look up to you and I think that you have to realize that and be an example. If you are in practice and you are sitting there and you are grumbling and you are grumpy all day, I think that is an insult. Especially if you have patients, like I have a lot of underprivileged patients. You know, patients that are making five dollars an hour and working three jobs and they still can barely make ends meet. If you are sitting there grumbling about how little you make, making $50 or $60 an hour, driving a Mercedes, I think it is a little disingenuous.

Now, part of that is that I grew up in Portugal and I came here when I was eight. I was on welfare until I was sixteen. So, I know what it is like to be really, really poor. When I was living in Portugal, my dad was here trying to get us over here. So, when I came over, my dad worked three jobs and my mom worked two. So, I essentially grew up – well, I was a latch key kid from the age of eight and I had to learn, you know, how to enjoy myself with little things because I didn’t get to play a lot of sports and things like that. When I was ten years old I would have to go and pick up my brother from kindergarten. And, I didn’t have a lot of clothes and I didn’t have a lot of toys. You know, for me, it is almost in excess that I can be doing so well and be doing something I really like. I can’t complain because I remember having the free lunches at school and I remember being teased and all of that stuff. I know that if I were still in Portugal, I wouldn’t have this kind of life.
That is something that bothered me in residency. I mean, a lot of times the residents would sit in the lounge and just complain about this attending and that, and it was just so frustrating. I felt like telling them, “You didn’t have to go to residency! There are a lot of people out there waiting that would kill for the chance to go to residency.” You know, you are HERE – you should be HAPPY! You should say, “Wow, I got into residency! I am given the chance to learn medicine, here in America and the opportunity to have a really good education so that I can go out and practice.” … A lot of people in residency act like it is a jail sentence and they need to remember, YOU CHOSE THIS! Nobody said, now your punishment is that you go to residency!

I didn’t practice when doctors made lots and lots of money, so, I never really had that expectation. I was just happy to have the opportunity to learn medicine. You make plenty of money and you are in a job that is wonderful and you use your mind which is great. You are not in a job where you have back breaking labor and even though reimbursements are going down and practice isn’t what it used to be, you still make a decent living. If you want to make money, DON’T go into MEDICINE! Unless you go into plastic surgery or some of those fields, but you are not going to make a ton of money being a pediatrician! If you enjoy what you do and not just work somewhere because you need the money, you are already ahead of the game. I mean, everybody has to work. If you like going to work, that is a plus.

Between me and my wife, we have about $200,000 in school debt and now we are down to $192,000, so we are doing good (he says sarcastically.) So
we actually came out with just as much debt between the two of us that most individuals come out with. So, I knew that I was going to have a lot of debt and I knew that I wasn’t going to make very much money as a pediatrician. I drive a ’98 Geo Metro and I have no problems driving my ’98 Geo. But, I would rather do that and live in my little three bedroom house than have all of these material pleasures and be sacrificing myself to make more money. Now you have to keep in mind that I was thinking about doing research where you are lucky to make $30,000 a year, so money has never been a driving factor for me. As long as I have enough to pay the mortgage and pay the loans, I am fine.

Reflections

By nature, he is not a very reflective person; he lives life in the present, and doesn’t reflect much on the past or speculate about the future. He claims his life motto to be “carpe diem” and his demeanor reflects that. He told his story and was ready to move on. Because of his very “matter of fact” view of things, he found it interesting that as he talked about his experiences he became a bit philosophical. He never thought of himself in that way.

His unique perspective on his profession and his life makes him different from most other physicians. He likes that and does not see himself changing to fit the profession. He would like his attitudes and ways of approaching the job to rub off on other people. Ricardo talked a lot about his “laid back nature.” When he discussed this further, he recognized that this is his greatest attribute and his biggest nemesis all wrapped into one. While he can’t imagine living any other way, he realizes that his perspective is “out there” in comparison to his colleagues
in the field. This is why he is so happy that he found a practice where he can be himself. He enjoys being at work and his narrative reflects that energy. In the same respect, he sees himself as just an ordinary guy doing his job. His entry into the profession went smoothly. To him, it feels like he has been doing this all of his life. There were no bumps in the road and everything is going great.

If Only They Would Have Mentioned This in the Brochure

Mariah

Mariah is a 30 year old African American primary care internal medicine physician. She is currently single. She attended medical school in a large metropolitan area, and completed her residency at a prestigious Ivy League program. She completed a fellowship in the Robert Wood Johnson Clinical Scholars Program. She was employed at her current position for three months when she was first interviewed. Mariah is currently employed in an academic position at an Ivy League Medical College.

Background

When asked why she decided to pursue a career in medicine, Mariah vividly remembers being six years old and sharing with her family that she wanted to be a reproductive endocrinologist. So, how does a six year old develop an interest in a profession that many adults do not even know exists? She explains,

From very young I have been fascinated by medicine. My grandfather is a cardiothoracic surgeon and my mom is a nursing professor, so there was a lot of medicine around me. Also, I am an avid reader. The books in our house were mostly medical text books and nursing text books, so that is what I read, even when I was very, very little.
As she continues, she explains that even though she was surrounded by medicine, her passion for the field resulted from what she encountered when dealing with the medical system during a family medical crisis. She goes on:

I didn’t have a passion for medicine until I got a bit older. Actually, some of the negative experiences I had with my dad and other family members who were ill and having bad interactions with health care facilities and health care providers really made me passionate about going into medicine. I had goals to make things better and I decided to hold on to those goals.

The goals that she held as her motivation to attend medical school were focused on changing the system, but Mariah decided to attend a medical school that had a reputation for clinical excellence. She recalls that, at that time, she believed that she wanted to be a clinician and see patients all day. Going back to her childhood dream of being a reproductive endocrinologist, she decided to focus on obstetrics and gynecology during her third and fourth year rotations in medical school. She chuckles as she reflects upon that time in her life, articulating,

I really went to medical school wanting to do obstetrics. I was going to be an ob/gyn. I wasn’t sure at the time, if I was going to pursue the endo [endocrinology] part of it, but I was sure I was going to do OB. If you look at my transcript from medical school, all of my elective rotations during my 3rd and 4th years were Obstetrics and Gynecology. I did no medicine electives, just the obligatory rotations in medicine that I got out of the way early so I could focus on OB! I was convinced that was what I wanted to do. BUT, being completely honest, all of the people that I got to know or knew in OB told me not to do
it…They told me that it is horrible! Saying that, “You are on call all of the time, you never see your family, reimbursements keep going down, and there is all of these malpractice issues that are out there. IT IS CRAZY, don’t do it.” That scared me enough to rethink my decision.

So, late in her medical school training, she had to reevaluate her decision. Recognizing that she could still focus on Women’s Health, which was her primary interest, she narrowed her decision down to, “Do I want to be a surgeon, or don’t I?” and decided that the demands of life as a surgeon where just not worth it to her. This created a bit of a dilemma when she was looking for a residency because her focus on OB left her without any experience or electives that supported her being an internist or primary care provider.

*Residency and Fellowship Training*

Mariah decided to pursue her residency training in internal medicine-primary care at a well known residency program that has a reputation for training academics, policy makers and administrators, not clinicians. This is a 180° difference from the medical school that she attended. She explains, “I didn’t realize what kind of impact it would have on my career. The people who usually come to this kind of residency have an idea about their career and how the residency fits. That is why they went there.” She recognizes that her decision definitely was against the norm because she was still planning on pursuing a clinical career, but she wanted to experience what it would be like to be at this particular institution. As she reflects, she recognizes that as a result of her interactions with both faculty and peers during residency, she explains, “The horizon just got much bigger.” She goes on to clarify:
The medical school I attended is a place that trains for clinical excellence. But, when I arrived at my residency program, I was exposed to something very different. Everyone that you get exposed to is so multi-dimensional, wearing six or seven hats, and even though I had an interest in clinical medicine, seeing this made me realize that medicine can go in many directions, research or policy, or advocacy, or all kinds of things. So, from very early on in your residency, you become exposed to different ways to construct a medical career.

Initially she thought, “This is very interesting and it is good to make these kinds of connections, but I want to do more than that.” She recognized that she wanted to, as she explains it, “Work on both the micro and macro level. I wanted to spend part of my time making a difference for individuals and part of my time making a difference of the population.”

Though she articulated this as a goal, as she began thinking about what she wanted to do after residency, she still was not sure. So, she decided to pursue a fellowship. She reflects upon this time in her life, recalling how much she struggled with the decision:

This was very hard for me because I am very bad about making decisions about life. I am very spontaneous about these decisions. I am not a thinker or planner like many of my friends. So, I was torn. I wanted to do a fellowship but I could go a number of ways. There are a number of general medical fellowships that exist, but I hadn’t decided if I wanted to do an academic fellowship or go in a different direction. In all honesty (with brief laughter), one of the reasons that I chose the fellowship that I chose is because the application had to be out way
before other applications had to be submitted. I applied, and was accepted before any of the other applications were even due! So, this kind of made my decision for me, but, I still needed to make a choice about what institution I would go to...

She proceeds to explain the criteria she used to evaluate institutions, including the geographic location, research emphasis, and the general feeling she had when she visited the sites.

She finds her chosen career path quite different from what she ever could have imagined. Prior to attending residency, She was emphatic that she would NEVER pursue academics, stating that she was just too close to it, having grown up with her mother being a nursing professor. In the same respect, she remembers thinking about leaving the academic setting and thinking, “This is scary. I won’t have medical students, interns, and residents around me all the time. I won’t be going to noon conference. How am I going to know anything if I don’t go to noon conference?”

In hindsight, while she expresses that she is not a good decision maker when it comes to these types of things, she is pleased with her chosen career course, though she keeps her options open. She explains, “I must say, I am very happy that I went this way. I can always be a clinician or do this or that, but this is my chance now to try academia. The other thing is that as a Black woman trained in the clinical scholars program, there are so few in academics that I decided to give it a shot.” She qualifies this with, “I like it, but I still have a crisis of confidence at least twice a week. I mean, I think, ‘I can’t do this, but I still really want to try this.’”
Settling into Her Medical Career

Mariah decided to begin her professional career at the institution where she completed her fellowship training. Since she decided to pursue a scholar/clinician career path, she has clinical, teaching, research, and administrative responsibilities. Her position dovetails nicely with her overall career goals of helping both individuals and influencing the health care system at large.

According to her contract, her position is broken down into percentages of time that she should spend on different aspects of her job. Her day to day reality is a very different story. She begins to explain,

I put myself out on the job market and I interviewed at other places. I had offers at other institutions, and I played that whole game of sitting down and putting all of the contracts out next to each other and trying to figure out where I wanted to go and what I wanted to do. So, when I started out, things seemed very clear, but it is not like that anymore. I compared contracts and decided what I wanted to do, but now it is much different than what I expected.

Reality Sets in Quickly

It did not take long for Mariah to learn that life as a new faculty member at a large institution was not at all like what she experienced as a fellow at the same place. She begins to explain the obstacles she faces as she tries to understand her role,

Take for example, administrative support. I still do not have administrative support [at the time she stated this she was in her position for three months]. So, things like faxes, I have to cross over campus to another office and send them. I’m losing time. Like scheduling meetings and that kind of stuff – I do it all
myself. Now, honestly I would NEVER hold myself up as a model of time efficiency; but, I would be more time efficient if I had the structural support that I am supposed to have.

And, most days the numbers on the contract are all wrong. Like today, I think I spent one hour doing my research, which is not enough time. Something that is supposed to be only ten percent of my job can easily fill up fifty percent of a day or a week, especially when it comes to meetings and talking with other faculty about projects. I don’t know how other people do it. I mean, as a researcher, primarily, most of my deadlines are internal deadlines. But other things, such as teaching, meetings, clinical care and other projects have external deadlines. So, if something gets pushed aside it will be MY work.

She goes on, “Memories around here are short. Everyone here has gone through this experience-- trying to figure out where to put energy and attention, but knowing that doesn’t really help when you are feeling like you don’t really have support.” As her frustration becomes evident, she continues her description by discussing how she often feels lost and alone as she tries to navigate her way through her new position. She feels isolated, explaining,

I sit in a little office and I don’t interact with others all the time. I have this really, really, little, temporary office space. It has no window. It is really horrible. It is partitioned off and I sit here until I go out and get lunch.

As she gives more examples of the frustrations of her position, she starts to think about what she is doing to cope with all of it.

She goes on,
The other day I decided to email my mentor asking if we could meet and I could share some of these things that I am feeling and talk about what I am doing. We have a positive relationship. So, I guess there is support, but it is there for the asking. There is no manual. It is uncharted water. It is hard because even things that seem to have some structure really don’t. It is all self-directed. I think it is hard for anyone. I think I have to remember to manage up and make sure that I am getting advice and support and all of the things I need, but it is never easy.

**Trying to Identify What It Takes to Succeed**

As a relatively new faculty member, Mariah is trying to understand what it takes to succeed in her profession and in the institution where she is employed. Because she decided to begin her career at the institution where she completed a two year fellowship, she has some sense of how the system works. Yet, she acknowledges that what it takes to navigate the system is very different now than it was when she was a fellow. Her mentor has reinforced that one key skill she needs is the ability to say “no.” This is in direct conflict with her internal value system and how she was socialized in medical school, residency, and fellowship training. She clarifies,

As an African American woman, I am asked to sit on every committee and I don’t even know how these people know me. I mean, I am a nobody at this institution and I am being flooded with requests to be on every type of thing. I don’t know, maybe there is a lottery system and my name keeps coming up, but my idea is that there are not very many people of color at this institution and they want representation. So, I have to say no (she says with a nervous laugh.) It is difficult because I think, “How can I do this, how can I say no?” I mean, this institution
pays my salary! Plus, when you are a resident or fellow, you always have to say yes. But, this is where having a mentor is good, because my mentors are strict and firm about this. They tell me, “You have to say no. Tell them that we said that you need to say no.” But, I am still very nervous about it and I would be lying to say that I didn’t feel bad about it. When I send out the emails I say, ”Well, right now is not a great time but you can check back with me in a couple of months.” I mean, how can I possibly say no to the institution that hired me? Is it really so bad for me to take some time so I can be on committees?

As she reflects upon the role of her mentors, she begins to digress, “Yeah, come to think of it, what ever happened to these people?” She recalls how much quality support and advice they gave her prior to her taking the job, especially during the contract stage. She goes on, “If I asked questions and went to them for direction, they would give it to me, but now I don’t really see them. I am trying to reestablish scheduled meetings with at least one of them and follow the advice that may come out of that.”

As she reflects more on her situation, she again recognizes how isolated she feels in her current position. She realizes that there are very few people with whom she interacts. When discussing the role of non-physicians in her career, she recalls,

Yeah, I really miss hearing other people’s perspectives of the institution. I mean when I first got my fellowship appointment, I met with the support staff and they gave me advice. And certainly in the hospital, as a resident, I got all of the best information from the nurses and support staff as opposed to the attendings. But now it is different because I don’t have these people around. There is no one who can tell me—now, for this person, make sure everything is right, or in this
situation, do this, or he or she is like that. And that is very stressful for me. Also, the ones that do talk, talk to me about “them,” referring to the organization. These people will say, “Watch yourself, because THOSE people have no loyalty.” That is the advice you get from people around here, to be watching and to be cautious and that kind of thing. There is just not a lot of trust.

**Working the System**

Mariah gives these two tidbits of advice on how to succeed in her institution: (1) “You have to find someone in the institution who feels that it is in his/her best interest to see you succeed. And you have to push and push.” (2) “Success is having a few people in your universe who know more than you and know who to ask.” She sees this as a real problem for herself, articulating, “The squeaky plow gets the oil is definitely true here. And I’m not a squeaker, and that is that.” She goes on to give an illustration to support her point.

Before I started this position, I thought that I would have to search for mentoring, but, I didn’t think that I would have to search for administrative support. I didn’t realize that THIS is something that you need to be successful. Here is what happened. In my contract there is funding of 25% fte for an administrative support person. I thought, because I was really naïve, that there would be a person already hired and I would get to use this person 25% of the time. WRONG. There was salary set aside, but no person! So, I went and found someone else who also has the same kind of contract, so that we could hire someone half-time because nobody is going to want to take a .25 job! Then, he and I had to find a person in the business office who was willing to help us by
posting a job, which is something I never thought about. But, I spent an afternoon working on this. Then I had to go into interviewing people who applied! I mean, I guess there is some creativity in talking to people in the same situation and then coming up with a plan. It seems like if you are a better networker or negotiator you have a better chance of success.

*Reading People and Figuring Out Who to Trust*

Mariah admits that she is not the world’s most trusting person, but she recognizes that it is very difficult to survive, especially in a complex institution, without building relationships. Also, she knows that it can be difficult to find people whom she can really trust within a complex competitive work system. She feels that as an African American woman physician pursuing a career in academics, that this is an area where she has heightened awareness. She describes her view,

People are largely self motivated and not really looking out for your interests. So, knowing that I try to develop relationships and I really, really listen to what people have to say and then I file it away... Basically, I rely on the sense I get from the person, and at the end of the day, I think about it and that that what I felt was probably valid. I think that as time passes, I begin to listen to messages by understanding who the messenger is. I ask myself questions, trying to figure out the motivation behind telling me what they are telling me. I question who is going to benefit and why is this person really telling me this? So, I guess, I just go along and try to make sense of it as it comes.
Work-Life Balance

Mariah tries to assess her life objectively when she reflects upon how she balances, or doesn’t balance her life. She articulates her thoughts, “Let me step out of myself for a minute and really figure out how to discuss this topic [work-life balance] because my reflex is to say, ‘Yes, I value work-life balance and I want to stay balanced,’ but I don’t know if that is true. As she continues, she begins to differentiate between the time constraints of physicians who are tied to a daily clinical schedule, and her experiences as a clinician/scholar. She provides this illustration,

For some people, an academic career provides a tremendous amount of flexibility and control. For example, if I had a certain obligation at 3:00 pm on a Wednesday afternoon and I had to be somewhere, I could probably go. There wouldn’t be rescheduling or juggling schedules; I could just go. But, while I am there I will be fretting about things like email or how to frame a project, or thinking about how to word something that I have to send out later in the day. Then on Saturday afternoon, when I am technically not working, I will be writing or reading or thinking about work…On the other hand, one of my good friends is a hospitalist and she works 75 hours, 7:00 to 7:00 for seven days, and then has a week off. Now, on the week that she is working her life is not very balanced, but when she is not on, she is NOT ON…I think that for me, in my role, it is easier to physically be places but much harder to be there emotionally.

As she continues to discuss her challenges with work life balance she recognizes that one of the issues that she faces is that she works in a world of abstract expectations, she explains,
In academia you can always be doing something or at least be thinking about something. And then there is the guilt when you are not doing something or thinking about something. You say to yourself, “I’ve been given this opportunity, I need to do it well.”

While explaining all of this, she recognizes that part of the reason that she may not be balanced is that at this point in her life, she may think about work all of the time because she really does not have other obligations. She explains,

Maybe I am “always on” because I can be. I don’t have any external pressures like a child to take care of or anything like that. My life for now is about my career. Well, I guess it has been for a long time, with medical school, residency and my fellowship. So life now outside of work feels that same as it did before; I just might think about it more now than I did before. I just allow everything to blend together.

The Challenges Associated with Becoming a Physician

Mariah confides,

I have no regrets about going to medical school and going through the process, but, none of this was in the brochure. I never really saw it for what it is. My friends who went to Law School or Business School – it was in their brochure! Basically you do this, then you do a clerkship or internship, then you go to work at some firm in a job that pays way too much money and all of these kinds of things. You know, they were given a career path. And, honestly, I wouldn’t have wanted that life for myself; that is not the issue. I just wanted more transparency at the beginning.
I felt like I never had an idea where it was going. I would get over a big hurdle, but then there was a bigger mountain around the bend. Maybe it is just a personality thing, but I don’t see the level of “crisis of purpose” in my non-physician friends that I see in myself and my other physician friends. I guess I mean, for them, there was a job at the end of the road and they trusted that it was going to be worth it. But, with all of the surprises throughout the process of becoming a physician, and all of the changes that are occurring in medicine, I feel that my future is always in peril. In some ways I thought it would be cool because I was going to be a doctor. And maybe it is true that I may never have to worry about unemployment, but what that job is going to look like, and how desirable the life is going to be, is constantly in question.

While she expresses these frustrations, she begins to postulate as to why this occurs. She suggests that the reason, in part, is that the appearance of the profession needs to be upheld. She explains,

I don’t think that any of us are willing to express how bad it will get. I think back on when I was a resident and would meet with interns. I never told them that it was really hard and that they were going to be exhausted all the time and constantly question why they ever went into medicine. Instead, I told them that internship is great because you get great experience, see lots of different things and are constantly learning. I was LYING, but what are you supposed to do? These people made commitments to the program and to being part of the profession. They were looking forward to coming, and beginning their training. Are you really going to tell them how miserable it really is? I mean it is not
helping (she says as she begins to laugh) to say, “Yes, this is going to be the worst experience of your life.” Instead, when I spoke with them, I was focused on projecting, “Look at me at the other end. I am fine and you will be to.” What I am finding scary is that I am living this phenomenon again right now when I am told by those who have been around for a while, “Hang in there,” or “It’s all a learning process.” I think we temper the picture that we give because we don’t want to discourage.

Finding Her Own Way

Mariah reflects upon how she got where she is today and is still amazed that she is pursuing a position in academics. As she discloses her path to where she is today, she expresses her frustration with always feeling like she had made serious life-changing decisions without really knowing why or how she got there. She explains,

I think what I see in medicine is that we are asked to make some pretty big decisions prematurely, just from the start. We are asked to choose a specialty before we really know anything about it. You are asked to pick from these very separate career paths and every exposure you have is going to influence your career trajectory. You meet the GI (gastroenterology) attending at 4:00 am who is just so sweet, and all of the sudden you are going to be a GI!

She moves from speaking about aspiring physicians in general to how it affects her personally, sharing,

I am still surprised that I am in academics, because even when I came to my fellowship, I thought about being a “non-traditional scholar” if that is a category for scholars. I thought of myself as somebody who might do a fellowship, then
go work at, I don’t know, a foundation or something. I just didn’t think that
academics was on the other end because I always thought, “Who wants the stress
of that type of job?” And, my personality is not ideally suited for sitting in front
of a computer alone for eight hours a day, so I saw that as a BIG detriment.

It was the same after medical school. I wasn’t sure that I chose the correct
specialty, and then in residency, I was kind of pushed into thinking about
academics before I was converted by them to actually want to be an academic. I
really always thought about Women’s Health or working with children, or being
in an underserved community providing patient care. I am just in a very, very
different place. Yet, I feel good about where I am. This makes me nervous
because I think, “So, in five years what will my life be like?” because I have done
such a poor job predicting now five years ago. I have no idea what the future
holds.

*Delayed Gratification, Financial Sacrifice, and Passion for the Profession*

Mariah expresses her joy associated with no longer being a trainee and finally,
after many years of training, beginning her professional career. She shares,

You know, in many ways it feels wonderful! There are some very tangible things
about it. For example, three weeks ago, I closed on my first house. That is a very
tangible symbol that I have entered my career. And there are nice things too. The
paycheck is much more than I ever saw. I am still so amazed that sometimes I get
my check and just look it for two days!!! Sometimes I am pleased that I now
have a voice and am not ALWAYS told what to do and that I don’t need someone
checking over my work. But, some days, I still feel like a resident. In fact, some
days I still feel like an INTERN as I resort back to being in the mode of “Yes I will” because as a resident or a fellow, it is always, “No problem.” Now, professionally I am told that the answer needs to be, “It is a problem and no.” That is a very hard transition to make. After so many years of not really having a voice, I now have to exercise my authority.

As she shares her experiences she flip flops back and forth from the personal to the professional, explaining that the flexibility that she learned from moving through rotations and moving from place to place for training, is what evokes fear when she thinks about settling down or establishing roots.

One thing for which she is grateful is that her parents funded her entire education. She apologetically explains, “I have to say that I don’t feel trapped. I have been very fortunate in that my parents funded all of my education for me and I am debt free. This makes me extraordinarily different, and I don’t really disclose that about myself.” In the same respect, she does not feel that she has not endured hardship and sacrifice to get where she is today, explaining,

I have experienced the sunken cost phenomenon because of all of the education and training and time that I was not part of the workforce actually making money. I am in a very different position than my friends who did not go to medical school. Also, there is the emotional cost. I have already put so much into this; I cannot walk away from it. So, it is not really a financial tie that I have to my profession, it is relational, and I don’t think that I would ever give up and walk away, no matter what.
With this there is a counter-phenomenon occurring and that is that, if the ship is sinking, should I really go down with the ship? I never really thought about leaving medicine, but I do think, “Who in the world is going to want to do this in the future?” I have a friend who is currently a medical student and has decided to take a year off to reevaluate her decision to become a doctor. That is something that never happened before. Yet, in the end, I think she is going to go back. Like I said before about my smart friends who didn’t go into medicine, I think those of us who choose to do it, do so because we have such a passion for becoming a physician and we are driven to get into medical school – this is not easily deterred. If it were, we probably wouldn’t have many doctors today.

Reflections

As a researcher, herself, Mariah has a unique perspective on what she has experienced as she shares her narrative. She believes that there needs to be a space for this type of information to be shared, so that others can benefit from the experiences of those who have traveled the road before them. On a personal level, she expresses, “I think this is very cathartic. I think that doctors will be surprisingly willing to talk about these kinds of things because there really aren’t any spaces where you can be real and talk about how you really see it.”

She also recognizes that physicians often do not have the time or take the time to reflect upon their lives and the career decisions they have made. She shares, “It is a nice opportunity for people to reflect and think about their experiences. It is great to have the opportunity to talk about these things; even sometimes, just think about them for the first time.” In the same respect, she recognizes that throughout the process of training to be a
physician, time is at a premium and physicians are conditioned, in a way, to protect their time, which often leaves little opportunity for this type of reflection.

I am Living the Dream

Robert

Robert is a 33 year old White male family practitioner. He is married and has three young children. He attended medical school in a rural/suburban setting, receiving his MD/PhD upon graduation. He also has a pharmacy degree. He completed his residency training at a community hospital, near where he grew up. Currently, he is employed by a large hospital system as a solo-provider. He has plans to someday purchase the practice from the hospital system. He was employed at his current position for approximately three months when he was first interviewed.

Background

For as long as he can remember, Robert desired to pursue a medical career. As he begins to tell his story, he shares that he has told it many time before. He gives an organized, thoughtful illustration of the “hows and the whys” of his medical journey.

Choosing a Career

Robert shares his recollection as to why he decided to pursue medicine:

I remember actually seeing my family physician. He is still practicing in this area. (He stated quite proudly.) I was twelve or something and he asked me, “What do you want to be when you grow up? And I said, “A doctor.” He then replied with, “Oh, no you don’t” (He begins to laugh.) But, this always stuck in my mind. When I went to college, there are always doubts in your mind like, “Am I going to get into medical school?” “Are things going to work out, even if do I get in?” I wanted to have a career in case I didn’t get in to medical school. So, I went to pharmacy school.
In about my third year of pharmacy school, I thought, “This is for the birds.” I am going to finish this degree, get a job, and maybe this will be a nice enough life. I was comfortable with my decision for a few months. Then the assistant dean approached me and asked me if I would be interested in being in a pilot program at the University to get a dual degree with the honors college, and I said, “Sure, why not?”

Part of doing this meant that I had to do some undergraduate research. So, I started volunteering in the lab, and I absolutely HATED it. There was NO WAY that I was ever going to do research. But, I decided to stick it out, so I could graduate from the program that I was in. One day, I was sitting in the lab reading the paper, and below the crossword puzzle was an ad for a summer position in the Department of Pharmacology, and I thought, “Well, if I am going to be miserable, I might as well be getting paid for it.” (He chuckles.) So, I applied for the job, and I wish I could say that I got it on merit, but there were five positions and three people applied. So, I got the summer internship there.

During that summer, to make a long story short, I caught the research bug, and then I really started liking to work in the lab. I thought that maybe I wanted to go on and get my PhD. I thought that way for a few months and then I started doing my clinical years in Pharmacy school. I realized that I liked that as well, so I started thinking about some combined degree programs, like PharmD/PhD. At that time someone mentioned, “Have you ever looked at an MD/PhD, which I didn’t know existed. I looked into it and it seemed to be exactly what I wanted;
some research, and some clinical, so I looked into it, applied to programs and got accepted.

Pretty much, my clinical aspirations have always been to the *old fashioned* family doctor. You know, kind of off by myself, and seeing my patients from birth to grave, doing house calls and that sort of thing—just being part of the community. During medical school people tried to convince me that this wasn’t really possible anymore, but I kept it in the back of my mind and continued making Plan B and Plan C.

*Deciding on a Residency Training Program*

Choosing a specialty was not an easy feat for Robert. In the back of his mind, he held on to his idea of being an, as he puts it, *old fashioned* family doctor. But, in the world of academic medicine, the Family Practice specialty does not have prestige or respect. Since Robert was completing both his MD and his PhD, it was assumed that he would pursue a career in academic medicine, or at least a specialty that had some level of respect, but Family Practice, no way. He explains that he spent much of his third year of medical school vacillating between Family Medicine and Internal Medicine/Pediatrics which gave him the same training for the most part, but seen as a step up in the medical community. He finally made a decision after conferring with a senior resident in internal medicine. He recounts the conversation,

He [referring to the senior resident] sat down with me and said, “Okay, let’s talk about this.” And we spent some time talking it through. He said, “Okay, what do you want to do with your life? What kind of practice do you picture yourself in?
You know, if you could do anything you wanted, what would it be?” As I
described it to him, he said, “It sounds like you want to do Family Medicine.”
Robert goes shares, “From there on out, I was convinced.” But, he still had to
choose a residency program. He completed a medical school rotation at a
residency program (Hospital Y) that was not far away from the medical school he
attended. The program happens to be lauded as one of the best in the country, so
he just assumed that he was going to go there. But, as he started interviewing, he
changed his mind. He explains his thought process,

I was sure that I was going to Hospital Y for residency. I had done a
rotation there, and I liked everybody. But, they work their residents hard. When I
interviewed at Hospital Z, it just changed my mind. I thought, “I could work
here. I could be friends with these people.” There also was part of me saying that
it would be good to do my residency in the geographic area where I want to
practice. It is good to get to know the people and learn medicine where you are
going to be practicing and learn the problems, because every area has its own
little nuances.

