

Mountain Promise

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Paint Lick Family Clinic, located in a renovated garage, serves as one community's answer to meeting the health care of rural patients. See story on page 8.



MEDICINE IN APPALACHIA

Meeting Today's Health Needs



Appalachian Leadership and Development

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Mission of Brushy Fork

For more than one hundred years, Berea College has served the people of Appalachia.

The Brushy Fork Institute carries forward this commitment by working to develop strong leadership in the mountains.

Working with both existing and emerging leaders, we draw on local understanding and vision to help communities build for tomorrow.

The Medical Liability Crisis

A Looming Catastrophe for Rural America

by Michael A. Weiser

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The malpractice insurance crisis currently gripping many areas of the nation has all the characteristics of a runaway train plunging down a mountainside toward a devastating catastrophe. This speeding locomotive, which appears to have no one at the controls, continues to gather deadly momentum as it barrels down the tracks. Escalating jury awards necessitate staggering rate increases in malpractice insurance premiums. These increases directly affect the cost, quality and access to care for the average American consumer, which in turn threatens to derail the entire U.S. health care system.

Because of rapidly rising malpractice insurance rates, and in some cases the inability to obtain insurance coverage, doctors throughout the nation are facing the prospects of either drastically altering how they practice medicine or closing their practices and retiring altogether. In cities across the country, physicians have taken to the streets to protest and voice their outrage over sky-rocketing liability premium rates that threaten their ability to practice medicine in the best interests of their patients. These physicians live with the fear that they will not be renewed by their current malpractice insurance carrier, will face insurance premiums four times their present rate or will be unable to find insurance at all. While physicians are the most visible and immediate group to be caught in the headlong rush of the "Malpractice Express," the American public—and in particular rural Americans—will be the true victims of this crisis as access to care in many states becomes more and more limited.

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Although the present circumstances have made professional practice difficult for many of the nation's physicians, most often they still have a choice about how they will respond. However, this crisis leaves many rural Americans little or no choice regarding their physician or health care options. In many high-risk and litigation-prone regions of the country, physicians are being forced to reduce services, eliminate high-risk procedures and/or move their practices out of high-risk areas. These "remedies" to physician concerns end up creating significant health care access issues in many rural areas that now face a limited pool of remaining physicians.

One area of medical specialty critical to rural life is the practice of obstetrics and gynecology—those physicians that deliver babies and care for women. At the annual clinical meeting of the American College of Obstetricians and Gynecologists, ACOG president Thomas F. Purdon, MD, reported: "Across the country, liability insurance for obstetrician-gynecologists is becoming unaffordable or even unavailable, as insurance companies stop insuring doctors. Without insurance, ob-gyns are forced to stop delivering babies, stop surgical services, or close their doors. Women and newborns are hurt the most."¹

This problem is most acute for rural areas where only a few physicians may still deliver babies. Tim Maglione, the Ohio State Medical Association (OSMA) senior director of Government Relations, stated: "In several Ohio counties, there are only three or four doctors who continue to deliver babies." If one or two physicians decide that they can no longer afford to deliver babies, or if they move to another area or quit practice altogether, the task of caring for new life and providing women's health services begins to evaporate.

Defining the Crisis

ACOG has identified several states across the nation that are now embroiled in a medical liability crisis with regard to obstetric and gynecological care, as well as those states which either have a crisis brewing or mounting problems that should be watched. In the immediate Appalachian and Ohio Valley region, ACOG lists West Virginia as already having reached the crisis level, Ohio with a crisis looming in the near future and Kentucky with a number of problems that need to be followed closely.

Reduced care for women and infants?

[The American College of Obstetricians and Gynecologists] lists West Virginia as already having reached the crisis level, Ohio with a crisis looming in the near future and Kentucky with a number of problems that need to be followed closely.

An ACOG fact sheet, "Red Alert: The Hot States," released on May 6, 2002, outlined the problems facing West Virginia. "The state is known for high jury verdict awards, and unaffordable insurance rates could fuel an exodus of doctors from the state. The majority of the state is already classified as medically underserved and cannot afford to lose physicians."¹ Anecdotal reports indicate that some West Virginia physicians in border towns have begun to close their offices and cross the Ohio River to set up practices in neighboring river cities in the hope that they can continue to care for some of their current patients. Reports indicate that some West Virginia physicians have traveled to Indiana where the serious medical liability problems have yet to materialize.

In Ohio, the OSMA has characterized the state as being in "Critical Condition" based on the results of an exploratory survey of Ohio physicians regarding the impact of rising medical lawsuit insurance rates on patient care. Of those surveyed:

- 98 percent expressed concern over patient access to care;
- 96 percent expressed concern about physicians' ability to practice in the best interests of their patients;
- 79 percent reported an average increase of 41 percent in insurance rates; and,
- 76 percent said that rate increases had reduced their willingness to perform high-risk procedures.²

Several of these physicians mentioned that they had begun to order more tests and consultations—a practice known as defensive medicine—in an effort to lessen their exposure to malpractice claims. Unfor-

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Unfortunately, the practice of defensive medicine puts added stress on already scarce health care resources, and tends to increase the amount of money that insurers must pay out in order to cover these additional tests. This practice aggravates the cycle of ever-increasing malpractice premiums.

