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Qualitative Research in Medicine & Healthcare 2017; volume 1:1-5

Finding myself in medicine

Erin Nissen Castelloe

Private Pharmaceutical Medicine Consultant, San Diego, CA, USA

ABSTRACT

In this article (part one of a two-article piece), I, Erin Nissen Castelloe, a woman who has worked almost twenty years as a doctor, first in the practice of Family Medicine and later as a Pharmaceutical Medicine consultant, ponder the next phase of my career. In an attempt to understand myself and my experiences in medicine – and to connect with others who may share my belief that medicine (and those who practice it) must evolve in order to empower and serve – I share my personal story: the influences and idealism that led me to medicine; the best career advice I ever received (from a patient, not a doctor); my past and present frustrations with clinical medicine; my struggles to balance my personal and professional aspirations; my growing dissatisfaction with a career in Pharmaceutical Medicine; and, ultimately, my attempts to collect, sow, and cultivate ideas that may – nurtured with tinctures of time and collaboration – become strong, new branches on the magnificent tree of medicine.

Introduction

When I let go of what I am, I become what I might be.
Lao Tzu

Always go with your passions.
Never ask yourself if it's realistic or not.
Deepak Chopra

Correspondence: Erin Nissen Castelloe, Private Pharmaceutical Medicine Consultant, 12594 Kestrel Street, 92129 San Diego, CA, USA.
Tel: +1.858.3546441.
Email: erin.castelloe@gmail.com; erin@castelloe.org

Acknowledgements: Anthony William Fox, MD, PhD.

Contributions: Erin Nissen Castelloe wrote and submitted this article.

Conflict of interest: Erin Nissen Castelloe works as a paid pharmaceutical medicine consultant to several drug-development companies; she does not own or accept stock (or stock options) from any drug-development company for which she works. Erin Nissen Castelloe also works in health education and *pro bono* patient advocacy.

Key words: Medical careers; Individualized medicine; Tree of medicine.

Received for publication: 21 September 2016.
Revision received: 8 December 2016.
Accepted for publication: 12 December 2016.

Qualitative Research in Medicine & Healthcare 2017; 1:1-5
doi:10.4081/qrmh.2017.6301

Medicine is a tree with many branches, and a career in medicine can be spent microscopically examining the cells of one slender stem; or, climbing from branch to branch. My career has been more of a branch-to-branch affair, and I still haven't found a truly comfortable perch. Perhaps that is because I haven't settled firmly into my own skin; or, perhaps that is because I haven't reconciled what I thought medicine would be with what it is; or, perhaps it is because I need to nurture a new branch of this magnificent tree.

Materials and Methods

In this piece, in an attempt to understand my past and blaze a meaningful future, I analyze my path to and through Family and Pharmaceutical Medicine, to the crossroads at which I now stand.

Results and Discussion

I don't know how I chose to lean my ladder against the tree of medicine. There were no doctors, nurses, or other medical types in my family; we didn't even have a veterinarian. What we did have were farmers (lots), a teacher, and a farmer-turned-preacher. Yet, I announced – from the age of five – that I was going to be a doctor. What did I think a doctor was? How did I reach those conclusions? Observations of my own doctors (with whom I, a healthy child, had very little contact)? Skits on Sesame Street? My early experiences with injuries and blood?

Farms are certainly not safe or bloodless places. My mom's cousin lost an arm in a farming accident and wore a prosthesis with a hook (which I found endlessly fascinating and admired as surreptitiously as possible at family gatherings). When I was three, my older brother got his pant-leg caught in the power-take-off of a tractor. As

he lay on the grass alongside our gravel driveway, waiting for my father to bring the pick-up truck that would haul him to the hospital, he must have been screaming, but I don't recall any sound. Instead, I see crimson blood spreading across the bright-white, cloth diapers held over his wound; seeping under and around my mother's white-knuckled fingers. When I was four, my father crushed his big toe with a jack-hammer while breaking up a cement feed-lot. I'm not sure if I actually remember helping him change his bandages, or if I have manufactured memories from his repeated telling of the story; but whenever I think about it, I smell salve, feel rough gauze, and see flashes of his mangled toe – with bruised blackish-purple skin and excoriated-pink flesh peeled away from shiny white bone. Did these early experiences lead me to medicine? Perhaps. What I do know – without a doubt – is what fueled my climb: praise from teachers, professors, family, and community members, encouraging a little girl to follow her passions, to stretch and reach the next rung of her ladder.

