Hermes Monato, Jr. Memorial Fund Rural Health Paper

Reflections on a Primary Care Clerkship: November-December 2003 and February-March 2005.

April 15th, 2005

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My primary care clerkship begins in my third year of medical school.

Sometimes I feel guilty that I don't like primary care as much as I dreamt I would as a child because primary care is my personal definition of medicine and doctoring. Often when things are exciting for my preceptors, as a student, I am bored. There is too much time between patients and while tests are being done. I wish at times that a medical assistant were not present so that I wouldn't have to wait for them before seeing a patient. I am surprised that I don't enjoy the free time more and allow myself to adjust to the relaxed atmosphere. After all, I have just finished my surgery rotation and could use a break. The change from one rotation to another is shocking to the system. On primary "vacation", our day starts 4-5 hours later and ends 2-4 hours earlier than on trauma surgery and we have a legitimate social lunch hour in the middle of the day. I am not sure that I would run my clinic this way. Despite this schedule; however, my preceptors don't seem particularly relaxed. They are just as stressed as the surgeons that I worked with last month; the pressures that my primary care doctors feel are those of vastness, differential diagnosis, medication regimens and follow-up through sickness and health.

My internal medicine preceptor is one of the more interesting people in the office. She is sort of a serious version of Bette Midler. She has big hair with Yiddish flying everywhere. It is hard to tell if drama and tragedy follow her or if she follows it. It seems that the latter is impossible though, since she has experienced losses that you would not wish on your worst enemy. Two years ago this Thanksgiving, her brother who was a college professor at Georgetown and his young family were burnt to death while staying in a hotel in France. He and his wife were comatose from severe burns and their two children died. My doc had to fly to France and negotiate her way through the French healthcare system to eventually "pull the plug" on her brother three weeks later. The wife was kept on life support longer, so all of the family assets and heirlooms went to the wife's family, much to the heartbreak and disappointment of my doc's 90-year-old mother. My doc's mother then died a year later with a lawsuit pending trying to get back her things. My doc said that she could care less about the heirlooms, but felt badly for her mother.

When my doc heard of her mother's death it only compounded the grief she had for the loss of her brother. In fact, my doc had quit smoking 15 years earlier, but when she went to her mother's house after receiving a telephone call from the police that she had lost her mother, she was crying and for reasons unbeknownst to her all she could think of was that she wanted a cigarette. Of all things in the world, she wondered how on earth that came to mind as a source of comfort.

Today the lawyering continues. She finished her mother's estate business, but has now moved on to sue someone else. When she gets fed-up she talks about moving to Florida. I see that she has very little support and while she is an expert diagnostician, she has minimal interest or ability in developing an assessment and plan and sometimes

just seems to skip it altogether (maybe this is an example of how medical education has evolved in the last decade). Anyway, I still learn from her despite the stresses of her personal life. However, I do find myself very tired after her clinic. Her patients are complicated diabetics, those with congestive heart failure and uncontrolled hypertension. In addition, instead of reporting on patients I would listen to my doc's plight between patients. Her medical assistant is also continuously ailing. Perhaps, I am overreacting in the spirit of the clinic, but the emotion is strong and I wanted to translate it into words.

My other preceptor is in family practice. She worked her way through medical school with two small children and now is a UW faculty member. On the second week of my primary care clerkship, I was at clinic on a Friday afternoon. My doc said that she was having trouble seeing out of her left eye. She had noticed a flash of light and now here vision was disturbed. At first she blinked a lot and rubbed it too. She asked her NP friend to do a fundoscopic exam, but she couldn't see anything obvious in her undilated eye.

Then she decided that she might as well start seeing her patients since they were waiting and well, perhaps her vision problem would resolve. She went in for a well child check and I followed. While she was examining the baby she excused herself, and well, I followed. We went into her office next door. She distressfully told me that while she examining the baby it looked "wavy and distorted" to her. She then proceeded to call an ophthalmologist friend of hers at the hospital. He asked her to come to the hospital right away. My doc burst into tears sitting behind her desk. Her mind was flooded with concerns of losing her vision or worse yet, a brain tumor. I am sure that her differential was long and morbid.

After she composed herself, we went into the hall to talk to the support staff and the nurse practitioner that worked on the other side of the clinic. The NP said that someone should drive the doc to the hospital; it didn't seem safe for her to drive herself. The doc said "no", she would drive herself after all there were patients waiting to be seen and the others could cover for her without canceling all of clinic. Then the congregation in the hall turned around to face me on the outskirts of the circle. The MED STUDENT could drive her. After all, I was useless without my doc anyway. I was there to follow her. I stepped up to the offer. Okay, did she want to take her car or my truck… and by the way I have only just moved to here and only know the street that I live on and the street where my clinic and my gym are located. So the one-eyed doctor and the disoriented med student set out on there way to the hospital for an emergency ophthalmology appointment. My doc curiously remarked that we should take my car noting that she had never been in a pick-up truck before.

So we headed out on the highway. My doc was talking a lot. She was nervous and trying to keep her mind off things. I was worried that I would be caught with my doctor "stroking out" on the highway. I felt responsible because I knew something, but clearly not enough to "save" her if I had to. It definitely would not look good on the six o'clock news. When we made it to the hospital parking garage, I was relieved to say the least. My doc was still chattering away about her family and her previous marriage. To my

surprise her first husband had turned out to be gay… and well so is my dad. It seemed we had more in common than just medicine to cross the generation gap.

We got to the opthalmology clinic and waited for the doc for quite awhile. It was very busy and we chattered away talking about our families and various interesting patients. It was apparent that emergencies are all relative and that we had been triaged to the slow line. When we see the opthalmologist, my doc is still chattering and teaching. I chided her, saying that she mustn't worry about her Evaluation since she continued to teach even during her own emergency health appointment. She even asked the opthalmologist if the "med student" could see anything on the peripheral retina exam. He said "no" due to the fact that seeing required the head instrument that he was wearing. I really didn't mind.

We returned from the hospital with a diagnosis of exclusion: an ocular migraine. Interestingly, no further imaging or testing was ordered. The clinic was emptied of patients when we returned late that afternoon. My doc was relieved although her vision was still distorted. She said that her injury had morphed into a "heat on the highway in summer" sort of hallucination. Even in her blurred state, my doc remarked that it was wonderful that we got to talk today. We got to know each other better than we would have in-between patients during weeks of this rotation.

