Being Mortal Study Guide

Being Mortal by Atul Gawande

BOOKRAGS

Contents

Summary

“Being Mortal” by Atul Gawande is an accounting of the care and treatment of the elderly and the dying as it has evolved over the last century to what it is today and could become in the future. In the United States in the early 1900s, old people who were sick and poor – most were poor and many were sick – were institutionalized in poorhouses which provided little care and largely accelerated the decline of the sick and old. There was a great contrast between the treatment of the elderly in America and in Asia and India, cultures that revere their elderly and take them into their homes until they require advanced care.

Before the mid-century hospitals had been used mainly as custodial institutions. After World War II hospitals began to be equipped with antibiotics and monitoring machinery and became care giving centers. The elderly who were hospitalized quickly became a thorn in the side of medical staffs. Doctors and nurses were trained to treat and cure people, fix them. But old dying people weren't fixable and were taking up valuable time and space with no good results – at least for the doctors and hospitals who became heroes to younger patients who feel the system saved their lives.

There was no place to put these elderly people who were not fixable until the federal government awarded grants to hospital to augment their facilities with a wing for the elderly. This was the green sprout of what later was to become the nursing home. Grant money was only available to facilities that met the standards set out by the government. Financially-challenged southern hospitals had a difficult time meeting those standards but, no problem, the government changed the law to state that the hospitals had to come near in meeting those standards. What resulted from this ambiguous piece of legislation were substandard facilities that morphed into what later became nursing homes, cold-hearted facilities that the elderly feared and detested.

Dr. Gawande is a general surgeon who took an interest in the care and treatment of the elderly. He relates his own experiences with his elderly patients. including his own father and younger patients who had terminal diseases. He began to recognize that once a nursing home got hold of a person that individual's wishes, dreams and desires no longer mattered. He found that many other like-minded professionals in the health care industry existed and were determined to change things.

Dr. Gawande reports on improved facilities like those that follow the assisted living model which is somewhere between independent living and the nursing home. Gawande also gives voice to the Green Houses developed by Dr. Bill Thomas who believed that by interjecting life – real life in the form of plants, pets and children – into nursing homes that the elderly could only benefit. Palliative care which focuses on what a terminal patient wants the rest of his life to be like is coming into vogue with more and more health professionals adhering to its ideology. The palliative caregiver focuses on removing as much pain and suffering from the patient as possible and finding out what he'd like to do with the rest of his life and trying to help him achieve those aspirations.

Assisted suicide may become more of an option in the future. However, it should never replace the responsibility of health care professionals to make the end-of-life experience satisfactory and a fitting conclusion to a life well-lived. There is hope for the aging, a group that includes everyone on earth. Doctors are beginning to recognize that not everyone can be cured and that some people just need comfort, kindness, attention and understanding and the chance to have purpose. Death waits for everyone of us but the pathway doesn't have to be wrought with misery and a loss of independence and purpose.

Chapter 1

Summary

Dr. Atul Gawande grew up in a healthy family. His parents were both doctors and immigrants from India. They were raising Atul and his sister in Athens, Ohio. The only elderly person he knew as a youngster was the elderly woman down the street he gave him piano lessons. In college, he met his girlfriend's 77-year-old grandmother, Alice Hobson, on Christmas break 1985. His girlfriend, Kathleen, would eventually become Atul's wife. Alice grew up on a the family's flower farm in Pennsylvania. Alice and her siblings were the first in the family to go to college.

Alice met her husband, Richmond Hobson at the University of Delaware. He was an engineering student. They couldn't afford to get married for six years after meeting because of the Great Depression. They had two sons, Jim and Chuck. Rich worked for the Army Corps of Engineers involved with dam and bridge construction. He was promoted to work in the chief engineer's office in Washington, D.C. The family moved to Arlington, VA. He died of a heart attack at age 60 when Alice was 56. Alice kept her house and had lived independently 20 years when Atul met her. She was generally healthy but suffered from arthritis.

Atul's father, a urologist, was amazed that Alice lived independently. He was a resident in New York City in 1963 and met his wife, a pediatrics resident from India. He embraced the American culture and proudly became a citizen on July 4, 1976. The only problem he had with America was how poorly they treated their elderly. Many died in isolation in a strange place with people they didn't know. Atul recalls visiting his grandfather when he was more than 100 years old. He of course had physical issues but he was a dignified man and was surrounded and supported by his family at all times. He was revered because of his age not in spite of it. In America he would have been in a nursing home. Atul's grandfather lived with one of his son's and his family. There was always someone around to help him if he needed it. His family saw to it that he was able to have a hand in running his farm, a business he had since he was 18. The family got him a small horse so he could check out his property. Someone always rode with him. He took these rides until the time he died at age 110.

The way Atul's grandfather was treated has been the norm over most of human history. The elderly were always cared for by the family. Often the youngest child would stay home and not marry to care for aging parents. It was expected that the elderly would remain in their homes and the family would do what was necessary to care for them. In modern society in the U.S., the elderly and infirmity go hand-in-hand. Culture has changed the view of the aged. People are living longer than they used to. The elderly were considered the head of the family in years past and were duly respected. The Internet has created a new way of working and gaining wisdom which has made the knowledge of the elderly, once revered, obsolete. The elderly used to maintain their property longer which created for those looking for an inheritance to care for them.

Children and grandchildren no longer follow in the footsteps of their elderly relatives. Globalization has opened up new opportunities for the youth of the world. When Atul's father emigrated to the U.S., he sent money home to help his family.

As time passed, the elderly had means of saving money for the future and the concept of retirement became popular. Longevity allowed most parents to see their children mature to adulthood. The majority of elderly people do not want to live with family; they want to maintain their independence. Even in Asian countries that traditionally took their elderly in, more and more of the elderly are living alone. The development of retirement communities became popular in the 1960s. Residence was limited to retirees and these facilities included activities geared for the elderly. The elderly overwhelmingly prefer an independent life.

Unfortunately, nature takes over and the elderly eventually become ill or too frail and weak to care for themselves. Alice stayed healthy through her 84th year; however, dementia was setting in and she was taking a few serious falls. It was obvious that her independent days were nearing their end.

