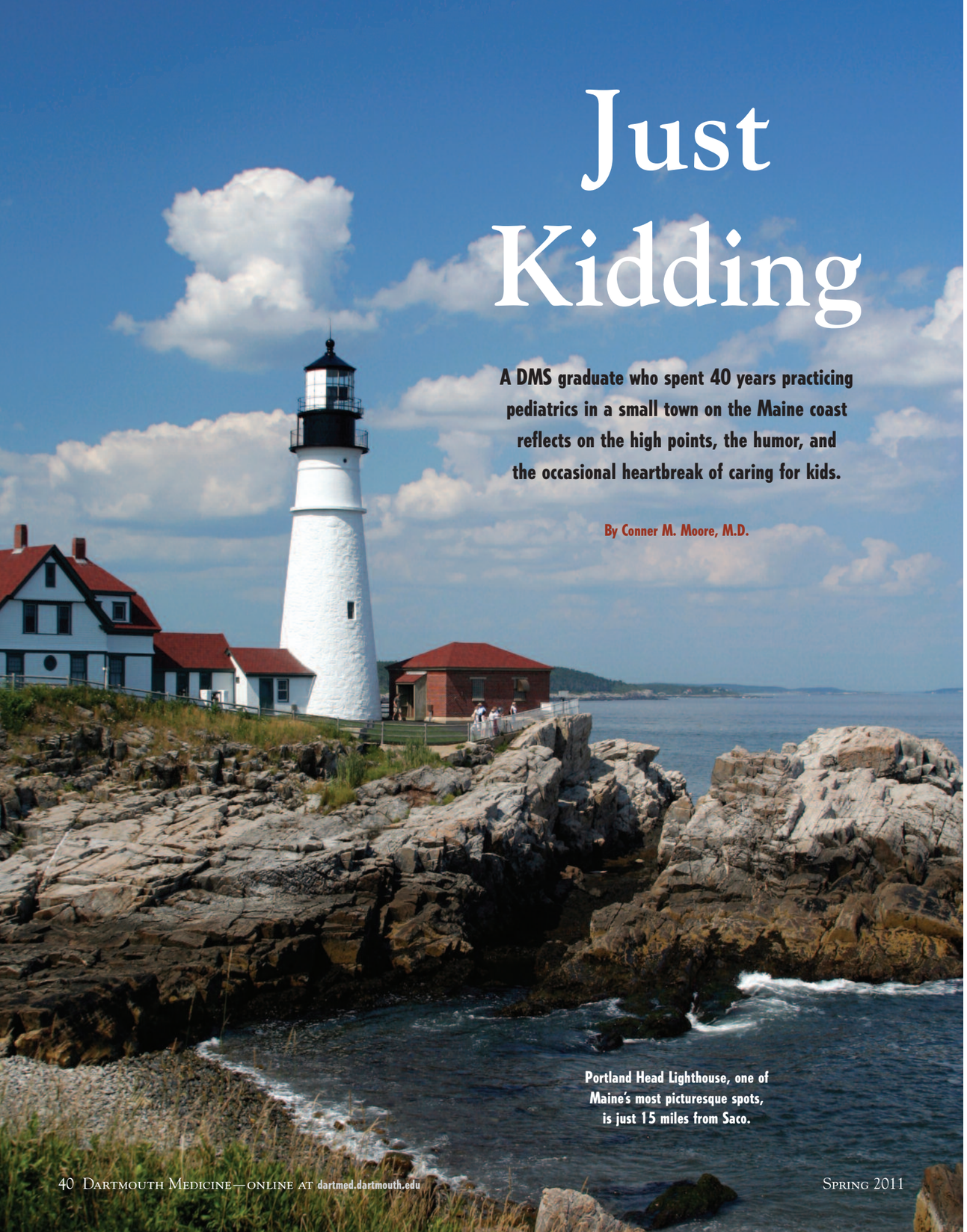
Just Kidding

A DMS graduate who spent 40 years practicing pediatrics in a small town on the Maine coast reflects on the high points, the humor, and the occasional heartbreak of caring for kids.

By Conner M. Moore, M.D.



Portland Head Lighthouse, one of Maine's most picturesque spots, is just 15 miles from Saco.

In 1956, a week after graduating from high school, I knocked nervously on the door of a modest suburban house. A middle-aged couple opened the door and, although we had never met, embraced me. They had awarded me a scholarship in memory of their only child, John, a classmate of mine who had succumbed to polio early in our senior year. The scholarship money had been earmarked for John's college tuition.

Two years later, I sat in the gymnasium at Dartmouth College taking my final exam for Organic Chemistry—a mandatory premed course that's the dreaded 500-pound gorilla guarding the door to medical school. Failure to wrestle this beast to the ground did and still does redirect thousands of aspiring doctors to other pastures every year.

As we were handed a one-page exam, a collective groan echoed through the vast space. The sheet bore two questions. The more challenging ran as follows: *This is the chemical formula for chloramphenicol, a new antibiotic. Please make it from scratch.*

Hadn't it taken Parke Davis millions of dollars to engineer these chemical reactions? Several students rose and silently left the room. Although my humanities grades were rarely better than the proverbial gentleman's C, chemical compounding was my forte. A brew of carbon, hydrogen, and chlorine appeared effortlessly on the pages of my blue book. "Damn, I'm good," I whispered. An A in Organic Chemistry offset a disaster in Advanced Spanish and paved my way to medical school.

