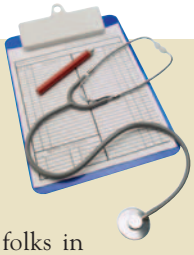
CLINICAL OBSERVATION



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

ON TARGET: Dr. Edward Merrens, chief of hospital medicine at DHMC, got to tour Turin as a physician for the U.S. Olympic biathlon team. Biathlon is cross-country skiing combined with rifle sharpshooting; Merrens was a cross-country skier in college.

MARK WASHBURN

Joe O'Donnell, left, has recruited especially articulate patients like Holly Field, right, to talk with medical students, as one of many ways to help them realize the power of relationships.

professionalism, human values, and conduct and what they actually see and learn in the medical setting.

The conference came on the heels of DMS's preparations for a reaccreditation site visit last year, in which all aspects of medical education were evaluated.

Lack: The School had learned from a student-run survey that below the surface, students feel surprisingly high levels of loneliness, isolation, and inadequacy and a lack of approachable role models. DMS is known for having a collegial and supportive atmosphere and a humanistic faculty and student body, so administrators were surprised by these findings. O'Donnell was determined to respond—to become "the best in the world" at caring for those who study and work within its walls.

Students say they don't know "who to go to," says O'Donnell. "There's no place for them to show vulnerability." This is not unusual for medical students at other schools, but O'Donnell knew Dartmouth could do better.

The meeting in Indiana could have been called a physician-heal-thyself session, since one precept of RCC is that caregivers need to themselves experience self-knowledge, appreciation, a sense of belonging, and values in their own lives before they can transmit these qualities to students, each other, and their patients.

The DMS team brought to the meeting ideas gleaned from many years of experience working with students. Those who joined O'Donnell in Indiana were Dr. Lori Arviso Alvord, associate dean of student and multicultural affairs at DMS; Sue Ann Hennessy, assistant dean of student affairs at DMS; Tommy Woon, associate dean of pluralism and leadership at Dartmouth College; and Dr. Nan Cochran, an associate professor of medicine who has worked on RCC efforts with O'Donnell.

The challenge of implementing RCC is a huge one, yet success is measured in small, human ways. The DMS team returned to campus with ideas they hope to implement soon. They range from the broad and formal—for example, to get the whole School to adopt the values of RCC—to the informal and personal—to show joy in their work, to show empathy everywhere, to know each other better, to say thank you.

The team has decided to use three new student societies, formed to foster cooperation across all four years, to carry the RCC message. O'Donnell and the other mentors of these societies hope that will give students the "feel-safe place" they lacked.

"Bringing RCC into the societies," O'Donnell says, "brings more connectedness to each other and to the School. . . . We've got our feet in the water, but we have to go a little deeper."

Lessons: Armed with stories, poems, and life lessons, the Indiana conferees summed up their experiences by writing about the difference this unusual conference had made in their commitments to each other and to their profession.

One wrote this: "I sat and looked at the microphone at the end of the meeting, flooded with thoughts and feelings. Joe just used the word 'ripple waves' as I felt this flood. Tom talked about bringing our whole self into life and our work life. . . . I have been a reflective and emotional person, I guess forever. In my professional life I have adopted a 'quiet' life. . . . Often I tell myself I am satisfied with my quiet accomplishments, but in some ways the concept over the past few days has made me realize that I can take my 'quiet' skills and inject them into the culture of medicine . . . take the risk and hope that I can leave an impact that will be 'heard.'"

ROSEMARY LUNARDINI

THEN & NOW

A reminder of the pace of change, and of timeless truths, from the Spring 1986 issue of this magazine:

Dr. Ross McIntyre, then director of Dartmouth's Norris Cotton Cancer Center, wrote about a 1985 visit to the Soviet Union: "I learned that there were more than twice as many hospital beds per capita in the U.S.S.R. as in the United States . . . but that the percentage of the gross national product devoted to health was about one-fifth that of this country. The apparent discrepancies in statistics were resolved by the comment made by one observer that hospitals in the Soviet Union were 'dormitories' for people who didn't feel well."

Today, Russia spends 6.2% of its gross domestic product on health care, compared to 14.6% in the United States.