After two and one half weeks of my primary care clerkship, I find myself moody and jaded. I am disappointed in myself. When I sit down to read about low back pain and headaches, I find my self under-stimulated and obsessed with biting my nails. I have a need to call my old therapist from the hospital library because I am overwhelmed with all of this downtime. I have tried to enrich my time with additional unscheduled time in my clinics. I have also set up meetings with community health workers in an effort to spice things up. When I am at my internal medicine clinic, I wander across the hall to an AIDS doctor's office to see a few patients with him. I ask to be involved, but I am not really their student and they seem reluctant to take me in on many visits, meanwhile I don't want to neglect my assigned preceptor even though she is currently dictating patients from last week. I ask an AIDS nurse if I can attend a Women with HIV support group that she facilitates. Instead of inviting my to join, she asks my what my intentions are and suggests that I come only if I have something to teach. This makes me uncomfortable and I slink my way back to the other side of the office to see an asymptomatic and therefore self-decidedly noncompliant diabetic patient. I am not sure if it is the others or myself that are making things difficult this week.

At the clinic across town, I also yearn for stimulation. I have a few specific goals from my time at that clinic. I would like to learn to identify otitis media (middle ear infection) and I would also like to independently perform a female speculum exam. The clinic is comfortable, but I am still seeking something more. I like the psychiatric aspect of our patients' stories. Perhaps because I have already had my psychiatry rotation, I feel comfortable addressing some of these issues. In fact, a clinic in a poorer part of town just closed, and those patients are being diverted to our clinic. They are getting new patients with STDs and substance abuse problems instead of just physicals and well child checks.

A woman was referred by her therapist to our to clinic to see a nurse practitioner about medication for obsessive-compulsive disorder. The nurse practitioner asked her what her obsessions and compulsions were. I am glad that she asked, although, it would probably not have changed the medication that we prescribed. I suppose that we could not have been sure that the disorder was obsessive-compulsive, and not something else, despite the referral and diagnosis from her therapist. It quickly became evident that asking about her obsessions and compulsions was emotionally loaded question. This question overwhelmed her and she began to cry. It appeared that she had never told anyone besides her therapist about her concerns. After encouragement and reassurance from us and a great deal more sputtering and tearing she shared that she was worried that she "smells". She was concerned that she had terrible body odor. We told her that we didn't smell anything at all and beyond that we told her she was a beautiful woman. The nurse practitioner asked, "Did anyone ever tell you that you smelled?" She replied, "Yes, an old boyfriend used to call me smelly because he knew that it upset me." She also added that she grew up on a farm and maybe that is where some of her worries came from. Additionally, she felt most smelly when she was intimidated or insecure, like when she is at her college classes. I wanted to ask if she was ever abused, sexually or otherwise, in the past, but I was new to the clinic and uncertain about interrupting. I am still more comfortable with being seen and not heard, but that is changing. When I mentioned the "abuse factor" to the NP after the patient left, she agreed that it would have been useful to ask about. Then I really wished that I had asked… but aren't all of these things being addressed by her therapist?…Do we have to rub salt in these wounds too?…Or is it rubbing salt at all?…Is talking to us part of the therapeutic process?…Part of the healing?…Or are we just the medication conduit?

An elderly woman came in who hated her brother's cat that she was babysitting while he and his wife went to Japan for a vacation. She was also desperately disappointed that, in her 73-year long life, no one had ever offered her any marijuana. Much to her chagrin, she even had a neighbor that smoked pot after dinner each day while he walked his dog. She also was concerned that perhaps her depressed mother was not able to give her the love she needed when she was a child. All in all, she was finding it difficult to keep up appearances with her friends and family and felt that they did not want to see her less than perfect side anyway. She was an intelligent and introspective woman so my preceptor referred her to a Jungian therapist. Interestingly, yet predictably, her chief complaints for this appointment were fatigue and weight loss. When I sat down to write a note about her, I found that we had not really addressed her chief complaint. In fact, it appeared that we did not address any life threatening illnesses that would cause fatigue and weight loss… like CANCER! However, after I looked back in her records and saw that this had been her chief complaint for more than two years and that she had been worked up for everything under the sun that could cause fatigue and weight loss including complete imaging and multiple scopes from either end of the gastrointestinal tract. The only telling comment in my interview may have been that she just doesn't care to eat alone and that she is able to eat more when other people are around. My diagnosis is weight loss secondary to loneliness?

It was 4:45 pm on December 2, 2003. It was thirty years to the day that I was born. I was looking forward to an evening with friends, when into the office walked a new patient to "establish care" according to the HMO schedule. He was scheduled for a

fifteen-minute appointment. My preceptor looked at the face sheet for the patient and noted this 45-year old man carried Medicaid and Medicare for insurance and she said to me "this is not a good sign". She also noted that he had not filled out any information on the medical history form that they give all patients. At the doorway of his exam room, she asked why he had not listed his medications. I could not see him, but heard him reply "I cannot read or write". My doctor looked at me and asked, "Do you want to do this?" Boldly, I said, "Sure, why not?" I introduced myself to our new patient.

As we began to talk for what became the better part of an hour, I realized that this man was beginning a new chapter in his life. He had just been released from prison within the last month. More importantly his prison sentence had interrupted a lifetime of drug addiction and crime. Before prison he had known nothing but drugs and the business of drugs. Up until his prison sentence, he smoked two packs of cigarettes per day, he was addicted to heroine and cocaine and he drank a 12 pack of beer per day. Somewhere along the way he contracted Hepatitis C.

I began to develop his problem list. Depression scored high and he had been suicidal most of his life. Then there were the physical symptoms of angina, diabetes, bleeding hemorrhoids, impotence and of course chronic low back pain. But here he was. It was almost as if he had just arrived in society as if from another planet. How did he get here to our clinic?

His mother, who he was living with, was on dialysis for renal failure from diabetes at another suite in our building and the clinic was walking distance from their apartment. He literally just walked in. There was nothing emergent in this man's work-up. There was no true reason for us to see him every week for an hour that we would never be reimbursed for, but I felt protective and didn't want to let him out the door. Part of me felt unwilling to let him make his own decisions and mistakes again. His constellation of risk factors was larger than I had ever seen in one life, the illiteracy being the icing on the cake. It was my birthday, but it was literally the first day of the rest of his life.

