REFLECTION

Three Thirty-Two AM: My Last Call

Sarina B. Schrager, MD

University of Wisconsin, Madison, Wisconsin

ABSTRACT

In this essay, I describe my last overnight call as I transitioned out of practicing obstetrics. I was worried that by giving up doing inpatient medicine and practicing obstetrics, I would lose my identity as a family physician. I realized that I can embody the core values of a family physician, including generalism and patient centeredness, in the office as well as in the hospital. Family physicians can stay true to their historical values even while giving up inpatient medicine and obstetric care by remembering that it is not only what we do, but how we do it that is important.

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I hung up the phone at 3:32 AM. As calls go, it was relatively routine. The resident was calling to tell me about a woman she was sending home from triage because she was not in labor. In retrospect though, this call was momentous to me. It was possibly the last middle-of-the-night phone call about a patient situation that I would ever experience. At 7 AM that morning, the last overnight call of my career was over. I was not going deliver another baby. I was not going to see another patient in the hospital. I lay back in bed that night after talking to the resident and had a hard time falling back to sleep. My stomach churned and my heart pounded as I wondered if I was making a mistake. Would I be a "real" doctor if I wasn't on call or taking care of patients in the hospital? Some of my most fulfilling moments as a physician have come in the middle of the night, after a long labor, when I hear a newborn cry at the same time as everyone in the room has tears in their eyes. Being present during such an important moment in a family's life has helped me create lifelong bonds with women in my practice. I have also treasured the intense time bonding with residents, talking for hours about their hopes and dreams. With a lurch, these experiences were coming to a close. And I wondered, after 27 years of practicing obstetrics, would I keep my identity as a family physician?

These questions continue to go unanswered even several months after my last call. I have worked in an academic setting at a residency clinic my whole career, where full-spectrum family medicine has included some type of inpatient care: medicine, obstetrics, or both. But I know that is not the norm for family physicians around the country. Estimates suggest that less than 15% of new graduates of family medicine residencies practice obstetrics.[1] I witness residents graduate each year choosing to work exclusively in urgent care, as a hospitalist, or do solely outpatient medicine. Part of me has always judged them, thinking that they are not practicing everything that we have taught them. Personally, though, I can now understand the desire to be available and present with both your patients and with your family. Limiting my practice scope will enable me, during this stage of my life, to balance responsibilities of young adult children and aging parents. As I have taken on more research and editing responsibilities, I realized that I, too, needed to contract my scope of clinical practice in order to maintain my work/life equilibrium. For several months before this last call, I had found that the balance between joy and stress while taking obstetrics calls had been changing. I was feeling more stress and less joy. It was time to make a change.

Such a choice brings up some challenging questions. What about generalism? What about seeing patients in all settings, from cradle to grave? Does limiting our practice threaten our specialty? According to Barbara Starfield's 4 C's of primary care[2] (first contact, continuity, comprehensiveness, and coordination), family physicians can practice generalism in a variety of settings and in different ways.

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CORRESPONDING AUTHOR

Sarina B. Schrager
University of Wisconsin
Family Medicine
1100 Delaplaine Ct
Madison, Wisconsin 53715
sbschrag@wisc.edu

Generalism, in its literal sense, speaks to scope of practice, but in a more figurative sense, it can also refer to a broad approach to patient care. Paul Genberg, in an essay in a business magazine about generalism stated, "All knowledge builds on itself, and the generalist takes his suitcase packed full of wide-ranging experience with him wherever he goes, offering companies a tremendous amount of value."[3] Family physicians bring their unique view of the medical landscape and the comprehensiveness of their training to any patient care situation they face. It is that broad experience that underscores the role of family medicine as "counterculture."[4] In his groundbreaking essay about what makes family physicians different than other clinicians, Gayle Stephens, MD, describes how family doctors treat people, not diseases, welcome all patients into our offices, and work to improve health of communities.[4]

What makes a family physician? Is it what we do or how we do it that matters? I chose family medicine because I value taking care of all members of each family. It felt fundamentally wrong during my obstetrics rotation as a medical student that we handed the baby over to the pediatrician. I felt a sense of loss when I was no longer part of the care team that was treating the maternal-child dyad. The sanctity of that maternal-child bond has kept me practicing obstetrics my entire career. The feeling of "rightness" that I experience when seeing multiple generations of a family embodies to me what family medicine is at its core. At a recent well-child check for an 11-year-old girl, I was able to talk to her mother about her worries about her own mother (I take care of 3 generations of their family), and we came up with a plan to help her not transfer her anxiety to her young daughter. That all happened in a 25-minute visit.

We are patient centered, family centered, and community centered. We see people in the context of their daily lives, not as medical problems. And that can be done no matter the setting. I can practice that type of care in any locale. I have trained hundreds of family medicine residents over the past 25 years and I hope that regardless of the setting in which they choose to practice, whether it be as a hospitalist, as an outpatient doctor, or at urgent care, they come to every patient visit with the same comprehensive and patient-centered attitude toward their patient.

I have to admit that I do not miss being in the hospital. In some ways, I feel relief to be absolved of so much responsibility. I am actually working more total hours, but in different ways.

This practice change is so new that I cannot fully comprehend how it will ultimately change me. But I will keep my commitment to patient-centered care, focus on the context of care, and on empowering patients to make healthy decisions. As I continue in my role as an outpatient family physician, I will strive to embody those principles and continue to train residents and medical students in the foundational values of family medicine.

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