

Split between two worlds

The experience of one Metis physician

Brittany Penner MD CCFP



We spoke for nearly the entire 15 minutes allotted in my schedule for her appointment. This young woman was new to my practice and although it was not the way I prefer to meet patients for the first time—over the phone owing to our current pandemic—I did have a better sense of who she was once we hung up. It took only a few minutes for me to realize she had already been through more in the span of her short life than so many of my other patients. Her tone was quiet, her responses thoughtful. I wasn't quite sure if she was shy or if life had treated her in such a way that she had learned her voice held apparently little value. Since that first appointment, she has consistently missed follow-up appointments and failed to complete investigations I've ordered. She struggles to take her medication regularly and it often takes several phone calls to a few different numbers for my office to reach her. It is difficult for me to not feel, in many ways, that I am failing her.

I know there is a limit to how much we are able to provide for patients. We can write prescriptions and offer advice but we cannot heed that advice or take the medication for them. Our interactions with our patients can only go so far and sometimes, especially when freshly embarking upon our new careers, it takes time for us to accept this.

We often start our practice with a newfound freedom after completing residency. With patient panels of our very own and more control over our schedules, there is a sense of ownership over our practice of medicine that we didn't necessarily anticipate. With that can come a renewed sense of hope in the opportunity to influence the lives of our patients. For many reasons, encounters with patients who appear uninvested in their own health leave many of us feeling disheartened and frustrated. Many of these encounters can feel deeply unsatisfying, rubbing against the basic principles of primary care we learned at such an early stage in our training. I have thought of this young woman and how challenging it might be for some physicians to provide care for her. I've sometimes wondered: If I had not had some of my life experiences, would I also feel disconcerted when treating her?

Much of this young woman's life has been influenced by her exposure to the Child and Family Services (CFS) system in Manitoba. And, like 90% of Manitoban children in CFS, she is Indigenous.¹ My life, in more ways than many are aware of, has been influenced by my experience with CFS as a Metis child.

I was adopted as an infant through CFS in the 1980s, when the system still sealed adoption records and limited information about birth parents or cultural heritage. I spent the first 2 decades of my life with no knowledge of who my family was or what my original name had been. Until recently, I had no information on my ancestors or the lives they lived. After spending the first few weeks of my life in foster care, I was adopted by a Mennonite family in southeastern Manitoba and raised with foster siblings and fostered and adopted cousins, aunts, and uncles. Many had been adopted during the Sixties Scoop. More than the sharp visual contrast between us, there are inherent characteristics that dramatically separate us as well. I have experienced various traumas throughout my life, as is the case with many children adopted or fostered through CFS, that have left me with a persistent and deeply rooted sense of not belonging. After spending a few minutes with this patient, I had a sense she had experienced much of the same.

Grounding my practice

I have spent most of my time in medicine, from the start of medical school through residency and on to my current practice, feeling split between two worlds. I often feel as though I have one foot grounded on the side of call schedules, resident teaching, and staying current with updated practice guidelines. My other foot, despite the countless sleepless hours and a certain degree of cynicism that seem married to the job, remains firmly planted on the side housing vulnerable (read: resilient) patients.

For years, I feared this feeling discounted me from becoming the model of a good family physician. Much of this feeling was influenced by what I saw and heard throughout my training and—probably most strongly—by the fact that no one I met had a backstory like mine. I felt torn as team members would voice their frustration with certain patients (often Indigenous) who seemed unable to care for even their most basic medical needs, while I could easily relate to many aspects of these patients' backgrounds. The feeling of not quite belonging persisted, even in this world that I worked so hard to become a part of.

While I was on my psychiatry rotation at the tail end of my clerkship year at the University of Manitoba in Winnipeg, the team answered a page from the emergency department (ED) at the Health Sciences Centre. We were called to assess a patient's competency to make medical decisions. She was a young Indigenous woman with


considerable comorbidities who frequently left the hospital against medical advice. It was clear that the ED staff knew her well, recalling her history without glancing at her chart. *Frequent flyer* was the term used. The ED physician, someone I had worked with previously, was obviously quite busy, but I didn't sense any jadedness on his part toward the patient, and I was grateful.

At one point the resident went to speak with the ED physician regarding the consult and I stayed in the room with the patient. Without speaking, a part of me knew how she found herself in her current circumstances, not knowing how best to care for herself. She told me of the pain caused by her mother's inability to raise her that still lived within her spirit decades later. She spoke of the traumatic assaults against her and the deep pain of having never felt like she belonged anywhere. She wept. They were the kind of deep sobs I knew well. They were the kind that flow from a cavernous well of pain one never manages to forget.

There are many reasons physicians might get frustrated with these patients. After all, most of us have seen the painful, seemingly preventable, outcomes for many of them. At the same time, we cannot deny the systemic societal and medical barriers that make these types of stories painfully common among Indigenous people. These encounters can be especially difficult for physicians when we walk into the room and the inherent trust of the patient, to which we are accustomed, isn't present. Oftentimes there can be a guardedness to these patients that precedes us into the room, which some of us feel we do not deserve.

At the same time, anyone who has ever experienced the unforgettable pain of feeling anchored to nothing and no one in this world recognizes it is not all that simple. To live life believing, sometimes being outright told, you do not belong—to your mother, to your father, to a society that continually discriminates, to systems that do much of the same, or to your own body—can be a searing experience. It fractures our understanding of our

identities and leaves us not knowing which ground is steady enough for us to walk on or which space is safe to enter. It is a pain that stalks, preventing us from understanding what our deepest needs are. Remembering to take a pill every day or attending every appointment simply isn't a priority some days.

I understand, in some ways, the frustration felt by physicians when it comes to these patients, but I understand, perhaps more deeply, these patients' feelings too. When it comes to the young woman in my practice, I continue to worry about her, concerned where she might find herself in 5 years. I have come to let that concern and my ability to relate with her experiences be my guide. It influences my interactions with foster children in my practice as I sneak them extra stickers and remind them of my delight in seeing them. I always make space in my practice for these patients. My hope is that they look forward to our appointments at least a little and that they never leave my office feeling judged or that they should hide parts of their story they wish to share. I am genuinely happy when this young woman does come to her appointments and I show compassionate concern, not just for her medical conditions, but for her whole personhood. I am coming to embrace feeling split between these two worlds. I continue practising with my feet planted firmly, one on each side, only now it has become an effort of my own choosing. 

Dr Penner is a family physician practising in Steinbach, Man, and Lecturer with the Department of Family Medicine in the University of Manitoba's Max Rady College of Medicine in Winnipeg.

Competing interests
None declared

Reference

1. *Transforming child welfare legislation in Manitoba. Opportunities to improve outcomes for children and youth. Report of the Legislative Review Committee.* Winnipeg, MB: Government of Manitoba; 2018.

Can Fam Physician 2021;67:141-2. DOI: 10.46747/cfp.6702141

Cet article se trouve aussi en français à la **page 143**.

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