Country Real Estate, #328: FOR RELEASE on June 27, 2014

Fight night: Melissa goes 15 rounds

By Curtis Seltzer

BLUE GRASS, Va.—"I might need you to powder my butt," she said last week after I brought her home from the hospital.

What a thrilling prospect, I thought. A first—it only took 31 years!

However…after leading me on and raising my hopes, she did it herself.

I wuz robbed.

Second and third weeks after the horse wreck:

Melissa inexplicably escaped major health concerns like death or paralysis on Friday, June 13th, when her horse, Spirit, went to the ground without cause or warning. None of the fractures in her neck, ribs and back required surgery.

On the other hand, she did make a one-point landing on her chin. Her jaw was broken; her teeth -- none lost -- were misaligned; her lower lip was almost severed. After four days in the University of Virginia's Hospital in Charlottesville, she was discharged into my care, pending surgery.

Pain expressed itself in her face, neck, back, ribs, hands, forearms and butt. She was wearing a collar that immobilized her neck. She could eat liquids and glops through a straw or with a spoon. It was hard for her to talk owing to two days of having a breathing tube down her throat, which saved her life.

She lost 10 pounds in 12 days and has been touted by Oprah as the new diet guru. (Just for the record, I've been trying to stuff her with calories and protein. The problem is not a lack of supply; it's a lack of demand. As the resident undocumented nutritionist, I'm dealing with a client who has lost her appetite and is a tough cookie to boot.)

Last week, she was able to lie on her back, sit and walk a little. But mostly she worked on mastering, "Stay!" Let's put it this way: She's having conceptual difficulties understanding what a "patient" is.

On the upside, her injuries brought us to a new level of marital intimacy involving anatomical regions the Dowd family historically referred to as "the tandy bogus" and the "wazoo."

Normally, "wazoo" refers to the part of the body on which one sits—one's butt, in the vernacular.

The local interpretation reverses these definitions, so that one sits on one's tandy bogus and things either go up or out of the old wazoo. I may not have this exactly right.

It's frustrating to be dependent, especially on the likes of me. She was able to hold a cup, swallow pills, work the remote and tend to her bathroom needs last week. She even managed to deprive me of my moment in the soft powder.

On Tuesday, the 24th, Melissa reported at 10:30 a.m. for surgery to reposition her jaw, redo her lip and get her upper teeth to meet her lower teeth as they once did.

We waited for seven hours in the UVA's pre-op station as emergencies bumped her twice out of the operating room. We understood that emergencies took priority.

I talked with her surgeon afterward. He and his team had aligned her jaw and teeth perfectly. This was tricky, because he had to muscle her jaw around while keeping her head and neck absolutely still.

The lip was redone and stitched again, leaving a piratic line of sutures running toward her chin. Much cooler and more swashbuckling than a tatoo.

The anesthesiologist put her under and brought her back, as she had promised. I didn't ask for more than that.

Her surgeon gave himself a "B." I gave him an "A," and I've always been a hard grader.

I met Melissa in her "short-stay" room around 8 p.m., Tuesday.

Then, it took four hours to get the hospital to give her pain medications.

The problem was that her surgeon had prescribed narcotics in pill form, which because of swelling and jaw pain she couldn't swallow.

The night nurse stalled for two hours, afraid to ask for a change to the same painkiller in liquid form.

At 10 p.m., as Mel's surgical drugs were wearing off, I started asking to see the resident to make the switch. More stalling at the desk. More "we're on its." More "it's coming." More No Show.

At 11:30 p.m., Melissa was climbing the walls. At 12, I pitched a fit.

A syringe of Dilaudid, an opioid for severe pain, arrived in five minutes, and the liquid oxycodone got there five minutes after that. The nurse gave her the Dilaudid through her IV and the oxycodone by squirting it in her mouth with a syringe. The rest of the night was calm.

Melissa was scheduled for discharge around 8 a.m. We waited for the prescriptions to be signed. Her doc was tied up in a complicated surgery that lasted 12 hours. The supervising resident had been on the job for three days. He didn't know the computer system. He wasn't sure what to do without authorization.

I, finally, got the Dilaudid going again.

I tried to give Melissa a shower before we left, complete with a full powder job. No hot water. It wasn't even warm.

She blamed me for sticking her in a cold shower.

