

INTRODUCTION

My Mother's Hip

MY MOTHER, JUNE, would have wanted me to tell her story. She was that way. When she had her first child in the late 1930s, she was terrified because nobody would tell her what childbirth was like. She had an uncomfortable breech delivery without anesthesia, and afterward she told everyone the smallest details. They listened. When she underwent a radical mastectomy in her early thirties, she told everyone she had been hospitalized for breast cancer. The subject was taboo, though, and nobody wanted to hear about the big "C." Word quickly got around the neighborhood that Mother's death was imminent. She soon realized that frankness served no useful purpose, so she stopped talking about her illness. She was ahead of her time, and this was one of the few occasions when she decided it would be best to remain silent. Throughout her lifetime, we had many talks. I learned what it was like to be a working woman in the 1950s, when not many women left home; what it took to nurture a happy marriage; what growing up as a first-generation American was like; how to balance a career and family; and much more. It was natural that Mother and I would talk about her hip fractures and that she would tell me about events that cropped up during her protracted treatment. I learned a lot about hip fractures just from being by my mother's side.

Few people suffered from hip fractures years ago because they rarely lived long enough to experience the consequences of severe osteoporosis, a chronic disease characterized by bone fragility and associated with aging. Now we are in the midst of an "elder boom" in which the population older than sixty-five is ten times larger than it was nearly a century ago. John Riley, Jr., and Mathilda White Riley, pioneering researchers on aging, have called the expanding number of old people a "social phenomenon without historical precedent" (1994:16). This trend is unlikely to change

soon. The graying of America will be fueled by the coming of old age of some 76 million baby boomers who will celebrate their eighty-fifth birthdays between the years 2030 and 2050.

Two factors have contributed to this demographic revolution. The first is longevity. Average life expectancy, a mere forty-nine years at the beginning of the twentieth century, may well be higher than one hundred by the middle of this new century. The second is the growth rate. The elderly are growing much faster than the rest of the population, and their demographic composition is changing as more and more people survive well into old age. Seventy-five is no longer "old" compared with the growing ranks of octogenarians and nonagenarians who now constitute the fastest-growing segment of the American population.

The traditional population pyramid has already disappeared. Many people are concerned about the "squaring" of the pyramid and what they consider to be a skewed demographic structure. Will the new demographic realities create an enormous dependent aged population incapable of caring for itself? Or will we experience a social epiphany as our aging populace achieves novel and creative ways to confront the challenges of advanced old age? Will our aging baby boomers live longer and better, or will they face the specter of chronic, degenerative conditions as they approach the twilight of their lives?

Optimists believe that as life expectancy expands, morbidity will be "compressed," resulting in added years of healthy living because infirmities will cluster at the end of one's life. The breach between our life expectancy and our natural life span will narrow. Leonard Hayflick, the author of *How and Why We Age* (1994), predicts that by midcentury we will attain our natural life spans in full possession of our physical and mental faculties and die swift deaths as we approach our 115th to 120th birthdays.

Pessimists claim that as life expectancy increases, so will the debilitating chronic conditions associated with old age, putting onerous pressure on a health-care system that is ill equipped to deal with them. Health status *does* decline with increasing age; old people *are* less resilient; and major problems *do* tend to arise among the old as chronic conditions undermine their autonomy and ability to function. Modern medicine has certainly played a

cruel trick on the elderly. Saved from sure death from infectious diseases now easily manageable, thanks to medical advances, the elderly await an old age marred by osteoarthritis, osteoporosis, cardiovascular disorders, Alzheimer's, and other degenerative diseases that seriously compromise their quality of life. Undoubtedly we have come to a crossroads in the history of medicine as we face the new longevity revolution.

My mother's hip is every mother's hip. The inescapable reality of our times is the epidemic growth of age-related diseases, like osteoporosis, that demand new kinds of medical approaches. Osteoporosis is both a common and a serious disease that leads to hip fractures. Hip fractures, in turn, are life-threatening and require extensive periods to heal. How many elderly women can survive such a protracted period intact? How many elderly women can navigate the route to a successful recovery on their own? Not many. Complications can be transformed into consistent patterns destined to terminate poorly. Repeated crises can reduce one's chances and tip the prognosis negatively. An elderly woman may achieve a tentative truce with a chronic condition, but a hip fracture and its ensuing complications can upset the delicate balance. Victims of hip fractures die of complications every day, and if they manage to survive, they are often unable to care for themselves.