In Kentucky, some of the telltale signs of an impending crisis have already begun to surface. A recent medical malpractice survey of 553 physicians conducted by the Kentucky Medical Association showed:

- 512 respondents had experienced increases to their liability insurance;
- the average rate increase was \$16,650 per physician;
- physicians saw an overall rate increase of 79 percent across the state—an increase totaling nearly \$5 million dollars for all responding physicians; and,
- 44 physicians had been denied coverage.

Marty White, the Director of Public and Government Relations for the Kentucky Medical Association, commented that the immediate dilemma facing the state was the mounting problem of maintaining access to care for Kentuckians. Mr. White pointed to the closure of a family practice residency program in Barbourville, Kentucky, where the clinic providing resident training recently lost its malpractice insurance coverage. The residency program included training in obstetrics. Dozens of pregnant women are counting on doctors in the same clinic to deliver their babies this year.

The crisis affecting the immediate tri-state area has grave implications for obstetric and gynecologic care in the region. And yet, the crisis is not confined to this region or the “medical” profession alone. It stretches across the nation and affects health care providers at all levels. Any provider that must carry malpractice insurance is feeling the pinch in the marketplace, and any facility that provides medical care or services will encounter the ripple effect as this problem sweeps through the health care field. Medical schools across the country have also been hit hard. Dean Jack Brose of the Ohio University College of Osteopathic Medicine in Athens, Ohio, recently commented on the crisis at his school. “Our malpractice insurance—for the same coverage—increased

The immediate cause of the crisis in medical liability insurance is the combined effect of ever-increasing damage awards, malpractice insurance premium increases and insurers either narrowing guidelines . . . or leaving the market altogether.

dramatically this year. This is despite the fact that our carrier didn’t pay out any money to plaintiffs over the past three years.”

The Scope of the Crisis

Across the nation, many states already find themselves facing a full-blown medical liability emergency. The American Medical Association now lists 12 states in crisis: New York, New Jersey, Pennsylvania, Ohio, West Virginia, Georgia, Florida, Mississippi, Texas, Nevada, Oregon and Washington (notice that the AMA considers Ohio to be in a crisis at this time). As this list indicates, the states span the length of the country. Of the remaining states, the AMA lists 30 states that have begun to show the signs of an impending crisis, while just eight states currently exhibit few or none of these problem signs.³ Unfortunately, the situation shows no indication that it will slow or halt any time soon.

The medical liability insurance crisis is caused by a combination of factors. Damage awards follow an ever-increasing rise. Malpractice insurance premiums have increase even as insurers have narrowed the guidelines determining which physicians they will insure, often excluding high-risk specialties. Some insurers have left the market altogether. Among the nation’s malpractice insurers, “PHICO Insurance Co. is in liquidation, Princeton Insurance Co. announced it would leave the Pennsylvania market, and the St. Paul companies pulled out of the medical liability market nationwide.”⁴ Other causes to this problem include the compounding negative effects of litigation practices, insurer competition, the extended medical liability insurance cycle and adverse publicity over medical errors.

Some insurers, speaking candidly, will point to their industry as having helped to create the current situation by establishing an artificial impression

among the public that a trip to the doctor costs only ten dollars. By insulating the public to the true cost of health care for so many years, insurers now face a backlash over what the public sees as excessive rate increases. Intense competition in the insurance market in the 1990s also contributed to the difficulty. Many insurers underpriced their rates as they expanded into new markets. Combined with low interest rates, which resulted in a lower return on investments that insurers make to cover claims, these factors caused a cash reserve dilemma for insurers that could be corrected only by increasing premium rates for physicians.

And yet, insurers are not alone when examining responsibility for the current situation. Physicians must also accept their share of the burden for the crisis. The 1999 Institute of Medicine report on medical errors, "To Err is Human," established that as many as 98,000 deaths may occur each year as a result of preventable medical mistakes. The bulk of these errors were revealed to be medication errors directly related to prescribing practices and procedures. Even though this report points predominantly to "systems" errors rather than individual physician error as the cause for these adverse events, the negative publicity surrounding the report has been cited by many to be the touchstone that has ignited the current firestorm of excessive jury awards.

Finally, lengthy litigation processes and excessive legal fees pose formidable barriers to the swift and just resolution to many medical liability cases. In 1999, it took roughly 45 months to resolve a claim. This extended timeline directly benefits lawyers; more time spent working on a case means more billable hours. The most troubling aspects of the legal process is that only 30 or 40 cents out of every premium dollar actually finds its way to an injured patient. The rest of that dollar goes to support the plaintiff's lawyers, defense lawyers, experts' fees and other litigation expenses.

