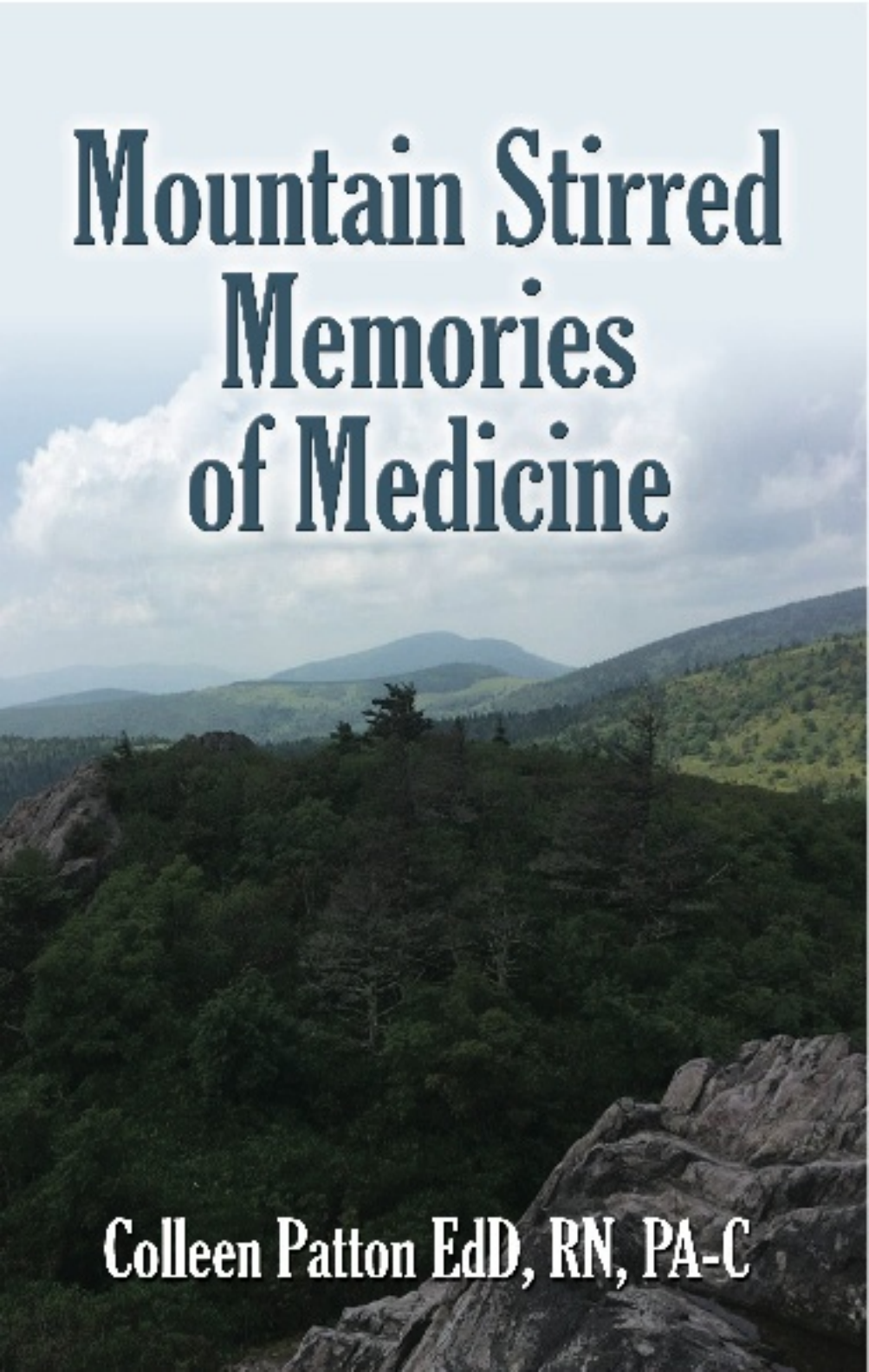
Mountain Stirred Memories of Medicine



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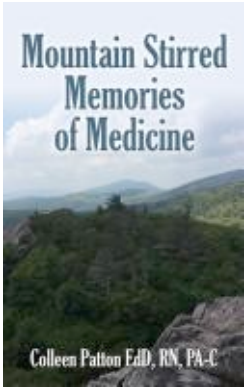

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ISBN 978-1-63490-421-6

Published by BookLocker.com, Inc., Bradenton, Florida, U.S.A.

