

# Goodbye Marcus Welby: The Professional Entry of Primary Care Physicians

Patricia M. Thompson  
Penn State - Harrisburg

**Abstract:** In this paper I report the findings of a study of primary care physicians' experiences as they enter the medical profession after residency training. Using narrative inquiry to learn about the participants' experiences, this study found that despite strong professional socialization during training, the participants constructed their medical practices to meet both their professional and personal aspirations while conforming to organizational expectations.

## Introduction and Purpose

Vocation and work are integral elements of both the research and the practice of adult education (Dawson, 2005). This is evidenced by adults' participation in education being predominantly motivated by work or career (Merriam & Cafferella, 1999). Historically, careers or vocations were built around societal needs and particular life goals or callings providing individuals with a singular identity; this was especially true for professions such as medicine. "For a person who has achieved a sense of vocation, person and work are united" (Cochran, 1990, p.3). In the contemporary world, identity, especially vocational identity, has become more dynamic. Gergen (2001) argues that in contemporary society, "the concept of 'intrinsic' interest is virtually lost from view" (p. 185); nowadays what people do for work is no longer a calling but a construction of skills and experiences to meet a particular niche (Gergen, 2001).

These changes appear to be affecting most professions, even medicine which has been held by many as the archetypical example of an autonomous profession (Friedson, 1970). The practice of medicine in the United States is facing unprecedented changes (Scott, Ruef, Mendel, & Caronna, 2000). Some of these changes include: decreasing numbers of individuals interested in entering the profession, changes in the health care system that create volatility and uncertainty for the profession, advances in technology which require on-going training and development, increasing gender and racial diversity within the profession, and the loss of professional autonomy due to increased regulation, systemic controls placed by insurance companies and decreasing numbers of physicians choosing private practice (Institute for the Future, 2003).

There has been some research interest focused on how practicing physicians are coping with these changes. There have been studies of how physicians adapt to managed care environments (Hoff, 2001, 2003); why they choose to be employees rather than own practices (Briscoe, 2003; Hoff, 1998); how communication affects physicians' development of identities within organizations (Real, 2002); physicians' professional satisfaction in HMOs and other employment settings (Chehab et al., 2001; Hueston, 1998); and how physicians adjust to taking managerial and administrative positions within organizations (Hallier & Forbes, 2005; Murphy, 1999). But, these studies focus on physicians who already are in practice, not those entering the profession. The purpose of this study was to investigate what beginning physicians experience in this new healthcare industry climate as they transition from residency to practice, and how they interpret those experiences.

## Theoretical Framework

This study is informed by social constructivism. To understand the experiences of physicians entering professional practice, it is important to recognize the influence of

socio-cultural factors. Social constructivists specifically focus on the interaction between the individual and the socio-culturally informed environment (Phillips, 1995). In relationship to this study, a social constructivist perspective suggests that individuals' professional, organizational, and personal identities and values are learned in a social context. "Identity – whether individual or group – is not derived from the nature of the world. Rather, "identity is a relational achievement" (Gergen, 2001, p. 184). This study investigates physicians' experiences, their interpretation of those experiences, and how they develop as people and professionals in light of their experiences. All of which are inherently social. Their beliefs have been informed by socio-historical events. They interpret the events of their lives informed by their past experiences. They build their understanding of their profession and themselves as people in community, not individual entities. Recognizing this intersubjectivity, as explained by Rogoff (1995) as the shared meaning and understanding that occurs among individuals with common interests, assumptions, and beliefs that ground how people communicate and relate with each other and the world outside of their community, was very important in understanding the physicians' experiences.

### **Methodology**

This qualitative study utilizes narrative inquiry as its methodology. The idea that we live our lives and understand our being by constructing stories is the keystone to this method of research. "Stories order experience, give coherence and meaning to events and provide a sense of history and of the future" (Rappaport, 1993, p. 74). Patton (2002) states that "narrative [inquiry]...honors people's stories as data that can stand on their own as pure description of experience" (pp. 115-116). Specifically, in the context of the medical profession, Johnson (1983) recommends the use of life stories to better understand how physicians arrange the subjective elements of their careers and identities, and Hatem and Ferrera (2001) suggest that "Narrative probes the depths of medical experience, [and] allows for greater understanding of [doctors'] patients, work and selves" (p. 14). According to Elliot (2005), narratives have three key features. First, they are chronological meaning they represent a sequence of events. Second, they are meaningful in that they do not just report events, they give meaning to events. Finally, they are inherently social meaning they are produced for an audience.