The computer screen in her room gave me a phone number to call if the phones were not operating.

Where exactly had we landed?

Then more waiting for the discharge prescriptions to be signed. Nothing.

I was bugging the nurses about every 30 minutes. The resident would not appear; he was "busy," he later told me. I'm sure that was true. The whole place appeared understaffed.

More squabbling over pain medications as our forced stay in the hospital extended hour after hour beyond her scheduled dismissal.

We faced a four-hour journey home that involved getting prescriptions filled at three pharmacies, groceries and supplies. I had to have her doped up just before we left for Blue Grass. More hemming, hawing and "we're on its." (I did wonder what exactly they *were* on.)

The supervisor walked in around 12:30 p.m. He said he "understood," and would get it resolved. Nothing.

At 2 p.m., I'd had it. I told the desk nurses that I was carrying my wife out of there, authorized or not, prescriptions or not, in 10 minutes. Several words were used for emphasis. I tried to look larger and even more deranged than usual.

Melissa usually pretends she doesn't know me in these situations (which really are not that common), but this time she was ready to jump into my arms and say, "Giddyap!"

Five minutes later, the resident appeared with seven typed prescriptions and pen in hand. The final going-home syringe of Dilaudid came at the same time.

We got home around 7:30.

Things have settled after escaping the UVA hospital. The pain killers work. Her face is swollen and hurts, but getting better. She will be in a collar for six weeks and it's hard for her to speak. Her voice has gone from tenor to soprano. As I write, she's sitting up and watching soccer. The stitches will be pulled next week.

She just accepted a chocolate-fudge protein drink. Big step.

Lessons I have learned:

Never go into a hospital by yourself. A patient needs to be accompanied by an advocate who keeps his or her wits through sleeplessness and bureaucratic stonewalling. Three times in two short hospital stays, Mel needed someone to intervene on her behalf.

It may be advisable to hire a professional fit-pitcher with certain hospitals, or at least go into them with a highly ranked amateur.

Don't be intimidated. Medical conditions and care are complicated. The vocabulary is unfamiliar to a layperson. Acronyms abound. Everyone is under time and performance pressure. The patient

is in the hands of the doctors and hospital staff. All approach their work and their patients with the best of intentions.

But…mistakes are easily made. We were asked the identical set of background questions five different times, and no one seemed either to read or process our responses that were on the computer screen in the room.

You have to ask why, and you have to get explanations in language that you understand. Some docs are better than others explaining what's going on in lay terms. Press the ones that don't, even if it takes a little more of their time.

Mel had terrific docs—each of whom appeared in our lives through a process that was never explained.

Be nice and understanding. Everybody is supposed to be on the same page, of getting the patient fixed and out the door. I tried to be as nice and as understanding as I could, as patient as possible and as reasonable as a center-of-the-road judge for as long as I could.

Squeaky wheels get the grease. One hopes that one doesn't have to raise hell in a hospital with people who are caring for the patient. But, ya know, sometimes it's the only way to get things to change for the better.

(At some point, I should write about the sit-in I conducted with Melissa [who was ready to file for divorce] in the office of the Dean of Admissions at the University of Virginia's Law School that got her admitted.)

By the time, I pitched my final fit, the nurses were rooting for me. I was asked to fill out a survey. The delay and stalling were driving them batty, too. They knew what was going on.

Modern medicine and hospitals are amazing. The level of technology, science, knowledge and sophistication is world-class.

On the other hand, the logistics of care-giving at UVA was something that had escaped from the Fourth World.

The hospital could not get medicines, equipment, patients and services from one place to another in a timely fashion. Everything tried for the first time was delayed beyond comprehension.

Understaffing seems to be part of it. Summer schedules and the infusion of inexperienced residents were other factors.

But it appeared to me that it was the cumbersomeness of the paperwork and procedures that built delay and miscommunication into having the different system parts work smoothly with each other. Each segment worked well within its four walls; it was getting the components to work together that was the problem.

Here is the bottom line, in more ways than one. Melissa's improving. With her lip, she's not allowed to laugh, smooch or spit. (Not much left, is there?) She's out of danger, except from me. I've kept my powder dry.

She sends thanks to those who have sent her cards, emails, prayers, secular-humanist good wishes, agnostic and atheistic crossed-fingers, food, flowers, presents and, finally, warnings about husbands as nurses who double as writers.

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