Printed on acid-free paper.

BookLocker.com, Inc.
2015

First Edition

Fields of Tobacco

I remember as a child, riding through the ridges and mountains of Appalachia seeing hillsides and riversides dotted with tobacco fields. Yes, tobacco. The much-maligned product linked in modern day to a myriad of disease states and carcinogens—but when I was a young girl—children knew nothing of these. It was the 1960s and in those days, school-aged children made ashtrays in school as Christmas presents to give our families. Each home I entered contained a coffee table that held an ashtray politely for company to use if they smoked. It was expected and considered quite the sign of what I would call southern hospitality.

We would hear children and family members discussing times of the growing season accented by the specifics of the tobacco crop. We all knew of the dreaded "blue mold" and the threats of too much or too little rainfall.

Tobacco grows very, very well along these mountain hillsides and creek beds. It begins as seedlings purchased from the various nurseries and farms in the area. Over the course of weeks and months, the plants grow tall, and they appear above the surrounding weeds. The green leaves fanning out from the primary stalk of the plant, eventually reaching 4-5 feet in height. As the season progresses, the "tops" appear—flowering and bushy—white in color atop the stalk looking very much like an exotic tropical flower. This event of course leads to the

"topping" which must be done. Topping is the removal or cutting of the bloom to promote larger leaf growth.

Topping was followed a few weeks later by the cutting of the tobacco plants in the field. This occurred during late summer days full of humidity, afternoon thunderstorms, and otherwise very sweltering working conditions for those farmers. Plants were loaded into trucks and taken to a nearby barn or shed to be hung over long racks of wood suspended from one wall to another. Here the plants would hang and "cure" over weeks until they came "into case" as the farmers would say. This meant it had to be then carefully loaded and taken to market to be sold at the market prices for the year.

In the mountains of Appalachia these farmers were most often small-scale operations with most looking to make some money to carry them through the winter and Christmas holidays. When I was a young girl, these same farmers often smoked, chewed, or dipped a form of tobacco product from these same fields and efforts. I do not recall hearing discussions or conversations about the links between tobacco products and diseases. I remember seeing older men and women with barrel chests and some with oxygen tanks and tubes in stores or churches—yet no one in those days verbalized the cause of these conditions nor ever hinted at the complicity of growing tobacco as the cause of disease. All I really knew growing up was that most farmers in the mountains were poor and they raised tobacco to make money to live on. Their plight was much discussed and these same farmers were to be pitied if the weather ruined the crop, or the market prices dropped.

Riding through these fields of tobacco today gave me pause, as I now know all too well the burden of the addiction to smoking and tobacco has on those who suffer from it. Just such a memory came to me on an afternoon trip to the store with my husband. We were passing fields of tobacco in full bloom when my husband said to me, "they'll be topping this soon".

I grew up in these mountains and became a registered nurse in my mid-twenties, graduating from a community college in Appalachia in 1987. My first job was in a very small rural hospital in these same mountains. I was offered and accepted the position of registered nurse, working the night shift from 11 pm to 7 am. I was just out of school and so excited to have a job!

The hospital had only 35 beds and the entire night shift staff consisted of two registered nurses (RNs), two Licensed Practical Nurses (LPNs), and one male orderly. The setting was so rural and small that we literally locked the hospital at night. If anyone came to the Emergency Room for care at night, they had to ring a doorbell to be allowed entrance. No physicians staffed the hospital at night. We had physicians on call of course, and one physician assistant who stayed or slept in an apartment across the street and would come when we called him for emergencies.

Night shift is a unique time in any hospital, especially a rural one. The usual hectic pace of rounding physicians, shift changes, laboratory and radiology, administrative staff and training stop, and the hospital takes on a much more quiet and informal atmosphere. Patients generally sleep the majority of the time; yet there are those who are

awake and either due to their condition or location they are at times frightened. Stories are shared, questions are asked, and lives are touched—and these include lives on either side of the bed rail.