We hear about "little old ladies" all the time. The patronizing "little" refers to the obvious physical abnormalities of frail elderly women who look shrunken and caved in as a result of the decrease in bone mass—osteoporosis—that leads to collapsed vertebrae and hip fractures. Women with collapsed vertebrae have a pronounced curvature of the spine, called kyphosis. These women walk slowly and unsteadily and may need a cane for support or a companion to guide them. They are a frightening reminder to younger women of what may await them if they live long enough.

When I looked at my mother, I never saw a "little old lady." Inside was an ageless beauty who did not feel or act old until well into her sixties, when she was stricken with polymyositis, a rare muscular disorder. Even then she carried on and tried to maintain

control over her life. She was not one to allow a chronic condition hinder her independence. It was not until she fell that I had to admit: This is my mother, June—a frail elderly woman with a double hip fracture.

September 19, 1993. Nearly five months had elapsed since my mother broke her two hips—a week short of five months, precisely, since she had suffered a spontaneous hip fracture and fell to the floor, jarring her other hip and cracking it. The prognosis was guarded. Mother did not expect to survive the double hip surgery, but she breezed through, only to embark on a period of extended rehabilitation whose object was to return her to the way she was before. For five months, Mother was in and out of the hospital, bouncing back and forth among rehabilitation, intensive-care, and nursing facilities. She made it home once, for only nineteen days. As she worked her way through the medical maze, the possibility of recovering her former self became increasingly elusive.

She was determined to walk again, but her good intentions were barely relevant to the broader picture. Instead of regaining her mobility and cherished independence, Mother suffered repeated complications that left her vulnerable to more relapses later on. Finally, she reached her limits. She yanked the oxygen tube from her nose and refused all medication. “I’ve had enough,” she said. “I’m tired of the whole business. I want to quit.” That evening, she had trouble breathing and went back to the hospital. Now Mother was in the intensive-care unit at Boca Raton Medical Center fighting for her life.

For five months I hovered over my mother. We discussed many of the ramifications of her hip fractures and their treatment. I participated in her recovery as her caregiver and medical advocate, and I observed the unfolding events not only as a daughter who suffered enormously watching her mother decline but also as a medical anthropologist who could relate this personal experience to the broader issues elders and their families face when a life-threatening medical crisis occurs. At times it was difficult for me to remain calm and collected so I could carry out the tasks of participant-observation, the *sine qua non* of the anthropological

approach. My intense involvement with my mother—my role as a daughter—kept intervening in my effort to analyze events objectively, and I realized that if I had any hope of understanding what I had observed, I would have to force my anthropological sensibilities to reign. Seeing my own mother as a frail, chronically ill woman with limited options, compelled by circumstances to spend the last months of her life in an institutionalized setting, was a powerful and discordant experience, almost like seeing her floundering in a foreign world, hopelessly immersed in an exotic culture. I, too, was sucked into this maelstrom. I had no notion of what awaited her in her medical travails or of what the outcome would be.

My mother's hip fractures sent me on my own philosophical odyssey and medical inquiry. I wanted to cut through the intellectual tangles and arguments about the meaning of chronic illness—her illness, in particular. I spoke extensively with her doctors. I interviewed the supporting cast; many of the medical professionals who were involved in her treatment served as key informants. Later, I read her journals and notes. I visited nursing homes and rehabilitation facilities. I attended gerontology meetings and conducted research in medical libraries. I also searched for clues in her extensive medical records. They were of crucial importance in piecing together a consistent story of Mother's hip fractures and helped me delineate the patterns of medical care. I lived with these documents for many months and treated them almost like living informants—they allowed me to verify and corroborate the events I observed directly and those described to me. They served as a series of checks and balances to buttress the validity of the medical details discussed here.

Thanks to these approaches, I realized that there are valuable lessons to be learned from my mother's experience that can aid others. Her story in itself is important, because hip fractures are occurring in epidemic proportions. But her story would be incomplete without relating it to relevant issues about aging and chronic disease, housing arrangements, ethical dilemmas, caring for elderly parents, and how our health system treats the elderly. Even if you do not have a mother who breaks a hip, similar issues will crop up in the course of caregiving, because chronic illness

is becoming a more intrusive element in the lives of Americans as the age barrier is pushed to its limits. These issues should be aired. Those who have not yet confronted them as patients are likely to do so as caregivers, because a drawn-out medical event such as a hip fracture involves the entire family.

