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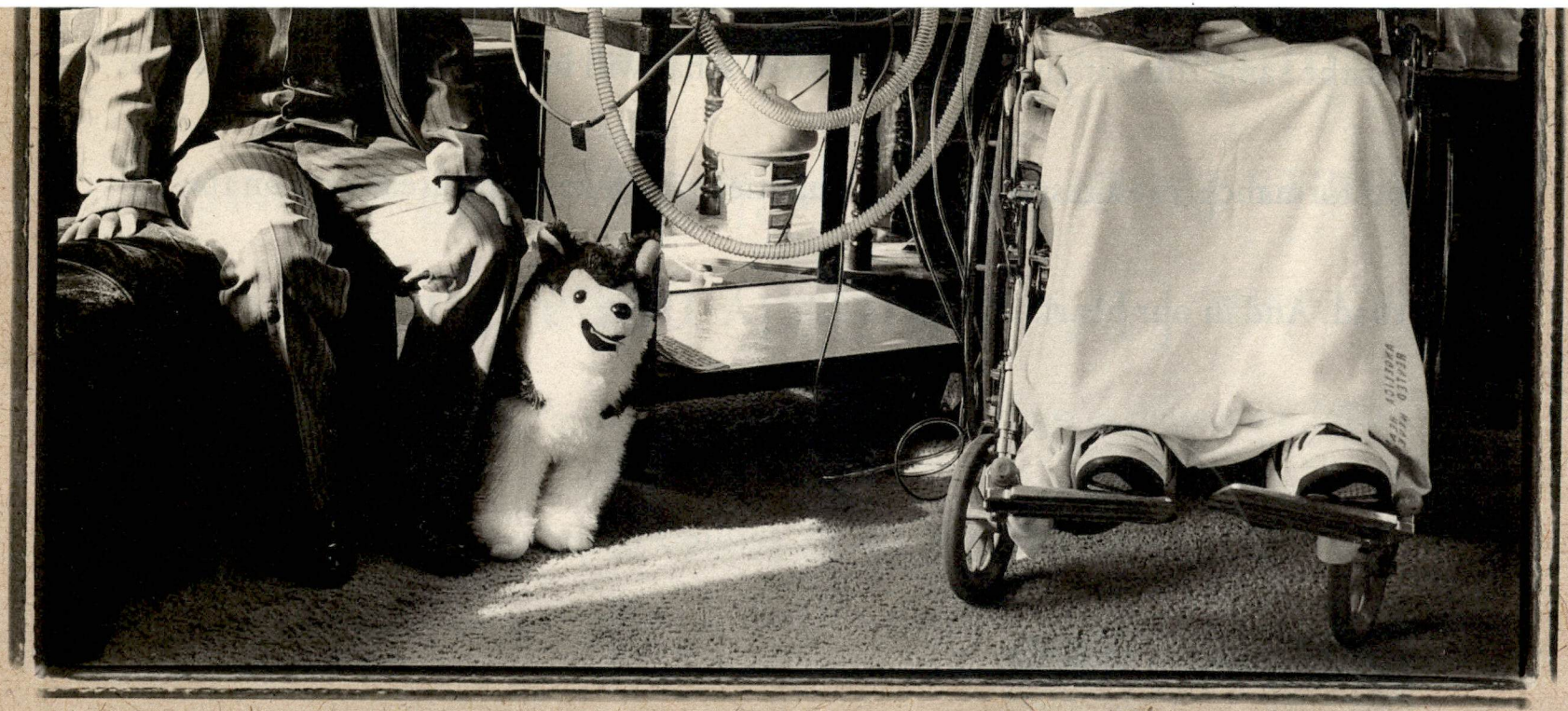
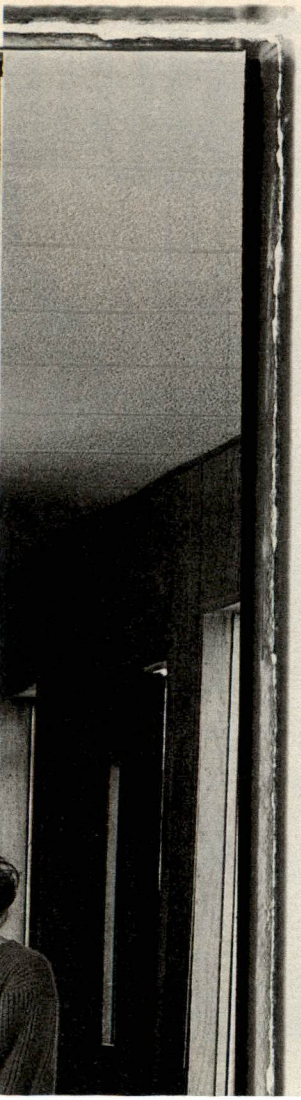


The hospital staff saw Armando Dimas as a potential organ donor, a gunshot patient sure to die. But he didn't, and by the time he went home four and a half years later, his care had cost $727,008.71.

HE LIVED. WHO PAYS?

BY LISA BELKIN

PHOTOGRAPHS BY KEITH CARTER



The High Cost of Living

BY LISA BELKIN

The hospital that saved Armando Dimas's life subsidized his treatment for four and a half years. Then it decided it couldn't afford to care

four and a half years. Then it decided it couldn't afford to care for him for the rest of his life. So, angry and fearful, Dimas was sent home.

DR. DAVID MACDOUGALL WAS TAKING a brief, well-earned nap on a couch in the neurosurgery department at Hermann Hospital in Houston when his beeper sounded at 3 A.M. on July 24, 1988. It was the emergency room calling and the conversation was brief, a basic recitation of the facts. The patient was a Latin American male, age 24, who had been shot in a dispute in Madisonville, 85 miles away, at 1:15 A.M. One bullet had grazed his skull, near his left temple, and the other had entered through the back of his neck, penetrating the spinal cord.

The patient had been taken to a local hospital in a private car. It was unclear whether he had been able to breathe on his own during that trip or if any lack of oxygen had affected his brain. When he arrived at the hospital, about six minutes after the shooting, he was given cardiopulmonary resuscitation and put on a ventilator. After he was stabilized, he was transferred by helicopter to Hermann. Officially, Hermann's emergency room was full that night, closed to incoming trauma patients. But this young man was admitted. The word in the E.R. was that he would probably make a good organ donor.

MacDougall hung up the phone and walked quickly down the five flights of stairs between the neurosurgery floor and the emergency room. The patient, whose name was Armando Dimas, lay on a stretcher in the middle of the gleaming room. He looked small for a grown man, about 125 pounds. Heavily drugged but conscious, he was squinting in the bright overhead lights. A nurse stood beside his stretcher, adjusting the monitors that tracked his heartbeat and respiration rate. His clothes had been cut from his body by the staff in the emergency room, and a hospital-issue sheet was tucked around him from the rib cage down. Numerous and dramatic tattoos were fully visible against his pale brown skin. A snarling tiger crouched along his left arm, a sultry woman vamped down the length of his right arm and a woman, a man and a flower were sketched randomly across his chest. Colorful, MacDougall thought, as he entered the room and saw his patient for the first time.

