A doctor struggles to provide mental health care in Appalachia
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As a West Virginia primary care doctor, I frequently—read: daily—find myself in uncomfortable situations. A few recent events, however, are out of the ordinary, even by the standards to which I am accustomed. Though unique to Martinsburg, WV, I expect similar themes in myriad offices across American health care. If your job resembles mine, I wonder if you feel as lost as I am, though I'm not sure where we are, exactly.

During my workday, I interact with patients who are suffering the invisible effects of lifelong trauma. The monumental problems of Appalachia are poverty, isolation, lack of education, a scarcity of good jobs, and physical labor. The twentieth century, the one which devastated my state, bequeathed these foundational disorders to West Virginia's collective health. Or, more accurately, our collective illness.

Inadequate medical care, lack of food, physical abuse, transient housing, tobacco—these are so common that I must assume my patients lived through these experiences. And, this is before we consider the heavy-hitters of sexual assault and addiction. This is the tattered canvas onto which the horror graffiti of OxyContin and all of its rotten in-laws—methadone, heroin, fentanyl—was splattered.

I read an article in a major newspaper last month describing how complex pain, trauma, and substance abuse must be handled by a psychiatrist. I couldn't agree more, but I don't have any realistic options in my town. Here

in West Virginia, I barely have any of the colleagues I need, and this newspaper's prescription seemed so out of touch with my reality, which is a common experience for those of us living in Appalachia.

So—I do have a few skilled psychiatrists nearby, but they are, to put it bluntly, overwhelmed. I could use—no exaggeration—twenty-five more in Berkeley County today. This expertise is not readily available to me, and my patients are as aware of this fact as I am.

In a fragmented "system" of health care, patients know that my specialty is, at its core, everything: primary care. They come to me with a plethora of problems and ask—cry, beg, demand—that I help them. After years on the frontline, I have a skillset that many primary care doctors don't have, simply because I have improvised out of necessity. Or, more precisely, desperation, mine and the patients'.

I routinely prescribe antidepressants, medications which do not, in fact, worry me. They are safe, effective, and I counsel patients on how these medications, along with other measures that promote mental clarity—sleep, nutrition, exercise, positive coping, etc.—can help. I validate feelings of depression, and we build a strategy of helpful things, with medication being one piece.

I also can prescribe benzodiazepines, intoxicating medications to relieve panic symptoms. Pervasive in my patients, panic comes from simple phobias, but, more often, from flashbacks of trauma—PTSD. Many of my patients are triggered on a daily basis, forced to relive being beaten, raped, or experiencing other horrors. My goals are to help patients function as parents, spouses, workers, and humans. These panic symptoms, which explode on impact, are as real as the original trauma. The medication I provide helps, but it is habit-forming and requires "babysitting" by me.

Where I get stretched thin is when patients have emotional problems compounded by "other drama." As their only source of mental health care, the treatments I provide are mixed with other, more problematic, medications. Often, a patient arrives to me on methadone, the "souvenir" of a previous heroin addiction, or other opioid pills. It is almost routine, patients arriving to me taking oxycodone or hydrocodone, often from "a pain clinic out of town." Don't get me started on the pain clinics—that's another essay.

Pain clinics do not provide mental health care, so they, justifiably, send patients to me for "everything else." With methadone, Prozac, and Klonopin on the table, I am providing proper psychiatric care. But, like I said, I am a primary care doctor, and my patients have no one else. Do I disqualify these patients on opiates, telling them that I cannot add antidepressants and benzos to their regimen? In many—read: most—primary care offices, that is exactly what happens. When it does, patients are screwed, abandoned by the very folks they sought out for help. And, when primary care turns someone out on the street, let me just say, that very same street is where they will look for assistance.

Another area of quicksand is my patients who take stimulants, like Adderall and Ritalin. Piled atop everything else, patients often have a legitimate history with ADD, and, as you can imagine, stimulant medication can be the difference between keeping or losing one's job. I have folks trying to get their lives in order and, to do so, are on methadone (previous addiction), Prozac (current depression), Klonopin (omnipresent PTSD), and Adderall (never-properly-treated ADD). Without obvious teammates to help supervise parts of this cocktail, I am left to decide just how many psychoactive ingredients I am prepared to stir into the potion.

"Professional discomfort" is my working term for how much risk I believe is reasonable for me to assume as I try to help someone. Over time, the level of

risk has grown as the complexity of my patients has increased. Despite twenty years of experience and my willingness to help, I am stretched to the point of cracking and breaking. I don't know what the "best" or "right" answers are in these situations. I am ill-equipped to properly supervise these addictive medications, and it weighs on me. Primary care was never meant to be the repository for this complex care, but it is, in reality, the last-chance saloon for many Appalachians.

If I turn patients away, there is nowhere else, and often no one else. My career is littered with desperate folks who have taken their own lives, or had theirs fall apart. And I cannot ignore these realities or pretend like I can let someone else address them. So—I am often stretched into a very uncomfortable position. When I find myself there, I try to remember the pain inside the patient and how they need, more than anything, a doctor who, at least, is aware of the discomfort they carry within. When I find myself contorted, painful, and anxious, I try to remember the suffering human in front of me, one whose life makes them feel this way, every day.

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