A calling
By Monica Kidd

It started out as an amiable conversation. On the evening before the CaRMS match, my soon-to-be husband was trying to reassure me about having ranked family medicine first. For months I had tortured myself about the decision: I loved the women and the drama and the handiwork of obstetrics & gynecology, but I also wanted to believe in the value of a good generalist. Two days before the final rank list was due, I changed my mind for the third time, and put family medicine first. Two days before match day, I began having serious second thoughts.

I was doing a rotation in Corner Brook; I lay on my bed looking out my window at the lights of Western Regional Memorial Hospital with my cell phone wedged between my shoulder and my ear. I was whining, again, about how throughout medical school, family docs are the butt of all the jokes. About the old refrain from well-meaning family and friends: *Are you going to specialize or are you* just *going to be a family doctor?* I've always identified with underdogs, but by the end of medical school and residency, closing in on forty, I'd like to not have to fight for respect.

"What does it really matter?" Steve asked – again. Steve is a resident in orthopedics. He trained and worked as a mechanical engineer before medical school. "People make too much about doctors. Pipe-fitters and masons have just as much specialized knowledge as doctors, it's just a different kind."

I was familiar with this argument: before quitting work to go to medical school, I'd made it to colleagues in response to their near universal: *Wow, you're going to be a doctor!* "Yeah, well," I'd demur. "It's just another trade." I hated the sound of my words. They smacked of false modesty, the worst kind of arrogance.

But I believed it, in a way. Every line of work, whether stringing power poles or resecting brain tumours, has a particular set of skills learned at the elbow of a mentor. It has its comfort and no-fly zones; it's up to the sense of the tradesman and the rules that govern him (hopefully more the former), to determine his boundaries. The trade quip also got me nicely out of the why-do-you-want-to-be-a-doctor question I'd answered so many times I couldn't bear listening to myself anymore.

But now, thrown back at me in this context, it raised my hackles. Would I want to be cared for by a doctor who believed he was "only" a tradesman? Just logging his hours, just fixing a broken part? No. And I didn't want to hear it from Steve. I simply didn't believe it from him. Just the other night he'd told me about treating a narcotic addict in emerg: the proud young man was badly constipated and staff had insisted on sending him home – more than a little disgusted with his lifestyle choices – with instructions on how to give himself an enema. Steve, knowing the guy would never eat humble pie and do it himself, insisted on administering it for him. Scuffing back from the bathroom, the young man actually thanked Steve. "Uh, thanks for being so professional about that,

man," he mumbled, and the two had a little laugh together. I am not at all saying tradesmen don't show decency and ingenuity, but I don't believe Steve saw himself as just fixing a broken rectum. He saw a kid in a – er – shitty situation who was embarrassed and asking for help, and he did what he promised he'd do: *I will practice my profession with conscience and dignity*[1].

It's weighty stuff. I haven't been at this long, but already I lose sleep over patients. They teach me. They linger with me; some haunt me. They prod me to try to do the right thing. They illustrate truths. When I worked as a reporter, people I interviewed had a similar effect on me. But I wasn't responsible for their well-being; while some may have sought my help to change the system or to at least be heard, none expected me to fix their problems. But that's exactly what people will expect of me when I am a doctor. And they will expect it in a tangle of fear (theirs and mine), in the middle of the night, when there is no time, and when there is no answer.

There are easier ways to make a living.

This question of whether medicine is a career or calling has long intrigued medical educators. Simple perusal of the newspaper is testament to the fact modern medicine is increasingly steered by technology (although more rigorous examples are available in the literature; e.g. Connor, 2004) and the drive for so-called "evidence-based practice" (Holmes et al., 2006). This mechanistic view of medicine – and even the multiple-choice exam approach to medical education, I would argue – promotes medicine as "career," executed by trainees armed with expandable memory cards and suitably programmed with incontrovertible facts.

Yet a counter-movement in favour of the medical humanities (Haidet et al., 2005) shows this version of medicine rings hollow for many people, as my *it's-a-trade* thing with my co-workers did for me. A decade ago, the American Association of Medical Colleges, which represents medical schools in the United States and in Canada, stated four main objectives: that physicians be altruistic, knowledgeable, skillful and dutiful (AAMC, 1998). Knowledge and skill are imparted every day, from the kindergarten sand box on up. But altruism and dutifulness? I agree with those researchers who insist students either come to medicine with these tendencies or they do not (Duffin, 2003). Some argue convincingly that the so-called "hidden curriculum" of medical school threatens to *erase* humanitarian ideals altogether (Haidet et al., 2005). Others, perhaps more optimistic, insist teaching medical humanities can help create more empathic, astute doctors at least by making space in an intense curriculum for self-reflection (Hafferty, 1998; Coulehan and Williams, 2001), if not by making space for "the somewhat heretical notion that medical thinking... very often [fits] a narrative, rather than a hypothetico-deductive paradigm" (Squier, 1998).

Thus, rich debate rings among medical educators about the value of medical humanities teaching, as I discovered after conducting a survey of medical humanities curricula in

[1] From *The Declaration of Geneva* (1948).

Canadian medical schools (Kidd and Connor, 2008). Our survey showed Canadian educators appear to have two broad goals: to encourage curiosity about the human condition and skepticism about the nature of medical "truth," and to model acceptable moral behaviour. One informant, a clinician and administrator, summed it up like this: "The great masses out there are way ahead of us on this. They will support a school, a medical curriculum, whatever, if they know their doctors who are being trained out in the factory over there are being introduced to some aspect of the human condition. The national accreditation bodies … are going to be under the gun if they aren't already." Sadly, Canada currently has no governing body, no association, no national curriculum, no accreditation guidelines, not even a formal national discussion regarding medical humanities instruction, which led us to conclude there is no legitimate room for medical humanities in medical education in Canada right now. Perhaps one day.

Why all the fuss, if medicine is only a career? That old standard, Merriam-Webster's online dictionary, defines a calling as "a strong inner impulse toward a particular course of action especially when accompanied by conviction of divine influence.[2]" We make a fuss because we know medicine is not a career; it's a calling. And because we're all patients, we all want to make damned sure we trust doctors' inner impulses.

Our phone call ended badly. I was upset by my loss of courage; Steve was impatient with my chronically unsettled state. I smoldered to myself: doctors differ from pipe fitters because you don't (necessarily) drop your pants for a pipe fitter, you don't (necessarily) tell a pipe fitter about your miscarriage. That stuff matters. Being trusted with the delicate contents of a human heart *means this is different.* I continued my Olympic pouting for the rest of the night.

A few days later he called to say he'd met up with an elderly patient he'd had on another service who recognized him straight away, called him by name; the old man's family gathered around his bed, smiling, introducing Steve to wives and husbands. "You must have made an impression," I said.

"We had a family meeting once," he explained. "The family wanted to take him home, and I guess I just told it like I thought it was. The nurses said it was the best family meeting they'd been to." Family meetings are tricky, full of conflicting beliefs and needs, of *humanness*. Judging by his reception, he must have navigated it with grace and compassion.

"It's different, isn't it?" I smiled, smugly helping myself to the last word. "It's different than swinging a hammer."

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[2] Not to mention "the characteristic cry of a female cat in heat." *www.merriam-webster.com*

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