Recent research findings of trends in the medical liability arena suggest that the frequency of lawsuits is holding steady. However, the findings reveal that the severity of jury awards has been on the rise over the past decade. According to Jury Verdict Research, the median medical malpractice award—the middle value when awards are listed in ascending order—

rose steadily from \$503,000 in 1996 to more than \$1,000,000 in 2000. From 1999 to 2000 alone, malpractice awards were up 43 percent.⁵

Resolving the Crisis

In a situation as complex and confusing as the current medical liability crisis, one cannot merely point a finger at the nearest physician, lawyer, insurance agent, or the groups they represent, and assign blame. Each of these groups bears some degree of responsibility.

Physicians and insurers, however, point to the unprecedented growth of jury awards in recent years, particularly the growth

Torts are civil wrongs recognized by law as grounds for a lawsuit.

in non-economic damage award—such as pain and suffering and mental anguish—as the driving force behind much of the current situation. These punitive damages routinely top \$500,000 and are the basis for many requests for legislative reform of the legal process.

The Association of Trial Lawyers of America (ATLA) argues that legal reforms would arbitrarily cap damages for non-economic loss in medical negligence cases and create hurdles to bringing claims. The ATLA points out that "[m]edical malpractice premiums amount to less than 1 percent of national health care costs, according to the U.S. Congressional Budget Office. Eliminating medical liability altogether would thus do little to contain health care costs."⁶ The Ohio Academy of Trial Lawyers echoes these points and maintains that no clear relationship exists between tort reform and malpractice premiums.

The Doctors Company (TDC), the first national physician-owned malpractice insurer, disputes the trial lawyers' dismissal of the relationship between tort reform and malpractice premiums. TDC holds up California's Medical Injury Compensation Reform Act (MICRA) as the current national standard for effective tort reform. TDC reports that MICRA-like reforms significantly reduce professional liability insurance premiums—which can translate to lower patient fees, decreased medical costs, and a reduced need for defensive medicine.

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At the American Medical Association's Annual Meeting in June, physicians agreed to make medical liability reform the AMA's highest legislative priority. The AMA plans to launch a public education campaign geared to help the public understand how this crisis affects access to care, as well as a state-by-state analysis of litigation costs under the current tort system. In addition to its vow to inform the public, the AMA is calling for legislation at the state and federal levels.

Tim Maglione of the OSMA feels that legislative remedies at the state level would result in a patchwork quilt of 50 different liability reform laws that could vary greatly from state to state. For that reason, he believes that reform at the federal level would provide a common standard malpractice and medical liability precedent and lend greater consistency to the liability insurance market.

Several bills have been offered in the 107th Congress to deal with the problem of medical liability reform. The Help Efficient, Accessible, Low Cost,

Timely Health Care (HEALTH) Act of 2002 (H.R. 4600) offered by Rep. James C. Greenwood (R-PA) on April 25, 2002, appears to be moving quickly through the House and is expected to reach the floor for a vote before the end of the year. The American Osteopathic Association strongly supports H.R. 4600, and asserts that passage of the bill will increase access to medical services, eliminate the practice of defensive medicine, improve the patient-physician relationship, improve patient safety, and slow the wasteful use of health care dollars.

As the "Malpractice Express" rushes headlong toward potentially catastrophic derailments in the nation's rural communities, brakemen do appear to be scrambling to check its speed and avert disaster. As communities struggle to overcome physician flight and reduced medical services, this train may yet be diverted to a safe siding that will revive rural medical practices.

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Moonshine, Buckeyes, & Dirty Socks

By Tina Rae Collins, Brushy Fork Staff

Folk medicine. Moonshine. Superstition. Faith healing. Sometimes we become confused when we discuss traditional medicine. While most people who use herbs feel that God placed them on the earth for our healing, we must differentiate between herbal concoctions and faith healing, and especially superstition.

We all have our own stories that have been handed down by our parents and grandparents. Some of them seem fanciful and almost magical. Have you ever slept with a dirty sock tied around your neck to cure a cold, or carried a buckeye in your pocket to ease rheumatism pain? Did your mother ever press an iron key to the back of your neck to cure a nosebleed?

When my younger sister was about four years old she had chronic nosebleeds. My mother finally took her to a local faith healer so the woman could “try” on her. We’ve all seen preachers on TV who claim to heal those who come to them believing.

Even medical doctors acknowledge the health benefits of faith and prayer. And we might try not to step on any cracks for fear of breaking our mother’s back—just in case. But in this article I want to focus on herbs, roots, fruits, and other plants that we have traditionally used to try to cure diseases, ease pain, and rid us of unsightly warts and other unwanted blemishes.