Data were collected from a purposeful sample of nine physicians currently practicing in primary care (internal medicine, family practice, or pediatrics) in Northeastern United States. The participants were recruited through residency training programs. To be considered for participation the physicians had to be salaried employees of organizations, be involved in patient care, be practicing medicine for less than three years, and be willing to be involved in reflection and construction of personal narratives. The sample included: five White females, one African American female, two White males, and one Latino males. Prior to being interviewed, preliminary background data were collected. Participants were given questions for reflection and asked to reflect upon their experiences in preparation for the interview. Participants were interviewed and the interviews were taped and transcribed. Interviews were 1 ½ to 2 hours in length. Participants were provided with the interview transcripts and worked together with the researcher to construct narratives.

### **Professional Entry: A Time of Transition**

One challenge the participants faced when they began their professional career was the transition from trainee to professional. For most of the participants, this was the first time in their lives that they were on their own and had any control over their life and their time. Two of the physician had worked in other contexts prior to pursuing medicine. Still, they had very

similar experiences transitioning from training to practice because they spent almost ten years of their lives in education and training for their medical careers, so in many ways it was like starting over for them. This section discusses three of the general experiences that surfaced in each of the physicians' narratives as they shared about their entry into the medical profession.

#### *Attaining the Brass Ring and Moving Forward*

Memories of medical school and residency were fresh in the physicians' minds and those experiences were intertwined in their narratives of professional entry. So much of how they felt about beginning their careers was associated with how relieved they were to be finished residency. There was a sense of sacrifice in all of their narratives. They sacrificed financially and personally to become physicians. Each of the participants was in a different phase of recovering from residency. Also, their perceptions of the experience differed. Some felt a sense of accomplishment having survived and now being able to fulfill their calling. Others felt that since they put so much time and effort into their training they were trapped in their careers. One participant confided, "I have no regrets about going to medical school and going through the process, but, none of this was in the brochure. I never really saw it for what it is."

They also had to make sense of what they were experiencing in light of what they expected. Their training was extensive and required a tremendous amount of delayed gratification. Once they were there, they had to reconcile the reality with the dream. One participant expressed that he was living his dream; it was everything and more than he ever expected. Another was on the opposite side of the spectrum. The struggle that she experienced during residency continued into practice. She changed jobs three times in her first year. Eventually she reconciled the reality of practicing medicine with her previous expectations and concluded, "I'm not trying to save the world. . . I am now satisfied knowing that at the end of the day, I helped people and didn't kill anybody."

By the end of their narratives, the participants expressed that they had gained some level of control as to how they were going to live their lives and practice medicine. How they exercised their new found control differed by individual, but they all recognized that it was their responsibility. They were no longer going to be told what to do; they had to negotiate roles in their professional and personal lives. They moved from a socialized way of looking at the world to a more self-authored view which is reflective of Kegan's (2001) stages of development.

#### *A New Perspective on Calling*

Contrary to much that has been written about work being perceived as a commodity exchange (Adkins, 2005) or medicine being more of a career than a calling (Real, 2002), the participants in this study saw their profession as a calling, and many used that term to describe it. The origins of the calling may have been different—some were called to help people, others were called to the personal and professional challenges—but in some way they all pursued medicine because they wanted to make a difference. One participant summed it up nicely when she said, "If it wasn't a calling I wouldn't have spent the entire decade of my twenties working all of the time on education and training." This is consistent with Dirx's (2006) thesis that those in the helping professions such as teaching and medicine, still have this emotional dimension to their work.

However, much of what they relayed in their narratives indicated that while they perceived medicine as a calling, it is not their identity, which is very different from what is traditionally seen as a calling. Cochran (1990) explains that a calling "is not contingent but personally necessary, a relationship of being and doing" (p.3). This is not the way the participants of this study described their careers in medicine. They discussed multiple interests

that they are pursuing, and medicine happens to be one of them. This is consistent with how Gergen (1991) views work in contemporary society. He argues that what people now see as their work or vocation is a construction of skills and experiences to meet a particular niche. Thus, even though participants felt called to pursue medicine and go through the rigors of professional preparation, they were not experiencing this phenomenon as it is often described in the literature. Each of the participants needed to construct a career path that fit his or her personal and professional desires. While they described their desire to enter the profession a “calling,” they were very selective as to what they were willing to do to carry out that calling.