Issues or lessons? I use the term “lesson” in the following sense: “a useful or salutary piece of practical wisdom imparted or learned” (*New Century Dictionary of the English Language*, 1946:943)—as in, my mother’s experience taught me valuable lessons. The lessons are organized as separate sections and arranged to build directly on the chapters that precede them. Feel free to read the lessons in sequence or to skip around. If you want to learn about the issues that cropped up during my mother’s treatment, then read the lessons as they appear. If you prefer to follow the story without interruption, then save the lessons for last.

CHAPTER ONE

Coral Bay Memorial Hospital

"I broke my hips."

APRIL 28–MAY 18, 1993: 20 DAYS • The emergency calls came around dinnertime in Caracas, but I was not home to receive them. I was taking advantage of my husband's business trip to work late at the office and catch up with my field notes. Our housekeeper, Carlota, was at the door when I walked in at 9:00 P.M. I did not like her grim look.

"Marisa called," she said, referring to my mother's helper, "and your sister-in-law called twice. Your mother had a bad fall early this morning and was taken to the emergency room of Coral Bay."

"Did she break anything?" I asked.

"I don't know, but Marisa sounded very worried."

"Well, hold dinner," I said. "I'm going to try the hospital number Marisa left."

I knew this would be a chore. My stomach was churning at the thought of Mother's fall, and I expected difficulty with the Venezuelan phone lines. It was after 10:00 P.M. when I finally got through to Coral Bay Memorial Hospital in Fort Lauderdale, Florida. The operator refused to connect me with Mother's room because it was so late and told me to call back in the morning. Next I called Marisa, who explained that she and my father had been at the hospital all day. He was exhausted and now asleep.

Mother had called for help in the early hours of the morning. Marisa found her sprawled on the rug in the bedroom hallway. She was in severe pain and could not move. She was also fully conscious and refused to complain. Marisa brought Mother the cordless phone, and she called 911 herself. Within five minutes, an emergency team arrived with a special stretcher and administered a painkiller. Mother asked to be taken not to the nearest hospital, as is customary in an emergency, but to Coral Bay Memorial Hospital, where she could be met by her family internist. After bringing in an orthopedic surgeon to handle her case, the

emergency-room team took an electrocardiogram, X-rayed her hips, and performed various preoperative diagnostic tests. They swathed her hips in special pressure bandages to hold them in place. Marisa was with her when she was moved to the orthopedics floor later that day. Mother was calm but complained that her legs felt “dead” and that the hip bandages were too tight. She instructed Marisa to call her two children and inform them about the impending operation.

My last call that evening was to my older brother, Noel, a gynecologist–obstetrician who lives in the Chicago suburb of Oak Park. The news was not good. He informed me that Mother had broken *both* hips and had to have immediate surgery. Nevertheless, she had spoken to Noel and told him to remain calm.

“Noel, are you sure?” I asked, panic-stricken. “I’ve never heard of anyone breaking both hips at the same time.”

“Yes, I’m sure. I spoke with her internist, and she has to have emergency surgery. She’s resting comfortably, and she’s scheduled for tomorrow afternoon.”

“Noel, there must be a way to avoid surgery. It’s too risky. Remember what happened last winter when Mother was going to have a minor outpatient procedure on her finger? She ended up in the hospital because of an extremely high white count, and her cardiologist told me she wasn’t a candidate for surgery.”

“Unfortunately, there’s no choice. The area will become infected. It has to be cleaned out. Without surgery, she’ll be in a wheelchair for the rest of her life. What kind of life is that? There’s simply no choice.”

We were both silent. Finally I said, “Noel, I’m scared, really scared. What can I say? Mother won’t come through the surgery. You *must* get on the first plane tomorrow—please! Somebody has to be there with her.”

“I can’t. I have several births scheduled for tomorrow. I won’t be able to get away.”

Noel’s specialty often forced him to work around-the-clock, and he disliked leaving his patients in the hands of a covering physician. “Okay, I’ll make my own arrangements,” I replied. “Somebody in the family has to be there.”

I ate no dinner that evening. I was so upset I could not sit still and paced back and forth most of the night, wondering how this

accident could have occurred. I did not think my seventy-eight-year-old mother would survive the operation. She had fibrosis of the lungs and was not supposed to have general anesthesia. I knew that her chances were poor, yet no other options occurred to me. I prepared my passport and papers and packed a small bag for the trip I would surely have to take the next morning.

On Wednesday morning, severe tropical rains caused a black-out and flooding in Caracas. Although I would have preferred to be with my mother before the operation, it was impossible to leave early enough. At 8:00 A.M., I called my travel agent and told him to prepare a round-trip ticket to depart that afternoon and with an open return. I asked him to deliver the ticket to the house, then sent Carlota to the bank to withdraw several thousand *bolivares* for my taxi and departure fees.

