Connie Adler quotes Marian Wright Edelman: “Service is the rent we pay for living.” And she means it. For 25 years she has been dedicated to the care of women—women and those important to them, children and families. Working in a free clinic and as a lay midwife in Seattle, Washington, in the early 1970s, she was caught up in the burgeoning women’s movement and has never really left it. Her commitment carried her on to medical school, training as a family physician, 5 years of service in the National Health Service Corps in a migrant health clinic in eastern Washington, and now a family practice specializing in women’s health in western Maine.

Daughter of a Jewish immigrant psychoanalyst and an Irish American mother, Dr Adler grew up in an environment that valued intellectual achievement but discouraged women entering medicine. It took a degree in history and 10 years of vocational wandering before she found medicine and gravitated rapidly to family practice. Primary care was not valued at her research-intensive medical school in the mid-1980s, but with a few colleagues, including her soon-to-be husband, she made it through school with her generalist values intact, graduating Alpha Omega Alpha.

She is upbeat and loquacious in discussing her life and her work, chuckling easily and telling stories on herself. She understands what she has accomplished and she describes it with clarity and a sense of continuing mission. Dressed in brown clogs and burgundy scrubs with her wedding ring and watch neatly pinned to her collar, she is at home in the obstetric suite of the Franklin Memorial Hospital in Farmington, ready to deliver one of the scores of infants she brings into the world each year. She pauses for 20 minutes in her chat about her career, delivers a 7-pound infant to a 16-year-old girl, reflects on the challenges awaiting them both, and returns to her own story. She is never far from giving service to someone.

—F.M.

In my mid-20s in the early 1970s, I was “called.” That was when I knew exactly what I wanted to be doing—working with women in labor and delivering babies. That was one of the clearest moments in my life, and since then I have known that’s really where I belong.

Wandering Toward Medicine

I had moved to Seattle after college and was active in community organizing. I helped to start the Country Doctor Clinic, a collective that was one of the first community clinics in Seattle. A group of 10 or so people got the clinic built and going. Then another woman, Margie Joy, and I started the prenatal clinic there. She was doing home deliveries and I was helping and became sort of an apprentice. She was a lay midwife and had a physician for backup. I started doing deliveries, always with somebody else. The only ones I ever did by myself in those days were by accident when nobody else came out or got there on time. Within a year, though, I felt that I didn’t want to be a part of doing what seemed like inadequate medicine to me, that if I was going to say I had some skills, I really needed to have them. And it wasn’t enough to know only the reproductive system. Women would come in who were pregnant but who also had a sore throat or some other problem, and it just wasn’t enough to know only the reproductive system. That’s when I started thinking again about going back to school.
The other major and more important thing that happened during those years was that I had a baby. My daughter was born in 1973 and so of course I was involved with raising her. I was in a variety of different collectives at various times, but I did not have a partner. So I was single-parenting. At that point was the beginning of a crackdown on lay midwives. I was definitely worried about supporting my daughter and more concerned about consequences like jail once I became a parent.

My father was a physician but I don’t think that had a lot to do with my decision about medicine. He escaped from Germany in 1937, a German Jew. The rest of his family was killed in the camps. My father was a product of European Jewish intellectual culture between the two world wars, and he brought this incredible Renaissance man character to everything he did. He died recently so I think about him a little bit more right now. He was a psychoanalyst trained in Austria, France, and Germany. He taught neuroanatomy in Turkey for awhile. He actually practiced both neurology and psychiatry for a long time, then stopped doing neurology as he got older. During World War II he was in the US Army practicing largely as a neurologist.

My mother came from an Irish-English family that had been in New York for a century. An interesting combination. The two families would not probably have spoken to each other had my father’s family survived, but it never was an issue. My parents shared their love of the arts and took us to the ballet or the opera or museums almost every weekend. Just as an interesting snapshot of my parents, when my father had 3 months off between when he was demobilized after the war and when he started practice again, he and my mother visited every church and museum in New York City. That’s what they did with that time. That’s who they were.

I grew up in Queens; later we moved to Upper Brookville on Long Island. My parents were Democrats, but not terribly political. From the time I was very young, justice was an overwhelmingly important concept for me. There certainly were things that promoted that feeling, including learning other languages. My father spoke eight languages, and we all started by age 7 taking French lessons, and then, when I was 13, I went on my own to France for the summer. When I was 15, I went to Guatemala and learned Spanish, and later I went to Germany. Both learning languages and traveling to other countries were politicizing experiences. When I was in Guatemala, I witnessed incredible poverty next to incredible wealth. Guatemala has 95% illiteracy, and 5% of the people own 90% of the land: a tremendous eye-opener for a 15-year-old.

We grew up in a racially mixed neighborhood in Queens, which felt completely normal to me as a kid. Later I discovered that people didn’t think that was normal. By the time I was in ninth grade, on Long Island, I was getting kicked out of class for being a Communist. During my high school years, of course, people were starting to organize in the South, voter registration and so on. That’s when a lot of my intellectual and political activities started.

