States of the Union

CARING WHILE CURING

BY RICHARD J. MARGOLIS

IT HAPPENED one August night without warning, while our family was vacationing on an island off the coast of Maine. One moment Philip, our 12-year-old, was on a porch rocker joking with us; the next he was on the bare floor writhing in pain.

In a panic I carried Phil to his bed—he couldn't walk—while Diane ran to get Alex, a Boston internist who happened to be summering at the cottage next door. "Torsion of the right spermatic cord," Alex pronounced, gazing down on our stricken son. Somehow a vital connection in Phil's groin had gotten twisted. The warp was choking off his blood supply.

"I've only read about such cases," Alex confessed. "Never actually saw one before."

Very tentatively he reached down and touched the tender area. Phil jumped and let out a howl. "Sorry," Alex muttered. He took Diane and me aside. "I think we better get your boy to St. Andrews right away. For something like this you don't want to wait too long."

St. Andrews Hospital lay an hour across the water in the little town of Boothbay Harbor. Could people who worked in such an out-of-the-way place be expected to possess the skills our son so urgently needed? We had our doubts, but there was no time to speculate. With another neighbor's help we managed to get Phil down to the dock and onto a borrowed boat equipped with an outboard motor. In smooth dark water we sped off, following a streak of moonlight that seemed headed toward Mill Cove and the hospital dock. Not another soul was on the bay.

Alex had telephoned ahead. A nurse with a wheelchair and a blanket awaited us at the pier. Within minutes Phil was lying on a bed in the emergency room and being examined by Dr. Gregory, the hospital's sole proprietor and only physician. Dr. Gregory was a large man with lots of gray hair and a reassuring voice.

"Let's see what we have here," he said to Phil. We held our breath and watched as the doctor's long fingers searched for the offending knot. Phil's body stiffened but he made no sound. "Just relax," Dr. Gregory murmured. "Maybe I can unravel this thing for you."

Between his thumb and middle finger the doctor was delicately kneading the invisible rope. Suddenly Phil's muscles went slack; he emitted a deep sigh. So did we—for it was plain that Dr. Gregory's educated fingers had untwisted the cord.

He patted Phil on the shoulder and stood up. "We'll want to keep you here overnight," he said, "just in case that thing decides to get troublesome again. You don't mind spending the night with us, do you?"

"Nope," Phil said. And for the first time in five hours, he smiled.

All of the above occurred 19 years ago. Through the intervening years, until very recently, I held to the idea that our family's luck that scary night had been extraordinary, that in St. Andrews we'd happened upon a rare rural gem. Now I think otherwise. One of the many things I have learned from a recent round of visits to rural hospitals in several states is that our good fortune was just a routine entry in the annals of small-town medicine.

The knowledge has taken some getting used to. We live in a city that boasts two major hospitals, one with 491 licensed beds, the other with 875. Each in its way typifies the sort of high-powered, university-affiliated complex that most city dwellers equate with first-rate health care. By contrast, an urbanite's mental picture of a rural hospital is likely to resemble a faded turn-of-the-century etching, complete with shabby furnishings and primitive equipment.

Such hospitals did in fact once dot the rural landscape. Here, for example, is the late Arthur E. Hertzler, a Kansas country physician, reminiscing about those early institutions in a 1938 autobiography, *The Horse and Buggy Doctor*. In his youth, Hertzler recalled, the typical small-town hospital was "in a private residence.... Sometimes the doctor and his family lived downstairs and the wife did the cooking....

"There were usually half a dozen or fewer hospital beds in these houses. The operating room was the bedroom of the former cook.... The kitchen stove supplied the heat for sterilization of the instruments and dressings. This made it necessary for the doctor to eat an early breakfast, so that the stove could be available as a sterilizer when it came time to prepare for the operation. Oper-

ating in such hospitals was but slightly removed from the kitchen surgery of any private residence...."

"It is enough to make one weep," Hertzler mourned, "to think back on those early beginnings."

These days the good doctor would not have to weep. The hospitals I visited were indeed small in comparison to their big-city cousins—they ranged downward from 73 beds to a mere eight—yet they gleamed with modernity. In most instances my first impression was that of an urban medical center in miniature. Even the tiniest boasted an outpatient clinic, operating and recovery rooms, a blood bank, a pharmacy, a hospice, a 24-hour emergency room, social work services and maternity and nursery facilities. Many maintained intensive care units equipped with monitors that could flash the jagged trajectory of a patient's heartbeat.