While Hospital Z’s residency program has a fine reputation, it is not held in the same
esteem as Hospital Y. So, it baffled his medical school faculty; an MD/PhD choosing
Hospital Z? Robert recalls their reaction,

Yeah, there were people who were surprised that I went into Family Medicine and
I think those same people were surprised that I decided to go to Hospital Z.
Hospital Y has an academic reputation. There is a lot of feeling, especially in the
PhD side of things, that reputation is important. You know, that is how you get
ahead. You get to know somebody at a lab and that gets you a better job. That is the sort of mentality that goes through the entire profession, from an academic perspective. I think a lot of people thought that I was taking myself out of the possibility of keeping myself connected.

I forget who it was, but one of my graduate school mentors allowed me to know, through the grapevine, that he was displeased with my choice of Family Medicine. And I thought, “Well, good for him.” I think that being married and having children has allowed me to make decisions like that. I know that there are people out there who want the best for me. Well, what THEY think is the best for me, or who want me to do X, Y, or Z. But, I have to do what’s right in my heart. You know, what is best for me, and best for my family. You know, being where God wants me to be.

*Life as a Resident*

Despite being sleep deprived and feeling over worked, Robert had a great experience in residency. Because of his research background and MD/PhD he got involved with research projects. Not surprisingly, he was chosen as the Chief Resident during his third year of residency. Following is an excerpt from the speech he gave when he graduated from residency:

Dr. Gary Smalley is an author who specializes in writing about family relationships. He has a theory that I’ve always found very interesting: that mutual suffering is the source of some of the deepest and strongest bonds in our lives. He points to fond memories formed during family camping trips as an example. There’s something about “roughing it” together that can bond a group of people.
I think that Dr. Smalley is right. We members of this class and this residency have “roughed it” with the best of them. Who else has shared so many sleepless nights? Who else has been there when you were so physically, mentally, and emotionally exhausted that you didn’t think you could go on? Who else has encouraged us when we were afraid and unsure of our own knowledge and abilities? My fellow residents and dear friends, you have become my extended family.

Entering Professional Practice

Robert’s practice situation is quite unique. He is employed as a physician for the hospital system in which he trained, but he is a solo practitioner. While in his residency training, he met a few solo practitioners in the area who were, as he puts it, “Doing what I wanted to do, and being successful at it.” He explains this as if, at first, it was a bit of a shock to him that anyone is still practicing this type of medicine. He is employed, or as he refers to it, sponsored by the hospital system. The hospital system is paying the bills, dealing with the business aspects of the practice, and paying his salary and benefits, and the salaries and benefits of the two support staff who work in his office. If he desires, after two years, he can purchase the practice from the hospital.

He explains,

When I was recruited, the way the hospital described it was that it is my office and it is being run as if I am ready the owner of the office as long as I am working within the boundaries of the hospital system. So, I get the advantages of being an employee. I don’t have to worry about where my first few months of pay are going to come from or fighting with insurance companies and things
along those lines. But, it is more of a bureaucracy than if I would have gone off and started the office on my own. For example, I have to turn in expense reports if I want to buy a picture for the lobby, and I have to get approval for different pieces of equipment. But, it seems to be working well.

**Networking within the Organization**

While Robert plans on owning his practice some day, for now, he is a member of an organization. He is relatively well connected within the organization because he was the residency program’s Chief Resident last year. In addition, he has family and friends who work for the system. He gives his perspective,

The way I navigate the organization is mostly by, I guess the technical term is *networking*. I got to know a lot of people, and it wasn’t for the purpose of being able to get things that I need, but, it is sort of the way I am built – I just get to know people. Also, I was chief resident last year, so I got to know a lot of people on the administrative side. It helps that I have some family within the system. My sister works in the pharmacy and by brother-in-law works in respiratory therapy. So, whenever I need things, there are people to call.

He proceeds to think out loud about all of the connections that he has made over his three years of residency, and there are many. As he talks, the necessity of these relationships becomes evident. He gives examples of how he had to call the emergency room to borrow instruments, and how he negotiated flu shots from the pharmacy, because his did not arrive. He recognizes that he is currently working the bureaucracy quite well, but he is also cautious. He shares,
I don’t want to go to the well too many times. You can’t ask for too many things. People have been very understanding and they are offering. Everybody seems to want to help out. There are people that know me and I have become friends with over the years, but I still don’t want it to appear that I am taking advantage of these relationships.

**Facing Obstacles and Addressing Problems**

Initially, Robert expresses that he is pleased with how his practice is progressing. He explains, “I came in knowing that I was going into a big bureaucracy and that I just have to be patient and understand that things won’t always happen the way I want them to.” But, as he continues to discuss his first few months of practice, it becomes apparent that there are obstacles and frustrations associated with trying to start up a solo practice within a large organization. He explains,

So far it is pretty good. We are now two months into the practice and we are seeing, on average four or five patients a day, which isn’t bad for starting from scratch. It is kind of neat to start out slow and have a break from how hectic residency can be. But, things moved a little slower than I would have preferred for getting things started. I think if I had been off own my own, I would have been a little more intense in the beginning, trying to advertise, get things settled with insurance companies and getting all of my ducks in a row. They keep telling me, over, and over again, not to worry, it will all come, just be patient. I figure if they are the ones paying the bills and they tell me not to worry about it, then I am not going to worry about it!
He goes on to share that initially, he was concerned about being out on his own. He questioned how he would practice without other physicians around to talk to about complex cases and for camaraderie. Most of these concerns subsided quickly. He believes that he was well trained and received tremendous experience both in residency and moonlighting (additional work during residency for pay). Also, he realized that his preceptors from residency and other physicians are just a phone call away.

His focus returns to the difficulties of establishing a system within a bureaucracy.

He shares,

You are promised autonomy but you know, in a big bureaucracy, things can change in a moment’s notice. For instance, to be candid, I am not pleased that my medical assistant [currently his office consists of him, a nurse/office manager, and a medical assistant] is working at another office right now and I am here answering the phones. It is not so much that I am answering phones, but, because she is not here, my office had to be closed today because my nurse needed to be off. The person that just called wants to be seen today, so I am actually going to see her by myself, here in my jeans and t-shirt. Ultimately, my concern is not that I need to have complete control. No one ever has complete control, but that I want to be able to make those types of decisions.

Later, Robert shares that he is conflicted about the issue with his medical assistant. Not just because she is not available at his practice, but, because he knows that when she took the job she took a pay cut in order to have a shorter commute. Now, she is placed in an office that is farther away from home than the job she left! From the way he
talks about the situation, it is clear that it presents an ethical dilemma for him personally, but he feels his hands are tied. He is trying to wait it out, but with every passing week, he gets increasingly frustrated.

*The Privilege of Being Involved in Patients’ Lives*

When Robert talks about what he loves about his job, it is being involved in people’s lives. While he recognized that there are pros and cons to that and not everyone is grateful for your services, knowing that he can have a positive impact in people’s lives is what motivates him to get up in the morning and go to work. As he reflects upon the few months that he has been in practice, he shares about how he helped someone who was misdiagnosed with diabetes and feeling really sick, get off medicine and return to a normal life. He explains that it is a wonderful feeling to “make somebody better by doing what I was trained to do.” He goes on to talk about the fact that he has already had to diagnose two patients with cancer. He believes that it is the relationships that he builds with patients that really matter and currently, because he is only seeing 4-5 patients a day, he has plenty of time to build those relationships. He explains that he feels privileged and honored to be able to share in the two biggest events in people’s lives: birth and death.

*The Financial and Emotional Costs of Choosing to Pursue a Medical Career*

Now that Robert is somewhat settled in his profession, his wife is beginning to look at career possibilities. He relays the different options that she is considering. One option is something “medical related.” He says that he tries to discourage her from moving in that direction. He gives his rationale,
I think that every job, no matter what you do has downsides to it, so everyone tends to bad mouth their job. But I think that the medical field has seen its hay day. The best days of medicine as a career are probably behind us, unless something changes. I don’t want to sound skeptical, I love my job and I can’t see myself doing anything else. But, I think if you are looking at career choices and thinking, “Okay, I want to pick a career and I don’t really care what I do…,” there probably are better paths than medicine. If you just want a career and you aren’t passionate about medicine, or feel a strong calling, then there are much better ways to make a living.

Just from a financial standpoint, the financial return of being a physician is not what it used to be. It is not bad, I can’t complain and I don’t really want for anything, but you can do much better in other careers or fields. And you can do that without eight years of higher education, three years of residency, sleepless nights, being on call, and not being able to go to a family function without somebody saying, “Hey can you take a look at this rash?”

And there is all of the debt associated with medical school. You know, I have sat down a couple of times and I did the math on how much money I have lost because I decided to become a doctor instead of staying a pharmacist! Again, I can’t see myself doing anything else. I believe that this is what I was meant to be. It is a calling, if it weren’t a calling; I’m not sure why anyone would do it.

In fact, the chief resident when I was an intern has decided that he is going to work as a physician until he pays off his loans and then go into business in an entirely different industry. Yeah, he is going to start his own business. He is not
enjoying being a doctor. I think that is the case for many people and we are starting to see people drop out. But, for most people, they get into the amount of debt we are in, and then they are stuck. You start to think, “The only way that I am going to pay off my debt is if I stay a doctor.”

Managing Work and Family

There are times when Robert struggles with competing demands from work and family. But, he believes that he handles it well because he keeps perspective. He shares advice that the assistant pastor of the church he attended when he was in medical gave to him, “Wherever you are be there.” He explains,

I try to live by that. If I am at home, my focus needs to be at home, but when I am at work, my focus needs to be at work. There are times when things spill over, one comes into another. Like when I am at work and my wife calls and says that our daughter put Kix up her nose! You know, stuff like that. But those are rare.

Setting Priorities

“I am too busy to be excited!” is how Robert addressed an acquaintance who asked him if he was excited about starting his career. He explains what he meant sharing that during medical school and residency, he was so busy doing what he had to do that he really did not spend a lot of time thinking about what it all meant for his life in the future. He explains,

There really are no systems or structures in place within medicine to help people think about their careers or their futures. We just do what we have to do. We don’t have a lot of time to really think about. I am fortunate. My wife and I
have always been very involved in any church we attended, where ever we were. Our faith has always been very important to us and essential to our lives. I think it grounds us. Also, I think being a non-traditional, traditional student, if that makes any sense has helped. What I mean is that I went straight through from undergraduate, to medical school, to residency. But, I was non-traditional in that I got married as an undergraduate; my first child was born during my first year of medical school. I did the MD/PhD program, so that took extra time, making me older than the other residents.

By the time I got to residency, and now, at this point in my career, I have older kids and I have been married for a while. I think that that really helped me have perspective about what is really important. Yeah, this is my job, and there are very important things that I do in my job. But, there also are very important things that I do outside of my job, such as: going home at night and helping my kids study for a spelling test; or sitting down and reading family devotions with them at dinner; or reading a book before bed at night; or, just sitting on the couch at night with my wife and talking about how our days went. Those are the things that make it all worthwhile. THIS IS MY JOB, BUT THAT IS MY LIFE.

*Having Family Support and Understanding*

Robert readily admits that he would not have been able to pursue his dream without the support and assistance of his wife, and the flexibility and understanding of his children. He credits his wife with making sure that everything keeps going, especially when he gets busy or needs to be at the hospital for extended periods of time. Here is an excerpt from his residency graduation speech that paints a picture of how he feels,
I’ve saved the best for last . . . What can I say about a wife who will put up with thirteen years of this nonsense: the studying, the long nights, the seemingly endless uprooting and moving of our family? I could not be the man I am without my wife being the incredible woman that she is. Solomon once wrote “Who can find an excellent wife?” I know the question was somewhat rhetorical, but I can say without hesitation that, I HAVE. Maria [note: names have been changed] goes out of her way to make sure home doesn’t interfere with work, even when work did not pay her the same courtesy. Maria has been there when I needed a shoulder to cry on or an ear to listen. She has been my tireless helper and at times my adamant defender.

At home, I am treated better than I deserve, and I am loved more than I deserve. Maria took very seriously, her unofficial and unpaid role as “chief resident’s wife.” She opened her home and her heart to my coworkers and friends. She made us food on call, she has been alternately surrogate mother, sister, counselor, babysitter and friend to the other residents and their families. She has repeatedly found ways to help the residents enjoy and appreciate our time together. Mark, you’re right, this residency will not be the same without her. (Sam has big shoes to fill [he refers to the husband of the next chief resident]). Maria, we did this together, and you’ve earned this.

He laughs when he talks about his children’s perspective on life. “My kids have grown up thinking that this is normal.” He shares on of his favorite stories about his oldest daughter,
I was in my third year of medical school and I got out early from my surgery rotation, which is unheard of, so I decided that we were going to celebrate. The kids liked Chi-Chis at the time, this was before the whole hepatitis thing, and so, we went there. We were sitting at the table when my daughter got a strange look on her face and asked, “Daddy, do these people sleep HERE all night?” (he begins to laugh.) She thought that no matter what job you had, you had to sleep where you work! Yeah, I warped them.

Robert feels that his family is so accommodating to his career because they know that they are his first priority. He explains that they, as a family, are secure in knowing that they are what really matters to him.

Plans for the Future and Wanting to Do it All

As Robert begins his career he sees limitless possibilities. He plans to eventually own his practice and he wants to be involved in his patients’ lives from cradle to grave. He has decided that he wants to take his own call, admit his patients to the hospital, and take care of them when they are in the hospital. Also, He wants to deliver his patients’ babies. Since he has a Ph.D. he thinks like a researcher. He is hoping to continue his involvement with research, and be involved in teaching medical students and residents.

This is how he expresses his feelings about his career,

I really feel that I am sitting her on top of everything I ever wanted, career wise. I mean I am looking around here and the music in the background is the CD that I picked; the pictures on the wall are the ones that my wife and I like. The patients call and I am THEIR doctor.
I just didn’t expect it to turn out as good. I was a little more pessimistic. I expected to have to compromise somewhere and not get exactly what I want or not find a job back home. I thought that I would not be able to live where I wanted to live or do the things that I wanted to do. I thought for sure I would have to compromise somewhere.

So, that has been the biggest surprise for me. I told someone the other day that “I AM LIVING THE DREAM.” This is how I feel! I am incredibly blessed and incredibly surprised. I am very surprised at how comfortable I am with it. I can do this! This is doable! I’m not cocky or anything like that but, there is this feeling of, “Yeah, I have been trained for this and I know what I am doing.”

_Owned His Practice_

Robert plans to purchase his practice from the organization in two years. He goes on to explain, stating, “Here is the plan”,

The way the deal works is I have to pay start up costs less depreciation, and then, the practice is mine. They have offered to either, finance it themselves as a loan, or to help me get a loan to pay for it. . . I have talked to other people who have done this, and the people who are in charge of setting up practices. Relatively speaking, this is actually cheaper than setting it up myself. Everything associated with the organization goes away after two years, if I want it to. Then I will be re-credentialing with everybody [he means that once he is on his own, he will have to reestablish himself with insurance carriers and deal with his own insurance issues, including malpractice, because he will not be associated with the organization.] As time goes on, I will have to pick the brains of some docs
around here to find out the best way to do these things, but that is several steps down the road.

Becoming an Old Fashioned Primary Care Physician

For now, Robert is attempting to run the practice like what he calls, “an old fashioned family doctor.” He excitedly shares how he deals with call and after hours coverage.

The solo practitioners around here cover call for each other and that kind of stuff. It is almost like we are a group, but we have our own little offices that we run ourselves. There are two call groups and they both have different stylistic approaches. In one of them, they actually cover weekends for each other and it is like being in a large group. There are seven of them right now, so you are on call every seventh weekend and they cover their own weekday call.

The group that I chose to be in has a different philosophy. The physicians in this group feel that you can do this, but, then you end up losing one in seven weekends. Instead, we think that when you cover your own stuff when you are in town, you may have one or two patients to see on the weekend. Basically, I am on call 24/7 except when I am out of town.

I was scared to death of that, at first, but then I talked to a gentleman, he works at the other hospital but his office is about five doors down from me. He explained that with the patient load of one physician, that you only get one or two calls a day and maybe one admission a night, or in a 24 hour period. He told me, “I had to get out of bed twice in the last two years.” Talking to him I felt much
better, because I was picturing residency-like call for the rest of my life and I didn’t want that.

Continuing as a Clinician/Scholar

Robert shares how his experiences as a clinician/scholar have skewed his perspective a bit.

I had a patient come in the other day and he was having a rare side effect from one of the medicines he takes. I said to my nurse, “Hey, if this turns out to be what I think it is, I should write this up!” And she replied with, “You should do what?” And I said, “You know, submit it to a journal!” She looked at me like I was entirely insane.

He explains that he still has, what he calls, “the research bug” and hopes to fit research and teaching into his practice at some point.

I want to stay involved with the research that goes on at the hospital and in the residency program. Also, I want to get involved in teaching at some point. But, I don’t want to over burden myself, because, like I’ve said, the family thing comes FIRST. I am going to have medical students at my office, I talked to the Health Education Corps about having students do rotations here. I am going to keep my fingers in teaching. I am thinking about teaching a pharmacology course because there are a few PA schools around and there are a couple of nursing schools.

He continues to think about all of the possible things that he is trained to do and interested in doing. But, for now, he is concentrating on getting his practice up and running.
Reflections

Robert is reflective and communicative. He explains that he has spent quite a bit of time preparing for his residency graduation speech and that afforded him the opportunity to think about what it all meant and what it all means now. If he had to come up with a life motto, it would be, “Be true to what I believe, to my faith, to be a good father, a good husband and a good doctor and to treat people around me the way that I would want to be treated.” He hopes that his narrative reflects that.

His entry into the profession has been more like a vacation for him. He is relaxed and not worrying about the future. His patient load is very light, so he can spend time getting to know them. The hospital system is paying his salary and taking care of all of the administrative aspects of his practice. He does not think about how much money he is bringing in, the cost of overhead, negotiating with insurance companies and paying salaries for his employees. That is all taken care of for him, and he is very appreciative.

Robert is a self-professed traditionalist. He wants to live in a small community. He likes the idea of “family values,” and he is looking forward to his life as an “old fashioned” Family Practice doctor. He recognizes that medicine is not what it used to be, but it is similar enough for him to be comfortable. He is very content with his life and looking forward to spending his life helping others.

I Realized that I am Just the Doctor

Sarah

Sarah is a 54 year old White female family practitioner. She is married and has children, stepchildren and grandchildren. She attended medical school in a large metropolitan area and trained in a variety of residency programs. She is currently employed in a mid-sized fairly affluent suburban Family Practice office that is owned and operated by a hospital system. She was employed at her current position for approximately 3 months when she was first interviewed.
Background

Similar to many practicing physicians, Sarah pursued a career in medicine motivated by her love of science, but she took quite a circuitous journey to her present position as a Family Practice physician in a mid-sized fairly affluent suburban practice. Unlike most physicians, Sarah returned to the classroom to complete her medical degree at the age of 42.

After graduating from High School, Sarah attended nursing school but did not finish. She explains,

Well, I started off in nursing school right out of High School and, well, I didn’t finish. I had it in mind that I wanted to do something else, or something more, something different. At that time I was young and immature, but, I thought that I wanted to go to college and I was interested in biology. So, I set off. I left nursing school after a year and went off to a college over 1000 miles away! And unfortunately, while I was there I met the man of my dreams, so I thought, and I got married. I didn’t finish and college. I was always going to go back. Then I thought about going back to nursing school, but you know, life got in the way.

After the marriage didn’t work out, I moved back home and blah, blah, blah, you know how it goes. I needed to find a job and I found myself in a position where I got a job working for a vaccine manufacturer. I got in at an entry level position and it was wonderful because I was so interested in microbiology! I just lucked out. I started in the glassware preparation area where all I did was wash glassware and sterilize glassware. But, I was a good employee and worked my way through the ranks. Just a little bit at a time, and a bit of luck mixed with
hard work, and I went from production to quality control and then to research! I ended up working there for almost ten years.

_The Journey to Medical School_

Sarah found out that her employing organization had a tuition reimbursement program for job related college courses so she decided to go back to college. She recalls, I found out that they would pay for my education, so I started going to school. I started going at night and most of my work related courses were in the pre-med curriculum such as virology, microbiology, and chemistry. It all just fit in there and when I matriculated, pre-med was my major.

I had always been interested in medicine. A couple of years after I quit college I ended up working in a hospital as a unit clerk and I sort of ended up working in the OR (operating room) as a secretary. When they needed extra help or there was a local procedure going on they would let me go in the OR and help. I learned how to be a scrub technician. So, I always had this idea of how cool it would be to be a surgeon, and that was always in the back of my mind; all of those years! So, now I was in college and thinking about going to get a PhD in biochemistry or molecular biology.

Around that time, I got transferred to the research department at the lab. I decided that I didn’t really like research. I knew I could do it, but I was really just tired of being stuck in a lab. I found research people to be very secretive and they were always afraid that they were going to be scooped and that you were going to steal their idea which was just such a turn off for me. Since I was going to be a nurse at one point in my life and I liked people, I decided that I might as
well try to get into medical school. I took the MCAT (the medical school entry exam) and I did alright. I applied to medical school and I was on everyone’s waiting list. I didn’t think I would get in so I was ready to go pursue my PhD in biochemistry. Then I got a call. I was accepted!

Off to medical school she went. As with many medical students, she left her options opened and talked with attending physicians and residents during her 3rd and 4th year clinical rotations. She recalls,

Because of my experience with the vaccine manufacturer, I thought that maybe I would go into infectious disease. I thought I could do some research in that area while I was in medical school, but my advisor wasn’t an infectious disease specialist and she didn’t think that it was a really good field to go into. So, I don’t know if that was good advice or bad, but it sort of pointed me away from infectious disease. Then when I did my surgery rotation, I just LOVED it. I loved surgery! I mean it was just, well, I just thought that it was the coolest thing. That is when I decided that I was going to be a surgeon. I really wanted to be a surgeon!

So, Sarah went through the residency match for a general surgery residency. As she remembers her decision making process, even though it was years ago, her face lights up when she talks about the human body and surgery, explaining,

I wanted to be in general surgery because I liked working with all different kinds of people and different ages: males, females, children, I liked all of the different areas of surgery; especially the belly. I thought the belly was so interesting so I decided that general surgery would be a good choice for me.
Entering a Surgical Residency

Sarah participated in the National Residency Program Match to be assigned to a residency. She interviewed at a variety of residencies and matched at a small hospital close to her home. She was very excited until she realized that the hospital and residency program had financial difficulties and ended up in bankruptcy. She reminisces:

My first two years of surgical residency were at a small hospital near home. I chose the program because I was in living in the area and it was close to home. I figured that I was probably going to go into practice in the area; so, it made sense for me to go there. I made it my first choice in the match, and I got a position; but there were lots of problems there.

There were a lot of problems with the surgical residency program. First of all, the hospital was a small community hospital and they didn’t have revenue. They were having a lot of financial problems at the time and in fact, eventually went into bankruptcy. So, it was a 300 to 400 bed hospital when I started my residency and by my second year the hospital had been downsized to 100 beds. There weren’t a lot of operations and I felt like I really wasn’t learning surgery and I found out later when I went to another residency program, that I really wasn’t.

I decided that I had to change residency programs. So I found a position at a large university based surgical residency program far away from home. The program had openings because they closed their plastic surgery residency. Plastic surgeons needed to do three years of general surgery, and then three years of
plastics. Since there plastics residency closed, they had a mass exodus of all the residents who were interested in plastics.

It was a large program, an academic program, and I was coming from a little community hospital where they really didn’t teach me how to operate. Now I was in a big mess! I was expected to know how to do a lot of things that I didn’t know how to do. It was a HUGE step up for me, and, I would say that for the first three or four months, I did miserably! Then, honestly, I worked very, very hard and I think that I was one of the better residents by the end of the year. But, they decided not to keep me.

Yes, at the end of my third year after working very, very hard, they decided not to keep me. I was told from a few of the faculty members that there were more politics going on. There were other plastic surgery residents who left the program the year before and weren’t able to find a position for their fourth year and wanted to come back. They gave me wonderful recommendations and were supportive. There ended up being a big stir over it because there were a lot of people who really supported me, because I really was a good resident. I mean I wasn’t the best surgeon in the world, but I just needed a chance to learn; I just needed the experience that I didn’t get my first two years.

She goes on to explain that the same tenacity that drove her to enroll in medical school motivated her to not give up on her surgical dream. She packed up and applied for a fourth year residency position in the Northeast, closer to home and family. She was accepted into a new program; but, during orientation, she decided to change specialties to
Family Medicine. Her mannerisms and expressions as she was describing this time in her life reflected frustration and exhaustion. She elaborates,

I was really ready to go home. I missed my children who had grown. I had a grandchild born who I never got to see, and I was just tired. But, it was more than that. It was the whole old boys’ club mentality that really, really made things difficult for me. I mean, not only was I a woman, and I hate to have to say that, but I was an OLDER woman, and I’m sorry, but people looked at me and would say, “What is this grandmother doing in surgery?” They weren’t very nice to me and I pretty much had to learn how to operate with people screaming at me. I had to be (she pauses), and my female advisor (stated hostilely), who was the assistant program director, said, “Yeah, yeah, it goes on all of the time but we can’t say so. You just have to be better.”

When I think back I realize that I survived the year, but I was physically and mentally exhausted. I don’t even think I really thought about what I was doing or needed to do to survive; I just tried to move forward. I would try to go home when I could and I flew home for long weekends. I mean, I lived at the beach and I only got there twice the whole year. It is all just such a blur. Surgical residencies are still bad for women, but most of the women are traditional aged. It was just a disaster for me.

Changing Directions toward Family Practice and Primary Care

She goes on to explain what happened next. Originally, she was planning on returning to the northeast for a surgical position, but her plans changed.
I went back and I was ready. I had been through the resident orientation, yes, another residency orientation, and I thought, “You know what, I just don’t want to go through this again.” Before I left the university residency, I was torn between leaving surgery and trying Family Practice, so I actually applied to a Family Practice position along with the surgical position. I got both of them! And, I went to both resident orientations (she begins to laugh) trying to make up my mind!

I just couldn’t make up my mind because I have such tenacity. I think it is one of my biggest, best qualities, but sometimes it is a disadvantage as well. Once I get going on something, I am just not going to quit. I just got so stubborn about surgery. Especially with everyone wanting me to quit; it was like, “No, I am not going to quit. I have invested too much into this.” But, then when I finally WANTED to quit, I had to convince myself that it was OKAY to quit. But, I did make the right decision. I didn’t know it for a while, but I did the right thing.

After three years of surgical training, Sarah started over as a Family Practice resident in a large academic hospital. She smiles as she remembers the experience, stating,

I was always really good at talking to families and giving bad news…I don’t know, at the time, it just felt that, that maybe I needed to have more interaction with people than when they were asleep on the operating table! When I think about it, even as a surgeon, I had a lot of ICU patients and I would be really concerned about their whole person. I would be looking at their depression
associated with being very sick and in the hospital. You know, surgeons, they just don’t do that! The typical surgeon just doesn’t look at things like that.

The change was very positive. I was learning and growing as a physician, even though I was once again an intern, AGAIN. I felt that my peers and the attending physicians accepted me. Being a woman and an “older person”, was no longer a detriment, I was just me.

*The Final Decision*

The peace that she felt during her Family Practice internship was short lived as the hospital announced that it was closing the residency program. Once again, she found herself changing programs, but this time things worked well. She found a second year Family Practice residency position in a desirable geographic location (she chose the area because she started dating the man who is now her husband and she wanted to be geographically closer to him.) Shortly after relocating to begin yet another training program, she was informed that the same hospital with the second year Family Practice opening had an opening for a fourth year Surgical resident! She had another decision to make. As she describes the experience she begins to laugh,

I went and I interviewed for it and they offered me the position. Then I sat and thought about it all weekend and I was just making lists. You can make those lists say ANYTHING you want, you really can! I realized at that point, that I really didn’t want to be a surgeon. It was just so hard. I really let go of it for sure then…I think it was time to let go.

The next two years of training went smoothly. During her last year of residency, as she prepared to finally practice medicine as a full-fledged physician, she weighed her
options. She decided to take a position with a non-profit agency that provided clinical services for the underserved and uninsured. She explained that most people would think that this was altruistically motivated, but, while there was clearly a desire to serve, the need for job security and a steady paycheck was the main motivation. She states,

I thought that would be a good place to start because it was a JOB, it wasn’t a practice. I did interview with a group that offered me a position with the type of thing that you would buy into the practice. That is NOT what I wanted. I just wanted job security. I had a lot of student loans; especially being in residency for six years. My deferments had run out and I was forebeared for a couple of years, so I wanted to have, you know, A JOB so I could start paying back these loans. Plus, I just wanted to get on with things. I think my age had a lot to do with that decision. I didn’t want to start building a practice. This position was in a clinic, and I was the only physician. There was a nurse practitioner as well. I thought it would be a good job, but it wasn’t a good fit.

The Transition to Practice

Starting a career in medicine was as rocky a road for Sarah as her training experiences. She stayed at her first position for only a few months. The expectations and culture of the small organization where she was employed did not fit her picture of what it meant to be an ethical, conscientious physician. She had no idea of this prior to starting at her job, but within a short time both she and the board of directors of the organization knew that this was a mismatch. They mutually terminated the contract. In hindsight, she acknowledged that she didn’t feel that she was ready for the position right out of residency. She explains,
I had an issue with the organization’s philosophy of medicine. In my opinion there were too many pain medicines flowing and I didn’t like that. As a new physician, I didn’t have the skills I needed to make the kind of changes that I knew needed to be made. Yeah, there were some inappropriate things going on, but I think now that I should have taken a more subtle approach, you know, if I had been intent on staying there, but I just wasn’t ready. I was really gung ho. I was over zealous.