MacDougall leaned over the stretcher so that Dimas did not have to turn to see his face. The patient's eyes were open and he looked responsive and alert. The doctor made a mental note, which would soon become a more formal chart entry, that the lack of oxygen did not appear to have made him a vegetable.

Straightening, MacDougall reached for the X-ray envelope and pulled out the films. What he saw made him inhale so sharply he whistled. The devastation caused by a bullet to the spine depends largely on where it enters. The lower the bullet, the less the damage, because the severed nerves will most likely be below the point of injury. A shot to the lumbar region, or the lower back, will likely paralyze the hips and legs but leave the arms alone. A shot to the thoracic vertebrae, or those in the back of the rib cage, will take away the feeling in the chest area, too. A bullet in the cervical vertebrae, which are in the neck, can paralyze everything from the neck down. The opaque sheets that MacDou-

FAMILY SUPPORT

Armando Dimas, who is paralyzed from the jaw down, surrounded by the family members who take turns tending to him at his five-room trailer in Huntsville, Tex. His mother is third from left, his son is fourth from left and his father, with the moustache, is at rear right.

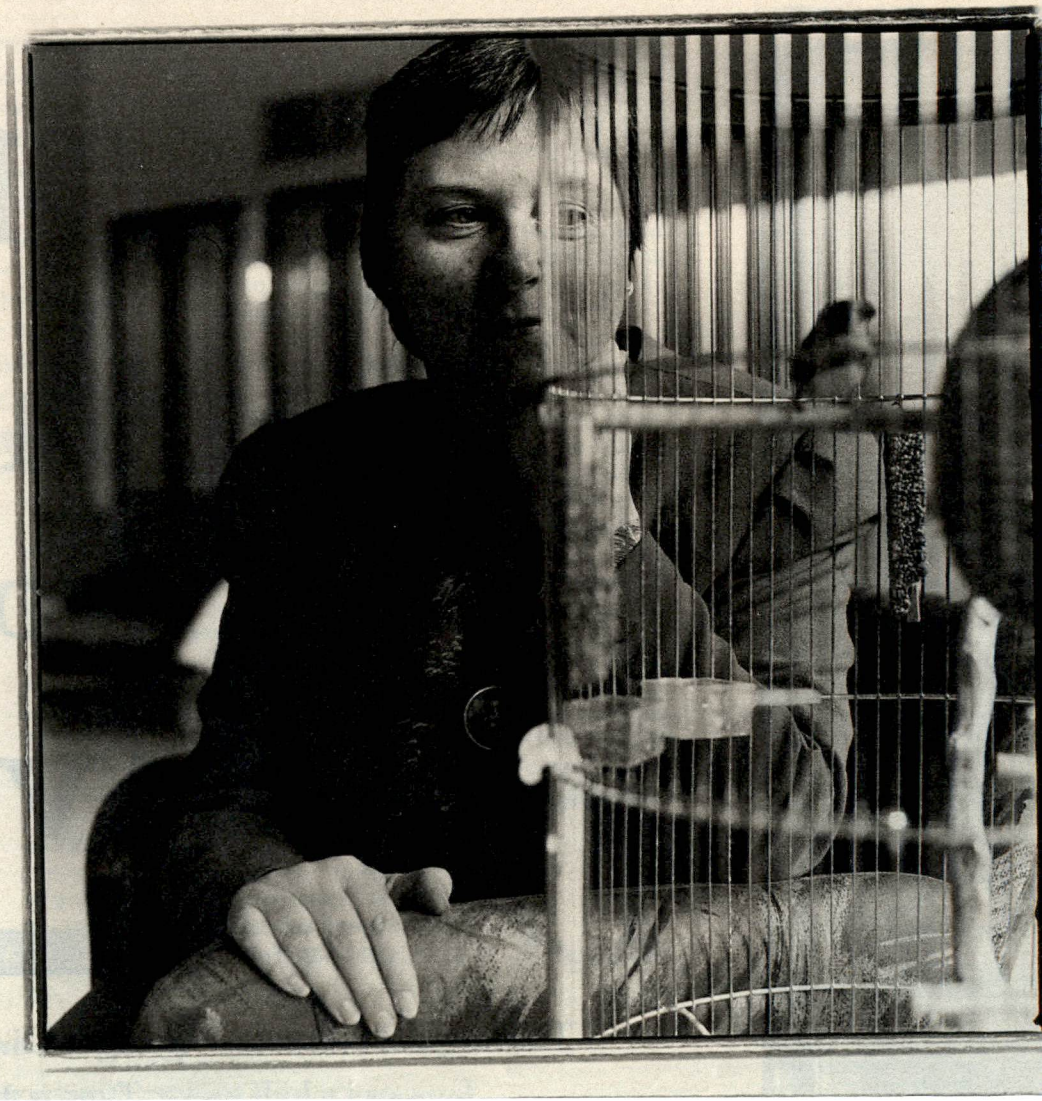
Lisa Belkin covers health care for The New York Times and is the author of "First, Do No Harm," from which this article is adapted. The book will be published by Simon & Schuster next month.

THE 'SAINT'

TOP: *Hermina (Bart) Bartkowski, who runs the Total Life Care Center where Armando Dimas found peace.*

THE OCCUPATIONAL THERAPIST

BOTTOM: *Mary Coffey improvised treatment as she went along, trying to teach Dimas the tasks of everyday life.*



gall was holding against a lighted box in the emergency room showed a bullet lodged higher in the spinal cord than he had ever seen in a patient who survived.

"This guy should be dead," MacDougall thought, and slipped the X-rays back into their envelope.