The good news was that he was regularly attending non-smoking, twelve-step, poly-substance abuse groups. In a way, he was attempting to live a "cleaner" life than many of my friends who have more life skills and have still failed their various, lifestyle changing, New Years resolutions. I wanted to follow him closely, but my preceptor said that there was no reason to do that. His medications could be managed monthly and maybe she could eventually set him up for treatment of his Hepatitis C. Her goals were quite different than mine. From what I know, Hep C treatment is hard for people with good support systems. It drives the most emotionally resilient people into deep depressions. The ray of hope for me was that he was cooking his own meals for he and his mother, he was attending meetings and he actually had a sister that was trying to get him into a reading program. Maybe he did only needed medical management from us. Part of the "plan" was to ask him an important question that had gotten lost in the shuffle…was he HIV positive? I hoped that this was the beginning a beautiful patient-doctor relationship.

Overall, I am amazed at how many lives that I have traveled through in these thirty years. First my family expanded and then I began to travel the world both physically and

through my mind and down to the molecular level and back again. It has been a pleasure to pass through. It is strange to know that I will not settle down again until after I begin my residency, in some unknown location, in about a year and a half. I have many more rotations to go before I graduate. I wonder where I will end up and who my family and friends will be.

There are many more stories to tell. There was a postal worker who actually did get bit by a dog. A suicidal transsexual patient who had gone off all of her medication and proceeded to bring her gun to the clinic and threaten to kill herself there. Then there was the first time I performed a pap smear… it was on a 19-year old girl with her 5th chlamydia and gonorrhea infection and a pierced clitoris. And one of my favorites, the family history of a man with secondary malignant hypertension caused by an untreated pheochromocytoma. Over the visit, he told me that his parents were both alcoholics and that by the way his father was an albino. Oh… and his mother and father were also both blind, but he and his five brothers and sisters all could see.

Life goes on…it is a year and a half later.

So much has changed in one year. My parents, who live 1000 miles away, went off the road and hit a tree in their Volvo last March 18th. The Madison city police contacted me four days after the accident since my parents and their cell phones were incapacitated. The general surgeon in the ICU exclaimed that he didn't even know that they had a daughter. Mom was on a ventilator surviving Acute Respiratory Distress Syndrome (ARDS) and open femur fractures. Her nurse reported on the phone that my mother moved her hand a little when she bathed her. What was I going to find? My stepfather, Joe, was already having a second surgery to save his fractured leg.

My roommate, Thomas, got me a flight for two hours from the police call and set up a rental car while I cried and talked to doctors at their hospital. I packed my parents advanced medical directives and some office clothes. My best friend and martial arts training partner, Nick, wrote out some breathing exercises for me and slipped them into my pocket as he wiped my tearful eyes good-bye at the airport. I called my current rotation attending at home to tell him about the accident and my trip back east as I boarded the plane.

Six hours later and after telling my predicament to an ex-marine on the plane, I arrived at a deserted New Hampshire airport and picked up my rental car. I drove alone in the dark to the newly built Dartmouth-Hitchcock. It did not exist when I left home for college. I arrive at the hospital at 2 am and went directly to the ICU.

Mom was bloated with the additional 20 liters of IV fluid required to maintain her blood pressure. He face was swollen shut; sprouting only a breathing tube. She was heavily sedated, but not in a coma.

An anesthesiology intern and rock-climbing guide from Portland, Oregon was working in the ICU that night. He sat with me and proceeded to go through my parents' laboratory results, service notes, surgeries and imaging studies. He was patient as I attempted to understand what had happened. The ICU staff offered me tea several times an hour. At

4 am, I went downstairs to my stepfather's hospital room. He was sleepy and attempting to read the paper while enduring pain from his leg surgeries and itching from a morphine rash. I slept on a cot in his room and checked on my mom every 3 hours. Her oxygen requirements were very high and her lungs were resisting the forced air from the ventilator, only life support and time would reveal her prognosis. She was too unstable for surgery, but her wounds had been cleaned and her long bones were in traction; held in place with external fixators that looked like radio antennas.

I met their doctors on rounds the next day. Joe's room was teaming with family friends, colleagues and politicians. My parents were both retired academics and currently serving their second term in the state legislature when the accident occurred. They were front-page news.

I coerced my medical school and Dartmouth to let me continue my rotations at my parents' hospital rather than taking a leave of absence. I lived with the state deputy democratic leader and her husband, a longtime Professor of Child Neurology at Dartmouth. They took me in like a stray dog from the neighborhood. The fed, housed, clothed and supported me as I made medical decisions and coped with my ailing parents. This adoptive family had children who were doctors and they were experienced in negotiating the medical, academic and political channels. I tried not to depend on them, but I had nowhere else to go. I wanted to relieve their burden, but needed their love, support and experience. Onlookers, wondered what would become of me, but this new family managed to keep me in one piece mentally and physically. I adopted them as much needed parents and mentors. At night, safely in my rooftop room at their house and after a nightcap, I often sat vigil, rolled in clean sheets, beside their golden retriever and cat whose cuddling was accompanied by the quiet scurrying of mice in the walls.

During my cardiology rotation at Dartmouth, my mother failed extubation and her heart stopped. She was reintubated and I agreed to a tracheotomy for her on Easter weekend. Joe had courageously graduated to rehab for his injuries. As mom was weaned from her tracheostomy, my surrogate family arranged, with the department of pediatrics, for me rotate in a rural clinic. They found a four-physician practice, filled with their own graduates, situated next door to the very inpatient rehab facility where my mother would be a patient while she healed. The small 50-bed hospital with ample parking and home cooked Vermont-style meals was perched on the edge of the Green Mountain range. As unlucky as my parents were, my own luck and support system seemed endless.