Because the prior physician and the nurse practitioner saw this as status quo, the organization really didn’t understand the problem. I don’t think they wanted to understand the problem, they just wanted things to run smoothly and I wasn’t doing that. I wanted to screen people and to test formally for medical conditions such as pain and ADHD, especially adult ADHD, before handing out meds but that wasn’t well received.

After this experience, panic set in. As if there was not enough transition in her life due to the derailments that occurred during her medical training, her personal life changed as well. She married a man rooted in a specific geographical location which significantly limited her employment options. She explained that she was thrilled to have found someone with whom she could share her life, but anxious and frustrated about the career for which she spent a decade preparing. As a result, she focused on getting a job, any job that will help pay the bills. Job number two was in a small practice that was barely surviving financially. She explains,
I just wanted a JOB! I NEEDED a job in this area. That was what was driving me at that point. Just trying to find a job in that kind of situation was awful! I did find another job that only lasted a couple months because there were so many financial problems. It was a small practice and barely surviving. I was working, but they didn’t have any money to pay me! There were so many financial problems in this practice that they ended up closing. It was a very odd situation. I told them, “You are going to have to pay me something; I have loans to pay off!” Seriously, where do you hear of a professional providing service to an organization for no pay? They told me that if they had to pay me, they would have to close because they couldn’t survive financially. They counseled me that I needed to see a certain amount of patients to cover my share of the overhead and then, once I covered my overhead, I could draw a salary. So, I went along working for nothing for a couple of months. Then I said, “You are going to have to pay me or I am going to have to leave.” (She begins to laugh.) They replied with, “But if you leave we are going to have to close!” (She laughs harder.) What was I supposed to do? I decided to leave. Because they could not cover the overhead, and they had to close. Obviously, I was not following a normal career progression (she shakes her head and laughs.)

As Sarah continues her narrative, it begins to sound more desperate. She talks about having bills to pay, kids to feed, and nowhere to go. She moves on and begins to describe job number three.

So then job number three. Again, I am looking for a job. I NEED A JOB. I have to pay my school loans. You know, it is a lot of money and now I’m married as
well. I moved in with my husband and we have a new house and more bills plus kids to take care of, you know all of that stuff. So, I really needed to work. People often look at professionals as having money, especially doctors and I couldn’t even find a job!

Well, I had to do something, so I went back to my residency program (she gets lost in her thoughts). Okay, here is how it went. I called my advisor from residency and he told me that the residency program was closing. So, the program was closing and they were trying to set up a practice downtown as a free standing doctor’s office. When the residency existed, it was staffed by residents. My advisor was going to be one of the physicians in the practice and I knew he was great. We had a great working relationship. We worked well together and I went on a medical mission trip with him to Costa Rica when I was a resident. You know, I think we have a lot in common and we worked well together, so it seemed promising. Plus, another person from my residency was going to be one of the physicians there as well. I knew her and I thought she and I could work well together. So, I thought, hey, this could work, so I went back and took the job.

I worked at this job for a year. The first six months went well, then the other female physician left and we were short handed. Also, the man who was my advisor was trying to assume more of a role as an outpatient clinician but he was only there half time. He spent most of his time at the hospital because with all of the changes with the residency, the organization needed hospitalists. So, I was practically the only doctor working there.
I was seeing 30 patients a day and I didn’t like it. And these weren’t easy patients. As you know, the practice serves the inner city population and they seem to have many medical issues for a variety of reasons. I was working all of the time and making no headway. I got to the point that I was so fed I was going to leave – leave medicine that is. I had had it. I was looking at labs and I was thinking about going back to doing what I had done before, but this time as a physician. I really thought, “The heck with this!”

At one point I thought about going back to the practice that didn’t pay me! One of the doctors took it over as a solo practice and was looking for someone to join her. She worked out an agreement with a local hospital and she kept her costs LOW. She only has one person scheduling appointments and her employees are married and covered by their spouse’s medical insurance. It seemed to be working for her. It is amazing to me now, but I was so unhappy that I was thinking about it! Luckily, I talked to my husband about it and we decided I couldn’t do it. I would have to build a practice and that would probably take five years. I needed to pay bills and pay off my huge school loan debt, and just get on with life! I mean, I needed to start thinking about retirement! By this point, I’m already 54 years old – it was definitely not time to start a practice.

So, I decided to talk to my colleague, since he was the lead doctor. I told him, “Bob, I have had it. I have had it with this job and I am leaving medicine.” He talked to someone in the administration and the physician recruiter called me and said, “Please don’t leave, we don’t want to lose you, we need a doctor in one of our suburban offices. Will you come over and check it out?” It took three 
months for me to get there just to look at the practice because I was the only
doctor at my office. Finally they hired a nurse practitioner and another physician
and I was able to check out the practice. I LOVED it. Now, I am so happy to be
here. I mean, I work in a regular, stable practice that is not full of drug seeking
people!

*A Whole New World*

On to job number four. Sarah is now practicing medicine in a Family Practice
office located in a relatively affluent suburban area. Most of her patients are insured and
they are, for the most part, educated health care consumers. Sarah reports that she loves
her job. She recants her prior questioning of her career decision and with exuberance she
states that she didn’t make a mistake going into Family Medicine and she really does
enjoy what she is doing. She is so excited that she exclaims, “Yea!!” as she describes her
current position. She appears settled and comfortable with where she is in her career and
her personal life. As of now, the storms have calmed and she finally has the opportunity
to enjoy her vocation.

*Learning the Profession and the Organization*

One of the biggest surprises that Sarah faced as she pursued her dream of being a
physician is how complicated the process really is. She explains that when she set out on
this path, she was excited about the potential of studying medicine and being able to
eventually help people, but she really didn’t understand what she was getting herself into.
She explains,

> It is just so complicated. The business side of medicine, malpractice, all of that is
> just so complicated. There are all of these other things going on in the
background that I didn’t even imagine. All I thought was, “Wow, how cool to be a doctor; to be able to study medicine and advance at the level and to be able to help people. I was just as naïve as my younger counterparts. I remember telling a practicing physician that I was going to go to medical school and he responded in horror, asking, “Why would you do that?” I was like, “Wow, is he negative.” She dismissed him along with other naysayers and focused on moving forward.

**Medicine is a Calling**

Despite the trials she faced, when Sarah talks about medicine, you can hear her passion. She considers her career a calling. She explains,

You should only do it [be a doctor] if you can’t imagine doing anything else. You have to really just want to be a doctor. There is no other reason to be a doctor…It is not attractive financially; it is not attractive legally; it is stressful; and there are many long hours…being a doctor is a vocation. You really have to want to serve people to do it. You have to really care about people to do it.

As she reflects about what she has learned about being a physician after residency, she states that she realized that despite the frustrations, it really is a great honor to practice medicine. She smiles as she says,

I guess I don’t take a lot of things as seriously as I used to. I mean, things that I thought were very important in practicing medicine, I probably realized aren’t. It doesn’t pay to get upset because you don’t get to practice medicine the way you imagined you would; it is just great that you get to do it.

With a calm demeanor she goes on to talks about how content she is with her profession. She talks about how she feels:
Being a doctor is not like anything else. Well, maybe it is like being a clergyman. Being a doctor is a vocation. You really have to want to serve people to do it. You have to really care about people. There really is no other way you can do it today. You have to really want to do it because there are so many other things you can do and still help people while still have more time and probably making more money. I’m not trying to save the world and I don’t really focus on all of things that are wrong with the medical system, and there are many. Instead, I am now satisfied knowing that at the end of the day, I helped people and didn’t kill anybody. Seriously, it may sound simple, but that is how I feel.

The Business of Primary Care

Having experienced a variety of practice settings, Sarah clearly understands that medicine is a business. She tells of her surprise when she recalls the first time that she recognized that keeping a practice afloat is the 21st century is quite difficult. She describes her profession as a calling, but her day to day routine sounds more like that of a factory worker. She explains,

It is hard work. I try to see a minimum of 25 patients a day in order to cover my salary, and I am always thinking, “Oh, man, I need to see more people!” I frequently work through the lunch hour trying to catch up from the morning, and then I stay late trying to catch up from the afternoon session, finish charting, return messages and review results. You have to stay organized to make it through the day. I always thought that, you know, especially coming from surgery, when I was really crazy. Even with the number of patients I am seeing, it doesn’t seem like I am that busy now. I mean if I can get out by 6:00 at night, I
am okay with that. I have accepted the fact that I have to work ten or eleven hours a day. That is what I do; and it is manageable. It is when it gets unmanageable and you are double booked and running all the time that it gets exhausting.

This work environment is created, in part, because she knows that next year she will be on a productivity plan, which she says is often described as, “You eat what you kill.”

Sarah clearly does not appreciate the system, nor does she think that it is beneficial to patients, but she realizes that it is difficult to make it all work in the problematical world of decreased reimbursements, capitations, and increasing overhead and administrative costs due to the complexities of the system. She says that an important lesson she learned during her first few months of practice, is that as the doctor, she is not really what makes it all work. She shares her perspective:

You learn very early that you are not the boss of the organization. You are not who really makes it all work…you are JUST the doctor. So you just learn, you know, you are given two rooms and you expect your medical assistant to bring that patient back and vitalize them. No matter where you are, those things don’t change. I still get to do my style of medicine once the patient is in the exam room and the door closes because it is then just me and the patient.

Now the administrative things like whether you dictate or write your charts and how things are organized, that seems to differ from organization to organization, and these responsibilities seem to be increasing, as more and more information needs to be recorded in each visit. You know, whether you are writing a note or using a form, you just learn the system. You do what they want
you to do. You really learn how to bend in medical school and residency. You learn that when you go to all of the different hospitals and all of the different clinics. All of the organizational stuff becomes like background noise. You are still doing what you are doing.

Practicing medicine and having the necessary support structures in place is what is important to Sarah. The organizational context is almost non-existent in her mind, despite the fact that her current employing organization is consistently voted as one of the best employers in her geographical area. She explains how she sees her role:

As I said, I am just the doctor. There are a whole bunch of other people making appointments, pulling charts, billing for services, and generating all of this work for you. You just get to be the doctor which, I think, is the coolest part. But, from the business or organizational view it is not really the most important part of medicine. I guess at one point I thought it was the most important, but I learned that it isn’t. It is really the team that makes it work well.

I think that I have the coolest job of all, but maybe not the most important. Maybe the person who is coding things and generating the chart or making sure we get paid, maybe one of them has the most important job. When you think about it, they are the ones who are really keeping the doors open for the patients and for the business. I do not know much of what goes on from a business point of view. Patients sometimes ask me when we are in the rooms, questions like, “Well, I don’t know if I can pay this, what should I do?” Or they ask, “Does my insurance cover this or that?” I have to say, “I don’t know, I am sure that the
person checking you out can answer all of your questions or she will find someone who can, but I surely can’t!”

I enjoy working in an organization that takes care of the business aspects of medicine so that I can just see patients and practice medicine. I think that I have more autonomy than doctors in private practice because I don’t have to think about the business. I can just see patients.

Balancing Work and Life

Life didn’t stop for Sarah when she decided to enroll in medical school. Her grown children started families of their own, and she remarried during residency and acquired step children who were still living at home. When asked how she keeps herself from burning out, she stated,

I get enough rest. I go to bed pretty early at night. I get up at 5:00 am and exercise. I try to do things for myself. I garden and I enjoy cooking. I try to have a life with my children and my new family. I really have a BIG life.

She does not attribute her success in juggling it all to herself but instead, she recognizes that it works because of the people around her.

As she expounds upon her life routine, it becomes clear that she is a master at life management. She works in a demanding job, takes care of the home without outside help, such as a housekeeper. She makes time for family, and is quite poised and relaxed as she explains it all. In comparison to life as a resident, especially a surgical resident, life as a practicing physician seems quite manageable. But, she clearly knows her limitations. She has her priorities and wants to be a good doctor, wife, and step mother.
She claims that neither she nor her husband need a lot of social time, but they do enjoy cooking together and spending time with family.

When asked how she sets priorities, she talks about physicians that have been in practice for a long time and have that “older doctor mentality.” She explains, They just buy into it. I don’t know, they are different. They buy into the idea that to be a good doctor you have to work all of the time. Some of them are really jaded and some of them really believe that you just have to work this hard to maintain your skills and you should be HAPPY doing it. Yet, some are just, you know, burned out.

Clearly, she does not want to follow that path. When she talks about her future in medicine, she clearly wants balance, and needs balance considering that most people at her phase of life of planning their retirement. Joking around she says, “In ten years I see myself on a houseboat with my husband.” She begins to laugh saying, “Yeah, sponging off his retirement.” As she becomes more serious she says, No, I see myself winding down. Unfortunately, you know, I think that is a reason that I wouldn’t tell somebody that is older to go ahead and go for it because after doing what I did and working so hard to get here, I really want to practice for at least 20 years. So, I see myself still practicing [even though she will be 64 years old]. Hopefully my health will be okay, but I don’t see myself working full time in ten years.

Reflections on the Profession

Sarah’s demeanor is quite serious as she talks about the current state of medicine and she becomes glum as she talks about the future. She expresses her opinion, “Yeah,
unfortunately, patients are the ones who are ultimately suffering with our new way of practicing medicine. It is just about the business.” Later, she expands upon this and states,

I don’t think it is going to get any better as far as the organizational demands. I think we are still going to have to see X number of patients to keep the doors open and uh, I see that in the future there is going to be, well, we will be stretching doctors even thinner. There will be more nurse practitioners and PAs (physician assistants) and there will be more responsibility in regard to supervising them. We are going to see less RNs and more MAs in the profession. I don’t think it is going to be good for patients, but it is what organizations need to do to financially survive. I don’t think it is good for the profession. I am not real optimistic about the future of medicine.

Her outlook on the future sounds dismal, but she does not seem discouraged. Instead she states, “As far as I am concerned, I just do what I can.” As she talks about the constraints and frustrations that she faces on a day to day basis, it becomes clear that she is called to be in the profession and truly sees her position as a way of serving others. As she shares her experiences, her narrative begins to sound like that of a teacher or social worker who decided to follow a passion rather than the pursuit of income and comfort. The picture is so different from the common perception of the American doctor, working hard but living a life of comfort and luxury.

Reflections

Sarah experienced so much flux and transition in her quest to become a physician and to find a position where she was content that telling her narrative was quite cathartic.
There were so many times when discussing her career or reading the transcript that she said, “Wow, I’ve never looked at this as a complete picture before.” Throughout the interview and narrative process she apologized for not being what she thought she should be (for example, she apologized for not taking a traditional career path, for having so many residency program experiences, for changing her mind about her specialty, for changing jobs so frequently, etc.) It wasn’t until the end of the process that she recognized that this is her narrative and it is the path that she took to get to where she is today.

Sarah is very content in the present. The process of talking about her experiences was a way to unpack all of the baggage and move forward. Through this reflection, she realized how much her perception of a career in medicine had changed. She was so driven to be a physician because, as she puts it, it was “so cool.” She had the archetype of both surgeon and general practice physician etched in her mind. As she reflects on the past and recognizes this, she decided that it is probably that “brass ring” mentality that provided the perseverance and tenacity that she needed to get through it all.

Chapter Summary

The stories of the professional entry experiences of nine physicians are presented in this chapter. The purpose is to provide a holistic view of the participants’ lives as they begin their professional practice. While the series of events that the individuals experience on their road to becoming practicing physicians are quite similar, their narratives are very different in theme, form and content. The next chapter, Chapter Five, presents my analysis and interpretation of the narratives through the eyes of the researcher.
CHAPTER FIVE

FINDINGS: HOLISTIC, STRUCTURAL, AND COLLECTIVE ANALYSES OF THE NARRATIVES

As explained in Chapter Three, the data were analyzed in multiple ways: holistically, structurally, and collectively. This chapter is separated into two sections. The first section presents the findings from the holistic and structural analysis. The second section includes presents the findings of the collective analysis.

The Complex Nature of Analyzing Personal Narratives.

I believe that the power of narrative is its deep, personal nature and how that resonates with readers. This is why I included the full narratives in Chapter Four. But, I also recognize the importance of analysis. In analyzing the data, I was concerned that doing only a collective analysis to find the general themes across the participants’ narratives would be a disservice to the participants and the narratives that we worked so hard to construct. Also, true to social constructivism, part of the purpose of my analysis is to “explore relative differences in narrative social construction” (Boje, 2001, P. 18).

Thus, I analyzed the narratives holistically as well as collectively.

On the surface, physicians have similar life paths. At some point they decide they are going to be a doctor. They attend college. They attend medical school. They spend their last two years of medical school on the “floors” and at the end they decide on a specialty. They have an internship year and then become residents (house staff.) Finally, they practice medicine. This predetermined path contributed to the participants’ narratives taking a very linear form. The stories that make up the narrative, how they interpret these events, the decisions they make, how they go about making these
decisions, and the how they construct their individuals lives and careers, are what make each individual narrative unique. Analyzing the narratives both holistically and collectively allows me to focus on the uniqueness of the individual participants. This is consistent with a constructivist approach to narrative which highlights the “how” questions instead of the “whats” (Gubrium & Holstein, 1997, as cited by Elliot, 2005) and unearth commonalities in their experiences.

The first section of this chapter presents the findings of the holistic and structural analyses of the individual narratives. Within each participant’s narrative of how he or she became a physician and entered practice are numerous stories of the events that transpired during that time period. These stories were often about issues and concerns that they needed to evaluate and resolve in order to move on with their lives and careers. The structural analysis uncovers the complicating actions, evaluations and resolutions that appear in the participants’ narratives. Unlike, the intact narratives presented in Chapter Four where I tried to preserve the voice of the participant, this analysis is my interpretation of what is presented in their narratives.

The second section of this chapter presents the findings of the collective analysis. While I do present my impressions of general themes that surfaced in each of their narratives, I do not think that a collective narrative can be constructed using these general themes, nor do I believe that these themes alone constitute the findings of this study. This is contradictory to much of what we think about qualitative research, but I stated previously, I believe that the value of this study lies in the power of the holistic narrative. While presenting general themes adds insight, the themes in unison present an incomplete analysis of the data.
In an effort to reduce redundancy, since the full narratives are presented in Chapter Four, the results of the analyses include paraphrases and brief descriptions of events from the original narratives presented in the previous chapter rather than numerous supporting quotes. This is not to diminish the actual words of the participants. It is more an effort to separate the mutually constructed narrative from my interpretation of the narrative.

Holistic and Structural Analysis

I analyzed the narrative as a whole, but I also analyzed the stories within the narrative to uncover the complicating actions that were found in the individual stories embedded in the narratives. Following are my analyses of the complicating actions that occurred in the participants’ narratives and my interpretation of how they evaluated and resolved the events. Each analysis will contain an abstract, orientation, complicating actions and the corresponding evaluations and resolutions. Because narratives are about the past, the analyses end with the final structural component, the coda, which interprets how the participant brought the narrative back to the present.

Chris

Abstract

Chris is a physician in his forties who pursued medicine as a second career. His narrative is about his quest to practice what he believes to be “good medicine.” He sees himself as a healer; someone who helps people help themselves get better. His approach to medicine can be summed up in this quote:
My code is that I am not here to make love to these people. I am here to help them get better. I’m not a doctor to please people; I need to practice good medicine by getting them in, getting them better and getting them out. Yet, his commitment to his patients and medicine goes much deeper.

Chris’s narrative reflects his pragmatic approach to his career in medicine and his life in general. His narrative appears mechanistic and objective, which reflects the scientific bio-medical model of practice and his prior profession as an accountant. Yet, he does not suppress his emotions. He talks about the boredom and lack of purpose he felt in his career as an accountant. He shares his frustrations with patients, bureaucracy and 21st century medicine. He also expresses his passion and enthusiasm for life through his multiple interests and his energetic demeanor.

There were two major themes or complicating actions that appear in his narrative. The first was his having to deal with a series of detours that changed his career aspirations and path. The second was the quest for homeostasis which describes his adaptation to his career and lifestyle after residency.

Orientation: Chris’s Background

Chris’s path to becoming a physician is non-traditional and his background and experiences prior to pursuing medicine are found throughout his narrative. Chris began his professional life as an accountant, but he always had a nagging desire to pursue medicine. He had a few setbacks along the road, but he eventually became a physician. He grew up in a small conservative town where stability and security were paramount. He has a practical, down to earth way of looking at the world. He attributes that to being older (a baby boomer in his eyes) and his small town upbringing.
Complicating Action: A Series of Detours

The events that Chris chose to share in his narrative reflect his pragmatic approach to life. He recounts the joys and disappointments that he faced in his personal and professional life. Chris’s narrative is filled with stories of what could be perceived as disappointments, or at least detours. As soon as he entered college he gave up on studying science due to an altercation with one of his first professors. His dream of being a military pilot was terminated due to a knee injury. After college he was an accountant, a career that he did not like, for eight years. Due to his father’s illness, he could not pursue plastic surgery and chose family medicine as a specialty because the residency was close to home. Finally, he had to take a creative approach to his medical career in a specialty he did not like.

His narrative also includes the joys in his life. He took a leap and left a secure career to pursue medicine. He was one of the few students out of his undergraduate program that was accepted to medical school. He was fortunate to have a lucrative, successful career right out of college which put him in the financial position and gave him the confidence to pursue medicine. Finally, at the time that we wrote his narrative he was very content with his personal life. He was expecting his first biological child. His stepson was in college and doing well. He had moved in to a new home in the country that both he and his wife loved. And, even with a busy professional schedule, he was able to find time for his many interests.

Evaluation and Resolution: Take the Good with the Bad

Chris shares in his narrative that he enjoys restoring motorcycles and, if he could make a living doing it, he could easily see himself as a motorcycle mechanic. This hobby
provides a strong metaphor for how he evaluates the events in his life and his medical career. Basically, he fixes things and moves forward. He told his narrative as a series of events that took this course: problem occurs, problem is assessed, solution is developed, resolution occurs, and Chris moves on. His narrative reflects his desire and strong ability to rationally and objectively “fix things” in his professional and personal life. At the beginning of his narrative, he explains how he wanted to pursue medicine, so he evaluated his options and chose to stay in New England for school since it was the most cost effective alternative. He goes on to share how he faced his father’s illness and decided that he could not put off his residency training, so he trained in Family Practice designing so that he could pursue Emergency Medicine rather than a general office practice that he knew he would not enjoy.

There are a number of events shared in his narrative that powerfully illustrate his propensity to “fix” things and the satisfaction he get by doing that; one was personal and one was professional. On the personal level is the story about how he decided to lose weight. He went to the doctor and realized that he was up a few pounds. At first, he avoided it but when it came to his next appointment, he realized he needed to take action. He started eating more healthy foods and less junk, and he lost weight. To him it was simple, do what you need to do to get back to baseline.

Professionally, he shared that one of the most memorable events of his medical career, thus far, was when he intervened and helped a patient recover from a stroke with limited residual effects. He told the a story about how he got her to a stroke center and TPA was administered and he described his feelings of accomplishment saying, “I look at
that on as one of my grand slams...It was one of those moments where you can always look back and go, ‘Wow, that was really pretty fun.’”

The desire to fix things is not confined to medicine; it permeates all of the facets of his life. He shared that he is always fixing things in his house (sometimes when it is not warranted). When he was telling his narrative, he was moving around changing light bulbs and tightening screws in cupboards. In order to fix things there needs to be some level of control. In his narrative, he is very forthright regarding his need for control. For example, he shares that he likes in internal medicine because patients are “prisoners.”

“You order their tests, and they do it. You restrict their diet and they follow I . . . they have to follow your rules and do what needs to be done to get better and get out of there.”

Another point in his narrative where he demonstrates his need for control is when he talks about his wife’s pregnancy. Because he knows what can go wrong and how little control he has over it, he chooses to be very guarded. He told his wife that he would not allow himself to get excited until he felt that the baby was going to be viable. Explaining that, “With what I know and what I have seen it is hard for me to not be pragmatic. I come at it from a very pragmatic view – bad things happen.” This pragmatism weaves throughout his narrative.

*Complicating Action: The Quest for Homeostasis*

When he started his first professional position after residency, he found it difficult to adjust to the slower life pace. Part of this is that he is a very active person and part of it is his value system. So, he decided to fill his life with work. He states that his did this to keep himself out of trouble at home, but later in his narrative he talks about how he was trying to recoup the money he lost during medical school and residency. Also, it
took some Chris some time to find a place where he was comfortable. As mentioned
previously, he did not want to be a family doctor. He became board certified in family
medicine because the residency program was convenient. Yet, he also wants his identity
to be more than just his profession. Chris expresses that, “When I am gone, I don’t want
people to define my life as a physician. I want to be defined as a person who happened to
do medicine.”

In light of the stories he tells throughout his narrative, and how he tells the stories,
this appears to be an accurate description of how he identifies with his profession. His
narrative suggests that he chose medicine because it is a challenging career that provides
a comfortable income and he can make a difference. He did not do it because he
identified with being a caretaker, and be involved in people’s lives. He gets his
satisfaction from fixing things and solving problems not from the interpersonal
interactions associated with being a doctor.

Evaluating and Resolution: Finding Peace

It took over a year for Chris to find the right blend of work environment and
challenges that could keep him content professionally and personally. He worked in
inpatient, outpatient and emergency medicine. What he realized was that he likes the
mix. Working for different organizations and in different settings provides the challenges
and professional satisfaction that he was looking for and never achieved in his accounting
career. He realized for him to have professional and personal satisfaction he had to
balance what he enjoys with what he can get paid to do. That is why he likes medicine.
He can make a difference and make a comfortable living.
Coda: His Narrative Comes to an End

Chris ends his narrative by explaining that he has found a place where he is comfortable. He plans on enjoying his career in medicine, retiring early and doing other things he loves like woodworking, spending time with family, being with his dogs, and enjoying his life. Also, he recognizes that the birth of his daughter is something that will impact his career. He wants to be involved in caring for her and his stepson and this takes precedence over work.

Chris works many hours but that balances him. He feels that he has perspective on his life and that guides him personally and professionally. He is not trying to prove himself or create a professional legacy. He likes what he does, but does not live for it.

Ellie

Abstract

Ellie is a family physician who decided to return to her hometown and practice medicine with her father. The difference in what she is doing versus what she expected and her quest to become her own person are what ground her narrative.

Orientation: Ellie’s Background

Ellie grew up in a small town where her father practiced medicine as a family physician in a solo practice. Her father worked long hours and her mother worked in the home and raised her and her sister. As with many children whose parents have small businesses, Ellie worked in her father’s office after school and during summer vacation. From an early age, she knew that she wanted to be a physician but she did not want anything to do with her father’s specialty or practice. She verbalized that she did not like the small town atmosphere. She did not like family medicine, in particular “geriatric
medicine,” and she wanted to work for a large organization. She chose to attend medical school in a large metropolitan area away from home.

The central themes of Ellie’s narrative, based upon the complicating actions and events are: *Embracing and resisting her father’s influence* which describes her professional and personal relationship and identification with her father; *creating a space to practice* which describes her efforts to build a satisfying practice; and *learning how to live in the present* which describes her transition from residency training to practice.

*Complicating Action: Embracing and Resisting Her Father’s Influence*

Ellie asserts that she did not want to follow in her father’s footsteps. Despite her resistance, her parents, especially her father, and the roles they carried out while she was growing up had a strong influence on her personal and professional aspirations. For example, she shares that the relationships her father built with his patients are what attracted her to medicine. The stories she tells in her narrative also suggest that she values a strong traditional nuclear family which is how she grew up.

She began her narrative by sharing her desire to be her own person and practice medicine her own way. As the narrative continues, her external struggle for independence competes with her internal desire to emulate and please her father. The stories she tells throughout her narrative reflect how she set out on an independent road but ended up coming back home. While she is personally drawn to Family Practice, she initially resisted it. Ultimately though, when it came down to final decisions, she made decisions that reflect her father’s professional experiences. She changed her specialty from Pediatrics to Family Practice, she did her residency at a community hospital and she ended up practicing with her father.
But, she does not want to be like her father and give everything to medicine. She recognized that she has her father’s work ethic and struggles with the self-perception of being lazy and unmotivated. But she tells stories throughout her narrative that show that she challenges these thoughts and feelings and makes a conscious effort to not let them control her. She is adamant about not wanting the responsibility of running a practice and wants to continue being an employee in her father’s office or somewhere else.

Finally, A number of times she expressed her desire to have a family and she was very clear, should that happen, her family will come first. She even stated that if she had to make a choice between raising her children and her profession she would leave the profession. To me, that was a strong statement for someone just beginning her career. There are places in Ellie’s narrative that suggest that she has a more traditional view of gender roles. She commented that men take their profession more seriously than women do. She also made comments during her interviews and our discussions, such as: “Now what lady doesn’t love kids?” “That just shows how men and women approach work differently.” “I’m a woman, of course I love pediatrics!” These held beliefs have informed her beliefs about her profession, her practice, and her professional relationship with her father.

_Evaluation and Resolution: Moving from Daddy’s Little Girl to Colleague_

Ellie tried to exert her independence and control by being very specific and business-like when dealing with her father. She thought that this type of interaction would keep their work relationship at a professional level. She explains that she developed a one year contract for herself that outlined her roles and responsibilities. She
told her father that she was just trying this for a year, and if she would choose to leave she hoped there would be no hard feelings.

On the other hand, shortly after she started she realized that he had ultimate control. The majority of his patients wanted to continue to see him, and she felt that her role in the practice was that of “greeter” or public relations representative. She was frustrated that rather than addressing issues with her, patients would often call her father when they were displeased with her service and performance. Her father was constantly giving her “pep talks,” providing professional advice, and assisting her in her duties when she got behind schedule or became overwhelmed.

As her narrative and her career moved forward she began to soften, accept her father’s position, and appreciate the opportunities that he was providing for her. For example, when she felt like she was working too much, he told her to decrease her weekly schedule. When she felt like she was on call too much, he took over some of those responsibilities. When she took over the patients of a retiring pediatrician, he agreed to accept medicare, which probably cost him money, so that she could have the satisfaction of serving the needs of the community.

