"My brother owns a nursing home in Lakewood, New Jersey, and the things he sees you could make a book out of. If some-body wrote it, it might do the world some good."

— Philip Roth, *The Anatomy Lesson* (1983)

Chapter One
Do You Play Chess?
Overture

Sam Rosen is telling me once again he was married for seventy-seven years, and suddenly he's all alone.

He is one hundred and two. A year ago, he was still living at home with his one-hundred-and-one-year-old wife. But at ancient ages your life expectancy is limited. She's buried in the cemetery. He's buried in the nursing home.

"Fit as a fiddle, and then she catches pneumonia! Then my kids sell the house and put me here. They don't even visit," Sam says.

"Seventy-seven years!" he reminds me.

He's sitting on his bed in the corner of a room considerably smaller than the average middle-class living room. I'm in a chair squeezed beside his bed. Books and magazines—most of them of a left-wing variety—are piled high on the nightstand. This small corner of the universe is all that is left to him after more than a century of living. It is no different from the small corners allotted to the hundred other residents of his nursing home or from the two million corners of similar rooms in the eighteen thousand nursing homes across our nation.

Two million out of a population of three hundred million may seem like a small number, but the nursing home experience will touch almost all. If you are sixty-five, your lifetime chances of spending time in a nursing home are 43 percent. If not you, it could be your parents.

As you age, your chances increase. Only 12 percent of people between sixty-five and seventy-four are in nursing homes, compared to one-third of those between seventy-five and eighty-four. If you live to eighty-five, your chances are better than one in two.

Sam defied the odds. For most of those seventy-seven married years, he lived in a big old Victorian house. It had only a few years on him. Queen Victoria died just a few years before Sam was born.

On the wall is a vintage sepia photo of a cute couple.

"That's me and my wife," Sam tells me—the wife with a flapper bob, Sam with wavy hair looking early Cagney.

Next to that photo is one of Sam, a lifetime later. He and the family are blowing out a one-hundred candle cake. I idly wonder how they lighted the last candles before the first ones went out.

If you looked up "wizened" in the dictionary, there might be a picture of Sam. But he's ambulatory, can still read, and knows he's unhappy.

"Do you play chess?" Sam asks. "Or Scrabble?"

Every week I see him, I get this invitation along with a reminder that he was married for seventy-seven years.

The other day my daughter was flipping through the *Guinness Book of World Records.*

"What are you looking at?"

"I'm looking at the Longest, Daddy."

"Like what?"

"Well, the longest marriage was eighty-two years."

So Sam doesn't hold the record but still gets elected to the Marriage Hall of Fame.

I tell Sam I probably don't have time to play chess. I make a note to ask someone on the staff if they could play.

On the other bed, Ralphie, a mere child of eighty-two, is sitting on his bed flipping through sports magazines. I'm not sure Ralphie knows to read as he looks at pictures of Alex Rodriquez, Michael Strahan, and Shaquille O'Neal, his radio tuned to the soul music station.

Ralphie, an African-American, and Sam, a Jew, are demographic anomalies in this largely Polish facility. Not that it doesn't happen, but I've never seen Ralphie or Sam with a visitor. For many of the Poles, if Mom can't be at home, the family will bring home to the nursing home—all the kids still arrayed around Mom, just like Sunday dinner. One younger woman, I thought she was on the staff, except she was a daughter sitting by her mom all day. The mother in her wheelchair holding a doll, the daughter wiping the drool off the perpetually smiling face.

Ralphie spent most of his life working construction interrupted by a few years in the Negro Baseball Leagues. "I took away a home run from Josh Gibson. Reached right over the fence. It was already gone." This might be the crowning point of his life. Occasionally, the staff tells me, one of his buddies comes by and they drive over to another nursing home to visit yet another buddy who has Alzheimer's. Then, in an act of defiance, he goes out for ice cream, fresh-made ice cream at the University dairy. It's poison to his diabetic body, already missing some amputated toes. For days his blood sugar goes out of whack, but he bitterly complains at the lack of sweetness in his diet—and his life. He curses at the cook. The cook won't speak to him. Why control your impulses when you're a dead man walking?

Ralphie is one of the never-married. He was living in subsidized senior housing, more or less not taking care of himself. They found him passed out with hyperglycemia following an ice-cream binge. Someone wondered whether the flavor was Forbidden Chocolate. For Ralphie, landing in a nursing home is arguably landing on his toeless feet.

"I'd just as soon die if I can't have ice cream," he once told me.

Ralphie is in love with Gladys, another African-American.

Gladys sits most of the day in her wheelchair. A couple of strokes and she's mostly mute as tremors roll like waves through her body. She can hear us, and she struggles to respond in words contorting her lips into indescribable shapes before she collapses in frustration.

They say she's depressed.

Along with contraband ice cream, Ralphie lives for Gladys.

He's often wheeling her around. I wonder if she does more than tolerate him.