After medical school (preclinical studies at Dartmouth's then-two-year medical school and clinical studies at Cornell), internship at Boston City Hospital, two years in the Air Force, and a pediatrics residency at Cincinnati Children's Hospital, it was time to settle down. In the summer of 1968, my wife, Wendy; the first of our three sons, Christopher; and I moved to Saco, Maine, where I joined the practice of Dr. Maurice Ross. I was the first new physician in 11 years in Saco and neighboring Biddeford.

My fellow residents in Cincinnati had been politely aghast at my career choice—general pediatrics was bad enough, but rural Maine was compounding the error. Many of them pursued academic careers in pediatric subspecialties, changing institutions every few years. But, 41 years later, I wrote this account at my kitchen table in Saco.

Dr. Ross had been practicing pediatrics in his hometown since 1947. The vast majority of Maine pediatricians back then toiled in solo practice while frantically searching for partners. Dr. Ross and I were the only pediatricians in all of York County. Our office was in his house—a not uncommon situation then.

York County's geography dictated the predominant livelihoods: fishing, farming, and logging. Seaweed, cow manure, and sawdust regularly decorated the office carpet. (The region is somewhat less rural now but still more country than city.)

Within days, I was mixing a vial of chloramphenicol antibiotic that saved the life of an infant with meningitis and was administering the polio vaccine that had been unavailable to my high school classmate.

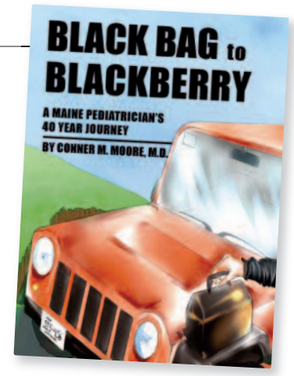
But there's a lot we didn't have in small-town Maine in 1968: emergency room doctors, intensive care units, ventilators for newborns, pediatric surgeons, pediatric specialists, or transport services. I administered chemotherapy, gave allergy shots, put in stitches, stabilized basic fractures, and occasionally assisted with surgery. Insurance didn't cover office visits, but we never refused to see a sick child, regardless of the family's ability to pay.

I learned a number of lessons quickly: That I would need a keen sense of humor and wonderment. That I must know the parent's occupation and the child's hobbies and sports interests, preferably without glancing at the chart. That I needed to be suitably appreciative of any gift from a child—be it a drawing, a popsicle-stick house, or a rock. That days off were rarely truly off; there always seemed to be emergency C-sections or transfusions. Vacations were restorative, but when I returned from mine, my partner would immediately take off for his 10 days of rest and relaxation.

I learned that the reality of small-town pediatrics ranges from house calls to phone calls, footballs to snowballs. The best part? The beautiful, courageous families and children.

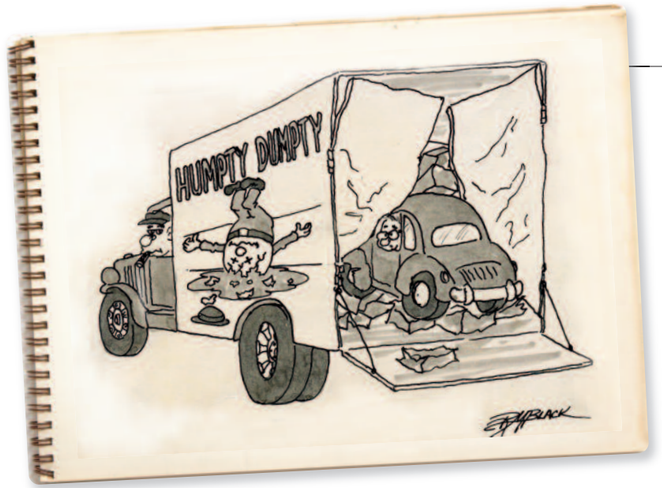
The average annual snowfall in southern Maine is 70 inches. But, knock on wood, my only winter fender-bender occurred shortly after my arrival. I was headed down a marginally plowed hill in Biddeford. I drove a VW Beetle then, and its brakes failed to grip the gently sloping ice rink that passed for a road. At the same time, two blocks away, a delivery truck emblazoned with the Humpty Dumpty potato-chip logo was having a similar

Moore grew up in the suburbs of Westchester County, N.Y., and graduated from Dartmouth College in 1960 and from Dartmouth Medical School in 1961. This article is excerpted and adapted from a memoir he wrote following his retirement from full-time practice in 2008. His book, Black Bag to Blackberry: A Maine Pediatrician's 40-Year Journey, *was published by Bryson-Taylor Publishing; the proceeds from its sale are going to a nonprofit foundation that supports nursing scholarships. All the patients and families about whom Moore has written gave permission for their stories to be shared. Moore still lives in Saco, Maine, and now works part-time as the staff pediatrician for a family services organization and children's residential home in Saco and volunteers in the Maine Medical Center pediatric residency program.*



This article is excerpted from this memoir by Moore, a DMS '61.