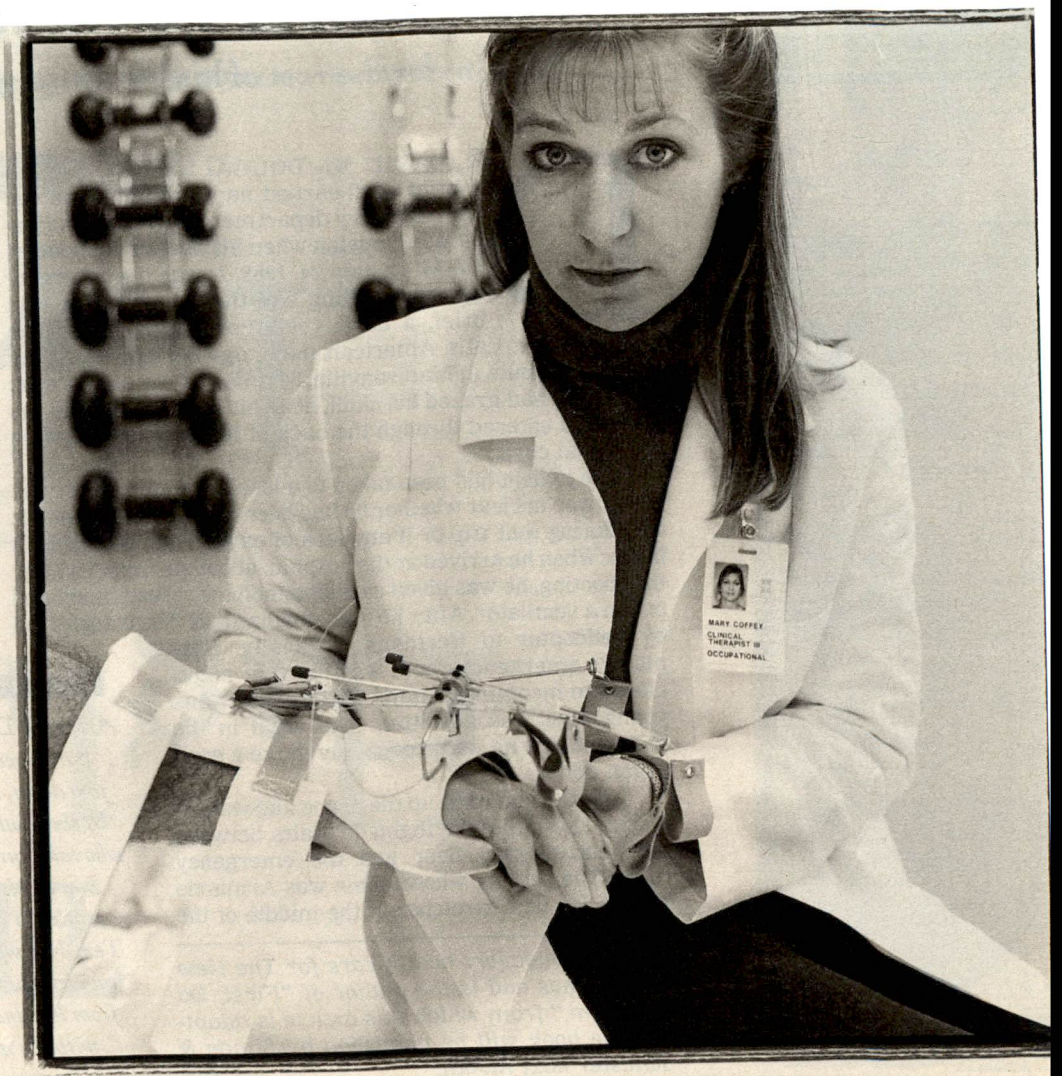
For the next 15 minutes, he conducted a physical exam that essentially confirmed what he already knew. As he went through the familiar game of neurological Simon Says — "Can you move your right leg? Your left leg? Can you wiggle your nose?" — MacDougall was frustrated. Not with the poor response he was getting, but with the fact that he was doing these tests in the first place. This man had no chance of recovery. Even if he survived, which was unlikely, injuries like this one do not reverse themselves. In neurosurgery slang, Armando Dimas would spend his life as "a head in a bed," with a body that was more or less irrelevant.

In every hospital of every city in the United States there is a patient like Armando Dimas. The illness or injuries might be different, but the message is the same — medical progress often raises more ques-

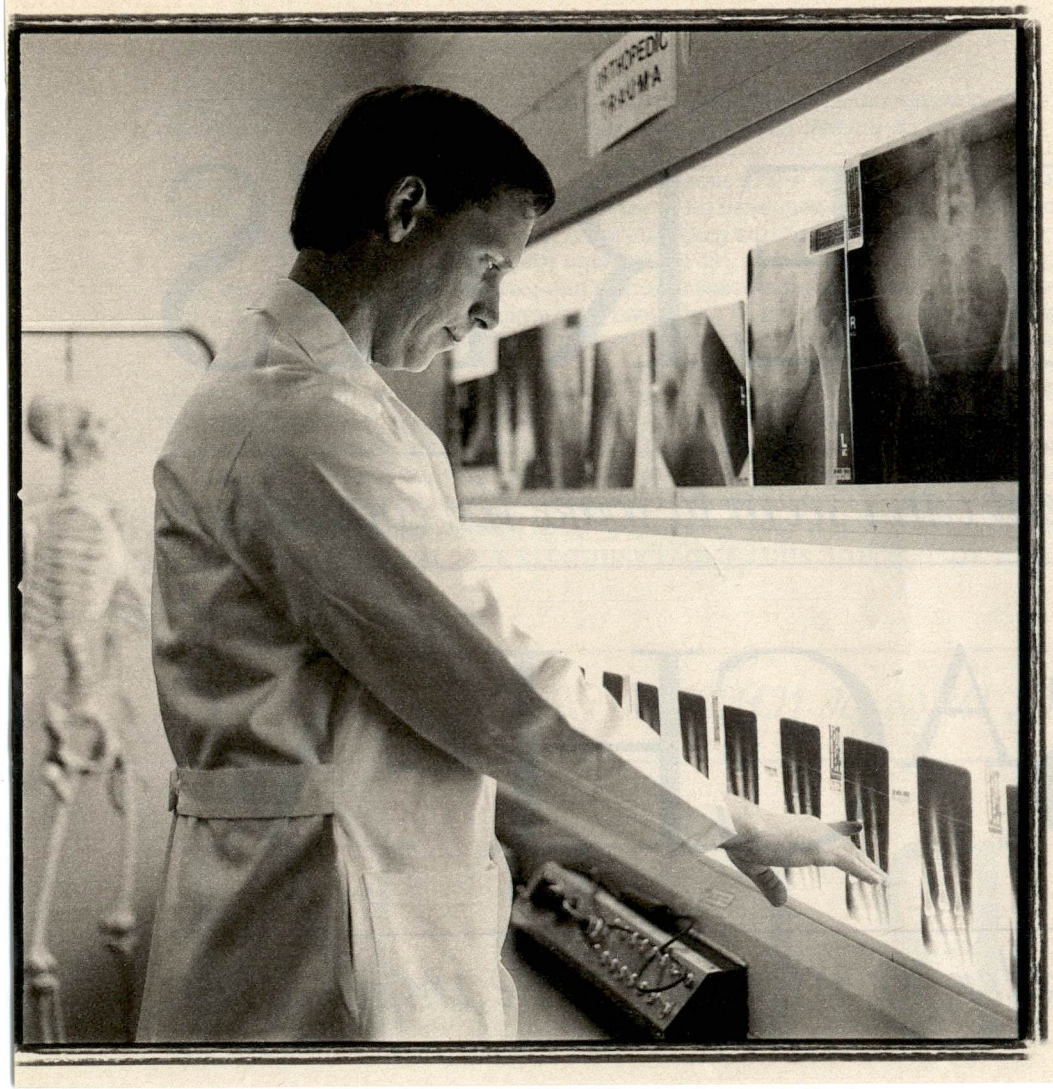
tions than it can answer. At first, the question asked by this young man's doctors was one of life and death: Is it worth saving a life if it is to be spent trapped in a motionless prison? Later, the questions would turn to money: Who should pay — and where would they find the money to pay — the stratospheric cost of that motionless life? One of the earliest rules learned by medical students dates back to Hippocrates: First, Do No Harm. But the complexities of modern medicine mean it is impossible to be certain what constitutes harm. Would it be more harmful, David MacDougall wondered as he left the examining room, to let this patient die or to let him live?

