Slow medicine

By Dennis McCullough, M.D.


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As a geriatrician practicing in America today, I often think about a Japanese film I saw years ago. It tells the story of three generations living in extreme poverty on a remote northerly island that afforded its residents neither doctors nor anything beyond the simplest folk remedies. Life was hard. Food was scarce. When an aging grandmother recognized it was her time to die, she broke her teeth with a stone so there could be no arguing about her eating the family's food. Reluctantly, inexorably, the old woman weakened. Finally, her loving and dutiful son was forced to undertake the community's arduous tradition of carrying his mother on his back to the top of a steep and holy mountain, where she would be laid out with other frail elders to die a peaceful death by falling asleep in the freezing snow.

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The mountain climb was long and difficult. The son's balance, strength, and grip occasionally failed. Engaged in their shared ritual, parent and child seldom spoke except to acknowledge their mutual trust and the difficulty of their task.

Inevitable: Those caring for aging parents today find their journey up that figurative mountain equally difficult and considerably longer, even with the ample benefits and miracles of contemporary medicine. There's no getting around the inevitable necessity for physicians and families alike to undertake the care of aged loved ones over months, or even years, of decline and on through the actual work of dying—truly a "carry up the mountain." Yet so often today, despite intending to do the best work we can, we face a medical-care system that seems to work at odds with our parents' stated desires and wishes—"to die at home," "to let go when the time comes," "to avoid the suffering I have seen my friends go through."

As a geriatrician, I know that the canary in the coal mine of our failing health-care system is the plight of the old and frail and their families. The vast machinery of modern medicine, which can be heroically invoked to save a premature baby, when visited upon an equally vulnerable and failing great-grandmother, may not save her life so much as torturously and inhumanely complicate her dying.

In a recent opinion piece, titled "It's Time to March," published in the *Journal of the American Geriatrics Society*, Drs. Knight Steel and T. Franklin Williams, two of the specialty's wise elders, urge that, since reform within the larger medical profession has failed, specialists in aging should take to the streets with the public in protest. Our system of "fast medicine" is running a lockstep, breakneck course, and no one in or out of health care seems to know how to put on the brakes. To maximize efficiency, doctors and nurses are always over-scheduled. Taking time for listening and understanding—much less time for interactions with families—is not paid for and hence not usually undertaken in today's corporate medical environment. Patients are briskly shunted off for various kinds of expensive but Medicare-covered tests and procedures or quickly put on medications based on rapidly made decisions and standardized protocols.

Frail: My vision of better care for elders in late life is not a call for a nostalgic return to some imagined romantic past when the lone family doctor sat by the bedside by candlelight tending the ill. It is, rather, a stern and impassioned call to help families struggling to care for their aging and frail elders; to preserve quality of life even in the face of difficult and accumulating diseases; and to mend elders' neglect by modern health-care "systems."

American medicine is best at managing acute crises and supplying specialized elective procedures, such as joint replacements, organ transplants, eye surgeries, cosmetic changes—all of them modern technological wonders. As for the more ordinary and common management and support of elders and families dealing with the chronic problems of aging and slow-moving diseases, our medical-care system has not done so well.

Some elderly patients are fruitlessly subjected to what some critics now call Death by Intensive Care—patients who are sedated (and thus unable to communicate) and subjected to enduring impersonal medical protocols in strange, disorienting surroundings or stranded in limbo on life-support machines while their families hover in waiting rooms, uncertain how to help.

Burdens: This high drama happens for some, but much more commonly elders suffer the accumulating burdens of illness and exhausting medical regimens that extract all their available energy and time, leaving nothing left for living beyond a "medicalized" life.

But there is another way: "slow medicine" where family, friends, and neighbors team up with an elder and with health-care providers—including visiting nurses and other home-based care providers—to improve the quality of care and avoid inappropriate, sometimes harmful care. Excellent chronic care attends to the day-to-day needs and conditions of the patient—by offering emotional support and social stimulation, supplying better nutrition, and making sleeping, moving, bathing, dressing, and voiding easier.

"Slow medicine" is not a plan for getting ready to die. It is a plan for caring, and for living well, in the time that an elder has left. ■

The Grand Rounds essay covers a topic of interest to the Dartmouth medical faculty. McCullough, an associate professor of community and family medicine at DMS, has been a family physician and geriatrician for 30 years. This essay is adapted with permission from his recent book My Mother, Your Mother: Embracing "Slow Medicine," the Compassionate Approach to Caring for Your Aging Loved Ones. *For more about the book, published by HarperCollins in 2008, see* **www.mymotheryourmother.com/**.