Her professional entry experience was as much about her relationship with her father as it was medicine. As her narrative progressed, her father’s flexibility continually surprised her. With every concession he made to his practice in order to help hers, she gained confidence and a deeper appreciation for him and their relationship. It also helped her learn what was important to her and construct the career that she wanted.
Complicating Action: Developing a Space to Practice

Ellie’s narrative illustrates the difficulties that beginning physicians face when they start practicing in a small community where people have set expectations of what a physician should be. She had to develop a persona in the community. She expresses frustration with what she describes as her “role as a politician”–greeting people, shaking hands and kissing babies,” explaining that because she is practicing in a small town, people have certain expectations of the personal and professional personas of physicians. She was in the process of developing a public persona and a way of managing her “celebrity” status in the community where she grew up. On one level, she is uncomfortable with the role she has acquired through her profession. At another level, she wants to be recognized and respected as a physician. Establishing her new identity in her old community is part of her professional entry experience.

Evaluation and Resolution: Practicing on Her Own Terms

Ellie pursued medicine to be involved in people’s lives and to help people. She was not experiencing that when she initially started practicing with her father. She was not sure what she wanted but she knew it was not what she had. When she picked up the pediatric clientele in the area, she, in essence, started a new job. She was busy and challenged; most of all, she felt that she was making a difference in people’s lives and the community without practicing her father’s type of medicine. Her father’s relationships with his patients motivated her to become a physician, but she wanted her practice to be distinct from her fathers. She does not refer to the patients in the practice as “our patients” but differentiates “his” patients from “my” patients. This is what she wanted and she attained it.
Ellie wants to make a difference, but she also wants a full life outside of her practice. Balancing the demands of working in a two person practice with her desire for time for herself took some negotiating, but she found a place where is comfortable at this point in her life. She states that she is willing to walk away from her profession if it interferes with her personal life, especially if she has a family. But, in the meantime, she enjoys taking care of patients and meeting a need in her community.

Complicating Action: Learning How to Live in the Present

For most of Ellie’s life, she had to be future oriented. She explains that during college, medical school, and residency she had to delay gratification and what she wanted to do in the present for the goal that she had for the future. A final theme apparent in Ellie’s narrative is that for the first time, she is living in the present and not for the future.

In her narrative, she shares some of the struggles that she faces as she moves from living for the future to living in the present. For example, she had to talk with her father about her work hours because she did not want to be working as hard as she was, yet, she did not want to appear as lazy or uncommitted. She also tells of her struggle to not feel guilty and to enjoy the freedom that she had to go to the mall in the middle of the afternoon. She shares that when she first started practicing she felt like she always had to be looking things up and learning new things, but as time went on she learned how to relax a bit more and enjoy life.

Evaluation and Resolution: Finding Balance

At the time that she told her narrative, Ellie was enjoying her life. She had negotiated her schedule and felt comfortable with her workload. In her narrative, she shares that she is so happy to be at a point where she no longer has to look ahead and say,
“I have to do all of this, so I can do that.” Stating that now she can “Just enjoy doing what I spent all of these years training to do.” As she proceeds with her narrative, says that she has absolutely no future that she is planning for and she loves the freedom.

**Coda: There is Something Good for the Soul**

Ellie entitled her narrative, “There is Something Good for the Soul.” Ellie feels that at this point in her life she is where she is supposed to be. She believes that she is making a difference for others and giving back to the community where she grew up. Her life is not everything that she wants it to be, but she is content and comfortable where she is. She is not looking back or forward, she is firmly grounded in the present.

**Jacki**

**Abstract**

Jacki’s narrative exemplifies the struggles faced by mothers with young children who are also trying to have a successful career. While she enjoys her work, she is a mother first. The abstract for her narrative can be summed up in her own words, “I am going to have a hard time getting everything I want out of life.” She is working very hard to have everything, but at this point, she finds it overwhelming.

**Conflicting roles** is the central theme or complicating action of Jacki’s narrative. As she begins her professional career, she finds her desire for a fulfilling career and family life often overwhelms her and results in her feeling that she is not making the grade in either realm of her life. A second complicating action of her narrative is waiting for the future. Similar to her experience in medical school and residency, Jacki is in a place of delayed gratification because her husband is currently pursuing his law degree. Even though she has entered the professional world, she still sees it as temporary because
when he graduates and starts practicing, she plans on reducing her workload to have more time with her children.

**Orientation: Jacki’s Background**

Jacki background reveals how important her family and children are to her. She was married during the summer before she started medical school and she had her first child while attending medical school. She stayed close to home for college, medical school, residency and practice. Before she ever set foot in medical school, she was strongly convinced that her professional life was not going to overshadow her personal life. To illustrate this, she told a story about her medical school interview. Her father was concerned that if they saw that she was engaged, they would think that she wasn’t serious about medicine. Her response was, “This is what I am; this is who I am. I am going to be married when I come here whether they like it or so they will have to deal with it.”

**Complicating Action: Conflicting Roles**

Jacki states that doctors today want the whole enchilada. She shares that she thinks that her desire to have a manageable work schedule with a reasonable amount of overnight call (which she does not really define) reflects the new face or medicine more than it suggests that she is less dedicated or motivated than anyone else. Jacki likes practicing medicine and takes her job seriously, but the stories she tells indicate that she sees her family role as more important than her career. So, she puts a lot of energy into that as well. She has two small children and a husband in law school. Her narrative often reflects her feeling that there is just not enough time in the day to accomplish everything she wants to do. She takes pride in her ability to multi-task, but there are only so many
hours in the day. Much of her narrative reflects the challenges she faces in making sense of this limitation.

She depicts her profession as a job—a way of paying the bills. She mentions that she would quit if she won the lottery. Yet, she takes her role very seriously and wants to be a good physician. This often leaves her in a lose-lose situation. In her narrative she provides a strong illustration of her priorities when she explained how she re-arranged her patient schedule to attend her Girl Scout leader training (she was training to be the co-leader of her daughter’s brownie troop) during work hours so that she would not have to leave her family to attend training in the evening. Even though she made the decision to put her family first, she felt conflicted and concerned about what image that would project to her partners if they knew. Throughout her narrative she struggles with her desire to be taken seriously as a physician while establishing a family similar to the one in which she grew up.

As a result, her narrative is full of stories of the day-to-day difficulties she experiences in balancing work and family. She does not share much about her husband. It appears, because of the demands of law school, he is on the periphery of the family. She is in charge of the household and the children. In addition, she holds the responsibility of the primary breadwinner until her husband finishes law school. This seems to be the center of her life. She struggles with letting go of her household responsibilities and does not like that her babysitter spends more time with her children than she does. She has compensated for this by trying to put her family first whenever possible. Therefore, there are times that she has to rearrange patient schedule, get colleagues to cover her call, and as she puts it, “whine and complain” until the doctors in
charge of the organization listen and afford her the time and flexibility she needs for her to have a rewarding family life as well as a rewarding career.

Jacki’s narrative reveals how well she knew what was important to her as she started down the path to a career in medicine. She tells stories about how she paid attention to how the residents managed their lives. She was always trying to find residents with families and watch how they dealt with it. She learned from this. She told a story of how watching residents with no family support reinforced her desire to train and practice in her hometown so she could have a support network. Despite all of the forethought, professional entry has been very difficult for her because she is working so hard to manage multiple facets of a full life.

*Evaluation and Resolution: Learning to Manage the System and Practice in Her Own Way*

Jacki presents a dichotomy between the old tradition of medical practice and the new generation of physician throughout her narrative. Because she was the first person hired in the group for eight years, she became the new face of medicine to the established physicians. She was given latitude in her position because the managing partners did not want her to fail. Her organization was predominantly comprised of middle aged men. For almost a decade prior to her taking the position, the group struggled with recruiting because they presented demanding schedules to candidates who just were not that interested in doing that. When Jacki arrived, they followed her lead. She explains, “They just let me play the role; they just let me make up the job!” This allows Jacki to work hard at her job, and manage her life outside of work.
A powerful experience that shaped the way she approaches her practice occurred shortly after she began her position. She calls it her “defining moment.” She had a complicated pregnancy and missed a lot of work. This experience taught her that despite the fact that patient schedules are set months in advance and lots of tasks need to be done on a daily basis, the system can accommodate and make do. This experience strongly influenced the way she approaches her practice. She shares, “I take my job seriously and I don’t slack off, but, at the same time, if I have to be somewhere for my family, I am going to change the job, not the family commitment.”

The stories she tells about her organization and the way she has chosen to practice medicine suggest that at times she feels that she is blazing trails for those who follow her. Consciously or unconsciously she decided that she was not going to bend for the system but push the system to bend for her. Because she was the only woman in the practice who is raising children, it appears that her requests were met and not challenged by the other physicians in the practice.

*Complicating Action: Still Working toward the Future*

Even though she finished residency and has been practicing for over a year, she still is seeing this phase of her life as very temporary; her husband is a law student and she expects to make career changes when he finishes school. She is still actively attempting to make sense of her world and find a place where she is comfortable. Her life has been scheduled and predetermined for such a long time that she does not comprehend how others can have the free time and flexibility that she desires.

She often said in her narrative, “I don’t know what I was thinking.” This, from my point of view, indicates her questioning why she thought she could have it all. When
she reflected on past experiences while constructing her narrative, she recognized that the message that it was going to be difficult was given to her but she was not ready to accept it.

_Evaluation and Resolution: This is Temporary_

This area of Jacki’s narrative is not resolved, but she does recognize that it will not be this stressful forever. She has optimism that things will get better for her with a lighter on call schedule and her eventual shift to part-time work. Her professional entry experiences were heavily influenced by the fact that she has two young children. When she told her narrative, her daughter had just started kindergarten and her son was a little over a year old. So, along with juggling the demands of a baby, her work and her husband’s school schedule there is the added stress of her daughter’s schedule with school, birthday parties and Girl Scouts. Unlike most of her peers who finished residency and experienced some stability and the opportunity to have some free time, the demands in her life actually increased.

She recognizes that this time in her life is temporal, but being in a constant state of exhaustion and having to juggle multiple priorities sometimes gets overwhelming for her. In the same respect, she expresses a level of satisfaction in knowing that she is able to accomplish so much and juggle her life as well as she does. While she is pleased with what she can accomplish, she looks forward to the day that she can reduce her work hours.

_Coda: Moving Forward_

About a month after we finished writing Jacki’s narrative, I received an email from her. It went something like this, “My daughter’s birthday party went well and I got
my new call schedule for next year. It looks manageable (but, we will see.) Things are looking up!” Despite all of the frustrations and obstacles that Jackie deals with on a day to day basis, she still has hope. She can appreciate life and recognize that joys that occur along with the frustrations.

Jessica

Abstract

The overriding message of Jessica’s narrative was her struggle to, as she puts it “make it” and “get ahead” referring to both economic security and some level professional esteem. Jessica grew up in a small town where there was a teaching hospital and residency program (the residency program she attended). The physicians she knew were held in high esteem in the community. She entered the medical profession with a preconceived notion that there was a level of privilege associated with the title “Doctor.” Her experiences in medical school and residency did not confirm her ideas and beliefs. It was not until she finished her fellowship in sports medicine and was identified as a “colleague” by one of the well known surgeons in her department that she felt like she was finally in the place that she expected to be.

There are two central themes or complicating actions in Jessica’s narrative. The first is the frustration of practicing contemporary family medicine, which describes how she perceives her profession; and the second is creating balance and finding a professional niche, which describes how she finds contentment personally and professionally.
Orientation: Jessica’s Background

Central to Jessica’s narrative was her background and culture. She grew up in the small town where she trained as a resident and currently resides there despite an hour to an hour and a half commute into the city each day. The town had a community hospital with a Family Practice residency program. Each year, local physicians go into the schools and recruit bright young people to the profession. The physicians visiting the schools were predominantly white men who attained some level of social and economic status in the community. A conversation with one of these physicians sparked her interest in medicine.

Complicating Action: Developing Her Beliefs about the Profession

Jessica’s narrative reflects her strong cultural tie with both her hometown and the American Dream of working hard to get ahead. She felt that if she worked hard and got through medical school and residency, she could, as she put it “make it” and “get ahead.” Part of getting ahead, in her view of the profession, is accepting, often uncritically, the beliefs and actions of those in authority. This has been a key component to her success within her current organization. It is what has been reinforced for her throughout medical school and residency and it is what she believes is necessary to excel in her current position.

She caught on to the organizational culture very early in her professional career and it works for her. She explains that in order to be successful in her organization you need to know your place, recognize who is in charge and keep everybody happy. This works for her. Throughout her narrative she tells stories that suggest that she is very in tune with the power structures within her organization and in the medical profession.
She was affected very negatively by her experiences as a Family Practice resident. In her narrative, she often compares her Sports Medicine world with that of Family Practice, and she is very pleased with the path she has chosen. She tells stories of her experiences that suggest that being appreciated for what she does is very motivational for her. Her experiences in Family Medicine did not meet that need. She illustrates this in her narrative when she says “And the end of the day, I think that for all that you do in Family Medicine, you do not experience much good. You know, you don’t get reciprocated in any way for it. Not from patients, not monetarily and not usually from where you work!”

Her experiences as a Family Practice resident informed her professional entry experience in Sports Medicine. All of the rewards that she did not gain in Family Practice were there to be taken in Sports Medicine, and this provided personal and professional satisfaction. This is especially true for her in terms of patient appreciation. This dichotomy befuddled her. Her perception is that in Family Medicine though she was dealing with life threatening conditions, the patients did not care about or appreciate her service. But, in sports medicine, she is not really saving lives but enhancing performance, and the patients are incredibly appreciative.

A final element that informed her views of the profession as she began practicing was the realization that the debt she acquired to finance her education along with the delayed gratification necessary to make it through medical school and residency left her in a precarious position where her earnings put her at an economic level where she is perceived as wealthy, but her debt and the hidden cost of not being gainfully employed
during seven years of school and residency create a financial quagmire. She finds it frustrating to have worked so hard and still feel like she is struggling to get ahead.

*Evaluation and Resolution: Recognizing her Interests and Moving in a Different Direction*

Jessica’s involvement in Sports Medicine afforded her the opportunity to meet the professional expectations that were not met in Family Practice. She admits that the best thing that she did for her career was to move away from general primary care and specialize in sports medicine primary care. Though she is technically a primary care physician and board certified in Family Medicine, she works in an orthopedic office with surgeons and only works with athletes or sports related injuries and illnesses.

Because she works with a very select group of patients, she finds the benefits of being a physician outweigh the frustrations. This was not the case for her when she was training in Family Medicine. She also likes the perks associated with being in a large, prestigious medical system. She alludes to this throughout her narrative. For example, she shares that the orthopedic department [where she now works] has parties at prestigious clubs in the city while family medicine is lucky to get a free meal at a pizza shop. She expresses her joy about being invited to events and her family received benefits such as her daughter being able to go backstage at the ballet and meet the ballerinas. She mentions that she has her own secretary and a beautiful office. Also, she finds that patients do respect and appreciate her as a professional.

*Complicating Action: Blending the Professional and the Personal*

Jessica articulates that when it comes to family and careers “You need to plan life and then your career will work its way around it.” But, this is difficult when dealing with
a demanding career and a family. Her life is hectic, sometimes overwhelming. She attributes her ability to manage life to her husband and her working as a team. Jessica’s husband works less hours and she feels that she “falls on the short end of the doing stuff scale” at home. This works for them. But, as she entered practice with colleagues who are predominantly men with wives at home, she recognized the differences in her life and theirs and was trying to make sense of her how she manages her life in contrast to the others around her.

For example, she finds the department has social gatherings overwhelming when the surgeons’ wives talk about how busy they are with their shopping, appointments and trips to the gym and she is thinking, “I haven’t had time to work out in over a month and our milk is past dated. I smell it every morning to make sure that it will be okay!” Also, her husband is often invited to social events for “spouses” where he is very uncomfortable because he is the only man. Her narrative does not reflect resentment, nor does she indicate that she would want to trade places with them. Her narrative has more of a tone of frustration and confusion; she seems to believe that she and her husband live in a different world than her colleagues and their families and she is trying to make sense of it.

Evaluation and Resolution: Planned Busyness

Jessica said that one aspect of her current position that was so appealing to her was that there was no evening and weekend call and no hospital responsibilities. During football season she works most weekends, but it is scheduled in advance and she can plan around it. Also, she feels that her office is family friendly and, if necessary, she can bring her daughter to work. Though she thinks that life sometimes gets crazy and it
seems that she and her husband can never catch up with meals, laundry and other household chores, they developed a system. What helps is that Jessica loves her professional life, so she willing accepts the frustrations because they are outweighed by the benefits.

**Coda: Yes, I Finally Have Made It**

Jessica ends her narrative with the realization that in her mind she had finally “made it.” Though much of her narrative suggests that she defines “making it” as being financially comfortable, and having some level respect and professional status; her feeling of finally making also seems rooted in the fact that she is finished her training and beginning her professional career. Considering that she was only in her position for four months when we started her narrative, she was still getting used to the autonomy and financial benefits associated with being a practicing physician. She seems content that she has achieved what she set out to achieve, whether it be some pre-conceived ideal, or the passage from trainee to professional.

**Lily and Ricardo**

**Abstract**

Lily and Ricardo’s narratives reflect their deep commitment to each other and their desire for a balanced life. Lily and Ricardo constructed their narratives separately, but they were analyzed together. Lily and Ricardo met in college, were married by medical school, and they now work across the street from one another. From their undergraduate days forward, they made decisions together and their narratives are fully intertwined. In this study, they were interviewed separately and constructed their narratives without sharing them first. Despite that, they seem to speak with one voice.
The series of complicating actions or central themes of Lily and Ricardo’s narratives are: *Planning for dual career* which includes the planning and organization that they used to prioritize their relationship while training to be physicians and choosing practices. *Establishing a practice* describes how differently Lily and Ricardo approached their medical training and their professional practices. And, *striving for success in life and in work* relates to how they have adapted to their practice settings and their lives after residency.

**Orientation: Lily’s and Ricardo’s Backgrounds**

Lily grew up in middle class family living in the suburbs of a large metropolitan area. She recalls that she always wanted a career in medicine. At first she thought she would be a nurse but decided that she would rather be a doctor because she is strong willed and wanted to be the one who made the decisions. She is a self-professed planner and she approached her education and training in that way. She is very methodical in her decision making and does not leave much to chance.

Ricardo emigrated from Portugal when he was eight years old. He grew up outside of a major city. His parents worked at whatever jobs they could find but their family spent most of his young life on welfare. He describes himself as a “latch-key kid” because his parents were always working. As a result, at a young age, he had to be responsible. Ricardo describes himself as “laid back.” He is very counter-culture in the medical world, but it works for him.

**Complicating Action: Planning Careers as a Couple**

Lily and Ricardo met in college, and as Ricardo shared in his narrative, Lily persuaded him to study medicine. Despite their different backgrounds they have similar
interests and values. Their careful career planning was informed by those values. Both of
them had to make decisions and sometimes personal sacrifices to achieve their collective
goals. For example, Lily was a year ahead of Ricardo in school. She took a year off in
medical school so they could begin residency together.

They also wanted to return home to practice medicine. Their families resided in a
large metropolitan area where there were many residency programs and medical schools.
This, along with the fact that most physicians find their jobs through networking or word
of mouth, made it difficult to find one pediatric opening let alone two. They started
early and worked harder than most to find positions that were both in the geographic
location where they wanted to live and fit their desired practice style.

Finding a practice that fit his personal style was important for Ricardo. He shared
that during medical school and residency, he often felt like a fish out of water, and
sometimes that caused problems for him. The tone of his narrative and the stories he tells
indicate that he does not take himself too seriously. He enjoys life and has a very
practical approach to life. This is a stark contrast to most individuals who choose the
medical profession. This approach to practicing medicine often ruffled the feathers of
those in charge. Before he started interviewing for a position, he knew that he had to find
a practice where his laid back demeanor would be accepted. He felt comfortable in the
first practice where he interviewed and the offered him the job.

Lily is persistent. Once Ricardo found a position, she methodically called
practices in the area. She wanted a position that had flexibility so that they could schedule
their vacations together and maximize their time together. She accepted a position in an
office across the street from Ricardo’s.
Evaluation and Resolution: It All Fell Into Place

They both recognize that their dual career life works because of a lot of planning mixed with good fortune. Things just fell into place for them and they are very grateful, almost amazed, that it worked out so well. They found practices in the same geographical area, and they were home with family. Their personal lives were in order as they entered practice. As a result, their narratives about their professional entry experiences were more about adapting to their practices than managing their lives. They could focus on the professional because they negotiated the personal from the time they became life partners.

They have a common interest in not having work consume their lives, and they have discussed that with the partners in their practices. They are comfortable with how they approach their profession but they each attribute this to something different. In Lily’s narrative she shares that she sees the culture in medicine changing and she credits this to the number of women entering the profession, especially in pediatrics. Ricardo never mentions that. Lily told a story about how amazed the “older” physicians were that she was willing to be a team player and help out when necessary. While Ricardo told a story about accepting the older doctors are of his youth-like approach. Despite being educated and trained in the same environments and hearing the same messages, these different perspectives suggest that gender played some role in how they perceived their profession as they entered practice.

Establishing a Career: Learning the Culture

While they constructed a corporate career plan, how they approach their medical practices and their careers is like day and night. Ricardo is quick and efficient; Lily tends
to be as she describes a “slower person.” Ricardo works a “laid back” practice within a small practice group where he can set the tone; Lily works in a larger practice with more organizational structure. Lily tends to do what people expect and fit the professional culture; Ricardo is counter cultural in the world of medicine. The one thing that both of them agree on is that they enjoy children and are pleased with their decision to pursue careers in pediatrics. Also, they are both committed to helping those who are less fortunate. Lily shared that their similarities and differences served them well as they began practice because they could bounce ideas off each other and get different perspectives.

As they entered practice, they had to learn and adapt to their practice cultures. Both of their narratives reflected their surprise with respect to how easy it was to move from residency to practice and how prepared they felt as they began their careers. They established practice routines quickly and learned the internal systems. But, they also had to create a presence in the organization. As mentioned previously, Ricardo chose his practice because he felt that it was “laid back” and he could easily fit in. In his narrative he talks about shooting rubber bands at the staff and skipping around the office with the kids.

Lily’s description of her practice is different, but it is a good fit for her. The practice is quite a bit larger and she is the youngest physician there. Due to some past experiences with female physicians, the elder male physicians have preconceived notions as to her dedication and practice ideals, and they tend to be tentative when asking her to take on additional roles and responsibilities. She explained that anytime she shows initiative and willingness to go the extra mile, they act a bit shocked because they assume
that she is not motivated. On the other hand, while she is out trying to build the practice by attending health fairs and prenatal classes, they are trying to reduce their schedules because they want to slow down prior to retirement.

In their narratives, their stories reflected the goals of their groups. Because they both worked as employees of private practices, they became aware of revenue generation and cost issues very quickly. The stories they tell reflect this. Lily talked about how concerned she with “earning her keep” as she began practice and how relieved she was when she knew that she was generating enough revenue to cover her salary. They tell stories about how they manage their patient visits according to billing protocol. They weigh the pros and cons of becoming a partner or continuing as an employee. They adapted very quickly to their environments.

Evaluation and Resolution: Internalizing Their Organizations’ Expectations

Ricardo attributes his different approach to practice and perspective of his career in part, to their different personalities and in part because of their cultural background. In analyzing their narratives, I felt the same. They had very different motivations for pursuing the same career. Lily grew up in a large suburban area where fitting in to the norm was desired. Because it was a very competitive environment, she learned how to plan and strategize to get what or where she wanted. If she didn’t do that, she probably would have been lost in the crowd.

In contrast, Ricardo’s family lived day to day. He recalls that he didn’t have clothes or toys growing up and was often teased and ridiculed by his peers. He was driven to rise above this and do something meaningful with his life. He and Lily participated in the same research program in High School. He did it because he wanted
to pursue research; she did it because it was good for her medical school application. Ricardo is driven, but not competitive. In his narrative he shared his feelings about the negativity and one-upsmanship that he saw during medical school and residency. His drive stems from his desire to make a difference. His background gives him a different definition of work. Rather than looking at what he does not have in his career, he focuses on the fact that he is in a profession where he gets paid to use his brain and help others instead of digging ditches. These differences are reflected in the type of practices they chose to work in and how they approach practice.

Learning the culture and being accepted within it came easily to both of them, this is due to them knowing what they wanted before they ever interviewed for positions. For example, Ricardo is pleasantly surprised that he can work in a culture that reflects who he is as a person and a physician. His narrative reflects the playful nature that he is free to express in his work. He gets to throw paper airplanes, shoot rubber bands and skip through the halls with children all day, what else is there to life?

While their narratives reflected their organizational fit, it also showed how easy it is to get very focused on the business and less focused on patients and how they are consciously trying to resist this while their practice demands it. Ricardo talked about how he sees how easy it to become consumed with seeing more patients to make more money, and how he observes how other physicians in his practice have done this.

A large portion of both of their narratives focused on how they individually manage their practice on a day to day basis: how they see patients; how they manage their time; how they attract patients to the practice; and how they earn their keep in the practice. Partially consciously and partially unconsciously, within one year of finishing
residency training they have taken on the culture and values of private practice; they have internalized the importance of being productive and working to keep the practice afloat financially. They learned how to “manage” patient complaints and make sure that they schedule follow up appointments. They have learned to practice in an environment where they can only bill for one complaint a visit. They also learned how to work around the system. They are aware of and manage their minutes so they do not fall too far behind. They are just doing their job; as Lily put it; it is just the nature of today’s healthcare industry.

Along this line, they both doubt that they will ever want to “buy into” the practice and become partners. Ricardo is fairly definite about it and Lily is trying to decide. When they weigh the financial gains with the inherit risks, they are not sure that they want to take the risk or the added responsibility. They do not think that it is worth it when they can be employees, draw salaries and not worry about it. They not only recognize the additional responsibilities associated with partnership, they recognize the change in focus. Life becomes more about the business and they do not like how they see the drive to make more money affecting peoples’ lives.

*Coda: Enjoying the Honeymoon Period and Recovering from Residency*

Both Lily’s and Ricardo’s narratives reflect their current career bliss. They both acclimated to the routines of their offices and they are euphoric about their manageable schedules. Between call, hospital responsibilities, weekend and evening office hours and administrative duties they both work 45-55 hours per week but they see this as a vacation after the stress of residency. In addition, Ricardo shared that he enjoys what he described
as “bread and butter pediatrics.” He appreciates having specialists and a tertiary care hospital that take care of the difficult stuff.

While they attributed their contentment with their current positions to their new found free time and control over their schedules, it goes deeper than that. They have finally accomplished their goal. They finished their medical training. Unlike many professions that start when you get your first job, their narratives suggested that they are celebrated an ending when they begin their first position.

Time and work-life balance is more important to them than money and prestige. Ricardo says that he does not need very much money. He has a ’98 Geo Metro that gets him two and from work, and he and Lily live in a small three bedroom home. From their perspective, they have everything they need. Lily shares that she does not need career advancement to feel like she has succeeded. She expresses what she believes to be the focus of this generation of physician, “Do some good, have a good life but still have our priorities the way we want them.”

**Mariah**

*Abstract*

Mariah entered medical school expecting to pursue a career in women’s health, specifically obstetrics and gynecology. During her last year of medical school, she decided that the lifestyle of a surgeon was not want she wanted, so she applied for an internal medicine residency. She went on to an academic fellowship and is currently working at the institution where she completed her fellowship. Her narrative revolves around her struggle to find her way in a career path that does not provide much external direction.
*Orientation: Mariah’s Background*

In her narrative, Mariah shares that she was immersed in medicine from the time she was a young child. Her grandfather was a cardiothoracic surgeon and her mom is a nursing professor. She recalls that all the books around her home were medical texts, so she read them voraciously. By grade school, she decided that she wanted to be a reproductive endocrinologist. She never pursued that specialty; instead she followed in her mother’s footsteps and became an academic. She struggled with this for some time because she did not think a career in academics was worth pursuing. Early in her life, she recognized that an academic career did not provide much structure or the financial rewards of other medical careers. She trained at a program that was clinically based, but then attended an academically based residency program and completed an academic medicine fellowship. Her hope is that she can influence medicine from a macro (or policy) level and well as a micro (patient care) level. Her narrative is about her experiences beginning her academic medicine career.

The central themes or complicating actions in Mariah’s narrative are: *Destined to become a physician,* which relates to how her family background and experiences influenced her life and her professional perspective; *isolation and loneliness* which involves her feelings and frustrations about her choice to pursue an academic career; caught between two galaxies; *policy versus patient care* which presents her attempts to make sense of the separation between policy/academics and medical practice; and, *looking for direction* which presents her feelings and frustrations regarding the lack of structure and predictability in her medical career.
Complicating Action: Destined to Become a Physician

Mariah grew up in an upper class family with medicine all around. When she was six she did not tell people, “I want to be a doctor when I grow up.” She took it one step further and told them that “I want to be a reproductive endocrinologist when I grow up.” She was a member of the medical aristocracy by birth. This influenced her choices and effects what she believes about her profession, the depth in which she analyzes the profession, and how she proceeds with her career.

She does not remember wanting to do anything else. This focus helped her achieve her goals. But, throughout her narrative are stories that signify her questioning where she is and where she is going. She says that she is still exploring her options. In many places in her narrative she questions herself and her ability; but counters that with a boost of confidence. She states very clearly that she would not leave medicine. She feels she put too much into it. She explains that she is not talking about the financial resources; she is talking about how much of herself she has put into it. For her it is a relational obligation, not a financial one.

Though Mariah experienced privilege because of her family’s societal and socio-economic status, she also experienced marginalization because she was an African-American woman. She admits that she feels some level of responsibility because there are so few people of color, let alone female African American scholars in the world of medicine. She wants to be successful in order to be role model for others. She provides a number of vivid examples of how difficult this is for her. For example, she questions why she is invited to sit on so many committees. She jokes, “I don’t know, maybe there
is a lottery system and my name keeps coming up, but my idea is that there are not too many people of color at this institution and they want representation.”

