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Journal of Medical Education and Training

Editorial Open Access

A Tale of Two Doctors

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Received: 30 December 2020; **Accepted:** 13 January 2021; **Published:** 15 January 2021

Editorial

"*The mediocre teacher tells. The good teacher explains. The superior teacher demonstrates. The great teacher inspires.*"

William Ward, 1921-1994, American Writer

All students want to emulate, in some way, their teachers and mentors. As a fellow just starting a career in infectious diseases, it is fair to say that AW was more than just a mentor and inspiration; he was a legend. I am fairly certainly that all of us fellows felt the same; he was the epitome of the successful and beloved academic physician. On the wall outside our shared office were neatly ordered pictures of the last 25 years of ID faculty and fellows standing on the granite steps of our esteemed institution; in all of them, AW looks the same, with pure white hair and a welcoming smile, almost timeless. His academic contributions were numerous, including seminal work on endocarditis and *Staphylococcus aureus*; his visiting professorships many; and his capacity as a clinician unmatched. In case conferences he would not just speak from experience, but from memory provide detailed reviews of pertinent manuscripts, sorted by author, journal, and year, as if he had just read them. We fellows always looked on in awe and would pantomime to each other *why can't we do that?* More importantly, he was simply the nicest person; faculty told stories of him wheeling patients out of the emergency department and into his clinic just to save them the wait; he once told me "never miss an opportunity to be nice." I wanted to be like AW; everyone wanted to be like AW. He was a living legend and a giant in the field.

After fellowship, I took a job at an academic center in a rural state, and much of my time was spent at an even more rural community hospital 90 minutes and a ferry ride away. The community this hospital served was rural and poor, with a median per capita annual income just above $17,000. Although fairly large at 300 beds, it had few specialists and it sometimes took several days to complete simple procedures. The hospital permanently kept alpacas on the grounds to entertain patients and children. To say it was a change in pace and mindset is an understatement, and in my narrow, academic-centric mentality the last thing I expected to find was an inspiring physician. KC, though, changed my mind on what it means to be a successful physician. He was the local Infectious Diseases physician and committed to remaining so.

Likely very few people know KC; he publishes rarely, does not sit on national guideline committees, and has not been invited anywhere to be a visiting professor. KC just takes care of patients; and by that I mean to say he is dedicated to his patients in a way I rarely saw in academia. He did all the inpatient consults, all the ID clinic, and ran antibiotic stewardship and infection control. He could spend hours on a consult, making sure everything was just right, fighting to make sure his patients got the best, most evidenced-based care possible in a system where that was not always the default. In an effort to get one patient a medication approved, he once made a dozen phone calls, wrote four appeal letters, and when that all failed called a judge (which ultimately worked). When the COVID-19 pandemic came, he immediately volunteered to work as an intensivist in the MICU. In an under-resourced rural setting where it so often seemed challenging to get anything done, KC was the glue that held his patients together. No one else was doing this work.

All of us fellows wanted to be like AW, but no one talked about the glory of a career in the community. Why is that? Community specialists often make more money [1]. Perhaps the long hours steer our millennial generation away from community careers [2], though lifestyle concerns are a frequently cited reason to avoid academics [3,4]. Literature exploring why physicians seek academic versus community careers tend to view the latter as a negative outcome [5,6]. There seems to be a pervasive perception that community careers are less worthwhile and less esteemed than academic ones. As Dr. Tait Shanafelt wrote, "A message that academic careers are 'more prestigious' or 'a better use of talent' may be subtly or overtly implied" during training [7]. This begs the question: what is wrong with just taking care of patients? For KC, patient care was the end-all and be-all, and I found myself astounded that that simple career goal was not presented more generously in academic training. We venerate our stellar academic physicians, and certainly they are deserving. But where is the celebration of the hard working community provider in under resourced settings, in the trenches doing work that few others would accept? If we are to get our healthcare system back on track and serve patients everywhere, we are going to need a lot more physicians like KC. Should we not praise and hold them in high regard then?

Several proposals may help; graduate medical education training programs could conscientiously develop relationships with community providers interested in offering mentorship, as well as invite them to share career experiences and advice. Rotations outside of academic medical centers and within community settings may provide a helpful lens for trainees to consider similar paths. National professional organizations could create career awards to recognize outstanding community providers from underserved regions. And perhaps most importantly, we in academics should encourage our trainees to take a serious look at community careers, with a sense of service and placing help where help is needed.

There are many ways to forge a successful career in medicine. AW deserves all he has accomplished and achieved and will always be a legend. KC is similarly deserving of admiration, and bringing balance to where we see value and esteem in medicine will benefit our field, our patients, and our trainees.

References

1. Tsoi M, Teitge BD, Madan CR, Francescutti LH. Personal values influencing career path in academic medicine: Perspectives of selected Canadian trainees. F1000Res. 2016; 5:1903.
2. Borges NJ, Manuel RS, Elam CL, Jones BJ. Differences in motives between Millennial and Generation X medical students. Med Educ. 2010; 44:570-6.
3. Borges NJ, Navarro AM, Grover A, Hoban JD. How, when, and why do physicians choose careers in academic medicine? A literature review. Acad Med. 2010; 85:680-6.
4. Marshall AL, Dyrbye LN, Shanafelt TD, Sinsky CA, Satele D, Trockel M, et al. Disparities in Burnout and Satisfaction with Work-Life Integration in U.S. Physicians By Gender and Practice Setting. Acad Med. 2020.
5. Horn L, Koehler E, Gilbert J, Johnson DH. Factors Associated eith the Career Choices of Hematology and Medical Oncology Fellows Trained at Academic Institutions in the United States. Journal of Clinical Oncology. 2011; 29:3932-8.
6. Oxentenko AS, Pardi DS, Schmoll JA, Gores GJ. Factors predicting initial career choices in gastroenterology fellows. J Clin Gastroenterol. 2007; 41:445-50.
7. Shanafelt T, Chung H, White H, Lyckholm LJ. Shaping your career to maximize personal satisfaction in the practice of oncology. J Clin Oncol. 2006; 24:4020-6.