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Medical Systems in a Small Town

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Medical Systems in a Small Town

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April 1, 2005
# Table of Contents

Introduction .................................................................................................................. 3  
Factors Influencing Healthcare in a Small Town .......................................................... 5  
   Sociological Definitions ......................................................................................... 5  
   Doctor Shortages ................................................................................................. 7  
   Quality of Care .................................................................................................... 10  
   Insurance ............................................................................................................. 14  
   Technology and Advances .................................................................................... 15  
Case Study – Urban vs. Rural Healthcare ................................................................. 17  
Historical Comparison .............................................................................................. 19  
Brookings: A Small Town Health System .................................................................. 21  
   Methods .............................................................................................................. 23  
   History ............................................................................................................... 24  
   Doctor Shortages ................................................................................................. 34  
   Quality of Care .................................................................................................... 40  
   Insurance ............................................................................................................. 56  
   Technology and Advances .................................................................................... 59  
Conclusion .................................................................................................................. 64  
Bibliography ............................................................................................................... 71  
Appendices  
   A – Respondent Data ............................................................................................ 73  
   B – Respondent Questionnaire ............................................................................. 74  
   C – Interview Questions for Doctors/Nurses ......................................................... 75  
   D – Interview with Dr. Plum ................................................................................. 76  
   E – Interview with Dr. Mustard ........................................................................... 81  
   F – Interview with Nurse Peacock ........................................................................ 84  
   G – Interview with Drs. White and Butler .............................................................. 90  
   H – Interview with Nurse Scarlet ......................................................................... 95
Introduction

The debate surrounding healthcare in the United States of America has increasingly been taking center stage in government policy discussions as well as individual discussions. Patients are reporting less satisfaction with their medical experiences and beginning to demand better services. In the near future there will be the need to address this situation before the population’s trust in healthcare is completely lost.

The following study examines this problem by looking at one medical system and how it succeeds or fails at providing quality medical services to its community. The chosen model healthcare system is in a small rural town called Brookings, which has only one medical facility in the town. The effectiveness of this family practice was evaluated based on personal opinions from the patients and the doctors. From the ensuing ethnographic data, four major categories were distinguished as factors in the level of healthcare achieved in Brookings. These factors were doctor shortages, quality of care, health insurance, and technology and advances. Each of these sections was explored and a determination was made as to if the Brookings Family Practice was successfully addressing each aspect. This modern day information was also compared with past healthcare systems in Brookings as well as documented research on other medical systems around the country.

Overall, Brookings was found to have a successful medical system that met the needs and expectations of the residents of the community. While there remain some disadvantages to this type of setting, the majority of the respondents were content with their healthcare. There are many possible reasons for this but it is suggested to be the
result of the family practice reflecting the ideals and lifestyle of the community and thus being able to more effectively fulfill the health needs of its patients. This model system in Brookings can be used in the general discussion about healthcare as an example of the way a medical practice can most successfully provide healthcare to its community.
Factors Influencing Healthcare in a Small Town

Sociological Definitions

Until recently, rural medicine has received little attention from national health organizations in the form of studies and recommendations for improvements. Last November, a report was published by the Institute of Medicine (IOM) called “Quality Through Collaboration: The Future of Rural Health,” that started the process of changing this trend. “Rural health industry experts said they were delighted that they are starting to be included in national quality-improvement discussions and are optimistic that they can help their urban counterparts improve quality at their facilities.” (Mantone, 2004) This new focus on rural medicine has helped to illuminate the unique problems that these clinics are facing.

It remains difficult to universally define the term “rural” both in the scientific world and popular culture. One scientific approach is to use the Bureau of the Census’ definition of “urban” as a “metropolitan statistical area” to thereby define “rural” as everything that is not urban. Using this definition, the residents of rural communities make up about 20% of the Unites States population. (Mantone, 2004) Still, the popular view would probably consider only a small portion of these areas to be rural. In the sense that the average American defines “rural,” only those living removed from a town center, usually associated with farms, would be placed under the category “rural.” This certainly is the situation in the community that is the subject of this case study, as it would be statistically called rural, but many of the residents living in the town itself would not place themselves in that category.
The family physicians practicing in these areas face a large number of challenges in addressing the concerns of the rural population. Residents living in these communities have been found to have more chronic disease, be in poorer health, experience more injuries, and perceive themselves to be less healthy than their urban counterparts. (Blondell et al., 1992) These problems fall to the family physicians, as "there is not another entity like family medicine that can address the needs of rural health across the multiple dimensions of education, service, location, and political influence." (Bowman, 1996)

There are several critical areas that need improvement in rural healthcare practices. The first and most critical is to remedy the current shortage of health professionals in this area. Methods to increase recruitment include selective admittance to medical schools, increased rural experiences during medical school, and improved programs for recruitment by rural communities. Second, the improvement of quality of care must be a focus from the federal level to the community level. One solution is the formation of primary care organizations to maintain responsibility by these networks for the doctors under their supervision. A third and increasing problem recently has been the additional cuts to Medicare, which are affecting large numbers of rural physicians and forcing them to turn away patients carrying this insurance. Finally, methods for achieving continuing education for rural physicians must be developed as well as the increased use of computer networks for the exchange of information between health professionals. These problem areas in rural health care will be addressed in further depth by examining the causes, as well as possible solutions, for each one.
Doctor Shortages

Despite one-fifth of the population living in rural areas, there remains a drastic shortage of physicians to serve these areas. "By 1988, 17 million people still lived in rural areas with a shortage of physicians." (Bowman, 1996) To address this problem, more and more physician assistants and osteopathic doctors are being recruited into these areas to supplement physicians. Among the medical specialties, only family practice obtained a distribution similar to that of the general population. (Bowman, 1996) This specialty has, by necessity, become the focus of recruitment efforts and programs to increase the flow of trained physicians into these needy rural areas.

There are several different aspects of this shortage of physicians that contribute to lowering the total healthcare of the regions affected. Often, this problem is the result of several shortcomings in the education and recruitment of new doctors. They are not being aggressively enticed to open practices in rural areas through incentives and marketing of the town. Also, the shortages cause rural doctors to be overworked and to be forced to cover large distances. For the patients, this means that there is a lower quality of care and less accessibility to their physician. This makes it difficult for a patient to find an appointment with a rural doctor who must make time for more patients than normal. Also, to see a specialist, the patient must travel long distances, and it may be weeks before an appointment is available. This problem of rural physician shortages must be addressed if the quality of care in these areas is to improve.

There are several ways of increasing the number of rural doctors, but medical schools must make the most important changes. First, the selective admittance to medical schools of students showing an interest in rural medicine will increase the
possibility of graduating rural doctors. (Blondell et al., 1992) But, discovering a
student’s real intentions is not an easy matter, and so care must be taken in evaluating an
applicant. “A rural background plus a family medicine interest in currently the best
predictor.” (Bowman, 1996)

Another important factor in creating student interest in rural practice is including
a rural experience during training. In 1992, only 20 percent of medical schools required a
rural experience, according to Barbara Barzansky, Ph.D., assistant director of the
Division of Undergraduate Medical Education at the American Medical Association.
(Bowman, 1992) Without these experiences it is difficult to imagine residents being
interested by or prepared for rural practice. There have been several recent attempts to
increase the number of rural experiences during medical school but these are currently in
danger due to the possibility of federal funding cuts. The National Health Services Corps
was able to reestablish rural experiences through the development of fellowship programs
in several states. (Bowman, 1996) The Society of Teachers of Family Medicine (STFM)
is also taking a position of leadership in rural health. Since 1990, this group has made
rural health care a focus with a goal to reaffirm academic family medicine’s commitment
to rural health care. (Blondell et al., 1992) These two groups have seen the need in rural
communities, but there remain money shortages leaving the future unclear.

It has been shown that the rural experience is more effective if it takes place in the
first part of medical school specialization. “Family medicine needs to take advantage of
the influence of the first exposure to rural medicine by placing rural rotations earlier in
residency training.” (Bowman, 1996) Without this, few medical students will be exposed
to the real difference of rural practice – the unique relationship between a family physician and the community. (Bowman, 1996)

There are also several shortcomings in the practical training of future rural doctors that leaves them unprepared for the realities of practicing rural medicine. "The national trend toward not allowing students and residents as much direct responsibility for patient care does nothing to instill confidence in the ability to meet the challenge of rural practice. (Bowman, 1996) These students need the opportunity to push their own limits before going out on their own. It is essential that medical schools graduate rural doctors that can be readily placed into needy communities, otherwise the shortage of rural doctors will not be immediately resolved. Also, it has been found that an increase in obstetric training will produce more rural physicians. The STFM Group on Rural Health produced a study in 1995 that showed that family practice programs with only a two month obstetric requirement graduated 23.8 percent of their residents into rural practice, those with three months graduated 31.2 percent, those with four months graduated 34.1 percent and those with five or more months graduated 42.1 percent into rural practice. (Bowman, 1996) This shows the need for obstetric training in the residency programs, but this is threatened by recent cuts in national requirements for family medicine accreditation.

Finally, the rural communities themselves need to create more aggressive campaigns to attract doctors out of residency programs. There is often an inability by the community to get the word out to recruits, and actually speaking to a viable candidate is rare. (Bowman, 1996) This gives the advantage to urban family practices with their easy access to most major medical schools and obvious attractions to young professionals. The government can take a role here in increasing the attraction of rural communities.
This can be done through scholarships and financial aid to students pursuing careers in the rural settings, which will attract more students to this path. (Blondell et al., 1992) Also, local rural economic development may help to enhance the retention of family physicians by increasing the community’s ability to provide for the needs of spouses for jobs, education, social contacts or recreation. (Blondell et al., 1992) (Bowman, 1996) These steps will help rural communities to take action in resolving their shortages of family physicians.

**Quality of Care**

There are several important contributing factors in the level of care that is provided by a physician. First is the health outcome – Was the patient’s major health concern treated successfully? This is the most important aspect of the health care that is provided and will reflect most strongly on the overall opinion of the experience. Next, the patient’s own experience must be taken into consideration. This is necessary because the role of a physician is to make the patient comfortable and give them a feeling of security. Without this security, the patient will be more likely to withhold information that could help the doctor in giving adequate treatment. Also, if the patient feels unhappy with his or her visit, it will lead to poor quality of care in the patient’s mind as well as the possibility of the patient not following the treatment due to a mistrust of the physician. Another aspect of quality of care is the efficiency of the system that is being evaluated. The patients need to be treated by the proper doctor for their illness and not use unnecessary resources such as excess tests or unneeded specialists. This will help increase the cost-efficiency of the health system and therefore provide higher quality of
care from the appropriate doctors. All of these aspects contribute to the overall quality of care given by a health system.

The first method of improving the quality of care of health systems is to create accountability for the level of treatment provided. One approach for this is to establish a system of monetary awards for high quality practices. This would involve both a national contract that specified the minimum quality of care – standards of care, range of services, accessibility, and availability – as well as local contracts that offered incentives based on individual area needs. (Pringle, 1997) This incentive program would encourage physicians to raise their level of care but it would still remain adaptable to different localities.

Another possibility is to create “primary care organizations managed by community trusts or by consortiums of general practitioners.” (Pringle, 1997) This organization would hold the control of governmental contracts being distributed to local practices and therefore would be collectively responsible for the standards of care. With this power the organization could offer practice management, financial control, information technology, and clinical audit systems to those under their supervision. (Pringle, 1997) One example of this system being carried out is in Australia where 104 independent, locally based networks of general practitioners have been created. In return for a small fee, these networks have established integrated, community based health services above that which is already provided. (Silagy, 1994) These networks have been met with widespread support and have enabled the quality of care of these practices to increase significantly in recent years. Overall, these organizational systems enable the
practitioners to realize that higher quality standards would earn higher monetary
investment in their practices and create incentives for the physicians and the entire staff.

Once the treatment standards are established, the experience of the patient must be determined. There are several aspects of a family practice that are important for patients. First, it is important for the patient to be familiar with the physician and for his health history to be known by this physician. This helps to create trust between the two individuals as well as providing better care based on past health experiences of the patient. Often, this familiarity between patient and physician is achieved in a smaller practice that can establish a long continuity of care with a patient. “Patients registered with smaller, non-training practices consistently express more satisfaction with their care.” (Pringle, 1997)

Another factor in patient opinion of the care is the length of consultation time with the health professional. One study by Myraim Deveugele compared determinants of consultation length of general practitioners from different European countries. (2002) Here, the significant result of this study is that urban practices have consultations that lasted 1.5 minutes longer than those in rural practices. While there are several possible explanations for this, including that urban patients discuss multiple problems at once, this is still a concern for rural health professionals. The length of consultation time can be related to the confidence a patient has with a physician. If the physician is rushed and cannot spend the needed time with the patient, the patient may fear that the physician will not consider the proper treatment carefully and therefore is providing substandard care. This can be improved by ensuring that the patient is comfortable and has the time to express all of his health concerns.
Finally, the family practice provides a means for reducing the costs to the overall health system. Its role is to filter the demands of the patients so that the necessary timeline can be used based on urgency of the medical problem and any necessary specialists can be provided. This may in fact cause a decrease in patient satisfaction because “a general practitioner may offer advice and an appointment at a time appropriate to the problem but less convenient to the patient.” (Pringle, 1997) Often a patient will ask to see a specialist or claim they are experiencing an emergency when the reality is that a family practice physician is fully capable of dealing with their problems during regular office hours. This tendency to exaggerate health problems creates higher expenses for health systems but can be controlled by the filtering of patients by the general practice physician. The primary health care sector can be placed firmly at the base of the American health care system, with a crucial gate-keeping role to regulate access to the high cost secondary and tertiary sectors. (Silagy, 1994)

All of these methods would increase the quality of care provided by the physician in a general practice. These solutions address the overall treatment outcomes as well as the patient opinions of the quality of their visit. They also provide means to reduce costs of health care systems by using the general practitioner as a filter which will ultimately result in better and more efficient care given to the patient. Together, these suggestions can create a better experience for the patient, both psychologically and physically, with an overall increase in the quality of care provided.
Insurance

A serious problem that has been recently developing in rural areas is the growing costs of serving Medicare and Medicaid patients. Usually, a rural practice carries a heavy load of patients using both due to the relative poverty and age of the rural populations. For example, Dr. Barretta Casey’s practice in Pikesville, Kentucky has about 60% of her caseload using Medicare to pay their bills. (Silverman, 2003) Lately, this has become a serious impediment to a viable family practice due to overwhelming costs that Medicare refuses to cover. In 2002, a 5.4% cut to Medicare reimbursements went into effect with the possibility of more cuts by the federal government in the near future. (Silverman, 2003)

This leaves little choice for rural doctors but to limit the number of Medicare patients they accept. A survey conducted by the American Medical Association found that 60% of the primary care physicians and 44% of the specialists intended to limit the number of Medicare patients they treat. (Silverman, 2003) In an attempt to maintain these Medicare patients during this reimbursement crisis, general practitioners were postponing the purchase of new medical supplies or technology and decreasing their staff. (Silverman, 2003) All of these steps decrease the quality of healthcare that can be given and ultimately create a significant problem for rural residents holding Medicare insurance. The subject of the case study below, the Brookings Family Practice (BFP), sees mostly Medicare and not Medicaid patients due to the mainly middle-class population in the area.

There are also other problems that all health insurance companies have brought to rural healthcare practices. They are now dictating which doctor a patient must see, and
with frequent changes in coverage, a continuity of care is not possible. Also the
insurance companies are covering only certain medicines and treatments and therefore
limit the methods for improving a patient’s health in significant ways. These limitations
on the healthcare provided combine to decrease the quality of care that is available to
patients and will ultimately need to be addressed in rural settings to improve healthcare.

Technology and Advances

An important component of being a family practice physician is the continuing
need to learn and adapt to new techniques and developments. As the required knowledge
in this medical field is large; staying updated becomes difficult in rural communities.
This results in out-dated methods being used in treatment and new medications, with
diagnoses being missed altogether. There are several ways to combat this problem of
continuing education in rural areas.

The main obstacle to this goal of education is the large area separating rural
physicians. “Keeping personal development and continuing education going when
distances are large and professionals are isolated is never easy.” (Pringle, 1997) This can
be alleviated in part by the previously discussed primary care organizations, which
promote communication between rural practices. Also, governmental funds devoted to
the continuing education of rural physicians will become a necessary part of achieving
this goal. The funds provided could expand opportunities for education by placing them
closer to rural practices as well as helping to pay the physician for time spent away from
his practice.
Another way to overcome this geographic isolation is by using information management systems to connect groups of physicians. These systems form "information highways" that allow general practitioners to be in contact with a range of other health professionals. (Silagy, 1994) This allows for the exchange of information on new health developments as well as creating computerized medical records. This computerized system provides a number of advantages to the patient and the physician. "Record linkage between hospitals and general practice has been improved, and there have been advances in providing computerized diagnostic and therapeutic decision support systems at the general practitioner's desk." (Silagy, 1994) This helps to provide the patient with higher quality and faster care by enabling vast amounts of data to be accessed quickly. Also, this system is then able to check for physician mistakes and quickly provide diagnostic aids to the general practitioner when confronted with unusual illnesses. This computerized linkage system does create some unresolved concerns for patients and physicians. These include questions about the storage and transfer of large amounts of confidential data and whether this threatens the patient's confidentiality. (Silagy, 1994) This issue needs to be addressed to allay the patient's concerns about the ownership of the data and to safeguard against theft.

Another problem for the rural family practice is the difficulty in receiving new research information. There is often a considerable lag between primary research and the incorporation of those results into clinical practice. (Silagy, 1994) This is a particular problem in general practice because of the wide-range of information with which the practitioner must be familiar. Computerized systems will help to easily provide physicians with new research in their field. In the opposite direction, for rural physicians
“it may take an even longer time for ineffective therapies or services to be removed from routine medical practice.” (Silagy, 1994) This in often due to older physicians maintaining the methods they have used over the years despite new evidence for better treatments. Often, the solution for this problem is simply education and training in the new techniques. These two things may require governmental monetary support but this is perhaps necessary to ensure the advancement of the general practice discipline.

**Case Study: Urban vs. Rural Healthcare**

In order to examine these problems in the rural setting, a case study of diabetes care in a rural family practice clinic and an urban internal medicine clinic in Alabama will be examined. The study, carried out by Miranda R. Andrus et al., examined medical records of patients with diabetes, and management practices were compared to current American Diabetes Association (ADA) standards of care. (2004) The results were striking in their discrepancies between the two clinics in terms of the level of care that was provided.

In 1999, diabetes was the sixth leading cause of death with the long-term complications being responsible for most of the morbidity and mortality of the disease. According to the authors of the study, the goal of the physician should be “a continuous quality improvement approach to intensive patient management that will allow clinicians to achieve optimal outcomes through the prevention of acute complications and reduction of the risk of long-term complications in their diabetic patients. (2004)

The results of the comparative study of the two clinics showed significant differences in the diabetes care indicators chosen. These indicators included eye exams,
foot exams, microalbuminuria screening, influenza and pneumococcal vaccinations. All of these indicators had a much lower percentage of use in the rural clinic, particularly in comparing vaccination numbers – no rural patients had the pneumococcal vaccine while 34% of urban patients did. “Rural patients were also less likely to receive screening and preventive services” with the rural practice having fewer patients at goal LDL and goal blood pressure. (2004) This shows a much lower standard of care in the rural setting than in the urban setting and most likely leads to worse patient outcomes based on general health guidelines for those with diabetes.