Her narrative suggests that at this point into her professional entry, she is feeling lost but confident that she will find her way. When she brings up a concern in her narrative, she usually addresses it shortly afterward. She likes the atmosphere at a teaching hospital and she is excited about the challenge, she just does not feel like she has found direction. She has been able to look back upon her previous successes and experiences and boost her confidence, but her narrative reflects self-doubt and indecision as well. This makes sense since she is so new to her profession and has not received much guidance.

_Evaluation and Resolution: No Idea What the Future Holds_

In her narrative, Mariah poses a rhetorical question saying, “So, in five years what will my life be like? Because I have done such a poor job predicting now five years ago; I have no idea what the future holds.” She explains that she is not a planner like many of her friends, and she tends to be spontaneous in her decision making. She has resolved for herself that this is the career path that she is going to follow for now, but that does not mean that she will not change in the future. She displays confidence in her willingness to change career paths if this does not work for her. Yet, she vacillates between “I can do this.” and “What am I doing here?” sometimes on a daily basis. She explains that there are days that she feels that she made the right career decisions despite her daily crises of confidence, but she still wants to continue on.

Overall, she is content with where she is, but she questions if it is right for her in the long haul. She consistently compares her career to other professions and her, as she
puts it, “smart” friends who decided to pursue other fields. This has little to do with her decision to work in academia, but it is her questioning and evaluating the medical profession as a whole. Also, she has concerns about the medical field in general, which factor into her interest in keeping options open.

*Complicating Action: Adapting to Her Position and a New Set of Rules*

Professional entry has not been easy for Mariah. She is in the same environment learning how to work under a different set of rules. She has little or no support and is expected to figure it out on her own. While most of her peers from medical school have started in clinical practice and know what is expected of them, she is living in a realm of abstract expectations. After so many years of doing what she is told to do, she now has to do what she needs to do. She recognizes this and expresses her concern saying, “That is a very hard transition to make. After so many years of not really having a voice, I now have to exercise my authority.”

Throughout her narrative, Mariah shares how isolated she feels. This is ironic, since one of the reasons that she wanted to stay in an academic setting was that she perceived it to be a collegial environment (noon conference, residents, medical students, etc.). At times she is amazed at how much had changed since her fellowship because she was in the same organization, but now she feels very alone. One telling remark she made regarding her lack of support was, “Memories around here are short. Everyone here has gone through this experience—trying to figure out where to put energy and attention, but knowing that doesn’t really help when you are feeling like you don’t really have support.”
Her narrative is filled with stories about how she constantly has to move out of her comfort zone and work in a different way. She shares how she misses hearing others’ perspectives on things, how she feels like all of her mentors have disappeared, and how she needs to seek them out if she wants to get any feedback or advice. She describes her office as a “Really, really, little temporary office space…it’s horrible.” She shared her frustrations about being on her own to find an administrative support person and how nothing that she is experiencing is what she expected.

*Evaluation and Resolution: Just Tell Me What to Do*

Even though she stayed in the same organization and spends part of her time working on the same project that she did during her fellowship, Mariah’s role significantly changed within the organization. As she moved from her role as a trainee and became a peer or colleague, the environment became much more competitive. At the time that she was constructing her narrative, she was just beginning to make sense of this. There were times when she was still feeling hurt and ignored, but as mentioned in the previous section, she had a strong rational sense that helped her objectively work her way through it. While she was telling her narrative, she was also working through some of these issues.

The competitive environment of a prestigious academic medical center is at times intimidating and concerning for her. Plus, she is still trying to find her place in the system. She explains the demands and frustrations she faces in academic life such as diminishing grant opportunities, hospital budget crises, and limited resources. While she recognizes and understands this on a rational level she had not yet internalized what it meant for her career and her relationships within the organization. In certain places in
her narrative, it seems that she struggles balancing what she rationally understands not being consistent with how she feels.

Mariah’s narrative is entitled, “If Only They Would Have Mentioned This in the Brochure” because she sees her medical career as unstable and undefined. In her narrative it is evident that she has given this much thought. She explains her feelings about the culture of medical education and her frustrations with what she perceived to be a lack of disclosure in the profession. She feels that at this point in her career, she should be standing on much more stable ground, but instead, she is still questioning and waiting to see what is going to happen next.

While she is critical of the culture, she sees her role in perpetuating the culture. She explained that she believes that there is a professional unwillingness for physicians to express to aspiring physicians or those in training how bad it really is going to get. So instead of disclosing that the internship year is very difficult and physically and mentally exhausting and you are going to continually question why you chose to do it; doctors put a positive spin on it and say that it is a great experience because you get to see and do so many different things and you are constantly learning.

Along with what she sees as the disingenuous portrayal of the field is her feeling that medical careers are unstable because the medical profession is in crisis. Everything she sees, from her experiences to the experiences of her friends from medical school, points to the profession moving in a downhill direction. She explains that when she was choosing medicine, she thought it would be great to be a doctor because she would never have to worry about unemployment. But she then shares that she feels fairly secure that she will not be unemployed, but she fears that the job may be so undesirable that no one
is going to want to do it. She questions whether she will jump ship as it is going down, or just sink.

Complicating Action: Policy Making versus Patient Care

Mariah discusses the dissonance between her career expectations and career reality. She wanted to practice medicine at both the macro and micro level, and this may not be possible. Since she is still in contact with many of her friends from medical school who are practitioners, she hears about the day to day realities of medical practice. Her experiences as a practicing physician in medical school and residency are still fresh enough in her mind that she can relate to it. But, in the academic world, she does not experience this. She works in an environment where seeing patients is a necessary nuisance to keep your clinical skills.

Evaluation and Resolution: Trying to Bridge the Gap

Though she does not label it, her narrative suggests that she is seeing the clinical world and the academic world as two very distinct cultures motivated by very different, and sometimes adversarial agendas. Yet, she is still trying to bridge the gap and see things from both sides of the aisle. This shows the depth with which she thinks about her position and medicine in general. In her narrative she uses electronic medical records as an example of where she is trying to see the issue from both sides, but finds no resolution because the issues from the practitioner perspective versus the policy perspective are so disparate.

Mariah’s narrative also indicates that she is recognizing and assessing the practical differences between a clinical career and academic career as well. She shared the differences in lifestyle between her and her friend from medical school who chose to
be a hospitalist. She explained that while she is not tied to a set schedule and has
flexibility to come and go without messing up patient schedules, she takes her work with
her, no matter where she goes. She concludes that in her role it is much easier for her to
be at places physically, but much more difficult for her to be emotionally present because
she is always thinking about work.

*Coda: Moving Forward*

Ultimately, Mariah is happy that she chose to be a physician. She was raised with
medicine all around her and she cannot imagine doing anything else. She recognizes that
she is in the early stages of her career and that she needs to be patient. Yet, her
frustration lies in not being told what to do and what comes next. In the medical culture,
residents and medical students are expected to do what they are told, say yes to
everything and follow the lead of the attending, resident or whoever is the highest
ranking doctor on the case. They are not informed what is coming next, they just follow.
This enculturation, along with her self-proclaimed lack of decision making skills and
planning skills, has left Mariah feeling lost without a road map. Unlike her friends in
other professions who are settled into a routine and know where they are going; she is
still seeking direction. She finds this intensely frustrating. In her narrative, she displays
an uncanny ability to deal with her emotions and frustrations by rationally talking her
way through her issues. As a result, she moves forward and tries to learn and grow in her
position.
Robert

Abstract

Robert is pursuing his dream of being what he describes as an old fashioned family doctor. His description of his ideal practice reflects the archetypical “General Practitioner” prevalent in the 1950s and 1960s. In practice this translates into working in a small town; being on call for his patients every night and weekends; conducting rounds in the hospital; and doing house calls if necessary. Managing the business is the only aspect of the practice that he was not involved in because he decided to work as an employee of a community health care system and have them set him up in practice. This provides him financial stability while he builds a practice. He plans to eventually buy the practice from the group and be an independent practitioner.

Robert’s narrative seems too good to be true. It has an upbeat tone and seemed like it was very well rehearsed. He attributed this to having told the story so many times, but part of it is just how he lives his life. As with any narrative, every time it is told, it is reworked, so it does seem a bit more polished than most. But, even when he was talking about his feelings on specific events that occurred recently (which he could not have rehearsed) his tone stayed the same. It appears that he lives his life on a fairly even keel. Unlike many people who would be looking toward his future goals and stressing about how everything will ever be accomplished, he just takes it one step at a time.

Robert is a true traditionalist. He holds a romanticized and idealistic view of medicine. Despite having told his narrative so many times and perceiving himself as a “reflective person,” his narrative does not reveal much critical reflection. Part of that may be because up to this point in his life, everything has just fallen into place. He has
the family life he wants. His was at the top of his class in college and medical school. He was Chief Resident during his last year of residency and he is in the practice situation he has always dreamed of. His narrative is that of the all American boy who pursued a medical degree (PhD/MD) while striving to be a devoted husband and father and always putting his faith first.

Orientation: Robert’s Background

Robert is married and has three young children. His wife works in the home. He recognizes her as an integral part of his career success thus far, explaining that he would never have been able to make it through medical school and residency without her. He has strong ties to family and is very involved in his church and community. I knew Robert and his family prior to his volunteering for this study. His daughter was in my son’s first grade class. At that time he was in medical school and interviewing with residency programs. A few years later, when I was recruiting physicians for this study, his name was given to me by a residency director at a program approximately 300 miles away.

The central themes or complicating actions of Robert’s narrative are: The illusion of independence which includes the struggles he faces as a young physician trying to start a solo practice with the assistance of a large organization. The next complicating action is wanting to have it all which is related to the manner in which he presents his narrative and his desired career path. This is followed by tradition gets rewarded which encompasses the privileges associated with his traditional approach to a medical career and how that shapes his life.
Complicating Action: The Illusion of Independence

Robert was in his first few months of practice when we began constructing his narrative, so he really did not come to the table with many experiences that would motivate him to reevaluate his goals and expectations. The start up of his practice was funded by an organization that owns and manages most of the hospitals and outpatient practices in the area. It also is the healthcare system where he trained as a resident. He plans to buy the practice from his employing healthcare system in two years and become a solo practitioner. He says that from the day he opened the doors of his office, he practiced medicine as if he was a solo practitioner.

At times throughout his narrative he expresses concerns about the organization’s control and continually expressed his desire to buy the practice and be on his own. He recognizes that as long as he is on salary and the group is managing the practice, he only has the illusion of control. For example, he is able to make decisions about what radio station is played and what pictures are on the wall. But, he is frustrated because the organization pulled his medical assistant to work at another office. These discrepancies have been central to his entry into the profession. He is trying to make sense of two worlds. He wants to see himself as a solo practitioner, but every time he goes back to the organization for assistance or the organization comes and exerts authority over him, he realizes that he is still an employee.

Also, at the time that we constructed his narrative, the practice was slow and he was not generating revenue anywhere close to what he would need to keep it afloat on his own. Unlike physicians who need to put together business plans in order to get bank financing, he has not had to examine the financial realities of solo practice. He has yet to
put together a plan as to how to fund this endeavor and whether or not he can fiscally keep a small practice afloat in the current medical climate.

Outside of a guaranteed salary, Robert attains other benefits from being employed by an organization. Because he did his residency training in the hospital system that finances his practice, he knows all of the players and has built strong relationships with them. One example of this presented in his narrative the access he has to other departments in the hospital, such as the pharmacy, and how beneficial this was for him when he was unable to get flu shots. He just borrowed them from the hospital pharmacy. This works for him. He sees it as having the best of both worlds at this point in his career and he has not thought much more about it.

_Evaluation and Resolution: Having Faith and Hoping for the Best_

Robert’s evaluation of his current situation and how he resolves the issue is simple; he just states, “People have done it and I think I can do it as well.” He shares that people keep reassuring him that it will be okay and at this point, that is enough for him. He explains that he was very frustrated with how much time it took initially to get his office open and running, but everyone in the organization told him to relax and everything would be okay. So, he decided to do just that, and take some time to recover from residency.

This is one of the areas where Robert’s strong faith in God is evidenced. He believes that this is his destiny, his purpose for being born; stating, “I can’t see myself doing anything else. I believe that this is what I was meant to be. It is a calling, if it weren’t a calling. I’m not sure why anyone would do it.” He concludes that if this is meant to work, it will. He believes that his destiny and the destiny of his career are in the
hands of a higher power. So, where the rational side of him may recognize that there are many obstacles to fulfilling his dream, he believes that neither he nor the organization can make or break the opportunity if it is meant to be.

Complicating Action: Wanting it All

In his narrative, Robert shares that he feels that he is “sitting here on top of everything I ever wanted career wise.” He explains how exciting it is for him to go to the office and listen to music he picked and see pictures in the office that he and his wife purchased. But, most of all, he feels incredibly privileged that when patients call the office, they are calling for him. He is their doctor and he can build a cradle to grave relationship with them.

In his narrative, Robert implies that he wants to do everything. He does not phrase it this way, but as he goes on to explain what he wants to accomplish in his career, it is clear that he has not set limits or boundaries at this point. He wants to practice as a solo practitioner which means being available all day and every day (24/7) for his patients and having both inpatient and outpatient responsibilities. He also wants to precept medical students and residents in his office. Because he has both a PhD and MD, he plans to be involved in research as well. Finally, he wants to put his family first and be available for them and involved in his children’s lives.

Because he was in the initial stages of building his practice, his entry into professional life is much different than most of his friends and colleagues from residency. While he recognizes that they are working much harder at the moment, he realizes (or at least hopes) that will change for him. When he talks about all that he wants to accomplish, he does buffer it with a “We will have to see how it goes.” He is still in an
exploratory stage when it comes to his career. He has not come to a point in his life, where he realizes that he has to make choices and cannot do it all. He has so many interests and is so enthusiastic about everything that he has not honed in on what he really wants to do and how he is going to accomplish his goals. He has been fortunate up to this point because his choices allowed him to be divergent and leave his options open. For example, rather than being a pre-med major in college, he chose to study pharmacy just in case medicine was not for him. Then when he couldn’t decide whether he wanted to be a researcher or a practitioner he enrolled in an MD/PhD program so he could do both. Throughout his narrative he provided rich examples of how difficult it is for him to narrow down his options and hold to a specific path.

Another factor in his pursuit to have it all is his family. He explained that he tries very hard to not let home life spill into work life and vice versa. He asserted that he lives his life guided by advice he received years ago: “Where ever you are, be there!” For the time being that works because the pace of work has not been very demanding. He enjoys his job, but his family is his life.

*Complicating Action: Tradition Gets Rewarded*

During one of our conversations, Robert said that one day the residency director told him, “You know, your father raised you right. I hope my son grows up to be the man you are.” In every phase of his life thus far, he has risen to the top and was afforded the associated privileges. He gave examples of this in his narrative. His success in residency and having been chosen as Chief Resident afforded him the opportunity to know and be known by many of the decision makers in the organization. He describes how he asks for favors and has many people help and support him in his endeavors. He describes his way
of gaining social capital this way, “I got to know a lot of people, and it wasn’t for the purpose of being able to get things that I need, but, it is sort of the way I am built – I just get to know people.” His successes in the past provided him the confidence to go for what he wanted and to expect that he would get it.

His traditional view of medicine and desire to be an old fashioned doctor is appealing to those who are in authority in healthcare organizations. While it goes unsaid in his narrative, it is hard for people in charge not to gravitate to someone who has that level of devotion to the profession. This is the same with patients. At one point in his narrative, Robert notes how excited he is that he is going to be thought of as his patients’ personal physician. In a world of doc in a box medicine (as many physicians call it), this is appealing to patients.

But, along with the perks and advantages come high expectations. He experienced this during medical school when he decided to pursue family medicine instead of academic medicine (which was expected because he had PhD and MD degrees.) He experienced it when he was in residency and was the only resident at the program who had the academic background (PhD) to do research and all eyes looked at him when a research opportunity surfaced. Finally, it appears that while he is very competent and motivated, his past successes and experiences as the one who stood out above the crowd have in some ways put him in a position where that is what is expected and anything less is not okay for him.

*Evaluation and Resolution: Taking it One Day at a Time*

Robert evaluates and resolves the issues related to wanting to do it all and the privileges and expectations associated with being successful in what is seen as a
traditional medical career path, by focusing on the present and not allowing himself to think too far ahead. At one point in his narrative, when he is talking about proctoring medical students and doing research, he realizes that he may be taking on more than he can handle. He explains that these are things that he wants to do, but he pulls back and says that time will tell as to whether he will be able to accomplish everything he wants. As he builds his practice, he is taking his career one day at time. Yet, he does admit that he and his nurse are counting down the days until they are able to fly solo. He recognizes that if he gets too ahead of himself, it would be easy to panic or be pessimistic because pursuing a solo practice is a big undertaking for a young physician. This may be seen as poor planning or a lack of ability to objectively assess his goals and aspirations, but to him, he is acting on faith.

As mentioned in the last section, his belief system is founded upon the fact that God is in control and has a plan for his life. Because of this, he claims that he does not see a need to fret or be concerned about the future. Yet, throughout his narrative he shares how he seeks counsel and advice from others when making decisions. He also spends time analyzing his options. But, once a decision is made, he moves forward. He illustrates this when he talked about his residency decision. He explains that one of his mentors let him know through the grapevine that he was displeased with his choice of residency program. Robert responded with, “Well, good for him…But, I have to do what’s right in my heart. You know, what is best for me, and bet for my family. You know, being where God wants me to be.”

There is some irony in his evaluation of this aspect of his life. While his narrative presents him as busily exploring his options and trying to figure out how he is going to
approach his career, he sees his life a bit differently. He states that he feels that he is more equipped than most beginning physicians to handle career decisions because he has a strong support system outside of medicine and he is a bit older and more settled in his personal life than most traditional students pursuing medicine.

The final area where he wants it all is in his family life. When it comes to managing his work life and his home life, he feels that his decision to be a solo practitioner actually gives him the flexibility he needs to be involved in family life. While he recognizes that his decision guarantees that work will spill into his home life because it became a 24/7 job when he decided to take his own call. In the same respect, he notes that working as the only physician in a small office allows him to control his daily schedule to some extent. In his narrative he shares how he can take a few hours during the day to attend parent/teacher conferences or tend to other issues.

Robert’s narrative reflects his belief that being a physician is a calling and physicians have to take on the role of “helper or servant” for their patients. He wants it all because he holds on to an archetype of the family physician that few beginning physicians aspire to obtain. He is not interested in wealth and prestige; he wants to be a healer and a helper to others. He stated that he feels that medicine has seen its heyday and the best days (in terms of rewards and prestige) for the profession are over. He shared that he feels that “If you just want a career and you aren’t passionate about medicine, or feel a strong calling, then there are much better ways to make a living.’’

_Coda: Counting Down to Independence_

Robert wants to be an independent practitioner, and he is counting down the days until he can buy the practice and no longer be an employee. He has not put thought into
how he is going to do this. Also, even when he is a solo practitioner, he will still be admitting patients into the health system that now employs him, so there will still be some level of control imposed upon him. He brings his narrative to the present by sharing that he is in a position where he has everything that he has ever wanted for his career. He is relieved to be finished medical school and residency and he is enjoying living in the present. He feels so incredibly blessed, and he is “living the dream.” He is doing what he spent many years training to do. He has finally made it to where he wants to be.

Sarah

Abstract

A central theme of Sarah’s narrative is her quest to survive in a career and a medical education tradition that privileges youth and convention. When Sarah volunteered for the study, all I knew about her was that she was out of residency for a little over a year and she had changed jobs within the hospital system where she was employed. About 45 minutes into our first meeting, I was still thinking, “Now, when is she going to get to the point where she explains how she got into Family Practice?” As we worked together to construct her narrative, her focus and tenacity was evident. What also was evident was how much she learned about herself and her profession through the adversity she faced.

Sarah’s narrative is about a woman who took a non-traditional path to becoming a physician. She was already a grandmother when she began her residency training, and her journey to becoming a physician was full of challenges and adversity. Throughout her narrative, Sarah shares how enamored she was with the vision of being a physician.
She just thought that it would be, as she puts it, “So cool to be a doctor.” Her narrative slowly moves from her amazement and excitement about pursuing medicine to an eventual realization that in today’s complex medical system she is, “just the doctor.”

**Orientation: Sarah’s Background**

Sarah started medical school when she was 42 years old. After four years of medical school and six years of residency, she started her career. Her first position lasted only a few months. She stayed in her second position for less than two months. Her third position lasted longer, but she wanted it to be over within six months. Finally, she settled into a position that fit who she was and how she wanted to practice medicine. She was in this position for four months when we began constructing her narrative.

Many people would have given up faced with the adversity that Sarah experienced over the twelve years between deciding to become a doctor and finding a practice that she enjoyed. But, Sarah was not a stranger to adversity. She was a single mother who finished her undergraduate degree while working in a vaccine lab. She is tenacious and driven. This tenacity can be seen as both a blessing and a curse throughout her narrative.

Sarah’s narrative has two major themes or complicating actions. The first is a non-traditional career which presents how her age and non-traditional career path affected her pursuit of medicine. The second is doing it her own way which is about how she dealt with having to create her own path.

**Complicating Action: A Non-Traditional Career Path**

At one point in Sarah’s narrative she reflects that she was probably more naïve than the traditionally aged students with whom she went through medical school and
residency. She so desired to be a physician and had such a long road to get to medical school that did not critically assess her decisions. Throughout her narrative, she shares the adversity she faced, which was at least in part due to her naivety and how that affected her ability to make informed decisions. For example, she started her residency training at a small community hospital near her home. Because she was a non-traditional student and a woman, she was pleased to be accepted into a surgical residency program. She never looked into the training she would receive at the program and whether or not that would adequately prepare her to be a surgeon. She also did not look into the stability of the program. The program closed and she was faced with having to move away from home and she was not prepared for the demands of her new surgical residency program.

This happened over and over during her training. What she does not recognize in her narrative is all of the informal learning she did not experience because she was different from the other students and residents. She did not participate in study groups and did not socialize with the traditional students and residents. She was not part of the informal networks that teach medical students what to look for in residency programs or the provide support and a sounding board when making career decisions. She went to class and did what she thought she needed to do to be successful – she was highly motivated, compliant and diligent.

While she does not attribute all of her setbacks to her age and gender, she does recognize that these factors did have an impact, especially when she was attending a surgical residency. At one point she even states that she is sure that the others were thinking, “What is this grandmother doing in an operating room?” She also shared that
she had spoken to a female attending surgeon who told her that she just needed to deal with it and work harder because that is just the way it is for women. She was in survival mode through most of her training which in turn, did not prepare her to make an informed employment decision when she graduated.

When she graduated, she was tied to a specific geographic area and again moved forward without assessing the situation. As she reflected back to when she made the decision she explained that she was not thinking about whether or not the job fit her personality and style, she was in need of a paycheck. This cycle continued until, after her third position, she came to a place where she decided that if she could not do a job that was somewhat satisfying to her the she was no longer going to practice medicine.

*Evaluation and Resolution: That Which Does Not Kill Us Makes Us Stronger*

Sarah moved through her eight years of medical school and residency training without critically assessing her decisions or the path she was taking. She just did what she had to in order to survive all of the chaos. The road to becoming a physician is challenging enough, but having trained in four residency programs and two different specialties is incredibly stressful. One might think that these experiences would cause a bit of doubt or at least some re-evaluation of her chosen path, but it did not. Instead, she charged ahead, doing what she needed to do to accomplish her goal of being a doctor.

In her narrative, Sarah shares that most pivotal point in her journey was not when she decided to change her specialty from surgery to family practice, but when she turned down the surgical residency position at the hospital where she finally finished her family practice training. This was the first time in her narrative that she felt like she was in
control, that it was her decision, and not circumstances that lead her in that direction. She was finally in a place where she was content, and that was comforting for her.

Another interesting revelation in Sarah’s narrative is that she would not advise someone to follow in her path. She explained that she would never recommend that an older person try to pursue medicine because it takes too long and requires too many resources to get started. She shared that she felt that she should be thinking about and planning for retirement and she is still paying off school loans. She also lamented that she put so much time and energy into pursuing a career that she was only going to do for ten years. Basically, when she assessed her life, she decided that the ends did not justify the means. Still, she is quite happy with where she is.

*Complicating Action: Doing it Her Own Way*

Throughout her narrative, Sarah presented strong examples of her independent and sometimes stubborn nature. She is a person who makes her own decisions and paves her own way. At times her narrative seems to suggest that she just goes full steam ahead with blinders on; focusing on her goals and objectives and ignoring all that is going on around her. It is almost as if she thinks that if she wills it hard enough it will happen.

This is probably how she survived all of the adversity that she faced in life and especially in her pursuit of a medical career. It also was the root of some of the adversity, especially when she entered practice. In her narrative she described the organizational chatter as “background noise” and said that she does not pay much attention to it. Especially in her first positions, she probably needed to pay more attention to it. She worked for an established organization that had a mission and value system in direct contradiction with hers.
Sarah is a survivor—someone who weathered many storms—and she was going to work with a patient population that by nature and nurture had few coping skills. Her approach was “tough love” and the organization’s approach was care and in some respects enabling. This is something that she probably could have seen during the interview process, if she was looking. But, through her experiences, she had so learned to block out the things that she did not see as essential, so she just didn’t attend to the organizational culture.

The same thing happened with her second job. The practice was in financial trouble, she knew that going in. But, she was desperate and ignored this aspect of the position. Her past experiences conditioned her to believe that if you just persist, it will eventually work out; this time it didn’t. But, this experience did teach her a lesson that she took with her which was the complexity of the business side of medicine and the importance of attending to it.

Again, she repeated this in her third position. This time she knew the organization and knew the people who were going to be her colleagues. She felt comfortable with their practice philosophy and with them as people. But, she also knew that the patient population that she would be serving was the same as her first job which she hated. In her narrative she talks about how the clinic was understaffed and she was overworked, but much of that is endemic to serving indigent populations. It is why physicians who work in those contexts often burn out and become disenchanted. She experienced this in her first position, but she started this position thinking that it would be different. Plus, she was stuck, it was the only position available and she convinced herself that she could make it work.
Evaluation and Resolution: Adapting and Realizing She is “Just” the Doctor

Sarah’s repeating the same mistakes can be attributed to a number of possible reasons. First, she is independent and strong willed. Second, the culture in medicine rewards people for accomplishing goals, getting the job done, and moving forward. Physicians and especially physicians in training are not encouraged or rewarded for being reflective and looking back. The culture is “You made a mistake; shake it off and move on.” This, combined with her own tendency toward that type of behavior set her up for repeating behaviors that did not work in the past.

The title of Sarah’s narrative is “I Am Just the Doctor.” She uses that phrase in her narrative when she is discussing all of the background personnel who are necessary to keep a medical practice running, but it has a much deeper meaning than that. Once Sarah found a comfortable practice where she felt that she could fit in and establish her career, she had time to reflect. She recognized that she was driven to become a physician because she held the profession in such high esteem. It was a dream for her that she thought that she would never achieve. Because she had such high regard for the profession, it was very difficult for her to critically assess her life and her career path. She just kept being disappointed. Eventually, she found a position that fit her and she found peace. But, in doing so, she recognized that at the end of the day, being a physician can be a rewarding job, but it is still just a job.

Coda: Finding Peace and Contentment

Through this process of telling her narrative and reflecting upon her narrative she realized, “Yes, I am just the doctor. It is just a job, a wonderful job that I enjoy.” She realizes that she had been so consumed with becoming a doctor and so convinced that
being a doctor was going to be one of the most amazing experiences in the world, that she had lost perspective, and it took a long time to get it back. She explains,

I guess I don’t take a lot of things as seriously as I used to. I mean, things that I thought were very important in practicing medicine, I probably realized aren’t. It doesn’t pay to get upset because you don’t get to practice medicine the way you imagined you would; it is just great that you get to do it.

This was a turning point in her career and her life. She explains,

I’m not trying to save the world and I don’t really focus on all of things that are wrong with the medical system, and there are many. Instead, I am now satisfied knowing that at the end of the day, I helped people and didn’t kill anybody.

In fact, as she started looking back at all of the obstacles she faced on the way and how much she struggled to get there, she wonders how things would have changed been different if she realized that she was just going to be a doctor.

Insights from Structural Analysis

Analyzing the participants’ narratives from a structural perspective reinforced the importance of recognizing that narratives are temporal constructions. As Chase (2005) describes, they are “interactive performances – as produced in this particular setting, for this particular audience, for these particular purposes” (p. 657). As I analyzed the structural components of the narratives, I noticed what information from the interviews, meetings, and artifacts was included in the narratives and what was not. The narratives were co-constructed by the participants and me. The purpose and focus of the narratives was on the professional entry experiences of the physicians. But, the interviews were
more inclusive, not by intent, but by form. Because I tried to facilitate the participants’
telling of their narratives, I encouraged them to talk without much intervention. The
interviews were semi-structured and certain questions were presented to all of the
participants, but much was shared between the questions. The participants had a lot to
say, and I wanted to hear their narratives the way they wanted to tell them.

As a result, I had useful background information which aided in my analysis of
the narratives. But, it also created more questions, such as: Why did we include this and
not that? How did the structure and intent of the research affect the participants’
narrative? How did I influence the narrative? How would this narrative change, if it
were told today?

Additionally, the participants’ narratives took a certain form; the narratives
focused on the chronological flow of their professional development. When I did the
structural analysis and went to the next level to find what was going on behind the scenes
in the physicians’ narratives, the analysis took a different form. The structural analysis
provided insight into how the physicians were developing as people, where they were
“stuck” developmentally and trying to make meaning of their world. It also showed how
the personal, professional and organizational intersect and cannot be separated. It also
revealed that while they were training to be physicians and beginning their professional
careers they were continually trying to make sense of their lives and experiences.

Finally, one thing that the participants in this study had in common was that they
constructed their narratives in a very linear fashion. When they were interviewed they
answered the questions very purposefully and methodically. If they diverged during the
interview, they would be apologetic and get back on track. They unconsciously
recognized the need for a beginning and an ending and provided it. When we were constructing their narratives from the numerous data sources, they wanted their narratives to flow, to move from one point to the next. This can be attributed in part to the linear nature of their career paths. But, it intrigued me and caused me to look deeper and ask “Why?”

