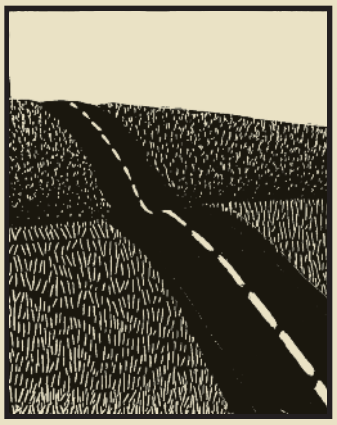
Rural delivery

By Isaac Howley



SUZANNE DEJOHN

I grew up on a farm in central West Virginia, a state where 20% of the people who live in rural areas are poor. I left almost a decade ago to go to a New England prep school and then Yale. In my junior year of college, a book on emerging infectious diseases inspired me to go into medicine. I wanted to provide medical care to poor people around the world. I did clinical research in Ghana last summer and was impressed both by its similarities to my home state and by how foreign and naive I felt in Africa. After that experience, I started to think seriously about going into practice back home, where I have a much better grasp of the cultural and economic context within which health and medicine fit.

As I drove farther south, into the West Virginia coalfields, I feared the worst—demoralized doctors and crumbling clinics.

When I returned to Dartmouth, I phoned some West Virginia doctors and arranged to shadow them over the holiday break. I realized that I had little idea how medicine is practiced in my home state.

Haphazard: In December, I drove home after my final exams and the next morning got up and drove still farther south, into the West Virginia coalfields. The mountains grew steeper and steeper, and the valleys narrowed. I tried to imagine what lay ahead. Knowing what I did of my home state, I feared the worst—demoralized doctors, crumbling clinics, and haphazard health care.

I had arranged to first spend a day and a half at the New River Health Association (NRHA) in Fayette County, shadowing Dr. Dan Doyle. The NRHA, which Dr. Doyle founded in 1978, provides primary care for more than 20,000 patients at several clinics in the county. I watched and listened as he talked to one of his patients—a retired schoolteacher who had recently been discharged after a hospitalization complicated by a methicillin-resistant *Staphylococcus aureus* infection. During the 15-minute appointment, Dr. Doyle asked several questions, mostly about the patient's concerns and priorities for treatment. He addressed her fears about traveling to spend the holidays with her son's family and educated her about how to minimize the risk of transmitting the infection to her infant grandson.

Encounter: Later, he confirmed what I had learned in my DMS On Doctoring class—that while establishing a diagnosis and choosing evidence-based treatments are important, addressing patient concerns and beliefs is at the heart of an ideal clinical encounter.

Several weeks before my shadowing stint, Dr. Doyle had sent me an article he'd written for his medical school alumni magazine about the NRHA. Included in his "Ten Commandments of Community-Responsive Practice" was a recommendation to "define community geographically; no one can be excluded." I got excited when I read this, since my own career goal is to provide care to everybody in a community, not just to patients who qualify for Medicare or can afford insurance.

Primary-care physicians often complain about low reimbursement rates for patients on Medicare and Medicaid. I asked Dr. Doyle how the NRHA handled this problem, since 40% of its patients are indigent and 30% are on Medicare or Medicaid. "There's always a risk that we could go under," he told me. "We don't have unlimited resources, so we have to make sure that the care we do provide is efficient."

The NRHA staff doesn't turn away patients who lack financial resources, but instead looks for creative ways to provide effective care. For instance, the staff formed a chronic-pain group, which uses DMS-like evaluative clinical sciences principles to establish guidelines to better help patients who were misusing their prescription medications. This program reminded me of a new elective I'm taking at DMS. We're observing how providers and patients interact to manage hypertension and are then looking at published research to come up with guidelines for more effective care. The NRHA is using similar evaluative principles for its chronic-pain program.

Checklists: I then spent part of the next day with Dr. Sarah Chouinard, the medical director of Primary Care Systems in Clay County. We met over breakfast at a small-town café. Dr. Chouinard barely paused to eat as she told me about various changes her clinic has made in the past year. The staff had started using an electronic medical records system, which has helped them reorganize patient care and maximize caregivers' skills and abilities. The electronic system includes reminders and checklists regarding screening tests, blood-pressure checks, tobacco use, and living wills. Over the past six months, the proportion of the practice's adult patients with a living will had increased from 2% to 98%.

This team model reminded me of a journal article that I'd read about an outpatient practice that had improved both patient outcomes and provider satisfaction rates by implementing similar rules for managing its hypertensive patients.

At Dartmouth, we think of ourselves as leaders in clinical improvement and cultural sensitivity. Until recently, I had never realized that these principles could be applied in resource-poor settings like the one where I hope to practice some day. Far from finding West Virginia a medical backwater, I met physicians there who practice progressive, cutting-edge community medicine. I'm now excited by the possibility of applying the principles I'm learning at Dartmouth to a successful, rewarding medical career in my home state. ■

The Student Notebook essay offers insight into the activities or opinions of Dartmouth medical students and trainees. Howley, a second-year M.D. student, is a cofounder of Dartmouth Medical School's Rural Health Interest Group and a participant in several other DMS student organizations. He has longstanding interests in public health and social medicine and plans to do his residency training in family medicine.