I loved my science courses—except physics. We had aptitude tests. Each time I took one, people said I ought to become a doctor, and every time that happened, they also said, “But that’s silly. You’re a girl.” And so I went to college as a history major because it was “silly” for me to think about being a doctor, because I was a girl. That was 1965.

I went to Cornell and liked it a lot. I actually loved my history courses, American cultural and intellectual history. It was an exciting time with the antiwar movement and the black student takeover of the Student Union. Dan Berrigan was there; we had Seder with him. But then I went to Yale to do graduate work in history and just hated it. It was the beginning of the women’s movement in New Haven, which I became involved in. Actually what I wanted to do was oral histories of women, especially women in the labor movement. The history department was very much Old Guard and thus a real conflict. I left after a semester, eventually moving to Seattle and getting involved in midwifery.

A Woman for Women’s Health

After Seattle, I came back East to start on my uncertain but determined journey to medical school. Women’s health was my focus, my goal. The ’60s and early ’70s, of course, was a time when the women’s movement was just taking off. I was a middle-class kid and hadn’t suffered any horrible economic discrimination. But I knew from my own experiences the unequal position of women and the violence against us. I had already been involved in some antiviolence issues, violence against women, as well as the abortion issue. I ended up in Boston working different jobs, raising my daughter, taking premed courses. I remember sitting on the beach with my 3-year-old so she could play in the water while I studied organic chemistry.

It was 1979—10 years after I graduated from Cornell—when I started Tufts Medical School. I was 10 years older than almost everybody. The very first day I sat in class next to this kid who looked like a kid. I said something about my daughter, and he said, “Oh? What does your husband do?” And I said, “I’m not married.” And he said, “But I thought you said you had a daughter.” I felt like I had to explain to him that those two were not necessarily related. I met Mike Rowland, who is now my husband, in the first few weeks of medical school, and that actually helped quite a lot. We had each other to get through school. He was also an older student. He had taught high school in Maine and Vermont and he is the one who first started talking to me about family practice. We got married in the spring of our third year in medical school. Mike and I had a second daughter our last year in school, which was also a challenge.

When I started in medicine, I assumed I was going to do obstetrics and gynecology. While learning the science of medicine, I felt that way even more. I love OB. It is still the thing I love most in medicine. There’s something about that interaction of several hours of labor and coaching and birthing that’s special and wonderful, but it’s a lot more wonderful when it’s somebody you’ve seen before and you will see later, seeing the child grow up, interacting with the mother throughout her life cycle, or throughout the child-raising years. I wanted to take care of that unit. The further I got into...
medical school, the clearer it became that I wanted to be able to care of the whole life cycle. There were about five of our class of 150 who became family docs.

Mike and I both received National Health Service Corps scholarships to get us through school. Mike needed the help and had planned on doing rural practice anyway so it was up the right alley. For me, similarly, I was on my own with a child and had to find some way to support her. I really did not want to pile up big debts to influence how I practiced afterward, because I wanted to do shortage-area medicine. I felt that no matter where I went with the National Health Service Corps, I’d be doing shortage-area medicine. I never wanted to do suburban practice.

Payback Time: Split Internship and the Health Corps

We had to do residencies before we started our payback practice. We chose the Maine-Dartmouth residency in Augusta because it was a good place—a great place—and we got them to agree to let us do it in 4 years instead of 3 because we had the new baby, as well as my eighth-grader. So we split our internship year. We alternated months: one month at home, one month at work. So we both did the internship year over 2 years. I loved it. We also chose the Maine-Dartmouth program because of the great people there and their attitudes. It was the only place we found where people could be openly gay in the residency, and where women were valued for who they were. The program’s commitment to training physicians for rural areas was very clear. I learned a lot about family counseling. My practice has always been a lot of women. Women want to come to a woman physician. I did more deliveries during my residency than anyone had ever done in residency there before. The obstetricians really came to trust me so I got to do a lot—C-sections and other procedures. Obstetrics was always a focus, but I loved every part of it. I did a lot of work with family counseling with kids, family counseling with the families of children who were diabetic, and teaching and learning how to cope with chronic illness. It was a wonderful time for me.

When we finished residency in 1987, Mike and I owed the National Health Corps 4 years. We liked the Zuni reservation, but we ended up going to Moses Lake, which was a migrant hospital in town where we did deliveries and hospitalizations. The hospital had a medical staff of about 25; the others were all in private practice. So we took care of everybody who didn’t have health. There was a 50-bed hospital in town where we did deliveries and hospitalizations. The hospital had a medical staff of about 25; the others were all in private practice. So we took care of everybody who didn’t have any money, and they took care of people who did. Some of the specialists supported us but we did almost everything for everybody. I had 8 hemophiliacs in my practice, and in fact ended up being sort of the hemophilia expert in eastern Washington. There were several families where I was taking care of four generations of people.

