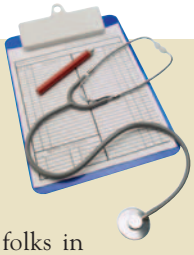
CLINICAL OBSERVATION



In this section, we highlight the human side of clinical academic medicine, putting a few questions to a physician at DMS-DHMC.

Patricia Glowa, M.D.
Assistant Professor of Community and Family Medicine
Glowa, who's been at Dartmouth since 1995, was named Family Physician of the Year in 2005 by the New Hampshire Academy of Family Physicians. She specializes in women's and children's health and child sexual-abuse evaluations.

How did you decide to become a doctor?
After leaving school halfway through my bachelor's in English, I was working in New York and got the flu—genuine, sick-for-a-week flu. I found myself thinking about medicine. I had always enjoyed science and math and wanted to be in a helping profession, but it had never crossed my mind before to consider medicine—which I think was part of the gender legacy at the time.

When did you choose family medicine?
When I was at Harvard Medical School—which is the farthest thing from a proponent of family medicine one can imagine. My image of medicine was my family doctor from childhood in Springfield, Vt. When I spent a rotation with a family doc in Gardner, Mass., it became clear that was what I wanted to do. And when I went to Rochester, N.Y., for residency, the program director was my childhood family doctor!

Are there any misconceptions that you find people have about family medicine?
Primary care, and family medicine in particular, tend to be at the bottom of the medical hierarchy in terms of respect. In family medicine, you have to stay competent with a very wide variety of medical issues. There are some particular skills required in family medicine, such as learning your limits, coping with uncertainty, and navigating the boundaries of almost all the specialties. It is a complex job. I think a lot of other folks in medicine don't quite get some of the complexities and so don't give us credit for what we do.

What advice would you give to a medical student who is considering family medicine?
Figure out if you enjoy a good deal of what family docs do. If there are a variety of things you enjoy that only partially mesh with another field, maybe you want to be a family doc.

What have been the most fulfilling aspects of your career?
I love obstetrics. Obstetricians take care of people during pregnancy and delivery, and pediatricians pick up the babies afterwards; I get to do both. I also enjoy some things nobody else likes to do, such as child sexual-abuse evaluations. It's high emotional intensity and has high potential for burnout, but I really enjoy being able to do that work—helping kids have nontraumatic exams after they have been in terrible circumstances and advocating for child health.

How do you avoid getting burned out on that work?
Because it's only a part of what I do.

What about you do you think would surprise most people?
I'm a mildly obsessed amateur potter. And, as Garrison Keillor puts it, I am a recovering shy person. I don't present as being particularly reserved, but I'm pretty introverted really.

What bores you?
I don't do things that are boring. I don't have time. I can't remember being bored in a very, very long time.

Not even doing paperwork?
Oh, that's aggravating. That's not boring. It's got to be done. I plow my way through it. Most of it requires some thought process.

Is there a famous person, living or dead, whom you would like to meet or spend a day with?
Probably one or more of the early suffragists.

Putting relationships at the center of medical education

It sure wasn't your run-of-the-mill, speaker-at-a-lectern professional meeting. As the official program got under way, deans and faculty members from nine medical schools engaged in animated conversation, told stories, shared their feelings, and got to know each other—and themselves—a lot better. They also learned how to practice "appreciative inquiry" by framing questions in positive rather than negative terms.

Concept: The attendees had been invited to Indiana University School of Medicine for what was billed as an immersion conference on relationship-centered care (RCC). An outgrowth of a movement known as patient-centered care, RCC expands on that concept. Its basic premise is that patient care is affected by a physician's relationships not only with patients and their families, but also with other health-care professionals and with the community at large.

Medical students learn how to conduct themselves in an organizational culture largely by means of what's come to be called the "hidden curriculum"—the attitudes and values that get transmitted outside official classes. Dartmouth's Dr. Joseph O'Donnell, senior advising dean at DMS and one of the attendees at the conference, wants to shed a lot more light on the process. He sees a gulf between what students are taught officially about