I finished my pediatrics rotation on the inpatient service at Dartmouth. When mom was ready to go home from rehab I returned to Wisconsin and the operating room. I flew through my orthopaedic subinternship to make sure that I really wanted to apply for residency in orthopaedic surgery. I wrote a case report with a spine surgeon who was 6-foot 7-inches tall. I required three operating stools and other scaffolding to stand on when I operated with him. I wrote and submitted a case report to SPINE on the most feared complication of spine surgery: paralysis. I even called the patient on the phone at her dairy farm to ask her how she was managing and reassured her that we were doing everything we could to learn from her trouble.

I took the Step II Board Exams and attended a conference on psychiatric disease by a long time friend and mentor. Not long after that I returned to my adoptive parents home and Dartmouth for a subinternship in orthopaedic surgery. The orthopods granted me full access to their department, operating rooms and clinics. At Dartmouth, they let me saw off a frail diabetic man's septic leg under the guidance of a semi-retired world famous trauma surgeon. I presented two talks to the department and also co-authored a review article on "C-spine Trauma and Assessment" and submitted it for publication.

My own mother and my host mother both underwent orthopaedic surgery while I was there. I was able to attend doctor's appointments with my parents as the surgeons convened and attempted to reconstruct mom's femoral non-union: a bone that had not healed more than a year after the accident.

My roller-coaster ride through medical school continued as I returned to Wisconsin once again for a mixed rotation in neurology, ophthalmology, neurosurgery and rehab medicine and psychiatry. I learned how to do a neurological exam and observed one brain injury (traumatic, vascular or oncological) patient after the next. I also applied for residency in orthopaedic surgery against reasonable odds. I was a short in height, class rank and scores… and I was a girl, but I matched anyway.

Today, part of me feels like my work is done. I did what I said I was going to do. I am on the verge of completing medical school. That, in itself, has been my long-term goal. I have rarely imagined life beyond this degree, but I don't seem to be dying anytime soon. There is much that I don't want to be part of in this world and little in which I want to participate, but the future has arrived despite my apprehension. I discovered that I have high standards, so sometimes nothing looks appealing and I often fail my own standards. Nevertheless, I have continued to meet one wonderful and courageous person after the next and find myself inspired nearly everyday. Really, what happened is that I lived… to tell the story.

My primary care preceptorship begins in my fourth year of medical school.

This experience begins on the side of the road to my new rotation site with a police lights flashing in my rear view mirror. I have been pulled over for speeding. The officer looked down at me under his wide brim and over his moustache, "The speed limit has been 35 mph here for quite some time now." I was going 48 in a 35. Most med students I know would have tried, under the halo of their white coat hanging on the back of their car seat, to get out of the ticket by saying they had to get to an emergency surgery at the hospital. But I didn't care, after all I had just spent $160,000 on the purchase of my medical degree, what would $77.23 more matter? I patted myself on the back for at least going to work when I really just wanted to play hooky.

Or maybe my preceptorship really began the night before the ticket when my new preceptor asked me, "What do you hope to get out of this 6-week primary care rotation?"

I have practiced keeping my emotions to myself as to not to act out what I was feeling inside to avoid punishment. However, I was too tired to conceal my despair and frustration and replied directly, "I really don't even know why I am here. They had told us this elective is a relic from the 1920s and that no other medical schools have this. It seems out of date." Then the truth really came out, "I have not even had any time off all year." Then, I bit my lip to hold my tongue, so that I did not dig myself any deeper into a hole.

You see, when you start a new rotation you are not supposed to say anything like this. You are supposed to be optimistic and ready to work and get involved. You are always supposed to express interest whether you are fascinated with the field or not. This is clearly written between the lines of every medical student handbook.

But even when I am honest, I know that I can still connect with patients. I can still breakthrough the stigma of despair and fear that holds people. I can still make someone smile and feel respected and hopeful. In my cynicism, I still had dreams of something better. Dreams that made me feel as light-hearted and hopeful as an early morning running while listening to my own breath. Dreams of accessing my own energy and allowing it to blend with my environment, like wind in a storm, where I ultimately feel part of something greater than myself.

My new preceptor didn't skip a beat. When presented with my negativity he expertly diffused the bomb that I had dropped, "This will be the best your best rotation in medical school AND the only one you will remember."

I said something like, "Oh." I mean really, what else could I say to that? There was nowhere to run to and he left nothing to argue.

So how did I get so bitter? Starting my third year in medical school, the big clinical inpatient rotations came forth. There the specialists of specialists taught us at a huge tertiary care hospital. There was little follow-up of patient care. They enforced the existing stereotypes and passed judgment on local primary care doctors on a daily basis.

Two of my previous primary care instructors during 2nd year in medical school worked in HMOs and seemed to be punching the clock. They did not perform careful physical exams and preferred gossip to critical thinking. There was rarely even a diagnosis to talk about. I even petitioned to switch preceptors thinking that I had just hit a bad apple, but no, the next one had little else to offer. I began to believe the sub-specialists: the rest of the world really seemed to be doing triage for the big names at this cutting edge national research and treatment center.

My experience in primary care until now fell in sharp contrast to the fact that the surgery service kept me awake and busy. The lights were bright. My first trauma surgery case was a murder-suicide by man who shot his wife in the head and then himself. Forty people were in the trauma room working and learning while the couple bled out onto the floor. More blood and fluid was pulsating out of their heads than was going in. Several trainees practiced some invasive procedures in preparation for the next less

badly injured accident victims who might live. I was shaken by the experience and acutely aware that the ER trauma bay was a place that I could learn to be useful.

I completed more rotations. I like sports and happy people, who doesn't? I like experts in their fields. I like working with my hands and helping people to walk and play again. I understand power tools and body mechanics. I felt focused in the operating room. I learned that I could be an orthopaedic surgeon even though I was not a giant football player. I could even use my research background in molecular biology to address the current challenges in bone healing and disease.

But where did practicing subspecialty surgery leave my goals of saving the world? Bad knees were not exactly the plight of humanity; although, you can find many people who would argue that their knee pain was ruining their lives. Pain often exacerbates depression, homelessness and poverty, but maybe I am trying to justify my own interest in sawing bones.

As a kid, I never wanted to be a socialite or academic, but I did want to be Hawk-Eye Pierce from the TV show MASH. To me he had integrity. He was ever challenging the status quo and got away with it by being a trauma surgeon extraordinaire. And I liked him because he was a martini drinker, passionate about his work, an activist, a flirt, had great bedside manner, was a practical joker, friend and humanitarian and he did this all from comfort of his ragged, red bathrobe over scrubs. Of course, he did end up with a nervous breakdown and returned to Crabapple Cove, Maine after the war. In reality though, I am a little more like Radar O'Reilly and even have the sensitivity, resourcefulness, short stature, anxiety disorder and pet rabbit to prove it.

