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Choosing OB-GYN: One Practitioner's Story

Ms. Rosario:
Welcome to *Advance's in Women's Health* on ReachMD. I'm Ana Maria Rosario, and today I am joined by Dr. Patricia Boatwright, who is the Women's Health Medical Director at Louis A. Weiss Memorial Hospital in Chicago, Illinois. Dr. Boatwright has touched so many patient's lives that I know personally. She is here today to share why she chose being an OB/GYN as her specialty and some of her most memorable and pivotal moments during her 40 plus year-career. Dr. Boatwright, welcome. So let's start off, can you share your professional background?

Dr. Boatwright:
Well, I am a native of Los Angeles, California, and I've been in practice now for, well I graduated from medical school in 1981 and attended the University of California, Los Angeles, UCLA, and did undergraduate there. I'm one year master's work in cell biology before I moved to Michigan, Ann Arbor, in particular and went to medical school and residency there for OB/GYN. So I've been in private practice since 1989/88. Prior to the private practice, I was academic practice at Rush University with their specialty group. I was the only generalist and was with a group of sub-specialists, reproductive endocrinology, oncology, maternal/fetal and stayed with them three years before I decided to enter private practice.

And so presently, I actually ended my obstetrical career in 2019 because the first baby I delivered turned 40 in 2019. And I'm presently, a benign gynecologist concentrating on primary tumors of the pelvis, abnormal pap smears, endometriosis, pelvis pain, and the like.

Ms. Rosario:
And so Dr. Boatwright, what led you to become an obstetrics/gynecology specialist?

Dr. Boatwright:
Well the obstetrical part was never my favorite part. But I wanted to be a surgeon. In particular, I knew I wanted to be something that dealt with the abdomen, but I didn't like the mentality of most of the general surgeons that I met at the University of Michigan, so I thought, "How can I operate in the abdomen and the pelvis without going to into general surgery?" and it was either going to be urology or OB/GYN. And I elected to do OB/GYN. And with that came obstetrics because at that time, there were very few gynecologists coming out that just did gynecological surgery. We all did OB/GYN. I'm very good at obstetrics but it was always the surgical part of me that was the most exciting. The obstetrical part was exciting, only when you had to jump in there to save a life or you dealt with a lot of blood. I like that excitement and that challenge. But sometimes to get up in the middle of the night for a normal, spontaneous vaginal delivery that just drops into your lap, that was challenging. But I did private practice. I delivered patients I had a rapport with, that I knew.

Ms. Rosario:
I personally know that you are at the top of your game. How do you continue to stay on the top of your game and how do you encourage your colleagues to stay on the top of your game?

Dr. Boatwright:
Staying busy. I don't give up my cases in the operating room. You know, I was at Rush for several years, almost 40 years. I don't pass it off to the younger generation. I always tell the kids when I'm operating and I'm educating the residents in the operating room and they all ask all the time, "Can I do your side of the hysterectomy? May I do this? May I do that?" but I'll say, "No. I've gotta keep my hands active. I have to prove to myself I'm able to do it as well as I've always done it because when I'm not able to do it, that's when I need to leave the operating room suite." Besides that, of course, I'm board certified and re-certified and re-certified and re-certified every year. And just continuing to keep a fairly high-volume practice. When you become less busy, if you slow down too much, you don't see the pathology, you don't get into the operating room suites with the big tumors, and that's how you decrease your game, your technical

skills, in particular, and your clinical intuition.

Ms. Rosario:
At one point we had a discussion about the importance of keeping on top of the pathology, like the basics.

Dr. Boatwright:
Yes. University of Michigan medical school training is so different now. Residency training is so different now. We were presented with a chief complaint, we worked that patient up based on her interview and on her examination and then based on normal physiology, and therefore when we are picking up pathophysiology, you were able to come up with a management plan. The residents now are presented with the chief complaint, then they go from that chief complaint to A then B, then C, then D, as far as diagnostic workup and management because they do protocols. Whereas I go from A, and because I know the pathophysiology, I can skip B, C, and D and go straight to E. That train of thought is lost. So I emphasize that I'm still teaching, not at Rush, but at Weiss Pipeline Hospital in Lakeshore Drive and I teach the residents there from St. Joe's program. I emphasize the pathophysiology. I go over with them the normal physiology and how to pick up the pathophysiology.

Ms. Rosario:
What are one or two cases that you can speak on in regards to how they've impacted the way that you've practiced when you first started and how you are doing medicine now?