I called Coral Bay again, and even though the operator insisted it was too early, she reluctantly rang Mother's room. "Mother, I'm so glad I finally reached you," I said. "They wouldn't put me through last night. Tell me what happened and how you are."

"Darling, I'm having surgery at one o'clock this afternoon. I broke my hips. I don't know how it happened. I was sleeping on the living-room couch because my back hurt. I was worried about Dad and went to check on him."

"Oh, Mother, how many times have I told you not to get up at night? You need your rest. Why didn't you call Marisa? She left the bell by your side for just this purpose. Why didn't you use it?"

"Frankly, I don't know why. I think I also had to go to the bathroom. When I got to the linen closet, I knew I was going to fall. I could feel it. I didn't lose my balance. I just went down very gently."

"Where was Dad when all this happened?"

"Dad was in the bathroom."

"I can't believe this story. You never fall."

"Well, I did. I asked Marisa to bring me the telephone and even managed to call 911 on my own. I haven't slept much lately. I keep worrying about Dad, who's been wandering around at night."

"You don't have to watch over Dad every minute. That's one of the reasons Marisa's with you. That's why she gave you the bell. Why didn't you call her?"

"I really don't know. As for the surgery, I'm not afraid. Whatever will happen will be. I know I may never wake up, but I'm going to enter surgery without fear."

"Mother, I'll be thinking of you every minute. I can't get there before the operation, but I'm flying up this afternoon and will be there when you wake up. Believe me, you're going to come through this because you're a very brave person. I know you'll be fine, and I'll see you later today. And, as we say here in Caracas, *suerte!*"

"Darling, I'm not afraid, believe me. I know what the situation is, and I accept it."

"Mother, have faith. I'm on the way, and I'll see you this evening."

I then called Kathy Summers, my parents' Medicare processor, and asked her to pick me up at Miami International Airport at 6:00 P.M. In addition to handling Medicare paperwork for the elderly, Kathy offered rides to and from the airport. Luckily, she lived near my parents and was always willing to come for me.

Kathy was waiting for me at the international flights exit. The plan was to drive by the house to drop off my bag, then head straight to Coral Bay. But as we were pulling into my parents' home, Dad arrived with Marisa. I jumped out of the car.

"Dad, how did it go? How is Mother? How was the operation?"

Dad turned and looked at me. He appeared confused and startled. "It was terrible," he said. "It's not good."

I was shocked. "What happened? Marisa, tell me quickly. What happened?"

"Señora Luisa, don't worry," she replied. "Señora June is fine. Your father became hysterical when she came up from the recovery room. He kept saying, 'It's Albert; it's Albert.'"

Dad was in a bad way, Marisa told me. (I'll explain later how Marisa became part of the family picture.) After all, they had been at the hospital since shortly after breakfast. The operation took four hours, and Dad was very nervous. After a seemingly endless wait, Mother's surgeon appeared and told Dad that everything had gone smoothly. Her condition was stable.

Mother was half-asleep after she was wheeled in from the recovery room. Dad took her hand. "June, June, wake up, wake up. June, answer me," he implored.

Mother managed to respond, "I'm fine, I'm really fine," but she was too groggy to continue. Dad was reluctant to leave, but he finally agreed to go home before Mother was fully awake.

"Dad, listen to me. Mother came through the operation well and is waking up," I said. "She's fine, and I'm going to visit her now."

Dad barely glanced at me and continued walking upstairs. I said good-bye to Kathy and carried my overnight bag to the second floor. I grabbed the car keys and prepared to leave for Coral Bay right away.

It was 9:00 P.M., after visiting hours, when I arrived. I did not ask anybody's permission to go up. I just walked briskly through the lobby as if I worked there and took the elevator to the fifth floor. I did not even stop at the nurses' station; I went directly to Mother's room. Her eyes were still closed, but she was beginning to come out of her deep sleep. She was flushed, and her face was slightly swollen from the massive dose of prednisone she had been given just before the operation. I wrapped her hand in mine.

"Mother, open your eyes. I'm here, and you've come from the recovery room. Dad is home now and exhausted. It was a long operation, but you're going to be just fine."

Mother slowly opened her eyes. "I can't believe it's over," she said, "and I'm alive. I thought I was still waiting to go in. You mean the operation is really over? I can't believe it."