I charged through more clinical rotations absorbing everything that I could. I wanted to talk to and lay hands on everyone who crossed my path. I wanted to understand our world and everyone in it. But, I was getting tired and I feared the future. I was soaking wet. I had sipped water from a fire hydrant and I could not absorb anything more. I felt like one in every ten teachers pointed me towards the horizon. The rest held signs of confusion and regression while insisting that they were right. It was hard to decipher who was who. I focused on not hurting anyone instead of trying to actually improve the system in order to survive.

I showed up at my Wisconsin primary care preceptorship against my own free will, but I wasn't the only one. When my friend arrived at her preceptor's office in another part of the state, she was asked, "So why did you choose to come here?" She looked at her doctor, astonished and said, "I didn't." My school, despite training all of its students at a tertiary care center, prides itself for its commitment to rural health and requires that all students scatter themselves across Wisconsin for 6 weeks in a rural health practice in order to graduate. As for myself, I had already been to some of these "triage clinics" and felt them to be a complete waste of time; like watching the weak fail to help the meek, like watching rain fall on water in an attempt to wash away the pain. Yeah, I was bitter and dramatic, looking back: what I hated the most was feeling useless.

When I finally did arrive this winter, my preceptor wasn't even there. He was taking CME credits with a neurosurgeon… at the where else? You guessed it …the tertiary care

center where I just completed a rotation in Neurosurgery. Sourness welled higher in my throat. The clinic staff put me with a pediatrician who was about to give birth to her own, god knows what number child, and to my already irritable mood she seemed to talk to the kids and their parents like a high-strung Grover. My head pounded. I feared that this was going to be the longest six weeks of my entire life. Couldn't I just go back to the operating room or maybe it would be better just go back to bed?

My family doc finally showed up at 5 pm and held clinic for another 4 hours. It turned out that the clinic bore his namesake. So did he run the place with his dad? No. It turns out that his brother, a pediatrician who had first burned the candle at both ends in neuroscience research, was his partner in business and medicine. They were 6-foot tall 43-year old twins with another brother who worked as a local dentist. Sometimes, their clothing matched "accidentally", while their cell phones matched on purpose. But in general, one kept his hair in a feathered-mullet and had shed his granny glasses following a recent laser surgery for a diamond earring and tended a small chicken farm while the other preferred GQ clothes and hair, donned dark rimmed glasses and escaped to the city to see his girlfriend. Oh, and last but not least, they are best friends and in a rock band too.

As I ruminated, I speculated whether I had been sent here by my school to insure some government funding for my state medical school. Or perhaps the tradition of this rotation was the only thing keeping it in the curriculum, since medicine had obviously changed dramatically since the inception of this requirement one-hundred years ago. I narcissistically wondered what I had to gain from following someone who was not actively renowned in their field. I mean rural ER? If it were up to me, I would go to Cook County in Chicago for ER medicine and see some real pathology and trauma treated by master technicians.

With the promise of a good rotation and more clinic the next morning, my preceptor let me out of the building after the first night to drive the one-hour of dark highway home and think about what he had said.

After following morning's clinic he had the afternoon off and therefore sent me home. I have never been so thrilled to have time to do my laundry, which had built up during the preparation for a recent final exam in neuroscience. I also opted to get a long overdue pap smear to insure that I would not drop dead of cervical cancer while treating someone else's. I even had a moment to work on my ortho research project during these newly found free hours.

So let me start again: with clean clothes, a normal pap smear that had previously been abnormal and a freshly aroused curiosity about how this would be "the greatest rotation of my medical school experience", I returned to the clinic ready to listen, learn, and work.

My preceptor organized my day and watched me work. His staff expected me to be there and did not make me feel as though I was in the way like so many others had. My doc listened and critiqued my patient presentations with interest as I stumbled through the history and physical of each preliminary patient encounter. He often sat down or at

least looked at me while I spoke. More importantly, he did not type, talk on his cell phone or insist that I walk with him while I spoke. He asked questions as I presented information. Then he did what no teacher had done: he asked my what I thought we should do for the patient.

Of course, I floundered. I had not been in this position before. He further encouraged me with a gentle kick in the pants, literally. It must have been challenging for him to try and coach such a weak student along when he could have just seen the patient himself and drawn his own conclusions. He encouraged me to have confidence, but how could I be confident in something that I had never done before? Then to my further amazement he continued to listen and teach…. day after day even when he was tired, ill or if patients and staff were waiting. The truth was his patients liked him, his nurses liked him and now his medical student liked him too.

He seemed to even enjoy being asked questions. He would humor almost every request. When it was late, he would remark that he was just getting his second wind and was available to reflect on more of my inquiries. I learned more and more as I realized that I was not going to get hit over the head with a two-by-four for my failures.

His medical business was unique during a national insurance crisis. He owned his own practice. In fact, this was his third practice success. He grew up in the shadow of a gifted physician father who some say should have been nominated for a Nobel Prize for the invention of the field of nuclear medicine. He was a recovering Catholic and had even left his first fiancé "at the alter", before he found the love of his life with whom he raises their three small children. Through his practice he remains insightful regarding his own tendency towards arrogance and rather than patting himself on the back for a winning diagnosis, he reflects with dismay at how many others he has and will miss.

However, sometimes his brother and partner does not want to be there. He recently lost his wife to a terrible disease. To a disease that he could not cure despite the letters MD and PhD behind his name; a disease that may have been iatrogenic or idiopathic, but either way could not be helped. She was beautiful and very sick for much of her life with cystic fibrosis complicated with infection and lung transplants. She seems to have died a hard, hard death. To honor her, this doctor adapted the vegetarian diet she followed in order to help him mindfully mourn her loss. As he moves on, he is driven to remember and to escape her memory at the same time. He runs from the country to the city. He is in constant motion. He only pauses to momentarily to allow his soul to reflect in the eyes of the occasional child. In the same hour that his self-absorption ignores me in the hallway, he openly reflects on how his own dark cloud permeates the atmosphere. He exasperates as he works, "I hate my life."