"When she dies, I'm out of here."

How far can he get? He walks with a stiff-legged Frankensteinian gait characteristic of those who can't bend their arthritic knees. He lurches from left to right as he totters forward.

Occasionally, a frustrated denizen of a nursing home will fly the coop, rolling off in a wheelchair or shuffling down the street pushing his walker before him. You could measure staff negligence by how far he gets. Typically, when caught, they'll say something like, "I really missed just having a beer." Or, "I was tired of being told when I could smoke." Or, "I was going to see my mother." The escapee might be eighty. Mom might be dead for thirty years.

The staff hates this stuff. Hours of paperwork and inquiries from the State.

Sam asks me again.

"Do you play chess?"

"Not very well," I answer this time.

Sam has told me his story many times. Aside from being married for seventy-seven years, as a very young man he led what appears to me as a romantic life in the nascent aviation industry. Flying his plane into a town, lifting the locals in the wild blue yonder for a dollar a ride. Things went bust in 1929.

Back in Connecticut he married, scraped by, and started a small machine shop, something he learned from fashioning his own airplane parts. It was one of the thousands of shops that served Connecticut in its glory hard-core manufacturing days. He sidelined in radical politics.

"Did you ever hear of Paul Robeson? The singer? He was a friend of mine. Stayed at my house whenever he was in Connecticut."

Another story I've heard more than once sitting next to the latest copy of *The Nation* or *The Progressive*.

This time I get a variation on the theme.

"You know I like to play chess. I like to play Scrabble, bridge, all the games. I taught my daughter cribbage. She was terrific. Hustled her way through college beating all the boys. I taught this one fellow to play chess and then I was going to be drafted for the war, but he was on the draft board. As a favor to me, I wasn't drafted."

I find it hard to reconcile his radical politics with draft avoidance during World War II. Maybe he's confused. After all, he was almost forty years old when we entered the war. Maybe he got a pass on the basis of his already advanced age nearly sixty-five years ago. Maybe they needed him at his machine shop building military parts. Sam couldn't have been thinking about World War I. He was only twelve at the time.

"Seventy-seven years. I was married for seventy-seven years and now I'm here by myself," I hear again. "Can you imagine? Seventy-seven years! And here I am all alone. Do you play chess?

We're interrupted. A nurse at the door. "I have something for you, Sam," she chirps.

Living in a nursing home is life interrupted. Your door is always open. The staff views closed doors with the suspicious eyes of a teenager's mother. But these people aren't sneaking joints or downloading porn. Walking down the hall on a typical morning, peering through the open doors, they're mostly lying in bed—some eager for the staff to come, others hoping they won't bother.

Oblomov comes to mind, the hero of an 1858 Russian novel by Ivan Goncharov. On page one, Ilya Ilyitch Oblomov is lying in bed—"in his dark-grey eyes there was an absence of any definite idea, and in his other features a total lack of concentration." Sounds like some of my case notes. On page one hundred fifty, Oblomov gets out of bed. Idle and rich, Oblomov—living in the last decades of the czars—is superfluous, unproductive, and parasitical. There's little reason for him to get up. Nursing home residents—despite outward appearances—are hardly superfluous, unproductive, or parasitical. Their care and feeding is a $115 billion industry. We're not quite the Alaskan nomads who leave behind Old Koskoosh in Jack London's *The Law of Life*. Old Koskoosh waits helplessly by his fire, dreaming of youthful hunts while the wolves circle in. Resigned and uncomplaining, he reflects, "Nature was not kindly to the flesh. She had no concern for that concrete thing called the individual. Her interest lay in the species, the race." In our supposedly humane culture, we keep our elderly alive as long as scientifically possible, and the elder care industry profits from our humanity. Bottom line for me: if life expectancy were lower, or if it didn't so often end in a frail passage through the nursing home, I'd be in another line of work.

Looked at yet another way, the morning nursing home ritual is a parody of the morning levee of King Louis XIV. When the Sun King rose at 8:30 a.m. each day, the First Valet de Chambre would pull the curtain surrounding the bed and announce, "It is time, Sire." Louis would open his eyes to a group of courtiers—each ready to play a precise role in his theatrical routine. In the nursing home, two or three aides enter the room and announce, "Time to get up, Joe." The aides draw the curtain around Joe and begin their morning routine. With the king, the First Servant took hold of one of Louis' sleeves and the Master of the Bedchamber took the other and they pulled off his nightshirt. These royal tasks imparted great prestige, fulfilled not by peasants by by high ranking nobility. Louis like to keep on eye on the possible opposition. He was an early adapter of Vito Corleone's advice for leadership: "Keep your friends close, but your enemies closer." Joe's nursing home aides aren't thinking in terms of prestige or affairs of state . The aides' white outfits are an upwardly mobile step up from the blue jackets of Wal-Mart. They'll get Joe dressed and deposit him in his wheelchair. Maybe they'll turn on his TV and pause for Jerry Springer before moving on to the next room. Louis would move on to being the King of France.