TO EVERYONE'S SURPRISE, ARMANDO Dimas did not die. But for the rest of his life he would be paralyzed from the jaw down. He would not be able to breathe without a machine. If his cheek itched, he could not scratch it. He couldn't cross his legs, wiggle his toes, change the channel on the television set or turn off the overhead light. In his old life, he might have whistled at the attractive women who walked in and out of his room all day. Now, as they dressed and undressed him and handled his body as if it were another piece of hospital equipment, he fantasized instead that he could feel the water on his skin as they washed his limbs and that he could bat their hands away and finish the task himself.

On the day he was shot, Dimas had been in the United States for 12 years. He was here illegally, although he and his entire family had applied for legal residency under the new amnesty law. He had come from Matamoros, Mexico, a town that defines poverty. His father was the first to cross the border, and he worked and saved for several years before he sent for his wife and 12 children. They walked together across the Rio Grande at a point where the river narrows to a trickle, then hitched a ride to Houston, 354 miles north. It took three weeks for them to make



PHOTOGRAPHS BY KEITH CARTER FOR THE NEW YORK TIMES



THE NEUROSURGEON

TOP: *Dr. David MacDougall's first thoughts were that "this guy should be dead," that he had no chance of recovery.*

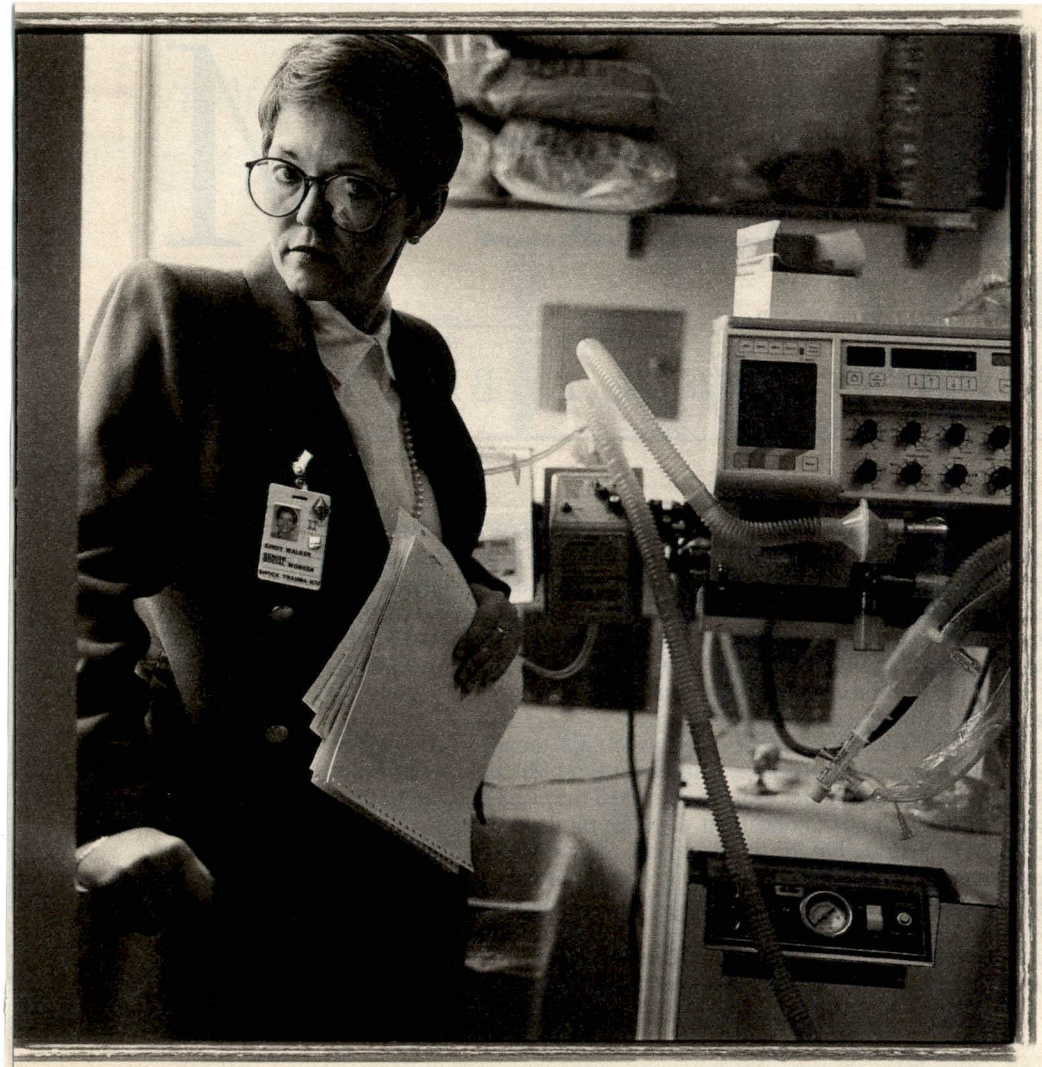
THE SOCIAL WORKER

BOTTOM: *Cindy Walker's ultimate goal was to make it possible for Dimas to be cared for at home by relatives.*

their way to the small rural town where their father was working in a mushroom factory, cleaning and stemming the vegetables.

Home for the family of 14 was a five-room trailer with cracked windows. Armando and four brothers shared one cramped bedroom. His young son, Armando Jr., who lived with his mother, shared the room on his frequent visits. The heating system never really worked, but the stove usually did and everyone gathered in the kitchen for warmth during the blessedly short Texas winters. The better life they had moved here to find was always a few paychecks out of reach.

What was Hermann now to do with this helpless man? His mother, Victoria, refused to face the fact that her son's injuries were permanent, insisting that a big hospital like Hermann could find a way to work a miracle. She would not allow doctors to tell her son that he would never move again, a restriction that brought mixed reaction from the staff. If he were told his fate, they were certain, he would ask to die (a request they could not legally meet). But they could agree not to save him if he had a sudden cardiac arrest — a likely event in someone



so sick. Whatever his decision, they insisted, it should be his to make, regardless of what his mother said. Yet everyone was hesitant about asking Dimas directly, against his mother's specific instructions.