There's a lot we didn't have in small-town Maine in 1968: emergency room doctors, intensive care units, ventilators for newborns, pediatric specialists, or transport services. I administered chemotherapy, gave allergy shots, put in stitches, stabilized basic fractures, and occasionally assisted with surgery.



problem as it tried to turn left in front of me. In a gentle, slow-motion crash, I became the first pediatrician in America to injure a children's nursery icon. My nurse's cartoonist husband captured the moment in a piece of artwork that I still cherish. (And the local auto-body shop *was* able to put Humpty Dumpty back together again.)

Another time, a call came in the middle of a blizzard from the mother of a week-old infant who was coughing, breathing rapidly, and had poor color. I headed out in the trusty Jeep Scout that I'd acquired by then. The snow was icy and blowing sideways. At the entrance to the trailer park where the family lived, I had to blast through several high snow banks—justifying the expense of four-wheel drive.

The mother had not underestimated the problem. The struggling infant was the color of black raspberry ice cream, a popular local flavor; we occasionally used the reference to describe poorly oxygenated newborns. Crackles resonated in the infant's chest.

I had a small oxygen tank, left over from football season, in my black bag. (I'd inherited the job of physician for the local high school—a post that included patrolling the sidelines at football games.) It was probably illegal to carry the tank in a passenger vehicle due to possible combustion, but it's a good thing I had it with me: after I placed the mask over the baby's face, her blue hue lessened.

Getting the baby to the hospital was the next challenge. There were no infant car seats yet. "Hey, Doc," said the mom, "you can put the baby in her bassinet in your passenger seat." I called ahead to the emergency room. Our trip to the hospital was uneventful; traffic was sparse, and we skidded into the ambulance entrance with a flourish. A few days of antibiotics and good nursing cured the infant.

Why did I, like many doctors back then, make house calls? Well, most mothers were at home during the day and often lacked a car. Moreover, if you didn't make a house call during the day, you might have to head to the hospital at 2:00 a.m. In addition, a handful of my patients were bedridden with serious chronic illnesses. These children would have pumps and tubes arranged around their home hospital beds. Hanging above them would be elaborate wall calendars covered with rainbow-colored markings about hourly medication schedules and weekly blood draws. Such visits were always a stark reminder of the herculean efforts of parents and visiting nurses.

House calls also offered a valuable peek into a family's life. One winter I made home visits to two very similar older apartments, only a block apart. A single mother of three complained that her dwelling was too old to clean properly. The odor was overwhelming, beyond description. A twin rental on the next street was occupied by an unwed teen mother and her infant. It looked as if she had waxed every surface. You could have eaten off the floor.

On one memorable house call, it seemed like nothing went right. The family watched in horror as I pulled into their driveway and nearly sideswiped a cow. I sheepishly went inside and introduced myself. The sick child shivered with fever in her bedroom. Her siblings peered anxiously around the door frame. After greeting the patient, I gathered my stethoscope, eased myself down onto the quilt next to her—and splintered the pine bed frame. I determined that the now bedless and wailing child needed a shot of penicillin, which added insult to injury. The family did not receive a bill. Years later, however, I received an invitation to the child's wedding.

Sometimes the hardest task was simply finding the right house, back in the days before cell phones and GPS systems. One snowy December evening, a call came from a new trailer park. On the phone, the mother said I couldn't miss their white trailer with a green wreath. When I arrived at the park, dozens of wreath-bedecked, white mobile homes twinkled below. Even the manager's white trailer, where I stopped to ask directions, sported a green wreath.

"Can't miss it, Doc," the manager told me. "First right, then next two lefts, then down the hill to Pheasant Drive. Can't miss it."

Off I went. But after two circuits through the park, I was back at the manager's trailer.

"Couldn't find Pheasant Drive."

"Actually, I haven't put the sign up yet," the manager responded, in typical Maine style.

"Get into the Jeep!" I ordered. "You are about to witness a real, old-fashioned house call."

We soon arrived at the correct trailer.

"Didn't have any problems finding us, did you, Doc?" said the mom.

Sometimes, to forestall navigational problems, a child would be stationed on the porch, waving a flashlight to guide me into the proper driveway. Other times, the porch light would be flicked on and off to signal that I'd reached the right house.

House calls are now seen as inefficient. Yet I found that they

From the left: The cartoon of Moore's run-in with the Humpty Dumpty truck; his partner's home-cum-office in Saco; and a parade in nearby Biddeford.

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It was common practice to arrive for a house call and have the mother ask me to phone the hospital or my office. Or I'd arrive home after a long day to find Wendy on the back porch, flicking the light on and off and rotating an arm overhead. This was our secret code indicating that I was needed back at the hospital.

stripped medicine to its core—anxious parents, an ill child, a doctor, and the bare essentials of instruments and medications.

