Where's My Defense?

By: Lisa Jernigan MD

"I'd like to talk to you about the people in Blake county sometime," one of the residents commented. She was in the middle of a rural pediatrics rotation down there, and apparently reflecting on some of the challenges of this particular population. Having been visiting there at least monthly to provide prenatal care at the health department, it was an affirmation to realize that finally, somebody was going to articulate what I had been experiencing for years. This place is different, very different. We didn't have the time to talk about it that day, but I basked in the anticipation of someone "feeling my pain" for the week until the conversation could take place.

My hopes were not disappointed when the time came. In fact, being the very bright and insightful person that she is, the resident brought me along to an even greater understanding of what the issues really are there. "I can shut them down, as far as relating with me goes, in an instant," she noted. She went on to share that it was when she challenged or downplayed a fixed belief about health issues that the "shutdown" occurred. In her four week rotation, she had encountered several such incidents, and I wondered what the buzz was in the county about this new doctor at the pediatrician's office. The resident has a keen mind for the evidence in the case, and adheres to the practices and beliefs about health that make rational, proven sense. With a strong sense of her own personal responsibility for her own health and that of her family, and discipline matched by few in our program, she is arguably the most fit person in our office. I could imagine her, knowledgeable and certain of what she knows (not prideful), offering a puzzled look and a contradictory statement, with the intention of educating, to a poorly educated mom as to the likely efficacy and safety of decongestants in her one week old baby, when the mom had already gotten five others through a similar stage. Having seen the disdaining and dismissive look of disgust on my fair share of patients in similar situations down there, my heart went out to her.

I can remember the time another OB attending got fired by the mother of one of our pregnant girls. The mom was overbearing and never wrong in her own mind, and was determined to force us to do what she "knew" was right for her daughter: 38 weeks pregnant and experiencing the misery common to that gestational age. "You're gonna have to induce her," she said, "'cause you know I carried her to eleven months, and was even in the paper for it." The attending, trying to digest two false ideas in one statement, failed miserably. She could have educated the admittedly contentious and stubborn woman on the lack of evidence for post-datism's hereditary nature, or criticized the dating methods of our medical forefathers. She could have reminded the lady of the risks inherent to induction, although it would have been wise to offer a nod of understanding to the misery induced by the frequent complaints of the daughter which had led to a record of thirty-two prenatal visits during the pregnancy. She did neither of these things, but instead looked the woman straight in the eye and said, "only elephants carry their young that long," and left the room. She was rapidly pursued by the grandmother-to-be, spitting fire at the idea of someone trying to steal her fifteen minutes of fame from her, the only notable fact in her life of misery and defeat. We ended up delivering the girl anyway, given that no one else would even agree to see her, but "adversarial" does not do justice to the relationship that developed from that point. Thank goodness the girl went into labor on time and had a good outcome. She did have to convince her faithful but not-so-bright boyfriend that this patently african american baby really was his, in spite of both his and her clear anglo-saxon heritage. But that was her issue, not ours.

Many areas of the world have fixed health beliefs, but none of them so contentiously held as in this one county. The whole character of the area seems argumentative to me, and more so than any of the other rural clinics I serve. The normal patient encounter there begins as I enter the room to find the woman and possibly one or two friends sitting with their arms crossed, staring at me without smiling. My greeting, coupled with a smile and a query as to how they are is often met with a "hmmph!," followed by two or three complaints plus a demand. For example: "You guys have got to induce me now. My back is killing me, this baby moves all the time, and those people at the hospital wouldn't do anything about it the last time I went, and we can't afford the gas to keep going back." This presents a challenge. If I start right in explaining that we do not induce women who are not overdue, and certainly not at her gestational age of thirty-six weeks, she will either argue or shut me out, and I have had women just get up and storm out. Brightly reassuring her that an active baby is

a good thing has gotten me into long wailings about how this keeps her awake, and besides her grandmother thinks it will wrap the navel cord around its neck with all that. Questions about back pain will lead to waving of forms to excuse her from work and requests for narcotics. If she looks especially aggressive, I offer her the paper drape, ask her to remove her clothing below the waist, and make a quick exit.

We are taught to ask open ended questions and explore all of the patient's issues. There is this persistent idea that enough education will lead to consensus and a satisfied patient. Fourteen years of surviving the attack-first-ask-questions-later culture of Blake County has taught me that often the best course is a sort of relational Tai-Chi. Direct resistance is futile, and leads to prolonged conflict and fatigue. Anything that smacks of education on an issue also implies that the patient was mistaken or uninformed about the facts, and this is like a red flag in front of a bull down there. Letting the patient defeat herself with her own momentum requires some practice, and a certain retraining of instinct, but is far less stressful in the end. So, in this case, I would re-enter the room to a somewhat de-energized woman, as most cannot maintain the same degree of bravado once their pants have been placed on the chair and they are wrapped in a giant paper towel. Pulling out the lower part of the table and having her lie down for exam further levels the playing field, and I begin to go over her concerns as I palpate the abdomen for the position of the baby. "So, the baby is trying to get you ready to stay up with it at night, is it?" If said with the little shake of the head that means "yeah, it's hard," the usual (and desired) response is a rueful grin and some description of the excessive motion. My favorite so far is, "you'd think it was on crack or something," from a mom whose drug screen was positive for cocaine. Yeah, I would think. A good listen to the heart tones will often allay concerns about the navel cord issue. From there, the nurse is called in and we proceed to collect specimens from the cervix and perineum, and check for dilation. The patient generally has been talking non-stop about the pains, the unsatisfactory visit to the hospital (no induction, no pain meds). I often don't say much, knowing that the cervical exam will usually result in at least an interruption in the verbal flood. While most women do not find this painful, I always keep an eye out for the right hand of the patient, having had to doctor myself following quite a few wounds inflicted by acrylic nails during such an exam.

The exam safely over, I assist the woman to a sitting position and briefly rub her lower back, asking if this is where it hurts. A suggestion that she get someone to rub it for her often leads to another "hmmph!" but at least not directed at me. Next, the most difficult hurdle: the imminent refusal to fill out forms to get her out of work with pay, or worse, out of classes for those wanting to be on public support. Both require me to say that she is unable to sit in a chair in an air-conditioned room, with frequent breaks to walk about or use the restroom. They require me to declare her pregnancy a disability, and list the complicating conditions she does not have. My response is always that I cannot tell the truth and say she cannot do these things. After all, if I do release her from work or class, is she not going to sit in a chair at her home? There are times they get filled out, when I am particularly worn down, or there are eighteen more patients waiting, but mostly they don't. One woman followed me all the way down the hall cussing and threatening, and finally cocked back her fist at me. I backed off two steps, and in my quietest voice requested that she leave, and now. The last time I gave in and filled out the forms, the woman came back the next week wanting a note to say she could work after all, since she had figured out that total leave with pay was limited to six weeks at her job, and she wanted that for after the baby.

Frequently, the woman is still talking and complaining as she leaves, but somehow she is satisfied. In Blake County, I guess even such a poor attempt at listening and empathy is more than expected, and accounts for my (to me) inexplicable popularity with the locals. As the resident and I commiserated over these experiences, I realized there is a soft spot in me for this county, and an off-beat enjoyment, almost, or at least on some days (when I am not too tired or stressed), in dealing with this particular cultural variation in the doctor-patient relationship. On other days, the sight of their phone number on my beeper is enough to break me out in hives and raise my blood pressure a few points. But at least there is someone who understands that now.