But still, he advises his patients constructively on how break cycles of emotional and physical abuse. He teaches parents that their children will respond to them in the same way that they behave towards their children. If they yell, nag and tease then their children will reciprocate. If they take their own time-outs and parent deliberately to meet their children's needs, their children will also. He teaches us that there are things that we can learn to do better, but that we don't have to necessarily become better people to do this. We don't need to morph into magical gifted and saintly unblemished

people to be good parents, friends and lovers. He reminds us that there are skills that can be practiced for the improvement of our relationships with our loved ones.

He also tells us to take practical measures towards our health. To eat 4-5 small meals per day or to moisturize, moisturize and moisturize our skin some more! He recommends that parents, "use this lotion instead of that one" due to its cheap price and greaseless, scent-free residue. And behold: watch as he demonstrates on a child's legs how the creamed skin glows radiantly compared to the adjacent dry skin. Spend this time touching your child he proposes: gently, lovingly, with purpose AND don't do it in front of the television!!! All of this enlightenment resides in the face of poverty, riches, love, abuse, sickness, health, growth and mourning.

After a brief, but heartfelt stint on the pediatric side of the practice and a bout with the flu, I returned to the family and sports side of the hallway per my own request; when at this time I could have gone to the OR for the remainder of the rotation.

A long time patient of my preceptor, an elderly gentleman with interesting character, below average intelligence and little formal education, came to see his doctor with a form from the police department. He had a history of hypertension and gradual loss of memory. The form required a physical exam and approval of a physician to regain his suspended driver's license. The patient was dressed in cut-off jeans with 3-inch suspenders loosely holding his pants at waist level. He wore a trucker's hat bearing the American flag and had a figurine of a deer pinned to its brim. His head and chin were covered with silver hair. His blood pressure was 220/116, but that he was feeling "fine" even though he couldn't remember where he lived unless he referred to his hotel key chain in his pocket.

But how could you get this man to voluntarily go to the hospital on a Friday afternoon when he does not feel ill, values his independence and would really just like to get his driver's license back and go home??? There was lots handshaking and smiling. How have things been going? Pretty good, except I couldn't remember where I parked my car the other day so I went to the police station to ask them to help me find it. They found it for me about seven blocks away from where I thought I had left it. Now the police say they don't want me to drive unless the doctor says it is okay. Where are you living? He reached for his key chain again to look. It said CandleGlo Inn, Room #7. How long have you lived there? Oh six weeks, or six months or something. I like it there. Your blood pressure is REALLY HIGH. Let's measure it again. It is still WAY TOO HIGH.

Meanwhile we are going to ask you some questions. Some will be hard and some easy. It is just to see if the blood pressure is affecting your memory. Okay??

We did a Mini-Mental Status Exam. He did not even attempt the subtraction of serial sevens with encouragement and did not think he could spell. We tried to have him work with numbers using dollars and cents, but he could not "make change" either. He could not remember three objects and named three random presidents of the United States instead.

We proposed that he go to the hospital for the weekend so that they could bring down his blood pressure with medicine. The patient expressed his concern that nobody paid attention to him at the hospital when he was there last time and that they were not very nice to him. Again he just wanted his license back and to go home. The patient acquiesced after much cajoling and agreed to drive himself across the street to be admitted.

Then the doctor had to go call his "friend", the admitting physician and explain why he thought this man needed to be admitted. My doc was openly chided by the admitting physician for such a "soft" admission and pressed for ways that the patient could be treated without a hospital admission. In spite of this, the doctor advocated for his patient's admission on the grounds that this patient was a danger to himself and others if he kept driving or burnt down his room. He was admitted and declared incompetent for medical decision making by more than enough doctors and a psychologist. He exhibited weakness during psychological testing in attention, initiation, construction, conceptualization and memory with no overall areas of strength. All that means to me is that without his room key this guy was more lost than the rest of us in the world.

One morning, another patient who was a young man left blind and uncoordinated by cerebral palsy came in with his mother. I have the pleasure of indulgently hearing about his abilities and limitations. He understands more than he lets on through his language. He is shy and dysarthric behind lots of smiles. He is insightful and somewhat embarrassed by his speech. He had taught himself to tell time and prepare food in the microwave. It turns out that he has a room full of awards from the Special Olympics at home. His best sports are bowling and Bocci ball, the latter of which his mother is the coach. He has been on a waiting list for volunteer activities with special needs groups for more than 8 years with no opening in sight. His mother tries her best to keep him busy, but cannot afford any services for him. A job coach for him would cost $15 per hour while he would only be making minimum wage at a store like Shopko. This adds up to boring, under-stimulating days for this young man. His mom takes him to work with her several times per month where he shreds paper for her office. He enjoys the work and being useful. On physical exam, he is all giggles and squirms under my light touch. My preceptor circumvents his ticklishness by allowing the young man to participate in his own abdominal exam. He has him press his hands over the doc's hands for deep palpation. When it was over, the doc then shook the patient's hand and signed his Special Olympics participation form as a clean bill of health.

My next patient reports almost immediately, "My husband has been drinking a lot." I ask, "When did this start?" More than 20 years ago. I ask, "How much does he drink?" One liter of whiskey every two weeks and a lot of beer. I asked, "What does he do when he is drunk?" He ignores me. He does not want to be intimate. We have not had sex for more than 10 years. We tried two years ago, but it did not go well. He was finished before I even started. I asked, "Do you argue?" He gets angry when I ask him about his drinking, but no we don't argue. I don't ride in the car with him when he is drunk. I commended her for that by saying, "I am glad that you are watching out for yourself. That is very important. Do you feel safe at home? Does he get violent?" No he is a quiet drunk. He has a new contractor job and is drinking with his friends from work more than ever. He drives home drunk most nights and I never know when he is coming home.

When we go up north we take two cars because we have so much stuff and he fills a thermos with vodka and orange juice and drinks it all they way up there. I reply, "I am so sorry. Do you work?" Yes, I have my own business and most of my earnings go back into the business. I like to go my church group. I also have gone to a few Al-Anon meetings, but I don't really like the format. I also have a sister in the area who I can talk to. I have been reading a lot about alcoholism and addiction. I would really like to help my husband. I ask, "Would you consider seeing a counselor yourself for support?" Yes, I would. "What are your other concerns today?" I ask. "I see you are here for your annual physical and pelvic exam." She is worried that she is not sleeping well and often has insomnia. She also wonders if she might have adult ADD and could she have her moles checked too.

