Lessons From Our Learners

William D. Grant, EdD

Feature Editor

Editor’s Note: Submissions to this column may be in the form of papers, essays, poetry, or other similar forms. Editorial assistance will be provided to develop early concepts or drafts. If you have a potential submission or idea, or if you would like reactions to a document in progress, contact the series editor directly: William D. Grant, EdD, SUNY Upstate Medical University, Department of Family Medicine, 475 Irving Avenue, Suite 200, Syracuse, NY 13210. 315-464-6997. Fax: 315-464-6982. grantw@upstate.edu.

A Stroke and Its Consequences

Casey B. Patrick; Jennifer Joyce, MD

As I worked my way through the first 2 weeks of the family medicine clinical rotation, I would periodically mention to my preceptor that I had to make home visits to a willing patient. Throughout each day, though, both the physician and the head nurse never seemed to be able to find the right patient. Then, on a busy Monday afternoon, the nurse came in and said that Norton Brock was in room five. Dr Brock’s eyes lit up. “The perfect patient for you!”

Before I entered the exam room to see Mr Brock, I skimmed over his chart. I found that his problem list was fairly short for a 72-year-old gentleman. Until August of 2002, Mr Brock’s medical history was quite uneventful. On August 23, 2002, Mr Brock suffered a stroke. As I read this in his chart, even though I had never met the patient, my heart sank. My preconceived notions began to form. I was almost afraid of entering the room for fear that I was going to find a man devastated by a stroke.

When I opened the door, I thought I was in the wrong room. I found a very healthy looking elderly gentleman sitting on the exam table. As we began to chat, Mr Brock told me about the day his stroke occurred. He told me that his left side had suddenly become entirely numb, causing him to fall in his driveway. He described how scared his wife was while driving him to the emergency room. The entire time he was talking, however, I was trying to find evidence of his stroke. Though I noticed a crutch in the corner of the room, his speech was clear, and his anatomy was symmetrical. When I examined him, I found that his muscle strength and sensation were only slightly decreased in his left upper and lower extremities. I was surprised to find such a highly functioning post-CVA (cerebral vascular accident) individual. Weren’t strokes supposed to be 100% devastating?

As I began my presentation of Mr Brock, Dr Hall immediately asked about the patient’s INR (international normalized ratio) and half-heartedly listened to the completion of my story. However, as Dr Hall and I entered the examining room together, Mr Brock perked up. The conversation did not seem to revolve around medicine. Mr Brock and Dr Hall had seen each other at the local Chinese restaurant, and Dr Hall jokingly attributed Mr Brock’s problems to the egg rolls. Then Dr Hall asked about Mr Brock’s family, the current arctic weather, and “Oh, by the way . . . ” would it be all right for me to visit the Brocks’ house and discuss his health? Only briefly, at the conclusion of the visit, did Dr Hall offer medical advice, telling Mr Brock to continue his current Coumadin dosage and keep up the good work at rehab.

Leaving the room, I was somewhat surprised at the lack of “medicine” that took place in the physician-patient encounter. Driving home, I thought about why that situation may have bothered me. Then it struck me. First, I had not even considered Mr Brock’s family, social, and spiritual situation. Second, I realized that Dr Hall was using a broader knowledge base when caring for patients. Finally, I realized the need to focus more on the patient and the disease as one, rather than on the disease alone. At this
point, I began to look forward to the home visits so that I could gain a better idea of the “whole” Mr Brock.

During my first home visit, I learned that Mr Brock was born and raised in Williamsburg, Ky. He graduated from Williamsburg High School in 1947. Following graduation, he married his sweetheart Norma and went to work for a local factory as an electrician. Mr Brock retired from that same factory only 7 years ago. The Brocks have three children, all of whom graduated from Williamsburg High School and still live nearby. Norma Brock has never held a job outside the home.

I was sure that Mr Brock’s stroke would have caused a major rearrangement in the roles that Mr and Mrs Brock played in their home. This was a man who had worked for almost 50 years and practically built his own house, yet on August 29, 2002, he could not even walk. He discussed being upset at the fact that the stroke had initially left him with physical limitations so severe that he could not help with chores around the house. I responded, “But you answered the door without your crutch?” He laughed and told me that he only used that thing when he went to the doctor. Mr Brock further explained that he recognizes that his rehab continues every time he opens the door. He knew, “by gosh,” that he was going to get better.

As we talked, I learned more of how the Brocks’ family, social, and cultural backgrounds intertwined as one. It should have been obvious: the social and community structure of Southeastern Kentucky is derived from blue-collar immigrant coal miners who hold family, community, and spirituality in the highest regard. The entire extended family had attended First Baptist Church “since before I can remember,” according to Mr Brock. All members of the family had attended the same high school. The Brocks talked of their neighbors and church community like family. As we continued to talk, I could sense a bond the Brocks and I shared as products of the same cultural background—my neighbors were my family, my family was my church, and my community was also part of my family. It also became apparent to me how many times in the past 2 weeks that Dr Hall, also a Williamsburg native, had used that same bond to relate to and build trusting relationships with his patients.

After my visits with the Brock family, I began to better understand many of the issues that had been troubling me. I understood why Dr Hall had not focused more on “medicine” during our encounter with Mr Brock. As the primary care physician of a patient in stroke rehabilitation, Dr Hall’s role was to encourage Mr Brock through the rehabilitation phase of his care, since the patient himself was already properly connected to physical therapists, neurosurgeons, and neurologists. Over time, Dr Hall had been able to develop a level of family, community, cultural understanding, trust, and respect with the Brock family that allowed them to follow his referrals and recommendations with a high degree of confidence.

To be perfectly honest, at the onset of this rotation, the prospect of home visits was not appealing to me. As a private person, I knew I would be somewhat uncomfortable entering the home of patients whom I barely knew. While I may still be uncomfortable at times, I understand the value of the experience. When I look back at the relationships that Dr Hall has built with many of his patients, I hope that one day I may have that same bond with my own patients. Personal bonds will not be formed by possessing medical knowledge alone. I want to always be aware that my patients do not exist solely in a 20-minute block once a month. They live, work, and go about their lives when I’m not watching them. One can gain knowledge about a patient’s physical status with a stethoscope or reflex hammer, but only conversation and relationships will provide the necessary knowledge needed to completely care for my patients.

Corresponding Author: Address correspondence to Mr Patrick, University of Kentucky, Department of Family Practice, KY Clinic Building, 740 South Limestone, Lexington, KY 40536-0284. cbparf0@uky.edu.