Analysis

Atul Gawande is the author of “Being Mortal.” In this first chapter, he introduces fundamental issues with aging and care for the elderly. He is from a family of physicians including both parents. He provides some background that includes his own relatives in order to establish that everyone – including physicians – face aging and caring for the sick and elderly in their own families. He does so to demonstrate that there are no pat answers to caring for the aged and that no one has all the answers even experts in the medical field.

This information is important because it softens the image of the physician/author and makes him less an expert but more a human who must deal with his own issues regarding aging and mortality. He discusses the importance of the elderly being allowed to live independently as long as possible which is one of the main topics of the book. The author sends the message that everyone is confounded by the proper care for the elderly.

The subject is one that is part of everyone's life. Whether the reader is young or old, the subject matter touches everyone. No one escapes dealing with aging and mortality. From aging parents to facing one's own mortality at the end of life, the book is relevant.

Vocabulary

angina, urologist, idyllic, senescence, infirmity, demographer, longevity, culminating, nostalgically, proliferated, veneration

Chapter 2

Summary

Public health standards, medical treatment and nutrition has increased longevity. Even those with a fatal disease often live years of productive life after their diagnoses thanks to powerful pharmaceuticals and advanced surgical procedures. Prolonging productive years also prolongs years of infirm. The elderly often feel ashamed of their declining physical abilities. Even doctors are often disinterested in the aged unless they can fix something. No matter how much care and attention a person gives to his personal health, aging trumps everything and physical decline is inevitable. Teeth soften and arteries harden. The walls of the heart thicken and shortness of breath occurs. Muscle weight decreases by 25% by age 80 which is largely responsible for weakness. Muscles, like those in the hand, lose their dexterity and decreases the ability to handle tasks that require small motor skills. Brains shrink and glands become dysfunctional. Memory and judgment becomes impaired.

Some believe that we age due to wear and tear on our bodies. A more recent concept is that we are programmed to age – we shut down instead of wear down. There is gene-alteration experimentation taking place today which allows worms to live twice as long as normal. Centuries ago it was rare to die of old age there were so many ways to die young. Perhaps we live beyond our appointed time in modern times. Inheritance has little to do with longevity so aging is not a genetic process. The wear and tear model may be the most viable explanation for aging.

There is a natural redundancy built into our bodies with extra organs and DNA that can repair itself to a degree. But eventually defects incurred with no back up system and the condition known generally as frailty occurs. Hair grays because pigment cells run out. Age spots occur because of clogged skin cells. Eyes yellow and develop cataracts. The natural age distribution in population had always been a pyramid with the large base representing children five and under. There has been a shift in that distribution over last half of the 20th century. In 30 years, it is estimated that the number of people five and under and the number of people 80 and over will be the same.

Many elderly live a solitary life. With the increase in the sheer numbers of the elderly, the number of geriatricians to treat them is decreasing. The incomes of geriatricians are among the lowest in the medical profession and many doctors just do not like caring for the elderly. Atul did not recognize the level of expertise necessary for caring for the aging until he visited his hospital's geriatrics clinic.

Alice began falling which threatened the independent life she wanted to maintain. She had a car accident because she had stomped on the accelerator instead of the brakes. Aging is an irreversible process that sneaks up on everyone. At one point, something happens that strips the individual of any hope for independence. Alice was also taken

advantage of by landscapers who overcharged her figuring she was an easy mark. Her son suggested that they look into a retirement home for her.

Death awaits us all but the path to it can be made more pleasant and comfortable. Physicians are often at a loss about what to do with an aging patient. Sometimes they make matters worse. Research shows that the elderly fare far better when being under the treatment of geriatricians. Geriatrics centers close in hospitals because the care of the aged is so costly and it is economically impossible for the centers to stay viable. Geriatric care does not clamor for new medical devices and gizmos. It involves monitoring of nutrition, medications and living situations and to accept the unfixables in life.

According to Dr. Chad Boult, it is too late to recruit enough specialists for the aging. It takes time to create geriatric specialists and there aren't enough new geriatricians to keep up with the attrition in the field. Boult suggests providing training in geriatrics to general practitioners and include courses in every field of medical training. Life can be better for the elderly.

Analysis

The author broaches the subject of prolonging life. While he points out that productive years can be added to a person's life through medical treatments and innovations, he also points out the downside – that the years of infirm are generally increased as well.

Gawande ventures in on some touchy areas about the aging. With prolonged life, there are more elderly than ever before; however, there are fewer medical experts to care for them. Many physicians do not find specializing in geriatrics appealing. The author is brutally honest by admitting that many physicians aren't interested in their elderly patients because they cannot be fixed. He sets up this premise as one of the major concerns in caring for the elderly and infirm.

The decreasing number of medical experts available to care for the elderly is important to everyone due to personal concerns for close family members who are aging and becoming frail and weak and are suffering from disease as well as future concerns that lie ahead for everyone who reads the book. It is a strong dose of reality but forewarned is forearmed.

Vocabulary

trajectory, vertiginous, atrophies, proponents, redundancy, metastasis

Chapter 3

Summary

The elderly are more afraid of their physical decline than they are of death. Health and welfare can be maintained for a period but eventually aging renders us in need of assistance. Alice's son, Jim, helped look for the right retirement home for his mother. He looked for a place that was affordable and close to her family. Also important was a place that offered a continuum of care for the eventuality of her further decline. They chose Longwood House, a high-rise that was affiliated with an Episcopal Church. She had some friends who lived there. Her one-bedroom independent living apartment was large and decorated nicely. However, when Atul saw her she was not herself. She wasn't overtly angry or bitter but withdrawn. She began eating less and lost weight and avoided group activities. Alice had it great at Longwood House compared to the elderly who suffered in the early 20th century going without food or medical care. But everything is relative.

Alice wasn't happy in a place that had top ratings for safety and care. She had many of the comforts and privacy of home. She never got used to Longwood House – it just wasn't home. In 1980, 83-year-old Harry Truman refused to leave his home in Washington when Mount Saint Helens threatened to erupt. Everyone was warned to evacuate but Harry wouldn't budge. If the place was going to go, he'd go with it. On May 18, 1980 at 8:40 am the blast went off with the force of an A-bomb. Harry, his house and his 16 cats were buried under the massive lava flow. Alice felt she had given up her life when she gave up her home. She hated being regulated but the frailer and weaker she got, the more she had to be regulated. The next step would be a transfer to a nursing home.