Mother looked comfortable and was in no pain. I was thrilled that she had come through so well. By no means did I think the path to recovery would be smooth, but she clearly had surmounted the first hurdle. She was happy to see me and smiled contentedly. I did not stay long but promised to return early the next day.

That night I established a pattern that would continue for the next few months. I called my brother and told him the results of the operation. Every evening thereafter, after I had left the hospital and while he drove home from his office, we chatted on the phone. Now I gave him the full report: No complications of any sort had arisen during the long double procedure. Mother had pulled through, and furthermore, she had done surprisingly well.

Was I too optimistic? Mother had a few strikes against her. First was the matter of her fractures. Bilateral hip fractures were rare

and usually resulted from a severe skeletal trauma. Joseph Bianchi, her baby-boomer surgeon, had performed only one such operation in his entire career, and that was on a woman much younger than Mother who had fallen from a tree. Few orthopedic surgeons have handled more than one or two cases.

Another strike was Mother's chronic muscle disorder. For fifteen years she had suffered from polymyositis, a one-in-a-million autoimmune disease characterized by progressive muscle degeneration. (The one other case I had heard of was that of Laurence Olivier, who wrote about his illness in *Confessions of an Actor* [1982]. The "sweet prince" died a peaceful death in 1989 after a long bout with the rare condition.)

Mother was on a downhill course characterized by flare-ups, painful spasms, and chronic fatigue, alternating with brief remissions. She frequently mentioned that in the morning her body was down, like a computer; each part was locked into place, making movement awkward and difficult. Mother felt like the Tin Woodman in L. Frank Baum's *The Wonderful Wizard of Oz*, but a few minutes under a hot shower acted as the oil can to loosen her up and prepare her to face another day of constant pain. The disease soon began to manifest itself in other ways. Her hands twisted out of shape, and she developed dry rales, or rattling, at the base of her lungs. Immunosuppressant drugs and maintenance doses of the steroid prednisone barely managed to hold her complicated condition in check.

Mother actually required two operations, or bilateral surgeries. Her X-rays showed an intertrochanteric fracture of the right hip and a displaced subcapital fracture of the left hip. She would need two separate procedures: pinning of the shattered right hip and total replacement of the left hip. On the day of the surgery, Dr. Bianchi decided to perform both operations at the same time. Despite her medical status, Mother sailed through the double procedure. Not only was her internist, Arnold Riden, pleasantly surprised, but even her surgeon was relieved that she had experienced no complications. Dr. Bianchi actually congratulated Mother after the operation. "You are a very strong woman," he said, "very brave. I've never seen a woman as strong as you." They exchanged pleasantries. Dr. Bianchi was from an Italian family. So was her son-in-law, Mother told him.

According to Dr. Bianchi's operative report (using plain language to describe extremely complex procedures), Mother's right hip—the side with the intertrochanteric fracture—was prepped and draped in the usual manner. Dr. Bianchi began the open reduction and internal fixation by making an eight-inch incision from the level of the greater trochanter down the side of the thigh and dividing the subcutaneous tissues and muscles. He drilled a hole into the neck and head of the femur and inserted a "lag" screw to hold the vertically shattered bone together. Next, he screwed a steel plate over the outer length of the femur to "fix" or align the fracture in place. He copiously irrigated the wound with antibiotic solution and found it to be "dry" (thus, no drains were required). Dr. Bianchi closed the wound in layers, using self-absorbing sutures for the muscles and subcutaneous tissues, and large staples on the skin. He applied thick sterile dressings to the site of the incision.

Mother was then transferred from the special fracture table to a regular operating table with a hip-immobilizing device, and turned on her right side, with great care to pad the right axilla. Then her left hip—the one that showed a displaced subcapital fracture, in which the head of the femur had almost been decapitated—was prepped and draped. The fracture table was removed from the operating room, and a new set of instruments was brought in. Dr. Bianchi left to rescrub and regown before beginning the arthroplasty. A representative from the manufacturing company also scrubbed and brought in a variety of titanium and polyethylene components. A laminar airflow system was used to create a highly sterile operating field and prevent bacteria from entering the large wound. Dr. Bianchi made another eight-inch incision, but this time, instead of repairing the fractured bone with screws, he gave Mother a completely new hip. Specialized tools like chisels, reamers, rasps, drills, and mallets were used to fit her with a sophisticated ball-and-socket prosthesis that allows universal range of motion. Dr. Bianchi cut the fractured femur to the proper angle and removed the femoral head. After testing various trial sizes, he tapped the definitive artificial head into place and bonded it with cement. He irrigated the wound, inserted drains, and closed the incision in layers. An abduction splint was placed between Mother's legs to keep them

parallel and prevent the dislocation of her new hip. She was carefully moved from the operating table to a bed and rolled to the recovery room. Dr. Bianchi noted that "the patient tolerated both procedures well under general anesthesia and left the operating room in stable condition."