There is another parallel. Most of us flow between a public and private zone. We have at least one door we can close to the world. People in nursing homes have lost this door as, like Louis, they live their life in public.

The nurse at Sam's door is mixing up some crushed medicine in a little cup—the kind in which you get a side of coleslaw at the diner. She's on her med pass, another of the many daily routines. This is a landscape where the only spontaneity might be the screams of a person with not enough medication. All the routines are scrupulously documented. There is one set of books—procedure books—telling you what to do. There's another set of books—record books—in which you write down what you have done.

The nurse pushes a cart quite similar to the cart a flight attendant pushes down the aisle of an airplane. Many of the folks complain about the "service" as if they were in a bad hotel: "I ring this bell, but they never come." The top of the med cart is loaded with carefully counted medications. There are cups of water and tools to crush meds for the toothless or for those with swallowing problems. Orange juice or ginger ale is there for a chaser. Crushed meds are blended into applesauce. There are high-calorie, vile-tasting health shakes to fatten up those with a "failure to thrive." This happens three shifts a day, one med pass per shift. Sometimes I'll ask a nurse for a favor and I'll get the response, "I'm in the middle of my med pass. Can you wait until I finish?" Residents—we try not to call them patients—ask a question or a favor and get the same answer, "Wait until I'm finished." The routines get the staff through the day. A med pass will get a nurse through at least an hour or two of her shift. And when she's doing her pass, she can't be interrupted.

For the staff, a day in the nursing home is like an industrial process. This is not a creative workshop but a place where every procedure is by the book—or, more accurately, every procedure is by one of the many books. These recipes bake no bread. The idea is not to come up with a product at the end of the shift, but to keep a body alive to pass on to the next shift that operates out of the same set of books.

One of the main processes is the process of medicating the residents. There's a long list of drugs.

Zyprexa, Prozac, Lipitor, Remeron, Xanax, Coumadin, Ativan, Ambien, albuterol, Lexapro, Percocet, insulin, Celebrex, Celexa, Vioxx, Neurontin, Plavix, Risperdal—the pharmacopoeia of American medicine today—but no Viagra or Ortho Tri-Cyclen.

The elderly—whether in nursing homes or not—represent a license to print money for the pharmaceutical industry. The average nursing home resident ingests about ten drugs a day—predominately gastrointestinal, analgesic, cardiovascular, and psychoactive. People over sixty-five spend $50 billion annually on prescription drugs, $5 billion of that coming from nursing homes—more than half paid for by the government. A particular nursing home may go bankrupt, but drug use is always on an upward trend. A 2001 survey by the Pharmaceutical Researchers and Manufacturers of America uncovered 261 drugs in development for diseases of aging—Alzheimer's, osteoporosis, and arthritis. This is not to mention drugs for diseases of all ages—122 for heart disease and stroke, 402 for cancer.

Some people wind up in nursing homes only because they can't keep track of their many medications. Is this age related? If you were taking ten drugs a day, how easily could you keep track? In and out of the rooms the nurse goes dispensing the pills one by one, checking off each one on her clipboard. If this were fiction, I'd write I hear the tune "Candy Man" coming from one of the rooms.

Finished with Sam, I wander off to approach an eighty-five-year-old woman asleep in her bed. Waking with a start, she screams at me, "Who are you and what are you doing here?"

I am a psychologist who travels around to nursing homes and talks to sad, confused, and, occasionally, happy old people. I work for a company that provides a range of psychiatric services—a team of a psychiatrist, a psychologist, a nurse, and a social worker. Unlike the medical staff that deals in a tangible and ingestable commodity—drugs—I offer an intangible—me. You tell a psychiatrist that the ninety-two-year-old lady in Room 12 is calling out in the middle of the night for her mother, she gets labeled as agitated, and there's a pill that will fix her right up—or so they believe. Sometimes they ask me to change a prescription. "When you guys lowered Mrs. Brown's Risperdal, she became much more delusional." I remind them I'm the psychologist and I only talk to people.

"It's the psychiatrists who do drugs," is my joke.

I get a confused shrug or condescending smile. Then they ignore me.

My eunuch-like quality when it comes to prescribing aside, all of us team members think in terms of disease and cure, in terms of symptoms with an underlying disorder. We're highly medicalized. In order to be paid, we have to specify a disease diagnosis. We have a book—*Diagnostic and Statistical Manual of Mental Disorders*—that has a code for everything from anxiety to voyeurism. I look up my diagnosis in the manual and enter the code on a form. I spend as much time writing things down as I do talking to people. No diagnosis, no code, no payment.

But I'm still the invisible man who doesn't do drugs. Not only do they ignore me, they pretend I'm not there. I can be in the middle of Mike Mindykowski confessing, "I beat my kids. That's why they never visit," when an aide will walk right in and start changing the bed. The maintenance man might saunter in with a mop to clean up the vomit from Mike's roommate. The cable guy might follow the vomit cleanup to fiddle with the TV.