Andrus et al. states that there are several possible reasons for this discrepancy in rural settings that fall under the categories previously discussed. The general nature of both clinical settings may intrinsically lower the quality of care, as a specialty practice would be better able to provide care that meets the ADA guidelines. This becomes a problem in the lack of access to specialists in rural settings. There were “almost 13 specialists for each 100,000 population in the urban areas compared with only one specialist for each 100,000 population in the rural areas.” (2004) Other preventive care issues include more time constraints, more acute care issues, and fewer physicians available in rural communities. These fall under the problem of health professional shortages in rural settings and also concern the quality of care provided. Lack of adequate insurance, such as those with Medicare may present as a barrier to preventive care in rural areas. A final factor cited by Andrus et al. in the lower care of diabetes in rural settings is the lack of patient education and understanding of the chronic disease. (2004) This can be improved with computerized networks that provide information to patients as well as physicians about their disease and treatment options. All of these
areas need improvement in rural clinics as shown by Andrus et al. using diabetes as a case study comparison.

**Historical Comparison**

It is perhaps useful for future discussions in this paper to examine a study comparing the treatment patterns of a modern family practice and a 1930’s family practice. Richard I. Haddy et al. studied the office billing records of Dr. Frank W. Brey, a general practice physician in rural Minnesota between 1934 and 1935. (1993) The researchers compared this information to the treatment patterns of a modern rural family physician in Yellow Springs, Ohio. The results show significant differences between the types of services provided in the two time periods.

Much of Dr. Brey’s practice was devoted to surgical procedures and their follow-up, which is not the case in the modern practice. This could be due to the introduction of antibiotics and immunizations that eliminated this need for physician treatment of certain diseases and problems. The authors noted that some of the most common modern diagnoses such as hypertension, hyperlipidemia, and depressive and anxiety disorders were conspicuously absent from Dr. Brey’s practice. The modern practice showed an overall greater emphasis on prevention as compared to the 1930’s as shown by the high incidence of health check-ups in modern times. “This review not only provides evidence that there have been changes in the day-to-day practice of family medicine, but also in the way patients perceive and define illness.” (1993) These differences in the definitions are shown directly by the absence of physician visits for benign illnesses and preventative care in the early 20th century.
Another difference can be seen in the way the physicians carried out their physician visits. Approximately 25% of Dr. Brey’s patient encounters were house calls (within city limits) and 15.9% were country calls (outside city limits). This can be compared to the absence of any house calls by the modern physician therefore limiting all patient encounters to clinical visits.

All of these differences will also be examined in looking at the historical progression of healthcare in our case study of the town of Brookings. Similar disparities in treatment will most likely be seen between the town doctor of the 1950’s and the family practice physicians of today. These differences can be related to the level of quality of care and patient satisfaction with the treatment received.
Brookings: A small town health system

The goal of this ethnographic study is to evaluate the health system in use by an individual community from the perspective of the health professionals and patients. Using these conclusions, the relative success of healthcare at this practice can be examined and can perhaps also be broadened to include general implications for healthcare in other similar geographic regions. However, this study is limited in its scope and will not discuss in-depth major issues related to this topic such as the public cost of suggested changes and the applicability to general family medicine or urban family medicine. These implications may help to guide further discussions surrounding the methods used to provide quality healthcare and the areas of this service that need to be improved.

The community studied will be called Brookings in order to preserve the integrity of the anonymous interviews done with those involved in the health system there. It is a rural community located in the foothills of the Appalachian Mountains in the eastern region of the United States of America. The town is situated in a valley surrounded by rolling mountains on each side. This is an area that has historically been a farming community but has seen significant change over the past decade. Brookings has experienced a 36 percent rate of population change between 1990 and 2000 due mainly to its popularity for young professionals who commute to the two nearby major metropolises. Located within 50 miles of each of these major cities, and within 15 miles of the medium sized city of A____, it allows for easy access to the amenities of urban centers.
With a population of 2,668 persons in the year 2000 and a projected population of 4,257 in 2010, Brookings is quite small but the surrounding region, which incorporates three other small municipalities, has a population of 17,093 persons. The county in which Brookings is located had a population of 199,369 in 2000 and is projected to reach 240,000 in 2010. The township as a whole is very homogeneous with only 1.5 percent African-American and 1.6 percent other ethnic groups and the remaining 96.9 percent Plum in the year 2000. Approximately 64 percent of the households in Brookings are married couples and 33.3 percent of the population is aged 20-44 years. This creates an overall dominance of young families in the community and has shaped the development of the town in many aspects.

In the town of Brookings there is only one major healthcare facility and that is the Brookings Family Practice. It is located near the center of town in a facility opened on January 23, 1978 and serves the township as well as the surrounding valley residents. In the practice there are four family practice physicians (the three interviewed will be called Dr. Plum, Dr. Mustard, and Dr. Butler) and one endocrinologist (who will be called Dr. White) who works part-time as well as numerous nurses (the two interviewed will be called Nurse Peacock and Nurse Scarlet) and nursing aides. In the nearby mid-sized city there is a general hospital capable of most surgical procedures and general emergency healthcare. Also, there are several major medical centers in the two metropolises close by that provide some of the best healthcare procedures in the United States.
Methods

In general, an interview approach was taken to attempt to emphasize the aspects of healthcare that they considered important. Four out of the five physicians in the Brookings Family Practice were interviewed using standard questions regarding their experiences in their practice and how they relate to other settings in which they have practiced medicine. They were also questioned on the advantages and disadvantages of a rural medicine setting as well as the types of services they provide. In addition, two of the nurses in the practice were interviewed about the healthcare they are able to provide and what advantages they see in their location for giving quality care. Two long-time female residents of the area were interviewed as well due to their close involvement in an urban hospital nearby. They were questioned on the changes in healthcare they have seen in their lifetimes, both negative and positive, and their opinion of the quality of healthcare they receive. The questions used for all of the interviews were developed based on the issues raised by the articles cited in the earlier background section of this paper. All of these interviews were done by myself with a hand-held tape-recorder and then transcribed. All respondents were given anonymity and thus a freedom to criticize or praise their healthcare experiences.

Finally, forty questionnaires were sent out to local residents with twenty-eight of them returned. Of those returned, nineteen were from females and nine were from males. The average age of the respondents was 60.17 years old with a median age of 60.0 years. The occupations of those who answered were diverse and most were long-time residents of the Brookings’ area. These questionnaires asked about their experiences in receiving healthcare in the area, both today and in the past. They also asked about the
disadvantages and advantages of rural healthcare and how they defined health versus illness. All of the respondents voluntarily gave their answers under the condition of anonymity.

While it is accepted that the results from this case study cannot be assumed to represent the feelings of the entire Brookings area nor all of the patients at BFP (due to non-random sampling methods), the conclusions drawn here can be used in the general discussion of healthcare. They help to illustrate one setting in which there are some problems but many ways that they succeed in providing quality healthcare. This example can be looked at as a contributor to the research on healthcare but not as a definitive summary of all aspects of the debate.

History

Brookings was founded around 1740 by English settlers but German immigrants soon followed and quickly dominated the area. The town itself is believed to have been laid out by an ironsmith who set up shop along a major trade route from east to west. Brookings was incorporated in 1834 and thrived due to its prime location along one of the first highways in the area. This success was represented by the construction of a telegraph line through the town in 1854 and the proliferation of many businesses in the downtown area.

During the period of time in which Brookings was founded, medicine was informal, domestic, and very unspecialized. (S., 1999) There were usually local individuals who specialized in the treatment of ailments using homegrown herbs and this knowledge was then passed down to an apprentice. There were no formal standards for
the practice of medicine at this time and therefore it can be assumed that the healthcare for Brookings was very limited and rudimentary. Some of the main techniques used were venesection, purgatives, laxatives, blistering, and harsh chemical treatment. (S., 1999)

In examining the local newspaper during the time period between 1897 and 1958, several patterns can be noted as indicative of the attitudes toward healthcare during that period. A major focus of the reporting done by the paper appears to be the deaths – by natural causes, accident, suicide, or murder – occurring in the local area. This shows the focus of the population on the attempts to avoid an early advent of death. Many of the deaths that are reported are the result of injuries or diseases that mostly likely would be treatable today. This highlights the lack of understanding of these medical problems at that time and the absence of effective treatments for these problems. It wasn’t until 1934 that births exceeded deaths in the state population but two-thirds of these deaths were between the ages of 45-64 years with the main cause being degenerative diseases. (R., 1935) This statistic shows the lack of medicine to effectively treat the growing health problems of the aged person and allows comparison to today’s medicine, which has significantly pushed back the average life span.

These gaps in knowledge leave the population susceptible to false claims of drug treatments and also cause them to be fearful of the ever-present possibility of death. For example, in the January 8, 1987 issue of the newspaper, there are several advertisements for a drug that claims to cure cancer and present personal testimonies to the effectiveness of the treatment. (R., 1987) This advertisement is preying on the fears of the population during that period and their misguided beliefs about health and medicine. There also appear to be many advertisements for new doctors in the area showing a frequent
turnover of practices in the area during this period of time. This follows the population
growth patterns as well as the development of standardized medical practices and state
medical colleges, which provide an increased number of trained physicians to the local
area.

The first hospital in the area was not opened in the nearby small city until May 1,
1902. (D., 1972) In the first year of the hospital’s service, only sixty patients were
treated but by 1967 it had expanded to treat 5,551 patients, 1414 infants, and 5,821
emergency room patients. (E., 1968) Today, it is the only hospital in the county and sits
only 15 miles away from Brookings providing easy access to emergency medical care for
the local residents. Also, healthcare services expanded locally with the opening of a
nursing home in the valley in 1958. (R., 1958)

In Brookings, during the time period recalled by the respondents, mainly local
country doctors provided healthcare until the establishment of the medical center near the
downtown in 1978. These country doctors were often based in one town in the valley but
provided care to many patients in the surrounding region. Several anecdotes provided by
long-time residents help to illustrate the way that healthcare was provided during the mid
1900’s and will be used later to track the progression of the quality and type of services
provided in the Brookings area.

A major figure in Brookings healthcare during the mid-1900’s was a local
physician, who we will call Dr. Green. He served the area between 1926 and 1976 and
was beloved and respected by the community. On his death in 1976, the local newspaper
wrote, “Dr. [Green] was an institution – a product of a long-ago past when the milk of
human kindness took precedence over the struggle for financial gain.” (R., 1976) Dr.
Green was well known for allowing his patients to pay him for his services in any form that they could – eggs, meat, a dollar – whatever they could afford. He was the only Brookings doctor during the half a century that he provided healthcare for the area.

Following Dr. Green’s death, the residents of the area immediately began to discuss possible ways to memorialize his work. A town commissioner summed up the feelings at the time by saying, “What can we do to pay a fitting tribute to Dr. [Green] and at the same time solve the problem of the alarming shortage of skilled medical treatment available to the community.” (R., 1976) Quickly, the town council agreed to donate town land to catalyze the creation of a medical center in Dr. Green’s memory. Following this crucial first step, the citizen’s formed a committee and began fundraising. The residents of Brookings, in honor of their dedicated physician’s work, raised almost all of the funds for the building.

In August 1977, ground was broken for the first medical center in the town and by January of 1978 the two new physicians, Dr. _______ and Dr. Mustard had begun seeing patients there. The Green Medical Center was reported to have “an X-ray room, ER treatment room with ambulance ramp, consultation room, examining rooms, lab space, office and reception area.” (R., 1977) Thus this facility was very advanced technologically with ample space for the growing town. As a result of this new building, healthcare services increased dramatically and it was all brought about by the town and its citizen’s acting aggressively to improve their healthcare situation. It was a special project for the people of Brookings in memory of a doctor who served them well for many years. The opening of the medical center led to a wide range of services being offered and healthcare available twenty-four hours a day. The building also attracted five
new physicians to the area by 1992 to keep up with the population growth in the community.

In recalling the healthcare of their childhood in the 50’s and 60’s, the overall theme of the residents questioned seemed to be the absence of preventative care in the past and the predominant use of house calls by the physicians. Mainly, a doctor was called only if someone was seriously ill and there were almost no comments about yearly physicals or immunizations. This relates to the quality of care that the residents experienced during that time and may have resulted in increased illnesses due to a lack of preventative techniques. Respondent 3 (R3) writes that “there was very little care and you would only see the doctor if there was pain or you were very seriously ill,” and respondent 7 agrees with this statement. Another respondent (R5) states, “I remember infrequent, but necessary, house visits by Dr. [Green] when we were seriously ill.”

Respondent 10 comments that almost all of her many siblings were born at home in the presence of a doctor and also recalls an incident where the local doctor had to be called to the house when her mother fell ill suddenly.

One time my mother, and this was after nine of us had been born, and she was walking and some of the kids were with her and she slowed up and the kids ran ahead of her, Johnny and me, and she got a spell that she just felt awful and mom was tough and she was a doer and a survivor. She got this bad spell and she said I have to go back to the house and they hadn’t gone nearly as far as they intended to. And Dad called the doctor because she went to bed and it was the daytime and he came and gave her some medication that she drank. I have the feeling that it might have been spirits of ammonia because they gave that a lot then... It had a stimulating effect but he told Dad it was good he called him because she might have died so evidently she had some cardiac episode.

This illustrates the fact that the only kind of emergency care available during that time was the calling of the local doctor to come to the house. The ability of the individual to
receive healthcare was reduced due to the unpredictability of reaching the doctor in time. R10 also continues on to discuss a time when she had an abscess on the back of her head and it went untreated for so long that when she was finally taken to a doctor it had to be drained and then a hood was worn to protect the injury. “That was something today that would have been observed and acted on more quickly. They would have gotten you on antibiotics or topical ointments to put there. But it’s a wonder in retrospect that I didn’t get heart disease or meningitis or encephalitis because there was bone there…” Once again, the lack of yearly physicals and preventative healthcare caused an injury to develop into something more serious because it went undetected.

One way that residents tried to deal with this doctor shortage was to use their own methods of treatment for minor injuries and illnesses. These techniques had often been passed down through the generations or shared between neighbors and were usually developed through trial and error. Respondent 11 recalls one injury that she had that was treated using home remedies and was never seen by a doctor.

One of the worst things I ever had was a splinter here on my leg - I still have a scar there. I stepped on a board and the board came up and splintered and I was an adult and you could still see the splinter in there. But you picked and picked but it wouldn’t come out. It was deep, so I remember we put a slab of bacon on there and tied it on my leg and it drew that splinter out.

These home remedies often had to replace the care that would today be provided by a healthcare professional. While many were effective, the individual still ran the risk of it developing into something more serious without doctor’s supervision. The reduction in available healthcare also led to families being forced to take care of older relatives who were sick or disabled because a nursing home facility was not available. R10 tells of a relative whom they took care of at home despite her health problems:
We are living longer but then we have the persons who have Alzheimer's or dementia so that adds to the cost. Years ago those people would be kept in the home and they wouldn't get very good care. In fact it was a great aunt who had a form of dementia that Mom talked about. She would wander off and she'd wander down the road and Mom would go down and walk along with her a little bit and say, "Why don't you come into the house and have cookies and milk," and she'd come back home with her.

This was probably a common occurrence due to the lack of adequate facilities to care for those with health problems. Thus many home remedies were used and relative often became the responsibility of the family to provide their healthcare.

Another observation made by R10 is that the doctors during that time were very possessive of their patients and were often reluctant to seek other professional opinions. This led to a feeling of close, personal care by the patient who felt that their doctor knew their health history and was dedicated to caring for them based on their personal relationship. An illustration of this was R10's father who fell seriously ill under the supervision of a local doctor who did not wish to seek others' advice.

Our dad was a farmer and he had had pneumonia a couple of times when he was younger but he was not a slacker, he was on the job all the time. In 1956, in November, he got a sore throat and went to the doctor and was given some penicillin tablets. That was on a Monday. He came home, within two days his feet were numb and his hands were getting numb. I came home on a Tuesday evening from a trip and found my mother shaving him in the kitchen, him sitting in the rocking chair, completely out of character. That was a big clue to me dad was really sick. I went to the doctor and told him I was concerned because something else seemed to be wrong with Dad, he had this numbness in his feet. He said, "You nurses, you think you know everything. You haven't given it time for the penicillin to work." He gave me more penicillin tablets. I argued with him, "But people don't get numb feet with a sore throat." I called someone else. That doctor did a spinal tap on him trying to rule out polio because that paralyzes progressively up the body. The next morning I was in there with Dad and [the doctor] called me and said, "I have to get a specialist to see him. I don't know what it is." He was very quick to admit he didn't know. Doctors were very possessive of their patients back some years ago and were very reluctant to let someone else see their patients and admit that they didn't know what was wrong. But this guy was young and readily admitted it. An internist at the hospital went in the room, saw dad, and came out and said he has _______ Syndrome." I said,
“What?” He had to spell it for me. “I’ve only seen six cases in my life.” This was an older doctor and he described what could happen, “It could move upward into his lungs.” And that’s what happened. He was dead on Sunday.

This vivid story shows the shortages that could be found in medical care in the Brookings area during the mid-1900s. R29 adds that this is one of the major changes in healthcare over her lifetime. She states, “There is more of a collaborative effort; its more of a team approach. Whereas before the doctor’s word was “gospel,” now they collaborate more with nurses, and other healthcare professionals for more comprehensive care.” The possessiveness of the country doctors could ultimately result in misdiagnosis and terrible consequences for the patient. However, as mentioned before, the individual attentiveness of the doctors was often greatly appreciated by the patients.

This propensity for misdiagnosis was seen throughout the surrounding area as well and was indicative of the lack of specialized knowledge about many diseases and injuries. Respondent 6 comments on how one doctor gave her a grave diagnosis that happily proved to be untrue. It is also noteworthy that no pain medicine was given either during or after treatment, which was a typical procedure during that time period.

I remember at age 8, being taken into this [small town] because of kicking a beach ball, and falling, hitting my knee on the hardwood floor. My kneecap was pushed out of place, well toward the back of my leg. We were on the farm. My knee began to swell immediately. When Mother saw this she screamed! We had farm help who rushed in to see what had happened. A farm hand drove Mother and I in to see the Dr. I remember the Dr. having people hold me down and pushing my kneecap back in place, putting a cast on and giving me no medicine to relieve the pain. The Dr. told my parents that I would always have a stiff leg, unable to bend at the knee. I remember how frightened I was when the cast came off, because this leg was so much smaller in size than the other. No one told me that this was because of a cast. Well the Dr. wasn’t right about my leg remaining stiff, for I persisted on running and playing with the other children. I’ve had little trouble with my right leg during my lifetime so I believe this went well.
In this story, the lack of education about health is seen to create fear in R6 because of her atrophied leg. This is indicative of the general fear of quick and unexplained deaths during that time due to a failure to educate the public about causes and treatment of disease and infection. This lack of knowledge led to a trend of “very few people [going] to the hospital” during those days, as remembered by R10. “Often there was a phobia about going to the hospital. If you went to the hospital, you were going to die, you wouldn’t get out was what people thought and sometimes that happened.” This fear may have been based on the fact that most people sought medical care only when very seriously ill and so the disease was often untreatable by the time they went to the hospital for care.