Dr. Bianchi had performed the two types of surgery that currently exist for treating femoral-neck fractures—a hip arthroplasty, or total hip joint replacement, in which the head of the femur is replaced with an artificial ball and socket, and an internal fixation in which the fractured bone is held together with screws. Some orthopedic surgeons believe that the decision to use one method or the other depends more on the art than the science of medicine. Total hip replacements result in fewer postoperative complications but often need to be redone after ten to fifteen years of wear and tear. Internal fixation is permanent and allows better movement. However, internal fixation fails more often, resulting in a re-operation rate of some 20–36 percent. Overall mortality at the end of a one-year period is similar for the two procedures.

We were fairly confident that Mother would gradually regain her strength after the operation and go on to complete a program of physical and occupational rehabilitation. I had nagging doubts, but I kept them to myself. There were too many unknowns to consider. Still, Mother was a fighter and would do her best. Noel was emphatic over the phone that Mother should get out of bed the next day, cough frequently and vigorously to clear her lungs, and exercise with the spirometer, a plastic breathing device that helps surgical patients maintain optimal lung capacity.

Mother had a Foley catheter in her urethra so that the urine ran directly into a plastic bag, which prevented the dressings from getting wet while she was bedridden. Noel also stressed that it was important to remove the catheter as soon as possible because it could cause an infection. But the attempt to remove it after a few days failed. Mother could not wait for the nurse's aide to respond to her call for a bedpan, so the catheter was reinserted. Mother developed a urinary infection, which was treated with an antibiotic. The Foley catheter was a source of constant embarrassment and concern. When Mother started therapy, she had to drape the bag over the wheelchair's armrest, making sure that the plastic tube was not twisted. The bag followed her from the bed

to the wheelchair, from the wheelchair to the bed, back and forth like an albatross. Eventually, the doctors decided to leave the catheter in, even though it meant risking another infection.

But I am getting ahead of myself. For the first few days, Mother did not move from her bed and was attached to a pole holding an intravenous infusion of painkillers that included morphine. She administered this patient-controlled analgesia by pushing a button at the end of a cable, although the maximum dosage was regulated by computer. Mother was comfortable in the first few post-operative days and did not experience any throbbing until pills replaced this ingenious device.

Both doctors, Bianchi and Ridsen, were pleased with Mother's progress and planned to discharge her to a rehab center within two weeks. Dr. Bianchi estimated that she would be in the hospital a week longer than usual because of the double fracture. Therapy began almost immediately, with exercises carried out in a prone position. Two days after surgery, a student therapist started Mother on a series of leg lifts and rotation exercises. It immediately became clear that her left side—the one with the complete hip replacement—was more flexible and less painful than her right side. For all practical purposes, this became the "good" side and the one Mother was rolled onto. One is not supposed to turn onto a newly operated hip, but Mother had no choice.

On the third day, Mother sat up but was too dizzy to leave the bed. Her doctors were adamant about getting her moving. The longer a hip-fracture patient is immobile, the greater are his or her chances of developing a blood clot or lung complication. Mother wore special stockings to prevent an embolus and was instructed to "wave" her feet every so often, but nothing is as effective as getting out of bed. The therapist persevered and brought a wooden board to the bed, sliding it under Mother's legs and enabling her to move them with less effort. Twice daily, with the therapist's help, Mother exercised to strengthen her hip muscles. Within a few days, she could easily do ankle pumps, gluteal sets, and quad sets on her own. But she could not do the exercises that involved lifting her legs off the bed. The quad roll, for example, was a real killer: It required Mother to bend both knees while her heels remained on the bed. Then she had to straighten each knee and try to kick toward the ceiling. Mother's therapist helped

her, lifting each leg up and counting out the seconds. On day four, the nurses transferred Mother to a wheelchair, and from this point on she did one of her two daily sessions in the small therapy room down the hall.

Mother had to follow a few precautions in the strictest sense. Otherwise, she could easily dislocate her recently implanted prosthesis. She could not point her toes inward (although outward was part of the exercise program) or bring her legs together. Nor could she flex her hips more than 90 degrees. She could sit up in bed but could not lean forward, and she could sit in the wheelchair but not bring her legs up.