Most people, including the older and old-fashioned among us, have a practical attitude with regard to medicine and good health practices. We might use herbs in hopes of curing a cough or to make our nails or hair grow longer and shinier, but when we have major life-threatening illnesses we seek the advice of a doctor. However, herbs still play a significant role in our lives and herb gatherers in Tennessee and Kentucky augment their income substantially by gathering and selling them.

In earlier days when it was more difficult for people to travel and get to a doctor their only solution was to go out into the hills and collect herbs. I can remember my father’s hunting yellowroot to make a tea for my mother when she was stricken with

asthma. Even today plants are a part of many medicines we buy at the pharmacy. For example, cough syrup contains cherry bark.

We sometimes treat coughs and colds with tea made of sassafras, horehound, pennyroyal, and catnip. We boil the leaves and twigs of red cedar and inhale the vapor for bronchitis. Tea made from black willow leaves and bark brings down fever. (We use willow to make salicylic acid—*aspirin*—so you can see the wisdom in this.) Old folks know that the pitch from the white pine heals wounds and sores. Cooked pine needles help ease the pain of a toothache. When I was a little girl and had an earache my father blew tobacco smoke into my ear. *Rhododendron* oil is good for rheumatism.

According to Peggy S. Fisher, a home health care nurse in Glasgow, West Virginia, the following are a variety of cures that she has collected from her patients: Tea made from hot water and corn silk will cure bed wetting in children. To prevent boils eat sorghum molasses, raisins, and onions. Tea made from sumac leaves can cure asthma and hay fever.

Most of us at one time or another have drunk cranberry juice for a healthy urinary tract. Dong quai root is popular as a “female tonic.” And who hasn’t at least thought of buying St. John’s wort for its antidepressant effects? We have long known of the host of benefits of garlic: it is antibacterial, antifungal, and antiviral, and it lowers blood pressure and lowers cholesterol and fat in the bloodstream. We use ginger for nausea and motion sickness and parsley or peppermint to make our breath sweet after we eat. My sister, Deane Dickey, makes a tea of anise seed and fennel. She says it has cleared up her sinuses and she hasn’t had a cold in four years.

Ginkgo biloba is very popular because it increases circulation and is an antioxidant. We use it for a variety of conditions associated with aging,



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Paint Lick Family Clinic

Providing Primary Care for All

by Donna Morgan, Brushy Fork staff

Health care in the United States, in both rural and urban areas, faces a growing tension today—the tension between economics and the right of all people to access quality medical services. Authors of a report from the Kentucky Long Term Policy Research Center recognize this imbalance: “While the possibilities for medical science appear virtually unlimited, our fundamental ability to provide health care to all who need it clearly is not. Access to the medical abundance of our entrepreneurial culture remains linked to economic status. Indeed, a growing number of Americans do not have access to primary and preventive health care because they cannot afford it.”¹

As health care providers attempt to mesh their clients’ medical needs, insurance company mandates, and governmental regulations, some patients fall through the cracks. Answers to the questions about

how to create a system that can serve the needs of all people is a source of great debate and these answers seem a long way down the road. In the small community of Paint Lick, Kentucky, a local effort is taking one approach to resolve the tension between patients’ needs and the existing health care system.

The Paint Lick Family Clinic was started two years ago by a small group of people who undertook the mission to provide high quality family health care that is affordable to anyone, including people who can’t pay. Dr. John Belanger, a family practitioner, provides care for the thousands of patients who visit the clinic each year.

Dr. Belanger sees a variety of patients—people from within the tiny community of Paint Lick, as well as people who travel many miles to the clinic, including farmers, migrant workers, retail employees and construction workers. The problems that these

The likelihood of an adult U.S. citizen having health insurance is directly related to:

employment status: self-employed, unemployed, or part-time workers are much less likely to be insured;

employer size: employers with fewer than 25 employees are less likely to sponsor group plans;

industry: agriculture, food service, hospitality, and other service industries are less likely to offer insurance;

age and gender: young males are more likely to be uninsured;

income: even among wage earners, there is a direct relationship between hourly pay rate and the probability of having health insurance.

From *What Next for Kentucky Health Care?* (see information in reference section of this article).

patients face are really no different from the problems faced by people in more urban areas, noted Dr. Belanger. Most of his patients are employed but more than half have no health insurance, which is an increasing trend nationwide.

Basically these clients need an affordable place to go for health care. As with many Americans who are living paycheck to paycheck, they need a place that is forgiving if they have no cash on hand. "Illness is not a planned event," stated Dr. Belanger. "If patients are sick and unable to pay, this clinic sees them and requests that they pay when they are able. So far people have been paying."

The clinic also admits patients without an appointment. Being able to get to a doctor quickly so that a person misses less work time can help alleviate some of the issues that might otherwise keep patients from seeking care. In particular, workers who don't receive sick leave pay or who need an excuse from work for their illness benefit from this policy.