When I was on the move between my office, the hospital, and patients' homes back before there were even pagers, it could be a challenge for my staff or patients to track me down. It was common practice to arrive for a house call and have the mother ask me to phone the hospital or my office. Or I'd arrive home after a long day to find Wendy on the back porch, flicking the light on and off and rotating an arm overhead with her index finger extended, like a baseball player signaling a home run. This was our secret code indicating that I was needed back at the hospital. (It bears noting that Wendy was my pillar. Her support—as CEO of the household, medical consultant, sometime office manager, too often a single parent to our three wonderful sons, and my best friend—allowed me to play doctor.)

I also have fond memories of the simple but effective answering system we used when I first moved to Maine. Mr. L— ran it, and he even had a telephone switchboard—the kind with wires and plugs, just like in old movies. He always answered with a brisk but pleasant, "How do?" If you were not at home, he always knew where you could be found. And he'd offer unsolicited but useful comments about the caller's family. My very first phone call from Mr. L— went like this:

"How do, Dr. Moore. Welcome to Maine. Mrs. A— just called. Her daughter is dying of an asthma attack, but she always says that." (Local legend has it that Mr. L— once suggested to a mother in early labor that she try the local veterinarian, because all the obstetricians were out of town.)

Another out-of-the-ordinary encounter occurred my first weekend in Maine. I had finished morning office hours and wandered out to the lobby to lock the front door. An elderly man was sitting there alone.

"Is your grandchild in the bathroom?" I inquired.

"Hell, no," he boomed in a friendly voice. "I saw your name outside. Sign said M.D. Hurts when I pass my water. On vacation. Just me."

I started to explain the age parameters of pediatrics, but the senior citizen in front of me wasn't listening and appeared uncomfortable.

I quickly decided he was correct. I *am* a doctor and I'd done an internship in internal medicine before the Air Force made me a pediatrician. If I sent him to the emergency room, he'd wait until whoever was the on-call physician grumbled in from home to see him.

A urine sample showed evidence of a bladder infection. My new friend left with some antibiotic samples and a note for his own doctor on my prescription pad, with "infants and children" delicately crossed off.

"How much do I owe you?" he asked.

"No charge. Kept you waiting too long," I apologized.

"You Maine folks are very kind," he smiled.

My first major challenge after arriving in Maine was baby Robert, who had arrived a few weeks early and required every ounce of my attention. He had respiratory distress, jaundice, infection, and a host of other problems. There was neither an intensive care unit nor a ventilator at our local hospital. I was the intern, resident, and attending physician. I could see the nurses sizing me up; Robert would be my informal state license test and pediatric board exam, all in one.

Every few hours, I'd trot back up to the hospital. My mother had just arrived to help with my second son's impending birth, and she was horrified at the amount of time I spent away from my own family.

The nurses were very skilled and were the prime reason Robert survived. We exchanged his blood, treated his infection, and breathed for him when he forgot to. Robert's skin grew tight and waxy from a condition called sclerema, which I had seen only once before. We treated it with steroids. Gradually we won each battle and finally the war. Robert was a bit below average in school but never developed cerebral palsy or any other motor problems.

A few months later, I was called to the emergency room to see another infant in respiratory distress. The wheezing baby's chest was full of something. A chest x-ray showed spotty, dark areas, possibly aspirated food or saliva.

"Dr. Moore," said the mother, "every time I feed her she turns blue and coughs."

This is a fairly common complaint. I suspected reflux—a condition caused by food flowing back up the esophagus from the stomach—and suggested that the mother thicken the baby's formula and administer it more slowly. That didn't help. The baby slowly gained weight, but her symptoms persisted. Another chest x-ray still showed a few patchy areas in her lung.

I started to worry about a T-E fistula, a conflation of the windpipe (or trachea—the "T") and the esophagus (the "E"). These two tubes start out as a single tube in the fetus. They later separate, but sometimes not completely. In the most common type of T-E fistula, the esophagus ends in a blind pouch and never reaches the stomach. All the breast milk or formula winds up in the lungs. In another manifestation, the windpipe and esophagus develop normally except for a tiny hole between them. A little bit of each feeding gets squirted into the windpipe, with long-term consequences.

I sent the baby to the hospital and asked them to consider this di-

agnosis. At the time, our imaging tools were crude. The specialist placed purple dye into the baby's esophagus and could not see any stains in her windpipe.

The baby continued to gain weight very slowly. Then the family moved to New Hampshire; we transferred her records and arranged for the transition of her care.

A year later, I got called to the emergency room. I gasped as I walked in and saw the same baby, now a toddler, struggling to breathe like an 80-year-old smoker. I knew that we had missed the diagnosis.

This time, better imaging techniques revealed the sought-after hole between her esophagus and windpipe. The baby was filling her lung as well as her stomach every time she swallowed. The fistula was surgically tied off, and I assume the child did well.

Another puzzling case was a teenage girl hospitalized with a high fever, low blood pressure, and a whole-body, lobster-red rash. We gave her antibiotics and intravenous fluids but still had a hard time keeping her blood pressure stable. Her blood cultures were negative for bacteria. Her rash was unlike anything I'd ever seen.

Fortunately, she began to slowly improve. Pediatric patients usually have strong hearts and lungs free of smoke damage, so they handle disease better than the very young or very old. She finally left the hospital, but without a firm diagnosis.