Cindy Walker would gladly have told him, but for the first 48 hours she wasn't certain what he knew. Walker was the social worker in charge of Dimas's care, and her desire to do good runs as deep as her Texas accent. But she shows this compassion more often by chucking a patient under the chin than by stroking his hand. Her ultimate goal was to make it possible for the Dimas relatives to eventually take him home, ventilator and all, and care for him with the help of round-the-clock nurses. It was in Hermann's interest to find some way to discharge Dimas. As a patient with no health insurance, his care could cost the hospital thousands of dollars a month for the rest of his life.

But a ventilator-dependent quadriplegic is a weighty burden for any family, even one with limitless funds and free time, and this family had neither.

"HOW IS HE GOING TO RETURN home?" Mrs. Dimas asked Cindy Walker when the subject was first raised. "We aren't educated enough to run that machine. Something will happen to him, and we won't know what to do. We aren't educated, and it's too late for us to become educated. This is all we are." It pained Mrs. Dimas to say this, since she and her husband had always prided themselves on protecting their children. They had fled Mexico for what they hoped would be a better life and had worked dirty, difficult jobs every harvest season. Their life had not worked out as planned, but they still had their pride. Now they found themselves turning their son away.

Their inability to care for him, however, did not keep his relatives from expressing disapproval over the care he was getting at Hermann. Specifically, they did not agree with MacDougall's *(Continued on page 44)*

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increasingly certain statements that their son would never walk again. They insisted, regularly and loudly, that if the bullet that they saw on the X-ray were removed, their boy would be just fine.

MacDougall tried to explain that the real threat to Dimas's life would come from surgery to remove the bullet. "The problem isn't the bullet," he said "It's the damage the bullet did upon entry. To take it out we would have to cut into his brain. He would not be able to survive that operation, particularly not in his current condition."

Unconvinced, Mrs. Dimas asked Cindy Walker for a second opinion "from a different doctor of the brain," and within hours another specialist stopped by the rotating bed. He concurred with MacDougall's opinion, and his note concluded: "Prognosis for recovery very poor. Unlikely he will be able to breathe on his own. No further recommendations."

When told of the results of the second opinion, Mrs. Dimas insisted that a third doc- hospital, examine her son. The physician in charge of Dimas's care responded by asking Walker to call a meeting of the family, the social workers, the key medical staff and someone from the hospital chaplain's office. Everyone gathered three days after the shooting. The only person missing was the patient, who hadn't been invited.

There were no social pleasantries to open the meeting. "I think you know everyone here," Walker said to Mrs. Dimas.

With the help of two other neurosurgeons who had seen Dimas, MacDougall explained, once again, what his patient's chances were. For three days MacDougall had been tempering his message with hope — as a cushion and a hedge, a way to ease reality onto the family and to protect himself if an odds-defying recovery actually happened. Now he feared that approach had been wrong. Hope was the only part of the message that this family heard. He needed to speak more clearly.

"We have to make decisions," he concluded, looking directly at Mrs. Dimas, "and those decisions have to be based on the reality that this

Walker, the social worker, nodded. That's what she had been saying all along.

"Have you talked to him directly?" she asked. "How much of this has sunk in?"

First MacDougall and then the others on the case said they hadn't had a real discussion with Dimas.

"Isn't it time someone talked to him?" Walker asked, then waited as the question was translated for Mrs. Dimas.

The weathered, weary woman shook her head furiously, speaking so quickly that the adept translator had difficulty keeping pace.

"It's not true, it's not true. You can't tell him that because it's not true. He can walk, he will walk. He can breathe; he will not need that machine. Why do you say otherwise?"

Hermann is a big modern hospital, Mrs. Dimas said, as if daring the staff to meet her challenge. Surely all these doctors could cure him. Otherwise she would find someplace else.

MINUTES AFTER THE meeting ended, Cindy Walker called Lin Weeks, the chairman of the Hermann ethics committee, which de- hot) for one person to make. Weeks, in turn, called Randy Gleason, the hospital's lawyer, and the three met briefly that same afternoon in Weeks's cluttered office. This was an informal meeting of the ethics committee, of a type that Weeks held every so often when the question seemed simple and no formal request for a full session had been made. Walker was certain that what she was seeing happen was wrong. She wanted to know whether someone less involved felt the same.

Weeks and Gleason went over the details of the case, and then Gleason said: "We don't need the whole committee on this. We don't really have a problem. There is no reason *not* to tell him and every reason *to* tell him."

"What are his chances of surviving this?" Weeks asked.

"It's touch and go, but he's come further than anyone thought so far," Walker said. "He's bound to arrest sometime, and if we make him D.N.R. — we'll ask him first, I mean, but he'll probably want it. I sure would." A Do Not Resuscitate order can be placed on a patient's chart at his request.

cles were weakened, including the ones that held up his veins and hence his blood pressure. If his heart stopped, they would try to resuscitate him, and she described in detail what that would mean.

When she finished speaking, she asked him a long list of questions, each of which could be answered with either a yes or a no. He was to respond by blinking his eyes — two blinks for yes, one for no.

Do you understand what we're telling you?

Yes.

Do you want to have medicine for infections?

Yes.

Do you want to be resuscitated if your heart stops?

Yes.

Do you understand what that means?

Yes.

You know they will pound on your chest, they may break your ribs, they may use electric shock on your chest?

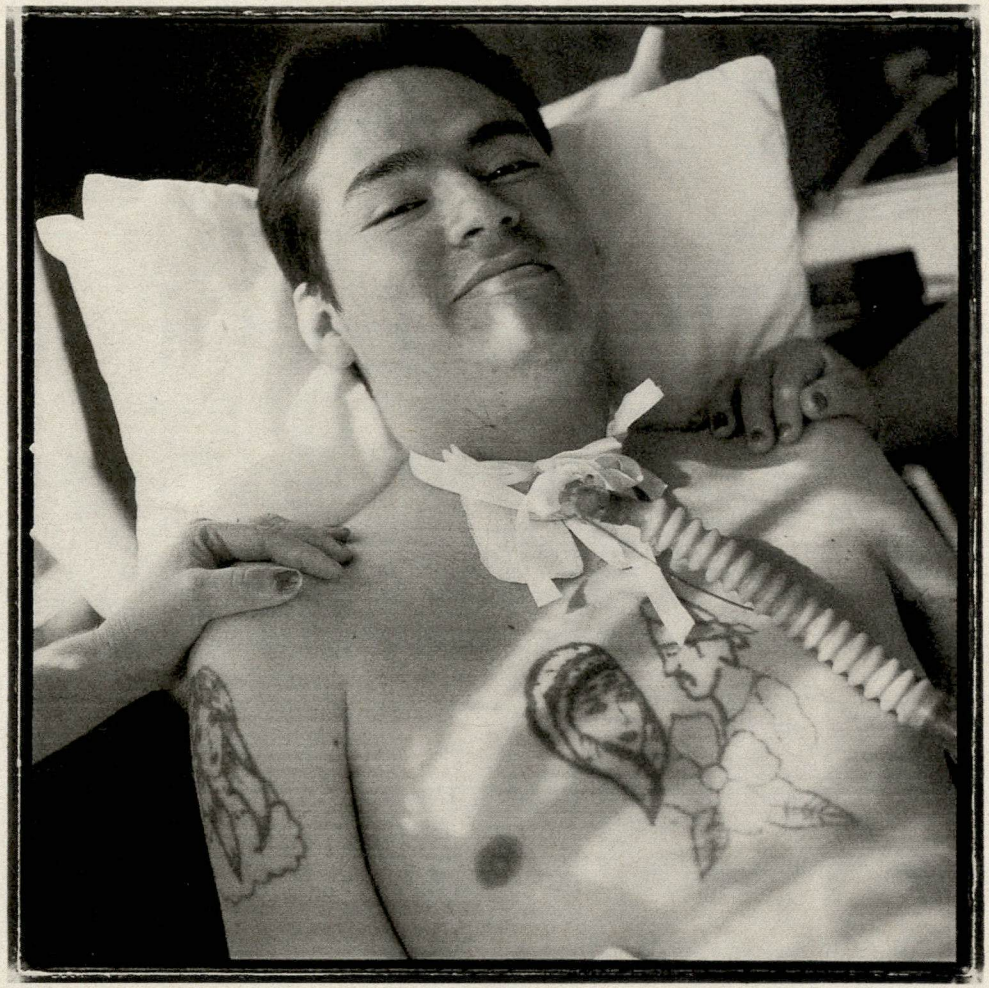
Yes.