Dr. Belanger also commented on another group the clinic serves—those that do have health insurance. "We sometimes see people who are in the unusual position of having health insurance but being unable to make the co-payment required by their insurance plan." For example, he explained, a patient with diabetes and high blood pressure might need regular visits to the doctor and require daily medication. The co-pay amounts can quickly add up. At times Dr. Belanger has seen patients that have been off their medications from six months to a year because they were unable to make their co-payments. Because this person has health insurance, federal and state programs cannot offer assistance.

Paint Lick Family Clinic does not accept insurance; therefore, they are in a unique position to help patients who can't make co-payments up front. Dr. Belanger explained that generally insurance company contracts with health care providers mandate that the doctors collect the co-payment at the time of service.

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The Uninsured: Key Facts

According to the Census Bureau, 38.7 million Americans lacked health insurance for all of 2000.

There were 8.45 million uninsured children (under 19 years old) in 2000—11.7 percent of all children.

The most important reason for not having health insurance, according to a national survey in 2000, was: too expensive (47 percent); job didn't offer coverage (15 percent); being in between jobs or unemployed (15 percent); unable to get coverage or refused (5 percent); and didn't think coverage was needed (3 percent).

More than eight out of ten of those who lack insurance are in working families.

Of the nonelderly uninsured in 1998, 36 percent lived on incomes below 100 percent of the federal poverty level; 31 percent lived between 100-199 percent of poverty; 19 percent lived between 200-299 percent of poverty; and 9 percent lived above 300 percent of poverty.

Consequences of Uninsurance

The uninsured are more likely to experience avoidable hospitalizations, and more likely to die during hospitalizations, than those with health coverage.

Uninsured adults were three times as likely as insured adults to have gone without a needed doctor visit, not filled a prescription, or not followed up on a recommended medical test or treatment in the past year because of an inability to pay (49 percent vs. 18 percent).

The uninsured—when they do receive needed care—are often charged more than the insured because major insurers, private and public, negotiate discounts with providers who often compensate by raising the prices to uninsured individuals.

From the web site of the Alliance for Health Reform; www.allhealth.org.

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Instead of collecting from insurance claims, the clinic charges a flat fee for all clients—\$25 for a new patient and then \$20 per visit for ongoing care.

Not processing insurance forms also reduces overhead costs. The office serves approximately 4500 patients per year, with a staff that consists of one full-time doctor, two full-time office managers and one full-time volunteer. Dr. Belanger stressed the importance of providing his services full-time: “When people come to the clinic, they know I am going to be their doctor. Continuity of care is a priority for me because it is easier to treat people you know.” The clinic staff strive to make their clients feel comfortable. “We cater to all patients and have avoided the stigma of being a ‘poor clinic’ that serves only the unfortunate.”

In fact, Paint Lick Family Clinic does not have an income requirement for patients. Dr. Belanger pointed out that discussing income levels can be embarrassing for patients and consumes valuable personnel time. Patients make their own decisions about how much they can pay at the time of service and how quickly they can pay any charged services. The clinic does not impose a collection process on patients. “Medical costs are one of the big reasons people go bankrupt,” explained Dr. Belanger. “Our charter states that we will never ruin someone’s credit over their inability to pay.”

The clinic can also provide assistance to patients who are unable to pay for lab services, x-rays or medications. Through a contractual agreement with a nearby MRI facility, the clinic covers x-ray costs for its patients, then has the patients pay them back as they can. The agreement also allows for these services to be billed at a fraction of the normal cost. “We have separate special funds to meet x-ray needs so we

don’t interfere with our operating budget,” noted Dr. Belanger. The clinic also fills patients’ prescriptions using generic drugs and helps with any lab work that is needed.

So what has made Paint Lick Clinic’s system work so well for the past two years? One way they have saved money is lack of debt. When building the clinic in Paint Lick, volunteers completely renovated an old garage into office space, from pouring a concrete floor to constructing walls between exam rooms. Careful budgeting is also crucial. Dr. Belanger pointed out that most of the furniture and equipment in the office were purchased used but in good condition. To make the system work, the staff and doctor accept salaries far below the national average.

Clinic staff also rely on the local community to support their work. “We know we can’t do it all,” commented Dr. Belanger. “Paint Lick and the surrounding area have a strong sense of community. We got tons of support from a network of people who were just pleased that we wouldn’t turn away any patients.” Besides constructing the building, these people have helped with fundraising and other projects.

Flexibility is also key to making Paint Lick Family Clinic successful. “Being small makes this work,” observed Dr. Belanger. The clinic’s size facilitates communication between the staff and the patients and allows for creativity in addressing problems.

Clinics like the one in Paint Lick are attempting to address a huge problem. Dr. Belanger sees his work as a Band-Aid on a system that is not working. “The need is huge or people wouldn’t be coming as quickly as they are. Our work is so rewarding. Our patients are so appreciative and make every day great.”

