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Editorial

Locum Tenens

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Locum tenens, literally "holding a place," is, in medical parlance, one who substitutes for a professional in an established practice on a temporary basis, fulfilling the accustomed duties and obligations. I spent 2 weeks in the dead of winter 1959 as *locum tenens* for Dr P, a 70+ year-old general practitioner in a coal mining area of Appalachia.

My motivation was strictly economic. I was in my 5th year since graduating from medical school and had been chosen as the next year's chief resident on the most prestigious service at Washington University in St. Louis, an important step in a career in academic medicine, but one obligating me to an additional 2 years of training. I had returned from a 2-year stint in the U.S. Army Medical Corps with the unpleasant news that I did not qualify for the GI Bill, having missed the cutoff for eligibility by 4 months. Prestigious though the position might be, Wash U provided its residents $50 a month, plus room, board, and laundry. Because I had a wife and 3 children, the room and board were of value only for the on-call nights (1 of each 3). I had savings from military service, but opportunities to supplement the meager pay were limited and strictly monitored by the training program. I performed physical examinations on incoming students for the student health service, did examinations on evenings off for an insurance agency, and, most important, remained active in the Army Reserve. Pay as a "weekend warrior" plus the mandatory 2-week summer camp exceeded the pay for my regular 100 hour/week job. At age 30, I was long past parental subsidies. Dr P was offering $50 daily for the 15 days I would cover his practice, a sum that would greatly ease the fiscal challenge of the succeeding 2 years.[1]

Dr P was to meet me at the Bluefield, WV, airport and spend a few hours indoctrinating me to the practice, but a winter storm was threatening to move in, and he and his hunting buddies decided to leave for their annual quail hunt, poker, and Jack Daniels jaunt to Florida ahead of the storm. I arrived late because of a missed flight related to the storm, and Mrs P and one of her friends greeted me and drove me the 20 miles to the small town in which the family occupied a large hilltop mansion constructed by a mine owner. The Ps had acquired it when the local mine was sold to a large Pennsylvania coal mining company and all the local management had been laid off or moved to Pittsburgh. She joked that Dr P had the uncanny ability to schedule his hunting trip a year in advance to coincide with the worst 2 weeks' weather of the year. She showed me my bedroom, gave me the keys to the Jeep, and informed me that coffee would be available at the office when it opened at 8 am. I was to see her only a couple more times during my 2-week stay in her home.

The next morning brought a lesson in topography. I had arrived after dark and was only vaguely aware of hills and snow. The P house stood in solitary splendor atop a hill some 3 acres in area, accessible by a drive that wound a dizzying spiral from the base up to the house. The town, Thornton, WV [a fictitious name], had been the bedroom community for the mine executives, while its sister town 10 miles away, Powhatan, VA, was the site of the mine headquarters, the access point for the major mine entries, and the station for the Norfolk and Western Railroad, vital for importing machinery and exporting the area's sole product, bituminous coal. The land was vertical in layout, consisting of steep hills, steeper hills, small mountains, and the valleys and hollows between. The 2-lane state highway linking the towns followed the state line generally, but at a constant elevation, so that a clockwise swing around a hill brought a sign "Entering Virginia" and the counterclockwise swing around the next greeted one with "Entering West Virginia." This occurred 8 or 10 times on the 10-mile drive. Powhatan, VA, boasted a drug store, a restaurant open only for breakfast and lunch, some mine offices (largely quiescent), the railroad station, and Dr P's office building. Across the railroad tracks were the mine entrance and 2 huge mounds of slag—the tailings of the mine—each as tall as a 4- or 5-story building, grayish black in color with patches of dirty snow and small straggling volunteer shrubs and trees

[1] To put things in perspective, $50 in 1959 had the purchasing power of $374 in 2010 dollars. First-class postage had just risen from 3 cents to 4 cents. A bottled Coca-Cola, for years a 5-cent purchase, was 8 cents at the supermarket and 10 cents from a vending machine. The least expensive Chevrolet or Ford cost a bit under $2,000, and the newly introduced Volkswagen Beetle, about $200 less.

courtesy of passing birds whose droppings brought a variety of plant seeds.