I go to get my preceptor to report my findings. My doc has known her for a long time. I tell him about the alcoholic husband and her desire for intimacy and to help him. I emphasize that I have reviewed her home safety and support system, but that her husband is really doing poorly.

We go into see her. My doc is really upset about the drunk driving. He has several patients in his practice who have driven drunk and killed people in the process. He is certain that at least one of them with congestive heart failure, who currently is waiting to be sentenced by a judge while his wife gives him Antabuse, will likely die in jail as a ragged, worn down 70-year old man.

There is point of engagement in many of my doc's patient interactions. It resembles a call to truth from a pulpit of sorts; a metaphorical "come to Jesus moment." The nurses are aware of these moments and try not to interrupt a visit during this time. I am a witness to many. It usually comes closer to the end of the visit after the history, physical and test results have been reviewed. Their reaction to the preaching often influences the negotiation of the Plan. Popular topics are usually those that contain an element of denial on the part of the patient. For example, people who continue to gain weight despite morbid obesity, people who stay in abusive relationships, people who smoke in light of documented heart and lung disease, and today's topic: enabling a murderer (a.k.a. a drunk driver). If I could recreate the quality of these diatribes here, I would no longer be a medical student and could strike out on my own. That is how powerful the rapport and impact of these moments can be for the practice of the art of medicine.

He asks our patient with the alcoholic husband, "Why don't you leave him if he won't stop drinking?" She said because of God and the church. He said, "You are enabling a murderer if you do not call the police on him the next time you know he is drinking and driving, there is nothing Godly about letting him kill someone." He pauses for her bewildered response, "The next time you know he is coming home from the country club or when he is driving north with a loaded thermos you can call 911 with an anonymous tip about a drunk driver and they will pick him up. He doesn't even have to know that it was you." He further explains why he is so concerned about her and her husband based on the problems of other patients in his practice and their motor vehicle homicides. He admits that it won' t be easy and agrees that she needs a counselor for support, but that there is no doubt in his mind that it is the right thing to do. He also makes it clear, that he is here for anything that she may need. Where I had offered only

hand holding, my preceptor opted for intervention. Then came the pap smear to round out this comprehensive care.

Later that week, a 50-year old man with low back pain for one year with worsening pain for two weeks that radiated into his right leg came into the Tuesday night clinic accompanied by his wife. It is about 8 pm. He appears uncomfortable. He has had plain films and a CT of his back in the past. He has done physical therapy and home exercises, but now has too much pain to participate. Based on exam, it is often difficult to differentiate between nerve root impingement and facet joint inflammation. We would like to order an MRI. However, this man has failed MRI screening in the past because a ball bearing (BB) is lodged in his cheek along the inferior orbital rim of his right eye. The MRI magnet could potentially move the BB into the eye during a scan and disturb his vision.

Upon entering the room, my preceptor and says "We really need you to get that MRI for your back, but to do that the BB has to be removed." My doc reaches over to palpate the miniature bullet that our patient had been known to fidget with from time to time. It does not bother him; it is pain-free and even brings him some pleasure when given the opportunity to talk about how it got there.

The story goes that he and his cousin loved to play with their BB guns. When they were both 15 years old, after several years of gunplay, his cousin shot him in the cheek "accidentally". Not to worry though, he got his cousin back by ambushing him in the hallway of their house. When his cousin came out of the bathroom he shot his cousin at close range (2 feet to be exact) in the cheek with a BB gun.

Our patient was told not to worry about it because it would probably work its way out of the skin eventually. Well, it never did, and thirty-five years after "the shooting" he is still packing some lead shot in his cheek.

Interestingly, my preceptor had once set his sites on becoming a plastic surgeon, but he realized that surgeons at his program served the motto "make an enemy a day". At that point, he decided that he would have more fun performing rogue office procedures resulting in prettier scars than what his surgeon colleagues could achieve while maintaining his integrity in primary care. The shear fun of office procedures involving the soft tissues still made his eyes gleam though, even ten years after residency. He would often smile and tell patients with sincerity, "I live to take off your mole, but we can just watch that one for now."

So my doc said to the man with the BB, "I could take that out for you. We could do it right here in the office, tonight, with local anesthetic." The budding surgeon in me piped up too, "Yeah. He is on a roll. He has been taking things out all day." I selfishly did not want the guy to wait, because… well, I wouldn't be here when he returned the next month for the procedure. It was now or never for me on this rotation!!

My doc didn't want to pressure the guy too much though, so he added, "You can think about it. I can do it quickly or I can refer you to one of my surgeon friends. Just let me know when you decide." The patient replied, "But I have had it for so long…" He and his

wife looked at each other speechless then replied to my doc, "I'd have you do it to get it over with, but... I just thought it would always be there." Then his wife said, "Yeah, every time we drive by the hill where his cousin shot him, he always says, 'that is where Johnny got me with the BB.' " This metal pellet had become a source of pride and nostalgia for this man and his wife, but now his back hurt and he wanted that addressed too. His final question, "Could I keep the BB?" My doc explained that it was against HIPA regulations to keep anything that is taken out of your body…tonsils and gallstones are no longer even allowed to go home with their rightful owners. But, my rebel doc and proud practice owner, assured him that he would make an exception in this case: "Alright, you can keep it", he granted.

With an air of giddy anticipation, the patient and his wife agreed to the procedure after my doc informed them of the possible complications of infection, nerve damage and bleeding that might give him a black eye, etc. I lead them to the procedure room and had the gentleman sit in the big, red, robotic chair. The doc organized his nurse and the sterile equipment and asked me to "scrub in".