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View the full report online at www.kltprc.net/Links.htm#Book19.

Is Your Doctor a DO?

By Jeffery D. Cobb, Public Relations Office
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Mrs. Jones glanced nervously around the room. She wasn't exactly a fan of her yearly physical, and the fact that this was her first time to see Dr. Smith only made matters worse. His office looked like any other she'd been in, but the co-workers who had recommended him described Dr. Smith as "unique."

He wasn't impersonal or distant like so many of the other doctors they'd been to. They said he was a warm, compassionate person—a doctor who would spend time with you, get to know you, and even remember your kids' names. An honest-to-goodness family doctor! That was reassuring, she thought, especially in these days of big HMOs and faceless, shuttle-service health care.

The doctor came in. Little did Mrs. Jones know, but this highly recommended, popular physician was not an MD. But he *was* a doctor—a doctor of osteopathy.

The previous situation is fictional, but the scene is probably played out every day. Many people cannot distinguish between allopathic physicians (MDs) and osteopathic physicians (DOs). Unless you know what to look for, it is very difficult for the average patient to notice the difference.

The two professions are very similar. Both prescribe medicine and diagnose disease and illness. Osteopathic physicians perform surgery, deliver children, treat patients, and write prescriptions in hospitals and private offices across the country just like MDs. Many armed services physicians are DOs. Both DOs and MDs must complete four years of basic medical education and pass comparable state licensing examinations before they are eligible to practice.

However, despite the similarity to MDs, osteopathic physicians form a separate branch of medical care. They are complete doctors with a philosophy that emphasizes preventative medicine. They routinely inform patients about the need for

proper nutrition, exercise, and healthy lifestyle choices that help prevent sickness and disease from occurring in the first place.

DOs are also specially trained to use osteopathic manipulative treatment (OMT), a technique in which the hands are used to diagnose illness and treat patients, giving particular attention to joints, bones, muscles, and nerves. The result of this manipulation is improved circulation, which creates a normal nerve and blood supply, thus enabling the body to heal itself.

From day one, osteopathic medical students are taught osteopathic principles and different manipulative techniques. It is part of the curriculum at all osteopathic medical colleges, along with Anatomy, Biochemistry, and the other basic sciences. "With OMT, osteopathic physicians are adding another tool to their arsenal," says Howard Hunt, DO, Associate Dean of Clinical Sciences at the West Virginia School of Osteopathic Medicine (WVSOM). "OMT brings an added dimension to healthcare and provides another treatment modality for osteopathic physicians to employ. DOs use it to diagnose, treat, and even prevent illness or injury," notes Dr. Hunt.

Once a DO has ruled out mechanical causes for your illness or injury, he may decide to utilize OMT. While it is commonly used to treat physical ailments such as low back pain, this non-invasive treatment can also relieve a number of disorders, including asthma, sinus disorder, carpal tunnel, migraines and even menstrual pain. OMT can relieve muscle pain associated with a disease and can hasten recovery from illness by promoting blood flow through tissues. When appropriate, it can even be used in conjunction with, or in place of, medication or surgery.

According to the American Osteopathic Association (AOA), osteopathic medicine was developed in 1874 by Dr. Andrew Taylor Still. Dr.

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Still was dissatisfied with the effectiveness of 19th Century medicine. He believed that many of the medications of his day were useless or even harmful. He was also discouraged and frustrated that orthodox medicine had been unable to save three of his own family members from dying of spinal meningitis in 1864.

Dr. Still was one of the first to study the attributes of good health so that he could better understand the process of disease. Based on his investigation, Dr. Still founded a philosophy of medicine based on ideas that date back to Hippocrates, the father of medicine. The philosophy focuses on the unity of all body parts. He identified the musculoskeletal system as a key element of health. He recognized the body's ability to heal itself and stressed preventive medicine, eating properly and keeping fit.

In his book *The DOs*, author Norman Gevitz writes that Still embraced the idea of man as a "divinely ordained machine" whose health depended on the unobstructed flow of fluid. "I proclaim that a disturbed artery marks the beginning to an hour and minute when disease begins to sow its seeds of destruction in the human body," Still wrote in his autobiography. The idea of a human machine whose parts worked together harmoniously with various bodily fluids serving as oil would become the foundation of osteopathy.

Dr. Still also pioneered the concept of "wellness." In conjunction with appropriate medical treatment, the osteopathic physician acts as a teacher to help patients take more responsibility for their own well-being and change unhealthy patterns such as smoking, high blood pressure, excessive cholesterol levels, and stress.

