5 · *A Better Life*

In 1991, in the tiny town of New Berlin, in upstate New York, a young physician named Bill Thomas performed an experiment. He didn't really know what he was doing. He was thirty-one years old, less than two years out of family medicine residency, and he had just taken a new job as medical director of Chase Memorial Nursing Home, a facility with eighty severely disabled elderly residents. About half of them were physically disabled; four out of five had Alzheimer's disease or other forms of cognitive disability.

Up until then Thomas had worked as an emergency physician at a nearby hospital, the near opposite of a nursing home. People arrived in the emergency room with discrete, reparable problems—a broken leg, say, or a cranberry up the nose. If a patient had larger, underlying issues—if, for instance, the broken leg had been caused by dementia—his job was to ignore the issues or send the person somewhere else to deal with them, such as a nursing home. He took this new medical director job as a chance to do something different.

The staff at Chase saw nothing especially problematic about

the place, but Thomas with his newcomer's eyes saw despair in every room. The nursing home depressed him. He wanted to fix it. At first, he tried to fix it the way that, as a doctor, he knew best. Seeing the residents so devoid of spirit and energy, he suspected that some unrecognized condition or improper combination of medicines might be afflicting them. So he set about doing physical examinations of the residents and ordering scans and tests and changing their medications. But, after several weeks of investigations and alterations, he'd accomplished little except driving the medical bills up and making the nursing staff crazy. The nursing director talked to him and told him to back off.

"I was confusing care with treatment," he told me.

He didn't give up, though. He came to think the missing ingredient in this nursing home was life itself, and he decided to try an experiment to inject some. The idea he came up with was as mad and naïve as it was brilliant. That he got the residents and nursing home staff to go along with it was a minor miracle.

But to understand the idea—including how it came about and how he got it off the ground—you have to understand a few things about Bill Thomas. The first thing is that, as a child, Thomas won every sales contest his school had. They'd send the kids off to sell candles or magazines or chocolates door-to-door for the Boy Scouts or a sports team, and he'd invariably come home with the prize for most sales. He also won election as student body president in high school. He was chosen captain of the track team. When he wanted to, he could sell people on almost anything, including himself.

At the same time, he was a terrible student. He had miserable grades and repeated run-ins with his teachers over his failure to do the work they assigned. It wasn't that he couldn't do the work. He was a voracious reader and autodidact, the kind of a boy who would teach himself trigonometry so he could build

a boat (which he did). He just didn't care about doing the work his teachers asked for, and he didn't hesitate to tell them so. Today, we'd diagnose him as having Oppositional Defiant Disorder. In the 1970s, they just thought he was trouble.

The two personas—the salesman and the defiant pain in the neck—seemed to come from the same place. I asked Thomas what his special technique for sales was as a kid. He said he didn't have any. It was simply that "I was willing to be rejected. That's what allows you to be a good salesperson. You have to be willing to be rejected." It was a trait that let him persist until he got what he wanted and avoid whatever he didn't want.

For a long time, though, he didn't know what he wanted. He had grown up in the next county over from New Berlin, in a valley outside the town of Nichols. His father had been a factory worker, his mother a telephone operator. Neither had gone to college, and no one expected Bill Thomas to go either. As he came to the end of high school, he was on track to join a union training program. But a chance conversation with a friend's older brother who was visiting home from college and told him about the beer, the girls, and the good times made him rethink.

He enrolled in a nearby state college, SUNY Cortland. There, something ignited him. Perhaps it was the high school teacher who predicted as he left that he'd be back in town pumping gas before Christmas. Whatever it was, he succeeded far beyond anyone's expectation, chewing through the curriculum, holding on to a 4.0 grade point average, and becoming student body president again. He had gone in thinking he might become a gym teacher, but in biology class he began thinking that maybe medicine was for him. He ended up becoming Cortland's first student to get into Harvard Medical School.

He loved Harvard. He could have gone there with a chip on his shoulder—the working-class kid out to prove he was nothing

like those snobs, with their Ivy League educations and trust fund accounts. But he didn't. He found the place to be a revelation. He loved being with people who were so driven and passionate about science, medicine, everything.

"One of my favorite parts of medical school was that a group of us had dinner at the Beth Israel Hospital cafeteria every night," he told me. "And it would be two and a half hours of arguing cases—intense and really great."

He also loved being in a place where people believed he was capable of momentous things. Nobel Prize winners came to teach classes, even on Saturday mornings, because they expected him and the others to aspire to greatness.

He never felt the need to win anyone's approval, however. Faculty tried to recruit him to their specialized training programs at big-name hospitals or to their research laboratories. Instead, he chose family medicine residency in Rochester, New York. It wasn't exactly Harvard's idea of aspiring to greatness.