Are you expecting privacy?

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) formalized standards for protecting patient confidentiality. Show up at a doctor's office today and they hand you a HIPAA form outlining your privacy rights. Ever read it? More likely, you're preoccupied with whether that mark on your face is melanoma. You're less likely to pay attention to your privacy rights than the fine print on your monthly credit card bill. It's kind of a joke, actually. All of our medical records and their deep dark secrets are sitting in databases all over cyberspace. Some clerk, possibly in India, seeing you're on Viagra or the date of your miscarriage.

Personally, I proceed on the assumption that the privacy of my own medical records is greatly compromised, and move on from there. For my patients, I do my best. When the aide comes in to change the bed, I jabber about the weather. If there's a roommate in the next bed, I'll do a quick assessment of his mental status. If he's too demented to follow the conversation, I'll assume we're in a zone of privacy. If the roommate is a cogent thinker, I may try to find an empty office or lounge. In nice weather we might go outside. I may be the first person to remove a resident from her room in days or weeks. With hard of hearing patients, I might close the door so when I shout out, "How's your mood? Are you depressed?" not everyone will hear the answer. If all else fails I may simply draw the Louis XIV curtain around the bed and conduct my session with an illusion of privacy, which doesn't always prevent a roommate from chiming in, "I don't know about her, but I'm very depressed."

This is not psychotherapy in a designer office with leather chairs, objets d'art, and the quiet undertone of a ticking clock. These are field conditions. I'm often moving piled-up clothing or a prosthetic leg to find a place to sit. One of my colleagues abruptly quit after she realized she had been sitting for the past half hour on a urine-soaked cushion. Sometimes I'll enter a room and then wander off to find a chair to carry back in. I've thought about bringing my chair-in-a-bag to be sure of a seat.

The staff's attitude to what I'm doing may be encapsulated in the comment I overheard, "Therapy for these people. What a waste." My patients themselves don't know quite what to make of it. This is the Greatest Generation. Most people in nursing homes are in their eighties, born in the 1920s. Growing up in the Depression, they didn't share my boomer luxury of exorcising their psychic demons in psychotherapy. Food, clothing, shelter, and staying alive were their childhood and youthful priorities, not looking for love and fulfillment in the consultation room. Graduating from grammar school—the eighth grade—was a mark of academic distinction. Later they got to escape the farm, factory, and office to kill Germans and Japanese. They're the ones who think you have to be crazy to see a shrink. I don't always specify I'm visiting them for psychotherapy. I low-key it, "I'm a psychologist. Can we chat?" Let them put two and two together however they please. They're often eager for the chat, even if they display an initial reluctance. I have many faults, but in the lives of many of these old folks, I might be the only person who sits down, establishes eye contact, and simply listens.

"How are the kids?" I ask Mrs. Abbot.

I can guess the answer.

"They're fine, but I dearly miss them."

She has a daughter in Paris and a son in Arizona. She can be proud. The girl writes chick-lit fiction for ladies who lunch—high-concept soap operas of the rich and famous. Her son is an astronomer who spends his nights in the clear mountain air of the Southwest looking for apocalyptic space garbage headed towards earth. There are grandchildren. I see their pictures at various ages, in soccer and basketball uniforms, in high school graduation robes, holding a lacrosse stick at Dartmouth. A much younger Mrs. Abbot, trim and tan, is in one of the pictures with toddler grandchildren at the

cottage on Cape Cod. The pictures sit on a French provincial bureau. Above the bureau is a watercolor of a regatta in rough seas.

I could learn to resent and envy her kids, probably growing up in a home with no yelling, sitting placidly around the dinner table, actually asking "How was your day dear?" Bunny—they do have names like that—is the successful writer I dream of becoming, and Junior doesn't have to worry about tuition for his well-mannered kids.

"That's my husband's sloop tacking around the flag well in the lead," she told me proudly, the first time she caught me looking at the watercolor. "I painted it." The painting has the mannered style of someone with skill and time to do it well, but not the drive to be great.

Mrs. Abbot's husband has been gone for more than two decades. She is eighty-three. Charles Abbot II was dead at his Wall Street desk at the age of fifty-seven. He's in the photos too, trim and tan like his wife. I don't envy the heart attack. I'm older than the man in the photo, but alive and reasonably well.

"So how are the kids?" I ask again.

"Bunny is off to Santorini for Christmas, and Junior is observing in the Andes."