According to AOA statistics, more than half of all osteopathic physicians practice in primary care areas such as pediatrics, family practice, obstetrics/gynecology and internal medicine. In addition, many osteopaths practice medicine in small towns, communities, and cities that would be classified as "rural" or

"underserved"; that is, suffering from a lack of medical professionals. There are three osteopathic colleges located in the Appalachian region that help to alleviate this shortage: the Ohio University College of Osteopathic Medicine in Athens, OH; the Pikeville College of Osteopathic Medicine in Pikeville, Kentucky; and WVSOM in Lewisburg, WV. A fourth—the Edward Via Virginia College of Osteopathic Medicine—is set to open in the fall of 2003 on the campus of Virginia Tech University in Blacksburg, VA. When it opens, there will be 20 osteopathic colleges in the United States.

At WVSOM, the admission policy reflects the osteopathic philosophy. While statistics and test scores—such as GPAs, course work, and MCAT scores—are significant factors in a student's application packet, admissions officials at WVSOM also look at factors such as volunteerism, missionary work, and other non-academic experiences. Non-traditional students often have life experiences and maturity that come out in an interview and can persuade the interview committee.

The basic tenant of osteopathic medicine is that people are more than just the sum of their body parts. DOs are taught to practice a "whole person" approach to medicine. Instead of just treating specific symptoms or illnesses, they assess the overall health of their patients. DOs also learn that the body's systems are interconnected and each one affects the others. They focus special attention on the musculoskeletal system—the system of bones and muscles that make up about two-thirds of the body's mass. DOs use

continued on next page

Addressing Appalachia's Physician Shortage

Schools of osteopathic medicine are helping address the physician shortage in rural areas. Of the 19 osteopathic colleges in the US, three are in the Appalachian region: The Ohio University College of Osteopathic Medicine in Athens, OH; The Pikeville College of Osteopathic Medicine in Pikeville, KY; and West Virginia School of Osteopathic Medicine in Lewisburg, WV.

A fourth—the Edward Via Virginia College of Osteopathic Medicine—is set to open in the fall of 2003 on the campus of Virginia Tech University in Blacksburg, Virginia, and will bring the national number of these schools to 20.

Moonshine, Buckeyes and Dirty Socks continued from page 7

including memory loss. Ginseng is a popular root and we all know people who go “senging” in the spring.

Are these remedies really effective? Obviously they have an effect or people would not continue to use them. Should we depend on them instead of seeking advice from a trained medical practitioner? Of course not. And we must be careful when we do use them. My mother-in-law told me that mullein leaves would help alleviate my asthma symptoms so I boiled some and ate them. I became so ill that I had

to force myself to vomit in order to get relief. I have a feeling I was supposed to make a tea out of the leaves.

Have you been waiting to hear about the healthful benefits of moonshine? According to Mamie and Emily Baldwin of “The Waltons” (based on Earl Hamner’s *Spencer’s Mountain*), their “recipe” could cure *anything*. And I think Granny Clampett would put her brew up against any medical doctor’s prescription. But here is what I have learned about moonshine: If you let the moon shine on your face while you sleep you will go crazy. Happy herbing!

Thanks to the following web sites for information and ideas:

<http://www.wvculture.org/history/wvhs1041.html>;

<http://www.pbs.org/riverofsong/music/e3-moonshining.html>;

<http://www.cbsnews.com/stories/2001/04/17/national/main286179.shtml>.

Is Your Doctor a DO? continued from page 12

their eyes and hands to identify structural problems and assist the body’s natural tendency toward health and self-healing.

Osteopathic physicians also employ their ears as important tools. While the technological advances in modern medicine are awe-inspiring, many complain that medicine has become cold, clinical, and impersonal. DOs are taught to listen to their patients. “I’ve had at least two patients diagnose themselves,” reveals David Essig-Beatty, DO, Associate Professor of Osteopathic Manipulative Medicine and Family Practice at WVSOM.

“They both had joined Web discussion groups and communicated with others who shared the same diseases. This helped them take control of their health problems, which fits right in with the osteopathic philosophy,” says Dr. Essig-Beatty. Had

he not listened to his patients and been open and receptive to what they had to say, Dr. Essig-Beatty says he would have likely missed his patients’ contribution.

By taking the whole person approach to healthcare, DOs look for the underlying causes of disease instead of simply treating the symptoms. Not only do they consider your physical condition, but they also take into account other factors, such as home, work and family life, when making a diagnosis.

It takes more than just a strong knowledge of the sciences to make a good doctor. It takes compassion, a caring soul, and a commitment to help people. Osteopathic physicians learn to care for patients, not simply treat diseases.

Fall issue will explore prisons in Appalachia

Some Appalachian communities have opted to build prisons as a stimulus for economic development. What are the pros and cons of this strategy? What are some of the issues that stem from contemporary prisons? If you have a story or an idea, contact us using the information on page 2. Deadline for the fall issue is October 15, 2002.