Physicians are experienced narrative tellers. They construct narratives all day long. From the time they step foot in a hospital until the day they retire, they collect data from patients and create life narratives. In their world, they are called “history” and “physicals” and they take a very linear, funnel-type form. There is always a beginning and the narrative always leads to why the patient is in their office or hospital today. In light of this, the linear fashion of their narratives makes sense.

Collective Analysis: General Themes Across the Narratives

In this section, I present and interpret five general themes that I found among the narratives. These themes are: **Professional entry: A time of transition**, which presents the commonalities in their professional entry experiences and how they perceived those experiences. **Constructing a career: Combining who I am with what I do**, which presents the elements of their narratives that illustrate the interaction between who they are as people informs their profession and vice versa. **Professional autonomy and systemic control**, discusses how their narratives reflected the tension between their professional autonomy and the current climate of the U.S. healthcare system. Fourth, **Perception or Reality: Gender and Generation in the Medical Profession**, which presents the findings on how the participants and the physicians with whom they work perceive
differences of age and gender in the workplace. I finish this section with, *Predictions for the Future*, which presents the participants general perceptions of the future of medicine.

**Professional Entry: A Time of Transition**

One challenge the participants faced when they began their professional career was the transition from trainee to professional. For all of the participants except Chris and Sarah, this was the first time in their lives that they were on their own and had any control over their life and their time. Chris and Sarah had worked in other contexts prior to pursuing medicine. Still, they had very similar experiences transitioning from training to practice because they spent almost ten years of their lives in education and training for their medical careers, so in many ways it was like starting over for them.

*Recovering from the Mutual Suffering in Residency*

Years before they ever set foot in medical school, the participants in this study knew that medical school and residency were going to be intense, and they would not have much time for other interests. They accepted this and adapted to it. It became their everyday way of life. They learned how to be compliant, quickly figure out what was expected of them and excel at it. Sarah explained that medical school and residency taught her how to be flexible and learn how quickly learn what is expected and adapt to various settings. Chris uses the phrase, “successive years of increasing torture” to describe his training years. Stating that, “You just become used to it. You can become acclimatized to anything if you gradually do it over a span of time.” Robert shared that he and his family just did not know any other way of life. He told the story about taking his family out for dinner and his young daughter wondering where the restaurant
employees slept, because she just assumed that everyone had to work all day and night like her dad did.

Memories of medical school and residency were fresh in the physicians’ minds and those experiences were intertwined in their narratives of professional entry. So much of how they felt about beginning their careers was associated with how relieved they were to be finishing residency. There was a sense of sacrifice in all of their narratives. They sacrificed financially and personally to become physicians. Each of the participants was in a different phase of recovering from residency and their perceptions of the experience differed. Some felt a sense of accomplishment having survived and now being able to fulfill their calling. Others felt that since they put so much time and effort into their training they were trapped in their careers. Mariah expressed feelings of resentment and disillusionment, not because she was unhappy about being a doctor, but because she felt like she never knew what to expect.

*Attaining the Brass Ring and Moving Forward*

The participants in this study described entering professional practice as the end of residency, rather than the beginning of a career. Residency (or fellowship) training and practice were very connected in their narratives and they often compared practice to residency. This meant different things to different people. For example, Sarah saw it as a time to make enough money that she could begin to pay back her debt from school. Ellie and Robert saw it as a time to finally use the skills that they spent so many years attaining during their training. Mariah saw it as a time to move from always saying *yes* and doing what you are told to do, to a time of having to figure out for yourself what you
need to do to be successful. Jessica described it as a time to finally have planned
busyness versus chaos and to be able to enjoy some of the fruits of her labor.

They also had to make sense of what they were experiencing in light of what they
expected. As mentioned previously, their training was extensive and required a
tremendous amount of delayed gratification in the hope that could finally achieve the
illusive brass ring. Once they were there they had to reconcile the reality with the dream.
For Robert, he expressed that he was living his dream. It was everything and more than
he ever expected. Sarah was on the opposite side of the spectrum. The struggle that she
experienced during residency continued into practice. She changed jobs three times in
her first year. But, eventually she reconciled the reality of practicing medicine with her
previous expectations.

By the end of their narratives, each of the participants felt that they now had
gained some level of control as to how they were going to live their lives and practice
medicine. How they exercised their new found control differed by individual, but they all
eventually recognized that it was their responsibility to figure out how they were going to
live their lives. They were no longer going to be told what to do and when to do it; now
they had to negotiate roles and exercise their autonomy in their professional and personal
lives.

Constructing a Career: Combining Who I am with What I Do

After reading the participants’ narratives and reviewing the analyses of the
individual narratives, it is apparent that one thing that each of these physicians had in
common was that they had to construct a career for themselves that reflected who they
are as individuals. Part of this meant having to learn who they were, what was important
to them and what they wanted personally and professionally. For some of the participants this was a very easy process. They started in their practices and it was just as they expected. For others, it was not so simple. They needed to experiment with different practice settings and schedules to create a space where they felt comfortable practicing medicine.

**Negotiating Roles and Exercising Autonomy**

The physicians in this study chose their positions for many different reasons. Some of the physicians thought about what they wanted their practice experience to look like, and others did not. For some, geographic location was important, for others it was organizational culture. Ultimately, what they all were striving for was some control over their professional and personal life. In order to do this, they had to determine their priorities, negotiate roles and exercise autonomy. For some this came relatively easily. They quickly adapted to their practices and moved on with their lives. For others, this was difficult. Their practices did not fit their expectations and they had to choose to stay and try to negotiate with themselves and others in order to get what they wanted. Some of the participants had to dig deep within themselves to figure out what was important to them professionally and personally before they could move forward in their profession. Some had external factors such as family or financial obligations that forced them in one direction or another.

The participants’ narratives suggested that they were in still experimenting with different work formulas to meet their personal and professional needs. Some felt that they found the formula that worked and others were still negotiating. They also recognized that what works for them now may not work in the future. This was
specifically true for the physicians who discussed having children or other changes in the personal lives in the future. The stories the participants shared in their overall narratives showed the complexity of these negotiations and for many, their struggle with autonomy once they left training.

Recognizing Limited Resources: Money

As they left residency and started in their new positions, the physicians had to manage their lives and resources. The two resources that took precedence in all of their narratives were time and money. All of the physicians in the study where quite emphatic that they did not pursue medicine for financial gain and that they knew prior to going into primary care that it was not a lucrative profession. Yet, medicine is their livelihood, and their narratives reflected that.

On one hand, their first paychecks were two to three times more than they saw for doing the same thing and working much harder during residency. Mariah explained that one of the tangible symbols indicating that she finally started her career was her first paycheck. Chris expressed that he was amazed at how much money he made as an emergency room physician doing the same thing he did in residency, but making three times the amount of money.

On the other hand, many of them are facing large amounts of debt incurred during their training. Throughout Sarah’s narrative she shared that her motivation for finding a job was to start paying off her school loans. Both Jessica and Jacki struggled with how fast their money disappeared after paying bills and school expenses. Jacki said that she did not realize how difficult it would be, she sees how much is coming in, but she never realized how much needed to go out, stating, “The money comes and the money goes.”
Ricardo joked about his debt, saying that after a year, he and Lily paid $8000 toward their $200,000 debt.

In their own ways, they were making sense of the fiscal reality they were facing in their lives in relationship to the popular opinion in our culture that physicians are wealthy. Many of them told stories within their narratives of how they had to make sense of the fiscal realities of their lives. In those stories they recognized the hidden costs associated with years of training versus income generation. Some talked about how much better off they would be if the had not chosen to pursue medicine. At some point in their narratives, they acknowledged that their incomes, though not that of a specialist, are above adequate. What they were trying to make sense of was why these big paychecks are not going as far as they expected.

*Recognizing Limited Resources: Time and Work-life Balance*

The participants in this study were emphatic that they wanted to live a balanced life, but what they believed to be a balanced life differed from person to person. Their strong focus on time, or lack thereof, was established during medical school and residency. There was never enough time to study everything that was required for class. Non-compliant patients took too much time in the office. They were woken up at night to admit patients, and they needed to be efficient if they were ever going to get any sleep. Also, for them, it was context dependent. They all talked about how busy they were in medical school and residency, but they did not find it surprising. They knew it was part of the culture and they expected it to be demanding. But, now they expected life to be different. They desired more control.
The two areas where time was presented in their narratives were managing their time in the office as they worked through their daily patient schedule and making time for family and interests outside of medicine. The participants did not take a “one size fits all” approach to either. Managing time during the work day was very important to the physicians who worked in office practices. Some had their daily routine calculated down minutes. For others, managing their time at work meant not scheduling too much and making sure they were doing the things that mattered most.

They all told stories in their narratives that represented what work life balance meant to them and what they are striving for a balanced life. Their perceived need for balance and what balance meant to them personally was dependent upon their responsibilities outside of work. For Ellie, work life balance meant having a half-day off to have some time for herself. Jessica saw it as having a predictable schedule. In contrast, Robert was not concerned about interruptions in his life, he wanted the flexibility to change his schedule when he saw fit. Mariah, who is unmarried and working in the competitive environment of academic medicine, was insightful about the topic realizing that on the surface, work-life balance is seen as a positive thing but at a deeper level, she recognizes that at this point in time she is content with work being the center of her life.

Working part-time was an option presented by some of the participants in the study. They saw it as a way to stay involved in practicing medicine and have a life outside of medicine. Chris disagreed and argued that the trend toward part-time physicians compromised patient care. Lily mentioned what she perceived as a negative
impact that the trend toward part-time medicine as well. While she recognized the desire and need for flexibility, she also recognized how this impacts the profession and patients.

In general the participants saw time as a precious commodity. For most of them, ending residency was like winning the time lottery. They had more personal time than they had experienced in a decade. For others, the demands on their time stayed the same or increased when they entered their professional careers. It was all context dependent.

For Jacki, who had her second child shortly after she entered practice, the demands of residency were replaced with the demands of caring for two young children. Sarah had few family responsibilities, but wanted a schedule that did not leave her burned out and exhausted by the end of the week. Time was a very individual construct for each of them and their idea of time management was fluid and changing as they experienced different responsibilities in their lives.

Professional Autonomy and Systemic Control

For beginning physicians, in June they are trainees and have an entire staff of experienced physicians available for consultation. When they leave residency they are on their own. Sarah shared that basically you are introduced to your medical assistant and shown the exam rooms, and then it is off to work. When the physicians in this study entered practice, they were given a very short time to acclimatize. Roberto spent some time with the partners in order to learn how things were done in his particular organization. Jacki explained that when she started, one of the partners would meet her at the hospital for rounds. But, that ended quickly and within a few weeks, they were on their own.
Technically Prepared and Ready to Go

One thing that all of the participants agreed upon was that their residency training prepared them with the technical skills necessary for entering the profession. They all expressed that they were pleasantly surprised by how quickly they acclimated to their practices and how comfortable they felt treating patients. This is not to say that they didn’t face challenges, but the felt that they were manageable challenges.

Along with the camaraderie associated with beginning practice, comes what the physicians in the study perceive as a high level of professional autonomy. In the blink of an eye, these physicians went from having to run everything past an attending and being on the bottom of the hospital chain of command to working on their own and having others do work for them. Their narratives reflect the pros and cons of this level of autonomy. For example, because Jacki was the first hospitalist hired in her practice, she was expected to design her job with little or no guidance. She continues to be amazed by how few “direct or indirect clues” she receives from the partners. Mariah felt lost and alone. She felt like all the rules had changed for her, explaining, “That is a very hard transition to make. After so many years of not really having a voice, I now have to exercise my authority.”

The Elephant in the Exam Room: Systemic Control

While the physicians in this study recognized their professional autonomy, they did not elaborate about how larger systemic issues such as generating revenue, complying with Medicare and insurance companies, and practicing in a litigious environment affect the way the practice medicine. Some alluded to it, but the systemic issues seemed to be uncritically accepted. The participants talked about their frustrations with the system and
their belief that it will continue to get worse, but they seemed powerless. No one discussed how to challenge or change the system. Instead, they shared how they acclimate and accept it as is.

*Generating Revenue*

The physicians in this study adapted according to the context of their practice. For the physicians who had predominantly office practices, this was very evident in their discussions of productivity and revenue generation. Both Lily and Ricardo work in group private practices that are acutely aware of how much revenue is being generated. This awareness does not stem from their desire to acquire wealth, it is more about keeping the practice thriving. Lily shares how she is aware of her numbers and is consistently looking for ways to expand the practice. She attends prenatal classes and mall health fairs to recruit patients. She makes sure that she schedules follow up visits. Sarah described her experiences with her practice having to close because they could not afford the overhead. Ellie talked about how her choice to treat patients on Medicare is probably costing her father money.

While each of the participants who worked in an office practice was aware of the need to generate revenue, they were appreciative that they were not bogged down with the business aspects of the practice. They liked being employees and having those details taken care of by someone else. Sarah shares that she feels that she likes having an organization that takes care of the business so that she can just see patients and practice medicine. All of the participants who have the option to become partners in their practices (Jacki, Ricardo, Lily and Ellie) are reticent to do so. They recognize that there
may be financial reward associated with partnership, but they are not interested in the risk and responsibility that is involved in becoming a partner.

*The Organizational Goals and Objectives*

Robert’s narrative is unique. He works in an office practice that he eventually wants to own. He is paid a salary by a large organization that is helping him start the practice. Yet, he was not concerned with generating revenue, recruiting patients or any of the business aspects of the practice. He was in a much different place than the others. This may be because he recognizes that there is no way that he could even cover his salary with his current patient panel or it is just too early in his practice for him to be concerned about it because he has a guaranteed salary for two years. His lack of concern with the numbers is consistent with Chris, Mariah, and Jessica, who are employed in positions where they are not compensated based upon their productivity, so they are not aware of how much revenue they are generating and they focus on different priorities.

For example, Mariah’s focus is on trying to discern what is important to the organization and how to add value to her department. Generating revenue will do nothing to help her secure her position. Jessica is in a similar situation and her focus is the same as Mariah’s. She is working in an academic institution and her focus is on figuring out what those in charge expect and meeting those expectations.

*Patient Care According to Protocol*

A more subtle effect of the systemic control of the healthcare system can be seen in patient care. There are two areas where this is seen in the participants’ narratives. First, some of the participants, especially those in office practices, give examples of how they have learned to work around insurance constraints and organizational protocol to get
what patients need. Still, these constraints affect the way the practice medicine. For example, Ricardo shared that he learned from his office manager that their practice is not reimbursed for labs. So, now he sends his patients to the lab down the street when they need blood work or other tests. The physicians working in office practices were very concerned about time and how they allocated their time to illnesses, or as they refer to it, patient complaints. Within their narratives, some of them told extensive stories of how they manage this. These stories also uncovered that they work on a “one complaint per visit” schedule. That is how time is allotted and that is how they have to bill.

Another issue in terms of patient protocol is that the physicians try to be as “litigation proof” as possible and they are required to comply with numerous insurance imposed and government regulatory standards. This needed to be learned as they began practicing, since all organizations deal with it a bit differently. Documentation and paperwork are as important to their practice as seeing patients and helping them get well. Chris shared a story of an extreme case of documentation when he talked about having to document that a patient was told he/she gained weight so that when the patient had a heart attack, he could prove that he had given warning. While this does seem exaggerated it provides insight into the feelings he has about the process.

Even though the participants practiced in a variety of contexts, they did not have the luxury of just going to work, seeing patients and going home. They faced numerous organizational and systemic issues daily and those experiences shaped the way they practice medicine, interact with others in the workplace, and perceive their profession.
Perception or Reality: Gender and Generation in the Medical Profession

Generational issues, as well as perceptions of women in medicine were found throughout the narratives. The participants did not specifically talk about “women in medicine” but they would attribute certain changes or things that they observed in the profession to the growing number of women in medicine. No one explicitly said it, though Chris came close, but there was this general sense that now that women are dominating the profession, the profession is losing credibility.

Since over half of the participants in the study are women, this sentiment had a direct effect on their entry into profession. Lily talked about how the experienced physicians are very apprehensive to ask her to do additional work and usually surprised when she does. Jacki presents herself as someone who is constantly trying to get the message out that medicine is changing and women’s family responsibilities need to be recognized. Ellie compared her style of medicine to her fathers and attributed the differences to gender. The men in the study did not make the same connections to gender that the women did. Other than Chris’s brief comment on how part-time medicine is not good for the profession and how many women are choosing part-time, the men did not mention gender. Also, no one expressed how women entering medicine is helping the profession. In the stories they told, the women often reinforced stereotypes. Jessica talked about the surgeon’s stay at home trophy wives. Lily said straight out, “More women, more part-time and less people interested in pursuing specialties.” Their narratives suggest that even though there are more women practicing in primary care than there are men; the men still dominate.
There also was a pervasive “us” and “them” undertone in all of their narratives in regard to generational issues. It appears that this is not necessarily tied to chronological age, but to when the participant was trained. Sarah, who is much older than the other participants referred to “them” when discussing the established physicians she know. She explained that they just saw their roles differently and that they lived for medicine and she was not going to do that. While Chris shared that he is a “baby boomer” and holds baby boomer values; he also explained that he is different from the doctors who are his age that followed a traditional career path. Ricardo’s view of his group is that he is in the “young” office where they are laid back and enjoying their practice, while the other office, where the “older” physicians practice is more rule driven and orderly. An anomaly to this is Robert who, despite being in his 30s wants to be an “old fashioned” doctor. He did not once mention generation differences. This is probably because he is interested in practicing similarly to the established physicians and does not have a need to make distinctions between his values and those of the medical establishment.

Predictions for the Future

The participants’ predictions for the future of medicine are bleak. Their narratives convey their frustration about where the profession is headed and their feelings about the uncertainty of their own futures. They believe that as they progress in their careers the demands will increase and the compensation will decrease. Some expressed concerns about the negative effects the changes will have on patients. They see more bureaucratic control and standardization of a profession that was once thought of as an art. Those who practice in outpatient settings see how difficult it has become to keep practices financially solvent. Because of her position, Mariah sees how issues of policy
and funding will affect the profession in the long term. She comments that she used to think that there was job security in medicine and there probably is, but the question is, “Who is going to want to do it?”

While they are pessimistic about the future, they are happy with their decisions at a personal level. They are entering the profession in very uncertain times. They accept things as they are and expect that it may get worse. They do not see much sense in dwelling on it. Many of them were warned ahead of time that the road was going to be rough, but it did not stop them. So, while they see the profession losing respect and credibility, they also see that they do not have to live and breathe medicine. The general sense of their narratives is that they are just people trying to make their individual contribution to society, enjoy their families and live their lives. They feel that medicine may not be the grand profession that it was, but for the most part they are okay with that. They take more of a day to day approach to their careers rather than following a long term plan.

Chapter Summary

This chapter presented the analysis of the nine physicians’ narratives. The narratives were analyzed holistically to unearth the complicating actions, evaluations and resolutions that were embedded within each individual narrative. They were also analyzed collectively to identify general themes across the narratives. Analyzing the narratives in this manner provides a deeper understanding of the uniqueness and similarities of the participants in the study. It preserves their individual voices and experiences, and provides a general understanding of the common experiences that they experienced when entering the medical profession.
CHAPTER SIX

DISCUSSION AND IMPLICATIONS FOR PRACTICE

This study explored the professional entry experiences of beginning primary care physicians by engaging them in co-constructing personal narratives describing their experiences as they entered professional practice. The hope was that they would share their experiences, feelings, and impressions and we would learn more about who they are and how they grow personally and professionally as they enter practice. As we worked together, the interviews, observations, discussions and artifacts became narratives of their lives, both personal and professional. The participants’ narratives took their own form and revolved around the issues that they were grappling with personally and professionally as they began their careers. Their narratives were individually unique and did not present one professional persona or archetype.

In the United States and most industrialized nations, doctors are part of our lives. They are usually there when we are born and often there when we die. The narratives of doctors’ practices and lives surround us, in our communities and society at large. In our culture, there is a certain fascination with doctors’ lives. So much so, that television shows about doctors have been on the airways since the 1960’s. These shows have such a public impact that in a national survey, the Centers for Disease Control and Prevention (CDC) found that people actually learn healthy behaviors from listening to television doctors (Mishori, 2007). Through the media, we also construct beliefs about how doctors live their lives personally and professionally. We want to understand and relate to the people who are responsible for healing us and taking care of us when our bodies fail.
Primary care physicians are the frontline of our medical system. When someone is asked, “Who is your doctor?” They usually respond with their primary care provider, whether it is a family practitioner, pediatrician, or internist. This study provides an intimate portrait of what it was like for nine physicians beginning their careers as primary care physicians. In this chapter, I attempt to make sense of how these nine narratives add to the current literature. In the first section of this chapter I discuss my impressions of the general themes that emerge among the narratives. Next, I discuss the findings in relationship to social constructivism and adult development, which served as the theoretical framework for the study, and then in relationship to the existing literature presented in the literature review. After that, I reflect on the narrative analysis and how the methodology enhanced the study. The implications of this study for adult and medical education, and human resource development are discussed next, followed by suggestions for future research. The final section contains conclusions and reflections on the process.

Discussion of the Findings

When I set out to recruit participants for this study, I did not expect the diversity that I encountered. The physicians in this study wanted to share their experiences in the hope that it would help others and better their profession. I do not think that any of them would view themselves as extraordinary. As many of them put it, they were “just” primary care physicians, not surgeons or specialists. They were beginning professionals, trained and ready to practice medicine to the best of their ability. Many of them were in the process of settling into life both personally and professionally, after years of very structured training.
Some of the findings of this study are more about the process than the research questions. The participants constructed their narratives around the issues and concerns that they were trying to individually make sense of as they started their careers. This was different for everybody. What they had in common is that they were charting new ground personally and professionally. This brought both celebrations and frustrations to their lives. The analyses of their individual narratives highlighted how individualized their entry experiences really were. The participants in this study were not a generic “new face of medicine;” they were individuals who were entering the medical profession.

The findings within the narratives (the holistic and structural analyses) also demonstrate how the personal and professional aspects of their lives are deeply intertwined. Their professional entry experiences were affected by what was happening in their personal lives, their daily work life, and the cultures of the organization. There were so many things happening within them and around them as they began their careers. Yet, they decided consciously or unconsciously to talk about certain aspects of their experiences and not others. For example, some narratives emphasized experiences related to patients and patient care. Other narratives centered on family life and the challenges of managing the demands of work and family. Some narratives were about managing the day to day and others focused on how to manage a career over the long term.

As they sorted out what was important to them as they began their careers, general themes and common experiences emerged across the narratives. The findings across the narratives (the collective analysis) pointed to more systemic issues of the profession such of lack of guidance or career support after residency or the influence of
gender and generation on perceptions of the profession. The themes found across the narratives provide a bird’s eye view of what types of issues and common experiences new physicians face as they begin practice.

Theoretical Framework: Social Constructivism and Adult Development

This study is philosophically grounded in social constructivism and constructivist theory of adult development. Simply put, I approached this study with the belief that reality is constructed through human activity and interaction. The narratives presented by the participants are a product of the participants’ social and cultural experiences. The meaning they make regarding their lives and careers is not created in isolation. Their understanding of themselves and their profession was constructed through their interactions with others and their participation in community. This is what Rogoff (1995) refers to as intersubjectivity, the shared understanding that occurs among a community or group of people based upon common interests and assumptions. Social meanings are shaped by the interactions and negotiations which occur within the group or culture. Thus, personal meaning of the experience is affected by the intersubjectivity of the community or group (Kim, 2001). The role of community, whether it is family, residency program, or the profession at large, is seen throughout the participants’ narratives. Their experiences as they entered their careers were inherently social. The stories they told were often about social experiences or their interpretation of social experiences.

Intersubjectivity and the Social Construction of Narratives

Narratives can be analyzed through a number of theoretical lenses, each of which looks at the narrative from a different perspective (Boje, 2000). The narratives in this
study were analyzed through a social constructivist lens. Throughout the analyses, I focused on the individually and socially constructed realities that appeared in the narratives and the participants’ stories. How the participants went about making meaning of their experiences and their lives are examples of what Rogoff (1995) posits as the three levels of interaction and development: the personal, the interpersonal or social, and the community or institutional. Within their narratives are examples of how these three planes interact (which she refers to as intersubjectivity.) Intersubjectivity can be seen within the individual narratives as the participants shared stories about their families, their practices, their understanding of the profession and its place in society.

While all of the narratives have some elements of the three planes of interaction and intersubjectivity, I thought that Ellie’s narrative represents the essence of what Rogoff theorizes. In her narrative she provides numerous illustrations of how she constructs and reconstructs her understanding of herself, her profession and her relationship with her father through negotiation, resistance, observation, and, at some level, acceptance. She talks about the culture of medicine that she observed growing up and how she resisted following that path. Through this resistance and negotiation, she and her father develop mutual understandings and a practice that fits both of their styles. Yet, so much of what she believes about the practice of medicine is rooted in her earlier social experiences and what she learned from observing her father. Finally, even though her father’s practice adapted to allow her to practice medicine the way she wishes, the community they serve and the healthcare system at large impact how they operate and what they see as their reality. Thus, her beliefs about her profession, how she practices medicine, and how she lives her life are shaped by the socio-historical context of the
multiple communities in which she participates. The influence of each of these elements can be seen in what complicating actions appeared in the narrative, how she evaluated and resolved the issues, and how she presents her narrative.

The findings across the narratives demonstrate intersubjectivity on the professional and societal level. While each of the physicians was constructing his or her individual careers and deciding how to practice medicine, together they were constructing the profession by both adapting to the aspects of the current culture that they accepted and resisting what they did not. For the most part, this was an unconscious process. They did not consciously think about what parts of the medical culture they accepted or rejected. They acted as they saw fit.

The Social Construction and Reconstruction of a Profession

The intersubjectivity of the individual, inter-personal and communal is evident in how the participants of this study represent their careers and the medical profession. The beliefs they hold and the way they approach their practice has been shaped by many factors. Their professional entry experiences were influenced before they walked into their practices for the first time. The cultures in which they grew up, where they were educated and trained, and the organizational where they began their practice all had an influence. One of the findings of this study is that the beginning physicians needed to construct their careers in order to integrate the personal with the professional. While they had to pave their own pathway within their practices, much of what they expected to experience in their first position had been informed by multiple socio-cultural factors in their past. One of those factors was the image they had constructed of what it meant to be a doctor.
Physician Archetype. When the participants entered practice they evaluated their experiences in light of their pre-conceived expectations. These pre-conceived beliefs were built upon years of experiences as members of families, communities, as health care consumers and as professional trainees. Robert and Sarah talked about their experiences visiting their family doctor. Jessica talked about the influence of the physicians who visited her school. Both Mariah and Ellie grew up with family members who were physicians. As they entered medical school and residency, they became members of academic institutions grounded in strongly held socio-historical customs and beliefs (for example, the Hippocratic Oath, Osler’s bio-medical model). These ideas are not new; medical sociologists (for example, Parsons 1951; Goffman, 1961; Freidson, 1970; Abbott, 1999) have been debating these issues for decades in the context of society or the medical profession as a whole. What is different here is how the interpersonal relationships these participants had with their personal physicians, and/or family members who were in the medical profession, informed their understanding of the profession. Also, some said that the physicians they came in contact with discouraged them from pursuing medicine. So, while they were constructing beliefs about the profession, they were already seeing physician dissatisfaction. This dissatisfaction did not discourage them from entering the position, but it was something they revisited when they entered practice.

As they entered medical school and consequently the profession, they went through a process of reconstructing their understanding of what it means to be a doctor. They provide numerous examples of how they observed others in the medical community, how they talked to those who were more experienced, how they observed
others, and how they made decisions informed by the socio-cultural context within medical school and residency and continue to do so in their practices. Some of what they experienced was embedded in the system, and their individual perspectives mirrored those of the medical community as a whole. An example of this is their discussions about the demands of residency.

*Mutual Suffering in the Medical Community.* While residency is undeniably demanding and all consuming, it also is a socially constructed rite of passage. Yes, it is a training ground where physicians learn how to take care of patients. But, it is also an established system and set of values that exist within medical education. The participants had expectations and beliefs have been constructed and reinforced within the medical community at large, not just their individual training programs. The belief in “successive years of increasing torture,” as Chris explains it, is embedded in the medical community.

In contemporary medicine, the suffering is not just physical and emotional but financial as well. The skyrocketing cost of medical school has made leaving medical school with close to $200,000 in debt the norm. It is expected within the culture. So much so that Mariah kept it to herself that her family paid for medical school. She said that her peers just assumed that she was carrying the same debt load as they were. I shared this vignette with a colleague, who happens to be married to a medical student, to hear her impression. Without hesitation she validated the sentiment. She felt that for medical students and residents, suffering is equated to commitment, and debt is just part of what is expected, reflecting the intersubjectivity of their narratives.

*Counternarrative.* Chase (1995) explains that while there is a predominant narrative that is socially constructed in a culture or community, counternarratives often appear.
Counternarratives reflect beliefs and values that are counter to the dominant discourse within a community, group or culture. These are the narratives that often go unheard because of the strength of voice in the dominant narrative. Ricardo provides a counternarrative to the medical community. Though Ricardo was educated and trained in an environment similar to the rest of the participants, his background was uncharacteristic of most physicians. As a result, he resisted the dominant narrative during medical school and residency and continues to do so in his practice. Even though he did not accept the dominant discourse within the medical community, the beliefs are so ingrained in the culture that he felt a need to address them in his narrative. In doing this he brings a different perspective and illuminates the influence of socio-cultural context on how we interpret our experiences and learn.

Adult Development and Moving Toward Self-Authorship

This study was informed by the adult development literature and specifically the work of Kegan (1982, 1998), and Baxter-Magolda’s (1998; 2001) work with self-authorship in higher education. The participants were at various stages in terms of moving from a place in their lives where they listen to and are guided by others, (the socialized mind) to finding their own pathway and creating their own narrative (the self authored mind.) In their narratives are elements of resistance, acceptance, excitement and struggle as they move from their lives as students and trainees to professionals. It was a welcomed but abrupt change. In a short period of time they went from trainee to colleague, tripled their income, and for the first time in their lives, they were in the driver’s seat as to what happened next. It is now time for them to catch up personally and make sense out of the events of their lives. Jacki gives an example of this when she tells
of a defining moment during her pregnancy when she realized that her organization can be flexible and accommodating. Up until that point, through medical school and residency, she was socialized to do whatever was asked and to be there no matter what. When she realized that she can be in control, it changed the way that she perceived herself and her job.