As I sketch this picture, however, I realize that I have left out its most remarkable feature. Call it one-on-one graciousness; call it sympathy; call it, for lack of a better pun, small-town hospitality. Whatever the label, it is a force that operates at the very center of most rural hospitals in America. Yet it is so universally taken for granted that hardly any of the scores of doctors and nurses I talked with seemed conscious of its presence.

"Do you do anything special for bereaved families?" I asked a nurse at Grant Memorial Hospital, a 59-bed facility tucked into the mountains surrounding Petersburg, West Virginia.

The nurse, a veteran of many years' service, gave the question considerable thought. "No," she finally answered, "I don't recall our ever doing anything out of the ordinary for the bereaved. Oh, sure, we cry with them and we sing with them and we pray with them. But no, nothing you would call really special."

A rural hospital, then, may be a place where nothing special ever happens; where no one is a number; where everyone knows your name, tolerates your quirks and shares your griefs; where the nurses celebrate your birthday; where, when you telephone to say you feel sick and wish to be admitted, they turn down your bed and have the florist deliver a half-dozen pink carnations to your room; where visiting hours do not matter even if they are posted—relatives and friends come and go as they please; where a turned-on light over your door instantly brings a nurse to your bedside; where the kitchen staff makes bread and pies from scratch, and *real* mashed potatoes, and if you don't like the evening menu, someone will run to the corner and bring you a pizza with sausage, mushrooms and onions—and no anchovies; where your tattered pajamas may be mysteriously replaced one evening by a brand new pair, with the price-tag removed.

At Grant Memorial I was introduced to a patient whose lengthy sojourn there perfectly illustrates the bond between caring and curing. The patient's name is Shane. He is a dimpled, blue-eyed twin born three months premature on January 14, 1988, at West Virginia University Hospital in Morgantown.

Shane had two-and-a-half strikes against him. Within weeks after birth he went into heart failure and barely survived. Among other things, Shane was suffering from a malady doctors have dubbed "stiff lung"—the technical term is pulmonary bronchial dysplasia—meaning that his lungs were unable to absorb oxygen. Stiff lung, according to Dr. Felino V. Barnes, Shane's present pediatrician in Petersburg, is irreversible. There is no known cure. (Shane's twin sister Shena escaped her brother's misfortunes. She was born whole and hearty.)

For six months the doctors and nurses in Morgantown kept Shane alive. They fed him oxygen through tubes in his nose; they fed him nourishment through tubes down his throat. Then, with little hope for Shane's prospects, they sent him to Petersburg, where his 18-year-old mother Theresa was living with Shena and a three-year-old daughter. Theresa worked in a chicken processing plant while her mother took care of the children.

Shane ended up in Grant Memorial. "You should have seen him when we got him," says Linda Davis, the head nurse there. "It was pathetic. He just lay in his little crib without making a sound. A baby at six months is supposed to laugh and cry, but Shane couldn't do either. Absolutely no facial expression: He didn't smile, he didn't frown. Then we discovered he hadn't even learned how to suck, which meant we weren't able to feed him with a bottle much less with a spoon. Believe me, Shane was one sad baby."

What happened next seemed spontaneous and unrehearsed. "We sort of adopted him," Davis recalls. "We treated Shane like our own." The nurses gave him toys to play with; they clothed him in new, colorful nightgowns; they kept talking to him, cooing over him, and picking him up and carrying him around.

As Cathy Crites, another nurse at the hospital, notes approvingly, "That baby was spoiled rotten. When we had to do our charting at the desk, we took Shane with us and let him sit on our laps while we wrote out our reports. I don't think we ever set him down."

In time Shane began to respond to all the attention. He learned how to laugh and cry. He also learned how to eat with a spoon, but only when the spoon was proferred by one of the full-time nurses familiar to him. "The part-timers never had much luck feeding him,' Crites says. "But when one of us full-timers offers the spoon—wow!"

On Shane's first birthday last January there was plenty to celebrate. He had tripled his birth weight—he now weighed slightly over 14 pounds—and most days he was able to breathe without benefit of oxygen tubes. At his birthday party, says Mary Beth Barr, the assistant head nurse, "Shane giggled and ate cake with a spoon. We're proud of him. He's a *good boy*."

Such everyday celebrations are all duly recorded in my notebooks. They have become part of my education. From them I conclude that small-town hospitals draw energy from secrets all their own: Within the national health care system they emerge as unique institutions, where the curing and the caring are one and indivisible.