Holding a Silent Auction

Silent auctions serve as an effective fundraising tool for community groups. The Brushy Fork team from Floyd County, Kentucky, organized a silent auction to help raise money for their computer gift project. The Technology Gift Incentive Foundation Team (TGIFT) donates a computer annually to a deserving student from Floyd County. Below are some planning steps and issues team members considered as they organized their silent auction.

Before the auction

1. Schedule your silent auction in conjunction with another event that will bring in a good-sized crowd of people. For example, the TGIFT team held their silent auction during a dinner at which they awarded their first computer.
2. Gather items for the auction from team members, local businesses and other people who support your work. Items at the TGIFT auction included gift certificates, autographed books, art prints, crafted items such as quilts and needlework, tea sets, food baskets, and curios. You can combine several small items into a basket to help raise the bidding price. Log items as you receive them so you will have an inventory of donations.
3. Create a bid sheet for each item. The bid sheet should provide a space for bidders to record their bidding number and amount of bid, recognize who donated the item for the auction and provide any pertinent information about the item. (See sample bid sheet at right.)

BID SHEET	
Item: Quilted Wall Hanging (hand-made by a local artisan)	
Donated by: David Crafts	
Opening Bid: \$50.00	
Bid number	Bid amount
1.	\$50.00
2.	_____
3.	_____
4.	_____
5.	_____
6.	_____
7.	_____
8.	_____
9.	_____

^ Create a bid sheet for each auction item.

Silent Auction Sign-In Sheet	
Name: _____	1
Telephone: _____	
Address: _____	
Name: _____	2
Telephone: _____	
Address: _____	
Name: _____	3
Telephone: _____	
Address: _____	
Name: _____	4
Telephone: _____	
Address: _____	

During the auction

1. Create a sign-in sheet for bidders on which they can record their name, address and telephone number. This sheet should be numbered so that each bidder receives a bidding number, which they place on the bid sheet for items they wish to buy. This sheet also provides contact information for any winning bidders not present when the auction closes.
2. Once a bidder has signed in, he/she uses the assigned bidder number to bid on items of interest. This simplified bidding process keeps bids anonymous until the auction is over.

^ Have bidders sign in and receive a bid number.

Closing the auction

1. Closing the auction takes some time so the TGIFT group closed their auction just after dinner and before the keynote speaker began his address. Attendees at the dinner were able to take a quick break and make last-minute bids before the speech began. During the speech three TGIFT members processed the auction bids.
2. When the silent auction closes, two or three people can use the bid sheets to determine who receives each item and how much each person owes. TGIFT used two people—one called off the winning bidder and amount from each bid sheet and the other recorded the information on a totals sheet. A third person grouped auction items by winning bidder and labeled the grouped items with the winning bidder's number.
3. Each winning bidder's name was then matched to that person's bid number. The items won and the amounts owed were recorded on a 3X5 index card and used as a receipt when the person checked out of the silent auction.

WINNER AND BID AMOUNT PER ITEM		
Item number	Bidder number	Amount
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____

^ Transfer items won and amount owed for each bidder from this sheet onto 3 X 5 cards so bidders can check out.

Miscellaneous considerations

Get permission to hold a silent auction if you are using a public area or someone else's property. Make sure the property owner does not have any policies against using the space for fundraising activities.

Gathering items to auction can take a lot of time and energy. The group holding the auction should plan a work session a few days before the auction to inventory auction items, log them in and determine starting bids.

Someone in the group should be responsible for writing thank you letters to individuals, businesses and organizations that donated items for the auction.

Gift certificates can be easy to lose at an auction. If your auction items include gift certificates, keep them in labeled envelopes in a box during the auction. Just put out the bidding sheet with pertinent information and pull the gift certificates for the winning bidders at check out time.

Bidder # 7: Alice Crowe		
Item 5	lamp	\$25.00
Item 11	photo	5.00
Item 16	t-shirt	4.00
Item 27	quilt	75.00
Total owed		109.00

^ Use the 3 X 5 card as a receipt for bidders.

Happy auctioning!

Special thanks to Brushy Fork Associate Delora Kraus from TGIFT in Floyd County, Kentucky, for providing information for this toolbox.

Brushy Fork Receives Grants and Donations

Over the past several weeks, Brushy Fork has received funding from the Claude Worthington Benedum Foundation and from the Wayne and Ida Bowman Foundation.

The \$45,000 grant from the Benedum Foundation will support Brushy Fork's work in West Virginia, including the participation of two county teams in the Leadership Development Program.

The Bowman Foundation awarded the organization \$10,000 to be used for program activities.

The Institute would also like to recognize the following donors to the annual campaign:

John Cleveland
Deborah Garrett
David and Delora Kraus
Phillip Obermiller

Thank you!

Would you like to support the work of Brushy Fork Institute? A donation of \$15.00 will cover one subscription to *Mountain Promise*. You may download a donation form on the web at www.berea.edu/brushyfork/support.html, or send a note and a check to the address below.

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