You know you could live just like this for many years?

Yes.

There was annoyance in the blinks now. Dimas, as he later explained, had the feeling these women wanted him to give up and die, an idea he

tor, this time from another is all there will ever be."



Armando Dimas went home last fall, and a family member is always by his side.

cides cases too hard (or too

The next day, at 11 A.M., Armando Dimas was told. Among those who crowded around his bed were his mother, a translator, Cindy Walker and the chief nurse on the neurosurgery floor, Norma McNair. McNair did most of the talking, as the ventilator wheezed in the background. At one point, the alarm on the machine went off and a nurse came over to check the source of the problem. McNair kept talking while the nurse adjusted the dials.

She told Dimas that his condition was permanent. Nothing is 100 percent certain, she said, but we are fairly sure this is the best it will be. She explained how the spinal cord works, how it was damaged, that it doesn't grow back and cannot be fixed.

Then she described all the things that might happen to him because of the paralysis, further complications that might threaten his life. He would be susceptible to pneumonia because he couldn't cough on his own and his lungs could clog more easily. If that happened, they would give him antibiotics unless he said he didn't want them. He was also susceptible to heart failure because all his muscles cases too hard (or too found confusing since he was sure they would eventually cure him. Mrs. Dimas stood up and put her hand on her son's brow.

"You want to live?" Cindy Walker asked, her voice betraying amazement at his decision and admiration for what she considered pure but misguided faith. "You know you can always change your mind about this."

Dimas blinked twice.

"This isn't the only time we'll talk about this, so if you change your mind, you'll have a chance to tell us," Walker said. "We'll ask you again."

As they left the room, Cindy Walker whispered: "This guy is gonna survive. Now what do we do?"

HAZEL MITCHELL FIRST learned that Armando Dimas was a patient at Hermann several weeks after he arrived, when it was apparent that his condition was stable. Mitchell's job was to get uninsured patients out of the hospital as quickly as was medically possible, and until that could be accomplished, to see that their care was as economical as possible.

Dimas had been transferred from intensive care to

PHOTOGRAPHS BY KEITH CARTER FOR THE NEW YORK TIMES

the intermediate neurological ward nearly two weeks before Mitchell came to visit. When she arrived at his room, he was surrounded by nurses. Mitchell didn't stop to talk. Dimas barely noticed. From where he sat, she was just another stranger with a Hermann ID badge.

Hers was a particularly important, if thankless, job at a hospital that was seriously strapped for money. Hermann was already $4 million in debt when Dimas was admitted. Eventually, the hospital would have to close its emergency room to most trauma patients, meaning that there would be one remaining trauma center in an area of three million people. But for now, the hospital was hoping to solve its problems through stringent cost cutting. The 24-hour cafeteria, often the only source of food for on-call residents and families keeping vigils, had its hours cut back sharply, replaced by coffee makers and vending machines. And managed-care clinicians like Hazel Mitchell scrupulously reviewed patients' charts, to see where costs could be cut.

Back in her office, Mitchell pulled out the computer print-

billed at $495 per day, while a room in the intermediate unit is $410. The rotating bed, at a charge of $161 per day, could also be phased out.

Even with those savings, however, the remaining numbers were staggering. The ventilator carries a charge of $273 per day. Each time secretions are suctioned from the ventilator, which happens as often as once an hour, it requires a trach-care tray: $28.25 each. Every morning his blood is drawn to test the oxygen and carbon dioxide levels at a cost of $93.75. The two daily pouches of intravenous food cost $95 apiece. The saline solution that keeps him hydrated comes to $12.50 per bag.

These price tags, of course, do not reflect the cost of the items to Hermann. No mouthwash costs the $2.30 per gargle that Hermann charges. Each line item on the bill includes a certain amount of overhead to cover the salaries of the supply staff, electricity to light the storeroom, telephone and mailing costs. Security officers have to be paid, as do page operators, the cleaning crew and administrators like Lin Weeks and Randy Gleason. A few Hermann Hospital would not have worried about numbers like these. In fact, there was a time when Hazel Mitchell's job didn't even exist. When she graduated from nursing school in 1967, much of the technology that costs so dearly had not been invented. Ventilators were relatively new, and portable versions, like the one Hermann was trying to use to send Dimas elsewhere, were not yet invented. There were no CAT scans, sonograms, test tube fertilization, laser surgery or microscopic surgery. And the increase in costs was paralleled by a decrease in ways to pay for it all. The number of uninsured patients in the United States is rising steadily. When the patient cannot pay the bill, the hospital must absorb the cost.

As she worked her calculator through Dimas's chart, Mitchell saw no easy solution. Dimas was not a Houston resident, so he did not qualify for the county hosptial. Cases like his bring to mind an old Chinese proverb: "If you save a life, you are responsible for it."

For now, there was little to do besides keeping track of his charges and suggesting ways to save a few pen-

> Dimas was a quick learner, and it wasn't long before he was bossing the nurses around.

Coffey had never worked with a patient with a spinal cord injury as severe as Dimas's. She improvised as she went along. Over the weeks, she helped him to do things the textbooks said he should not be able to do, like sitting in a chair. But that victory simply revealed the frustrating fact that his wheelchair was too big — his head flopped in one direction and his body listed uncomfortably in another.