When did it become a choice between going down with the volcano or losing your home and dignity? Poorhouses of yore were replaced by the current retirement and nursing home facilities. The modern nursing home developed out of doctors declaring that elderly patients had medical problems instead of the conclusion that they were just aging. Before mid-century the ill were treated in their homes. Hospitals were used in a mainly custodial function. After World War II, there were many more antibiotic and pharmaceuticals available. Hospitals were being equipped with artificial respirators and other monitoring equipment. Surgical procedures become commonplace. Doctors were heroes and hospitals beacons of hope.

Even after a dangerous fall, Alice did not want to move to the nursing home. She fell again which required hip surgery. She returned to Longwood in a wheelchair and needed full-time care. She was forced to move to the the nursing unit. She was never able to walk again. She lived her life by going through the motions. Sociologist Erving Goffmann compared mid-century nursing homes to military training camps, mental institutions and orphanages.

In more modern times, the nursing home had the top priority of providing medical care. But it wasn't what Alice and many like her would call really living. Another elderly lady commented that the nursing home felt like a hospital not a home. Alice missed her friends, her privacy and having a purpose. It is the feeling of many that once physically impaired, an individual has no hope for a life of value and freedom. The elderly who rebel to regulations are called “feisty.” People admire old men like Harry Truman who stood his ground to a volcano. But nursing home personnel don't want to hear what their residents like and don't like. There is plenty of arguing and acts of rebellion that go on in nursing homes. No one talks to the residents about what is really going on because they don't want to think about end of life themselves.

One afternoon in 1994, Jim visited Alice. She told him she was ready. He knew what she meant. They arranged for a “Do Not Resuscitate” order to be placed on her records. She died a few months later.

Analysis

The author begins to broach the subject of what matters to the dying. He emphasizes that most elderly people who are terminally ill aren't afraid of death. Their main concerns are on the viability of their final days and that they have some say or choice on how they spend them. He discusses the importance of making final years, months or days as comfortable as possible. Death waits for everyone, he says, but the pathway can be made more satisfactory.

The author again discusses the lack of medical professionals who specialize in care of the elderly. One of the major problems is the length of time it takes to train a doctor in geriatrics. To to solve this problem, one medical professional floats the idea of training all doctors in some element of treating the elderly.

Gawande stresses that doctors are trained to save lives. He points out that doctors are often in a quandary on how to treat their elderly patients because they can't save their lives. Treating the elderly with the idea of just making them more comfortable is at odds with a physician's training.

This “inside” information is important to the reader so they understand that many doctors have difficulty in treating the elderly unless they are specifically trained to do so.

Vocabulary

fastidiousness, solace, facsimile, epochal, vehemently, cognitive, volition, cantankerous

Chapter 4

Summary

Maybe nursing homes should be burned down but no one has a better idea. The primary alternative is staying with family members. But families struggle even with two incomes. An elderly person with a daughter has a better chance of being taken in. Lou Sanders was 88 when he and his daughter Shelley had to make decisions about his future. He had a long up and down career as a small business owner, lost his wife and lost a son. His wife died when Lou was 76. Having cared for his ailing wife for years, he had learned to take care of himself. He had ten good active years until he suffered a heart attack at the age of 85. He recovered well but began falling a few years later and had developed a tremor. He was diagnosed with Parkinson's disease and was having memory lapses and seemed confused at times. He didn't want to go to a retirement home because it was full of old people. He moved in with Shelley and her husband, Tom.

Lou hit it off with a man who Shelley hired to be his companion. He began to adjust but it started to be too much for Shelley. She had a house, a job, a husband and two teenagers to worry about. Now she had him and he was becoming more frail and falling often and suffered from postural hypotension a condition in which causes a partial loss of brain function. She was all things to her father – chauffeur, caregiver, concierge, cook, maid and attendant. The burdens became too much to bear when he reached 90. A nurse consultant told him that he couldn't get the care he needed in Shelley's home. They visited an assisted living facility which is somewhere between independent living and a nursing home. Keren Brown Wilson was one of the founders of the concept and built the first assisted living home for the aged in the 1980s. She was inspired to find better care than what was available because her mother, Jessie, was in need of help as she aged.

As people age their needs shift. They spend more time with close family and friends. They focus on the present rather than the future. Understanding the shift that occurs in needs and aspirations is crucial in understanding aging. The reason for this shift has been attributed to choice, physical changes and necessity. This perspective shift is captured in literature. In Tolstoy's “The Death of Ivan Ilyich,” Ilyich's fading health compels him to abandon ambition; all he wants is comfort and companionship. That's what Alice wanted but couldn't find it; what Lou Sanders couldn't give her father and what Keren Brown Wilson was able to bring to a new kind of facility.

Assistant living isn't always the right answer. It didn't work for Lou Sanders. Shelley found the best assistant living facility that Lou could afford and was best suited to his needs. He was disturbed when he came for a visit. Every resident was using a walker. Later, he had a bad fall that knocked him out. He had to accept that things had changed and that he needed to move into the assisted living facility. But he didn't like it. He was

depressed and seemed lost. Shelley brought him home to stay Sundays through Tuesdays.

One reason that assisted living doesn't work in some cases is because these facilities are built more for the children of the elderly than the elderly themselves. The children make the decisions and marketing is targeted to them. Safety is stressed by assisted living facilities which is important to the elderly but it also eases the guilt the children have for putting their parent in the facility. The elderly delegate the decisions to their children. They could have more say about their situation if they kept control of it. Unfortunately, when Lou began to accept his situation and actually enjoy himself, he became weak and frail and refused to eat. He needed 24-hour care. Shelley had to put him in a nursing home. She had no choice. Atul asked her why she felt she had no choice. Bottom line he had to be where he was safe.

It all comes down to being safe even if a life is empty of everything else an elderly person cares about.

Analysis

The author discusses alternatives to nursing homes the primary source being the home of close relatives. Gawande discusses the pros of cons of an elderly person living with a family. The elderly person is usually not happy being in someone else's home and the family is under stress because of the care that the person needs.