Twenty-one years ago, accepted into the MD/PhD program at the University of Minnesota Medical School, I climbed with vigor and confidence toward a career in Gynecologic Oncology. I was idealistic and passionate. With the naiveté of inexperience on my side, I vowed that ovarian cancer's death-dealing days were numbered. I plunged into my studies and my research, dividing my time between lecture halls, the library, and the pharmacology department, where I diligently injected human ovarian cancer cells into T-cell-deficient mice so that I could study the efficacy of novel treatments. My mentor's laboratory was engineering *magic bullets*, monoclonal antibodies designed to deliver poisons selectively to ovarian cancer cells, sparing normal tissues. I was on fire with the idea of the work and its potential. But, I love animals; even inbred, hairless, T-cell-deficient rodents were not exempt from my love. And, as I watched the ovarian cancer cells – cells that I had injected – swell once-small, soft, pink bellies to grotesque, translucent balloons decorated with blue veins and shiny, black patches of necrosis, my dread for the lab grew. Even when one of the treatments showed great promise, my conscience gnawed at me, and my passion for the work waned. Around the same time, several gynecologic oncologists – with personalities as malignant as the diseases they treated – rotated through the lab. I began to question. Shouldn't I enjoy my daily work? Shouldn't I like (at least most of) my colleagues? Am I climbing toward the right branch of medicine?

Ultimately, I left the laboratory, relinquished my position in the MD/PhD program, and dedicated myself fully to clinical medicine. I was still committed to the tree of medicine; I just didn't know which branch. So, for the time being, I propped my ladder against its broad, sturdy trunk and explored its branches, one clinical rotation at a time. I approached each new rotation with the same objectives: learn as much as possible and figure out if *this* is how I want to spend my life. I got my best career advice from a patient I'll call Kay.

The nature and number of Kay's conditions meant that she was hospitalized on the Internal Medicine ward for almost six weeks, and I was assigned to round on her every day. I enjoyed seeing her so much on rounds that I got in the habit of sitting with her every afternoon, before I left the hospital for the day. She seemed to enjoy the company – at least, she didn't seem to be in a hurry to kick me out – and it was definitely the best part of my day. It was Kay who showed me that illness can disrupt or interrupt your life, but it doesn't have to define you. Sometimes, I would find her, reading glasses on the tip of her nose, perusing paperwork for the business she owned. Once she could walk without assistance, she would coil her feeding tubes, stuff them into her backpack, and push her IV pole so that she could walk around and around the ward, gaining strength with each lap. Just before she was discharged – in a show of faith, I think – she stopped wearing a hospital gown. Interestingly, the simple change in her attire made me realize that, albeit unconsciously, I had reduced Kay to her role as patient, just as I had reduced myself to the role of medical student.

After working so hard to get into the MD/PhD program, only to realize that it was not the right fit for me, I was giving everything to the one role I had left. I believed that, if I spent more hours at the hospital, read more medical literature, aced every exam, and simply gave medicine my all, the way forward would become clear. In retrospect, I know that Kay saw me – with all my insecurities and my doubts about the future – clearly. Yet, she did not judge, preach, or lecture. The day she left the hospital, she handed me what is still one of my most treasured possessions: a highly polished yellow stone into which was carved the yin and yang. She explained that the symbol meant balance and encouraged me to find my own.

In Family Medicine, I found *my* people and – I thought – the balanced approach I sought. I was drawn to Family Medicine by the teachers: unflappable, can-do folks, who had a respectful demeanor with their patients, me, and their colleagues. Plus, I liked the variety of people, ages, and conditions represented in a *womb-to-tomb*, family-oriented, general practice; and the possibility of working with the same patients for years to come. By nature of the fact that it is a *general* practice rather than a medical specialty, Family Medicine is at the bottom of the medical hierarchy. That suited me, too; resonated with my humble beginnings as an Iowa farmer-turned-preacher's daughter who came of age at potlucks and town socials and made spending money walking soybeans or minding children while their parents mowed hay or sorted cattle.

When I graduated from my Family Medicine residency and took my first job, I thought I had it made. I could finally build my own practice, taking time to educate and empower my patients, growing each relationship

over time, exploring the values, responses and attitudes of my patients so that we could individually tailor their treatment plans to meet their dynamic needs. My mentors had cautioned me against burnout, diagnosing me as too idealistic, too thorough, and too detail-oriented; saying I spent too much time per patient and too much time documenting. They said I would never survive clinical medicine. I didn't believe them.