The office was a modern, spacious 1-story dwelling, housing a roomy waiting room, 4 examination rooms, a larger procedure room, a private office, a combination kitchenette/laboratory, personnel work space, ample storage space, and 3 bathrooms. Office hours were 8 am to 8 pm Monday through Saturday and 8 am to 2 pm on Sunday, when Dr and Mrs P had dinner at the country club in Bluefield. There were no appointments. The fee schedule was simple: $2 for an office visit, $5 for a house call, and $3 for each injection. Health insurance in the 1950s, for those who had it, covered only hospital charges for inpatients, plus professional charges for surgery and deliveries. Cash payment was expected at the time of service, and those unable to pay were permitted to run a tab. The mines had a company doctor, and those still employed could visit him without incurring a charge. I gathered from the comments of patients and the office staff that this physician was often unavailable, seemed uninterested in patients' problems, and did not communicate well. There were hints of difficulties with alcohol or worse substances.

The 2 office assistants had been trained by Dr P to meet the specific needs of his practice. Each worked an 8- or 9-hour shift daily with frequent cross coverage to meet family obligations. Jeannie was in her mid-20s, Ora in her early 30s. They could perform simple laboratory studies, take electrocardiograms, and assist with suturing, splinting, and cast preparation for the relatively minor trauma cases. The x-ray machine was broken, and Dr P had elected not to repair or replace it. They knew every patient in the practice and could recall the diagnosis made, the treatment given, and, most important, the treatment the patient expected. A valuable asset was their knowledge of where everyone lived and how to get there. House calls were an important feature of the practice. I made calls on the road between the house and the office almost daily. A family member would flag down the familiar Jeep to summon my services. I would go out in the middle of the day to other parts of the county accompanied and guided by one of the assistants, while the other kept things going in the office. After we closed the office, I wound up each day by making calls in town and on the return trip to Thornton. Fifty to 60 office visits and 8 to 10 house calls comprised a usual workday.

Dr P had attended one of the hospital medical schools, unaffiliated with any university, that flourished in the 19th century and were still extant in the early 1900s. He entered practice immediately after graduation. He had held a contract to care for employees of the mine at some time in the past and had served as the county coroner, but he had been a solo practitioner in the community for close to 50 years. As did many general practitioners of his era, he designated each symptom as a specific disease, more by pronouncement than by confirmation with diagnostic studies. Thus, musculoskeletal pains became "arthritis," abdominal discomfort was variously "stomach ulcers" or "gallbladder problems," all headaches were "migraine," fatigue was "anemia," and puffy ankles became "kidney disease."

The office assistants told me that Dr P did not trust patients to take prescribed medicines, and indeed his patients were given no medications to swallow that could be injected. Very few prescriptions were written in the practice; there was a vast supply of samples of the latest nostrums provided by pharmaceutical representatives. One could not charge a patient for free samples, but there was no prohibition against giving a 3-day supply and instructing the patient to return in 3 days for another office visit and another 3-day supply. Pills were not the economic engine that injections were.

Respiratory infections and symptoms that might relate to a respiratory infection were treated with injections of one or more antibiotics at 3-day intervals, never mind that more appropriate antibiotics were available for oral use. Skeletal discomforts were universally treated with injections of adrenocorticotropic hormone (ACTH), a practice largely abandoned elsewhere a decade earlier, or of cortisone, by then available in oral form but discouraged for general use. The practice had a flock of insomniac patients with headaches or "stomach ulcers" who showed up just before closing time for a bedtime dose of injectable narcotics and another of the sedative anodyne. One redoubtable alcoholic patient came in every 2 or 3 evenings, when he could afford, for an injection of Demerol and his "toddy." Ora summoned me to witness this ritual. "Watch this!" she said, pouring a tumbler of elixir of phenobarbital (adult dose 1 tsp) for him. Had he been a race horse, he would have slept 2 days and still tested positive a week later. The practice revenues from injections exceeded those from office visits and laboratory studies.