Returning home to upstate New York had been his goal all along. "I'm a local guy," he told me. In fact, his four years at Harvard were the only time he ever lived outside upstate New York. During vacations, he used to bicycle from Boston to Nichols and back—a 330-mile ride in each direction. He liked the self-sufficiency—pitching his tent in random orchards and fields along the road and finding food wherever he could. Family medicine was attractive in the same way. He could be independent, go it alone.

Partway through residency, when he'd saved up some money, he bought some farmland near New Berlin that he'd often passed on his bike rides and imagined owning some day. By the time he finished his training, working the land had become his real love. He entered local practice but soon focused on emergency medicine because it offered predictable hours, on a shift, letting him

devote the rest of his time to his farm. He was committed to the idea of homesteading—being totally self-reliant. He built his home by hand with friends. He grew most of his own food. He used wind and solar power to generate electricity. He was completely off the grid. He lived by the weather and the seasons. Eventually, he and Jude, a nurse who became his wife, expanded the farm to more than four hundred acres. They had cattle, draft horses, chickens, a root cellar, a sawmill, and a sugarhouse, not to mention five children.

"I really felt that the life I was living was the most authentically true life I could live," Thomas explained.

He was at that point more farmer than doctor. He had a Paul Bunyan beard and was more apt to wear overalls beneath his white coat than a tie. But the emergency room hours were draining. "Basically, I got sick of working all those nights," he said. So he took the job in the nursing home. It was a day job. The hours were predictable. How hard could it be?

FROM THE FIRST day on the job, he felt the stark contrast between the giddy, thriving abundance of life that he experienced on his farm and the confined, institutionalized absence of life that he encountered every time he went to work. What he saw gnawed at him. The nurses said he would get used to it, but he couldn't, and he didn't want to go along with what he saw. Some years would pass before he could fully articulate why, but in his bones he recognized that the conditions at Chase Memorial Nursing Home fundamentally contradicted his ideal of self-sufficiency.

Thomas believed that a good life was one of maximum independence. But that was precisely what the people in the home were denied. He got to know the nursing home residents. They had been teachers, shopkeepers, housewives, and factory workers,

just like people he'd known growing up. He was sure something better must be possible for them. So, acting on little more than instinct, he decided to try to put some life into the nursing home the way that he had done in his own home—by literally putting life into it. If he could introduce plants, animals, and children into the lives of the residents—fill the nursing home with them—what would happen?

He went to Chase's management. He proposed that they could fund his idea by applying for a small New York State grant that was available for innovations. Roger Halbert, the administrator who'd hired Thomas, liked the idea in principle. He was happy to try something new. During twenty years at Chase, he had ensured that the facility had an excellent reputation, and it had steadily expanded the range of activities available to the residents. Thomas's new idea seemed in line with past improvements. So the leadership team sat down together to write the application for the innovation funding. Thomas, however, seemed to have something in mind that was more extensive than Halbert had quite fathomed.

Thomas laid out the thinking behind his proposal. The aim, he said, was to attack what he termed the Three Plagues of nursing home existence: boredom, loneliness, and helplessness. To attack the Three Plagues they needed to bring in some life. They'd put green plants in every room. They'd tear up the lawn and create a vegetable and flower garden. And they'd bring in animals.

So far this sounded okay. An animal could sometimes be tricky because of health and safety issues. But nursing home regulations in New York permitted one dog or one cat. Halbert told Thomas that they'd tried a dog two or three times in the past without success. The animals had the wrong personality, and there were difficulties arranging for proper care. But he was willing to try again.

So Thomas said, "Let's try two dogs."

Halbert said, "The code doesn't allow that."

Thomas said, "Let's just put it down on paper."

There was silence for a moment. Even this small step pushed up against the values at the heart not just of nursing home regulations but also of what nursing homes believed they principally exist for—the health and safety of elders. Halbert had a hard time wrapping his mind around the idea. When I spoke to him not long ago, he still recalled the scene vividly.

> The director of nursing, Lois Greising, was sitting in the room, the activities leader, and the social worker. . . . And I can see the three of them sitting there, looking at each other, rolling their eyes, saying, "This is going to be interesting."
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> I said, "All right, I'll put it down." I was beginning to think, "I'm not really into this as much as you are, but I'll put two dogs down."
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> He said, "Now, what about cats?"
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> I said, "What about cats?" I said, "We've got two dogs down on the paper."
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> He said, "Some people aren't dog lovers. They like cats."
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> I said, "You want dogs AND cats?"
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> He said, "Let's put it down for discussion purposes."
>
> I said, "Okay. I'll put a cat down."
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> "No, no, no. We're two floors. How about two cats on both floors?"
>
> I said, "We want to propose to the health department two dogs and four cats?"
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> He said, "Yes, just put it down."
>
> I said, "All right, I'll put it down. I think we're getting off base here. This is not going to fly with them."