Also adding to the increased misdiagnoses compared with today was the lack of technology available to the local doctors. R29 gives one example when technology would have made a difference in the healthcare provided:

In the late seventies and early eighties, it took about two months to diagnose my mother’s illness — which was a malignant brain stem tumor. It was small and hard to detect on a regular CAT scan. It wasn’t until they thought to use “contrast dye” (which was not readily available at that time) that they could diagnose it. Today, that technology is already “old.” With the newer MRIs and other sensitive technology, that diagnosis today could be made in one day.

The availability of advance technology to the residents of the Brookings area has significantly increased the quality of care available to them. This represents a major change in recent decades and helps to provide accurate and fast diagnoses of illnesses.

Another common memory of the respondents had to do with the method of payment used for the doctor. R3 remembers that the local doctor “had no set price for a visit. He would ask to see your money, either take money [out of what you had], or if a farmer, may ask for a ham or something he knew you would have.” Dr. Plum, at the
current family practice, also remembers some interesting examples of this by the previous doctor, Dr. Green:

They’d bring a chicken, or they’ll say, “How much do I owe you?” and he’d say, “What do you have in your pocket?” They’d pull out a dollar and he’d say, “That’s fine.” I even heard stories, they’d say, “I don’t have any money today.” So Dr. [Green] pulled out his wallet, took out a couple of dollars, gave it to the patient and said, “Here, give that to me.” They gave it to him and he said, “That’s it.” Things like that.

An interesting comment made by a couple of the respondents indicated that the doctor they saw as children intimidated them to a large extent. R13 recalls that “as a child and into my teen years, Dr. _____ was my physician. I remember feeling afraid and intimidated by him. His offices were located on M____ Street in one of the historical buildings. The offices had a dark, cold feeling to them and I’m sure that contributed to my feeling the way I did…. I don’t remember that he was especially personable.” R3 agrees in commenting that his doctor’s “very short manner of speaking made me fearful to go see him.” R30 adds, “I was terrified of him, his nurses, the way the place smelled – you name it – everything about it was just miserable.” All of these respondents report a close relationship with their current physicians, which may reflect on the aura surrounding doctors in the past. They were often seen as powerful men and little was understood by the general public about their methods and procedures. This led to feelings of intimidation and great respect for the local doctors. Today, more information about general medical treatment is known by the patient, which allows them to approach the doctor on a more level ground and therefore develop a closer and more personal relationship.

All of these memories from actual patients give insight as to the type and quality of healthcare available to the residents during that time period. It was characterized by a
local country doctor carrying a load of patients from a wide area and providing his services mainly through house calls. Emergency care was limited and rarely considered trustworthy by the residents and home remedies were often used in place of professional medical care. Lack of specialized medical knowledge by both the doctor and the patient greatly increased the risk of serious health problems and fears. Often this was compounded by an unwillingness on the part of the physician to seek second opinions and more advanced treatment. Finally, the payment methods for medical treatment were frequently unconventional and catered more to the individuals’ financial standing than is seen in today’s medical practices. These characteristics of the medical profession in the mid-1900s have changed greatly over the last 30 years. In Brookings, the creation of the family practice medical center changed the overall healthcare provided to local residents in many ways, mainly positive.

**Doctor Shortages**

The failure to have enough doctors and nurses to care for the rural population is a significant problem still today. While family doctors are becoming more numerous in these areas, there remains an overload of patients for the individual doctors. Also important is the difficulty of rural patients in accessing specialists easily and without long travel times. While these issues are alleviated somewhat in Brookings due to its close proximity to major metropolitan centers, it remains an inconvenience for the residents to reach these specialists.

In the Brookings Family Practice, the physicians decided not to have a high-turnover practice but instead leave enough time for each patient’s consultation. While
this has many positive aspects, there are the downsides to it especially recently with the increased population growth in the surrounding area. R3 asserts this conclusion saying, “This area’s service meets the need presently, but other medical persons could make a good practice in the immediate area soon with the [population] growth.” This patient-load pressure can sometimes lead to longer waits before your appointment and difficulty getting an appointment for certain types of health needs. An example of this is given by R1 who comments, “I find it relatively easy to get an appointment for an illness [at BFP], but scheduling a routine physical has a 3-4 month delay. I find this type of delay to be completely unreasonable.” Compounding the problem at BFP is the fact that the one specialist, Dr. White, only works part-time hours due to family commitments. This makes it sometimes difficult to get an appointment with her but her patients speak overwhelmingly positively about her care and therefore are willing to put up with this minor inconvenience. However, Nurse Peacock comments that for Dr. White’s patients who have an immediate need of healthcare, they are sent to the other doctors in the practice.

And the nice thing about this practice is they’re really good about, you don’t even have to wait long to get in for an acute problem. You make an appointment and you get seen pretty fast. Not always with the doctor you want but with [Dr. White] that’s different. You can expect it to be three months. That’s why we don’t see anybody with an acute illness, because it would be over by then.

When asked whether they feel that they have an excess demand of patients, the doctors had mixed responses. Dr. Butler feels that only during the flu season do they have difficulty seeing all the patients that want to come in for appointments. Dr. Mustard agrees with this sentiment stating:

We try to see people who are sick within the same day or two. I think the practice is limited by the number of insurances we take and the number of people we can
see. Most of the time we can see people within a reasonable period of time. I don’t think we are overwhelmed. I think most practices reach some kind of equilibrium. If people can’t get in they’ll go to another practice. I think with five different doctors here we have enough room to see people most of the time when they are sick, except maybe a flu epidemic or that kind of thing.

However, Dr. White does feel some burden of excess patients and hopes to alleviate that soon by increasing her patient hours. Therefore, most of the doctors in BFP feel that they are generally able to handle the patient demand although during certain periods this may be more difficult and lead to some frustration by the patients.

Another shortage for rural residents is the emergency healthcare available to them. There are no hospitals in Brookings, and while a doctor from the BFP is always on-call, this is not adequate healthcare for all types of emergencies. R12 notes this saying, “Many times your doctor is not available at night or on weekends so many people go to the Emergency Room [in A_____] and wait for hours.” R5 agrees with her adding, “A wide range of specialists are not readily available, especially in an emergency situation. However, Medivac [the emergency helicopter service] availability has lessened the problem.” This lack of emergency care can lead to a decrease in successful health outcomes and is certainly a disadvantage for a rural family practice.

Most significantly, rural settings often experience problems in accessing specialists easily. While seventy-five percent of the respondents said that getting an appointment with their family physician was easy, only twenty-five percent said the same about specialists. This shows the overload that the specialists in the nearby town of A____ are experiencing. They are attempting to serve the health communities of all the surrounding towns but this becomes nearly impossible and therefore makes it difficult for a patient to get an appointment.
Also, there is a limited range of specialties available to Brookings’ residents in this nearby town. This can force them to travel long distances in search of high quality specialty services. R4 notes the difference between a rural setting and urban setting in saying, “The breadth of specialty network as to who is really good for a particular condition may not be as expansive as an inner city or academic based health care provider.” The ability to seek outside specialty care is often limited by time and financial resources and may therefore affect the quality of care being received. R12 cites her concerns about this:

We did feel the need to go to New York University Hospital for [my daughter’s] final surgery because the doctor at the University of ______ Hospital had moved to NYU. I will follow a doctor if I feel the need. Not everyone can financially afford to do that. Will I be able to afford it as I get older?

These concerns are certainly shared by many other residents of the Brookings area and leave the possibility that access to this specialized care will not be possible when they have a need. This need is often not only for emergency situations but for everyday health maintenance such as Dr. White’s patients with diabetes. Nurse Peacock emphasizes the importance of having access to the necessary specialists:

Because her patients have diabetes, a lot of organs are involved in that. So she sends them to the cardiologist ... she makes sure they get their eyes taken care of by an optometrist or a retinologist depending on what’s going on. She sends them to wound care or infectious disease doctors when they have infections that just really won’t clear up. She is very good about not trying to take care of something that she knows someone else is much more expert at. Especially with people with diabetes because you don’t have ... you can waste a lot of time. She also sends people to major medical centers when she [finds something]... She doesn’t just look at their complaints, she does look at those, but she looks very deeply and looks for other things going on. So I know we have patients that have been to [the teaching hospitals 50 miles away] because she suspects adrenal tumors or pituitary tumors. That’s nothing that can be handled in A______. 
Thus, while some residents have the ability to seek high-quality care in the metropolises, all patients do not have this option and therefore their healthcare suffers from these specialty shortages in the area.

Several respondents brought up an interesting topic that I had not considered in my original thinking on the subject. They mentioned that one of the significant advantages in the BFP was the presence of a highly skilled female doctor. R23 notes that there are also many more women physicians in the specialty fields and this is seen as an advantage for her healthcare. R12 adds, “I’m glad there are more women in the field of medicine. I think they are more aware of women’s health needs and issues.” This certainly represents a historical change in the gender make-up of the area doctors in the respondent’s lifetimes. This also highlights another type of shortage that other rural settings might be experiencing as female patients seek a family doctor of their own gender. Many women feel more comfortable and cared for by a female doctor and will frequently provide more health information to her than to a male doctor. This results in better care provided by the doctor due to the comfort level of her patient. BFP’s female specialist, Dr. White, is highly regarded and is often sought out by female residents of the area. R13 helps to express the reasons behind this:

In an emergency, she bends over backwards to fit you in and has on numerous occasions, called me to discuss test results, etc. from her home. She is worth waiting for an appointment because I have never met a physician who spends so much time with her patients as [Dr. White] does. She truly has your best interest at heart and makes you feel like she is treating you like she would her own sister. I can’t say that about too many of my other doctors over the years. I’m very fortunate to have a female GYN like that too. Maybe, it’s a gender thing. Women, by nature, tend to be more nurturing.

This is of course not to say that the male doctors provide lower quality healthcare to the same patients. However, the comfort level of the patient will always raise the
effectiveness of the care being given and therefore a female physician may have this
effect on female patients. It is significant that BFP is able to provide this option to its
female patients and it certainly raises the quality of care given by the practice.

Finally, the increasing presence of physician’s assistants (PA) and nurse
practitioners (NP) is helping to alleviate some of the doctor shortages in rural areas.
While BFP does not have either of these, some of the other area practices do and several
respondents mentioned their satisfaction with these interactions. These health care
providers allow patients to get appointments much faster than they normally would.
Citing this, R24 says, “It is becoming more difficult as the population grows and ages and
puts a strain on the available physicians. However, I can usually get an appointment
within 24-hours with a physician’s assistant.” R2 agrees stating, “Occasionally we will
take an appointment with the physician’s assistant to expedite a minor visit if that will get
us in quicker. They are competent and will consult with the physician if need be.” This
shows the increasing need for PAs and NPs in rural settings to provide faster, quality care
to these residents.

The problem of doctor shortages is becoming increasingly common in rural areas
and will shortly become particularly obvious in Brookings as they experience a
population boom. These shortages can lead to long waits for appointments and difficulty
in seeing specialists. A patient’s ability to seek a specialist consultation should not be
limited to their ability to find transportation to a large hospital 50 miles down the road.
Thus, the necessary steps must be taken to alleviate these shortages and therefore
improve the care provided for the residents. These steps will likely include the addition
of physician’s assistants and nurse practitioners to the staff of the local family practices such as BFP.

**Quality of Care**

As mentioned in the background section, quality of care is measured in several different ways. Most importantly, the success in resolving the health problem will determine the general quality of the visit for the doctor and the patient. Also a factor in the patient’s opinion of the healthcare is the personal trust they have in the doctor and whether or not they feel that they have a personal relationship with him. This will affect the amount of information they voluntarily offer as well as the extent to which they follow the doctor’s instructions after the visit. Other factors affecting the quality of care are the feeling of having continuity of care with a doctor and the amount of time a doctor spends with them in the consultation room. Finally, quality can also be measured by the efficiency of the practice in treating those patients within their abilities and sending the others to specialists. All of these factors combine to give an overall impression of the quality of care provided for the patient and the doctor.

In looking at the quality of care being provided in the Brookings area, the responses of thirty local residents and two nurses and four doctors in the Brookings Family Practice (BFP) will be examined. Their own words will be used to describe their experiences in giving and receiving health care. While only seventeen of the respondents are patients at BFF, all of them will be used to give an idea of the quality of care in the whole area due to the close similarities to surrounding towns.
Overwhelmingly, the most important advantage for the respondents in their rural practices was the personal relationship they felt they had with their doctor. Around sixty-eight percent of those asked cited this reason for their preference of rural care. They all felt that it was important to feel comfortable with the doctor and have trust and confidence in them. Without this, the quality of their care would be lowered and therefore their own health would be affected.

Respondent 12 (R12) sums up these sentiments by saying, “The doctor and the patient develop a trusting relationship. The doctor is aware of the patient’s overall health and health needs. The doctor takes more interest in the patient – they become a friend.” Many people echoed this sentiment of the doctor seeing the patient as more than a number such as R5 who states, “You get to know your doctor better and he sees you as more of a whole person.” R26 adds, “I love rural healthcare because you usually see the same doctor and get to actually know them. In addition, the doctor really gets to know you as a patient and you can form a strong relationship.” This personal relationship is very important to their feeling of the quality of care they are receiving.

Many of the doctors and nurses that were interviewed shared this feeling of the importance of a personal relationship with their patients. Dr. Plum states simply, “The advantages [in a rural practice] are you definitely get to know your patients a lot better.” Agreeing with this sentiment was Dr. Mustard adding that at Brookings Family Practice, they emphasize this type of personal connection.

I enjoy the person to person relationship, the family—I think that has stayed the same [during his time at BFP]. I think we still have a close [relationship]. A long time ago we decided not to do a high turnover practice. We only see four patients an hour and set aside an hour for physicals. We never wanted to do a high volume practice. So we do spend time with patients and we get to know people that way.
These doctors feel that this personal relationship with their patients helps them to provide higher quality healthcare.

Also mentioned by the respondents is the feeling that if the doctor is someone you know and trust, you will be more likely to seek healthcare when it’s needed. R6 comments that the advantage for rural healthcare is that “patients are more prone to see healthcare provided they know them and trust them.” This helps to raise the community’s level of health because they seek care more frequently and therefore have fewer serious illnesses that go untreated. This is often a factor in the amount of information a patient shares with his doctor or nurse and therefore the quality of care provided. Nurse Peacock from BFP comments on her relationships with her patients and how that helps her to do her job better.

“Well, I know them, they know me. I like the relationship I have with my patients because I feel like we’re connected in a way, you know, I know them, I know how to make them comfortable, because they’re familiar to me. Instead of seeing somebody different all the time. [I feel like this helps me treat them better] because I get to know them better and I know what kinds of things worry them and that may slow us down because they talk to me, and then they talk to [the doctor] too because they know her that way too. We’re both pretty...ummm...how shall I put it...it’s not just taking their blood pressure. As they speak like that it gives them time to relax and think about what they need to bring up. [When I go to my doctor I have a different experience.] I mean [the doctor] is very nice but that’s all she does, she doesn’t ask after my family, she doesn’t know my family. And that happens down there in that small practice, in that small town practice...You just get a little more in depth, become more aware of what kind of things they don’t know, what kind of teaching they need, or how they best learn, or what kind of things you really know they’re doing that aren’t helpful, and you may not be able to change that but at least you know what it is.

Another important aspect of the rural doctor-patient relationship is that you know the doctor in other contexts then just at the healthcare center. This contributes to the feeling of trust and confidence felt by the respondents toward the doctors that they know
from the community. R24 comments that “the advantage to the “rural” was that [her children] were comfortable with [their doctors] since they knew them from church, knew their children, and we went out to dinner and to [amusement] parks,” with the doctors. R29 adds that her family is “personal friends with three of their doctors and their families. It is an advantage in that the relationship is already established and interpersonal skills come naturally. This helps doctors deliver more holistic care when they know a whole family and the family situation.” R13 sums up these feelings of rural advantages by saying:

Better rapport between doctor and patient due to the fact that you are more likely to have a personal relationship with your physician instead of strictly a professional one. This contributes to feeling like you have someone on your side who genuinely cares about you because they see you in church every week, have children who play together, etc.

She then continues on to cite an example of an experience where she felt like she had the doctor on her side:

I recently called in because I had [a serious health concern] expecting to be told I’d have to wait a month to even see [the doctor]. They called me back several times that day and had me in the office for an examination with [my doctor] the very next day. It was extremely comforting and I’m not sure that if I didn’t have a personal relationship with the people in the office I would have been treated that well. Who knows?

This example highlights the advantages of having a personal relationship with the doctor and how this can improve your healthcare. This was, by far, the most frequently cited reason for preferring rural healthcare. Having a trusting relationship with the doctor significantly increases the quality of care provided to the patient.

While this advantage is certainly significant, there is a small downside to having a personal relationship with the doctor and that person being a part of your community. A few respondents cited this as being a kind of disadvantage to rural healthcare. While R16
wrote about the advantages of a personal relationship, she also added, “I suppose one could feel like all of [Brookings] knows your business.” R24 agreed stating, “The disadvantage [to rural medicine] is that as [my child] matured physically and as [my husband and I] aged and needed more “embarrassing” exams, it became difficult to go to doctors we went out with.” R30 adds that in an intimate healthcare setting there is “no sense of anonymity; sometimes the setting does not lend to total privacy, just because everyone knows everyone else.” These concerns are valid and can be in fact returned by the healthcare provider as he attempts to lead a normal life in the community without patients asking about health problems in the grocery store or at church. Nurse Peacock even cites this as a reason for doctors running behind schedule.

You know, sometimes the patient is very upset and they just need to talk and there’s no way they told the front desk; that’s the small town problem. They don’t tell the front desk, because they don’t want everybody to know. So when we get them back in the room we find out that really there’s a much bigger problem than what they made the appointment for, just for privacy. That would be a negative issue of a small town practice.

This is certainly a disadvantage to the rural health practice but is generally out-weighed by the increased quality of care given in these settings.

Another important aspect of quality of care is the ability to have continuity of care for you and your family. Many respondents mentioned this as an advantage to the rural healthcare setting in Brookings. R26 states, “I like knowing that I’m going to see the same doctor each time I visit the practice,” and R20 says that “a total family approach to better health” is advantageous to her and her family. When a family practice is compared to a HMO (Health Maintenance Organization), R4 sees a clear difference commenting that at a family practice you see a “health care provider more consistently as opposed to an HMO where you might not see the same health care provider in a year’s worth of
visits.” Also helpful in having continuous care is the “awareness of medical background” that the doctor has as pointed out by R7. This will increase the quality of care being given because patterns of past health status can be examined and taken into consideration when attempting a new treatment.