I had inherited the *locum* position from my medical school roommate, who had made 2 trips to the coal mining region in the years before he entered practice, so I knew something of the nature of the practice. I knew better than to attempt to wean established patients from their accustomed regimens. I felt that new patients or old patients with new problems should be treated appropriately with medications and often with no medications, prescribed by the proper route. After all, I was revising and updating *The Washington University Outline of Medical Therapeu-*

tics, which served as the textbook for the medical therapeutics course I would teach to 4th-year medical students when I became chief resident, and I believed my store of information on treatment to be current. This approach sometimes worked but often did not. The community culture was such that if you were sick or felt bad, you went to the doctor's office and got a shot to make you well. Those who did not like becoming a human pincushion tended to go to the other doctor in town or sought care from a specialist in Bluefield. Therapeutic nihilism was not popular with patients in Dr P's practice.

The area was lovely during 3 seasons of the year. In winter, there were only shades of brown, black, gray, and white. The soil was rocky and infertile, and mining was the sole industry, one that was withering. The population was aging because young adults frequently entered military service or moved west to seek employment in Texas or California. Natives maintained ties to the area and often returned when they retired or even after a dozen years or so away. Jobs were scarce, but the cost of living was low. The immediate area had escaped the bitter, often bloody, struggles between miners and mine owners that plagued Pennsylvania, Kentucky, and other West Virginia coalfields in the 1920s and 1930s. During World War II, John L. Lewis, head of the United Mine Workers of America (UMWA), threatened with success to close down the war effort unless the miners received raises, stronger safety measures, and benefits. In the 1950s, the well-funded Miners Memorial Association trust constructed a network of hospitals throughout Pennsylvania, West Virginia, and Kentucky, and one in the soft coal area of southern Illinois. Care was free to eligible miners and their families, and sick and disabled miners were afforded pensions. Changes in technology, conversion to other forms of energy, and consolidation of ownership of the mines brought absentee ownership, closure of mines, and decreasing revenues to the union pension funds by the time I practiced there. The miners' hospital system eventually came under community control, operated by the Presbyterian Church.

There was widespread poverty, and the state welfare system was far from robust. I could look out of the office window and see adults and children high atop the slag heaps with burlap sacks, scavenging for chunks of slate containing enough coal to serve as fuel for heating and cooking. Others sought combustible material along the state highway, where road construction had revealed puny seams of coal on the hillsides. Despite the bleak economy, grateful patients often brought nuts, preserves, and baked goods. I was introduced to pamilla pie. Pamilla turned out to be a local term for a variety of winter squash used in an array of dishes. The squash is bland and slightly sweetish, so it tastes mostly of the other ingredients, in the case of the pie, sugar and nutmeg.

My lasting memories are of the house calls to the residences of patients. Some were sturdy dwellings; others were glorified shacks. One was reminiscent of descriptions of Georgia homes after Sherman's march from Atlanta. It had been a spacious dwelling before it burned to the ground. The only things left standing were a couple of charred columns. A family, not the original owners, was living in the estate's very large chicken house nearby. They had attempted to insulate the lath and wire walls with newspaper and plastic. The dirt floors bore visual and olfactory evidence of the building's previous occupants. Almost every home I visited had the same 3 portraits, often in simple frames but sometimes tacked to a wall: Jesus Christ, Franklin D. Roosevelt, and John L. Lewis. At times, a photograph of the family patriarch laid out in his coffin joined the 3. Ex-miners, crippled with black lung disease, sat tethered to large oxygen tanks next to their reclining chairs, with several tanks in reserve on the porch, courtesy of the UMWA pension fund. Afflicted after 20 years underground, the 40-year-olds appeared to be in their 60s or 70s, an age they would never reach. Patients discharged from one of the miners' hospitals for home care were supplied with equipment to survive, a benefit not provided elsewhere until the introduction of the Medicare program in 1965. I cared for a man in the final stages of amyotrophic lateral sclerosis (Lou Gehrig disease) who had a hospital bed, wheelchair, recliner, and enough pans and equipment to stock a small hospital.