What I had envisioned seemed possible for the first few months that I was in practice. I was new, and my schedule was slow to fill. Once my schedule was routinely full, the visits from the administrative assistants with red Sharpies began: *Just mark which appointments can be double-booked,* they said. *I don't double-book,* I replied firmly. *Double-booking is mandatory. Please mark the appointments,* they insisted. When I refused again, they glared irritably, turned away, and marked the appointments to double-book for me. Once the double-booking started, I was chronically behind, usually by an hour or more. The administrators complained, and my patients complained. I did my best to soothe everyone and stay true to my vision. My patient patients kindly said, *You're worth the wait!* The administrators scheduled lunch-time seminars to teach me and the other new physicians how to code properly (read: how to maximize charges to each patient and/or insurance company). I did not receive any guidance or supportive training in how to best communicate with or meet the needs of my patients. I did not hear of or attend a single medical-group-sponsored seminar to address the quality or cost-effectiveness of the care that we provided. More patients, each maximally charged, equaled more revenue for the medical group, and was the only metric by which I was judged.

Four years later, in the bottom of the Grand Canyon, leaning against the pontoon of the boat on which I was going down-river, enjoying the spectacular glow of the setting sun against the canyon walls, day-dreaming about the adoption of the first two (of our three) children, I knew I had to leave Family Medicine. Balancing the impossible expectations of my medical group with my new foray into parenthood was unthinkable. I wanted to give my children my best, and I had nothing left to offer anyone at the end of each workday. What kept me going and what seemed to be so gratefully received and appreciated by my patients and their families – spending time talking, scrutinizing medication lists for the culprits responsible for side effects or dangerous drug-drug interactions, performing thorough physical examinations, diligently researching their diagnoses and questions, and after-hours phone calls to discuss the results of my research or diagnostic tests – was not valued by the medical group for which I worked.

In fact, at each quarterly meeting, despite the fact that I arrived at the office at 6 a.m. and did not leave until 8 p.m. most days, I was labeled as a *low producer*, a physician who saw only eighteen patients per day, in contrast to the *top producer* who saw forty patients per day. I was utterly exhausted and fed up with being belittled because I refused to sacrifice my values for the earnings of the medical group. I did not care that they paid me less than the top producer; that was fine with me. Yet, the very public, quarterly shame sessions were not. I'd had enough. Though the no-compete clause in my contract ensured that I would not – at least for many years to come – set up a private practice anywhere close to home, giving up clinical medicine seemed like a small price to pay for regaining my strength and peace of mind before I became a mom.

For whatever reason, I did not feel wholly content as a stay-at-home mom. I love my children, their energy, and their antics, but I am a better, more engaged, and more patient parent when I have some time for myself – and my professional development – each day. So, a few months after my twin girls came home, I started investigating ways that I could still make medical contributions on a truly part-time basis. One of my former patients suggested clinical research and made some introductions. I was lucky enough to meet and be mentored by one of the few Faculty of Pharmaceutical Medicine (designation granted by the Royal College of Physicians-London) in the United States: Anthony, *Tony,* Fox. Tony recommended that I volunteer for the human subjects' protection committee (a.k.a. Institutional Review Board, IRB) of my former medical group, tutored me several hours per week for over two years, and immediately brought me onto projects where he could observe and mentor me. I was getting paid to learn and contribute. I was introduced to the national and international regulations related to clinical trials, and the ethical obligations of each IRB. I got to read informed consents and protocols and learned the vernacular and operational nuances of clinical trials. Later, I was invited to share this knowledge as an adjunct professor at a local university.

Over the past decade, I have expanded the Pharmaceutical Medicine practice that Tony helped me to launch. From time to time I've encountered clients who were more interested in profit margins than patient safety, but I've been able to gracefully extricate myself from those situations and find alternative projects on which to focus. I've been incredibly lucky to have a job that has allowed me to juggle my professional aspirations and the needs of my young children. Yet, lately, I've been increasingly dissatisfied.

Part of my dissatisfaction has arisen from arguments with drug company executives about the fact that we do, indeed, need to include all relevant side effects in the drug label, *even if they might scare people and prevent them from taking the drug,* and a deeper understanding that exorbitantly-priced drugs – drugs that may never make a significant difference in health or well-being – are being directly marketed to consumers in ways that I consider disingenuous. Another part of my dissatisfaction – the part

that fuels a deep ache to return to clinical medicine – is absorbed from family members, friends, neighbors, and colleagues who trust me with their stories of overtly disrespectful, arrogant, patronizing, and/or dismissive communications with doctors. I hear about missed or delayed diagnoses, too. The missed or delayed diagnoses frustrate me, but are more understandable; medicine is an imperfect science practiced by imperfect human beings, most of whom are dangerously overworked. The stories that *enrage* me are those in which doctors dismiss people's concerns without a complete assessment: the man without insurance who is obviously having a heart attack but is discharged from urgent care, minutes after his arrival, with a non-diagnosis of chest pain and instructions to go immediately to the emergency room if his persistent sweating, nausea, chest pain, left arm/shoulder heaviness, and shortness of breath do not improve; the young woman with new-onset, nocturnal seizures who is diagnosed with a *supra-tentorial issue* (anxiety and/or personality disorder) without a neurological exam, let alone a sleep study and nocturnal electroencephalogram (EEG).