How Mother broke her hip was a mystery. None of us could understand it, despite her severe osteoporosis. For a few days, this was the main topic of conversation. Obviously, the question should have been not "How did Mother fracture her hips?" but "Why did she fall?" She did not have balance problems and rarely fell. Now we were holding daily postmortems on the cause of her fall. At first, she blamed Dad, who had a tendency to wander. Sometimes he would forget to come back to bed, and she would get up to look for him. Dad's wakefulness was getting to be a problem between them, yet Mother could not bear to sleep in separate rooms. To recapitulate, on the night of the fall, she was sleeping on the living-room couch because of her bad back. She heard Dad get up and went to investigate. She saw the quilt bunched up in the walk-in closet opposite the hallway where she fell. Dad had disappeared—or, at least, she did not see him. Was he lying under the quilt, smothered, as she surmised? Actually, he was back in bed, but Mother had already fallen.

In another version, Mother said that she got up to go the bathroom and decided to check on Dad. She did not trip. She did not lose her balance. She felt weak and knew she was about to fall. "My body went down gently," she said. "There was no time to avoid it. I yelled for help. I couldn't possibly get up."

Mother fell on a Wednesday; she had been complaining about throbbing in her right hip since the previous Saturday. By Sunday, she could not walk and spent the entire day on the couch. On Monday, after a painful day on the couch, she called her rheumatologist, Dr. Kroeber. He told her to take the analgesic

Darvocet and wait until Friday morning, when she had a scheduled appointment. Mother now felt that Dr. Kroeber had given her the wrong advice: He should have told her to go directly to the nearest emergency room instead of prescribing the analgesic, which left her feeling woozy. Darvocet is a narcotic that can cause lightheadedness and affect balance, yet it is not much more effective than plain aspirin.

We kept going over this point. "Mother, did you tell Dr. Kroeber *emphatically* that you could not walk? Did you tell him about your sudden pain? Were you clear enough about this?"

"Yes, of course, and I'm really angry," she answered. "I don't even want to talk to him over the phone."

"Well, he is your rheumatologist and should know what has happened. Maybe he can give you advice about your medication."

"O.K., I'll call him, but not right now. Not yet."

I called Dr. Kroeber myself and told him what had happened. I felt he should know, especially when Mother did not show up for her appointment. I had always liked Dr. Kroeber, who received patients in a relaxed, smiling manner and never treated them as if they were too old to get better.

"How could this happen?" I asked, "particularly after eighteen months of salmon calcitonin injections to strengthen her bones?"

"I don't know. These things just happen. You know, your Mother is no spring chicken."

I chuckled. I was not offended. Dr. Kroeber always teased Mother, "You know, you're no spring chicken." In truth, she was remarkably resilient and plodded along despite the constant ups and downs. But shortly after Dr. Kroeber assured Mother that everything was about the same, she experienced the disastrous event the elderly are warned about—*don't fall!* Mother was not a faller, yet she blamed herself, which I thought was ridiculous. Just a month earlier, she had clipped an article from *Arthritis Today* on improving one's balance and preventing falls. Did she have a premonition she would fall?

Elaine Simmons, the visiting nurse who came to the house to administer Mother's weekly salmon calcitonin injections, thought that she had sustained a spontaneous fracture. This view is consistent with the intense pain she began to feel a few days before falling. Perhaps if Mother had gone to the emergency room

right away, the hairline fracture would have healed on its own with bed rest. Now she had a monumental disaster. Elaine's explanation made sense: Mother had suffered a spontaneous break, went down gently, and the other side—the side that received the brunt of the fall—also broke. Elaine said that this was not unusual; indeed it was becoming increasingly common as the population grayed. I liked this theory. It explained why Mother simply went down, without tripping or losing her balance.

I told Mother about this. "Now let's forget it," I said. "There's no point in going over and over the reasons for your fall. It's already done. Now we have to concentrate on getting you walking, so you can come home quickly."

But Mother continued to hold a grudge against Dr. Kroeber. Later, when I began researching osteoporosis, I developed considerable animosity of my own. At best, he had shown poor judgment in telling Mother to take a narcotic painkiller that could dull her mind and make her shaky. At worst, he had made a serious mistake whose repercussions would soon play themselves out. I found the "take-a-pill-and-rest" approach dictated over the phone particularly offensive. Mother was a disaster in the making, yet the best her rheumatologist could come up with was, "take some Darvocet and get some rest." Certainly, he had been warned a year earlier when Mother suffered repeated compression fractures of the vertebrae, which are usually a harbinger of hip fractures.