Several years later my partner passed me in the hall. "Remember our friend with the unknown illness and rash?" he asked.

"All too well," I sighed.

"I just saw her for a sore throat. I asked her if she was using tampons at the time of her hospitalization. She said yes. I think she had toxic shock syndrome."

Toxic shock syndrome is caused by staph bacteria growing on a foreign object, such as a tampon, in a body cavity. The bacteria produce a toxin that causes a rash the color of a boiled lobster and a drop in blood pressure that can be life-threatening. The illness was first described by Dr. James Todd, a Denver pediatrician, in 1978—several years after our patient fell ill. The seven children he described had staph on their mucous membranes but not in their blood.

There are still unanswered questions about toxic shock syndrome. But after 1978 we knew enough about it to be able to recognize it. I later had another patient—a teenage boy—who developed a case following nasal surgery, despite the fact that a plastic splint was purposely used instead of cotton packing.

I saw several other diseases too soon, before they were recognized as distinct conditions. For example, I don't have proof but I believe I saw some cases of Lyme arthritis before a physician in Lyme, Conn., described this tick-borne disease. Such cases are a lesson to physicians to report clusters or even individual cases of unusual ailments.

More often, we know all too well what's wrong. David came into the world at our community hospital in August 1972. His parents were visiting relatives in the area from their home in Montreal. Maine's frigid ocean waters may have induced early labor.

David weighed just over two pounds. He was 10 to 12 weeks early by the calendar, though he looked a bit older. There was not a single newborn intensive care unit in Maine back then. David's parents did not wish to have him transferred to Boston. A six- or eight-hour ambulance trip to Montreal would have been fatal. And the Air National Guard couldn't fly him home, as that was out of the U.S.

"Dr. Moore, do the best you can. If he survives, fine. If not, we understand." Can you imagine parents saying that nowadays?

David was a fighter and needed an intravenous line for less than a day. I treated his jaundice with fluorescent lights. His immature lungs improved rapidly, and he was weaned off oxygen after several days. By day three, his weight was 1 lb., 13 oz. We fed him formula by tube.

His major problem was apnea, or "forgetting to breathe." Each morning, the nurses gave us a running account of these spells. Often they had to hand-ventilate our tiny patient, as we had no mechanical ventilators in 1972. Manual ventilators are teeny versions of those you see in emergency room shows on television; the process is called "bagging." David tolerated the bagging and the tube feedings, and he slowly gained weight. His apnea episodes resolved. His progress was largely a tribute to our nursing staff. Without their skilled care, David would not have survived. They rocked, comforted, fed, and sang to our tiny summer arrival. His survival was not strictly a medical miracle, but it required skill and dedication from all of his caregivers.

David went home to Montreal well under the usual discharge weight of 5 lbs. After many kisses and hugs, the family headed north. We learned that Mum and Dad had no problem bringing the new Canadian back across the border.

But that's not the end of the story. In large urban hospitals, new-

From the left: The Moore family in 1974; Moore (right) with his patient David, who was born prematurely in 1972; and Michael's brother, Jonathan.

Michael was three and had a progressive neurological disease that is uniformly fatal. Debbie had been only 17 when she delivered Michael, but she had matured greatly since then. After Michael died, Debbie and I kept in touch, and I later cared for her son Jonathan. He now raises pigeons.

born specialists are rarely able to follow up on their premature patients. But David and his family often returned to visit their nearby relative. Each time, we'd have a tearful reunion in the waiting room. At age four, David was playing hard and speaking well; his only residual problem was slight hearing loss. A few years ago, David sent me a picture of himself and his bride, at a Las Vegas chapel.

In other cases, the definition of success is different. One Saturday afternoon, I had slipped home to feed the cat and make some coffee. I'd been awake most of the previous night, worrying about this and that. The phone rang. It was Debbie calling to say that her son Michael's feeding tube had come out and she couldn't replace it. She sounded upset. I said I'd fix it on my way back to the hospital.

Michael was three and had a progressive neurological disease that is uniformly fatal. Debbie had been only 17 when she delivered Michael, but she had matured greatly since then. She knew a lot more about life and death than I did when I was her age. Debbie cared for Michael at home for his first two years, but when he could no longer take feedings by mouth and his weight had slipped to 13 pounds, Debbie came to me in tears and pleaded, "Dr. Moore, I just can't watch him starve to death."

I placed Michael in a skilled-care nursing facility where he began to receive food through a tube in his throat. Unfortunately, the nursing home closed a few months later and Michael had to be transferred to a facility in an adjacent town. This proved to be a hardship for all.

Debbie tearfully asked me if she could care for her son at home again, and I said yes without hesitation. She quickly mastered the art of suctioning Michael's mouth and changing his feeding tube. Her apartment was between the hospital and home, so it wasn't a burden to make house calls. Michael quickly gained 10 pounds under Debbie's care.

Now, on my way to replace Michael's feeding tube, the pungent smell of low tide hung in the air as I drove past rows of old wooden houses. Two teens embraced on a corner as I guided my Jeep into Debbie's driveway. I winked at them. They smiled. A grimy-faced toddler sat in the doorway with his arm around a dog. I climbed the stairs into Michael's bedroom.