The process of constructing narratives was very useful for them in this respect. Reflecting on their lives, some of them for the first time, brought new insight and perspective. Harper (2006) argues that medical education has not done a very good job of preparing physicians developmentally. He believes the mantra in medicine is to “study the disease or the patient not yourselves” (p. 232). Thus, arguing that “the antireflective tradition not only omits the study of how physicians develop; it can actively discourage such observations” (p. 232). For a few of the participants, seeing their narrative as a whole reinforced their feelings about medicine and their belief that their career is a calling and not just a job. The love/hate relationship that they seem to have with medicine also seems developmental. As they gain control over their lives and move toward self-authorship, the practice of medicine becomes much more personal and fulfilling.

Their transitions illustrate the importance of what Kegan (1982) describes as holding environments, or the context in which the person learns and grows. A good holding environment is one where the individuals are both challenged and supported in developing their own meaning making processes. In this respect, the medical school and residency supported their professional development and hindered their personal development. This is consistent with a study of West Point cadets whose lives and
learning were so structured that they never had the opportunity to develop their own belief systems (Lewis et al., 2005). This can be seen as advantageous for an organization, such as the military, where uniformity is crucial to performance. But, it seems to be detrimental for the individual growth and development of those within the system.

Relative to medicine, the physicians in this study were rather compliant and throughout their lives they were rewarded for this. Because medical school is competitive they were probably highly performing students throughout their educational career. They conformed to the expectations of their college professors so they could do well enough to enter medical school. This continued in medical school and residency. The one participant, Ricardo, who chose to challenge the system and do it his own way, faced opposition from those in charge. This compliance is deeply rooted not just in medical education but in medicine in general. Physicians expect patients to be compliant. If a patient does not do what the physician requests or orders, he or she is deemed “non-compliant” or acting against medical advice (ama). Chris’s story about the way he went about losing weight provides an excellent example of this.

This emphasis on compliance is reinforced by the prominence of technical competence in medical education. Obviously technical competence is of the utmost importance in training physicians. This technical competence is often developed through cognitive apprenticeships and scaffolding. The old adage of “see one, do one, teach one” still dominates in most medical training programs. But, the intensity of the technical and skill based training often leaves the personal aspects of the developing physician neglected. In this study, the participants felt well trained to go out and practice medicine,
but it was the rest of life that caused them to struggle. This was not limited to the participants who attended medical school right out of college. The two participants who followed non-traditional career paths had similar feelings. This finding is supported in the literature. A survey of practicing physicians found that the majority of the physicians responding felt that their training provided a solid foundation for clinical work, but they were not provided with enough personal and professional direction (Petersson, Agergaard, & Riser, 2006). Susan Pories (2006), a professor at Harvard medical school also recognizes this limitation and proposes that reflection and personal exploration need to be encouraged during medical training in order to develop physicians who are both technically competent and personally reflective. This ideal parallels how Baxter-Magolda (1998) describes self-authorship, “A way of making meaning of one’s experiences from inside oneself” (p. 152).

**Emerging Adulthood and Participants in This Study**

In theory, emerging adulthood occurs after adolescence (late teens to mid or late twenties) as an addition to Erickson’s theory of development. It is a time for individuals to achieve a sense of personal responsibility and independence which prepares them for adulthood. According to Erickson’s theory of development, this is a highly individualistic process. It does not look at role transitions as markers of adulthood. It instead focuses on internal concepts such as independence (Arnett, 2000). As a result, it does not fit a social constructivist view of adult development. But, as explained in Chapter Two, I included it in my conceptual framework because Arnett’s rationale for adding another stage to Erikson’s developmental theory is to address the socio-cultural context in which adults are developing in the 21st century. He argues that the changes in
modern life require a reconceptualization of adolescence and adulthood and there needs to be a stage between the two where individuals prepare for being adults. Young adulthood does not get much attention in the adult education literature because it is viewed as a part of the higher education domain. As seen in this study, many young adults are no longer in higher education but are still not taking on what we consider traditional adult roles. This could be a result of professional education, as it is in this study, or other factors such as not having the financial resources to live independently from their parents. Thus, this is an important time in adulthood that should be considered in the adult education literature.

The lives of the participants in this study did not support or negate Arnett’s theory of emerging adulthood. For the most part, their stories still reflected more the sociological markers of adulthood than the individual markers of adulthood, theorized by Arnett, such as making independent decisions or being financially independent. There are many possible reasons for this. First and foremost, this study did not focus on their conceptualization of adulthood. Its purpose was not to categorize the participants into a certain stage of adult development. Other reasons why emerging adulthood did not apply to this group are largely socio-cultural. These young adults were not expected to take on adult roles; they were students. For the participants who followed a traditional medical training path, their twenties were not unstructured and filled with limitless possibilities and options. They spent those years in very structured environments: medical school and residency training. They did not have the opportunity to experiment with different roles or identities; the roles and identities were pre-determined by their choosing to pursue medicine.
Another factor differentiating the participants in this study from the larger population of young adults is that they are not affected by the same socio-political influences as young adults beginning other professions or vocations. Theorists, generally Arnett (2000; 2004; 2006) and Côté (2000), argue that emerging adulthood is a response to the changes and the complexity of modern life which occurred as a result of globalization and fierce competition in the marketplace. For the most part, these factors are just beginning to materialize in the healthcare industry. The career preparation experienced by the participants in this study is similar to what occurred in years past.

Recently, research has emerged that challenges the construct of emerging adulthood consistent to the issues raised in this study. Molgat (2007) and Bynner (2005) suggest that emerging adulthood needs to be reconceptualized to include factors such as socio-political climate, community expectations, and the availability of such things as jobs and affordable housing. The situations in which these young adults are living may not allow them to achieve what was once believed to be the sociological markers of adulthood.

Interestingly, a number of the participants in the study were married in their early 20s and had children during medical school and residency. The literature suggests that this is not out of the ordinary for emerging adults, postulating that marriage and family provide the support structures and control that is non-existent in other parts of their lives (Butler, 2005). But, the married participants in this study all were married before they were 25 years old which is below the national average for both men and women, which is 27 and 26 years old respectively (Arnett, 2004). It may be that because they had to delay other aspects of adulthood, marriage seemed like something they could achieve. This

One area where the findings of the study do reflect the literature regarding emerging adulthood is in relationship to the research on individualism. Schwartz, Côté, and Arnett (2005) argue that in most Western societies life-course events are no longer normatively structured, thus the ability for young adults to “individualize” their life course and exercise agency is crucial to their development as adults. Discussing agency in relationship to social constructivism is problematic. This was addressed in Chapter Two. But, the agency described here is psychological agency not sociological agency. Wandrei (2001) argues that individual self-directed activities that can be seen as psychological agency intimately interact with social processes and constructs. Thus, the concept of individualization as theorized by Schwartz, Côté, and Arnett (2005) is more about taking self-direction and intentionality than it is about individual agency.

The participants of this study did engage in varying degrees of self-directed activity as they began their careers. By their own volition and despite criticism, Lily and Ricardo started their job search eighteen months before they finished residency. Chris decided to practice in a number of settings rather than committing to one practice. These are both examples of what Côté (2000) describes as individualization. He delineates two paths to individualization: default (little psychological agency or intention on the part of the individual) and developmental (the individual takes initiative in pursuing goals). Because the nature of medical education is regimented, most physicians do not have an
opportunity to exercise psychological agency (intentionality) with regard to their career until they leave residency.

Once an individual decides to pursue medicine, most of his or her life choices are in the hands of others. For example, they have to apply and be accepted to medical school. Often this means moving. While they are in medical school they are sent to various hospitals and clinical settings where they do what they are told to do. When they leave medical school, they have to participate in the National Resident Match Program (NRMP) where they are interviewed at residencies and then matched via a computer program depending upon their rankings. Next they begin residency, where their lives revolve around the hospital. The medical students and residents who are successful tend to be very compliant and flexible in order to adapt to the demands and expectations of the system. Thus, the environment controls their life course.

When reading the participants’ narratives, differences in their intentionality in relationship to career decisions are evident. Côté (2000) argues that the more intentional individuals are (reflective of developmental individualization), the more content they are with their life path. Those that tend to leave these decisions to others, or let circumstances guide their decisions, (reflective of default individuation) tend to be less content. The approaches used by the participants in this study are consistent with this. The participants who put little upfront time into deciding what they wanted in a practice tended to experience more dissonance between their expectations and reality as they began their career. Their full narratives and the stories they share within the narratives reflect this. They did not include their decision making processes in their narratives they just told the decisions. For those who were more intentional with their job search and
career choices, they seemed to exercise agency, what little agency they could, their narratives reflected their decision making processes. Also, they were more content and settled with their decisions because they had thought about it in advance.

**The Study in Light of the Literature**

In Chapter Two I present the theoretical and empirical literature that informed this study. In this section I discuss the findings of this study in relationship to the literature and how this study contributes to the current body of existing empirical and theoretical knowledge.

*Purpose and Focus in Physicians’ Careers: Matching the Professional to the Personal*

One of the findings of this study is that the participants construct their careers in an individual manner. There was no defined career path for them to follow. This was both exciting and challenging. In the process of constructing a career that met their professional and personal expectations, they identified the reasons they chose medicine and their beliefs about the profession. Following is a discussion of these findings in relationship to the literature on constructing medical careers and finding meaning in work.

*A New Perspective on Calling.* Contrary to much that has been written about work being perceived as a commodity exchange (Adkins, 2005) or medicine being more of a career than a calling (Real, 2002), the participants in this study saw their profession as a calling, and many used that term to describe it. The origins of the calling may have been different—some were called to help people, others were called to the personal and professional challenges—but in some way they all pursued medicine because they wanted to make a difference. This is consistent with Dirkx’s (2006) thesis that those in
the helping professions such as teaching and medicine, still have this emotional
dimension to their work.

However, much of what they relayed in their narratives indicated that while they
perceived medicine as a calling, it is not their identity. This brings into question how
they define calling. “Vocation is not a goal I pursue; it is a calling that I hear” (Palmer,
2000, p. 4). Cochran (1990) explains that for a person who is called or has a vocation,
“The relationship is not contingent but personally necessary, a relationship of being and
doing, potential and actualized” (p.3).

This is not the way the participants of this study described their careers in
medicine, yet they referred to it as a calling, expressing that there is no other reason to
become a doctor. They discussed having multiple interests that they are pursuing, and
medicine just happens to be one of them. This is consistent with what Gergen (1991)
argues about careers in contemporary society. He suggests that “the concept of ‘intrinsic’
interest is virtually lost from view” (p. 185). He goes on to explain that he believes that
what people now see as their work or vocation is a construction of skills and experiences
to meet a particular niche. Thus, even though participants said they felt called to pursue
medicine and go through the rigors of professional preparation, they were not
experiencing this phenomenon as Palmer and others describe it. Each of the participants
needed to construct a career path that fit his or her personal and professional desires.
They did not approach their careers passively. While they described their desire to enter
the profession a “calling” they were very selective as to what they were willing to do to
carry out that calling.
Elements of their narratives also suggest that they see their professional pathway as fluid and they are willing to readjust their professional aspirations for their personal aspirations. In addition, their motivation for being employees rather than partners, suggests a more fluid approach to professional practice. The findings of this study suggest that physicians are keenly aware of the structural and economic changes in the marketplace and especially in the health care industry. Consciously or unconsciously they position themselves to be able to adapt accordingly. This is consistent with the literature which argues that security and stability are no longer the focus when constructing careers, but young adults need to be flexible, ready to change, and equipped to remain competitive (Geroy & Venneberg, 2003).

**Multiple Identities and Motivations.** The structural analysis of the physicians’ narratives demonstrated their individuality. This in turn illustrated numerous ways in which a primary care physicians’ career can be constructed, and the professional entry experiences associated with the paths they chose. The diversity in their narratives also reflected their relationship to the medical profession and beliefs about what their role is in society. For some, their interest in being a physician is tied to the profession itself. For others, it is about the patients. For some, the draw to medicine was the intellectual challenge and rewards associated with making a difference. For others, it was about the connections and relationships that are made with patients.

For most, these beliefs were foundational, and they emerged during medical school or even before they entered medical school. These beliefs and values provided their motivation for beginning and completing their professional training. For others, their professional experiences, both in residency and in their professional practice, caused
them to shift their perspectives. These findings are quite reflective of the literature on physicians’ identities. Just as Briscoe (2003) identified multiple reasons that physicians join organizations, other theorists (Dumelow, Littlejohns, & Griffiths, 2000; Real, 2002) have studied and categorized physicians by types of identity. The findings in this study reflect this research on the multiple identities within the profession.

These multiple perspectives are also seen when participants discuss work life balance in their stories. They want to have work life balance, but what that means differs by individual. This is consistent with the literature and is suggestive that there is no formula for work life balance; it is more about feeling control over one’s life (Gareis & Barnett, 2002; Keene & Reynolds, 2005). The stories the participants told within their narratives illustrated this, especially when they discussed their residency experiences. Because these participants were just beginning their professional practices and residency was fresh in their minds, despite having 50-55 hour work days, they felt emancipated. This is not reflected in the literature. The literature presents an opposing picture of stressed out and overburdened primary care physicians with demanding patient schedules (Murphy, 1999; West, 2001). But this literature is based upon studies of physicians who are already established in practice, not physicians entering practice after residency. This does demonstrate how the idea of “work-life” balance is constantly being constructed and reconstructed for the individual as well as society. It is a matter of perspective. There are some who argue that despite the dominant discourse regarding work-life balance, we have more leisure time than ever (Robinson & Godbey, 1999).


The Profession in Society: Professional Autonomy and Systemic Control

This study supports the multiple theories and perspectives seen in the literature with respect to the changes seen in the medical profession over the last two decades. This literature presents very complex sociological perspectives on the profession as well as some observational data published by medical schools and other physician related groups. The final discussion in this section is about the influence of organizations on physicians. The purpose of this discussion is not to evaluate the profession, but to describe how these sociological perspectives and systemic issues emerge in the participants’ experiences as they enter the professions.

Multiple Perspectives Reflected in Singular Narratives. Elements of various sociological perspectives about the current state of the medical profession are embedded in the participants’ narratives. For example, Freidson (1984, 2001) describes what he terms as professional dominance. Simply put, his stance is that while changes may be apparent on the surface, the structures already in place that support the position and power of the profession still exist and are unchallenged. One area where this perspective is reflected in the physicians’ narratives is when they discuss their medical school debt. This illustrates how professional dominance affects their lives and their professional entry experience. Currently, the average physician graduating from an allopathic medical school has accumulated $150,000 to $200,000 in debt before leaving residency (AAMC, Medical School Tuition and Young Physician Indebtedness, 2007). Evaluating this from a professional dominance perspective, the cost of medical education is prohibitive and reinforces the power and position of the profession. Its value is socially constructed and not contested. As a result, medical students are driven to choose prestigious specialties
over primary care, thus reinforcing the current “class” system that exists within the profession. What is important to recognize is that these socially constructed realities within the profession go relatively uncontested.

Another place in their narratives where the professional dominance perspective can be seen is the way they portray primary care in their narratives. Their narratives reflect this devaluation of primary care’s contribution to medicine. This is how the profession at large sees the specialty. As a result, primary care physicians receive less than half of the compensation of other specialties such as dermatology, radiology and cardiology (Bodenheimer, Berenson & Rudolf, 2007). This has been steeped in the medical culture, and because of policies and other regulatory practices within the profession, it is very difficult to change.

Glimpses of the proletariat perspective (McKinlay & Arches, 1985) are seen throughout the participants’ narratives. The simplistic definition of this perspective is that physicians sell their labor and surrender professional control. The findings of this study suggest that these physicians are not very interested in professional autonomy and the responsibility that goes along with it. They look for direction from others and desire to be employees. As discussed previously in the discussion of the themes across the narratives, this had a tremendous affect on the physicians who worked predominantly in outpatient clinics where generating revenue and “earning my keep” were very important. It existed but took on a different face for those who worked in large academic institutions. For them, implicitly knowing what was expected, meeting organizational goals and being a team player drove them. This was not as much a “labor for money” as
those working in outpatient clinics, but more of a “conformity for money” way of being controlled by the system.

The questions posed by the research of Hoff’s (1998) *physician as worker* perspective and Briscoe’s *bureaucratic flexibility* thesis (2003) do not focus on whether or not physicians are being controlled by organizations, but whether or not this is beneficial for the physicians. All but one of the physicians in this study do not want to run their own practices and deal with the business aspects of a practice. They want to practice medicine, and they are willing to reduce their compensation and autonomy in order to pursue the type of career and work life they desire. The reasons given by the participants in this study mirrored the findings of Briscoe (2003). This brings to mind two things. First, it resonates with what was discussed previously about careers now being constructions to meet particular niches and not having the intrinsic motivations or benefits that once existed, especially in a profession like medicine. Second, is their willingness and desire to give up their professional autonomy. While the argument behind this is that with the autonomy comes great responsibility, it can also be argued that there is considerable professional responsibility inherent in being a physician. Also, much of what is written about physician burnout and stress is tied to what they perceive as their lack of professional autonomy (for example Haig, 2007; Murphy, 1999; Sloan, Ratcliff & Hall, 2007). So, will this freedom associated with being an employee become a burden later in their careers?

A pragmatic question that surfaces when discussing the physician as worker/employee literature in relationship to the findings of this study is, “Do many of the physicians entering practice today even see private practice as a viable option?” The
narrative of the one physician in the study that is interested in running his own practice suggests that he is counter culture, expecting to do something that is unheard of in modern medicine. Thus, even though the participants in this study stated that they wanted to be employees, it appeared that part of their motivation was the complexity of the medical system (for example, billing, insurance, compliance, etc.) more than a desire to be part of an organization.

This leads to the final perspective on the changes in medicine which is rationalization (Jin, 2005; Ritzer & Walczak, 1998). This perspective argues that medicine is moving away from being an art. It has become institutionalized and governed by quality assurance and compliance audits that may or may not be in the best interest of patients or physicians. This did come up in many of the physicians’ narratives, both explicitly and implicitly. They discussed billing, coding, regulations and insurance audits. They told stories about how they have to allocate time according to patient complaints, allocating minutes to ailments. These are all system controlled aspects of their practice to which they have become accustomed, and accept as standard procedure.

This standardization and quantification is not endemic to healthcare organizations, it can be seen throughout society and has been in discussed by sociologists since Weber first wrote about this in relationship to the Protestant Work Ethic and capitalism (Beder, 2001). In relationship to this study and its purpose, what is missing in the participants’ narratives provides insight to the rationalization of medicine. While the participants stated that they pursued a medical career because they were called or they wanted to make a difference in people’s lives, I expected them to tell stories about their experiences with patients and how these experiences confirmed their calling, and some did that.
Ironically, Chris, who tended to be very pragmatic, was the most expressive about how personally fulfilling he finds it to affect people’s lives for the better. I also expected them to tell stories about how they had to make sense of the bureaucratic and organizational constraints in light of their calling to help people and be healers. This did not happen. Instead, they told stories about how they learned to practice following the guidelines and external constraints. The participants did not recognize or comment on the sociological changes in medicine, but their beliefs about the profession reflect those changes. For example, they hold onto the idea of professional calling which is reflective of what Weber (1992) calls \textit{substantive rationality}, which is defined as holding on to values, ideals and traditions; but their practices reflect what Weber calls \textit{formal rationality}, which is defined as determining the most efficient methods and procedures to realize goals.

While the intent of this study was not to analyze numerous sociological theories of the medical profession and the findings did not support or refute the sociological perspectives, they do show how what is studied at the macro level in terms of society and the profession can be seen in the individual lives of physicians at a very personal level. Also, elements of multiple perspectives are evidenced in both the small stories the participants shared and their overall narratives. What is also seen is how these larger issues within the healthcare industry affect the individual physician’s perception of the profession, and the early professional experiences of beginning physicians. Finally, while we often think of professions or certain groups within society as having their own culture that is impenetrable by the ebbs and flows of societal change, it is not the case.
The changes in medical careers and physicians’ perceptions of their work and lives are reflective of what is happening in society.

*The Changing Face of Medicine.* The changing demographics of the profession are evidenced in the participants who volunteered for the study. The individuals who chose to participate in the study came from diverse backgrounds and perspectives. This was not by design, but it does reflect what is occurring in the profession. The statistics kept by the Association of American Medical Colleges (AAMC) indicate that more than half of the current medical students and residents training in primary care are women. Also, the number of White male physicians is declining and the numbers of minority physicians are rising (AAMC Data Warehouse: Applicant Matriculants File, 2007). This is not surprising since there is significant pressure on medical schools to increase the diversity of their student base to reflect the diversity of patients (AAMC Diversity Research Forum, 2006).

Along with the changing face of medicine are the changing priorities of those entering the profession. This was discussed from an individual perspective in the previous section, but if we see professions as social constructions, the values and interests of the individuals will eventually become the values and interests of the profession. This point is argued by Briscoe (2003) when he posits that one of the reasons that professional autonomy in medicine is going away is because those who enter the profession do not want the responsibilities that go with it. There are different perspectives on this in the literature. Some argue that the profession has become less desirable due to external factors such as decreased medicare reimbursements, increased liability, and increased institutional control (Haig, 2007; Pescosolido, et al., 2001; Rothman, 2000). It is also
argued that the profession’s increased heterogeneity is what is changing the culture (Ellis, 2004; Giovino, 2005).

While there may be disagreement in regard to causation, both the literature and the findings of this study indicate that the medical profession is undergoing great change. This is seen in the participants’ narratives and has a significant influence on how they chose their practices, how they perceive the profession and how they will proceed with their careers. While they express their individual observations and views, there is a similar undercurrent in their narratives suggesting that this is not their individual construction, but commonly held and discussed views within the medical community. Often when the individual participants spoke about these changes in the profession in a collective using “we,” “us,” or “doctors of our generation.” They shared this not only as their personal opinion or belief, but as a professional reality. This undercurrent about the professional reality of medicine is so strong that Robert, whose goal is to be an “old fashioned doctor,” is amazed that he is able to resist the current medical culture and pursue his dream.

This is consistent with the current literature in the medical profession which suggests that physicians are interested in stable income, less work hours and less administrative responsibilities (Giovino, 2005; Kirch, 2007; Moody, 2002). These quality of life issues take precedence over money. As a result, many new physicians are opting to be salaried employees instead of partners in a practice (Institute for the Future, 2003). This was the case for participants in this study. All of the physicians who had the option of “buying into” their practices said that they were probably not going to do so. It just was not worth it for them. All of these changes are befuddling to the leaders of the
profession, most who are from a different era in medicine. This is such a concern that recently, Darrell Kirch, president of the AAMC, addressed these issues with the leaders in medical education on a Medscape Webcast entitled From Marcus Welby to Grey’s Anatomy: The Next Generation (2007). In this address he encouraged medical educators and healthcare organizations to consider what needs to be done in the system to accommodate this new generation of physician.

Medical Career Changes Reflect Society. These issues are not endemic to medicine, the same thing can be seen in the general workplace literature as well (for example Straus & Howe, 1991, 1993; Hall, 2001; Karp, Fuller, & Sirias, 2003). The changing attitudes about work, professional commitment and organizational commitment are consistent to what is being witnessed in society at large as global competition increases and the workplace faces widespread change and instability (Pink, 2001; Frasier, 2002; Tulgan, 2004). The movement toward flexible scheduling and part-time employment, especially for professional women, is also consistent with what is happening throughout society.

However, medicine is an archetype profession and ideals have remained constant since the Flexner Report elicited standardized education and training of the bio-medical model for physicians in the United States. The workplace issues related to generation differences that are discussed in the literature suggest that a level of resentment and confusion exists among those (usually from the baby boomer generation) who feel they have paid their dues to get where they are, and now the rules are changing (Kormanik, 2008). Considering the tremendous sacrifices and commitment exhibited by that the prior generation of physicians, it makes sense that more senior physicians would find
change disconcerting, but in the same respect, it appears to be what is occurring and this may be difficult to change. The findings of this study reflect this.

Most of the participants attributed the changes in the profession to the increased number of women entering the profession and how women see work life differently. Within their narratives, they told descriptive stories to illustrate this. Most interesting to me, was how some portrayed the senior physicians in charge as benevolent older men who are willing to do whatever it takes to keep the beginning female physician content. In fact, one of the female physicians found humor in the way the older physicians would ask her to do things assuming that she was going to say no. Frey (2007), a self-proclaimed older male physician who graduated from medical school in 1970, argues that “The era of faculty and older physicians singing ‘Why Can’t a Woman be More like a Man?’” (p. 250) has vanished. He contends that women’s experiences and perceptions of the profession are now the majority view and need to be incorporated in education and practice.

In terms of their professional entry experiences, the women in this study felt empowered because the leaders of their organizations were willing to bend to meet their needs and desires. But, as I thought about their stories, I also thought about the underlying assumption that women see their careers very differently than men do. It surprised me how explicit some of the participants, and especially the women were in their assumptions about female physicians. Ellie said exactly that when she was talking about her father’s willingness to work long hours. She attributed the differences between his view of medicine and hers to gender. Chris discussed his frustration with women practicing part-time medicine and his concerns about quality of care. Lily shared, that
more women means more part-time physicians and less people willing to make the sacrifices associated with pediatric specialties or department chairs. Also, the seasoned physicians described in this study from the perspective of the participants, seemed to be accepting and accommodating of these changes in the profession. But, in light of what is being conveyed in the literature and by professional organizations, it does make me wonder if this accommodation is because they do not feel that they have an option. This sentiment was also presented by one of the male physicians in the study. What is means for the profession in the future remains to be seen.

_Becoming a Member of an Organization._

All of the participants in this study wanted to be employees. Even Robert, who eventually wants to purchase his practice from his employing organization, decided to start the practice under the umbrella of a larger organization. The participants entered very different types of organizations ranging from solo practice to large academic institutions. Their experiences as they acclimated to the organizations were tied to the organizations’ form. Those who entered large, structured organizations, what Burns and Stalker (1994) refer to as mechanistic organizations, were very aware of how the organization affected their practice. They talked about how important it is to understand and fit into the organizational culture. They explained their frustrations and accomplishments in learning how to navigate within the organizations. They shared about organizational politics and the importance of paying their dues. Their stories also reflected some level of pride in being part of a reputable system. For example, Jessica shared how patients are willing to wait when she is behind schedule because of the reputation of the system. This is in stark contrast to Ricardo who explained that in his
office, they watched him and adapted to his style more than he had to adapt to the style or
culture of the practice. His organizational structure reflects more of what Burns and
Stalker (2004) term organic form. It has more of a lateral organization than chain of
command.

The type of organization they worked in was reflected in the kinds of stories they
told in their narratives. The influence of the organization ranged from inconsequential
background information to the predominant focus of the narrative. An even more
important organizational dynamic could be seen in all of their narratives—the importance
of organizational fit. Most of the participants did not think about this until after they
entered practice. But at some point early in their professional entry they did start
questioning and evaluating how they fit into the overall organization. Some, especially
those who thought about it before hand, found a good fit. Others were willing to accept
the differences between their perspectives and the organizations and continue the
employment relationship. Others recognized the lack of fit and either renegotiated their
positions or changed jobs. What was not apparent is whether the lack of fit was because
of personal factors, their previous professional socialization, or a bit of both, all of which
are discussed in the literature (Loyttyuniemi, 2001; Dukerich et al., 2002).

No matter what type of organizational structure they went into, the participants
seemed to adapt quickly to their practices. Sarah suggested that this is due to their
training in medical school and residency where they are constantly being sent to different
hospitals or practices. They also had to find their own way. They were given autonomy
from the organization and very little feedback or guidance. One element of professional
entry that was missing in their narratives was any mention or discussion of mentors or
any type of social support structure within the organization. Granted, Mariah said she had a mentor that she needed to seek out, and Jacki spoke about how people supported her need for more family time. But there was an absence of direction, feedback and support during their professional entry. This may be attributed to professional autonomy, and it is indicated in the literature that this is fairly standard (Giovino, 2002, Moody, 2003). But, the general literature on beginning professionals (specifically Generation X professionals) proposes that structured expectations, friendships in the workplace, feedback and organizational support are all important to new employees as they enter organizations (Pollach, 2004).

*Systemic Control within the Profession*

The physicians in this study adapted to their practices and organizational priorities. Those who worked in outpatient settings were very concerned about revenue generation, documentation and patient satisfaction (seeing patients on time, having patients like them, etc.) Those who worked in larger organizations were more concerned with organizational culture and dynamics. But organizational systems are not the only influencing systems in a physician’s practice. There are outside factors such as government regulations, insurance companies and the profession itself. One finding that warrants discussion is the way the physicians in this study depicted patients.

Their beliefs about the role of the physician and the role of the patient were developed long before they entered their practices. Those who talked about patients, especially adult primary care patients, expressed dissatisfaction with the relationships. They felt that patients did not listen to them and did not appreciate what they did for them. The pediatricians said that what drew them to pediatrics was that parents took
better care of their children than themselves. They were willing to listen to the doctor and do what they were told. Chris shared his feelings about this when he said that he liked inpatient medicine because he had control; the patients were prisoners and had to do what he told them to do. They presented a surprisingly “physician centered” philosophy of medicine in an era of patient centered medicine.

While physician-centered medicine is beneficial in acute situations, it has been found not to work very effectively in the treatment of chronic illnesses. Patients with chronic illnesses constitute the majority of outpatient visits to primary care physicians who ultimately have little control over outcomes (Gottlieb, Sylvester & Eby, 2008). Patients decide if they are going to take medicine, follow their diet, exercise and practice healthy habits, not physicians. The physicians in this study recognized that they had little control and that frustrated them. These frustrations are increasing as quality control initiatives and evidenced based medicine (EBM) become more important in practice.