The furnishings in this room do not come from either Source 1 Medical or Pier 1 Imports. Mrs. Abbot—possible *Mayflower* descendent, Seven Sisters graduate, and daughter of a New England industrialist whose mills have long left New England, first for the South and then Asia—is in one of the upscale nursing homes, Maldon Manor. What you get for your extra money is a building tucked away in leafy greenwood. There are thick—though easy to clean—carpets. You can bring in some of your own furniture. The facility saves a bit on overhead when it's your furniture, and you can get a bit of the homey touch. The staff calls you by your last name—no twentysomethings familiarly addressing people old enough to be their great-grandparents, no, "Hi Annie," to eighy-seven year old Mrs. Brown. The halls in Maldon have the required grab railings along the length of the walls but above them are quality art reproductions. A reproduction of Seurat's *A Sunday Afternoon on the Island of La Grand Jatte* is just outside the door.

Mrs. Abbot doesn't get around much anymore. She had a stroke from which she has rehabbed better than expected but not well enough to return home. She can feed herself, and her Yankee accent is only a bit slurred. But she has told me, as I have heard from many others, "If only I could walk."

Feeding yourself is an ADL—an activity of daily living. You get regular ADL ratings on bathing, dressing, getting in or out of bed or a chair, going to the toilet—"toileting" is the term of art for those in the trade—and eating. Your ADL record, a government-mandated requirement, establishes your level of need and care. Mrs. Abbot can feed herself but needs assistance for most everything else.

When her kids make their twice-per-year visits, she gets unhappy knowing that their appearance means that soon it will be months before she sees them again. She's a paradoxical thinker on a level with me who realizes that "thank God it's Friday" means it's only two days until Monday. Mrs. Abbot stews in her own juices. She used to be a gifted pianist. Last week she didn't leave her room to hear another resident's daughter—a Julliard graduate—play Chopin on the grand piano in the lounge—the lounge that exits to the award-winning garden.

"It would have reminded me of all I've lost," she stammers as I sit listening in on her expensive solitude.

Psychotherapy is often weighed down with all kinds of theoretical constructs and elaborate metaphysical superstructures—psychoanalysis, interpersonal theory, client-centered, transactional analysis, cognitive-behavioral. Brings to mind the image in Hesse's *Steppenwolf* of the great composers in hell dragging their orchestrations behind them. But however you frame psychotherapy, it gets down to one person listening to another. Psychotherapy, to have a chance of working, means you talk and I listen—with no agenda except to listen. I work hard to do that. I've had years of training. I've had psychotherapy. It's not easy to learn to listen with no object but to hear what the person is saying. I work hard to check my own *meshugass* (it's a training requirement for shrinks to speak and think Yiddish) at the door. Freud said that when two people get into bed, other people are crawling in with them. Grace Slick, closet Freudian, sang, "Your mother's ghost stands at your shoulder/face like ice/a little bit colder/saying to you/you can't do that it breaks all the rules."

When I sit at a patient's bedside—and bedside manner is all we therapists got—I try to make it just me in the room with her; or not even me, just a mirror that looks like me. I struggle against the feeling that the old lady in the bed complaining her children never visit is a proxy for my dead mother complaining I never visited her. I had a famous professor—Bruno Bettelheim, no less—who told me it's perfectly okay to fall asleep during therapy, just make sure to analyze your dreams. It would be less wear –and tear on the soul to be a psychiatrist: simply hand out the pills, free from the collateral damage of a personal emotional reaction.

Annually, according to the Kaiser Family Foundation, we spend $1.5 trillion on health care. Seven percent—$115 billion—is spent on nursing home care. The $1.5 trillion health care tab dwarfs the piddling $250 billion we spend on cars. In terms of revenue, the nursing home industry ranks well ahead of advertising, publishing, pornography, and the film industry. It's roughly equal to aerospace.

Most people have the naïve assumption that—unlike the rest of the postindustrial world—our health care industry is free market. Health care for the elderly is a mixed economy; private providers largely funded and regulated by the government. Medicare and Medicaid, the two big government insurance programs, pay for most nursing home care. Medicare, government insurance for people over sixty-five, pays for short-term rehabilitation—e.g., you are rehabbing a broken hip but they expect you to return home. That accounts for around 12 percent of revenues. But Medicaid—you're in for the long haul and either start with no assets or you have depleted them to qualify—pays for half of the annual $115 billion expenditure. That number represents only the basic costs, room, and board. Billions more in government dollars go into drugs and services such as physical therapists and people like me. And he who pays the piper calls the tune. Because the government pays the bill, it can regulate much of what I do from the minutes I spend with a resident to the forms I fill out to document those minutes. State governments—typically the public health department—license nursing homes and psychologists. In Connecticut, I ante up $450 to renew my license each year, which

expires on my birthday. For some odd reason, I don't have to rack up a quota of continuing education credits as do many of my colleagues in other states or allied professions in my state. I'm spared the early morning cups of coffee in a motel meeting room where someone projects slides on a screen in a canned presentation, lapping up the money stream decreed by mandatory continuing education.