Could I make a difference for such patients if I returned to clinical medicine? Or, would I make the same mistakes? Is it pure arrogance to think I could return to Family Medicine after ten years in Pharmaceutical Medicine? Sure, I've maintained my continuing medical education, board certification, and licensure, but am I simply too long out of practice? Would my time out of practice be an advantage or disadvantage? After all, the model of clinical practice in which I was trained – see as many patients as possible, as fast as possible, and charge them (or their insurance) as much as possible – is not a model that I want to emulate. What models might suit my personal and professional strengths? (I've found at least two models that intrigue me.[1,2]) If no ideal model is available, could I design and pioneer a new model? Would a newer model allow me the time to get to know my patients, to collaborate with, educate, and empower them? (At least one other person agrees that the 15-minute doctor visit is too short and is willing to assert it publicly.[3]) How do I find *my* patients, those for whom I would be the right doctor? Is what I want to offer something that patients want and need? Is clinical practice where I belong, or can I make more of positive impact elsewhere in medicine? I still feel like I belong in medicine; do I? If so, how can I – finally – find my place?

Conclusions

You can't connect the dots looking forward; you can only connect them looking backwards. So you have to trust that the dots will somehow connect in your future. You have to trust in something—your gut, destiny, life, Karma, whatever. This approach has never let me down, and it has made all the difference in my life.

Steve Jobs

Bone-deep, I know that each of my career shifts was necessary to achieve a sense of balance within myself, to ensure that I didn't completely lose myself to medicine. Yet, I harbor a deep sense of shame that I have contributed to the shortage of primary care doctors.[4] However, recent coverage of physician burnout[5,6] reminds me that I am not alone in what I have experienced. The resilience trainings and mind-body interventions[7] recommended for burned out physicians are certainly well-intentioned (and potentially effective for coping with the stresses of suboptimal work environments) but do not, in my opinion, address the root cause of my own burnout: a disconnect between my idealistic vision of medicine and the reality of my experiences in medicine.

From a distance, I had envisioned the tree of medicine as magnificent, lush, and thriving. Only after I was immersed in medical school, residency, and Family and Pharmaceutical Medicine was I able to see that the tree of medicine, though its roots are deep and wide, has many diseased and dying branches and is riddled with pests that bore into its bark and sap its strength. I truly believe that the tree of medicine will survive and thrive again, but that the process will take decades and will require the collaboration of many arborists. The chief arborist on each project should always be the patient, the one for whom this magnificent tree was planted in the first place. Collaborating arborists can help to determine which branches should be pruned, which removed, where new branches might be grafted, and how to best handle the pests in order to achieve each chief arborist's vision.

I have spent decades trying to *connect the dots looking forward,* carefully positioning my ladder along these proverbial dots so that I would ultimately arrive at the branch of medicine that was *right* for me, only to recognize that the *right* branch of medicine for me may not exist yet. Perhaps the past twenty years (not to mention my family's generations of farmers) have prepared me to sow, cultivate, nurture, and graft a new branch onto the tree of medicine. Maybe, instead of finding my *place* in medicine, I need to find *myself* in medicine.

So I, the quintessential planner, am trying something new. I am climbing down off my ladder and setting it aside. I am clearing ground in my schedule, fertile patches in which to plant the ideas provided by my intuition, my family, my friends, and my colleagues. I have no idea where I am going in the next phase of my career. Yet, new ideas about how I might impart healing and empower patients – therapeutic riding, sex education workshops for parents and teens, writing children's books about inspiring individuals who defy the challenges of their congenital syndromes, an urban garden in which to explore food as medicine – are sprouting, unfurling their leaves, and reaching for the sky.

In my next article (part two of a two-article piece), I will explore and analyze my ideas and questions within the context of recent publications – both lay and academic

– in order to extrapolate beyond the boundaries of my own experience and join the national and international conversations related to health and wellness and the implicit challenges involved in striving for both.

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