We stayed in Moses Lake for 5 years. The first 2 years we were alternating call every other night—with each other! It was ghastly. We never saw each other. Basically the way to change that was to build the practice so we could hire somebody else, and we eventually did. We were seeing lots of patients; we were busy, we took all comers and built up the clinic. By late in the second year we went to every third night on call, which was glorious. The clinic’s reputation in the community grew steadily so that the other docs were more accepting. By the time we left, there were four physicians and two physician assistants working at the clinic. We had a new building.

Moses Lake was a very, very conservative town. I was the only woman I knew who had kept my maiden name, and people gave me a lot of grief about it. It was an atmosphere that was stuck in the 1950s. People mostly identified by their church, and that’s how they socialized, by church group. So we were almost never asked out because we didn’t belong to any of the local churches. The Hispanic community was very open and we went to lots of “balls” and parties with our patients and staff. But the Anglo community was not all that open to us, with the exception of the clinic staff and one very supportive obstetrician.

The high school was a trial for our older daughter. She didn’t fit in very well in town either, but she ended up doing a lot of independent study. During her first week of school she came home in tears saying, “They have mandatory pep rallies here.” There was some culture shock, but she got over it. She did well and went on to Columbia University.

Back East, Back Home

At the end of 5 years, we decided to go back to Maine. We still had a lot of friends there and wanted to do rural shortage-area medicine. We chose Farmington because it has an excellent school system for our youngest daughter, with a lot of emphasis on music, which is her interest. I found two obstetricians here who were willing to let me do family practice and as much obstetrics as I wanted. We certainly saw a lot of communities where there were turf battles; the obstetricians didn’t like family docs. I do primary care, but the three of us share call. I do my own C-sections, tubals, and D&Cs, and I share call with the obstetricians. I enjoy surgery and do a lot of it. I also share call with the pediatricians and do all of the pediatrics I want. People talk about a women’s health care specialist and I guess that’s what I am, except I do a lot of pediatrics too. I was chief of staff last year at the hospital in Farmington. I get along with most of the specialists. People have idiosyncrasies, God knows, but there is not a lot of turf fighting here.

Farmington is an interesting community because it’s very rural, but we do have a college, the University of Maine at Farmington, so there’s some element of college professors and students. We have a lot of farmers and people who work in the woods. Maine is a poor rural state, with many folks who have nothing. There’s a big ski area nearby and there are yuppies who work there. It’s an interesting cultural mix. Almost everybody is white but I think that every Mexican American in Maine knows I’m here, and they come to see me because I speak Spanish.

I hate private practice, except for being able to make decisions about my schedule. But I think it’s a dumb way to do
medicine. I hate doing the business part of private practice. I’m good at it, I’m doing fine. In OB, a lot of people become eligible for Medicaid, so the OB part tends to pay for itself. The folks we see in the office who can’t pay, we write off. It all works out. We have some people who will pay over time, or pay with their services. I’m making a perfectly good living, got my kid through college. That’s all I care about. I hate having to think about insurance companies and reimbursement problems. I would much rather be working in a community clinic.

As far as managed care goes, Maine is way behind the curve. We’re probably 10 years behind California. So a lot of it here is just speculation. I have a group of managed care patients in my practice. I have learned how to use that system and play the gatekeeper role. I think we are going to have to learn how to talk to each other better and manage patients on a community basis a whole lot better than we have in the past. There are few specialists who do inappropriate things, and as a medical community we have to learn how to control that.

Right now I think we’re going from point A to point B in the system as a whole, point A being this nonsystem of independent practice, B being managed care in some form. It’s hard to get very excited about point B, but I think there’s a point C. Point C will be a lot more involved in patient concerns—which have gotten lost in managed care—and involved in public health but incorporate a lot of the savings and organization of managed care. I think I won’t be able to be involved in getting to point C if I’m not involved in getting to point B. I don’t exactly see what the ultimate product is going to look like yet. I had assumed it would be a single-payer system. I was very excited about the Clinton health plan and working toward some kind of rational health care system. Managed care can’t be the end. There are still all of the uninsured and the problems of “rationing” and the appropriate care of the elderly. But you can’t be a part of that dialogue unless you’re a part of this one.

I do feel that I’m doing what I set out to do when I decided on medicine. I’m the only woman physician doing women’s health in this rural area. The obstetricians are all men and so are most of the family docs. I have patients who are incest survivors, cult survivors, domestic violence survivors, and women with multiple personalities from childhood abuse. These are patients who really want to see a woman physician—and not just a doctor but a doctor/mom. These are people of all ages. This is the need that I fill in this community. It’s important to me to be of service.

I have lot of energy and a lot to give. I get enormous amounts back from my patients—some days. Other days it feels like all out-go, no input. But there are some very special moments with people, with their babies, with people who are dying, with teenagers taking on new tasks and figuring them out, that are rejuvenating, that give me as much energy back as I put into them. So it’s very renewing. Not every day. There are days when I drag myself around because I’ve been up all night and can’t figure out which end is up. But overall, it’s tremendously rewarding. There’s nothing I would rather be doing.