Dr. Boatwright:
One thing that I've learned and I've continued to learn, because you have to continue to learn, you always have to be open in order to stay abreast of what is being offered that's new and to incorporate that which is old with the new to come up with the best for the patient. So now, pick up this scenario. I'm a new third year resident at the University of Michigan, but I'm at Wayne County Hospital and that hospital, the attendings back in the day, they were at home. So you were the doctor in the hospital. And a lady comes in with vaginal bleeding and the diagnosis from my senior that checked out and left me with the case was "rule out ectopic." So of course, it was after hours, and I had to take her to the operating room for a laparoscopic procedure to see if she had this ectopic. I trusted my senior. Now we will add this to the fact that back in the day when we did laparoscopic surgery, we did not have video cameras. So you would put the microscope or laparoscope in the patient's abdomen to look at her tubes and ovaries with your naked eye. There was no video camera set up. I took the lady to the operating room. I was very secure with my operative procedure, and I didn't examine her under anesthesia before I put the scope in. I trusted what was passed off to me. So I had a young lady, rule out ectopic, vaginal bleeding, per the ultrasound that was very antiquated back in the day, we're talking about 30 years ago, did not see what they thought they should see for an intra-uterine pregnancy. I put a scope through the belly button, through the skin, through the uterus that was twenty-week size and without rupturing the bag, saw a baby floating in this lady's abdomen, she was 16 to 18 week size, moving the finger, the digits and so forth. And I called my attending Dr. Barkley who is now deceased, a great doctor, and I said, "Dr. Barkley, this is Boatwright. I did not do a EUA, I'm looking through a laparoscope at a live intrauterine pregnancy. I did not rupture the membranes and it is unbelievable." And lesson learned. And he said, "I'm on my way." I said, "Sorry Charlie, the scope will be out." I pulled the scope out, there was no bleeding, end of story. Exam under anesthesia. Exam under anesthesia is something that really has influenced my life because I will never operate on the patient and have subsequently never operated on a patient without examining them on the table first regardless of the procedure. That's your best exam.

What did it do? Not only does it sometimes change what I will do in the operating room because the patient is asleep and that's your best exam, she's totally relaxed, but I was able to train my hands, close my eyes and feel her pathology with my eyes closed. And then, subsequently, that same day, that same hour, see what I thought I felt. So that when I'm in the office, I am now able to do much better with my hands because I trained my hands to do that exam under anesthesia and get immediate feedback as to what I was feeling or not feeling. That was very influential.

The second case, and this is important because at some point, I will write this story. I met a lady named Thelma. I was a new fourth year resident at Henry Ford Hospital. This was an externship for the University of Michigan medical students. And I was assigned this lady to do a physical. Weight loss of unknown etiology. I was blessed. I picked up a lymph node and we took her for a biopsy. And it turns out she had a very aggressive lymphoma. That same rotation, after she started her chemo, she had a bad reaction to the chemotherapy and became septic. And I stayed up with her for 72 hours 'cause my senior was not as engaged with her care as he should've been. I did a workup on this lady, I did a spinal tap alone, I did a neckline on my own. Now I'm a fourth-year resident and I refused to let her succumb to her disease because, at this point, the sepsis was iatrogenic from the chemo being given correctly, but maybe a little bit too aggressively for a woman who had such bad disease and constitutional symptoms. And she survived. She lived. And her last words before she left us were, "Tell Pat thank you for this summer." And that was the first time that I could remember that saving a life had impacted me personally so much. And it was so rewarding and when I have difficult cases, I refer back to Thelma and say, "OK. I can

do this because of your words, these words will be said to me again.'"

Ms. Rosario:
Well why don't we conclude this podcast if you want any final words to your colleagues about being a gynecologist, a surgeon.

Dr. Boatwright:
Well, I'm blessed. I will recall when Michael Jordan was interviewed once. The newscaster was asking him about how he felt about leaving his work and so forth. And he says, "I never worked a day in my life," because to him, ball was not working, it was just his life. And that's how I feel about medicine. Patients sometimes will comment, "You know, Boatwright, we never see you dressed up," and I said, "Because I don't really feel like I'm at work." This is just that natural for me. I am truly blessed with that.

Ms. Rosario:
That's awesome. You shared with me one time and I would love for you to share this with our audience about something your father shared.

Dr. Boatwright:
Well, Daddy had two things: nothing of value comes easy; if it comes too easy, it's worthless. And when you're no longer servicing society, you need to depart from this world. And that's a Boatwright philosophy and that's from his dad, too. We work until we no longer can work and that means that we're moving on and transitioning to whatever comes after this life.

Ms. Rosario:
Yeah, well, I take from that all the work and service that you have done. As a physician, as a friend, as a confidant, as a mother to probably all of your patients.

Dr. Boatwright:
Yes.

Ms. Rosario:
So, I appreciate that.

Ms. Rosario:
Dr. Boatwright, that is such an inspiring note to bring our program to a close today. You've been listening to *Advances in Women's Health*. To revisit any of this discussion, and to hear more of my conversations with Dr. Patricia Boatwright, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.