I gained a great deal of experience in those first years. In nursing and in medicine after all, experience is the best teacher. Education philosopher John Dewey wrote, "Just as no man lives or dies to himself, so no experience lives and dies to itself… wholly independent of desire or intent, every experience lives on in further experiences" (Dewey, 1997). And as a nurse, you never forget your first experiences; you never forget your first code blue, or the first patients you see die. And all the while, you are learning from your patients.

♦♦♦

Jim

On previous shifts, nurses and staff had noticed Jim was becoming very agitated, confused and restless, so much so that according to hospital policy for safety, he had been placed in a posey vest. This is a cloth vest that fits over the chest with long cloth straps used to literally tie a patient to the bed frame.

Jim's agitation was due to severe hypoxemia, or lack of oxygen due to his continuing decline from chronic obstructive pulmonary disease and emphysema. He had been a smoker for all of his adult life. Years of smoking had resulted in his lung functioning gradually worsening. They deteriorated to the point where he could not breathe in enough oxygen or blow off enough carbon dioxide to

meet the demands of his body. He could not do anything but struggle for each gasp of air.

Tonight, his condition worsened and the oxygen mask and respiratory treatments were not able to stop his decline. His breathing became more irregular and shallow. There were no family members present. Only I, another RN, and two aides were on that night. On his chart were the standing orders stating do not resuscitate. He and his family had declined extreme measures to prolong his life—they had all decided not to intubate him to keep his lungs functioning.

Jim was in his 70s, frail, emaciated, and his body was struggling to breath despite oxygen and other therapies. Each breath took so much effort that all of his upper body muscles were strained. I could hear rasping and stridor, an audible whistling sound with each inspiration and expiration. He never spoke.

I stood there as a new nurse watching and trying to comfort him as he died. I became acutely aware this man was dying in what some would describe as a dehumanizing condition—without loved ones and tied to his bed, gasping for air. I reached down and untied the straps that held him there; feeling I had at least done the one small act of human compassion I could do. Medicine and treatments had been exhausted and so was he. Within a few more minutes, he was gone. His experiences were at an end.

♦♦♦

Riding through these mountains by these small tobacco fields that grow from one stage through to the

next, I find myself thinking of the simplistic beauty of the flowering plants to the often repeated end state of its use in the human body and spirit. I wonder if the men working the long hours in the fields tending the plants think of the possibilities of the likely end state as they work. Do they talk about smoking or chewing tobacco? Do they themselves smoke the plant they grow? On this day I find myself wondering if Jim himself was a tobacco farmer. Or is this simply another Appalachian tie that binds us to these mountains.

I don't really understand if I expect to find answers to the questions or thoughts stirred by these memories. Perhaps I will find it is just cathartic to place them down in words on paper. This trip home continued and I found myself leaving the road behind for a while and placing my feet on those hills and mountains as I always do when I am there. But just as I found myself relishing in the familiarity of places, sights, and sounds, I realized there were many things in these mountains I had never seen or realized before. And my seeing them in this way stirred yet another memory.

Before we leave this memory however, I want to share with you a poem by bell hooks about Appalachian tobacco. In memory of Jim:

all fields
of tobacco
growing here
gone now
man has made time
take them

surrendered
this hard crop
To other lands
countries where
the spirit guides
go the way
of lush green
leaving behind
the scent of memory
tobacco leaves
green yellow brown
plant of sacred power
shining beauty
return to Appalachia
make your face known
(Hooks, 2012)

The Family Cemetery

Driving through the grass covered hillsides and woodlands you see remains of old homes left to ruin in the weather. Some of these homes date back many decades and others are almost invisible except for the stones found in the fields revealing their foundation. Long ago farms worked by families sleeping as many as nine or ten people in one room. You see many old cabins and barns that are weathered to dark browns or gray. Some of these are close to our place and they are honestly visibly leaning or tilted to one side or the other.

Atop some hillsides you can see small wrought iron fences, or wood and wire fences in small square or rectangular shapes. If you take a closer look you might see tombstones, many of them as weathered or leaning as the family farm houses they belong to. In so many cases, the farmhouse is long a thing of the past and the family cemetery is the lasting monument to those who lived, worked, and died there. Small piles of stones, and others a stone with name, birthdate and date of death show us who rests on the hilltops mark some graves.

Genealogists and others have spent countless hours traveling and recording the location of these gravesites and when possible who is buried there and when. These records are then transferred to the county court records of lands and farms. Many descendants of the family members buried there maintain the cemeteries. It is a piece of Appalachian culture that in some ways binds us even tighter to the land we love.