Gawande writes about assistant living homes that are somewhere in between living independently and being moved to a nursing home. He explains why these institutions work for many but still present obstacles to others as far as quality of living. He sounds a cautionary note by explaining that many nursing homes refer to themselves as assisted living homes in order to get more “customers.”

This subject matter is vital information for those readers who may be looking for a living alternative for themselves or for loved ones. By describing both the ups and downs of alternative solutions to the dreaded nursing homes, Gawande provides a balanced view from an expert. He emphasizes that there is no silver-bullet solution for the care of the elderly and that the solution for each person is as individual as he or she is.

Vocabulary

debilitated, custodial, concierge, unequivocal, autonomy, fecklessness

Chapter 5

Summary

In 1991, a young physician named Bill Thomas in New Berlin, New York, was 31 years old and had just taken a job as medical director of Chase Memorial Nursing Home. There were 80 severely disabled elderly residents in the home. He had been an emergency room physician so it was a whole new world for him. The nursing home at Chase depressed him; he wanted to fix it. At first he thought that improved physical treatment would be the fix but he was confusing treatment with care – which his what the elderly residents needed. He decided to bring “life” into nursing homes which included pets, plants and many visits from children.

Although the administrator and staff members were totally against Thomas' ideas, he eventually wore them down through his salesmanship skills. Knowing that the application would have many skeptics, Thomas and his team traveled to the state capital to lobby legislators for approval of his application and were successful.

The implementation of the plan was given to Lois Greising, Director of Nursing. She had been working in nursing homes for years and had a positive outlook that Thomas's innovations could be effective. It was decided that implementation should be swift to fight inertia and any initial resistance. Animals were brought in; live plants were placed in each room; and, the kids of staff members hung out after school. A garden was planted in the back as well as a playground for the kids. A caged parakeet was placed in each room. With all the tasks to be done everyone – staff and residents – dug in and did what they could. The medication cart was equipped with medication and Milk-Bone dog biscuits.

Many of the nurses refused to care for the animals – especially cleaning up after them. Some didn't mind the extra duty. Some resented the money spent on these luxuries when they hadn't had raises in years. Greising did what she could to encourage their cooperation. The lights turned back on in the eyes of some of the residents. Others who were reclusive came out of their shells. Non-ambulatory patients suddenly wanted to take the dogs for walks. The residents took responsibility for their parakeets and monitored their health and behavior. The menagerie expanded with the addition rabbits and egg-laying hens in the back.

Researchers studied the Chase program, dubbed the Eden Alternative, and compared it with results at other nursing homes with traditional programs. Prescriptions fell at Chase with psychotropic drugs decreasing the most. The death rate was lower at Chase by 15 percent. Thomas felt the success was due to a basic human need to have purpose.

In 1908, Harvard philosopher Josiah Royce wrote a book entitled, “The Philosophy of Loyalty.” He posed the fundamental question: why does man need more than just being safe and cared for? It was Royce's conclusion that man needed a cause beyond himself

to feel satisfaction. Having loyalty to something beyond oneself for life to be worthwhile. The concept of death is only bearable knowing that an individual was part of a family or society or cause. The elderly may not have ambition and seek achievement but they are concerned with legacy. The medical field has looked at the elderly as needing physical care not spiritual uplifting.

Although the vast majority of nursing homes remained depressingly institutionalized, homes with new approaches inspired by Keren Wilson and Bill Thomas began to spring up. Peter Sanborn Place was built in 1983 and consisted of subsidized apartments for independent living for the low-income elderly. Director Jacquie Carson stayed in close contact with residents to understanding and accommodate changing needs. She exhausted all means to keep her residents as independent as possible. Carson had to defend the care provided by Sanborn Place when medical professionals concluded that certain residents needed to be in nursing homes. Carson's philosophy on keeping a patient with a resident with deteriorating capacity independent was, “We'll figure it out.” (128) Those who are taking an innovative and humane approach to establishing homes for the elderly share a philosophy that independence, autonomy and purpose in life were of the utmost importance and that all efforts should be expended to see that they are preserved for the individual.

Shelley was able to find a nursing home in North Andover for Lou that offered an advanced and innovative care program. Lou liked the single rooms it offered; maintaining his privacy was crucial to him. Lou thought the facility looked like a home more than a nursing home. Bill Thomas and his wife, Jude, were responsible for this home. They had founded the Pioneer Network, a like-minded group of nursing home owners and administrators who were dedicated to the reinvention of care for the elderly. Thomas had dubbed these homes Green Houses. Ultimately 150 of these houses were built in 25 states. Lou moved into one of them. He was cared for yet he held on to his privacy and as much independence as possible. Lou got to a point that he accepted his end but was content during the process. No one could ask for more.

Analysis

Gawande describes the Green Houses that were established by physician Bill Thomas who found nursing homes depressing. He was certain there was a better way for people to spend their last days and was determined to find a way to bring quality to a person's final days.

The author discusses how it is crucial for the human being to have purpose and that this need does not change just because someone ages. The elderly are concerned with their legacy – did they live a productive life and leave a mark on the world either in the form of self-achievement or through the family they raised? Gawande readily admits that the medical field has largely overlooked the fact that it is vital for the elderly to feel they have purpose by focusing on physical care and ignoring their emotional and psychological needs.

The reader can benefit from the information in this chapter because it will help them better understand what their elderly parent or relative or friend needs at the end of life that doesn't require drugs or heart monitors. While it is important for the doctor to include the patient's emotional needs it is also essential that the family understands these needs as well.

Vocabulary

discrete, problematic, voracious, autodidact, fathomed, crux, inertia, pandemonium, subversive, psychotropic, intrinsic, transcendence, mundane

Chapter 6

Summary

Atul Gawande realized something from the interactions he had with nursing home staffs and their residents. Physicians like Atul had to address the elderly person as a whole individual who may need medical care but who also needed focus on their desires, wants, ambitions and needs. A doctor had to be able to answer this question about an elderly patient: “When should we try to fix and when should we not?” (138)

Thirty-four year-old Sara Monopoli was pregnant and ready to give birth when it was discovered that she had inoperable terminal lung cancer. After delivering the baby, she was given one ray of hope. A variety of drugs were given to Sara that could prolong the life of young female nonsmokers with advanced lung cancer like Sara had. The chemotherapy didn't work; her cancer grew and spread and she grew sicker and weaker.