Debbie said that he was quieter now. With a few twists, I replaced the tube. Michael was sleeping. I wrote Debbie a few prescriptions and walked down the narrow stairs with Michael's grandfather. I asked him to show me his pigeon loft.

We walked to a corner of the backyard, and he apologized that the coop needed cleaning. The birds were quiet as we entered. They had been fed an hour before and were content. Grandfather snatched a bird out of mid-air and brought it down for me to see. The embossed aluminum band on its leg read "68."

"Wow, that bird is 13 years old," I remarked.

"She sure as heck is," he replied. "Can still race good. She's got over 90,000 miles on her. Sometimes at this age they'll be good as gold and then suddenly they'll just drop. Heart gives out."

"Wow—that's more miles than my Jeep has."

"I think she's as strong as ever. But sometimes their hearts just give out," he repeated.

In the past, he'd told me that pigeons can fly home from as far away as Cleveland. How they get home is a subject of intense and controversial research. There may be a magnetically sensitive area in their heads. If the homing system malfunctions, the birds will overfly their loft and eventually succumb to muscle failure.

"Maybe I've got a few more miles left on me," I mumbled, as I turned to leave. Suddenly I didn't feel nearly as tired as I had just an hour earlier.

Michael died a few months later. Debbie and I kept in touch, and I later cared for her son Jonathan. He now raises pigeons.

One blustery April morning, just as I arrived at the hospital, the ambulance came roaring into the emergency room entrance with its lights flashing. I stepped out of my Scout.

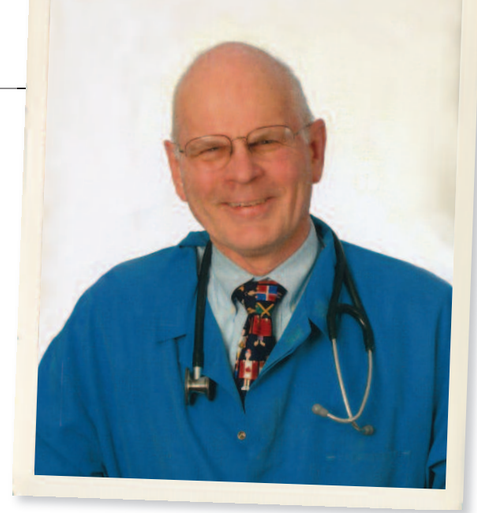
"Hey, Doc," yelled the paramedic. "We need you to pronounce one of the kids in the back. A lobsterman found them both hanging onto a capsized catamaran in the harbor. Don't know how long they were in the water. I think his buddy is okay."

My mouth suddenly went dry and my pulse raced. The paramedic's euphemism summoned up all the words we use to dance around death—passed, didn't make it, gone to heaven. I thought of the parents I've had to give such news, of how they sobbed, of how cold the ocean still is in April.

I quickly scrambled into the back of the ambulance. The boys appeared to be in their late teens. One was moaning. The other was ashen and silent. I grabbed a stethoscope, then yelled, "Clothes off! This one may be okay!"

People tend to think that a diagnosis of death is straightforward—but it's often not clear-cut. In the 1800s, people so feared being buried alive that inventors designed "safety coffins"—caskets with various mechanisms to alert relatives to a bogus demise. Even at the time of the catamaran mishap, EMT skills and monitors were primitive.

I asked the attendant to shut off the engine of the ambulance, and



sure enough I was then able to hear a faint and very slow heartbeat.

The first boater responded to minimal care.

His friend needed more rigorous treatment. We surrounded him with warm blankets and infused him with heated fluids. We treated his intense shivering with intravenous medications. There is a huge risk of cardiac ventricular fibrillation when rewarming a hypothermic patient, and we were lucky to avoid that problem (today, heart-lung bypass machines give doctors pinpoint control over it).

Both boys made full recoveries. The one who almost died sent me a note of gratitude. I replied that he should thank the lobsterman who had rescued them. They had been in 40-degree water for an hour—conditions that kill many people in 30 minutes. Was it the constitution of their young bodies, force of will, or just fate?

Not surprisingly, the outdoors figured in a lot of the injuries I saw over the years. On occasion, the outdoors even became an exam room or OR. One August, when my oldest son, Christopher, was 10, he and I made the eight-mile hike to Russell Pond in Baxter State Park. We fished on the evening of our arrival and caught our limit of trout in 30 minutes. Ducks landed in formation, skidding along the glassy surface. At the far edge of the pond, a dripping moose foraged for his dinner. The sunset was a brilliant magenta and pink. I didn't even try to capture the scene on film.

After supper (trout cooked over our campfire, of course), somebody ambled by and said the ranger was looking for me. I attempt to keep a low profile on vacation, but perhaps there had been some mention of my vocation on the registration card.

"Thanks, Doc," boomed the ranger with a smile when I checked in with him. "I hope you're not a psychiatrist."

It turned out that a fisherman had embedded a fishhook in his upper eyelid. The nearest emergency room was 30 miles away in Millinocket. Getting there called for either a floatplane trip from Russell Pond or an eight-mile hike to the nearest road. Neither was recommended for someone with a fishhook in his eyelid.