Continuity of care was singled out by all of the doctors and nurses interviewed as being a large advantage to the rural family practice system and something they are able to achieve at BFP. Each doctor and nurse spoke about the past experience of training or working in a more urban setting and how that compared to their experiences in Brookings. Dr. White sums up her experiences:

It is sort of nice here so most of the people who come here, live around here, so you get a great continuity of care here. You know you’re able to go back and say, “You know your hemoglobin A1c was this three months ago,” and you say, “This is your trend, you really need to do this, obviously that didn’t work when you were doing that.” So its kind of nice, you know the patients over years. In the [urban setting I used to work in], everything was set up as a clinic, and you know you just didn’t have that. You’d see different patients everyday you worked in clinic and the same thing at [the urban teaching hospital], you worked in clinics as well, and you would just see different patients all the time. And if you worked inside the hospital, if you were doing hospital rounds and stuff like that, that was a little bit of continuity of care, but even then, you never saw the patients when they got out of the hospital. Here, you know [before the hospitalists that arrived this year]...we knew exactly what was going on because [we] were taking care of them in the hospital and [we] would just come back and say this is what happened and its just nice, you know, to be able to do that...And I am very meticulous about my charting and I pretty much review everything every time they come in and make sure everything is up to date – pap smears and mammograms and everything else. So I spend a lot of my time doing that for my patients and a lot of that is because they are chronic, and they have chronic illnesses. So I would say my patients that come to see me get a lot of health maintenance stuff.

Dr. Butler elaborates on the problems in trying to achieve continuity of care in an urban setting:

There’s a variety of reasons, there’s not a lot of continuity of care [in an urban setting]. Its poverty, people have a job that they can’t get away from to get to their doctor’s appointments or they can’t get transported to get to their doctor’s
appointments, or maybe the clinic is set up inappropriately where the doctors or residents that are working there are not set up to see the same people routinely so there’s a lot of things that need to be working together. It’s rare that you have a clinic that’s open in the evening, for residents anyway. Some people could get more to the evening clinics if they had time. We do have evening hours [at BFP]. We do see some recurring patients in the evening. We’re open in the evening mostly for sick people but some people come in after five o’clock to get their routine visits, scheduling that kind of thing. It’s certainly easier here to get the continuity of care then it would be in an urban setting.

The aspect of continuity of care most important to these doctors and nurses was the ability to see whole families during all their life cycles. This helps the healthcare provider to better know the family and their health history and therefore provide higher quality of care. Dr. Mustard highlights how this helps him to provide better care to his patients:

We see kind of more families. With the residency I saw a lot of inner city poor people, clinic kind of patients, sicker kind of people. Here [at BFP] it’s more middle class, we see a lot of families, kids and parents and the extended families, three or four generations of the same family...I think that’s much better way to practice medicine. It was hard to do any kind of continuing care in the training program...some families would be assigned to you; you would see them for maybe a year or two. But here I’ve seen families, patients for twenty-five years, the whole time I’ve been in practice. I’ve seen people since they were five years old and now they are thirty...It helps to know the family.

Nurse Scarlet adds her feelings on the improvement in care she can give if there is continuity in the patients:

It’s a close knit, it’s a caring, not that you don’t have caring in urban hospitals but I think that you have time to care because of the continuation of the number of people you see who are the same people as opposed to a big city where, and especially in an emergency room, where you just don’t. I think it offers a whole new kind of nursing in that you can do nursing, as you want nursing to be. Because I’ve been [at BFP] 21 years, I’ve seen my kid’s friends have families, so I’ve seen their births, I’ve known their parents and seen some parents die. So you have a continuation of a whole life cycle. And you’re able to be part of it, in a small way, but to be part of it. And that may not be what you consider nursing but you can kind of have something positive to contribute to someone’s life. Especially if they’re sick and they don’t feel good or they don’t know what to, or they had a loss.”
Thus, all the doctors and nurses agree that the quality of care they are able to provide is greatly improved by having continuity of care for their patients.

While both the doctors and nurses report an increased demand on their patient load, they all emphasize the importance of taking enough time with each individual. Nurse Peacock says, “Right now the other doctors in this practice spend a lot of time with their patients and get behind, they get behind because everything is taken care of, because if they bring something up we take care of it rather than having them come back.” Recognizing this increase in demand, Nurse Scarlet mentions that there are times when there isn’t enough time for caring for the patients.

There are people with whom you would like to spend more time because there is a definite need to spend more time. The practice has grown so much, it has probably tripled, as we take on new insurances we get a block of people that can come in with insurance. So that’s kind of an outside factor we can’t control. I think sometimes we see a lot a people everyday. If we do every 15 minutes for 7 hours, break for lunch, that’s 28 people a day for each of these [doctors]. I think we do a good job with giving the time needed for strep throats or upper respiratory; that kind of thing. Sometimes we don’t have enough time, the nurses don’t, for somebody who’s had a loss. To give that a little more human than run through kind of thing. The people with whom I work, the nurses, I think [BFP], (I’ve been to other offices) I think it has a uniqueness about it. I really do. I think we’re still able to keep the human touch and still do the necessary job like call in the prescriptions and the paper work that’s involved.

This commitment to spending time with individual patients is reflected in the opinion of the patients that they are receiving a high quality of care from BFP despite its increasing patient load. This time allotment is a issue for many healthcare practices as R11 discusses from her personal experiences.

Many times the person we see today knows nothing about us when we get there. You may be referred to somebody. There’s pressure in medical systems now to see so many patients within a certain time frame, particularly in good practices and HMOs they’ve got to see this many. They cannot do the thorough exam. I have seen this from personal experience… Today when you go in for an annual
physical, I see so much concentration on documenting, documenting. The whole time the doctor is talking to you, he is writing. That’s tremendous pressure and there’s not the thoroughness.

For many of the respondents, the accessibility of healthcare was very important in determining the quality of the care they received. R18 and R19 both mention the advantage in the rural setting of having the family practice nearby. R16 agrees saying, “It’s convenient to have it so close. We can get there in any kind of weather.” This however, is not necessarily true for everyone in a rural setting as there are many places that are less accessible, especially during the winter. This is pointed out by R25 who comments, “There are times when it’s almost impossible to get to town to see the doctor. If you do not drive it is sometimes difficult to get someone to take you to the doctor.” Agreeing with this is R6 who adds, “Sometimes the poor don’t have transportation.”

Therefore, the rural family practice is convenient for much of the population in the area but for some demographic groups, such as the elderly and the poor, it may be difficult to travel the distance to seek healthcare.

One way that the doctors are attempting to alleviate this problem in Brookings is by continuing the practice of making house calls. This was widely practiced by doctors up until the mid 1500’s when the increase in the number of patients for each practice began to make this impossible. However, in some cases, the Brookings doctors continue to make these house calls for those who are unable to reach the office for their health care. Both R25 and R19 cite this as an advantage for the rural healthcare setting with the latter commenting, “I’m satisfied with our setup in [Brookings]. Our local doctors will make house calls in an emergency.” All of the doctors at BFP said that they still make house calls while also adding that it is not as frequent as before. Dr. Plum remembers the
previous doctor doing this frequently. “[The previous doctor] did a lot of house calls, gave shots at home, delivered babies...a lot of people around here who were delivered at home by him.” Now however, house calls are limited mostly to those individuals who can’t get to the healthcare center for various reasons. Dr. Mustard comments, “I’ve got a fellow I’m going to go see: a paraplegic with sores, that I’ve made house calls the last couple of weeks. So we’ve always made house calls but infrequently - every once in awhile – people who are housebound or can’t come in. It’s usually not very efficient because it’s hard to do testing on in-house patients but we’ve had some patients who are immobile or can’t come in, or won’t come in and we make house calls.” In many patients’ opinions this service is a significant advantage to rural healthcare and feel that it is a result of the personal care that their doctors are willing to give them.

Another contributor to the quality of care provided by the family practice is the amount of care that can be given at that location. R3 sees this as a significant change in the way rural healthcare is practiced over her lifetime. She states, “Now healthcare persons have more knowledge, have assistants and there are specialists to assist them. The equipment makes possible more variety of care at one location. We are taught to learn more about our bodies and how we are a great part in our healthcare.” This ability to treat diverse health problems can be seen in the types of illnesses that can be treated at Brookings Family Practice. Nurse Peacock compares BFP to her own healthcare provider in the larger town nearby:

And you know what’s different about the practice in [Brookings], which is a small town, and the practice I have to go to because of our insurance and a lot of other practices in A_______; they don’t draw blood. They might do EKGS in their office, they don’t do X-rays, and they probably have a microscope to check for a urinary tract infection because you know that’s pretty reasonable. But this office
[BFP] provides a lot more services than most doctors' offices. Other doctors' offices send people to the lab to have blood drawn.

This variety of services is important to the patients in giving them the comfort of having their health problems addressed by their own doctor without having to travel out of area.

Summarizing the services they offer at BFP is Nurse Scarlet:

We do urinalysis, strep tests, we do pregnancy tests, we do hemoglobin or red blood cell counts for iron. We can do testing for elevated blood sugar. We do, I don't want to say minor X-rays, that's not a good term, but we do X-rays for a chest and a fracture; yeah we can do arms and legs pretty much. We don't do the big ones, we don't do spines, and we don't do knees, X-ray wise.

Other injuries that can be treated are lacerations, cardiology or gastroenterology problems, and biopsies. Minor surgery such as removing a mole or cyst is possible in the practice and EKGs can also be performed. Dr. Butler adds that the problems that can be treated at the practice have changed over the years he has been at BFP. “We're lucky to have all the specialists that we do in ______. Insurances don’t really pay us to spend the time to take lesions off and do things that we could send out.” Dr. White, the endocrinologist, treats mainly chronic patients usually suffering from diabetes, thyroid problems, or polycystic ovaries. She and her nurse carry out complicated blood tests and examine vaginal slides under the microscope. Some of the major health issues that are not treated at BFP are major fractures, spine and knee injuries, MRIs, CAT scans, eye problems, and obstetrics. While the doctors before these four doctors that were interviewed used to deliver babies, none of the doctors today can afford the time and malpractice insurance necessary to continue this aspect of healthcare. While there are many situations in which a patient must be referred, BFP makes available a wide variety of basic services to its patients.
With this wide variety of services comes the opportunity to practice preventive medicine and increase the overall health of the patient. Both Drs. White and Butler see this as an important and rewarding aspect of their practice. Dr. Butler comments:

That’s kind of the nature of family practice, trying to do preventive medicine and trying to keep people healthy and preventing illness. So that’s like a lot of what [Dr. White] does with chronic illnesses and when we do physicals and seeing people on a routine yearly basis. You’re this old and this is what your weight is, and this is what your blood pressure is, and this is what your sugar’s doing and this is what we need to work on to keep you healthy and prevent illness. And you have different motivations. Some people are really motivated and some people have no motivation and so you got to work in their framework. If they’re not willing to help themselves you just do that best you can. You try to do the simplest things like try to help people stop smoking. So a lot of what family practice is based on is preventive medicine.

Dr. Mustard agrees with this idea and sees the increase in preventive care as a positive change from older styles of medicine. He talks about his preference for this type of medicine:

I think that we try to do preventative medicine a lot here. I’d much rather prevent colon cancer, heart attack or stroke than treat it. If you can figure what’s going on with people that makes them at risk for future illness, I think you can keep them healthy and in that regard treat diabetes, hypertension, colonoscopy and find a polyp before its colon cancer and do mammograms and pick up cancers and keep people healthy. The philosophy is away from - it used to be once you saw people you treat them - but I think the appropriate practice is if you can prevent things it’s much, much better in the long run.

Dr. White recalls her struggle to provide preventive care in her previous urban setting:

Well, working in an inner city and even at the _____ hospital, people just waited until the last minute to come in. Especially at the _____ hospital, and also downtown [large city], but things were just so much more advanced before they finally came to the ER and got admitted to the hospital and stuff like that. And they were less likely to be interested in knowing about what was going on. So you’d tell them they had diabetes but you’d give them a monitor, but they would never monitor. And the _____ hospital was kind of the same way, some of those chronic illnesses, the people weren’t that interested in taking care of themselves. Here, you have sort of a mixed population, you definitely have the much younger generation who is so interested in knowing everything about everything they have and monitoring like 8 times a day and different things like that. And you still
have patients that don’t monitor very frequently; but I do think that a lot of the patients here, at least like the younger generation, are more interested and they always have information from the internet, they always want this that and the other. Which is fine, it’s kind of nice to do some education; it was really hard to do that and know that it was not going anywhere over there [in the urban hospital].

As can be seen in these three commentaries, the doctors and nurses at BFP feel that they have a greater opportunity to prevent health problems than would have been possible in the urban setting where they practice medicine previously. They make this a commitment in their medicine, and this is significant in providing quality care to the patients in that practice.

A couple of respondents mentioned a negative aspect of rural health care that reduces the quality of care given to the patient. This was for R7 and others the “long waits for scheduled appointments” that they experience. This is frequently due to doctors spending extra time with patients, which is necessary for quality care but must be kept in balance with affecting the patient’s opinion of the visit due to waiting a long time. Dr. Plum agrees with this saying, “We schedule it to still try to keep enough time. I feel I get enough time although I usually take more time and run behind. Which is good and bad. People appreciate the time they’re given but they don’t appreciate waiting. It’s a double-edged sword.” Thus, both sides of the story must be taken into consideration when trying to provide quality care to the patient.

Dr. Plum also sees a significant change, with slightly negative ramifications, in the type of care their practice is asked to provide.

We’re probably seeing a little less total care than we used to; there’s more fragmented care probably. People are seeing their GI doctor and their cardiologist. We may not see them as much as we would have twenty years ago when you pretty much did everything. These doctors were still around but there weren’t as many of them; the family doctor probably had more say in their care.
Sometimes now you almost feel like a third wheel; sometimes we feel almost like we’re superfluous. But it’s a good thing in that A____ County has grown and there are more specialists. I shouldn’t down play that because even though you may not see someone for years, they still view you as their family doctor, and they depend on you even though you hardly ever see them. Suddenly someone shows up and says, “He’s my doctor”, and you look at their chart and say, “But you haven’t been here for three years.” “But you’re still my doctor.” You just have to stop and realize that.

While he notes that they are asked to do total healthcare less than in the past, Dr. Plum still points out the significant role the family doctor plays for the patient. This shows the importance of the relationship between the family and their doctor despite the increased specialization.

The final aspect of quality of care for a practice is the efficiency with which they play the gatekeeper role for the health community. This means that the family practice must identify those that they can treat and those they must send out based on their capabilities. This was in some ways addressed in the section discussing the types of care for illnesses and injuries that BFP can provide. This family practice has a wide variety of treatment options and thus helps to alleviate the pressure on the health system by caring for their own patients’ needs a significant part of the time. However, to the doctors and nurses, a focus on systemic efficiency risks the loss of many of the advantageous of the rural family practice. Nurse Peacock discusses this point:

For me personally, the changes that I see, there some things that I don’t like, that I worry about because there’s a tendency or a need for some of the people that are working there [BFP] to make it not like a small town practice, to make it a little more impersonal because that might be more efficient. It’s difficult because insurance companies are still dictating so much of the care and we can’t always give the care that we like to give. I mean, insurance companies don’t necessarily reimburse you for that. So from a business point of view there’s a real conflict. Because patients have always, even if they go to another doctor, and their other doctors need blood work, they come back to our office rather than going to a lab to get it done, and they can’t do that anymore. And that’s hard for them, especially the older people. They’re comfortable there [at BFP]; they know the
people there, the labs are not, and there aren’t any labs in Brookings. They have
to go back, way into A_____. I mean that’s a long way for some people in their
minds.

This highlights the struggle the rural family practice faces in trying to preserve the
personal relationships with their patients while staying efficient and successful as a
business. It is the achievement of a successful balance between these two ideals that
signifies healthcare at a high quality level.

A recent change in the way the physicians practice medicine at BFP illustrates
this balance between personal relationships and financial viability. A new field in
medicine is hospitalers and they have been introduced to the hospital in A______.
Hospitalers work only in the hospital and take charge of patients from their family
doctors upon their admittance. They treat and care for the patients when there are in the
hospital and then upon discharge, the hospitalists report the status of the patient and what
happened at the hospital to the local family doctor that is then in charge of the follow-up
care of the patient. In general the doctors interviewed seem to be in favor of this situation
because it saved them the time it took to make hospital visits. However, they do admit
that the patients have not yet gotten used to the idea that their personal family doctor does
not care for them in the hospital.

Two of the doctors interviewed discussed their feelings about the new hospitalists
taking over their patients. Dr. Mustard comments:

We’ve recently stopped going to the hospital. We took care of the hospital
patients and we covered the emergency room until just this year. That’s a big
change in the practice. We don’t go to the hospital to take care of our patients.
We visit in the hospital but we don’t admit anymore… I kind of miss not taking
care of them in the hospital to one degree, but it cuts out a lot of the headaches
and the hassles, most of the middle of the night phone calls and the middle of the
night admissions were in the hospital. That was more of the stress of the practice,
the hospital patients, which we don’t have any more. Of course, with three of us
you wouldn’t see your own patients anyway. If one of my patients was admitted and the other doctors were covering, they wouldn’t see me most of the time anyway so it wasn’t something where we took care of all our own patients anyway.

Dr. Plum agrees that the hospitalists reduce the time spent outside the practice:

We’d admit people to the hospital say for pneumonia, take care of them, see them every day, send them home. If it was complicated, we’d call in a pulmonary doctor. Or if someone had chest pain, we’d admit them with chest pain, call in a cardiologist, but we’d still see them. Of course we did that for twenty-four years, almost twenty-five, and then the hospitalists came so we had an option of not doing it. Many times we were calling in specialists to see people so we sometimes felt you’d go in and there’d be three or four specialists seeing the patient and you’d see the patient. You’d feel like you didn’t do anything but again the patients appreciated it you just being there and sometimes it was important to help coordinate everything. We weren’t absolutely necessary. It would take a lot of time at the end of the day so we decided to stop doing it. [But the patients] don’t like it. You don’t hear too many complaints anymore, they’ve gotten used to it. But they don’t like it, a lot of times they still come in and say, “I was in the hospital, where were you?” Fortunately I think the hospitalists are doing a good job of calling when someone is discharged, letting us know what’s going on, getting the discharge summary to us. I think it’s worked out all right. We are certainly busy enough that we don’t need extra work.

Thus, BFP has taken a large step toward reducing their workload through the use of hospitalists, but the patients see this as a loss of attention from the family doctor. This is the balance that must be maintained in a healthcare practice in order to provide quality, personal service while limiting the excess services that can be financially costly to the practice.