One day, after an overnight snowfall of a foot or more, I was summoned to attend to a young woman late in her second pregnancy. She lived in the next county but was visiting her mother, and they became snowbound. Labor began that morning, and they were unable to secure transportation to the hospital in Bluefield. Jeannie and I located a couple of obstetrical packs, gathered recent newspapers (surprisingly sterile), bundled up, and set out in the Jeep, which was fortunately equipped with snow tires and 4-wheel drive. The county road had not yet been plowed, and we made it onto an unimproved road to the point where Jeannie directed me to turn off the road and drive up the "holler." I drove a few hundred yards, found a level spot to turn around, and then we slogged the last hundred yards, straight uphill it seemed, carrying our equipment. When we arrived, labor had progressed. The patient was fine, and shortly thereafter the baby was crowning. I did not have time to order lots of boiling water or to try to remember how to apply obstetrical forceps (left blade,

left hand, left side of the mother). The infant emerged with minimal guidance, followed by the placenta. He was a mature fellow who screamed spontaneously when Jeannie aspirated amniotic fluid from his mouth and nose. We waited an hour or so, filled out the birth certificate, signing Dr P's name, and left the postpartal and newborn care to the new grandmother. We returned to Ora and an office full of patients. We speculated whether the charge should be $25 or $35, but figured the question to be moot, as it would never be paid. I have not delivered another baby in the 54 years since and do not miss the experience.

During my 2 weeks in the practice, I strove to maintain clear records and impose some discipline in the process by interpreting the basket of electrocardiograms that had piled up in the year since the last *locum*. I determined blood sugar levels on all of the diabetic patients I could locate, regulated their diabetes, and convinced at least a few patients suffering from heart failure to try salt restriction and the newly introduced oral diuretic preparations rather than intermittent injections of mercurial diuretics. I hoped that some of the innovations might last after my departure, and Ora and Jeannie promised to try to see that this happened.

After I had been in Powhatan a few days, I began to see patients who were not regulars in the practice. They had heard that a new, young doctor was in town, and they had unresolved difficulties they were willing to give me a crack at. Some patients' problems were relatively easy; others I clearly couldn't help. One young woman had had progressive difficulties with stiffness, skin problems, and a crippling circulatory disturbance manifested by extreme sensitivity to cold. Although she had seen physicians in the past, none had established the correct diagnosis. She had the full-blown spectrum of scleroderma with its most crippling side effects. A variety of treatments was applicable, none miraculous, but one was critical. Unless she moved to a location with year-round warm weather, she would lose her fingers and toes to gangrene. The important thing was to establish the extent of the disease and degree of organ involvement. I contacted the chief of medicine at the Miners Memorial Hospital in Beckley, WV, who agreed to admit her for full evaluation. After I returned to St. Louis, I received a follow-up report but never learned whether she responded to treatment or relocated to Florida. A couple of days after I saw her, the local dentist, approximately my own age, dropped in to congratulate me. He said that she had been his patient and was scarcely able to open her mouth to permit dental work and that every time he did a procedure, her fingers would turn dead white and icy cold. We discussed the nature of her disease, and he sent a few patients he felt might benefit from my services.

By the end of the second week, the flow of new patients had slacked, although I noted that the office assistants had brought in a number of their own relatives to get my advice about management of their medical problems. Two patients died while I was there: one of those afflicted with black lung disease and the patient with Lou Gehrig disease. Some of the old regulars, especially those who believed that I was too stingy with narcotics and sedatives, failed to show, waiting for Dr P's return and his more liberal dispensing philosophy. Dr P returned from his quail hunt on Saturday, and he and I shared the practice on Sunday while I filled him in on the events of the 2 weeks. A full roster of patients was in the waiting room, and Dr. P roared out what may have served as the slogan for his practice: "Come on girls! Let's inject some folks!"

I did not regret the 2-week spell as *locum*. I missed my family, but we stabilized our financial picture. I believed that I had accomplished a few things, but I doubted that I would have a lasting effect on the quality of medical care in the coal mining community. I developed an appreciation of the rigors of life in the mountains and the perils and vagaries of coal mining. The people were unsophisticated but warm, generous, and devoted to their families and larger community. I found that I had a good deal to learn about the realities of practicing medicine, about dealing with patients who were devoted to their physician, and about dealing with that physician when current medical thought and the patients' welfare called for a different approach. I thought long and hard about whether patients were better served by treatment from an uninformed but energetic, accessible, and caring physician like Dr P or from an equally uninformed but lazy and uninvolved physician like the company doctor. I did not approve of Dr. P's injection polypharmacy, but few were harmed permanently. I decided that his sins of commission were less harmful than the company doctor's unavailability and sins of omission.