The ranger had a tiny forceps used for tying flies, which I could use to hold the hook. We had good illumination from a Coleman lantern. The ranger produced some iodine. And in those days, before box-cutter terrorism, I carried a #11 Bard-Parker scalpel blade in my wallet. It has a very fine tip and is useful in removing splinters and tics. The antibiotic eye ointment that I always include in my backpacking first-aid kit completed the gear for this makeshift operating room.

The procedure went smoothly—but do not try eyelid hook removal at home. Our fisherman understood the consequences of any quick movements, and I was able to gingerly enlarge the entry wound by a millimeter with the tip of the scalpel—just enough to free the barb and pull the hook back out. His cornea had not been touched.

With advice to put ointment on the wound every two hours and to check in with his doctor, the patient left the next morning.

While there were many things we lacked in Maine, we also had some amenities that were in short supply elsewhere. Many years ago a foreboding envelope from the New York State Police arrived amidst the usual junk mail. It had seals, flags, and bold lettering. What had I done? How much trouble was I in? When had I even been in New York last? Then a recent event came slowly to mind.

I had been driving on a parkway in that state, when a motorcyclist ahead of me skidded off the road and down an embankment. I'd pulled over and sprinted down to the driver. He had obviously broken his leg, but that seemed to be the extent of the damage. As usual, I had my football bag in the trunk. I was able to splint the fracture and get the frightened biker wrapped up in a blanket. A few minutes later, the state police arrived. They determined the location of the nearest hospital and radioed for an ambulance. The victim remained alert and complained only of leg pain. His pulse remained strong and slow.

I helped load him into the ambulance. The trooper got my account of the accident as well as my name and address. The event delayed me for an hour, but I was glad to help. It hadn't seemed like a big deal.

Now I looked at the official missive again. Had I broken some law? Was I being sued?

I slowly opened the envelope, then heaved a sigh of relief. The police were thanking me for my aid. "We doubt the physicians in our state would have stopped," they added.

Maine mores were once again at the fore on a summer Saturday afternoon. A family was visiting from Connecticut, and I'd just given their baby an antibiotic injection. As per my usual routine, I scooped her up over my shoulder while rubbing her back and singing gently. After a moment I glanced at the parents. They were frowning and looking right through me. Had I not explained clearly enough the need for this shot? Was there blood spurting from the puncture? Did

From the left: Moore's son Christopher, on top of Maine's Mount Katahdin; Moore in work garb in 2006; and the Moores at his 45th DMS reunion.

FLYING SQUIRREL GRAPHICS

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my quick-stick style of giving injections strike them as primitive?

"Is everything okay?" I asked.

The parents whispered to each other, then turned to me. "We've never seen a doctor pick up a baby before," they confessed.

I started to suggest that they change doctors but instead said, "Well, it's an old Maine custom. The nurses taught me."

When my classmates and I entered Dartmouth Medical School in 1959, Dean Syvertsen told us he had three rules for us. The first was that we would always be seen in a coat and tie. The second was that during the day, if we weren't in class, we'd better be so sick that we were in the infirmary. Third, there would be one warning and that was it. On campus, our ties instantly identified us as either medical students or someone running for class office.

Once I was out in practice, novelty ties became my trademark, as they are for many pediatricians. Each morning, I'd pick a tie to match the season or an upcoming holiday or sports event or my mood or the weather. One of my favorites was a Snoopy tie—with tiny scrub-suit-clad Snoopy figures. Muppets ties were also perennially popular.

Grateful parents vacationing in Maine from upstate New York sent me a buffalo tie. Their child had come down with a high fever, and they'd visited several area hospitals without getting a diagnosis. Then a nurse in our emergency room obtained a urine sample, which proved to be infected. The dozen ferocious beasts charging across that tie always made me feel energetic.

A local family, needing a doctor while vacationing in Bermuda, called me. Luckily, I had some contacts there and was able to help. As a thank-you, they brought me back a sailboat tie from Trimingham's in Hamilton. It seemed to evoke tranquility whenever I wore it.

One young patient gave me a Christmas tie with a chip that played three carols. Sometimes I'd wear it in July and press the chip as I walked through the emergency room.

Once, I feared some grave neurological disease in a six-month-old infant who was rhythmically rotating his head while sitting in his mother's lap. Only after several minutes did I realize that the baby was just following the pendulum path of my new tie, which sported half a dozen yellow smiley faces.

My second summer in Maine I was alone in the office one Saturday afternoon. A mother visiting the area from Massachusetts brought in her daughter with a long facial laceration caused by a piece of metal. The wound was clean and not deep, but it extended from the child's eye down onto her cheek. There was no plastic surgeon in the area. I was it. And the mother, it turned out, was a nurse.

But the patient was cooperative (no bobbing and weaving head this time, luckily), the Novocain did its job, and everyone stayed calm. I was able to close the wound with 15 delicate sutures. But with the double challenge of a facial laceration on a girl and a registered nurse mother, I sweated every stitch. It took me half an hour. When I finished, the edges matched perfectly. I gave the mom written instructions and asked her to come back in three days so I could begin the early removal of alternate sutures to prevent cross-hatch scarring.