The homes don't get off as easy as me. In addition to their licensing fee, they must conform to volumes of regulations, endlessly documenting everything from the movement of a resident to the movement of his bowels, and smile when the state inspectors make their surprise visits. Everyone is on knife's edge—me trying to make my big frame invisible and the inspectors sweetly asking a nurse why Form 203 is missing in Mr. Harrison's chart. The state can lift your license, rarely, or fine you, less rarely. You can go to the internet and look up the violations in mom or dad's home. The ratings are color coded—like the defunct Homeland Security threat warnings—from green for no violation to red for actual harm or immediate jeopardy. When the State is around, they put up a notice on the front door announcing their presence and inviting any family members to come over and chat, which might be a good idea. The State has no statutory requirement to inform you about a problem, even if they discover Mom's diaper hasn't been changed for days.

I get a taste of scrutiny too. All of my notes go on forms that produce a carbonless copy. One copy goes in the chart, the other to my office. Periodically, a Medicare inspector shows up and sifts through my records, making sure I have crossed all the t's and dotted all the i's. Crossing i's and dotting t's could be a violation. But the inspector is not a clinician, more like a clerk who wouldn't be competent to rate my actual work even if she could read my handwriting.

We all like to complain about the regulations and the intrusive inspections, but it enables all kinds businesses and professionals to feed at the government trough. A half-century ago, this was a largely unregulated industry. Then came the tabloid shock of snakepit homes—Mom tied to the bed, rats running around, the owner off to jail. The aftermath was the government not only trying to control quality, but also the quantity of services. It mandated an array of services—physical therapy, occupational therapy, nutritionists, speech therapists, activity directors, podiatrists, dentists, and various mental health types.

We're not all on the staff with salaries and those pesky benefits. Many of the professionals serving nursing homes are free labor to them that is paid for by the government. There's a slew of us riding the circuit. I see the podiatrist, "Freddy, haven't seen you since April up at Marston Moor. Heard they went bankrupt."

When a nursing home hires my company or Freddy's, it can advertise it provides psychiatric or podiatric services. When I show up at Mrs. Ickles's door and she asks, "How much is this costing me?" I can say, "It's free. Medicare pays for it." Outsourcing to me is cheaper than hiring staff members with salaries and benefits. When you outsource to Psychiatric Masters of the Universe, Inc., it doesn't cost the facility a dime. All the rest of us are paying for it out of taxes. Who says there's no socialized medicine?

I know people who scoff and call Freddy's podiatry practice and my psych services group nothing but Medicare mills—companies that exist to feed off

government entitlements. When the government funds a service, companies will appear like mushrooms after a storm ready to be paid for that service. I don't see anyone even providing compasssion pro bono. There aren't enough nuns to go around.

As Tina Turner sings, "What's love got to do with it?"

Immanuel Kant, German philosopher about whom a student exclaimed, "I can't understand German no matter what language it's written in!" wrote that love is morally irrelevant. Kant—never married, never in his lifetime more than a few miles from his hometown of Konigsberg—said it is our duty to nurture others. We can't rely on love. It's a dangerous feeling. Feelings are fickle. "Tonight the light of love is in your eyes/But will you love me tomorrow?" Duty is a constant. If a child's welfare were dependent on its mother's love, what happens when the thrill is gone?

So it was with my father. My care for him was duty fulfilled—regardless of how I felt about him. Thanks to him, I got to experience the other side of the street as a consumer of nursing home services, not just as a provider.

Not so with my mother. In what was arguably a blessing to herself and her family, she up and died in the course of one day. A year before her demise, she survived a serious illness—pneumonia—and maybe her death was an act of kindness in which she recognized the strain her frailty put on her sons traveling inconvenient distances to New York City to do what we could.

My parents separated after thirty-seven years of marriage. My emotional landscape contains the residue of two people staying together for the sake of the children. Duty does not always have happy effects on children.

My father is one of the millions who didn't hit pay dirt but did hang on to get to Social Security. He was part of the army of the aged in Century Village, West Palm Beach, Florida—a retirement community for people who don't drive Cadillacs. There was no real estate bubble in this part of West Palm. These are condos that were going for $5,000 in the year 2000, not much more or less than the price thirty years before. Century Village is one of the many places for the elderly that started out with a fresh coat of paint and then aged along with its inhabitants. Many of the residents were lured by its spokesman, Red Buttons, who was a tummler in the borscht belt of their youth before his invitation to Florida at the dawn of their old age. Years after they moved to the Village in the 1970s the ambience looked "lived in." In Dad's apartment there were rust stains on the bathtub, worn rugs, and the air conditioner breathed as weakly as the residents. Walking around—and you had to watch out for the wide turns the drivers make around corners—it looked like an auto museum of noncollectibles—rusting Fords, Chevys, and Oldsmobiles.

When Century Village opened, most of the folks were in their sixties. They were attracted by the idea of Florida as a place with a golf course, pools, an activity-rich clubhouse, and no snow. It's motto: "We give years to your life and life to your years!" My parents were snowbirds. They drove down to their American dream from Brooklyn each winter for the few short years before it was over for their marriage.

