

## A Vow of Connectedness: Views from the Road to Beaver's Farm

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*The doctor-patient relationship lies at the heart of family practice. Yet in a digital age, our understanding of this relationship has been trimmed to a transaction between free agents that can be fully measured and isolated in time. The vow of connectedness restores the broader view. We know that lasting change—in attitude and behavior, toward healing and hope—arises from those relationships that encompass the doctor, his or her patients, and our common connections in the communities we serve.*

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We are leaving town on the Marsh Road. In the driver's seat of the Toyota pickup is my friend Michael Simon. Today we are searching for a Mother's Day gift for my wife, Lindsay, but our journey is also a gift between friends.

The road wends west by Dyer's Woodworking Shop and its lawn circus of windmills, wishing wells, weather vanes, lighthouses, and flagpoles. We pass by shacks and trailers, the Marsh Road Group Home, and the homestead of Joseph Miller, our community's founder. A right fork onto Poor's Mill Road draws us to the floor of the Passagassawakeag River Valley.

Here the abandoned triple-decker chicken barns, the unpainted farmhouses, and collapsed machine sheds all whisper the decline of a flourishing farm economy. Six miles from town, we cross the river Passy, then overtake it again on our meander to Morrill Village at the 9-mile mark. This small cluster of buildings boasts the Morrill Baptist Church, the elegant iron gates of Morrill Cemetery overlooking Smith's Millpond, and the Morrill General Store. Left on Berry Road and 2 miles beyond, we finally arrive at Beaver Simmons' farm, a dairy operation on the ridge of Morey Hill that he purchased in 1973.

On this rise, Beaver raised six children, established a small lumber mill, increased his pastures, built two

log cabins, and maintained 60 head of dairy cattle before passing the reins to his sons. My partner, Tim Hughes, once asked Beaver how he, as a city boy from New York City, ever ended up in a milking barn. He replied that it was the scent of the stalls that hooked him, a mixture of manure and silage, limestone, and the breath of cows.

I have known Beaver for a dozen years. He is a member of my parish, a patient in our practice, the host of our son's summer camp excursions, and a grandfather figure for my daughter, who helps with the summer milking. His daughter-in-law once worked in our medical office. Tim, my partner, began rowing with Beaver in a two-man racing shell. One of Beaver's sons married the next-door neighbor (she had been among my children's favorite baby-sitters).

Momentarily we spot Beaver, warm to his boyish smile, and shake his rough-hewn hand, then follow him to the manure pit behind the barn. This concrete basin, 50 feet square by 8 feet deep, was built with federal dollars to curtail fecal runoff into Smith's Millpond Bog lying directly below. The basin is filled from the bottom up by a pump from the barn, so that the most thoroughly composted manure rises and crusts at the surface. I have come to buy some of this worm-wealthy manure because my wife is a gardener, and I know her needs. We skim shovelful of this desiccated "black gold" into feed bags and load them on the pick-up. After hoisting the last bag, Michael fancies to take a shortcut across the manure pile. It trembles ominously beneath his weight, then buckles. But he is in luck: I am

within arm's length away and provide the leverage to wriggle him free.

Before leaving, Beaver invites us to the log cabin he fashioned entirely by hand. We talk of pioneers and apple jack, then Beaver drives us back up the meadow along a path lost in waves of alfalfa. Suddenly the truck stalls, and Michael and I tumble out to push as tires whir and slide on the grass-greased slope. At the top, Beaver thanks us for our help. Thank us? As we drive back to Belfast, I ask Michael how I might compensate a man who refuses any payment for his precious manure. With a shrug of the shoulders he replies, "You already have."

### **Connectedness**

Sixteen years of practice in Belfast, Me, has made me a part of the wider community. I am linked to patients' lives by more than the designation as their primary provider. There is a natural logic to it, as obvious and real as the stream that flows from Smith's Millpond Bog to my home at the mouth of Belfast Bay. Together we have learned how waste can both pollute or fertilize the land around us. My patients, in their Yankee bullheadedness and patched-together lives, assure me that I belong here. We—forever denying this fact—seem to need one another.

### **Politics**

One can be seduced into politics by the notion that popularity, moral righteousness, and a good grasp of the playing field are a guarantee for success. So, soon after establishing myself in medical practice, I joined the parish council, spoke up at hospital staff meetings, and ran for the school board. Mine was a voice for family practice values. I helped children become more involved in church worship, opposed screening programs that reduced health care to a commodity, and supported neighborhood schools that fostered strong relationships between teachers and with the wider community.

In these and other debates, I was frequently on the losing side. You might have thought that medicine—where the patient's struggle against mortality is conceded from the start—would have prepared me for poor outcomes. Even in victory, the politician is left with a compromised and transitory gain. He must cherish the political process more than the final vote—likewise, the doctor's reward, which lies in a love of his or her patients and the provision of good care rather than in any false hope of transforming the misery that parades past his or her door.