Sara was at that pivotal point where one question remained: What did she want her doctors to do for her? The costliest medical care in the U.S. is for terminal patients in the last few months of life. Often it is the doctors and family members that insist that everything be done for the dying patient to keep them alive a bit longer. Caregivers often suffer from depression after the passing of a person who is being kept alive by machines and drugs. Research has shown that dying patients have other things on their minds like staying mentally aware, not being a burden and strengthening relationships. The challenge for medical professionals is how to accomplish this.

In the days of yore, people often got sick one day and were dead the next day or two. There were no prolonged periods of time that they lay dying. In modern times death from a terminal illness is a process of days, weeks, months and even years. Like all physicians, Atul had to sign a document indicating that a patient had six months to live in order to be admitted into a hospice program. The goal of a physician is to save a patient's life. The goal of a hospice care giver is to keep the patient free from pain and discomfort. One patient that Atul visited had been in a hospice care center for a year but had only “weeks to live” when she was first moved there. Ninety-five percent of hospice patients know they're dying but hope they won't. Sara Monopoli failed to respond after three rounds of chemo. But neither Sara nor her family was ready to accept her fate and Sara entered into another chemo regimen. The expectations that some physicians hold out for terminally ill patients is to extend their lives but substantial amounts of time – months and years. Many oncologists may tell patients that their cancer is incurable but they resist providing a specific prognosis. Many doctors knowingly enter a patient into a treatment regimen even when they know it won't work. Atul was pressured to operate on Sara's thyroid cancer that was unrelated to her lung cancer. The thyroid cancer wasn't terminal and would not pose a health threat for years, long after Sara was dead. Atul checked on her on a regular basis but in the end did not operate on her. Sara continued to declined no matter what drugs she received. Cancer spread to her major organs

including her brain. Still Sara's family was not prepared for the end. They had fought to save her, to find a cure, ignoring reality. She died of pneumonia in the hospital.

The epic means that physicians take and patients and families support often make the end of a life filled with suffering and agony and leaves family members depressed after a loved one has passed. There is a school of thought that if patient families were required to pay end-of-life treatment costs for terminal patients instead of insurance companies, choices would be different. Some fear the “rationing” of end of life care which some refer to as death panels.

Elderly patients in La Crosse, Wisconsin, were more comfortable and satisfied with the treatment they received that included end-of-life discussions with patients. Medical leaders in La Crosse had banded together and adapted a city-wide program of holding these discussions. Sharon Block, a palliative care specialist at Atul's hospital, explained that the goal of these specialists was to help the patient navigate through the anxiety about their end-of-life concerns including death, pain, family and even finances. Palliative care specialists are taught to do more listening than talking and when they talk to be tactful and use the right words. Sharon used these techniques on her ailing father not because she wanted to but because it was necessary. Patients and family appreciate being able to discuss realities and accept them allowing themselves to enjoy their dying relative in the time left without the pressure of trying to save them when it's clearly impossible. A responsible physician will not prescribe treatment that is useless and give the family and patient false hope.

Analysis

Gawande poses the questions that doctors must ask themselves in the care of an elderly patient. They must know when to try to cure or fix them and when they should not prolong life artificially. This chapter broaches the morality involved in the treatment of the elderly. Doctors are well aware that they while they may be able to keep an elderly patient alive longer through drugs and surgical procedures, they also may be making his or her end of life miserable with undue suffering.

Medical professionals have not fully grasped the proper care for the elderly or dying. They are reluctant to provide a definite prognosis. Hospice patients know they are dying, but hope they don't. Doctors fear that telling a patient his real opinion about how long he has to live will destroy that hope. This chapter reemphasizes how medical professionals are often ill-equipped in treating the elderly and dying.

Gawande describes some bright spots in the care of the elderly with the increase in palliative care physicians and nurses who are trained to help the patient navigate through the end of his life in the most comfortable and satisfying way possible. Palliative care is a newer and growing approach to end-of-life treatment and will be informative and interesting to most readers.

Vocabulary

metastatic, solvency, oblivion, precipitous, septic, hospice, nebulizer, nostalgic, mantra

Chapters 7 and 8

Summary

As incomes and economies rise in developing countries, private sector health care is rapidly increasing. Cultures that formerly allowed their dying to die peacefully now have doctors who take extreme measures to save a patient even though there is no hope. Families are given false hope and often lose their life's savings. To counter this, hospice programs are also springing up around the globe. Use of hospice care is also on the upswing in the U.S. with 45% of Americans dying under hospice care which some receive at home.

Atul used palliative care tactics with a patient, Jewel Douglass, whose ovarian cancer had spread dangerously to other organs and lymph nodes. When the tumor blocked her digestive channel, Atul used the three words that palliative specialists had learned to be effective. “I am worried,” he told her. Those three words were a wealth of information. It told the patient that her condition was not improving and would probably be getting worse. It also told the patient that Atul was on her side – Atul was worried – he cared. Atul also used what he'd learned about palliative care to deal with his ailing father Atmaram Gawande who was also a physician. He had begun to lose feeling in his hand and learned that a large tumor had been growing in his spine. Atmaram was able to live with his relatively minor symptoms for two years until the pain intensified and paralysis was setting in. Atul helped him make decisions about his future and treatment. Atmaram felt he made the right decisions. The old system was easier; no decisions were necessary because everyone opted for the most aggressive treatment available.

Jewel's condition steadily declined. Atul spoke with her in the hospital where she'd been taken when she was experiencing unbearable bloating and blockages. There were chemo options and a surgical procedure could bypass the blockage to provide some relief. She also had the choice of rejecting both options and electing to have her pain and nausea controlled at home with hospice care. He asked her what she wanted and what her biggest concerns were. She wanted to be without pain and nausea and vomiting. She wanted to eat again and get back on her feet. And there was a wedding she just had to attend. Atul ordered some temporary steps that eased her pain and bloating. She didn't make it to the wedding. Surgery was the best option now. It was scheduled but Jewel canceled it. She feared that surgery and a difficult recovery would worsen her condition.