From these perspectives of the patients, nurses, and doctors, the level of care provided by BFP can be assessed. This evaluation must be made based on all aspects of the healthcare experience that would influence the overall outcome. These factors include the doctor-patient relationship, the trust given to the healthcare provider, continuity of care, preventative care, length of consultation as well as length of the wait,
and the overall efficiency of the practice. All of these will be discussed in depth at the end of this paper to give an overall evaluation of BFP’s quality of care.

**Insurance**

Overwhelmingly, respondents and healthcare providers identified health insurance as a major detractor to their overall health. This was cited as a significant change over their life times and often forces certain types of healthcare to be given. It controls the treatment, the medication, even what doctor you see. It also creates large amounts of paperwork and bureaucratic hassles that must be dealt with thus taking the healthcare providers away from their job of caring for the patients.

In many cases, the health insurance that the patient carries dictates which doctor you can see. This can cause patients to have to travel longer distances for healthcare, and a change in coverage can result in the loss of the family doctor that a patient had had for many years. R14 comments on this saying, “Unfortunately insurance companies often dictate what doctor we can see as well as what the doctor can do or prescribe.” This most certainly influences the quality of care that is given to the patient as well as frustrates the providers. Family practices are often forced to drop certain insurance companies due to lack of reimbursement, which results in a block of people having to find a new family physician. Dr. Butler explains BFP’s process for deciding which insurance companies to accept:

It varies; every year you have to change insurance companies because insurance companies don’t want to pay you and they...like [name of insurance company] didn’t increase what they paid us for like eight years, and when we were finally on the verge of getting rid of them they decided to push it up a little bit. You know, they play a game constantly not to pay you. So every year, ideally, to run a practice, you want to get rid of your lowest paying insurer or at least one, and then
you pick up others; you got to keep a variety of insurers so that one doesn’t get to
be an overwhelming part of your practice in case you need to get rid of that
insurer. So there is a fluctuation in and out every year. Most of the fluctuation
between primary care doctors I think is because their insurance changes. Most of
the patients don’t want to leave; its just that we don’t take their insurance
anymore.

A change in health coverage, as recounted by R6, can cause the loss of your family
doctor. She says, “When I became 60 years of age, Dr. F____ sent me a letter telling me
to seek another doctor since he did not deal with Medicare.” This avoidance of Medicare
is common, especially in rural practices, due to the small amount of reimbursement that it
gives the doctors. Thus, it can be a struggle for those patients carrying that insurance to
find quality physicians, and similarly it is difficult for doctors to stay in business while
accepting Medicare patients. Dr. Plum explains the Medicare and general insurance
procedure for healthcare providers at length:

Dr. Plum: “Yes, we still have a lot of Medicare patients. There are a number that
have secondary insurance. The big problem with Medicare patients is the cost of
drugs—Medicare would pay a good part for their physician, hospital stay but
when it comes to drugs up until this past year they wouldn’t pay. The new drug
program will help—they will pay for, I forget how many thousand dollars.
When we first started practice we pretty much accepted that people had insurance.
We’d bill the patient and the patient would send the form to the insurance to get
reimbursed. But now, we have to…pretty much now we work for the insurance
companies.”
Interviewer: You send it directly there?
Dr.: Yes, it’s all directly billed to the insurance company. We basically have
contracts with the insurance companies.
Interviewer: Do they always cover all…?
Dr.: It’s basically like a contract, now. For anything: for Medicare, Medicaid,
Blue Cross, HMOs. We sign a contract for how much we’ll get paid for an office
visit. Our fees now are set by the insurance companies, where before we could
set our fees wherever we wanted. Of course we had to be reasonable or people
wouldn’t come to us. …We had to set our fees in accordance with the market.
Now our fees are set for us according to what the insurance companies think is
right. Fortunately, we have some, I don’t know if you call it some bargaining
leeway. If the insurance company doesn’t up their…give us a raise after a while,
we can drop them. Of course that’s kind of hard, another thing patients have to
face if all of a sudden their family doctor’s not on their insurance company.
Interviewer: When you billed the patient, if the insurance company didn’t cover did the patient?
Dr.: Right, the patient was responsible for it.
Interviewer: Now it’s your responsibility?
Dr.: Yes, that’s a whole tricky thing now too. We have to bill the insurance company and if the diagnosis code or whatever we put in there doesn’t fit the bill, we don’t get paid. And if we don’t fix it within a certain period of time, I think it’s three months or something like that, they say, “Too bad, it’s past your time.”

This description provides insight into the struggle that healthcare providers face in trying to maintain their financial viability while also keeping their patients. Unfortunately, quality of care is decreased by the continual changing of primary care physicians and difficulty in finding nearby healthcare.

This control of the providers by the health insurance companies is seen not only in which patients they can treat but also in how they can treat them. Often an insurance company will make it policy to pay for certain treatment techniques and medications and will not cover other expenses. Dr. Mustard comments on how this has negatively affected his ability to treat his patients:

The HMOs, it seems like they are dictating more and more what we can do. I think someone should be on a certain medication, a lot of times I order it and they refuse it fill it and I have to fill out a form to get it okayed or they won’t let me prescribe certain medications at all. The HMOs have sort of taken over what you can do. As far as treatments too, if I think that somebody needs some kind of surgery for veins or different problems, the HMOs will decide whether or not they can have it. Usually they will let you do it but you have to fight with them for weeks to months and lots of phone calls and paperwork. More of a hassle and lots of time. Drive you crazy.

These problems with insurance companies continue to shape the quality of treatment that a patient receives. The changing of family physicians causes a break in the continuity of care, and often certain procedures that the doctor feels are necessary are not covered by insurance. This means that the insurance company is deciding what is best for the patient’s health, and this only decreases the quality of care these patients receive.
The struggles with health insurance remain a significant problem in all types of medicine and negatively affect patients’ health outcomes.

*Technology and Advances*

This component of being a family physician is often difficult to keep up with especially in rural areas. As a generalist, the physician must have a basic knowledge of all aspects of the body and thus must stay abreast of new research in almost every medical field. This vast amount of information is difficult for any physician to stay informed on, but in a rural setting there also may be more of a delay in learning new techniques and practices. Implicit in this area are the technological advances that are taking place rapidly but still not reaching rural practices. For these reasons, urban practices are often seen as more qualified physicians by the patients themselves. This needs to be changed through the import of new technology to these practices and the creation of computer connections among rural practices for the sharing of knowledge.

Several of the respondents cited this limited knowledge and technology as one of the disadvantages of rural healthcare. R2 commented, “A disadvantage might be the limitations of having just one doctor and only his/her knowledge with no specialists available.” R7 added that a rural healthcare facility “may not have access to up-to-date technology.” These concerns may reduce the quality of care provided in the patient’s opinion. However, many steps are taken by the doctors and nurses to keep their medical knowledge up-to-date through continuing education activities. Dr. Plum, while admitting the difficulty in staying informed on all the topics in general practice, also discusses the steps he takes to be educated on new advances.
There’s a lot of resources out there. Being in family practice, it’s impossible to keep up with everything, so that’s another thing about family practice; you have to know your limitations. You do a lot but you also have to know when to call for help. It’s kind of the same thing with new technology. You’re required to [do continuing education], actually. State of ______ requires continuing medical education for your license and the Board of Family Practice requires even more continuing education. Actually, I enjoy doing continuing education, but the tricky part these days is that medical information gets into the media before you even have a chance to hear anything about it. So we walk into the office and someone says—there are examples recently of all these arthritis drugs coming under fire—we will walk into the office and if you hadn’t listened to the news that morning, someone will come in and say, “Should I stop taking my Naproxen?” And I go, “Why?” “I heard in the news, it’s bad for you.” You don’t have a chance...and even when you do have a chance all you can find is in the newspaper, which isn’t the complete study; it’s just somebody’s interpretation of the information. So if you can get the whole study and look deeply at it then you can make a more informed decision about your patient, which you’re able to do with some of it, but some of it there’s just snippets of information. And then for the whole story to come out it takes a few weeks and by then people have sort of decided what they are going to do or not do.

This clearly illustrates the struggle facing family doctors in staying informed about new medical advances to best treat their patients.

In order to receive the advanced care a patient seeks, they may have to travel long distances to the metropolises. R8 says that for specialty care she is referred to a larger urban facility but that the disadvantage is that her local family doctor would not be involved in her care at that hospital. R23 gives her reason for traveling down the road for healthcare, “You often have to (or want to) go to larger teaching hospitals in big cities near your home rather than count on local hospitals. One reason is you feel that surgeons and/or specialists have had many more opportunities to experience your condition.”

Providing other reasons for seeking specialized care is R6 who states, “If one needs extended tests, expert advice, use of the latest technology, newest equipment, proven medicines, and latest surgical procedures, one might need to seek care beyond the rural
setting.” She illustrates this comment with an anecdote of her experience with both types of care.

In November 2004, I went to my primary care doctor for a medical check-up, and blood was discovered in the stool. The test was done the second time, still blood discovered. A colonoscopy was called for by my doctor and he referred me to a [local] doctor who has become further trained in gastroenterology… I was put to sleep but felt great pain. On waking, I was asked to go to [A_____] Hospital for X-rays. I did so, and two days later I was asked to go to the [urban teaching hospital] to see a surgeon… He told me that a stricture had been found in my colon, and his was assumed cancer until told otherwise but before surgery, he wished [a doctor at the urban hospital] to do another colonoscopy. He did, no stricture was found, only one lesion. This was biopsied – no cancer. Then a CAT scan called for to see if pressure outside the colon had caused the doctors here [locally] to think there was a stricture. Nothing was found… It paid to seek a second opinion.”

This experience of having a local specialist wrongly diagnose R6 clearly illustrates the need for more highly trained specialists in rural areas. It was only because she was financially able to seek a second opinion when her primary physician recommended such action that she received the proper treatment. Another interesting aspect of this specialized care in the large cities is the psychological advantage that these hospitals have over the local family practices. While as seen above, there is some validity to seeking the care of the urban center, these perceptions can also be psychological and therefore are not always true. R13 sums up these possible misconceptions:

On occasion, I have had to consult with a specialist in [the neighboring county], which I did not like. However, there was always a perception that if I was seeing a specialist “down the road,” he/she was truly an expert and that made me feel confident that I was getting the best care. I don’t know why but I do remember feeling that way. It’s merely a perception and one that I experience in my own business. If you get someone out of the area, they are an “expert”!

These psychological associations of higher quality of care being found in large teaching hospitals must begin to be broken down by the arrival of highly qualified specialists in rural areas. Once this takes place, the problem of doctor shortages will be alleviated and
healthcare will be better and more accessible to the local residents. Unfortunately, this
timeless solution does not take into account the cost of increased access to specialists,
which would be a problem in trying to provide more advanced care to the area.

Many respondents emphasized the lack of advanced technology in their local family practices. They felt that this could be a disadvantage for rural care because the best treatment options were not available to them. R25 states that “sometimes the most modern methods of treatment are not available,” and R23 adds that “large teaching hospitals are aware and practice the latest in each medical field.” However, several residents disagreed with this view and suggested that the latest technology was not the most important aspect of their rural healthcare. R26 comments, “I suppose they have more technology available in the city, but I am willing to trade all of that for rural healthcare.” R24 maintains her trust in her local doctor’s abilities saying, “There are resources for the doctors in the area to keep abreast with medical advances – and I believe they use them, so I don’t feel that our doctors are less able than urban doctors.”

An improvement seen in many rural health facilities in the last several decades is the development of computerized record keeping. R3 sees this as a positive development saying, “The response to tests are... faster as fax is used to talk from doctor to doctor and computers used for records.” These electronic records make it easy for doctors to communicate about their patients and to keep their health history within easy access. These technological connections help to raise the efficiency and effectiveness of the rural health practices.

The struggle to stay abreast of medical advances in research and technology is important in determining the level of care provided by a rural practice. While some see
their family doctors as well informed, many others seek care in the larger urban teaching hospitals due to the perception that there is higher quality of care there. This may be true, but all physicians, including rural physicians, are continuing to learn and stay informed about the new techniques being developed. This remains an important issue for rural health, and BFP seems to be addressing it with success and providing their patients with modern healthcare.
Conclusion

In looking at the responses gathered from patients and healthcare professionals, it can safely be said that the overall opinion of the healthcare in Brookings is positive. This grand conclusion made, it must then be dissected into its individual parts to truly understand the effectiveness of BFP in addressing the health needs of the community. Once these parts are understood, the example of Brookings can begin to play a role in advancing the discussion of healthcare practices today.

The Brookings area has had very low healthcare coverage in the past and this significantly affected health outcomes during that time. A single doctor for the residents of this community was not sufficient for the health needs of everyone. The building of the medical center helped to attract five new doctors in less than twenty years and thereby was able to sufficiently provide for the healthcare of the area. The way in which Brookings addressed their doctor shortage provides an example for other communities to follow. The town aggressively sought new doctors through recruitment at the local universities and also donated the land and money to create a modern facility for them. Without these actions, the town would likely have been faced with an increasing medical crisis as its population grew. Today, Brookings is fortunate to have a multi-doctor facility and medical center and it is one of only a few in the surrounding area that can boast this.

However, there are still significant shortages of doctors, especially specialists, available to serve this community. This results in long waits for scheduled appointments and difficulty in getting seen for routine check-ups. Certainly, this waiting can be seen as stemming from the large amount of personal time allowed with the doctor for each
patient as will be discussed below. The doctors at BFP do not feel overwhelmed and maintain that if a patient experiences an emergency, they will be seen almost immediately. These same problems are apparent in the availability of specialists nearby. It is often difficult to make an appointment with one of these doctors and the limited specialty network may lower the overall quality of treatment available.

Thus, despite the town’s proactive efforts, Brookings has not yet fulfilled the healthcare demands of the community. More doctors, and especially more specialists, are needed to allow patients access to the highest possible care without long waits. This problem is likely the result of a lack of funding for more doctors and so must be addressed either by the town government itself or by the resident’s demand for more appropriations toward their healthcare services. Also, as suggested by the studies reviewed previously, the use of Physician’s Assistants and Nurse Practitioners will help to alleviate the fiscal burden of hiring more physicians. Brookings Family Practice has not yet taken this step and may need to consider it in the future in order to meet the increasing demands of their patients.

The quality of care at BFP was highly praised by the residents responding to the questionnaires. For many, it far outweighed any disadvantages in other aspects of healthcare found in the rural setting. These positive opinions, however, are a dramatic change from the quality of care in the respondents’ childhood. In the past, many local doctors would not seek other professional opinions due to a sense of possessiveness of their patients. Also, there were increased numbers of misdiagnoses due to a lack of specialized knowledge and technology. Both the doctor’s and the patient’s
misinformation regarding healthcare contributed to a lower quality of care during that time period.

This contrasts sharply with the current opinions of the quality of care being received and given at BFP. The most commonly cited advantage of rural healthcare was the ability to achieve a continuity of care that then allowed for preventive medicine to be practiced. Patients felt positively about their level of healthcare at BFP due to their doctor knowing their health history and thus being more able to effectively treat them. The doctors also appreciated the opportunity that they had at BFP to prevent illnesses instead of just treat their effects. They compared this to previous experiences in urban settings where patients only came in for emergency healthcare and left the doctors helpless to improve the quality of care through preemptive action.

Another change from the past is the increased sense of a personal and trusting relationship with the doctor. Patients cited their increased willingness to seek healthcare when they had confidence in the doctor and were familiar with him or her. The small town community of Brookings provides the opportunity for doctors to be well known members of the community and thus strengthen interpersonal relations between their patients and them. Still, this advantage has a downside in the loss of privacy for the patient and can create a lower quality of care for a patient if this becomes an issue. BFP should try and address this concern by reassuring patients of the confidentiality of health concerns when they are presented to the doctor as well as to all the staff at the medical center. When patients feel secure in bringing up their health problems, their healthcare will be more effective.
There were also many other aspects of the healthcare provided by BFP that were cited as advantages to that setting. Patients saw longer consultation times, which allowed them to address all of their concerns at once. They also appreciated the ability to have a wide range of services available at BFP without it being frequently necessary to see a specialist. This situation makes the patients feel more comfortable because their personal doctor is the one treating them for the majority of their health problems. The one negative side that was mentioned was that this situation is slowly beginning to change as doctors feel that they are beginning to practice more fragmented care with the increased emphasis on specialists. BFP must be proactive in addressing this growing issue so as to preserve the continuity of care and personal relationship they have with their patients. In the long run, it is these aspects of healthcare that will improve the quality of care for the individuals.

Finally, an important aspect of quality of care is the efficiency of the medical practice. BFP's wide range of treatments available at their medical center helps to alleviate pressures on specialists and thus fulfills their role as a medical gatekeeper. However, this emphasis on efficiency must not become out of balance with the need for individualized treatment resulting in the loss of the many advantages discussed above. BFP has attempted to maintain this balance by the recent implementation of hospitalists who help them become more efficient as a business without losing their relationships with their patients.

Doctors and patients alike expressed their increasing concern over insurance companies' growing power. This was, by far, the most negative aspect of the healthcare experience discussed, but is not only a problem of BFP. The issues brought up here can
be applied to almost any medical situation and will need to be addressed in the near future. These issues included limited approval for certain medications, difficulties of doctors to receive payment for treatments given, and the forced rotation of insurance companies accepted by BFP. The latter problem has significant effects on continuity of care and certainly disrupts the personal relationships developed by the patient with the doctor. The resolution of these problems does not lie in the hands of the medical practice, but must instead be addressed through government policy brought about by patient demand for change. Thus, the issues being struggled with at BFP are similar to those at medical facilities in all types of settings.

Many respondents commented on the lack of advance technological treatments in the area. This often causes the patients to be forced to travel long distances to receive the most up-to-date medical services. While this is usually true, it must also be mentioned that this advantage of going outside the area can be psychologically constructed. A______, nearby Brookings, is increasingly attracting more advanced and skilled physicians yet many patients continue to insist on leaving the area for serious medical problems. This perception must be changed through the education of patients in the services available in the area. The continuing medical development of the region will help to slowly dissipate this notion but will ultimately depend on the ability to increase the patient’s confidence in these services. While the process of attracting the best specialists to A______ is only just beginning, BFP must play a role in recommending the area physicians that they find highly qualified to their patients. This will increase the confidence of the patients in the services available to them in their area and will increase their satisfaction with their healthcare.
As has been shown in the above discussion, BFP is largely successful in providing quality care to their patients. They have forged long-term relationships with their community and the families that seek their care. They effectively meet the medical needs of Brookings and do so in a way that emphasizes the advantages of a small town. BFP shows exemplary success in balancing these advantages with the business reality of modern times.