Muriel Miller Dressler tells of the family cemetery in her poem Appalachia,

> "….You, who never once carried a coffin
> To a family plot high up on a ridge
> Because mountain folk know it's best to lie
> Where breezes from the hills whisper, "You're home";
> You, who never saw from the valley that graves on a hill
> Bring easement of pain to those below?
> I tell you, stranger, hill folk know…" (Dressler, 2000)

They do sit, on hilltops, and are silent among the seasons and winds that blow over them. Those who lie in them were fathers, mothers, children, and most were born and buried on the family land they owned. My own grandparents are buried in a hillside cemetery deep in the rural Appalachian country. Not their own land, but in the same community they were born in. My great-grandfather lived in or built three houses on the hillsides there and we—the family—have known them as "number 1, 2, and 3". As I think about those who lived and now rested on those hills my thoughts went back to a patient I had just cared for as she made her transition from life to grave. Her first name was Ginny, but in the old southern tradition of respectful address of our elders, I called her Miss Ginny.

♦♦♦

Miss Ginny

I was working as a Physician Assistant in the Emergency department when one of the nurses took a phone call from a local nursing home. The staff there was making us aware they were sending a patient to us for evaluation. The stated main concern or chief complaint for this patient was she was "sleeping" too much. They stated the patient would just doze off at odd times and that this was not normal behavior for her. It had been going on for about a week.

A short while later the ambulance personnel came through the doors with Miss Ginny on a gurney and brought her over to the ER exam room. I noticed that for a patient who was sent to us for "sleeping"—she was very much awake. In fact, she was quite "with the program" as we say. She was chatting and smiling with the ambulance personnel and in fact called them "good looking boys".

A couple of the nurses, the "good looking boys", and I transferred her from their stretcher to our bed. All the while we were talking with Miss Ginny; we asked her if she had been having any pain, had she been sleeping "a lot more than normal". She denied any concerns at all and said she felt she was "doing pretty good for 93 years old".

After this move from one bed to the other, I placed my stethoscope on her chest to listen to her heart beat—at the same time the nurses were getting ready to take her shirt and other clothes off to place her in a hospital gown. I listened for the heart beat and heard very few of them, and then placed my fingers on her left wrist to palpate a

pulse—noting as I did so that I felt very few beats. I asked the nurses to place her on the monitor and get an EKG, an electrical tracing of her heartbeat.

All of this is going on while we were still talking with Miss Ginny, asking her more questions about her symptoms. She responded to us very appropriately and continued to smile and make jokes about the things going on around her. At 93, she was as we say; "pleasantly demented". She was not sure what year it is, or what month, but she knew her birth date and made us all smile with some of her comments about her life in the nursing home.

Miss Ginny continued to say she didn't have any symptoms, no chest pain, and no shortness of breath. She said she just "gets tired and falls asleep". But one look at the monitor showed us all that her heart rate was only 35-38 beats per minute—very slow—much slower than normal. A normal heart rate is anywhere from 60-100 beats per minute for an adult. The nurses brought over our cardiac equipment that has an external pacemaker on it. We placed the pads on her chest and back in the event we would have to provide stimulation for her heart to beat.

But Miss Ginny was at this time without any symptoms and her blood pressure was actually normal. Those findings allowed us to relax a little but we all knew she couldn't do well for any length of time with a heart rate that slow. The vital organs such as the brain and kidney depend on the perfusion of oxygen and blood from the heart and at this rate, they were most likely not receiving the amount of oxygen they needed. The ER physician had

examined her and began working on consulting with a cardiologist at a nearby larger hospital to discuss a transfer for possible implantation of a pacemaker. This device would be placed inside her chest with electrodes placed on her heart to stimulate a heartbeat at a more normal rate.

The nurses began placing an IV in her arm and drawing blood samples to be sent to the lab to see if there were any abnormalities that might contribute to her slow heart rate or alert us to other conditions that might be going on as well. We continued to talk with her and we told her about the findings of the slow heart rate and how we felt it was likely the cause of her "sleeping".

