

PATIENT EDUCATION IN THE RURAL COMMUNITY HEALTH CENTER

Cheryl L. Branche, MD
Belzoni, Mississippi

One of the most difficult aspects of the practice of rural medicine is patient education. It is one of the most frustrating aspects of patient care in my practice in the Delta. Many factors enter into this. Patient education requires patience, good communication skills, time, and resources. It also requires patients who are willing to make the care of their health a priority.

Patients cry out for information and, as a physician, I am reticent to have a patient leave the office without having taken time to address his or her need and desire for information about his or her disease process. Many patients have never had a caregiver discuss hypertension or diabetes with them. Some say that they have not had the opportunity to ask questions of their physicians about their health problems. Some are simply too intimidated by the health delivery system to ask a doctor to understand their need to know.

Patient education is time consuming and costly. Patients seem to prefer patient education during their regular visits, as opposed to scheduling appointments specifically for education. Most patient education visits require at least 20 minutes and commonly extend to 45 minutes. The length of the visit can be increased. Despite the general attitude that the community health center is a place where poor people can obtain free medical care, the response to patient education programs has been well-received. Community health centers, which are funded by government monies, are required to have a minimum number of appointments per year, which on a daily basis amounts to approximately one patient every 15 minutes. Imagine trying to

discuss diabetes and the role of diet with the angry and denying patient in 15 minutes (which is often the case). Thus, the provider is faced with the need to accommodate the government program protocol, which, in addition, recommends diet assessments, and, at the same time, accommodate the appointment requirements. It is very frustrating and a source of great consternation for both the provider and patient. Because the patient does not always benefit from cramming education into his or her regular visit and often will not keep a separate education visit, the provider cannot bill for the time spent on patient education and therefore revenues fall.

Moreover, in our population much of the teaching must include resource information. Patients are provided with information about national groups, such as the American Diabetic Association and the American Heart Association. We share information about support groups for the bereft, families coping with Alzheimer's disease, and many others. Transportation is a common problem, thus transportation services provided by the health and welfare departments are often discussed.

Elderly patients receive particular care since improved quality of life is a major goal for this age group. Issues surrounding incontinence, falls, trauma, meal preparation, heat, water, hygiene, and possible abuse are regularly discussed during the patient visit. These are psychosocial problems that could be handled better by a social worker. . . if we had a social worker. At our community health center, the provider and the nursing staff serve as social workers.

Teaching, too, must include an emphasis on the need for prevention of certain diseases and the techniques used such as mammography, ophthalmologic examinations, and podiatry examinations for the diabetic.

From the Humphreys County Memorial Hospital, Belzoni, Mississippi. Requests for reprints should be addressed to Dr Cheryl L. Branche, 116 N Hayden St, Belzoni, MS 39038.

Government protocols require attention to these details, which must be documented. Patients understand all too well the NEED for prevention; few can afford these often costly procedures. All too often, I must tell a patient that she is due for a mammogram or that she must have her eyes examined only to learn that she has no money, to which I supportively add that this is very important and that I can refer her as soon as money becomes available. That patients cannot afford health care, let alone preventive health procedures, is tragic. More and more often, a staff person reading the chart will find the statement written next to the "plan," "patient cannot afford." The chances are often slim that a patient will return to be scheduled for a procedure that was postponed for lack of funds.

One of the greatest pleasures I have known in medicine is to hear a patient tell me, "You have helped me" or "You know, no one has ever told me about diabetes before." The pleasure that the patient feels must be many times greater than what I feel. Patient education helps. It reassures the patient; it increases his or her esteem, and it improves patient compliance. It encourages the patient to participate in his or her own health care, helping the patient to help himself.

Patient education is a difficult aspect of patient care in our rural community health center. The factors are multiple. They range from the desperate need our patients have for education to the dramatic costs in time and money and from the overwhelming volume of information to which the term, "patient education," ultimately refers to the limited resources with which our patients must manage their health. While difficult, patient education still remains the most effective tool we have for helping patients to improve their health.

Total health care and patient education is a new approach to health in our community. Patient education is one of the strongest tools we have in our armamentarium for controlling disease. Patient education is one of the most needed resources in the Delta, where poverty, unemployment, undereducation, and illiteracy are rampant.

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