The question then arises of why BFP is so successful in their particular community. The answer to this can only be surmised, but I would suggest that is the ability of BFP to closely reflect the people of the town itself. Brookings is historically a farming community and this lifestyle is ingrained in the residents way of thinking despite its present day change towards a more suburban setting. In attempting to live off the land, a farmer must commit himself to taking the time to ensure the quality of his work from all possible aspects. If he fails to do this, it is likely that an overlooked detail will result in substantial losses in crops during harvest time. He must also rely heavily on his neighbors and friends for help during the harvest as well as during droughts. These two qualities can be seen in the basic philosophy that BFP uses to practice medicine. The doctors and nurses emphasize their commitment to taking the time to really understand a patient’s concern and thus can suggest the most effective way to treat this problem. This attention to detail is what many of the respondents value in their healthcare and see as the reason they receive a high level of care. Secondly, just as the farmers must create strong bonds with other residents, the doctors at BFP understand the importance of creating a trusting relationship with their patient. It is only when the patient is comfortable with a doctor that he or she will really discuss their most intimate health concerns. This
increases the possibility that the doctor will discover the cause of the health problem and be able to effectively treat it. While in no way am I suggesting that a majority of the residents of Brookings are farmers or even think about the farming lifestyle, I do however postulate that this way of thinking is ingrained in a community long driven by these principles. BFP simply reflects this underlying code of behavior in the way that they choose to practice medicine. Because the style of a medical practice is a choice, our question of why BFP appears to be so successful in meeting their community’s health needs become apparent. This final conclusion is the most valuable contribution that this study can make to the general discussion on healthcare. Quite simply, a healthcare practice must reflect the community in which it is located in order to provide the patients with the kind of quality care they seek. A shadow of this argument can be found in the discussion around how to cross ethnic boundaries when treating patients, but it must be focused on the entire community’s ethnicity, or lifestyle, in order to be effective. The healthcare practice must grow out of these people otherwise it will continue to miss the mark on meeting its patients’ daily demands and expectations. BFP provides an exemplary example of practicing medicine in the same way that its patients lead their lives and other healthcare centers must learn from this success story in order for healthcare in this country to improve.
Bibliography


Bowman, Robert C., “Continuing family medicine’s unique contribution to rural health care,” American Family Physician, 1996; 471-76.


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* In order to maintain the anonymity of this case study, the primary source documents that were referenced that had the name of the town were replaced with [Brookings] and only the authors initials were used.

## Appendix A – Respondent Data

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Appendix B – Questionnaire for Respondents

Name: ___________________________  Address: ___________________________

Occupation: ______________________  ___________________________

Date of Birth: ________________

1. How long have you lived in the Middletown area?

2. Do you see a doctor in the area or do you travel some distance to see your family doctor? Are you a patient at the Middletown Valley Family Practice?

3. What kind of healthcare did you and your family have as a child? What stories do you remember involving your doctor? What changes in healthcare have you seen over your lifetime?

4. What advantages do you see in rural healthcare?

5. What disadvantages do you see in rural healthcare?

6. Are you frequently forced to travel out of the area to see specialists?

7. Is it difficult to get an appointment with your physician? With a specialists?

8. In your opinion, does a rural or urban setting provide better healthcare? Why?

9. How do you define health and illness? (At what point do you decide to see the doctor, discomfort, loss of abilities, length of time etc)
Appendix C – Interview Questions for Doctors and Nurses

1. Name and Occupation

2. How long have you worked at Brookings Family Practice?

3. Where did you work before? What kind of setting?

4. What types of illnesses and injuries do you see?

5. What procedures can you carry out at BFP? What types of illnesses/injuries do you send to a specialist?

6. Do you have an excess demand of patients? How much time do you spend with patients?

7. What types of insurance do you see? What problems with insurance do you have?

8. What advantages do you see in a rural healthcare setting?

9. Disadvantages?

   Doctors only: Do you make house calls?

10. What changes have you seen in healthcare during your time in Brookings?

11. In your opinion, does a rural or urban setting provide better healthcare?

12. How would you define health and illness? Do you think that this is how your patients would define it?
Appendix D - Interview with Dr. Plum

Interviewer: You are a family doctor, general physician?  
Dr. Plum: Family doctor but a lot of people call it general practice.  
I: How long have you been at Brookings Family Practice?  
P: Started in 1978—whatever that comes out to be. Twenty-five years?  
I: Where did you work before working there?  
P: I came directly from my residency program...in family practice. It’s a three-year residency in family practice.  
I: Did you do it in _______ [nearby large city]?  
P: Yes, University of ______.  
I: So it was more of an urban setting?  
P: Yes, definitely. Although it wasn’t all urban, we did use other hospitals in the city other than University Hospital. In our third year of residency we did go out to practice in the rural areas, so I did work in [A_______] actually, in a family practice office for two months.  
I: What differences did you see between an urban practice and a rural practice?  
P: It was more...it’s hard to say. There were a couple of different changes: one was urban to rural, and the other was from being in a clinic to being in your own practice so it was combination of things. It also wasn’t quite as dramatic a shift as you might think because the family practice program is set up to be a family practice in an urban setting. So even though we were in downtown [large city] we had patients in families and during the three years of the program we continued to see those patients.  
I: So more continuous care than might be normal in an urban setting?  
P: We did work a lot in clinics, like in pediatric clinics or the VA. We did work a lot in clinics where you would see someone once and never see them again. Family practice program is set up so you learn the family practice style. So we did, even though we were in downtown [large city], see some families over a couple of years. Still quite different from coming here. The difference is basically...  
I: What kind of advantages did you see, do you see working in a rural setting?  
P: The advantages are you definitely get to know your patients a lot better. We’re not so rural here that there were any disadvantages, I’d say. If we were more rural, say when I started practice, [nearby small town] was considered rural and you pretty much did everything. The disadvantage there is your backup is hundreds of miles away, here your backup is five or ten miles away in A____. It wasn’t quite the typical rural family practice you might envision.  
I: What changes have you seen in [Brookings] since you started and now in your practice in the way you practice?  
P: The changes...it’s hard to say whether the changes are from [Brookings] changing, becoming less rural, or from our practice aging which is a normal phenomenon, too. Because in our practice pretty much all the doctors started young and all have gotten older (we have one new one). And a lot of times during that normal time, the practice ages too so we do a lot less pediatrics now than we used to—although Dr. [Butler], our youngest doctor, seems to attract more young families. So it’s a change. I think a lot of it is just our practice is older but also part of that is people are gearing more
to having their children see pediatricians. We're probably seeing a little less total care than we used to, there's more fragmented care probably. People are seeing their GI doctor and their cardiologist. We may not see them as much as we would have twenty years ago when you pretty much did everything. These doctors were still around but there weren't as many of them, the family doctor probably had more say in their care. Sometimes now you almost feel like a third wheel, sometimes we feel almost like we're superfluous. But it's a good thing in that A______ County has grown and there are more specialists. I shouldn't down play that because even though you may not see someone for years, they still view you as their family doctor and they depend on you even though you hardly ever see them. Suddenly someone shows up and says, "He's my doctor", and you look at their chart and say, "But you haven't been here for three years." "But you're still my doctor." You just have to stop and realize that.

I: Dr. _____ used to do obstetrics but none of you do that now, right?

P: Right, he was the only one who did obstetrics. When I was doing my residency I didn't plan on doing obstetrics, so I did very little of it. He enjoyed it and did more of it so he wanted to continue doing it. But doing it by himself was crazy. He enjoyed it but it was very hard on him.

I: So would you say your patients are older now—except for Dr. [Butler's]? 

P: Yes, for sure. We still see a smattering of newborn babies, but not like we used to. Most of the newborns we see now are even second generation—people we took care of kids are having kids. Its kind of fun.

I: Do you still make any house calls?

P: Yes, occasionally. Usually it's an older person who is really sick or dying.

I: Would you feel that you have an excess demand of patients or do you feel you have enough time with your patients?

P: We schedule it to still try to keep enough time. I feel I get enough time although I usually take more time and run behind. Which is good and bad. People appreciate the time they're given but they don't appreciate waiting. It's a double-edged sword.

I: Just in general, what kinds of things do you treat in your family practice versus what you send out?

P: There's the obvious send-out, major things, like I said, _____, obstetrics, we do some orthopedics but not a lot of major fractures and things like that, some minor surgery but not anything other than removing a mole or cyst, or something. We do lacerations. We do a little bit of everything: we do some cardiology, we do gastroenterology, we do everything else. One big change for us in the past year is that we don't see patients in the hospital anymore. I don't know if Dr. [Butler] mentioned that.

I: Oh yeah...hospitaliers, hospitalists?

P: Yes, hospitalists have come to A______.

I: Because you used to go to hospitals and do surgery?

P: We didn't do surgery at the hospital, we'd do inpatient work...We'd admit people to the hospital say for pneumonia, take care of them, see them every day, send them home. If it was complicated, we'd call in a pulmonary doctor. Or if someone had chest pain, we'd admit them with chest pain, call in a cardiologist, but we'd still see them. Of course we did that for twenty-four years, almost twenty-five, and a couple of things there: the hospitalists came so we had an option of not doing it. Many times we were calling in specialists to see people so we sometimes felt you'd go in and there'd be three or four
specialists seeing the patient and you’d see the patient. You’d feel like you didn’t do anything but again the patients appreciated it you just being there and sometimes it was important to help coordinate everything. We weren’t absolutely necessary. It would take a lot of time at the end of the day so we decided to stop doing it.

I: How do the patients feel about it?

P: They don’t like it. You don’t hear too many complaints anymore, they’ve gotten used to it. But they don’t like it, a lot of times they still come in and say, “I was in the hospital, where were you?” Fortunately I think the hospitalists are doing a good job of calling when someone is discharged, letting us know what’s going on, getting the discharge summary to us. I think it’s worked out all right. We are certainly busy enough that we don’t need extra work. You do lose some medical community relationships, you don’t see the other doctors very much in the A______ community. If I’d never done it, I’d sort of feel like I wasn’t part of the medical community. Having done it for a while, I still feel like I’m part of the medical community even though I never see them anymore.

I: Last question: how would you define health versus illness? And do you think it agrees with how your patients define it?

P: Health is maintaining well-being and illness is anything that is not well-being. That’s the simple approach. As for the patients we have a variety of outlooks on that. Sometimes it depends on their insurance, unfortunately. Some people come very regularly for check ups, they come once a year for annual physicals whether they need it or not. Some people are very good about that. There’s a lot in the media about health maintenance and they are educated that way and like I said sometimes their insurance allows for that. Some people are very good. Other people, if they feel OK, they don’t need to go to the doctor until something happens. In the old school that’s the way it was. Then a lot of it is media driven.

I: They’re more informed?

P: Yes. And then some of it is just individual personality.

I: I think that’s everything.

P: Let me see if there’s anything else I was thinking ahead of time.

I: Do you have trouble staying up to date with new research, with new technology?

P: That’s a good question.

I: As a GP it’s difficult?

P: There’s a lot of resources out there. Being in family practice it’s impossible to keep up with everything, so that’s another thing about family practice, you have to know your limitations. You do a lot but you also have to know when to call for help. It’s kind of the same thing with new technology.

I: Do you do continuing education?

P: Yes, you’re required to, actually. State of______ requires continuing medical education for your license and the Board of Family Practice requires even more continuing education. Actually I enjoy doing continuing education but the tricky part these days is that medical information gets into the media before you even have a chance to hear anything about it. So we walk into the office and someone says—there are examples recently of all these arthritis drugs coming under fire—we will walk into the office and if you hadn’t listened to the news that morning, someone will come in and say, “Should I stop taking my naproxen?” And I go, “Why?” “I heard in the news, it’s bad for you.” You don’t have a chance…and even when you do have a chance all you can
find is in the newspaper, which isn't the complete study, it's just somebody's interpretation of the information. So if you can get the whole study and look deeply at it then you can make a more informed decision about your patient which you're able to do with some of it but some of it there's just snippets of information. And then for the whole story to come out it takes a few weeks and by then people have sort of decided what they are going to do or not do. Of course then all the advertising...it's annoying. It's not so much that it's annoying that people come in and ask for a drug—they do but fortunately in that situation you already know about the drug and whether you want to use it or not. What's annoying is you see all these advertisements for these drugs and you know it may not necessarily be the best drug for the purpose and its extremely overpriced. So you see these advertisements for this drug, and it's true it does work for what they advertise it for but it is ridiculously overpriced.

I: But patients are asking for it?
P: Again it doesn't bother me that they ask for it...it's not like I don't know what they are asking for. The drugs you usually know about. You should talk to Dr. Mustard—he just read this book about how the drug companies are sort of....it's interesting.

I: Yeah, I'm going to ask him when I talk with him.
P: I think it's becoming more so because they are funding research. If medical schools would do a lot of funding and the government, it would be less biased but I think now they are funding a lot of medical school research. The review committees...have a lot of experts and the experts are also paid by the drug companies so you don't know who to believe. Some of those drugs that are out there are not fully tested, or not fully tested on a large number of people. The indication may only be 5% better than the other drug that they replaced. But it's just because somebody funded it and promoted it so highly as better but it's only 5% better and it may be not as safe. Another thing that's changed over the years are insurance companies.

I: Do you ever have Medicare patients? Because I know there have been so many cuts...?
P: Yes, we still have a lot of Medicare patients, there are a number that have secondary insurance. The big problem with Medicare patients is the cost of drugs—Medicare would pay a good part for their physician, hospital stay but when it comes to drugs up until this past year they wouldn't pay. The new drug program will help—they will pay for I forget how many thousand dollars. When we first started practice we pretty much accepted that people had insurance. We'd bill the patient and the patient would send the form to the insurance to get reimbursed. But now, we have to...pretty much now we work for the insurance companies.

I: You send it directly there?
P: Yes, it's all directly billed to the insurance company. We basically have contracts with the insurance companies.

I: Do they always cover all...they don't, they only cover...?
P: It's basically like a contract, now. For anything: for Medicare, Medicaid, Blue Cross, HMOs. We sign a contract how much we'll get paid for an office visit. Our fees now are set by the insurance companies, where before we could set our fees wherever we wanted, of course we had to be reasonable or people wouldn't come to us. Before the market...we had to set our fees in accordance with the market. Now our fees are set for us according to what the insurance companies think is right. Fortunately we have some,
don’t know if you call it some bargaining leeway. If the insurance company doesn’t up
their... give us a raise after a while, we can drop them. Of course that’s kind of hard,
another thing patients have to face if all of a sudden their family doctor’s not on their
insurance company.
I: When you billed the patient, if the insurance company didn’t cover did the
patient?
P: Right, the patient was responsible for it.
I: Now it’s your responsibility?
P: Yes, that’s a whole tricky thing now too. We have to bill the insurance company
and if the diagnosis code, or whatever we put in there, doesn’t fit the bill, we don’t get
paid. And if we don’t fix it within a certain period of time, I think it’s three months or
something like that, they say, “Too bad, it’s past your time.”
I: What a way to do health care.
P: There’s all kind of games you have to play. We have to have a specialist who
goes to classes to learn out how to bill the insurance companies. It changes every couple
of years too...
I: I told my mom I wanted to go back to when you got paid with like a chicken.
P: Like Dr. ______ (old physician) here in [Brookings]. Have you heard any stories
about Dr. ______?
I: No, but I’m going to do some research.
P: Actually I wonder if we still....we have a lot of his old equipment, I don’t know if
we have any old books or anything. I’ll have to look, we have a memorial section for
him. Yeah, if you talk to some of the older people in town, they’ll tell you things. Like
they’d bring a chicken, or they’ll say, “How much do I owe you?” and he’d say, “What
do you have in your pocket?” They’d pull out a dollar and he’d say, “That’s fine.” I even
heard stories, they’d say, “I don’t have any money today.” So Dr. ______ pulled out his
wallet, took out a couple of dollars, gave it to the patient and said, “Here, give that to
me.” They gave it to him and he said, “That’s it.” Things like that. I heard stories from
people when they were kids and came for their sports physicals and Dr. ______ said, “I
saw you run across the street, you’re all right.” And he signed the form. Someone told
me once, Dr. _____ said, “Pee in that cup.” So the kid peed in the cup. I don’t remember
if Dr. _____ smelled it or tasted it, but he said “You’re all right.” And he signed his form.
Probably he smelled it, not tasted it...but that’s what they did to test for diabetes, taste it
for stickiness, for sugar.
I: I’d go back and be a doctor in those days.
P: He did a lot of housecalls, gave shots at home, delivered babies...a lot of people
around here who were delivered at home by Dr. ______.
Appendix E – Interview with Dr. Mustard

