

Lessons From Our Learners

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Reflections on a Rotation in Appalachia

Josh Carter

Southeast Kentucky's mountainous countryside is cut with tight valleys that twist and branch like a network of arteries. A rich heritage pulses through these hills carrying the lifeblood of unity, hard work, and love of University of Kentucky basketball to all corners of the region. The heart of this region is fueled by plenty of biscuits and gravy, fried okra, and mounds of buttery sweet potatoes. This was my lesson-filled classroom for a rural rotation.

Lesson one: My Yankee accent and my formidable shirt and tie made it clear—I was an outsider. It took more than one coal miner covered in soot in the exam room, more than one duct-taped puncture wound before I realized that such sights were actually commonplace.

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From the University of Kentucky.

I found the lack of pretense, the disregard for façade, to be intriguing and noted ironically that I, myself, was the real spectacle in this community. As soon as my mouth betrayed my “foreignness,” I could sense that a different sort of interaction would ensue compared to my interactions with my preceptor. While the people would politely ask where I was from and if I was enjoying my time there, I still perceived a polite, but distanced, tolerance. One day, though, I offered up to a patient that I had married a girl from their county, and from that time on, it all changed. I was welcomed into the fold as family, applauded for my efforts, and met with genuine interest. I quickly changed tactics and began to practically introduce myself through my in-laws. This technique built a solid rapport with the patient and only cost me a few extra minutes listening to some mischievous story involving my father-in-law. I found the tradeoff to be quite worthwhile.

To be an insider in Appalachia is to be tied to the people. For them, community is everything.

Second lesson: A language lesson. For the last 3 years of medical school, I have had new words infecting my head like an uncontrolled spread of meningococci. Somehow, I have already forgotten that most people do not know these words and that my communication with them can therefore be quite limited. I found that I stopped getting quizzical looks when I changed “diabetes” to “the sugar” and when I swapped “diuretic” for “a water pill.” When a patient looked “lower than a snake's belly,” it helped to tell them so, and when a patient said their ankle was “rurnt,” they really meant it. In my excitement for patient education, I discovered that a brief discourse on distal esophageal metaplasia or lipid-laden macrophages proved to be entirely ineffective and only wasted everyone's time. But as soon as I mentioned “those Wildcats” or how the weather was “colder than

a well-digger's bottom" then my audience was all mine again.

Lesson number three: Being a physician is dangerous. Not, of course, in the sense of needing to dodge bullets or avoid hungry monsters. Instead, the danger lurks in the local belief that the doctor is practically omniscient, omnipotent, and omnipresent. Patients come into the clinic with a rock-solid faith in the doctor's curing power and never question their goodwill. Most folks are not impressed by statistics and don't give a rat's gluteus about evidence-based medicine. They do, however, greatly respect a doctor who they can trust. In fact, the phrase, "I don't care doc, it's whatever you think best..." constantly echoes down the clinic halls. Danger lies in abusing this trust. One day in the ER, the medical staff rolled their eyes as a patient, "Norma," was wheeled

in—again. Just before I strolled down to Norma's room, the staff was quick to inform me that Norma loved her Percocets and was clearly here to abuse the system. After all, they reminded me, narcotic abuse is infamous in Appalachia. With these words ringing in my mind, I opened the door to her room and found Norma doubled over on her bed moaning softly, clutching her abdomen in obvious discomfort. To my shame, I admit my history was brief, my exam was cursory, and my compassion was deficient. I could not remove the biased lens of scorn placed over my eyes. In actuality, while she suffered quietly on the exterior, she was inwardly screaming at the top of her lungs for help. Her lonely soul, with back turned to a world that ignored her cries, had given up hope. My human tendency to cut a quick corner and avoid being bothered by such a "lost

cause" devoured me. Medicine is a dangerous business.

Neither the human body or medicine can function without a heart. And here the heart is a love for the people. Appalachia showed me that such a love is not one-sided. The heart of medicine does not require a detached, stone-faced approach to robotically distribute help to sick people. On the contrary, I discovered great personal joy in caring for them (as well as a tasty butterscotch pie that one patient made me). Surprisingly, I found this heart to be the same one pounding life into Appalachia, the same one fueling this region's rich heritage by piles of 'taters and okra. A community love like that flows down every hillside and fills every holler.

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