The wife held her husband's right hand as we draped and prepped his left cheek. My doc numbed the area and when the patient couldn't feel it anymore, my doc palpated the sterile field for the BB. It was easier to feel if the head was slightly elevated. Then my preceptor dug right in through a 0.5 cm incision; bluntly dissecting the tissue down to the BB. There was a little blood. I tried to assist with instrumentation and blotting. It was nearly 9:30 at night now and my doc was fully engaged with the task at hand. Tonight, he was an ENT surgeon with his trusty sidekick at his elbow. He was sweating a little especially when the wound gushed a little. It was hard to stabilize the tethered BB in the mobile tissue. For a brief moment I wondered to myself, "What are we doing here?" My doc was wedging the BB between the iris scissors and his fingernail, which shielded the eye. He eased the BB up and out. The increased pressure caused the patient's voice to muffle from under the drape, "Have you done this before?" My doc replied, "Well, let's just say that I have never actually taken a BB out of someone's cheek like this before." "Ok, fair enough," the patient replied. The pea-sized BB eventually rose into the visual field encapsulated in 35 years of scar tissue. I drove a clamp under it as my doc trimmed it free. The BB popped up and out of the incision onto the patient's lap. It was rusty. We trimmed the rest of the capsule away in the cheek and my doc closed the incision, with 2 four-O stitches, 20 minutes after its inception. Estimated blood loss was less than a teaspoon; no band-aid required. We removed the drape, "How is your vision?" "Fine doc," the patient said as he relocated the precious rusty nugget to his jeans pocket. "You might still get a black eye, but I was very careful in my dissection so it shouldn't be too bad." I added proudly, "You have two stitches."

When we got to the office, I squealed with glee that this was the first "GSW (gun shot wound) that I had assisted on in my fledgling career!" I was getting ready for the promised Detroit "knife and gun club" trauma one BB at a time. My preceptor mused that he would have never done the procedure without me there for the extra pair of hands. He beamed behind his desk like he was a proud father all over again. Maybe the patient's cousin will be here next week for another BB removal?

There is also an unexpected element of homeopathic medicine offered in this evidence based medical practice. Certainly, a patient does not need a referral to a podiatry clinic to get their thickened and hard to reach toenails cut; rather a patient may have a no frills pedicure with their foot placed on the doctor's knee and clipped during a problem based health history. Further, blackberry brandy is often prescribed in place of expensive foul tasting cough suppressants. Saw palmetto may be recommended for treatment of a mild enlarged prostate. Hypnotic compact discs off of the Internet may be suggested for disorders of anxious hyperventilation after other causes of shortness of breath have been ruled-out. Alcohol intoxication and a good vaginal lubricant may be part of a treatment approach for vaginismus. Grapefruit juice mixed with vinegar can be used for mildly elevated total cholesterol and cranberries and lecithin poultice for hemorrhoids. And one of my all time favorites, a hair dryer used on the cool setting after showering is apparently great for revitalizing a boggy rectum.

My first ER patient of the day was a 69-year old veteran with right-sided weakness. He arrived in this small town ER, while the local family practice was closed. This ER has no trauma rating and is staffed by one doctor. The patient had nearly driven himself to the emergency room, before his right hand froze and couldn't respond to his brain. His wife rode with him, but she had not driven in 35 years. She later admitted that she didn't even think she remembered how; but nevertheless, she moved her uncoordinated, stunned and muted husband to the passenger side of the car and figured out by instinct how to drive her husband the rest of the way to the ER. When they arrived, the ER doc assumed the man was having a stroke. The patient was not talking and was neglecting the entire right side of his body. He stared into space and was not following commands. The doc became excited because this patient fit within the criteria and time window for use of clot-busting medication, so we sent him to radiology for a CT scan. The patient, helpless on the scanner table, had a grand mal seizure with tonic-clonic jerking in all four extremities as foaming saliva pouring from his lips. He was rushed back to the ER. After stabilizing him, he was rescanned. This time with venous contrast and we watched with the radiologist as a large, left-sided parietal brain tumor lit up like a light bulb. This brain tumor, has unknowingly metastasized from somewhere in his body.

As the scan revealed the tumor, our patient's daughter walked into the ER to comfort her mother. His daughter was someone that I knew. She was the billing specialist at the clinic that I had been training at across the street. Not only was this tumor seizing the brain of a man who was a father, but this man was also the father of a staff member at the family clinic. The "case" was transformed. This was no longer an interesting finding anymore, but the loss of someone's dad. I tried to introduce the daughter to the ER doc by explaining who she was and how I knew her. But remaining engrossed in the "case", he paid no attention. He didn't even ask the wife and daughter to sit down for the delivery of the bad news. Instead, he barely looked at them as wrote his note and said, "He has a tumor. A tumor is causing this." And then he left the room. To him it was nothing more than another case that needed to be expedited to a tertiary care center. I couldn't stand the way the moment had precipitated, so I stepped in to explain what the films had shown and was honored to express my sympathy.

One morning near the end of my clerkship, I found a cardboard box in the middle of the office harboring two peeping baby chickens hatched by my preceptor. Seeing them

reminded me of collecting eggs from my grandmother's chicken coop. Of holding a cardboard box on my lap containing a single baby chicken from a third grade science project. Of protecting that baby chick as it huddled against a hot water bottle scared and peeping as it was jostled on the greyhound bus that I road. The bus that carried us; both fragile, him so soft and full of fuzzy feathers nearly the color of my own hair. I briefly remembered the hard transitions, the moods, the loneliness and fearfulness of childhood that I felt as an only child caught between warring parents. But today, I just found solace in holding these little, lively birds between my palms. What a wonderful, joyful addition to the office.

As I caressed these fancy chickens with feathered feet hatched from green eggshells, I told the good family doctor that I never knew a practice like his could exist. One independent from insurance companies, where the physician's own wholesome values dominated the care that is provided. One where he could provide a complementary visit if he felt it was appropriate. One where he referred out patients who did not thrive there. One where disgruntled staff were retrained for different jobs within the practice. One where the boss demanded and insured that he enjoy coming to work everyday. One where chickens could run-free in the office to celebrate the Rites of Spring. One where the children and the medical students could blow pink, Easter Bunny bubbles during well-child checks. One that heals the healer, the patients and the staff and replenishes its own energy.

I don't know if it was the quiet rural setting or the personal coaching and attention that my preceptor provided or maybe it was just getting to see patients on a regular basis, which helped me remember why I wanted to be a doctor. In the end, from a place that I had so reluctantly arrived, I left with a certain, new-found optimism and interest about what the future might hold.