Though most physicians disagree with the quantification of patient outcomes and especially their being evaluated on this basis, it does present an opportunity for a paradigm shift. If those who educate physicians encourage new physicians to take on more of a leadership or coach mentality about patients with chronic illness, educating patients but also holding the patient accountable instead of holding themselves accountable, they may see the outcomes they desire. It may take decades for these types of changes to become systemic in the healthcare industry because both physicians and patients need to reevaluate their beliefs and expectations. This type of paradigm shift is actually taking place in an organization in Alaska. The transition began in 1999. In 2008 they report that they are seeing changes for the better. They have experienced
improvement in utilization, clinical quality, access, and both patient and staff satisfaction (Gottlieb, Sylvester & Eby, 2008). An empirical study of medical student and residents views of medical authority found that medical students enter medical school believing in an egalitarian relationship between patients and physicians. As they begin their clinical training this changes and eventually they see themselves in a more authoritarian role. It also was found that the culture of the medical school and residency program influences the level of physician authority that the resident physicians perceive (Lavin, Haug, Belgrave & Breslau, 1987). This suggests that the socialization and learning environment of medical school and residency develops this authoritative belief. The physicians in training become so accustomed to doing what they are told to do and seeing their attending physicians the ultimate in authority that they take on these values. This is reinforced when physicians enter practice and are held accountable for documentation and other risk management procedures in order to reduce liability. This is deeply imbedded in the culture of medicine, and though it may be beneficial for patients and the healthcare system to change, this is going to require an entire cultural paradigm shift which is not a simple endeavor.

The Power of Narratives

I explain the numerous reasons why I chose to use narrative analysis for this study in Chapter Three. At times, the process of constructing narratives was very difficult, especially when the participants were busy and I had to compel them into sharing just a bit more, but, the power of narrative and the privilege of allowing others to share their stories through my research made it all worthwhile. For “it is in the mutual exchange of
stories that professionals and scholars are able to meet clients and students where they actually live their lives” (Nash, 2004, p. 2).

**Maintaining Participants’ Voices**

The key word in the quote is “mutual.” I was fortunate because the participants of this study saw me as somewhat of an insider. When we were working together constructing their narratives, they would often ask me questions about my husband’s practice, my experiences as a wife of a physician, or even my children’s experience with a dad that is a doctor. They did not allow me to get to know them without them getting to know me. Having lived with a physician for sixteen years, I knew their language and understood their stories. Some of the participants trained at the hospital where my husband did his residency, and I could picture them in that space as they remembered events and told stories about them. This at times was also a detriment because they would say, “You know what I mean” and for the most part, I thought I did; but, I would have to ask them to explain it anyway, so that it could be said in their words not mine. As a result, the further I got into this process, the more I resisted diminishing their narratives to a few general themes. I think the narratives, and especially the stories within the narratives speak for themselves, which is why I conducted the analysis the way that I did.

**Narratives Reflecting Development**

Since this study focused on the organizational entry experiences of the participants and how they made meaning of those experiences and developed through them, it is important to revisit Rossiter’s (1999) conceptualization of development as narrative. She argues that development should be described from the inside as people
live it versus observed from the outside. The findings of this study strongly support her thesis. The participants survived a number of stages in their career development, but who they became during that process and how they made sense of the experiences is personal and reflected the four dimensions that Rossiter conceptualized. The four stages are contextual, interpretive, retrospective and temporal.

When we constructed their narratives, it was important to them that there was structure and it flowed in a linear fashion. There were times during discussions and interviews that participants would say, “Let’s back up” because they felt that additional background information needed to be added before a full understanding could be attained. They wanted to contextualize the stories they presented in their narratives. Because the participants’ narratives were tied to their individual contexts, they provided clarity as to the issues they, as individuals, were facing as they entered practice.

In the stories that composed their narratives, they did not describe events, they interpreted the events. They enjoyed taking a retrospective look at their lives and accomplishments. This was very meaningful for them. For many, it was the first time they looked back because most of their lives were spent looking forward toward the next milestone. Once they accomplished something, it was off to the next thing. There is also recognition of the temporal. One of the advantages of taking a hiatus from dissertation writing, especially when doing narrative work, is that the temporal nature of narrative becomes so evident. For some of the participants, it had been a full year from when they wrote their narrative until they saw my interpretation and analysis of it. While they did not give me much more than a cursory “looks good” or “thanks for sharing this with me” in terms of a member check validation of the work, they did share all of the things that
happened and how they have grown. Chris’s baby is a toddler now. Jacki is much more content with her schedule. Mariah has published an article in a prestigious medical journal and is much more comfortable in her role. Robert still has his choice of music in his office, but he has many more patients as well.

Implications for Practice

This study has implications for a number of educational contexts and for social science research using narrative analysis. In this section, implications for Adult Education and Medical Education are discussed. While there have been many studies in the field that utilize narrative analysis as a methodology, it is still rather ambiguous, especially when it comes to data collection and analysis. I took a rather unconventional approach in analysis in this study which both sheds light and raises more questions about using narrative analysis in social science research.

Implications for Adult Education and Medical Education

This study informs the fields of Adult Education and Medical Education in a number of ways. Because the implications for those three fields are often interconnected, they will be discussed together. The implications for narrative analysis are also discussed as this study demonstrates a unique way of constructing, analyzing and interpreting narrative research.

The Interweaving of Personal and Professional Development

First, the individual narratives presented in this study illustrate the connections between personal and professional development and how experiences in one arena of life affect the other. When discussing his own professional development, Singer (1982) states, “My experience of professional training was inextricably bound up with my own
adult development, which was itself interwoven with themes and residues from my early life” (P. 46). I think his statement would resonate with all of the participants of this study; their development as physicians was not an outcome of medical school, residency or their first practice experience. It is deeply rooted in those experiences along with their past and present personal experiences.

This is not a new idea for adult educators; it was discussed over fifteen years ago when Merriam and Clark (1991) wrote about patterns of work and love and how these patterns affect individuals internally in terms of their psychological development and externally in relationship to family and career. Yet, as researchers and practitioners we tend to separate the personal aspects of life from the professional side. When we think of career development or professional development and growth we still have the tendency to support the traditional “male” tournament model of career development which focuses on advancement and competition (Sullivan and Mainiero, 2008).

The participants in this study did not see professional advancement as their life goal. They were prepared to adapt their career aspirations in order to have a fulfilling personal life. Lily specifically mentioned this sharing that she did not desire to be a pediatric specialist, or a department chair; she was not willing to make the sacrifices that come along with it. This is consistent with an AAMC survey that found that US physicians under 50 of both genders see quality of life issues as very important and are willing to risk career advancement to attain it (Kirch, 2007).

The message of today’s physicians is similar to what we hear about today’s workforce in general; a balanced life is important. Thus, the connection between the personal and professional aspects of their lives is even more significant. Sullivan and
Mainiero (2008) suggest that conceptualizing careers using a model they call the Kaleidoscope Career Model (KCM) which builds in the recognition that careers may look different over the course of an individual’s lifespan will provide depth and understanding to the diverse motivations and constructions of careers. It also reflects a more intrinsic conceptualization of career success which includes authenticity, balance and challenge instead of advancement. The view of a successful career held by the participants in this study was much more reflective of these intrinsic factors. Unfortunately, this research and model are specifically focused on women’s careers, and should be studied and applied to be gender inclusive.

*Disclosing Multiple Career Paths*

Next, this study reveals how individuals who are thought to be deeply socialized in a professional identity still can approach their professional entry in many different ways. Also, they expect different things out of their careers. So, similar to most professionals, a setting that fits one individual may not fit another. The physicians in this study found a practice that met their interests and styles through luck or trial and error. They had little or no guidance from their residency programs in regard to career planning. The American College of Physicians provides an extensive on-line workshop for residents who are looking at their career options; but that does not appear to be enough.

Unfortunately, most graduating residents do not plan their future careers (Alguire, 2006). Also, most residency programs do not offer guidance on finding employment. They do not recognize the importance of organizational fit when they are committing to a practice. Dr. Gigi Hirsch, a physician turned career counselor, argues, “The culture of medicine can actually stunt professional growth because there is a lack of career guidance
throughout training, residency, and medical careers” (Proctor, 2000, p.3 ¶ 3). As a result 50%-60% of physicians end up changing jobs at least once during their first five years of practice (Alguire, 2006). The career planning of the participants in this study reflected this lack of guidance. This is what Mariah spoke about when she shared her frustration with the lack of transparency in the profession. In addition, those who planned their transition from residency to practice, Lily and Ricardo, had a much smoother transition than the others suggesting that there should be more emphasis on career planning during residency. This has significant implications for the healthcare industry that recognizes that it is becoming more difficult to recruit and retain primary care physicians (Valancy, 2007). It also reveals the importance of including career development seminars in professional education programs.

*Coping with the Changing Face of Medicine*

I think this study provides valuable insight for medical educators and healthcare administrators who are trying to make sense of what is labeled, “The Changing Face of Medicine.” This cultural shift within the profession and its implications for the future of the profession are continually being discussed, debated and surveyed. The AAMC now has an entire research organization that focuses on workforce issues and the research of this group is primarily aimed at understanding the new demographics and dynamics of the medical profession (Salsberg, 2006). Because most of the research is survey based, it often makes broad generalizations regarding nameless, faceless individuals. No wonder there is an “us” and “them” mentality within the profession.

Many administrators and decision makers within the profession may look at a qualitative study of nine physicians and think, “Now what can this tell me about
anything?” But if they take the time to listen to the voices of the participants, hopefully they will see the individual faces of the people who are the future of their profession.

The physicians who participated in this study are not numbers or statistics; they are committed professionals who feel called to be primary care doctors despite having their careers begin in a time when physicians do not have the respect, financial gain, and professional security that the generation before them experienced.

**Mentoring and Facilitating Relationships within the Profession**

One element of professional entry that is surprisingly absent from the narratives of the physicians in this study is the influence of mentors. Mariah shared about her feelings of loneliness and isolation; the others did not address it. They did recognize their medical school advisors as significant contributors to their specialty decisions, which is consistent with the literature. Aagaard and Hauer (2003, as cited in Sambunjak, Straus & Marušić, 2006) found that 98% of medical students chose their specialty as a result of their advisor’s recommendation and 78% chose their residency as a result of their advisor’s counsel. None of the studies in an extensive review of the literature on mentoring in medicine conducted by Sambunjak, Straus & Marušić (2006) focused on mentoring and relationships for clinicians. The studies focused on physicians in academic medicine, fellows and residents.

It is not surprising that clinicians have not been studied. It is also not surprising that the physicians in this study appreciated their professional autonomy and freedom to practice as they wish. Yet, the literature stresses the importance of relationships and mentors during transitional periods such as beginning a new occupation, entering a new organization or the transition from an academic setting to a work setting (Hallam &
Newton-Smith, 2006). Research suggests that informal mentoring relationships are often more effective than formal relationships because informal relationships are usually a result of a personal connection instead of an assigned responsibility (VanDerLinden, 2005), so the absence of a formal mentoring program is not as much of an issue as the absence of contact and feedback from others in their organizations. This lack of mentoring has implications for career satisfaction for entering physicians. But, it also may have long term implications in regard to physician disillusionment, burnout, and professional satisfaction; all of which were mentioned in the literature. It may also have an impact on patient care. Healthcare organizations and specifically those who are responsible for medical education and professional development can have an impact on this by providing informal ways for entering physicians to connect with one another.

**Implications for Narrative Research**

This study was informed by the numerous autobiographical memoirs and essays written and published about physicians’ experiences in medical school, residency and practice. I was captivated by the stories of their lives, and I wanted to do a research project that would emphasize their words and their lives, not my analysis. Unlike most dissertations that are written for a scholarly audience, primarily those in the field, I purposefully wrote Chapter Four for a broader audience. That chapter was designed to resonate with adult educators, medical educators, physicians and anyone in the general population that may be interested in physicians’ lives.

Barone (2007) poses a series of rhetorical questions about the audience of narrative research. In his discussion of the public educational system, he argues that it may be beneficial for parents, policy makers and other lay people to be exposed to the
issues that surface in scholarly research. I believe healthcare is in a similar situation. There is probably no industry in our economy that sparks more debate than healthcare. And similar to teachers, physicians are usually the people who get the bulk of the criticism. I think that purposefully constructing narratives that are analyzed in scholarly work, but can resonate with a larger audience is beneficial to advancing both scholarly understanding and providing a service to society as a whole. While patients, high school students interested in medical school, or even healthcare administrators may not be interested in the analysis of the narratives in relationship to theory or current literature, the narratives of these nine physicians may resonate with them and provide a deeper understanding of doctors and the healthcare system.

Secondly, I think that my approach to data analysis also contributes to the current body of research on narrative analysis. As I got to know the participants and we constructed their stories, I did not want to reduce the participants’ stories into themes. I did not want their stories to become a way for me to communicate my agenda. I was more than pleased to find that someone else shared my position. Hendry (2007) argues “My concern is and continues to be that analysis often becomes a mode for saying what we want to say and not really listening to what is being said” (p. 493). This is not to say that I think that the way researchers analyze qualitative data analysis is invalid; I believe narrative is different from other qualitative methods. It is about stories told by people not about uncovering a phenomenon.

In this study, the stories were developed into narratives. The narratives were not data, they were actual interpretations constructed by the participant and me. Thus, I did not think they should be analyzed in the same way that we analyze other qualitative data.
To me, these stories need to be engaged and respected as separate entities before I could draw out themes. If for no other reason, in becoming enmeshed in the participants’ story, you begin to understand them as individuals. Bochner (2001) argues that as researchers we are often so focused on making connections and formulating our opinions of qualitative data that we forget to listen to what individuals are saying. He explains that first we need to take time to understand the participants’ narratives or stories at face value before we try to read into them for a deeper meaning. This is difficult for me. I am always looking for a deeper meaning in what people say. As a psychologist, I was trained to think that way. It took a conscious effort for me to listen to the words of the participants first before I looked for a deeper meaning. I think co-constructing the narratives helped me do this and it allowed the participants voice to be preserved in the narrative.

Suggestions for Future Research

The significance of research is not only to gain a deeper understanding of something that you want to know more about, it also serves as a way of recognizing all you do not know. Because of the complicated nature of human beings, social science research often feels daunting. But, it is a process of building understanding a little at a time. This is why suggestions for future research are often as valuable as the research itself. Following are suggestions for future research.

Using Numerous Philosophical Lenses to Understand Physicians’ Entry Experiences

Using different philosophical or theoretical frameworks for this research would provide additional understanding of the multiple influences that affect physicians’ professional entry. This study used social constructivism and constructivist theories of
adult development as its philosophical framework. As a result data were collected and interpreted specifically looking at how participants constructed their careers and their beliefs about their profession informed by cultural-historical issues, their socio-cultural experiences and background, and the socio-cultural foundations of the profession. Collecting the data using a feminist post-structural framework, transformative learning framework, or even a critical perspective would result in very different findings. All of which are important in understanding the entry experiences of physicians.

For example, because primary care medicine is shifting from a male dominated profession to a profession which is now predominantly female dominated, a feminist post-structural framework could provide insight into the participants shifting identities in relationship to the social structures of the profession. This would be worthwhile in light of the findings of this study in regard to the participants’ perceptions of gender in relationship to their profession. Similarly, transformative learning would specifically address how the participants’ prior perceptions and worldview changed or stayed the same as they began their career. Critical theorists could study the perceptions and effects of the hegemonic practices, of which there are many, within the profession. Doing this would not only provide a deeper understanding of physicians’ entry experiences, it also would provide a wonderful learning model for teaching students the influence of theoretical/philosophical framework on qualitative research.

Longitudinal Research on Physicians Careers

Many of the studies that I found on physicians and medical students (for example: West 2001; Mizrahi, 1986; Balint, 1964) were longitudinal. The participants were followed over the course of three to five years. Ideally, this study could benefit from a
longitudinal perspective. Many of the participants were in their honeymoon stage of practice. Some were so happy to be finished residency and begin practice that they were not very interested in critiquing their experiences, they were just enjoying them. Others were still struggling for a foothold in their new profession making reflection difficult because they were just trying to survive. Following them over the course of several years would provide insight into how their perceptions of the careers and practices change over time. Since the literature suggests that many seasoned primary care physicians experience burnout, disillusionment and frustration (West, 2001; Murphy, 2002; Haig, 2007; Sloan, Rattliff & Hall, 2007) a longitudinal study may shed light on what events occur over time that result in these feelings.

Second Career Physicians’ Experiences

While medical school has not seen large increases in the number of individuals who took part in a previous career entering their corridors, according to medical school admission counselors, most medical schools do have a handful that enter on a yearly basis (Feldman, 2006). With the field of adult education’s rich research base in the area of non-traditional students, research on this specific population within the context of medical education could be well informed by the field. In return, it may also widen the contexts in which prior research can be used to inform practice.

In this study there were two participants for which medicine was their second career. They both recognized that their experiences in medical school and residency were altered because of their prior experiences. Sarah faced difficulty in her residency and training, not because she was not competent or diligent, but because it was so difficult for her to become an insider in the system. She did not have the social and informal learning
experiences of her peers because she did not have as much interaction with them. Also observed in the narratives of Sarah and Chris, is that their motivations once they entered their careers were a bit different. Because of their chronological ages, and the amount of time they spent in education and training, they entered practice thinking about retirement. Having to recoup the costs of medical school in an expedient way was important for them because they did not have the luxury of stretching it out over twenty to thirty years, which is what most beginning physicians are currently doing (AAMC Medical School Tuition and Young Physician Indebtedness, 2007).

Non-traditional medical students are a group that is often forgotten in the literature. There is a focus on the generational issues affecting medicine, but this usually means the differences between the beginning Generation X or Y physicians and the more established physicians. It does not recognize the non-traditional students who are entering medical school with them. An interesting question that arises from this is with whom does the non-traditional student identify? Though inconclusive, the findings of this study suggest that the non-traditional students’ values and perception of the profession were very consistent with their medical school peers and not the generation in which they were born. While Chris identified himself as a baby boomer, he also made a point of differentiating himself from the tenured physicians who are his age. So did Sarah. This would be an important observation to pursue in future research.

Research on Dual Profession Families in Medicine

One of the issues facing a number of the participants in this study was negotiating dual careers. Each of the dual career couples in this study managed it differently. There is a significant body of research regarding dual physician couples and the effect of dual
physician marriages/partnerships (for example: Archer, 2006; Kermode-Scott, 2004; Myers, 1994; Schrager, Kolan & Dottl, 2007); the effects of work-family interference on physicians (Montgomery, Panagopolou, & Benos, 2006); and general dual-career family work-life balance (for example: Bird & Schnurman- Crook, 2005, Hochschild 1989).

But, there has not been research on how these relationships affect physicians’ choices of initial practice site and professional entry experiences.

The physicians in this study reflect many of the physicians entering medicine in that they are married/partnered and have families before they enter their first practice. So, not only are they concerned with getting themselves acclimated to a new environment and new way of life, they have families that need to do this as well. Prior research suggests that this added dimension of family life puts strain on the physician and it ultimately affects the physician’s performance and focus on the job (Kermode-Scott, 2004; Montgomery, Panagopolou, & Benos, 2006). This is especially true for female physicians. Further research into how professional entry affects the family and how the family affects professional entry could provide valuable insight for Human Resource Practitioners and Healthcare Administrators who are responsible for employee policies and work arrangements.

Research Projects Focusing on Physicians Careers

This findings of this study present many exciting research opportunities in the fields of adult education, and medical education. This study could be replicated with different groups of people. Within medicine there are multiple specialty groups outside of primary care. In addition, it would be valuable to compare and contrast experiences across specialties. This could provide valuable information for medical educators and
others working in healthcare. From an adult education perspective this study can be replicated with different professions such as law, business and education.

The lack of career planning and career education for resident physicians entering practice was seen in the findings of this study and the literature. This provides a number of opportunities for action research projects with residents and medical students. Rather than researching about what education is not present or whether or not it is even necessary, an action research project where residents have on-going career planning seminars and career counseling could provide valuable insight into the necessity and salience of career planning prior to professional entry.

There are hundreds of autobiographies, poems and other literary works written by physicians to describe their lives and experiences. These works can serve as data for what Brookfield (2008) terms critical reflection in practice. Just as with narrative analysis, researchers can analyze the content of the autobiographies and other literary works for themes in structure and message. Though this is not the same as co-constructing a narrative for a specific research purpose, it does provide researchers with a wealth of data that would be difficult to collect using traditional interviews and qualitative data collection processes.

Final Reflections

In 2005-2006 when I first contemplated studying physicians’ careers, I had no idea of what the future would bring. I wanted to study something where I could be objective and not get too emotionally involved. I was trained in the scientific method and I prided myself in my ability to remain objective. It was a skill that was rewarded in
the past. But, it made understanding qualitative research a personal and professional growth experience.

As I grew to know the participants in this study and compared their experiences in relation to what I observed in my husband’s life and career as well as the lives and careers of his colleagues, the study became more personal and the work became multifaceted. I often had to challenge myself to question whether what I was finding in the study was a result of my experiences or what I was reporting of the participants’ experiences. In hindsight, I think it was a combination of both. From a constructivist perspective, just as the participants brought their background, experiences and culture to the writing table, so did I.

In the summer of 2007, I was hit head on with the subjective nature of qualitative research. My son became very ill and had emergency surgery, which ultimately saved his life. He had been in and out of the hospital for most of his life, but this time it was very different for me. This was in part due to the severity of his illness, but my new view was informed by my research. I gained a different level of understanding of physicians and their practices. At times, I was much more critical than usual. Other times, I was much more forgiving. I made sense of what I was experiencing in relationship to what I learned from the participants in the study. I shared my research with the physicians who were caring for my son and they often shared their experiences with me. I unofficially tested my findings by talking to nurses, physicians, and other hospital staff. I observed medical students and listened to their conversations while they were waiting for their coffee at Starbucks. I questioned why they were buying $4.00 cups of coffee when they were facing hundreds of thousands of dollars of debt from their training. I devalued my
study thinking it just did not matter; in my mind comparing it to child’s plastic boat that sails in a bathtub, attempting to be noticed by someone sitting on the deck of a Titanic sized cruise ship known as the U.S. healthcare system. In the end, I realized that these nine narratives are important, and should be heard. The words I placed around their stories, and how I analyzed them in light of the literature, pales in comparison to what we learned together while writing their narratives.

A few days ago, as I was waiting to see one of my son’s many physicians, I realized that he is not only an eye surgeon, who, while in the OR, holds the future of my son’s vision, he is also a person. As he finished the exam, I asked him who completed all of the jigsaw puzzles displayed on the walls of his office. He explained that his wife started doing puzzles when he was a resident because he was always at the hospital. As he reminisced, I realized that the puzzles were much more than decorations; they were symbols of his wife’s commitment to him and his career. Shortly after that visit, while reviewing the findings of this study, it came to me. While this study informs the research in adult education, it also can be beneficial for the general public to see past the white coat and the credentials. If we expect physicians to treat us from a holistic perspective and see us as people, not just cases; we need to make the effort to do the same. Hopefully, the narratives that comprise this study will encourage others, both within and outside the profession, to see the medical profession in a new light.
References


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APPENDIX A

Informed Consent

Informed Consent Form for Social Science Research

Title of Project:  Beginning a Career as a Primary Care Physician: A Narrative Analysis

Principal Investigator:  Patricia M. Thompson
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1. **Purpose of the Study:** The purpose of this research to better understand how primary care physicians, beginning their careers, develop as professionals by recording their experiences during their first 3 to 4 months working in health care organizations after graduating from residency. Individuals participating in the study will be interviewed about their organizational entry experience.

2. **Procedures to be followed:** You will be interviewed at least once and possibly twice to record your experiences. The interview will focus on both your expectations and your entry experiences. In addition, you will be asked why you chose the position, and baseline demographic information such as: college and medical school you attended, why you decided to become a primary care physician. You also will complete a basic demographic questionnaire. You will be asked to reflect upon your entry to the profession after residency and journal your experiences. The journal is for your benefit and reflection and will not be part of the research unless you discuss it during the final interview. Each interview will take approximately one hour.

Pending your permission, the interviews will be audio-taped and transcribed. The researcher will be transcribing your interviews and confidentiality will be maintained at all times. You will have an opportunity to review the transcript. At any time you can withdraw any/all of your information from the study. Please choose one option, shown below, by marking it with an “X.”
I give my permission to be audio taped.

I DO NOT give my permission to be audio taped.

The researcher will be available to participants by phone at 717-497-8056 and/or email at pmt125@psu.edu to answer questions or address participant concerns.

3. **Discomforts and Risks:** There are no known risks in participating in this research beyond those experienced in everyday life. You may refuse to answer any question posed to you and/or end an interview at any time. You may withdraw from the study at any time.

4. **Benefits:** You might learn more about yourself by participating in this study. You might have a better understanding about how you balance your organizational, professional and personal life. You might realize that others have had similar experiences as you have.

This research might provide a better understanding what occurred in the individual physicians’ lives as they entered organizations, and began their careers after residency training. Though the study is qualitative and not generalizable, it might facilitate health care organizations, primary care residency training programs and beginning physicians in better understanding what occurs during these crucial first few months of practice.

5. **Duration:** The interviews will take approximately forty five minutes to one hour. You will be asked to reflect and independently record your thoughts and reflections regarding your organizational/professional entry experiences in any manner you choose. In addition, you will be given a copy of your interview transcripts for your approval. You may remove any or all of your information at any time.

6. **Statement of Confidentiality:** Your participation in this research is confidential. Only the researcher in charge and her advisor, will know your identity. The data will be stored and secured at the researcher’s home in a locked filing cabinet and on a password protected computer file. All audio tapes/transcripts will be kept in a locked filing cabinet in the researcher’s home for 5 years. After 5 years the tapes will be destroyed. The following may review and copy records related to this research: The Office of Human Research Protections in the U.S. Department of Health and Human Services, Penn State University’s Social Science Institutional Review Board, and Penn State University’s Office of Research Protections. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

7. **Internet Confidentiality:** Because you may communicate with the investigator via email, please be aware that all electronic communication will be secured through password protected access. Your confidentiality will be kept to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet by any third parties. Finally, please note that investigators are obligated by ethical standards to report to the appropriate agencies any communication regarding illegal activities, suicidal ideation, or concerns for a child’s well-being communicated during the research.

8. **Right to Ask Questions:** You can ask questions about this research. Contact either Patricia Thompson at (717)-497-8056, the primary investigator, or her research advisor,
Patricia Cranton at 717-948-6405, with questions. You can also call this number if you have complaints or concerns about this research. If you have questions about your rights as a research participant, or you have concerns or general questions about the research, contact Penn State University’s Office for Research Protections at (814) 865-1775. You may also call this number if you cannot reach the research team or wish to talk to someone else.

9. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below. You will be given a copy of this signed and dated consent for your records.

______________________________________________  _______________
Participant Signature       Date

______________________________________________  _______________
Person Obtaining Consent      Date
Yes, I am interested in participating in the research study: “Beginning a Career as a Primary Care Physician: A Narrative Analysis”

My contact information is as follows:

Name: ________________________________________________________________

Current Address and Phone Number:

Future Address and Phone Number:

Email address: _________________________________________________________

Signature and Date: ___________________________________________________
APPENDIX C

PARTICIPANT BIOGRAPHICAL DATA

Thank you for agreeing to participate in this study. Please complete the following biographical sketch prior to our meeting.

Name: ________________________________

Age: ________________________________

Gender: ________________________________

Marital Status: Married, Engaged, Single, Partnered, Other, Not Willing to Disclose

Number of Children: _____________________________

Age: ______________

Gender:____________

Undergraduate College/University Attended: _______________________________

When? ____________________________________________ ____________

Medical School Attended: ______________________________________________

When? ____________________________________________ ____________

Other Graduate Education: ______________________________________________

Residency Program Attended: ___________________________________________

Graduation Date: _________________

Employing Organizations (including City/State): _____________________________

Start Date: ____________________________________________________________________
APPENDIX D

QUESTIONS FOR REFLECTION

Sample questions (to prepare for the interview):

1. What is your career history/progression and why you chose to be a primary care physician?
2. What messages are co-workers providing about the organization, expectations, and medical careers within the organization?
3. What were your reactions to these messages?
4. What strategies are you using to balance your work life and your life outside of work? How effective is this? What is working well and what would you like to change?
5. How is your position similar to what you expected prior to entering the organization? How is it different?
6. What critical incidents or defining moments occurred during your first few months of work?
7. After so many years of school and training – what is it like to finally be working as a professional?
8. What strategies do you use to manage the organizational demands and your professional responsibilities?
9. Practicing medicine in the 21st century is like……
10. If there is one thing I could change about my employing organization it would be….
11. If there is one thing I could change about the medical profession it would be…
12. Lessons learned through experience:
APPENDIX E

INTERVIEW GUIDE

Participant: ____________________________________________

First Meeting:  Review Biographical Sketch
Questions:
  1. What question on the reflection question list struck you the most? Why? Please tell me about that?
  2. Tell me about how and why you pursued a career in medicine? How did you get to where you are today?
  3. Tell me about an event that was significant to you as you began your career?
  4. Tell me more about your responses to the reflection questions?
  5. What was it like beginning your career at your organization? How is it now?
  6. Tell me about a day in your life?
  7. What have you learned about yourself and being a doctor?
  8. You talked about a number of things (review notes with participant) what important messages do you want to convey?

Second Meeting/Discussion:  Review transcript

Third Meeting/Discussion:  Review narrative and reflect on the process
Vita

Patricia M. Thompson

Education
D.Ed., Adult Education (ABD), Penn State University – Harrisburg. 2008
  Dissertation (Chair: Patricia Cranton): Professional Entry Experiences of Primary Care Physicians: A Narrative Inquiry
  Thesis (Chair: Robert Midkiff): Predicting Managerial Success through Personality Characteristics: An Empirical Study of Current Assessment Instruments
BS, Quantitative Business Analysis. Penn State University, University Park, PA. 1986.

Professional Experience
Editorial Associate. Adult Education Quarterly, Penn State – Harrisburg; March 2006 to present.

Graduate Assistant. Department of Behavioral Sciences and Education, Adult Education Program, Penn State – Harrisburg; August 2004 to May 2006.


Refereed Articles and Presentations