One day, when he was almost seventy, Dad drove down to Florida by himself, leaving Brooklyn, my mother, and a marriage of acrimony behind. My relationship with

my parents was based on denial and indifference. I saw my father about once a year for a few days of stilted, scripted interaction. And so it went for about twenty years with me denying he was losing whatever grip he had on life.

One day, I made my once per week dutiful phone call to Dad and there was no answer. There was no answer through the night and into the next morning. He's a missing person.

My duties to my father, missing or not, were hard to enumerate, being a melange of biblical and cultural injunctions with no clear guidance for the twenty-first century. Throw in my emotional superstructure and it becomes even murkier. In my professional life, my government mandated duties are quite clear. I have a fairly standard routine when I meet someone new. First, I'll do a combined 90801/91600 procedure—psychiatric interview followed by psychological testing. Like everyone else in the medical world, I have codes and procedures, and forms for documentation. I see people who are often not aware that their sons or daughters have signed them up to see me. "Who sent you?" is a common response to my appearance at their threshold. Typically, someone on the staff or a family member will express their concerns about a patient—"Mom just sits there all day weeping"—and it will be entered in the book for referrals. We can't see anybody without a doctor's order, but most physicians are perfectly happy to have us relieve them of the psychiatric burden. They also let the nurses write their orders for them.

My company doesn't make any money on my services. "We just about break even when you see a patient," I was told. The medical people—psychiatrists and nurse practitioners produce a profit. The psychologists are in the mix for merchandising. When my company makes a sales call on a nursing home, our reps say that unlike Brand X Psych Services that only has psychiatrists, we will provide you with a full range of professionals, including psychologists. "Full range of services" is a wonderful buzz phrase for marketing.

Bottom line? I'm a loss leader—the cheap gallon of milk that gets you in the supermarket door with the hope that you'll leave with an expensive cut of beef because they make you walk past the meat counter to get to the milk.

<<LI#>>

Considering how I, a total stranger, am intruding on the privacy of the people I treat, I'm amazed at the responses I get. These people come from a generation not used to spilling their beans to anyone, let alone a total stranger. These are not my fellow baby boomers who enjoyed a luxurious search for personal growth—often in a therapist's office. My patients are usually not aware I'm coming, and have no idea why I'm there when I arrive. My usual greeting is, "Hi. I'm a psychologist. My name is Ira Rosofsky, and I'd like to chat with you for a while." Yet, despite their suspiciousness, and maybe because I'm the only one who shows them total, undivided attention, they'll tell me their deep dark secrets.

I start with pleasantries.

"Nice day outside, Mrs. Jones. Where are you from?"

“Brooklyn, New York.”

“Oh, really, me too. I grew up in Borough Park, Ninth Avenue and Forty-seventh Street.”

“I’m next door. Bay Ridge, lived there my whole life—until my daughter in Connecticut said it’s not safe for me to be on my own. So here I am.”

“How do you like it?”

“It’s not home.”

After the chitchat, it’s not long before I’m onto the Beck Geriatric Depression Scale. Mrs. Jones, a private person trying to hang onto her privacy, is suddenly hearing intrusive questions.

“Do you think it’s wonderful to be alive?”

“Well, I wouldn’t say wonderful. I guess it’s better than being dead, but if I woke up dead, I wouldn’t be unhappy.”

I often get these passive suicidal ideations—PSIs for short. People who would never go and hurt themselves, but wouldn’t complain if they “woke up dead,” as Mrs. Jones puts it.

There is a fair amount of this comic relief. Two other favorite responses to my stock questions:

“Do you have trouble making up your mind?”

“Maybe.”

“Do you have problems with your memory?”

“No, not at all, I have only happy memories.”

However pleasant the memories, most of the people I see are unhappy when we meet, but not necessarily clinically depressed. Trading a lifetime of independence for institutional confinement with strangers changing your diapers does not make for happy campers.

After Mrs. Jones spills her unhappy beans, I move on down the hall to the next person. Time is money. I’m fee-for-service, working on commission. I’ll spend the required minimum number of minutes per patient, write my notes as fast as I can, get in my car, and get on the road to my next sales stop. I’m a traveling salesman but I carry no products. It’s only me.

And it’s not always clear who the customer is, the resident or the facility.

I’m sitting in my car after a few hours at Hopton Heath Health Care and Rehabilitation, and my cell phone rings.

“Where are you?”

“I’m just leaving Hopton.”

“Could you possibly go back in? There’s a problem.”

It’s wheelchair road rage. The director of nursing tells me that Tim smashed his wheelchair into Alice. Then Tim and Alice got into a shoving match. Could I please talk to Tim? Could I figure out if it’s going to happen again? Is he a danger to himself or others?

I walk over to Tim in his wheelchair.

“How’s it going, Tim?”