Without a proper wheelchair, her other plans were impossible. She wanted to teach him to use a "mouth-

end of August, the breathing tube in his throat was enhanced with a device called a talking trach. With proper training, patients fitted with this device can force air slowly through the double rings of the tube to produce a breathy, hoarse sound. Dimas was a surprisingly quick learner, and it wasn't more than a week before he was bossing the nurses around in a throaty whisper. Most of his orders and complaints were given in English. The staff wasn't sure whether two months in the hospital listening to his second language had improved his skills or whether he had always been more fluent in English than he had let on, preferring to eavesdrop on his caretakers.

He was even making progress physically. When Coffey touched his right shoulder, Dimas could usually feel the pressure. Every once in a while he also said he felt pressure when, as a test, she pressed her fingernail into the soles of his feet. He complained periodically of "pain" in his lower back, and when Coffey alternately held a cold towel and then a hot one to his skin, he could tell which was which three times out of five. Getting him into

out of Dimas's ever-increasing bill. Every item used at Hermann carries a computer-coded label — every packet of Tylenol, box of rubber gloves, tank of oxygen, tube of skin cream. And every time a patient is given a pill, has the cut on his forehead cleaned, needs a new tank of oxygen or wants lotion rubbed on his dry skin, a nurse peels the labels from the needed items and sticks them into the chart where they make their way through the bureaucracy, into the computer and onto his final bill.

The charges add up quickly. Each dose of Tylenol costs 70 cents. Swabbing the cut on his forehead costs 80 cents for the dab of hydrogen peroxide, $20 for the newly opened box of sterile rubber gloves and $2 for a sterile sponge. The oxygen runs $5 per hour, or $120 a day. A tube of Lubriderm is $5.30.

Armando Dimas's bill had reached $57,021.61 in just three weeks. Some charges were one-time items: $439.50 for the time spent in the Hermann emergency room, $1,248 for the helicopter at a rate of $12 per mile. Other charges would be reduced or eliminated now that he had left the I.C.U. A bed there is more cents are added to cover the patients who never actually pay their bills and insurance companies that reject claims long after services are rendered.

The numbers Mitchell cares most about are those that are left when the extras are subtracted, leaving the actual cost to the hospital. To find those numbers she multiplies the amounts on the bill by real-world percentages, figured out for her long ago and printed on a pocket-size chart.

During his first 21 days at Hermann, Dimas was billed $13,674 for supplies like rubber gloves, catheter tubes, enemas, abdominal support binders, foam bed cushions, adhesive tape and sterile gauze. Mitchell multiplied that by 0.441316 to arrive at the actual cost of $6,034.55. The respiratory therapy bill of $14,076 was multiplied by 0.374903, meaning it actually cost the hospital $5,277.13 to keep Dimas breathing. The pharmacy bill of $7,940.90 was multiplied by 0.491065 for an actual cost of $3,899.49. In all, the actual cost of Armando Dimas's first three weeks at Hermann was $29,837.

There was a time when nies here and there. For instance, Mitchell noted on the chart, Lubriderm lotion costs about half as much as Nivea lotion. Perhaps the nurses could use more of one and less of the other.

About an hour after she began her initial review, Mitchell put her findings into a folder that she marked with Dimas's name and patient ID number. She would add to the file weekly despite the odds against any form of reimbursement to Hermann. "Who knows," she said. "Maybe he'll win the lottery."

HOW MUCH WAS HERmann required to do for Armando Dimas? It was a question Mary Coffey, his occupational therapist, found herself asking almost every day. Occupational therapy is about reteaching patients the tasks of everyday life — feeding yourself, tying your shoes, opening the front door. The goal is not to do everything exactly the same way as before, but to learn to compensate, using muscles that are still strong in place of ones that are permanently weakened or using specially designed tools in the absence of sinew and synapse.

stick," a long, slender rod with a mouthpiece at one end that can be used to do tasks usually done by fingers, like pressing computer keyboards or writing on a chalkboard. Time and patience could eventually translate those abilities into a job. But first he had to be able to sit up straight.

While the occupational therapy helped Dimas with his posture, other departments were helping him do things like speak and eat. It took most of August before daily tests ruled out any physical reason he couldn't eat and several more weeks for speech therapists to teach him how to best use his functioning mouth muscles to help chew and swallow. He began by sipping clear liquids through a straw. Soon he was eating everything in sight. His mother, who had sat helplessly by his bed from 9 A.M. to 7 P.M. every day, saw this as a chance to reenter his life, and each day she came with plates of homemade tamales and burritos. She fed these offerings to him, placing each bite gently in his mouth, then patting his lips with a napkin after each swallow.

He could talk, too. At the his wheelchair was no longer the production it had been weeks earlier. He could be placed directly into something akin to full sitting position and stay there without any discomfort for more than two hours.

That was the good news. The bad news was that his wheelchair was still too big and his head control was nonexistent. Coffey had little hope that any of his physical and emotional progress could be translated into vocational ability until those problems were fixed. She tried stuffing pillows against his sides, like packing in an oversized crate, to keep his body straight. When that didn't work, she added blankets and seat cushions from the visitors' area — anything she could find. She rolled towels and wedged them behind his neck to keep his head from flopping from side to side. Eventually, she found three foam belts, used to strap patients down when they are wheeled around on gurneys, and she strappe- done each at his head, his shoulders and his legs. It was a technique she had occasionally used to align comatose patients, but this pa-

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tient could look her in the eye as she bound him to his chair. It became the worst part of her day.

"We might as well gag him too," she said. "It's got to be a scary feeling, and it doesn't do any good for his orthopedic alignment, either."

She had tried to find him a better chair. The pediatric versions were too small. The specially designed versions used by the neurology department were equally unacceptable, because when the headrests on those were raised, the footrests automatically lowered, and there were days when Dimas could not tolerate having his feet down. She tried to borrow a chair from the rehabilitation center down the block, but they didn't have enough for their own patients. She talked to Cindy Walker and Hazel Mitchell, who were sympathetic but not encouraging. "We can't just buy him a custom-made wheelchair," Walker told her. "We have to face the fact that we can't afford him as it is."

Over the weeks, the saga of Dimas's chair made Coffey steadily angrier. She knew all about Hermann's finite resources, but she believed her patient's needs deserved a larger portion of those resources than he was being given. "You have this totally, totally debilitated man whose only chance to interact with the world is to get him equipment that he could have control over," she responded to Walker. "It's so annoying that this man was admitted with open arms when he was a donor, and now that we have to treat him as a man, we're hemming and hawing." Finally, she put this frustration on two pages of single-spaced paper, which she then mailed to Hazel Mitchell.

INTEROFFICE MAIL moves slowly at Hermann, and Mitchell did not receive the letter until a week after it was mailed.

"A letter, out of the blue!" she exclaimed as she passed it around to the members of the hospital's nonresource committee, which meets weekly to discuss all the patients who cannot pay their bills. "A *two-page* letter. This is ridiculous. It came through the interoffice mail; I just found it in my box."

"In your opinion, does he need a new chair?" asked Willene Guttenberger, who conducted the committee meetings.