Interviewer: Are you a family medicine doctor?
Dr. Mustard: Yes.
I: How long have you been here?
I: Long time.
M: 27 years.
I: Did you come right out of residency here?
M: Yes.
I: Where did you do your residency?
M: University of ________.
I: More of an urban setting.
M: Right.
I: What differences do you see between the more urban setting you were in during residency and [Brookings]?
M: Your topic’s rural medicine right? I don’t think this is really rural medicine
I: Not any more?
M: Even when I came here not so much...I guess more so at that time because there weren’t any specialists in the area, there weren’t any cardiologists, there weren’t any pulmonary specialists, there weren’t any neurologists, so I guess at that time it was pretty much, it was more of a small town thing but now we have all the specialists. It’s certainly different from being in [nearby large city]. But at this you have all the specialists close by and major medical centers close by, so it’s not really rural.
I: What differences do you see...even if this isn’t rural? Do you see differences in the patients you see, did you not see whole families?
M: Yes, in that regard we see kind of more families. With the residency I saw a lot of inner city poor people, clinic kind of patients, sicker kind of people. Here it’s more middle class, we see a lot of families, kids and parents and the extended families, three or four generations of the same family.
I: Do you see that an advantage, then?
M: Yes, I think that’s much better way to practice medicine. It was hard to do any kind of continuing care in the training program...some families would be assigned to you, you would see them for maybe a year or two. But here I’ve seen families, patients for twenty-five, the whole time I’ve been in practice. I’ve seen people since they were five years old and now they are thirty.
I: It helps to know their history?
M: Oh yes, it helps to know the family, that’s a difference.
I: What disadvantages do you see to working here?
M: Not at this time. I think when we first came, there weren’t any cardiologists or specialists so we tried sometimes tried to take care of patients we didn’t feel comfortable taking care of but that’s clear in the last ten, fifteen years we haven’t had any of that, anymore.
I: From when you started till now, do you think your practice has changed, the way that you treat patients...do you send out more now to specialists, obviously...?
M: We’ve recently stopped going to the hospital. We took care of the hospital patients and we covered the emergency room until just this year. That’s a big change in the practice. We don’t go to the hospital to take care of our patients. We visit in the hospital but we don’t admit anymore.
I: Do you mind not seeing them in the hospital?
M: Well, it’s a mixed thing. I kind of miss not taking care of them in the hospital to one degree, but it cuts out a lot of the headaches and the hassles, most of the middle of the night phone calls and the middle of the night admissions were in the hospital. That was more of the stress of the practice, the hospital patients, which we don’t have anymore. Of course, with three of us you wouldn’t see your own patients anyway. If one of my patients was admitted and the other doctors were covering, they wouldn’t see me most of the time anyway so it wasn’t something where we took care of all our own patients anyway.
I: Do you still do any house calls?
M: Yes, actually we do.
I: Probably did a lot more before?
M: Over the years, yes, and periodically we do. I’ve got a fellow I’m going to go see: a paraplegic with sores, that I’ve made house calls the last couple of weeks. So we’ve always made house calls but infrequently, every once in awhile—people who are housebound or can’t come in. It’s usually not very efficient because it’s hard to do testing on in-house patients but we’ve had some patients who are immobile or can’t come in, or won’t come in and we make house calls.
I: The big problem the last couple years has been insurance. What struggles, limitations, has that placed on you as a doctor?
M: The HMOs. It seems like they are dictating more and more what we can do. I think someone should be a certain medication, a lot of times I order it and they refuse it fill it and I have to fill out a form to get it okayed or they won’t let me prescribe certain medications at all. The HMOs have sort of taken over what you can do. As far as treatments too, if I think that somebody needs some kind of surgery for veins or different problems, the HMOs will decide whether or not they can have it. Usually they will let you do it but you have to fight with them for weeks to months and lots of phone calls and paperwork. More of a hassle and time. Drive you crazy.
I: Do you feel the way your patients relate to you has changed or stayed the over same over the years of your practice?
M: I think it’s still pretty good. I enjoy the person-to-person relationship, the family—I think that has stayed the same. I think we still have a close A long time ago we decided not to do a high turnover practice. We only see four patients an hour and set aside an hour for physicals. We never wanted to do a high volume practice. So we do spend time with patients and we get to know people that way.
I: Are patients more questioning now, do they come in more informed?
M: Yes, I think so...with the internet I think they are more informed, more questioning, and I think with the bombardment with the advertisement, with the drug companies advertising, you get more questions.
I: Do you see that as a positive or a negative?
M: I think it’s a negative. Well, I think it’s nice with the internet that they learn, they are more intelligent in that. But I think with the bombardment by the drug companies,
they come in and say, “What about this medicine and this medicine?” and that kind of thing. I think the drug companies are just pushing the more expensive, more recent medicines, they are not always the better ones.
I: Yeah, it’s a business. They are just trying to make money off you.
M: Exactly.
I: How would you define health versus illness—what makes people come in to see you? And do you think that agrees with how your patients define it?
M: I think that we try to do preventative medicine a lot here. I’d much rather prevent colon cancer, heart attack or stroke than treat it. If you can figure what’s going with people that makes them at risk for future illness, I think you can keep them healthy and in that regard treat diabetes, hypertension, colonoscopy and find a polyp before its colon cancer and do mammograms and pick up cancers and keep people healthy. To answer your question: I’d much rather do preventative medicine to prevent strokes, heart attack and cancers that kill people than treat them when I see them. The philosophy is away from... it used to be once you saw people you treat them, but I think the appropriate practice is if you can prevent things it’s much, much better in the long run.
I: That’s why I want to go to medical school. I think that might be pretty much everything....Oh, you said you kind of limit the number of patients you have. Does that mean that there are not enough appointment slots for patients or you’re about right on that?
M: I think we’re about right with that. We try to see people who are sick within the same day or two. I think the practice is limited by the number of insurances we take and the number of people we can see. Most of the time we can see people within a reasonable period of time. I don’t think we are overwhelmed. I think most practices reach some kind of equilibrium. If people can’t get in they’ll go to another practice. I think with five different doctors here we have enough room to see people most of the time when they are sick, except maybe a flu epidemic or that kind of thing.
You mentioned the rural thing—I think I read a book about twenty years ago about a doctor in the Midwest who was two hundred miles away from the hospital, two hundred miles away from specialists. People were dying on him, from deliveries and from things like that. Here we are situated in a nice place. We seen kids come in with skull fractures and bleeding and we can get them to a surgeon and an operation in thirty minutes. We’ve seen kids with meningitis, getting real sick, and we can get them to the hospital, the pediatrician, and on IV antibiotics within a half an hour. When you say rural I think of being the only doctor in town, doing everything. Fortunately we don’t have to do that with family medicine, practically right at the tip of our finger we have some of the best specialists, the best hospitals in the country. So it’s not really in the trenches, boondocks kind of thing. It’s changed. It was that way a little more when we first started, but it’s certainly not that way anymore.
I: Thank you, I think that’s everything I need.
Appendix F – Interview with Nurse Peacock

Interviewer: When did you start working at [Brookings] Family Practice?
Nurse Peacock: 3 years, approx 6 years ago, 5.5 years
I: Did you work with Dr. [White] from the very beginning?
P: From the very beginning. It was when she went back to work after [Dr. [White]’s daughter] was born and [her] birthday is this month, she’ll be six. When she was about 3 months old we started up again.
I: And where did you work before that, in terms of nursing?
P: Not in A______.
I: Right
P: But the last place I worked was the University of _______ Medical Center in _______, which of course is a very different kind of place.
I: Yea so that was a big university hospital?
P: Big university hospital, tertiary care center.
I: It wasn’t small town, it was very different.
P: I also worked for the army, I was an army nurse, I worked in army hospital.
I: Was it in the country or...?
P: [Texas City] General Army hospital. And also...in Germany.
I: So of the patients you see here in [Brookings], how would you say the majority define being healthy or being sick? What makes them come to the doctor?
P: Well because I work for a specialist, most of our patients have chronic illnesses and they have already been diagnosed with them and they know they have them. or....so we can talk about them first. They don’t come because they are feeling bad, they come because they know they have to be followed to make sure their condition isn’t getting worse and hopefully is improving. There are some will come because, she’s an endocrinologist, so some will come because they know their blood sugars have been higher or they’ve been feeling bad and they might call. Then you have people who come to see her for the first time, because they have been feeling bad, and the way they feel bad, the reason they come to see her is ....it could be because someone else has referred them to her, they know they have problem with their blood sugar or with their thyroid gland. But some people come to her, they search her out because no one had helped them in the past and they think they have something. And those are serious symptoms their feeling tired, their hair is falling out, they’ve gained a lot of weight, they’ve lost a lot of weight, they have problems with their period, they’re not having them, too much hair. Its just things that bother them, that make them uncomfortable. That’s what would bring them to see her. If I was working for one of the family practitioners it would be different. People come to see them because they have a fever, they’re throwing up or their ears hurt or their throat hurts, or they’re coughing, they have a bladder infection. Things that make them uncomfortable.
I: But not necessarily prevent them from doing things in their day to day lives?
P: Things that interfere with their lives is what brings people to the doctor. You will ask them why they didn’t come before and it will be because, whatever their symptoms were, it wasn’t enough to interfere with their daily lives. As opposed to being proactive and
just wanting to make sure they’re healthy. I mean, we have people who do that too, have a yearly check up when they’re not ill.
I: Would you say there’s any difference between what you see here, in terms of people coming in, I’m sure you were working in a fairly different situation in ________?
P: Yea because that was a medical center and a lot of the...
I: Acute right?
P: Umm acute or chronic. They could have been the same kind of thing, people who had been sick. Now these were children so parents had been trying to find out what is wrong or maybe they had been sent to us by a doctor out of the state. A lot of people who came there didn’t even live in [large city]. They treated a lot of very serious illnesses. Children with cancer, we saw a lot of that, or tumors, or real kidney problems, kidney failure. The children who come to a medical center like that....they don’t come because they have appendicitis or they broke their arm, unless they just happen to be close enough to that medical center to just come in.
I: And with Dr. [White], she’s a specialist, does she ever have to send people out to other places?
P: Absolutely.
I: What situations does she have to send out?
P: Because her patients have diabetes, a lot of organs are involved in that. So she sends them to the cardiologist because a cardiologist needs to be following them to make sure their heart is ok. She makes sure they get their eyes taken care of by an optomologist or a retinologist depending on what’s going on. She sends them to wound care or infectious disease doctors when they have infections that just really won’t clear up. She is very good about not trying to take care of something that she knows someone else is much more expert at. Especially with people with diabetes because you don’t have … you can waste a lot of time. She also sends people to major medical centers when she….because she’s an internist, she finds lots of things wrong with people. She looks very carefully all the time, she doesn’t just pay attention to what they are talking about when they come in, she doesn’t just look at their complaints, she does look at those, but she looks very deeply and looks for other things going on. So I know we have patients that have been to [nearby university medical centers] because she suspects adrenal tumors or pituitary tumors. That’s nothing that can be handled in A_______.
I: Now most of the other, the things you mentioned in the beginning would be able to be handled in A_______.
P: The other thing that happens here is that when she finds nodules in someone’s thyroid gland, she will check that out first, she’ll do a biopsy, or send them for...
I: She does that?
P: Yea we do them in the office. Or unless they’re so tiny. It depends, but I don’t think its very pleasant for the patients because they’re awake, I mean, she doesn’t numb anything or anything, numbing is as painful as doing the actual thing. They usually get three samples from the tumor. So you know its kind of tilting your head back to expose the thyroid gland and then sticking the needle in.
I: Ah.
P: She does not examine the thyroid gland they way yours was examined yesterday.
I: Oh how’s that?
P: She gets behind the patient. She can get a much better, I mean doing this you don’t get as much as coming from behind. I watch her, she’s really, she’s got...its her specialty, she’s more sensitive. Anyway, if someone does end up with thyroid cancer, because sometimes those nodules are cancer sometimes not. But she also sends them to an ENT or there’s another endocrinologist in town who works full time and he manages the radiation therapy that’s done for that. She doesn’t do that. That’s one way to treat, put radioactive isotopes and..... So yea, she does send people out a lot really.
I: And then, so what kind of test, can you actually perform, at the office?
P: Well she can do biopsies, we can do complicated blood tests. The only blood tests that we can’t do are blood tests that the blood has to have something done to it right away. It has to be handled in a way different than being spun and refrigerated or frozen. Some blood tests it has to be put in an ice bath and kept at a certain temperature, its real temperature sensitive so you can’t just spin it and put in the refrigerator. It has to go in a tube that’s a certain temperature and we don’t have those kinds of controls. We can do pregnancy tests, we can do, they have a microscope, so she looks at urine samples and vaginal samples. Because she does a lot of women’s health too. And we do EKGs and we just don’t do this but the other doctors in this office do, biopsies, or they’ll take things off people’s skin, you know if there’s a mole or something, they’ll do that and that gets sent to the lab. We have the ability to put something in _______ solution and send that to the lab for analysis. Umm what else do we do there? Dr. [White] and I have stopped doing this because we’ve found a way that’s cheaper for the patient. I was telling you about the ACTH stimulation test and the way that test is done is the patients blood is drawn, so you have a sample before anything is done to them and then you inject, something that’s called cortisone, that acts like that of the ACTH and then you drawn their blood again in 30 minutes and again in 60 minutes, I do that. But we have found that it’s cheaper for the patient to go to that IV infusion center across the street from the hospital.
I: In a _______
P: Because medication is more expensive for the patient, they have to buy their own little vial of that stuff, and it’s been really hard for us to get it.
I: So it’s more expensive for you to buy it
P: The patient gets charged, Yea because the hospital pharmacy, since they’re connected to that IV infusion center, they just send the right amount. The pharmacy buys that stuff, they have to buy a whole pack of it, they have to buy 10 vials of it and you only need one for each patient. We don’t do enough of those tests for us to buy that and then charge the patient for one. So the patient has to get it. Plum Cells is really good about selling one to the patient but then they started having a hard time getting it and then the patient was being.....we had to get it from the hospital pharmacy once, and they charged the patient ten times what Plum Cells had charged so we just.....its probably better insurance wise if we don’t do that, its not that its complicated its just that its....
I: Bulk buying for the pharmacy
P: Yeah I’m trying to think what else we do. I mean we can do cultures from any body part there too, we have all the right kind of tools, stool samples we do them too. There are a lot of tests that can be done there. They can do X rays there. They’ll do chest X rays and if someone breaks their bone, if there is a possibility of a broken bone.
I: Do they actually set the bones there?
P: They would send them to the orthopedist for a cast but they would immobilize it and send that X-ray. And they'll know that they need an orthopedist from that X-ray. If there’s no break, sometimes they'll just wrap something for comfort. And they do put casts on people there. If it’s a simple break, they’ll cast it. I’ve never seen them do a leg or a foot, but I’ve seen them do wrists. They don’t do a lot of casting, but they can. But Dr. [White] doesn’t like to do that. I mean that’s not something she spends a lot of time doing.

I: Do you see any, I mean obviously with Dr. [White] you see certain patients over and over right?

P: Right.

I: Would you say the practice as a whole sees families usually?

P: Yea they do see people continuously pretty much. And you know what’s different about the practice in [Brookings], which is a small town, and the practice I have to go to because of our insurance and a lot of other practices in A_______, they don’t draw blood, they don’t they might do EKGs in their office, they don’t do X-rays, they might draw bloods, they probably have a microscope to check for a urinary tract infection because you know that’s pretty reasonable. But this office provides a lot more services than most doctors’ offices. Other doctors’ offices send people to the lab to have blood drawn.

I: What kind of relationship would you say you are able to have with the patients? How would you characterize it as nurse to patient?

P: Well I know them, they know me. I like the relationship I have with my patients because I feel like we’re connected in a way, you know, I know them, I know how to make them comfortable, because they’re familiar to me. Instead of seeing somebody different all the time.

I: Do you think that helps you treat them better?

P: Yea I do. Because I get to know them better and I know what kinds of things worry them and that may slow us down because they talk to me, and then they talk to her too because they know her that way too. We’re both pretty… ummm how shall I put it… its not just take their blood pressure. As they speak like that it gives them time to relax and think about what they need to bring up.

I: And then when you become a patient with your doctor, do you feel you have the same type of relationship with your doctor?

P: No, not at all. I mean she’s very nice but that’s all she does. She doesn’t ask after my family. She doesn’t know my family. And that happens down there that small practice, in that small town practice, not that it’s a small practice anymore. And it’s easier for me, I think working with Dr. [White] because she doesn’t work 5 days a week so our patient load, I mean she has hundreds of patients I think, but not as many as she could have, so you get to know these people especially as they come back over and over. Its kind of like when I worked in a hospital. The way it used to be in a hospital, people stayed longer. So and, at least where I worked, we always tried to keep the same nurse with that patients and you just get a little more in depth, become more aware of what kind of things they don’t know, what kind of teaching they need, or how they best learn, or what kind of things you really know they’re doing that aren’t helpful, and you may not be able to change that but at least you know what it is.

I: Have you seen any significant changes in the way that you’re able to care for your patients in the 6 years that you’ve been there, at the practice?
P: For me personally, I think just, because that was different for me, and because I’ve gotten better at it, the changes that I see, there some things that I don’t like, that I worry about because there’s a tendency or a need for some of the people that are working there to make it not like a small town practice, to make it a little more impersonal. Because that might be more efficient.

I: More money, more patients, more care, but perhaps losing on the quality.

P: Its difficult because insurance companies are still dictating so much of the care and we cant always, if you want to give the care that we like to give, I mean insurance companies don’t necessarily reimburse you for that. So from a business point of view there’s a real conflict. Because patients have always, even if they go to another doctors, and their other doctors need blood work, they come back to our office rather than going to a lab to get it done, and they can’t do that anymore. And that’s hard for them, especially the older people, they’re comfortable there, they know the people there, the labs are not, there aren’t any labs in [Brookings]. They have to go back, way into A_______. I mean that’s a long way for some people in their minds.

I: Yea it is.

P: And that’s because insurance companies wont reimburse us for drawing somebody else’s labs. They’ll reimburse the lab to do it but not us.

I: Just because you’re not supposed to be doing it?

P: No, its just, I’m not sure what the….we try to make it work, and Dr. [White] tries to go “you know I want those labs too” and then we put her down as ordering it and put the other doctor’s name on it too. I mean there’s no reason that people have to get stuck twice for no reason.

I: How do you feel about the quality of care you are able to give in a large university hospital versus the quality of care here both positives and negatives, because there are both?

P: Yea and that’s been awhile, I have no idea what its like there now and so that was twenty years ago and twenty years ago here would be different too. I’m sure it’s different in a hospital now, at that time the kids stayed longer and there would be kids that stayed for weeks. And because it was pediatrics, we were well staffed. There’s, I don’t know who’s rules they were but you never had more than 6 patients in pediatrics and on an adult floor in the same facility you could have 18. In pediatrics we did total nursing care so we did everything for that patient, we had nurse’s aides on the floor to help us and occasionally they did a bath for us but usually we were doing it together. Because you can make a lot of assessments about a patient when you are giving them a bath that you couldn’t if you weren’t doing that. You see a lot, range of motion, what their skin looks like, where their pain is. And if you have someone else do that you miss out. So I think they are similar in a way, the place that I worked. I don’t think that’s true of hospitals today because they have to get them out. I mean that was before insurance companies were running everything and you know, saying how long a patient could be. So we would keep them until they were pretty well. Now you don’t do that, you just get them started and then see them back later. But because we were there and we did have long enough and we weren’t over stretched on time, I mean we were working all the time, it was hard to get everything done, it wasn’t like we sat down with nothing to do. We were busy and short on time for some things but still you had enough time to spend with the patient and their parents, and teach and support the families through all that.
I: So its kind of similar to what you’re doing here now?

P: Right now the other doctors in this practice also spend a lot of time with their patients and get behind like we do, they get behind because everything is taken care of, because patients don’t... if they bring something up we take care of it rather than having them come back. Some doctors don’t work that way, you know, you’re in to see the doctor for what the problem is they came in for and if there are any other issues they have them make another appointment. Which helps them stay on time. We can’t really do that because it’s hard for patients to make another appointment with her because she is so booked and everything is tight. But you know, Dr. [Plum] is like that too. You know, sometimes the patients is very upset and they just need to talk and there’s no way they told the front desk, that’s the small town problem, they don’t tell the front desk, because they don’t want everybody to know. So when we get them back in the room we find out that really there’s a much bigger problem than what they made the appointment for just for privacy. That would be a negative issue a small town practice.

I: Well would you say that the clinic is ….

P: Cause everybody that walks in there knows each other so everybody’s in the same waiting room.

I: Right. Is the clinic able to provide the majority of the daily care for the people in [Brookings] who go there? Do you have enough services to basically provide general care, be able to take care of them without sending out because you have a lab and everything?

I: But they do, family practitioners, by their name, are generalists and when they see something that they think is a bigger problem, its their job to pass them on to the specialist. But they take care of a lot of things, they take care of high cholesterol, urinary tract infections, they take care of those until they have seen them several times in a row and then they send them to a urologist but they can take care of that. They take care of any amazing amount of stuff. Yea I would say they can. And the nice thing about this practice is they’re really good about, you don’t even have to wait long to get in for an acute problem. You make an appointment and you get seen pretty fast. Not always with the doctor you want but...

I: Right.