In Jewel's case, and many like hers, the choice was between the anticipating self and the experiencing self. She would probably experience less pain in the future if she had the surgery. But she feared she would experience greater pain. Jewell just wanted the chance to enjoy a few normal pleasures in the time she had left. It would be a good ending to her story.

Atul understood what Jewel wanted. He suggested he could change the surgery to a minor procedure that would temporarily alleviate her blockage. It wouldn't be a permanent fix but she did need that. The tubes that Atul inserted relieved her nausea and pain but wouldn't allow her to eat. At home she was receiving visits from family and friends. Atul discussed good memories of her life; she felt at peace with God. She died peacefully in her sleep a few weeks later.

Endings are not controllable but individuals are not completely at the mercy of their destiny. They can make endings better and see that certain desires at met. The medical field has to become cognizant of the fact that the dying have more on their minds than just being safe and living longer. “Assisted suicide” is considered the ultimate control by some. It's death with dignity. The medical field is complicit in that they can accelerate a death when it allows a dying patient to refuse water, food or medication. Some drugs that ease pain and sedate the patient may speed up the process. There is a clash of beliefs when proponents of assisted death encounter those who are convinced that keeping the patient alive as long as possible is the goal. Healthy people are stopped from committing suicide because they have value and their condition is temporary. Only the unsympathetic can see value in keeping a dying person alive knowing that his last days will be filled with suffering.

Countries including Netherlands, Belgium and Switzerland and U.S. States like Washington, Oregon and Vermont have laws that make it legal for a physician to prescribe a lethal prescription for a terminally ill patient. The ultimate goal of the responsible medical field is not to strive for a good death for a patient but a good life to the end. The concept of assisted suicide should not replace the goal for assisted living to the end. Those in the medical field often inflict great pain at the end of people's lives but don't acknowledge the harm they inflicted.

Analysis

In this chapter, Gawande describes his own experience with his father's declining health and the choices the family faced even though Gawande and his parents are all three physicians. He provides this personal story to emphasize that everyone faces the same questions, doubts and uncertainty when faced with end-of-life treatment and issues. Gawande describes how he used the palliative care techniques he learned over the years to his own father and how they proved helpful.

The author broaches the controversial subject of “assisted suicide” and how some find it immoral and criminal and others feel it is the final control on one's life and allows the very sick to die with dignity. Some countries and several U.S. states allow doctors to prescribe lethal prescriptions. He cautions that assisted suicide should not replace ending one's life with quality assisted living. He admits that doctors are responsible for inflicting more pain on their dying patients by keeping them alive and in their misery but take no responsibility for it. Doctors like Gawande are dedicated to finding a balance between providing quality care and letting go.

BOOKRAGS

Vocabulary

posited, errant, exacerbated, obliterating, ambiguous, cauterize, fungating, harbinger, cognitive, finitude, aghast, convocation, seminal, proponent, circumscribed, litany, penultimate

Important People

Atmaram Gawande

Atmaram Gawande, Atul's father, who was also a physician had been suffering from a pain in his neck for several years. It was discovered through an MRI that there was a tumor growing inside his spinal cord. Father and son both concluded that surgery would be difficult. They got the opinion of two specialists, one of whom recommended surgery immediately and the other suggested it could wait until the tumor progressed. Both doctors agreed that the tumor couldn't be completely removed but only decompressed. Atul's father was fearful of opening up the spinal chord due to the risk of paralysis. One doctor grew tired of his father's questions and showed his exasperation. His father chose Dr. Edward Benzel to administer his treatment. He was more empathetic that the other doctor and answered all of his questions. Atul's father and Benzel decided to proceed by the way he felt versus being guided strictly by imaging.

Atmaram Gawande continued to live a full life and even began taking on new activities and challenges. But two and a half years after his original diagnosis, his symptoms worsened forcing him to retire as a surgeon. He still did not opt for surgery and threw himself into civic affairs and family and social events. His hands and arms began to show increasing signs of partial paralysis. When his legs became effected the topic of surgery came up again. He knew he was becoming paralyzed and feared that he would be a burden on his wife. He couldn't accept a life of complete paralysis and wanted to maintain control of his world. He did not want any epic measures taken to save his life should he become severely debilitated. Finally, Atmaram told Dr. Benzel that he was ready for the surgery.

Atmaram decided on the surgery but a few hours into the day-long procedure, he experienced what seemed to be a heart attack and the operation was stopped temporarily. After a cardiologist confirmed that it was safe to continue the operation, Atul told the doctors to proceed. Paralysis would be more likely if he didn't have the operation and Atmaram was more afraid of being paralyzed than of dying. Atul only knew this because of the probing questions that he asked his father about his preferences for the future. Atmaram's heart remained stable throughout the lengthy surgery and Dr. Benzel had been able to successful decompress the tumor. He did not suffer any loss of mobility as a result of the surgery. He was walking again in a few weeks. He felt he'd made the right decisions all along.

The tumor contained a slow-growing cancer for which an oncologist recommended chemo and radiation. The treatment was tedious and uncomfortable and Atmaram began to have disturbing side effects. His decline after the six-week treatment was obvious. Numbness increased and his weight fell drastically over the next few months. Not only did the chemo and radiation fail to reduce the tumor, the tumor actually grew! The oncologist presented Atmaram, Atul's mother and Atul with a number of chemo options. The oncologist was not well-versed in palliative care and it showed. She was

informative but resisted in helping to make a decision. Although Atul and his parents were all three doctors the many choices that were presented to them were confusing. When pressed by Atul, the doctor admitted that the prognosis for surviving was at best three years. With treatment his chances were better than without.

Atmaram began to have more numbness and fell frequently. He needed nursing care but Atul's mother refused to even consider a nursing home. The family considered a home hospice service. A hospice nurse visited and immediately helped Atmaram make some decisions and learned what his biggest concern was. He wanted to feel no pain, be able to type so he could send emails and he wanted to be happy. The nurse was kind but direct with him firmly encouraging him to follow her instructions. She was able to moderate his medications so that he never felt drunk and or experienced much pain. With some assistance, Atmaram walked the length of the basketball court at Ohio University to be front and center for Atul's address to the graduating class. He refused to be wheeled in.