They were no-shows. I called their motel. Mother and child had checked out. There was no answer at their number in Massachusetts. Finally, 10 days later, I reached the mom.

"Dr. Moore. I forgot to call you. We took the long way home. I took the stitches out with my nail clippers."

"You what?"

"Don't worry, Dr. Moore. I sterilized them with alcohol."

"How does it look?"

"Great. The cut stayed closed. No infection. I have a friend who is a plastic surgeon. He'll follow up. Thanks again."

Sometimes a small-town doctor deals with emergencies all alone, but sometimes there's lots of help. Even then, essentials may be in short supply.

"Dr. Moore, this baby is getting yellower by the hour." It was early evening, and the nurse was concerned. An Rh-positive infant was about 12 hours old. Rh disease is a serious illness that damaged or killed thousands of babies in the last century. If a mother and her fetus have different Rh blood markers, the baby can develop severe jaundice at birth. The yellow pigmentation can stain the brain of the newborn, causing deafness, cerebral palsy, or death.

In 1968, a preventive treatment, RhoGAM, became available. This particular infant had just missed the debut of RhoGAM and needed an exchange transfusion as soon as possible. In this procedure, the newborn's blood is exchanged with banked blood, two teaspoons at a time. Fresh O Rh-negative blood must be used in such cases. Older blood cannot be substituted.

We looked at the dates on all the bags of O negative blood on hand. None were usable. We needed a fresh donor, and fast. Ten O negative donors were listed on the blood bank's roster, but none were home. There were no answering machines or cell phones back then. We were stumped.

Then a nurse floated the idea of *paying* an emergency donor. That triggered a recollection for me: Who was the last paid O negative

continued on page 56

Just Kidding

continued from page 47

blood donor that I was aware of? Myself.

During medical school, I would from time to time sell a unit of blood for $25. That sum would buy two weeks of lunch. And the duty was more pleasant than my other paid research job, which involved swallowing feeding tubes.

"Please call the lab technician from the blood bank to draw a unit of blood from me—stat," I told the nurse.

"I don't think they can do that, Dr. Moore."

"Why?" I asked.

"It sounds weird," she replied.

"What's the alternative?"

When the phlebotomist raised the same doubt, I played the "very sick baby" card again. All of the lab technicians had children of their own. My blood looked healthy as it flowed into the bag. The lab said my blood would be just fine.

The baby tolerated the procedure well, and his yellow hue faded quickly. He was discharged a few days later in good condition. My partners took a dim view of my action, but they never told me what other option they'd have pursued. The hospital administrators tried to find some rule that I'd violated. They found none.

I ran afoul of the hospital administration another time, just after we'd moved into a new building, in 1979. On a drizzly day, ambulances transported the remaining patients to the shiny new facility from the old building a mile away. Only after the last pieces of equipment were removed did we realize just how shabby the former hospital was. I had been one of three doctors who had voted not to build the new hospital but to renovate the old building instead. Fortunately the three of us were outvoted.

The grand opening of our new emergency room quickly attracted a very sick child. Just an hour after the ribbon was cut, a profoundly anemic infant arrived. The diagnosis was unclear, but there was no question about the need for an emergency transfusion.

I tried to reassure the anxious parents, while worrying myself about the fact that we did not yet have a pediatric pump designed to push thick donated blood cells through a tiny, infant-sized intravenous needle.

We did the best we could, hanging the blood bag from an IV pole. A few drops fell very slowly from the filter. At that rate it would take hours to stabilize the infant. Then I remembered the advice of my first ski instructor: "Let gravity be your friend!"

The nurses grafted a few IV poles together. With every added foot in height, the packed cells dripped a bit faster. Finally, I climbed up a stepladder, pushed aside a square of acoustical tile, and hoisted the bag above the false ceiling, among the pipes and electrical conduits. The nursing staff cheered as the blood dripped even faster—just as the hospital CEO, the whole board of directors, and a TV crew came around the corner and onto the new pediatric wing. Sharp words were exchanged concerning the alteration of hospital property. We finally agreed to an informal truce so that our difference of opinion would not appear on the 11:00 p.m. news. Everyone became less irritable as the baby's condition improved.

I had lots of favorite patients over the years. One was Jonathan. He had been born with defects in his lower spine. His right leg was short. He had bowel and bladder problems. He needed a colostomy bag and a draining tube from his bladder. Despite his severe disabilities, he grew and thrived. The family moved away and later returned. I followed this courageous child through numerous surgeries and problems at school. His father moved many miles north but still brought his son to see me. I particularly remember one day when I was grumbling about my back or maybe a cold. The examining room door flew open and there was Jonathan—crutches, tubes, and ear-to-ear smile. Then in a loud voice he asked, "Hey, Dr. Moore. How are you? Havin' a good day?"

A day that I was taking care of children like Jonathan was always a good day. One of my nurses had a poster that read: "One hundred years from now, nobody will remember the size of your house, car, or bank account—but they will remember if you made a difference in the life of a child." I tried to view my 40 years in practice as a time when I was given the privilege of caring for sick children. I salute all those—doctors, nurses, teachers, parents—who make a difference in the lives of children. ■