States of the Union

DEATH OF THE COUNTRY DOCTOR

BY RICHARD J. MARGOLIS

"THE PRINCIPAL characteristic of change in the U.S. population since World War I has been urbanization," notes a 1972 American Medical Association report, by way of explaining why rural Americans get shoddier health care than most other citizens. In consequence, the AMA continues, the nation's medicine must be urbanized, too—or at least regionalized. Like most observers of the rural health scene, the AMA foresees the construction of a network of large medical centers, each one serving dozens of surrounding small towns.

One finds the diagrams and schemas in the health planners' texts: The architects' renderings of modern hospitals look like sunbursts, with multicolored lines ("vectors") radiating outward toward the villages ("satellites"). And one should hardly be surprised that officials at the Department of Health, Education and Welfare (HEW), have already been spreading word of their intent to "phase out" the many 16- and 20-bed hospitals that still function in small-town America, thereby hastening the process of regionalization.

"Sooner or later," an HEW functionary cheerfully assured me, "we will arrange matters so that only the bigger hospitals will be able to meet our Medicare and and Medicaid standards of eligibility. When that happens, the small hospitals will disappear." Unfortunately, HEW has neglected to consider whether the move, or any of the grand building projects it embraces, will do very much to satisfy the needs of the people who are supposed to be the true beneficiaries.

To most rural Americans—i.e., to the 66 million citizens who live outside Standard Metropolitan Areas—ideas of this kind have an all-too-familiar air. They seem to be merely the continuation of programs that for more than half a century have imposed essentially urban solutions on rural problems: not only the regionalization of hospitals, but also the consolidation of schools, the abandonment of railroads, the mapping of highways so as to bypass small towns, and the denial of subsidies to communities unable to establish their credentials as "growth centers."

Such policies, which nearly everyone has taken for granted for too many years, have turned much of rural America into a valley of despair that begets untold miseries and triggers mass migrations from country to city. These in turn generate new pressures for more regionalization, consolidation and all those other "ations" that for rural Americans spell perpetual *frustration*. We are in the presence of self-fulfilling failure.

For example, the Appalachian Regional Commission (ARC), an invention of New Frontier days, has spent 10 years and millions of dollars trying in vain to stimulate economic development in poverty-stricken areas like eastern Kentucky. ARC's efforts were bound to fail, however, because Congress, in writing the law, insisted that the commission invest its dollars solely in those locations with a "significant potential for economic growth, and where expected return for the dollar will be the greatest."

This notorious "growth center" approach, that, for practical purposes writes off most of rural America, has deprived almost all Appalachian communities of Federal aid. Its net impact, according to the

ARC Accountability Project (a Nader-like watchdog group), "was to neglect the rural areas while encouraging migration to a few metropolitan centers near the edge of the Appalachian region. People were . . . forced to leave their homes in the hollows and rural areas. . . ."

Virtually every known expert today proclaims mobility and transiency as hallmarks of the American way of life. Yet many individuals who do not read sociology books remain loyal to their hometowns and would stay put forever if given half a chance. I have met exiles from Kentucky, now living in Michigan, who each weekend drive their jalopies the thousand miles it takes to get "home" and back, and there are families living in Detroit for 20 years or more who will tell you their home is Pikeville, or Drift, or South Mud Creek.

These people want essential services like health care to be available where they live, not in some remote metropolitan center that happens to look good on the planner's map. In the small towns I have visited, talk of regionalizaton is both rare and irritating.

Consider the response of South Dakotans to their health-care predicament. It happens to be quite a predicament. More than 5,000 towns in America are without a doctor, and 266 of them are in South Dakota. That makes the state the most consistently neglected by the medical profession. Moreover, a majority of South Dakota's doctors are clustered in cities like Sioux Falls and Aberdeen; in fact, just nine towns account for 351, or 61 per cent, of the state's 508 physicians. The remaining 157 doctors are thinly scattered over 900 towns and across 77,000 square miles of prairie, Bad Lands, and Black Hills. All this passes for a "Statewide Medical System."

The South Dakota health officials I recently interviewed spoke hopefully of attracting more doctors by ereoting newer and bigger regional hospitals, but the people in the doctorless villages will have none of it. They want physicians of their own. During the 1950s and '60s some of the towns even went into hock in order to build small hospitals, often with the encouragement of Federal and state officials.

Later, as local doctors retired or died and new ones failed to materialize, many hospitals were forced to close. Thus places like Murdo, Wall and Edgemont are stuck with empty, unused medical facilities and are searching frantically for doctors. Along Highway 18, one can read this forlorn sign:

DOCTORS NEEDED
IN
EDGEMONT, SOUTH DAKOTA
IDEAL OUTDOOR RECREATION
PLEASE CALL 605-662-7500

I called the number and learned it was the local Conoco station, owned by Jack Nelson, who was both mayor of Edgemont and chairman of the doctor recruitment committee. Edgemont's 16-bed hospital, I was told, was shut down in 1969, when the town's one doctor died of old age. The recruitment committee has been busy ever since, but without luck. Each year its members visit medical schools in other states (South Dakota still lacks a four-year medical college) in hopes of luring graduating seniors and interns to Edgemont. A brochure innocently points out that the local school system "maintains a library," and wistfully locates Edgemont "in the Heart of the Hard Grass Country!"

RECRUITING can be expensive. For one thing, any young doctor who shows the slightest interest in working in a small community is instantly invited down for a few days' "look-see," all expenses paid. As often as not the candidate brings his wife. "We wine and dine them," says Jim Stender, president of the hospital board of trustees in Custer, "and we introduce them around to everybody. They thank us and go away, and usually that's that. We never hear from them again."

Once in a while a town strikes it rich. Oneida (pop: 900) was lucky enough a few years ago to find John M. Knutson, a South Dakotan then attending the Rush Memorial Medical College in Chicago. In exchange for his promise to set up practice in Oneida, on a trial basis, the town's citizens offered him a $16,000 scholarship and the use of a rent-free clinic. Knutson, a kind man, considers the $16,000 to be a loan; he is paying it back out of his earnings in Oneida where he hung out his shingle last January. The clinic, gleaming with $30,000-worth of new equipment, was waiting for him. It had once been Oneida's hospital, but was closed in 1966 because the overworked doctor, a citizen explained to me, "left town out of self-preservation."

When word came last autumn of Knutson's firm intentions to practice in Oneida, people got busy remodeling the old structure. It was a community effort, just as construction of the original hospital had been back in 1950. (In those days the entire Oneida high school football team would help every afternoon following practice.) I asked John Zebroski, owner of the local hardware store, why the town had gone to so much trouble and expense to bring in a doctor when there were several available 50 miles away in Pierre.

"Well, of course we need a doctor here for emergencies," he said. "But that's not all. Frankly, I don't enjoy going to Pierre—too many strange faces. A person who needs a doctor shouldn't have to wander all over the state. He should have one right there on the spot."

From the planner's standpoint Zebroski's notions are irrational, irrelevant and obsolete. Yet I sometimes suspect they are all that stave off the concreting of rural America.