### **Change**

Is the family doctor an agent of social or political change? Perhaps some of us will shape and leverage the national debate. More will run for elected office in our home state or municipality. The rest will do their

part by maintaining the connections that are severed in patients' lives during the course of their disease, despair, addiction, or aging. For them, the doctor holds the flicker of hope, the reassuring hand, a mirror of their self-worth and sense of dignity. Through our own lives, we model the possibility of change.

I have saved only a few of my patients. I have seen alcoholics give up the bottle, wives flee the battering hand, the morbidly obese shed an elephant riding on their backs. But most of what the doctor accomplishes is infinitesimally small, barely a quiver, broad and trickling like the St John's River for those who are succored in the watershed of our care. We are stewards of a human ecology. Our practices are strengthened by diversity, interdependence, and the obligation for our mutual long-term survival. We are caretakers of what Robert Putnam calls "social capital."

The wife of a patient of mine, home dying of lung cancer, recently said to me, "Dr Loxterkamp, I just feel better knowing that you drive by my house every morning."

A child in church, whose cerebral palsy limits her to a space-age motility device, often hovers at my pew. At first I tried to ignore her, disturbed as I was by her jerking and drooling and those penetrating eyes. I feared that any attention might lodge her here permanently. But, once I touched her outstretched finger, she moved on, satisfied by the meeting of our fingers. Now others safely do the same.

I recently attended the coroner's case of a girl I had delivered 8 years prior. She had darted into the path of an oncoming car and died, as I soon discovered, instantly of a broken neck. When I called her father with my merciful news, he sounded grateful. But there was one favor he now dared to ask of me: since I had been there for her birth, been there at her death, would I honor them by being there, too, at their daughter's funeral?

### **The Practice**

The only place a family doctor—this family doctor—can create lasting change is in his own backyard. Over the years I have exercised this prerogative just four times. Nine years ago my partner and I provided each other with a year's sabbatical. After our reunion, we instituted the Thursday Morning Meeting, wherein providers gather for an hour each week to examine the enemy within. Earlier this year, we banned pharmaceutical representatives and their samples from our office. Shortly thereafter, I set a date for my retirement 10 years hence (at age 57) when I shall remove the mantle of a full-time physician.

These changes were the gift of sight. One year's leave of absence taught me that practice is a privilege, the practitioner a nonessential cog in its continuance. Within the support group, I began to articulate, for the first time among peers, the sense of insecurity, blurred

boundaries, fallibility, and an unmitigated need for forgiveness that we all share. Rejecting drug samples and industry propaganda forced us to acknowledge the barriers to free and informed choice that we ourselves had erected. And, setting the date of my retirement was a cock paid to my mortality and a first step toward helping younger colleagues—and my children—transition to the helm.

During my tenure in Belfast, I have witnessed (and been party to) the drama of doctors who could not retire and instead squandered their reputations on vestiges of power and self-purpose. I have known peers (and their temptation) to satisfy personal needs at the expense of their patients. I have found that doctors in my community choose to isolate themselves from the sources of feedback and support that I credit with my own survival.

### Professionalism

The family doctor is a hybrid in the field of medicine. We perform the generalist's role with specialists' ambitions. We are amateurs (from the Latin *amator*) who love our labor and shoot more from the hip than from the sights of expert opinion. We still consider medicine a vocation or calling and thus remain open to duty that lies beyond the roles for which we're prepared. And, we remember that professionals are those who profess something publicly about what they believe.

I have listened to the professions of Trappist monks at New Melleray, Gethsemani, and New Clairvaux abbeys. Not only do they commit themselves to the religious life (in the vows of poverty, chastity, and obedience) but pledge to live in one place (the vow of stability) in order that grace, working through community, may move them (by a conversion of manners) closer to God.

Family doctors, too, understand that our high incomes distort our perceptions of the poor; money tests our personal values and stands between patients and their access to medical care. Chastity reminds us to be respectful of the intimacies we guard and faithful to those who are marginalized by the loss of insurance or physical well-being. We remain obedient to a higher authority—the precepts of science and a moral conduct befitting our profession. We realize that patient care is not portable and that the doctor who lives among his mistakes and prejudices becomes a healthier person less prone to severity in the judgement of patients or peers. Lastly, family doctors are inevitably changed by the patients they serve. The merely responsible physician, tempered by mercy and groomed by grace, adds to the stock of moral credibility that has sustained our profession over the millennia.