Atmaran suffered great pain in the end and rapidly lost the independence he cherished. One morning, Atul's mother couldn't wake him up. His dilated pupils indicated had had suffered a narcotic overdose. Atul thought he'd be okay once the drugs wore off. But he turned blue and his blood pressure was fifty and falling. Measures were taken at the hospital to ease his pain and make him more comfortable. Atul already had the hard conversation with his father and knew he wanted no life support at the end. Atmaran had a good day the day before. Atmaran had gotten what he wanted. A good life until the end. He lived without artificial assistance for four more days. He woke and was able to spend time with his family and spend his last days at home. On the final two days he preferred to have heavy doses of morphine and not experience the pain. He stopped breathing with his family around him.

Felix Silverstone

Felix Silverstone was a senior geriatrician at the Parker Jewish Institute in New York City for 24 years. He had commented that there is no single cellular mechanism to the aging process. Aging is a process in which we fall apart.

Felix Silverstone was still active in the field of geriatrics at the age of 82. He had survived a near fatal heart attack and the natural decline of aging but remained dedicated to his field. He retired at 82 to care for his wife Bella who had become almost blind from retinal disease. The couple moved to a retirement community. When things deteriorated they planned to upgrade to the assisted living plan.

At 87 when Atul visited him, he recognized that he didn't think as clearly as he once did. His short term memory was declining. He suffered from occasional depressions that were “uncomfortable.” What he missed was having a purpose and being of service to others. He formed a reading club at the retirement home and helped the steering committee to improve health care services at the center. His main focus was Bella and helping her which was also the main source of his self-worth. At dinner one night, Atul

saw for himself the loving care he devoted to Bella. Silverstone's personal goal was to have as decent a life possible given the limits of his own body. Silverstone was still a good driver at 87. However, the risk of a fatal car crash with a driver who is over 85 is three times greater than with younger drivers.

Bella continued to decline over the next few years. She completely lost her vision and her hearing and memory were impaired. Silverstone continued to find great purpose in caring for her. A head cold caused fluid to collect in her ears causing a burst ear drum and the complete loss of hearing. Silverstone could no longer communicate with her. He life became a nightmare of confusion. The only option was to transfer her to the nursing home floor at the center. They had a slight reprieve when some hearing returned to one ear. On a stroll one evening, Bella fell and broke the fibula in both legs. Silverstone could no longer care for her and she was moved to the nursing home unit. Conflict arose when Silverstone noted that they weren't giving her the level of care that he had. He moved her back to their apartment and hired a nursing staff for the six weeks she remained in casts. She died four days after the casts were removed. Silverstone felt that part of his body was missing when she passed. He was happy that she spent her last days at home with him.

Laura Carstensen

In a study Stanford psychologist Laura Carstensen monitored the emotional experiences of 200 people of various ages. The study conducted over years, found that the elderly were generally grew happier with age and found living to be emotionally satisfying. A commonly believed cause for this result was that living is a kind of skill. The more skilled one becomes – which takes time and, therefore, aging – the happier one becomes. But Carstensen offered the possibility that changes in needs and desires is not connected with age but rather a change of perspective. Carstensen had a personal reason for her view. She had a near-death experience that changed her view of life.

Carstensen tried to find holes in her theory through other experimentation. There were certain questions like imagining how they'd feel if they were moving far away – that were answered similarly by young and old alike. Cultural differences did not seem to have any significance. Similar responses came from subjects in such diverse places as Hong Kong and America. In case after case, perspective was the main driver in needs and desires.

Jean Gavrilles

Atul sat in on a few visits with Juergen Bludau, the chief geriatrician at the Center for Older Adult Health. The first patient he observed, Jean Gavrilles, was experiencing a lower-back pain that she had had for months. She had been a widow for 20 years and lived alone. A test revealed that she might have colon cancer. A son lived nearby who checked on her daily and helped her with chores and errands. The doctor asked her about her daily routine in great detail. He examined her feet carefully and found there

was swelling and signs of neglect. The biggest danger Jean faced was from falling. Dr. Bludau referred Jean to a podiatrist who she should see on a regular basis. With good advice about nutrition and switching a few medications for her, Jean did well and a year later she had not experienced a fall. The lesson learned was the importance of not neglecting the health and well-being of the feet.

Keren Wilson Brown

Keren Wilson Brown developed the idea of “assisted living” facilities. The idea caught on and by the 1990s, there were many such homes being constructed across the country. People were willing to pay more to stay out of a nursing home. Unfortunately, some old style nursing homes used the “assisted living” moniker to take advantage of their success. A survey of 1,500 assistant living facilities taken in 2003 found that only 11% provided the privacy and services that would enable frail people to stay in their institutions. The lines had blurred between the concept of assisted living and nursing homes. Wilson stepped down as CEO because the board of directors that was most interested in profit and had all but abandoned her original concept. Since then Brown established the Jessie F. Richardson Foundation, in honor of her mother, to continue her work in transforming care for the elderly.

Bill Thomas

From a young boy on, Bill Thomas was accustomed to winning and excelling in everything he tried. He was a terrible student as a young boy but could sell anything. He was bright but didn't listen to his teachers – he did his own thing. Despite his lack of discipline as a child, he became a physician and had a successful career. At a young age, he was named head of the Chase Memorial Nursing Home and didn't particularly like where he landed. He finally pinpointed that what troubled him the most at Chase was that the conditions basically contradicted his concept of self-sufficiency. He felt the good life was one of optimum independence which was what the residents in the home were denied. He got to know the people. They had led full, productive lives. He felt surely there were better alternatives for them at the ends of their lives.

Thomas decided to actually infuse life into the nursing home via plants, animals and children. He was permitted to write an application for federal funding to cover his program. He saw boredom, loneliness and helplessness as the Three Plagues of life in a nursing home. He planned to plant flowers and vegetable gardens and bring in animals as official Chase pets. No pet birds were allowed but he wanted to push the envelope and proposed that each resident have a caged bird in his room. Although he had to do a lot of convincing and call upon his selling skills, he was able to get the plants and animals he asked for and the approval to build a playground in the backyard for visiting children.