P: With Dr. [White] that’s different. You can expect it to be three months. That’s why we don’t see anybody with an acute illness, because it would be over by then. Now she has patients that see her, and sometimes they luck out and call in and we will have had a cancellation and then we can see them for an acute illness, they like to stay with us because they know us, they know her.
Appendix G – Interview with Dr. Butler and Dr. White

I: What is your title? Occupation?
Dr. Butler: Family Practice
Dr. White: Internist and Endocrinologist
I: How long have you been at [Brookings] Family Practice?
B: About 12 years.
W: About 5 years ago.
I: So you started at an HMO, was that down...
W: It was here in A______, it was part of ________ Medical Plan and then it got bought out and so the management changed.
I: Where did you all work before? You did residencies in rural or urban settings?
B: It was a community-based clinic in [small town] and so that was a good family practice program. And where were you?
W: Inner city residence in downtown [large city] and part of my residency was working at the VA, the [large city] VA which used to be separate from the University of ________, physically separate. Now they are all kind of together in downtown but it used to be in a whole other area.
I: And what differences did you see between the urban setting and the rural setting? What advantages and disadvantages do you see between the two?
W: Well working in an inner city and even at the VA hospital, people just waited until the last minute to come in. Especially at the VA, and also downtown [large city], but things were just so much more advanced before they finally came to the ER and got admitted to the hospital and staff like that. And they were less likely to be interested in knowing about what was going on. So you’d tell them they had diabetes but you’d give them a monitor but they would never monitor. And the VA was kind of the same way, some of those chronic illnesses, the people weren’t that interested in taking care of themselves. Here, you have sort of a mixed population, you definitely have the much younger generation who is so interested in like knowing everything about everything they have and you know monitoring like 8 times a day and different things like that. And you still have patients that don’t monitor very frequently but I do think that a lot of the patients here, at least like the younger generation, is more interested and they always have information from the internet, they always want this that and the other. Which is fine, its kind of nice to do some education, it was really hard to do that and know that it was going anywhere over there.
B: It was kind of more of a mix of people like it is in [Brookings], professionals and farmers, maybe not the inner city population, but you did have some, [small town] had kind of a city population as well at times. The nature of the family practice is that you get the continuity of care and you get to do all age groups and you get the kids as they grow up and you get the adults and elderly and the nursing homes.
I: Do you find here that you are able to treat a lot of the families through their entire life because you’ve been here 12 years now.
B: Yup, I see patients here that have seen Dr. ________. The town is of course growing and so you see a lot of people coming up out of [nearby large city] and probably 80 percent of the people work down the road everyday. And I walk around town and there are a lot of people that I don’t know which is kind of surprising.
I: Are there changes in what you're treating, what you're sending out to specialists?
B: We're lucky to have all the specialists that we do in A______, We've changed since I've been here, we do minor fractures and such. But insurances don't really pay us to spend the time to take lesions off and do things that we could send out.
I: Do you have a lot of problems with Medicare, especially in a rural setting?
B: Medicare roles here are not as.........(unintelligible)
W: Well most of my patients are specialty patients, I do a lot of women's health, and I do some primary care patients that I've sort of hung on to from Health Plan, but mostly what I see is chronic care, sort of endocrinology patients, so a lot of diabetes, and thyroid disease, and patients who have polycystic ovaries. And it is sort of nice here so most of the people who come here, live around here, so you get a great continuity of care here. You know you're able to go back and say "You know you're hemoglobin A1c was this three months ago, and you say this is your trend, you really need to do this, obviously that didn't work when you were doing that, so its kind of nice, you know the patients over years, and so you can show them the numbers and say remember when you did this it didn't work and you know, its just nice, its nice to be able to do that. And you know, in the VA everything was set up as a clinic, and you know you just didn't have that. You'd see different patients everyday you worked in clinic and the same thing at University of________, you worked in clinics as well, and you would just see different patients all the time. And if you worked inside the hospital, if you were doing hospital rounds and stuff like that, that was a little bit of continuity of care, but even then, you never saw the patients when they got out of the hospital. Here, you know, we sort of, they have hospitalists now, they didn't used to, that's sort of a new thing so these guys (other FP doctors at BFP) don't go to the hospitals anymore. But before, we knew exactly what was going on because they were taking care of them in the hospital and they would just come back and say this is what happened and its just nice, you know, to be able to do that.
I: What disadvantages do you see to working in [Brookings]?
I: What other disadvantages do you see? Do you feel overloaded with patients, lack of ability to provide the care you want due to lack of specialists, too many patients, things like that?
B: I think we have, you know, a variety of specialists until this malpractices thing came up so we're losing our surgeons and things like that. So you know, we've always been pretty well covered with specialists.
I: Is there a community network in this area among doctors?
B: What do you mean, community network?
I: Like, you have certain specialists that you have a type of agreement with that you send your patients to them, or is it just wherever?
B: You just send them to who you, well first of all you have to check their insurance. So you got to make sure they have the insurance that the doctor takes. Second of all, the ones you feel are good doctors and that you feel the patient would do well with. So we all have our own referral patterns and who we like with our specialists but there are no agreements, we don't get any kick backs, unfortunately, and umm...
W: Chocolate cookies.
B: Yea sometimes they send us chocolate at Christmas. (Laughter)
I: Do you ever feel that you have too many patients?
B: Just during the flu season, you know its like sometimes we have a lot of openings but in the winter when you get a lot of illness going around, sometimes its tough to see everybody. It varies, every year you have to change insurance companies because insurance companies don’t want to pay you and they...like [Insurance Company] didn’t increase what they paid us for like eight years and when we were finally on the verge of getting rid of them: they decided to push it up a little bit, you know they play a game constantly not to pay you. So every year, ideally, to run a practice, you want to get rid of your lowest paying insurer or at least one, and then you pick up others, you got to keep a variety of insurers so that one doesn’t get to be an overwhelming part of your practice in case you need to get rid of that insurer. So there is a fluctuation in and out every year. Most of the fluctuation between primary care doctors I think is because their insurance changes. Most of the patients don’t want to leave its just that we don’t take their insurance anymore. But there are a lot of doctors and being in a group practice it really helps, we don’t get too overwhelmed. You know we’re on call only a certain number, I’m on only every Wednesday and every fourth weekend so it’s not too bad. Do you have anything to add? (to Dr. White)
W: I forgot the question.
I: Do you feel like you have too many patients?
B: Yes she does.
W: Yea, I feel like I have too many patients but you know, I have limited hours and so I definitely could use some more hours. We were just talking about this the other day. As soon as [my daughter] gets into school I’m going to definitely add some more hours. It would definitely give me a break because I work beyond my hours pretty often and end up getting out much later than I would like. But, you know, we were just talking about those insurance things and last year the practice stayed with [Insurance Company] but I gave it up as a specialist because they wouldn’t pay me as a specialist. They just wanted to pay me as an internist and I had a bunch of my patients write to them and had my office manager working and they fixed it. And it was kind of nice that I had a whole bunch of patients that write letters for me and different things like that saying they didn’t want to switch doctors and things like that. In that sense to have a community that will support you like that was really nice.
I: What types of things do you send out and what are you able to do in the practice. You mentioned you do minor fractures, you do some lab work, is that right?
B: We do urine analysis and microbes in the urine, we do strep tests, we do pregnancy tests, we do wet prep and KOH kind of looking at it in vaginal slides under the microscope.
I: You do some casting?
B: We do splints and casts and usually non-displaced fractures. We used to do more of that in the health service but because we didn’t have nearly enough coverage. But looking at malpractice if you do the standard of care you’re going to be ok. You want to make sure you are doing the standard of care and you want to make sure you are doing what’s best for the patient and the third thing is that insurances don’t always pay you. So if I wanted to set a fracture, an insurance wouldn’t necessarily pay me for that while they’ll pay an orthopedist for that. Or like if I have to take off a lesion over a certain size or if I take off a malignant lesion, usually you don’t know until it comes back from the lab so its totally ridiculous so they don’t pay you for malignant lesions.
after five o clock to get their routine visits, scheduling that kind of thing. Its certainly easier here to get the continuity of care then it would be in an urban setting.

W: Yea when we worked at VA and even at University of ______ downtown, you were so busy dealing with their illnesses that hadn’t been taken care of that you just kind of never got to the preventive care. And that happens here to some degree with some of the much older population and you realize that they haven’t had a tetanus shot in maybe 35 years or something or they haven’t, for diabetics, they haven’t had their flu shots and hemovacs and different things like that and its sort of like, “Oh my gosh.” But I would say, most of the people here, and because in my practice I have a lot of continuity of care. And I am very meticulous about my charting and I pretty much review everything every time they come in and make sure everything is up to date – pap smears and mammograms and everything else. So I spend a lot of my time doing that for my patients and a lot of that is because they are chronic, and they have chronic illnesses. I do see them sometimes when they have a superimposed illness on their chronic illnesses. But the majority of the time they see them [the other doctors] for that and I take care of their more chronic stuff. So I would say my patients that come to see me get a lot of health maintenance stuff. I’m very meticulous about it actually.

I: Do you find that your way to define healthy for them is the same as they define it?

W: Yes and no and it depends on the patient. There’s a whole new set of criteria, new recommendations for how to care for patients with diabetes, you know, everybody needs to be on a drug for cholesterol even though they don’t need it, everybody needs to be on high blood pressure medicine to protect the kidneys and you know, I tell everyone of my diabetic patients that those are the new recommendations and I would say across the board, in the last 4-5 months when I’ve told everybody about this, about fifty percent will say ok go ahead and start me on it. And you know, its not like, I do say to them, “These are the recommendations,” and I show them, I have everything charted. “These are what your labs look like, this is what your protein and your urine shows over the last 3 or 4 years. I think we’re safe, I’m telling you these are the recommendations but I think we monitor so closely that if anything moved in the wrong direction we could definitely get right on it.” And I would say that even the elderly people and even the younger people would say that they don’t want to do it, they just want to wait and see. Some of the older patients, and their style with the doctor is so different then to see somebody that is much younger. You know they say, “Whatever the doctor says.” I had a couple who I’d seen for a very long time here, and they were in their 80’s and they just moved to an assisted living place. And they, whatever you said to them they would be like, “Ok, if you think that is what I need, they’d be like ok go ahead.” Now a days, I think some of my younger people are less apt to do that. They get so much more involved in the decision making process then they used to be. (to D) I don’t know if you’re older population is more apt to take what you say right up front without asking a lot of questions.

B: It varies, but mostly.

W: The older populations, they don’t have a lot of questions, and that’s just how they were brought up and you ask them if they have any questions and they just say, “Whatever you say.”

B: I don’t think [Brookings] is as rural as it was when [Dr. _____] was here.
Interviewer: You’re a nurse at the family practice?
Nurse Scarlet: Yes
I: And how long have you worked there?
S: Umm, 21 years.
I: Did you work anywhere before you started working at the family practice here in [Brookings]?
S: I worked at the hospital in A______. How far back do you want me to go? I’ve also been working off and on since I graduated.
I: Ok, mostly in the area?
S: No actually probably about 12 or 15 years in [nearby] County. And I worked at ______ Memorial [Hospital] and I did the Emergency Room and then I did OB/GYN part-time. Emergency Room full-time.
I: So that was more of an urban setting?
S: Absolutely.
I: What differences do you see between that type of health setting and now here at [Brookings].
S: Oh, [Brookings] is just unique unto itself I think. Its still, what we used to think of, as the family doctor. They even, some of the doctors, will still make house calls. So it’s a close knit, its a caring, not that you don’t have caring in urban hospitals but I think that you have time to care because of the continuation of the number of people you see who are the same people as opposed to a big city where, and especially in an emergency room where you just don’t. I think it offers a whole new kind of nursing in that you can do nursing as you want nursing to be.
I: Right, you can connect more with patients.
S: Right, and you have time. You have time. Because I’ve been there 21 years, I’ve seen my kid’s friends have families, so I’ve seen their births, I’ve known their parents and seen some parents die. So you have a continuation of a whole life cycle. And you’re able to be part of it in a small way, but to be part of it. And that may not be what you consider nursing but you can kind of have something positive to contribute to someone’s life. Especially if they’re sick and they don’t feel good or they don’t know what to do and that kind of thing or a loss. No, its good, its good.
I: Are there any disadvantages that you see to a rural setting in terms of the amount of care versus specialization?
S: Had you asked me 4 or 5 years ago, I would have said no. But the situation right now with the doctors as far as the insurance is concerned and that kind of thing is going to be a determining factor as to what the shortage is. When I first came to A______ there was no staffed hospital emergency room for example. So I’ve seen that evolve into a complete emergency room staff. So 20, 30 years ago, it was more rural. Now we’re still rural but very up-to-date with all the facilities that are here. And I think people get shortchanged. The thing that our practice does here, and I’m sure you’ve heard it before, is they specialize in family practice but they’re very good, and non-egotistic about referring. And because we have doctors in A______ now that are so specialized, and we have two major medical centers just down the road. We have [large city] and we have
University of __________, [other University Hospital. So in this area, I don’t think it would be a rural kind of situation. We have both advantages.

I: What has changed in the way that you are able to nurse? Do you feel like you have a different type of relationship with your patients, are you seeing different kinds of patients?

S: Well, yes, we’re seeing many different types of patients, because we’re seeing people. So the things stay the same. New mothers are still new mothers, kids getting immunizations are still kids getting immunizations, people who have to go in for testing still have the same kind of what’s involved. People are diagnosed with cancer or you know something. That stays the same. So I don’t see changes there. I see changes in the availability, or the resources is the word I’m going to use, for where these people can be referred for the help they need. And I think that’s gotten better. And sometimes maybe not so good, so much testing and so much maybe intervention in just the testing that was not done before. And I’m not sure – opinion – I’m not sure this falls into progress or whether it falls into a whole compilation of insurance and availability.

I: That’s a major issue right now.

S: I think so. I think so. And I think the doctors with whom I work, and who I’ve seen, it can be a negative factor. It’s a negative factor for me when I have to call into an insurance company to get an OK for a medication that the doctor has prescribed that people have seen on television. That is so good, you know, this is the best thing going. So you have someone you know say, “Oh well this is the medication the TV tells me about,” and then find out the insurance company says no we want you to try something else.

I: People feel that they’re really informed these days with TV and the internet.

S: Exactly, and people do go on the Internet. It’s fun. We have people come in and they’ve run off 4 or 5 different things. And that’s a new factor, that I didn’t realize was a new factor until you said something, in that if someone comes in and they feel that, “Do they have A, B, or C.” Its important for us to say you know, “You don’t have A, B, or C because…” Because once that’s kind of implanted in your mind, you know, “I could have this and they didn’t tell me this.” So yeah, that’s a change. I wasn’t aware of before you said something.

I: Yeah you kind of have to explain things more and justify what your doing because it feels like they’re informed when really they could be misinformed.

S: Right, exactly. Or this is why you don’t have this. Or with the, and I’ll just give a simple example, with generalized joint pain and that kind of thing. People are concerned about lime [disease], and there’s so much of that, you can now do a test which will completely confirm or negate lime disease. So that’s an easy one and they’ll just do that. There are some shades of gray where you have the same symptoms for 55 different things.

I: What kinds of things are you able to treat and what kinds of things do you send out? You’re able to do some lab work there right?

S: We do urinalysis, step tests, we do pregnancy tests, we do hemoglobins or red blood cell counts, iron, when you do the hemoglobin that’s people’s iron. We can do testing for elevated blood sugar. We do, I don’t want to say minor X-rays, that’s not a good term, but we do X-rays for a chest X-ray and a fracture, yea we can do arms and legs pretty much. We don’t do the big ones, we don’t do spines, we don’t do knees, X-ray wise.

96
I: No one does obstetrics anymore, is that correct?
S: No one does obstetrics there anymore, no.
I: But they used to do that probably when you first started there?
S: Dr. Rudman did and he was the only one who did obstetrics. But no, we don’t do obstetrics at all and we don’t do women that are pregnant except for sore throats and things like that. But we do pediatrics. And the outside testing would be probably everything that you are already know. The MRIs, the CAT scans, the referrals to cardiologists, the orthopedics, the gastrointestinal guys, the optometrist, the endocrinologists. Now Adriana does endocrinology and she’s our specialist and she’s great.
I: Do you feel like there is an overload of patients that you’re trying to see, do you have enough time to spend with your patients?
S: Yes and no, there are people with whom you would like to spend more time because there is a definite need to spend more time. The practice has grown so much, its probably tripled, as we take on new insurances we get a block of people that can come in with insurance. Conversely we lose some people because their insurance changed. So that’s kind of an outside factor we can’t control. I think sometimes we see a lot a people everyday. If we do every 15 minutes for 7 hours, break for lunch, that’s 28 people a day for each of these guys and Adriana. I think we do a good job with giving the time needed for step throats or upper respiratory, that kind of thing. Sometimes we don’t have enough time, the nurses don’t, for somebody who’s had a loss. To give that a little more human than run through kind of thing. The people with whom I work, the nurses, I think [Brookings], I’ve been to other offices, I think it has a uniqueness about it. I really do. I think we’re still able to keep the human touch and still do the necessary job like call in the prescriptions and the paper work that’s involved.
I: How many nurses do you have at the family practice? I know there’s Diane Lowe.
S: Kara Harving, Kara’s been there for 24 years, Diane Payne, has been there for a while. Melissa, who’s last name is going to completely escape me right now and she is working on her LPN and is a kind of nursing tech but has excellent potential. I want to see her go on. Kathy Gross is there, she did laparotomy and then she did some courses. So she is excellent, if we can’t draw blood and Kathy’s there we get her. Dara Baker has been there for awhile. Kathy Baker who works at the hospital had worked for us but then went back to the hospital but she’ll fill in.
I: I didn’t realize there were that many.
S: Yeah and we have RNs, we have LPNs, we have techs but it doesn’t matter. In a hospital setting you’d have this kind of pecking order but it doesn’t really matter. To my knowledge we don’t have a pecking order.
I: So in general, in your opinion, a rural setting provides a lot of advantages to an urban setting in your experience.
S: In my experience yeah. I worked at the clinics at Union Memorial way back in the 60s. The set up was different, these are people who could not afford. But the set up, the social service set up was different. We provided a service and I think that was important but we didn’t always fulfill the need because we just couldn’t. So I think ideally in [Brookings], I don’t know that every practice in A_______ does the same thing. I’m just fortunate to work here. You have avocation and vocation, and when they are both good and combine, that’s what I think [Brookings] is. You can tell I love it, I really do.
I: Last question. How would you define health versus illness and do you think it agrees with your patient’s definitions?
S: I think health is a totality. I think illness is segments of that totality. If you’re in health, it’s a total sort of thing. If you’re ill you have a sore throat, an upset stomach. You have things that affect just segments of the totality.
I: And do you think your patients would agree with your definition, or do they come in more easily? Do they take a long time to come in? Do they come in early?
S: Well it’s individualized. We have people who come in a day if they have a sore throat. We have some people who come in two weeks with abdominal pain and diarrhea that they think will go away. Because I think people themselves, I think everyone has their own definitions. You know people who say, “I don’t feel good. I want to see the doctor. I want it gone.” We had a lady who fell off a chair Christmas Eve and she was finishing up her cookies and she had broken her arm. She was in her 60s. She had cookies to do, she had Christmas to do and so she knew it hurt but it didn’t hurt enough. And so she came in the day after Christmas saying her arm was a little angled and it didn’t take any kind of a genius to know that there was a fracture there. And I don’t know if that kind of thing answers your question or not.
I: That’s great, thank you.