“Okay.”

“Do you remember talking to me earlier today?”

"Uh, no."

"Something happen with Alice?"

"Alice?"

I write down something to the effect that "Tim is as likely to be nonviolent as violent in the future." These weasel words make the director of nursing happy. In fact, she's not at all interested in what I've written, and probably won't read it. She cares only that I've documented it—that there's a form with my signature in Tim's chart—which is what she is really concerned about. The State might get a whiff of the incident, and without documentation, it could be a problem or even a fine.

Old age is a majority female terrain. Finally, they're largely rid of us men. According to the Census Bureau, in 2005, sixty-five-year-old men had a life expectancy of sixteen years versus nineteen years for women. Contrary to the notion that longer-lived wives get to enjoy their dead husbands' estates, the data show that old women have fewer material resources than old men. In 2003, the median income for men over sixty-five was $17,359 versus $13,775 for women. Staying married—if you can manage to keep your husband alive—is the best of all, with a median income of $36,606. Older single women were almost twice as likely to live in poverty than single men—13 versus 7 percent.

But whatever your gender, if you live long enough, the alternative to death is an ever increasing prospect of disease. Aside from such cheery prospects as heart disease, osteoporosis, arthritis, and stroke, if you reach the age of eighty-five, your chances of dementia are one in two. Before modern medicine and public health, most people died off before they had the opportunity to experience old-age misfortunes. Until quite recently, "live fast, die young, and leave a good-looking corpse," was the way of all human flesh.

Prehistoric folks had a life expectancy of eighteen. But this brief span was world enough and time for reproduction and survival of the human species. They died too young to have a legal drink, but they had quite enough life span to discover fire and invent the wheel. A handful of twenty-year-old elders were sufficient to pass along their modicum of culture—how to organize the hunting and gathering, how to bury the bodies. Over the next several millennia, as life expectancy crept up to thirty, there was plenty of time to be Alexander the Great, Jesus, or Mozart.

Fast-forward to 1946, the year I was born, and life expectancy was sixty-seven—approaching the Biblical three score and ten—quite enough time to invent the computer, triumph over Fascism, and replace swing with bebop. People considerately exited before becoming complete demographic undesirables to TV advertisers. You could briefly savor your life achievements in full command of your senses and then leave the scene.

What's the meaning of the extra twenty or thirty years we have attained since my birth? Life remains mortal and finite. Spirituality aside, when you're dead, you're dead forever. There's a movie scene—I think it's Marcello Mastroianni—in which a dinner-party host cuts some flowers but doesn't put them in water.

"Why not put them in water?" asks a guest.

“It only prolongs their agony.”

With all the recent longevity gains, how can we say we’re not just prolonging the human agony? Thomas Hobbes—who lived more than three hundred years ago in a time of warfare and upheaval—mused that life is nasty, brutish, and short. Does three centuries of progress mean we can now say that life is nasty, brutish, and long?

The young have a delusion about longevity. They think of the big number but not the frailty, the illness, and the confusion. Ask a typical twenty-year-old, “Would you like to live to a hundred?” and the answer is usually yes but it’s always the Dorian Gray ideal—where you get old but don’t age.

Another misconception is that there once was a Golden Age of Family—now lost among our mobile strivers. I always ask the old folks, do you have brothers or sisters? And I often hear, “I have a brother somewhere. I think in Georgia. But I don’t know.” I get an image of the two of them long ago spending their childhood days at play together, or even sleeping together for years in a shared Depression-era childhood bed. I might see a photo of the two brothers long ago at a forgotten family reunion.

Millions of my grandparents’ generation left the old country never again to see their loving kin. Millions of their children left home as young adults looking for work during the Depression—never to return. My in-laws met during World War II in San Francisco. My mother-in-law was a Finn from iron miners in Northern Minnesota looking for war work. Her parents had fled the czar. My father-in-law came from Neapolitans who had migrated to New Haven, Connecticut. He was a sailor on shore leave in San Francisco. Their grandchildren—my children—have cousins they will never know.

Anthropologists suggest that all homo sapiens may have evolved from a small band of wanderers, all the issue of a single Eve. All of us billions from a singularity, just like the stars of the universe. And we, too, are ever flying apart.

Sam’s gone too. One day I arrive and someone else is in his room.

“He passed,” is the euphemism I hear.

I wish atheist Sam a heaven where he is playing chess with a Russian Communist grandmaster; or at least no more than a thousand years of purgatory across the board from an unrepentant Trotskyite.

I ask about the new arrival in Sam’s room. He doesn’t need me. Mr. Jack Piotrowski checked himself in. He’s happy to be free of independence and its risks to his frailty.

I have to remember that I’m mostly exposed to the unhappy. Not everyone is a Sam. Jack Piowtrowski sits there comfortably, along with his cup of not-too-lukewarm coffee and the Mets on TV. I could think of a worse fate for me.