Another 10-15 minutes passes and the nurses and I began to notice a change in Miss Ginny. She was not talking as much as she had been. And she was not speaking quite as clearly as she had been. We alert the physician, and he comes quickly to reassess her as well. By this time, she was unable to communicate in words at all. She appeared to understanding that we were asking a question, but her speech was a very garbled collection of sounds.

The physician communicated again with the cardiologist and while transportation has been arranged to send her to this larger facility, the discussion takes place between the physicians as to whether this change in her condition is a result of hypoperfusion or decreased blood flow to the brain or whether she was actually having a cerebral vascular event or stroke in front of our very eyes. The decision was made to continue with the transport to the larger facility but also to arrange for her

to go straight to the ER at that hospital for urgent evaluation regarding these changes.

I stood by her bed with the other nurses and again attempted to talk with this beautiful elderly woman with soft wavy white hair who less than an hour ago was talking and laughing with us, and bringing a smile to the faces of the "good looking" ambulance personnel. Now, her eyes appeared to be much less focused, she was moving much less on her own and her ability to speak was now gone.

The physician placed a call to the family to assess her "code status". This was done to find out what they wished us to do in the case of a cardiac arrest or respiratory arrest. In essence we were asking them if they wanted us to perform heroic measures in the event that she passed away. To receive a phone call like this out of the blue is so often one of the most intense moments we experience—a stranger on the telephone is calling to say that our parent or loved one is very ill and might die and at the same time they are asking you if you want them to be resuscitated with all technology and medicine have to offer.

Miss Ginny was 93 and this call was unexpected, but they had anticipated this occurring and they had a do not resuscitate order in place in the event that she did pass away unexpectedly. With this knowledge, a change takes place in front of my eyes in the nurses and staff—and I must admit within myself. We moved the cardiac equipment away from the bedside together. One of the nurses went to get her an extra blanket to keep her warm.

I and one of the other nurses go to her beside to attempt to talk with her and hold her hand.

She continued to worsen though just a few minutes have gone by. Her breathing is much slower and she is no longer aware of our presence. Before the next ambulance arrives with its compliment of "good looking men", Miss Ginny died.

♦♦♦

I have witnessed death many times over the past 28 years and with infants, children, young adults, and yes—the elderly and I still ask "how". I don't ask why, because I know the why—scientifically and clinically—I understand why death happens. The "how" is what I still don't quite understand. How does a human being transition from living breathing woman who can smile and laugh transform to this still body now lying on the stretcher? What happens in the moment of change from life to death? She was just there with us wasn't she, actively--vibrantly? And now she is gone?

Nurses, the physicians, and physician assistants don't stop working once a patient dies in the hospital. We keep on going. We close the curtain and in a few minutes another patient with a sore throat walks by and knows nothing of what has just taken place in that exam room or that Miss Ginny was just laughing there and now she is merely there.

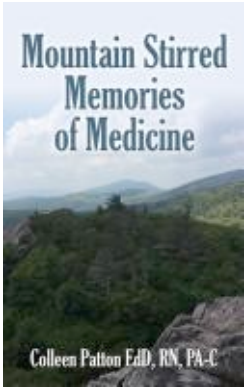
As staff in the emergency room or hospital I wonder how we do manage to go on with our work as if nothing has happened. Do we feel as if we must move on to the next room, to the next patient in a self-protective

mechanism to avoid feeling pain? Is this a trait learned in the practice of medicine that prevents us from acknowledging we have witnessed a life ending, or a tragedy occurring? Or is this a fallacy?

I read Miss Ginny's obituary in the local newspaper a day later. I saw she would be buried in a local church cemetery here in her mountain community. I wonder to myself about her life before, her husband, her home, and her children—all of the people who had been a part of the girl and woman she had been.

I think about her as I point out to my husband the family cemetery on the hillside and he says, yes, "I think that's one of the Phipps' family plots." He continues to say, "They owned most of this land in this area 'back in the day'". My mind goes back to my grandparent's hillside graves and how many generations of my family are there. I wonder if I shouldn't plan to try and be buried there with them—but my husband I know won't feel the way I do and I want to be buried beside him. How morbid is this, I wonder?

How peaceful is it to lie there at your rest? Are you aware of your "place"? Is part of you still there in some way—or is there some possibility to return to the beauty and land you loved and are buried in after you are gone? I wonder these among other questions silently to myself as we continue on down the road, and I glimpse yet another fence on top of a hill.



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