"It's not uncommon for us to use towels or tie patients in," Mitchell answered. "As you can see from the letter, the word she uses is 'dehumanized.' Dehumanized. I think that's a little dramatic. If the patient really needs something, for the most part I O.K. it." Her eyes narrowed and her words slowed slightly. "There are some people here with the feeling that they've got to go to extremes in their requests. I screen those requests; Iprioritize things. They have a tendency to rattle off everything he may possibly need and I say, 'O.K., let's prioritize. What does he *really* need?' And if it's a safety thing or if it's a deformity thing, of course he's going to have it. We will bend over backward whether it's starting him out with it here, hooking him up with the system after he leaves. It's our legal responsibility."

"Does he need that chair?" Guttenberger asked again. "Do we have an old one that can be converted?"

"He could be tied with a towel," Mitchell said, but her tone was less angry and hinted at compromise. "People are tied all the time like that. But I see the point. He's alert and awake, and it's different tying up a comatose patient than someone who's alert. So if this will help him from an emotional standpoint, we should do it. This man is not out to lunch, and maybe it *is* dehumanizing, considering most of the ones we tie up are out to lunch and he's not."

"Understood," Guttenberger said. "Now, how do we keep down the cost?"

Mitchell had done some research of her own. "I don't think we need to buy it outright. We can rent it, which Mary doesn't suggest in her letter. I got a quote of $78 a month, including a 40 percent discount. Mary had only gotten us a 20 percent discount."

Cindy Walker interrupted. "If he's going to be here for years, do we want to rent forever?"

"That's another thing we should talk about," Mitchell said. "I don't think he needs to be here for the rest of his life. I think we need to start talking about transferring him to Bart's." Bart is Hermina Bartkowski, and she runs something called the Total Life Care Center on a scruffy side street near downtown Houston, which cares for ventilator-dependent patients, among others.

"What's his daily cost here?" Guttenberger asked Mitchell.

"It's down to about $890 a day."

"And what would it be there?"

"About $300."

Guttenberger winced.

"We have no other options?"

"Not that I can think of."

"Let's see what we can do to get him into Bart's."

BART'S OCCUPIES A SINGLE-STORY institutional-looking building, which was originally built as a county school for the handicapped. An alternative inpatient health-care facility, Bart's is a place Hermann sometimes uses to get out from under the financial strain of patients like Armando Dimas. Without Hermann patients, Bartkowski's 40-bed facility would probably not stay solvent. Without Bart, Hermann would probably be in even more desperate financial shape.

Bart's is a cheerful place in spite of its grim, utilitarian reason for being. Two finches chirp in a cage by the front door, next to the sunny plant-filled atrium and across from the colorfully furnished recreation area. The hallways are wide and bright. All the rooms are filled with plants,photographs and stuffed animals — even the rooms of comatose patients who have no came back with a huge grin on their face. There's so little I can give them."

That Bart's stays open has become increasingly important to Hermann. Of the two dozen patients in her care at any given time, about one-fourth are being paid for by the hospital, which saves more than $100,000 each month by placing patients in her care. Bartkowski is able to provide high-quality care at a low cost because she hires people that other facilities will not. In addition to her 20 licensed nurses, she employs between 30 and 35 nurses's aides, depending on the number of patients. Many of those she hires are recent Polish immigrants and many are doctors or nurses who are waiting for certification to practice in the United States. Bartkowski hires them as technicians and nurse's aides, allowing her to provide a quality of care not usually available at such a low cost.

Armando Dimas arrived at Bart's on Nov. 1, 1988. He did not bring his specially ordered wheelchair, which despite Coffey's careful planning never properly fit. His room at Bart's was decorated with bright animal posters and pictures of his family. His much better shape than it had been five years before — decided it simply could not pay his bills for the rest of his life. His hospital bills were now approaching three-quarters of a million dollars. (His final total was $727,008.71.) But money was not the only reason for its decision, the hospital said. It was better for a patient to be with his family, and it was time to send Armando Dimas home.

"Where can I go?" Dimas asked forlornly, when his mother told him the news. "Why don't they just wheel me out to the sidewalk and let me die?"

Hermann gave Bart's one month to train the family to care for Dimas, and all his brothers, sisters, their spouses and children tooklessons in how to lift, feed, wash, change, position and suction him. During years of visits to Bart's, the machines had become less intimidating and his routines had become more familiar, but his parents still feared they could not handle the job alone. They moved 20 miles from Madisonville to Huntsville, where most of their children had settled and where there were more available hands. The stress took its toll on Victoria

idea that the cozy touches are there.

Many who work with Bartkowski call her a saint, a particularly flattering term given the tendency of medical professionals toward understatement. As she walks from room to room in the institution she fought to create, it iseasy to see where the description came from. None of the twisted bodies or the vacant stares seem to depress her, or more accurately: she refuses even to hint at that depression when there is any chance a patient might overhear. She speaks to the unresponsive residents as if they understand every word.

The responsive patients go on trips: the circus, the zoo, shopping at the mall for Christmas gifts. When one early-summer trip to the Astrodome was a disappointment because the home team lost, a late-summer repeat trip was scheduled and that time the Astros won. Had they lost on the second visit, she would have taken everyone back once more. "I didn't think it was fair that they would lose when my patients were there," she says. "The time they finally won, everybody parents came to visit every weekend, bringing his 5-year-old son, Armando Jr., who had moved in with them after his father was shot.

Dimas found a kind of peace at Bart's. Every so often, someone would ask him if he wanted to be made D.N.R., and he would always say no.

"I see my family," he told a visitor who noted that a lot of people would not want to live as he was. "My sister brings me food. It's nice here." Unable to point, he wrinkled his sunburned nose, a result of the morning he had spent sitting in the courtyard of Bart's. "See, I go outside a lot," he said. "In a lot of ways, things are good."

He paused, trying to explain the gritty life he led before and how the shooting and its aftermath had changed everything. "If I hadn't been shot," he said. "I would have died."

Last fall, however, just a few weeks after that conversation, Dimas found himself angrily asking to die. The cost of his care had increased steadily during his years at Bart's, to $12,000 each month, and in September 1992 the financial office at Hermann — though the hospital was in Dimas, who was hospitalized twice in the days before her son's return because she was having trouble breathing.

On Halloween morning 1992, an ambulance drove Armando Dimas home. He was frightened during the first few nights, certain that the electricity would fail and he would suffocate, since the family cannot afford an emergency generator. Only a battery pack or a hand pump would keep his ventilator working until power was restored.

But a call to the utility company brought assurances that he would not be left to die during a blackout. He feels safer now, secure in the fact that a member of his family is at his side every moment. His mother takes the day shift, two of his brothers alternate on the night shift and everyone else helps when they can.

He is happy at home, he said. It's good to have his son nearby, and he is resigned to the fact that Hermann's promise to care for him had an expiration date.

"I was angry, but I'm less angry," he said two weeks after he moved back home. "Things changed. This is the way it is. That's all." ■