What I am trying to describe is a doctor who is more than the sum of his/her parts, more than a tally of screening tests and minor procedures and patient encounters scored over the course of a career. We might more eas-

ily see that a rabbi or minister is not only master of ceremonies but a person praised as a man of God. We know that a teacher is more than a conveyor of facts and proctor of exams but someone dedicated to the channelling of curiosity in the pursuit of truth. So, too, family doctors, who through the blur of ICD-9 and CPT and codes will finally rest in those relationships that define and sustain their work.

### What Are Cows For?

Six years ago, Tim Hughes again took time off to enroll as an extern with *Salt Magazine*. For his journalism project, he focused on the growing debate over bovine synthetic somatostatin (BST). Under what conditions—with what labels or restrictions—would the state allow BST to enter the state's milk supply? Monsanto Corporation had spent a quarter billion dollars developing and marketing Posilac, a biologically engineered hormone that had been shown to increase milk production by 10% when injected into cows. Despite safety endorsements from nearly every major medical, nutritional, and scientific group—and finally, in 1993, FDA approval—politicians, consumers, and the state's 600 dairy farmers were divided on its risks and benefits.

For his sources, Tim interviewed two dairy farmers who had given opposing testimony to a state legislative subcommittee. He travelled to Cornell University to speak with the original investigator and national spokesperson for BST, Professor Dale Bauman. Dr Bauman was understandably convinced of the safety and societal need of BST:

When you do the population curve and project it out . . . then all the food needed in the world for the next 40 years is equal to the amount that was previously produced in the history of humankind. This ability to make gains in the productivity of animal and plant agriculture is really important in the long term [and] productivity is what BST is all about.

Stewart Smith, a former state commissioner of agriculture and professor of sustainable agriculture at the University of Maine, offered a tempering view. He saw a relationship between farmers' enthusiasm for biotechnological solutions (in contrast to management-intensive practices) and the structure and funding of agricultural research. He lamented farming's shrinking role in the food sector, from 41% in 1910 to 9% in 1990. The use of BST, he felt certain, would transfer even more cash from the farmer to Monsanto. He asked why the dairy industry needed more productivity when there has long been a milk surplus. BST in the marketplace would reduce the need for dairy cows and, consequently, the number of farmers to tend them. Is it worth asking, he wonders, if farming itself is a social good?

Beaver Simmons is the embodiment of Smith's philosophical argument against BST. He considers any potential health risk unacceptable for his cows. "As far as I'm concerned, it's abusive. And what right do I have to abuse my cows?" Beaver is headstrong in his distrust of chemical companies and believes that the greatest adverse effect of BST is to turn cows into machines.

Beaver farms the way I would like my son and daughter to live—with passion, respect, and gratitude. He is committed to his land and livestock and adheres to a high (albeit unspoken) moral code. The lowing of the milk barn is his calling, its sweet scent his ample reward. He grasps the rule of interdependence between the husbandman and his herd.

The bond between family practice and rural America goes deeper than an historical regard for the cradle of general practice. It cannot be explained by the fact that many of our leaders were raised on agrarian values. I can tell you that it is easier to be a family doctor, and to feel a sense of connection and interdependence, in a small community than in a large one—like it is easier to sustain one's religion in a monastery than in a mall. The conditions are ripe for the receptive mind.

While the specialties add to the clinical knowledge base and perfect our techniques, family practice quietly concerns itself with improving the doctor. We, like the evangelist Matthew, take seriously Jesus' rebuke to the Pharisees, "Go and learn the meaning of the words: mercy is what pleases me, not sacrifice." We ruminate on the question Tim Hughes forks at our feet, "What are cows for?"

The family doctor is rarely an agent of meteoric change. But, every day and closer to the earth, we are

its vehicle and eyewitness. Doctors who remain deeply connected to their patients will know this privilege, as will those of us who retain the capacity to listen, touch, and tether ourselves to the wounds of others. In modest ways, we accomplish the utterly profound long before the prescription is filled or the blood test is taken. We profit by the patients' periodic return and by the mutual exchange of friendship, intimacy, and trust.

What are cows for? To the bioengineer and corporate manager, they are machines; they are units of production. But, to those who have experienced "farming itself as an end, the stewardship and husbanding of the land, the plants, and the animals," as Dr Hughes observes, ". . . a cow is, above all else, a living thing to be respected if she is to enrich our own life." He might have said also that a cow can bring us joy and beauty, provide companionship, and inspire the next generation of farmers to love and care for them. It can sustain a small business and livelihood that relies on sustainable relationships with crops, animals, and the earth and on the natural intersection between life and death.

Clearly, my mind has wandered to the broader question: what are patients for and by extension the family doctors and their technologies? It is the most unsettled and unsettling of questions. It rises from a vow of connectedness and is the sentinel for those of us who seek change through the exercise of our art.

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