The findings of this study suggest that physicians are keenly aware of the structural and economic changes in the marketplace and especially in the health care industry. Consciously or unconsciously they position themselves to be able to adapt accordingly. Elements of their narratives suggested that they see their professional pathway as fluid and they are willing to readjust their professional aspirations for their personal aspirations. In addition, their motivation for being employees rather than partners, suggests a more flexible approach to professional practice. This is consistent with the literature which argues that security and stability are no longer the focus when constructing careers, but young adults need to be flexible, ready to change, and equipped to remain competitive (Geroy & Venneberg, 2003).

#### *Professional Autonomy and Systemic Control*

The physicians in the study perceived a high level of professional autonomy associated with their entry into practice. In the blink of an eye, these physicians went from being on the bottom of the hospital chain of command to working on their own. Some embraced their new found freedom while others found it stressful. One participant explained, “After so many years of not really having a voice, I now have to exercise my authority.” While they recognized their autonomy in practicing medicine, they also mentioned numerous systemic issues within the healthcare industry that guide their practice. These systemic issues seemed to be uncritically accepted. The participants talked about their frustrations with the system and their belief that it will continue to get worse, but no one discussed how to challenge or change the system. Instead, they shared how they acclimate and accept it as is.

The physicians adapted according to the context of their practice. Those employed in group private practices were intensely aware of revenue generation. This did not stem from their desire to acquire wealth; it was about keeping the practice solvent. One participant shared how she looks for ways to expand the practice by attending prenatal classes and mall health fairs to recruit patients. Another described her experiences when a practice where she was employed could not afford to pay her because the practice was not generating enough revenue to cover overhead. In contrast, the participants employed in large university systems were acutely aware of organizations’ political structures while the day to day operations were not noticed. One participant shared that she is constantly trying to discern what is important to the organization and how to add value to her department. Another focused on recognizing and meeting the expectations of those in power even when it did not make sense to her professionally.

The systemic control of the healthcare system can also be seen in patient care as well. The participants working in office practices gave numerous examples of how they learned how to work around insurance constraints and organizational protocol to get what patients need. Still, these constraints affected the way the practice medicine. For example, one participant shared that his office manager informed him that the practice was not reimbursed for lab work and he should send patients to the lab down the street for blood draws. The physicians working in office practices were very concerned about time and how they allocated their time to illnesses, or as

they refer to it, patient complaints. Some of them told elaborate stories of how they manage this. These stories also uncovered that they work on a “one complaint per visit” schedule. That is how time is allotted and that is how they have to bill.

Due to regulation and fear of litigation, documentation and paperwork are as important to the contemporary practice of medicine as seeing patients and helping them get well. Each of the participants shared his/her horror stories about this. One participant shared a story about having to document that a patient was told he/she gained weight so that when the patient had a heart attack, he could prove that he had given warning. While this does seem exaggerated, it provides insight into the feelings he has about the process.

### **Conclusions and Implications for Adult and Medical Education**

Much has changed in medicine since the days of Marcus Welby, MD (which was popular in the late 1960s and early 1970s). No longer is primary care medicine dominated by White men who lived and breathed their medical career and the societal status that accompanied it. Now the profession is diverse, not only demographically, but also primary care physicians have multiple career options due to the institutionalization of the profession. Some argue that this provides “bureaucratic flexibility” and allows physicians to practice medicine without the burden of running a practice (Briscoe, 2003), but it also constrains professional autonomy. The participants in this study were willing to make the trade because it provided the freedom and flexibility they desired in order to develop their interests outside of medicine, but they approached it without critically assessing what systemic control meant to them or their profession. It appears that the social construction of the medical profession reflects that of the workplace in the U.S. at large.

This change in the medical profession has implications for professional educators and society at large. First, primary care is often held by policy makers and politicians as the backbone of our nation’s healthcare system, yet it continues to struggle in attracting individuals to the profession. Despite the changes in the medical profession, medical education and how physician training occurs has not exhibited much change. While medical educators and the College of Graduate Medical Education (COGME) recognize this and are moving in that direction; the culture of medical education is deeply entrenched and changing it will be a slow and difficult process. Also, the meaning of work or profession in individuals’ lives is changing. The participants in this study saw themselves as very different from physicians of generations past. They were vocal about how they value their personal lives and do not want work to interfere with it. They clearly saw themselves as having multiple identities which will shift over the course of their lives. If we view professions as social constructions, the values and interests of the individuals within the profession will eventually become the values and interests of the profession and eventually society if that has not occurred already.

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