Dr. Kroeber was well aware of the association between corticosteroid therapy and bone fractures and knew that prolonged steroid therapy causes severe osteoporosis, leading to collapsed vertebrae and fractures of the proximal femur. Standard textbooks on bone diseases in the elderly point out that the sudden onset of severe pain in the pelvic region of osteoporotic patients probably indicates a fractured femur. The doctor of a patient with steroid-induced osteoporosis should send her to the nearest emergency room immediately. Mother's anger began to subside as she became preoccupied with more pressing matters, such as her impending therapy. Now I was the angry one.

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Mother was comfortably ensconced at Coral Bay. Although she was a Medicare patient, the hospital was not fully occupied, so

she was given a large private room with a sofa and comfortable armchairs. This made life easier for visitors, as well. After the initial hellos, I settled Dad on the sofa, where he napped before leaving. Fresh flowers or potted flowering plants from well-wishers stood on the end table, and we placed Mother's many get-well cards on a large bulletin board facing her bed.

We settled into a routine of sorts. I normally went to the hospital at noon and stayed with Mother through lunch. Then I made the twenty-minute drive home and picked up Dad and Marisa. We all went to the hospital and kept Mother company until dinner-time. At 6:00 P.M., I took Dad home so Marisa could drive to her English-language classes. The objective was to maintain a semblance of normality within a context of tremendous abnormality.

Mother was fully engaged with her surroundings. She had a good appetite—she had no special dietary restrictions—and seemed to be in stable health, despite the trauma. Her mind was on matters at home and everything she had left pending. Her folders were still sitting open by the living-room couch; I went through them and brought the bills up-to-date. Each day, I took paperwork to Coral Bay, and we discussed the routine running of the household. For the past year, she had managed the bills by herself because Dad was beginning to show signs of forgetfulness.

Although Mother was attentive to her personal affairs and made a point of being well informed, she constantly upbraided herself for falling. Her greatest fear was that she would fall while being transferred from the bed to a wheelchair. Then, she reasoned, the operation would be undone, and she would have to start all over again.

I had planned to stay for about two weeks, enough time to see Mother settle into the rehab unit at Sacred Heart Hospital of Fort Lauderdale. I brought work with me, and while Mother and Dad napped, I corrected my husband's book proofs. Graziano, a preservation architect and photographer, had recently published a book on Venezuelan houses; it had proven to be a best-seller and was now due to appear in English. We had co-authored several books on Venezuelan popular architecture, so I was asked to review the text.

"Mother," I griped, "this is turning out to be an enormous job. It's time-consuming and boring. I should be paid for my time."

"Don't be ridiculous. You're doing this for your husband."

"I'm only kidding. But I'm having trouble concentrating. You know, instead of sitting here and working on this, maybe I should be taking notes on what's happening to you."

She smiled. "Well, I've always told you you'll learn a lot more about aging firsthand from us—after all, we're in it—than from all those gerontology conferences you attend."

The truth, though, is that I felt too anxious to take notes. I was always taking notes for my anthropological research and rarely left the house without a notebook. But now I found it hard to be detached from my mother's illness. Nevertheless, even though I expected this medical event to conclude promptly, I decided to jot down a few observations and keep running notes on the unfolding events.

I forced myself to be pleasant, even cheerful and friendly, with the nursing staff when I certainly was not in the mood. I felt that Mother would be treated better if her daughter appeared unruffled. I wore my most colorful outfit—a hot-pink bodysuit and flowing Indian skirt in tones of pink, turquoise, and yellow. Everybody, including Mother, admired this inexpensive ensemble I had acquired at the Himalayan Arts Center in New York. My ethnic dress lifted my mother's spirits, and I did not have to think about what to wear. I just threw on the same outfit every day. My high-heeled shoes with leather soles were an indispensable accessory: From the time I reached the nurses' station, several yards from Mother's room, she could hear me clacking my way down the hallway.

"Mother," I said on one of the few occasions we were alone, "I want you to have something that will accompany you when Dad and I are not here." I took a laminated, wallet-size image of Dr. José Gregorio Hernández out of my shoulder bag and stuck it in the flap of her executive planner.

"Just hold it in your hands and pray to him. Put his image under your pillow or in your drawer. Whatever you do, remember: He's always with you."

"I know," she replied. "Don't worry. I'll take good care of him."

Mother had read, and even edited, most of my articles on José Gregorio Hernández, the Venezuelan physician and folk saint