George Weller

George Weller was convicted of manslaughter in the deaths of ten people when he plowed into a crowd at the Farmer's Market in Los Angeles. He injured an additional 70 people. He confused the accelerator with the brake. Weller was 86 at the time of the accident. The risk for fatal accidents involving drivers 85 and above is three times that of the average.

Abraham Maslow

Psychologist Abraham Maslow published a paper entitled, “A Theory of Human Motivation” which described people as having a hierarchy of needs. Water, air and food are fundamental needs followed by law and stability. Above that in the pyramid of need is love and the need to belong. Growth and personal goals are the penultimate needs and on the top is self-fulfillment through moral ideals and creativity. Nursing homes strive to meet medical fundamentals but fail to address the higher levels in Maslow's pyramid.

Mr. L

Mr. L was a resident of Chase Nursing Home. After Dr. Bill Thomas introduced plants, animals and kids into the home things changed for Mr. L. He began eating by himself, dressing himself and getting out of his room – all new activities for him. He got attached to one of the center's pet dogs and took it for a walk every day. Mr. L had lost everything in recent months – his wife, his home, his freedom and purpose. The joy of life returned to Mr. L with the innovations introduced by Dr. Thomas.

Stephen J. Gould

Stephen Jay Gould was a naturalist who was diagnosed with a rare and lethal form of abdominal cancer which came with a survival label of eight months after diagnosis. Gould decided that he wouldn't cave to the statistics and clung to the possibility of beating the odds. He lived 20 years and died of another form of cancer not associated with his original diagnosis. His mantra was to fight death with a mighty rage and not give up hope.

Nelene Fox

Nelene Fox was diagnosed with advanced breast cancer at the age of 38. Surgery and chemo therapy failed to eradicate the cancer and it spread. There were experimental treatments but her insurance provider, Health Net, refused to cover those costs indicating that they were not part of her plan. Through charitable donations she was able to have the treatment. But the treatments were delayed while waiting for the

donations to accumulate. She died eight months after her treatment. Her husband sued and won an award of $89 million against Health Net. Her case resulted in ten states enacting laws requiring that insurers cover bone marrow transplantation which was the experimental treatment that she finally had although it was too late.

Peg Bachelder

Peg Bachelder was Atul's daughter's piano teacher. She had battled with an aggressive form of cancer over several years. When it recurred she had to temporarily give up her piano lessons. However, she fought back and even though she knew her condition was terminal, she strove to regain a semblance of her old life. She began teaching her students again including Atul's daughter. She was able to organize two concerts – one with her current student and one with past students. She met with each student after their performance and gifted them with something that would remind them that they were special. She gave Hunter Gawande a book of music. She died just a few days after the final concert.

Sara Thomas Monopoli

Sara Monopoli was just 34 and pregnant when she was diagnosed with advanced lung cancer. After the healthy baby was born, Sara and her family took on the challenge of finding a cure for her and were certain that Sara would be saved. Sara had all the treatments that were available and that were recommended by her doctors. Her doctors knew that she was terminal yet they couldn't quite bring themselves to discuss her true prognosis with the family. The last few months of Sara's life was a series of nauseating chemo treatments, surgical procedures and ghostly hopes and wishes. Her family was shocked when she died but they shouldn't have been. The doctor owes the patient and family straight talk about the patient's condition and chances for recovery even if the family members are cheerleaders for a cure that doesn't exist. Sara's final days would have been more comfortable and less chaotic had she and the family accepted the hard reality of her condition.

Jewel Douglass

Jewel Douglass had been treated for ovarian cancer for two years when Atul was asked to speak with her about a surgical procedure. At the stage that Jewel was at, only about 20% of patients are cured. She tried a series of different kinds of chemotherapy but the cancer continued to spread. Atul was asked to look into the possibility of clearing a blockage in her colon that was causing unbearable bloating. She opted against surgery feeling that she may not recover from it. The blockage waxed and waned until it made her unable to eat and her life intolerable. Atul applied his palliative techniques and told her that the cancer was getting worse and that she will continue to suffer from blockages. He said he was “worried” which told her that she would get worse and also that he cared. When he asked her what she wanted out of life she told him that she

wanted to go to a friend's wedding, eat at home and put her feet in the sand in Florida. She died shortly after her Florida trip.

Objects/Places

Sun City

In 1960, Del Webb, an Arizona real estate developer, created Sun City in Phoenix. It was one of the first communities in the nation that limited residency to retirees. At first its development was controversial but Webb felt that retirees wanted to spend their leisure years having fun and being with people of their own age. His venture was highly successful and emulated in other locations.

The Guru Vishram Vridh Ashram

The Guru Vishram Vridh ashram is a charity-operated old age home in the slums on the south side of New Delhi, India. Open sewage flowed and emaciated dogs hunting in the trash were permanent fixtures. Half the residents were placed there because they couldn't pay hospital bills and others were homeless people with nowhere to go. It's an example of a poorhouse where people who no one wants winds up. In at least one instance, when the family was contacted to pick up their relative they denied knowing him.

The Chase Nursing Home

A young doctor named Bill Thomas accepted the position of medical director of the Chase Memorial Nursing Home in upstate New York. He had no training in the care of the elderly with his entire background being in emergency room care. There he dealt with patients he could fix. The nursing home depressed him. He saw despair in the eyes of all the patients. They were lacking spirit and energy. He first checked each patient out physically but all along suspected their problems weren't really physical in nature. He decided that the missing ingredient was “life.”

Thomas submitted an application for a federal grant in which he asked for funds to put a live plant and caged parakeet in each room, bring in several pet dogs and pet cats for everyone to enjoy, plant vegetable and flower gardens in the yard and construct a playground in the background. Thomas was convincing and got everything approved. He achieved his goal and indeed brought life into the morgue-like facility. The quality of life improved exponentially and the patients loved their new world and were ever grateful for his efforts.

Longwood House

Longwood House (not its real name) is a high-rise facility for seniors and is presented as the typical modern nursing home. It is a non-profit complex supported by the Episcopal Church. Dr. Gawande's wife's aunt Alice moved into this facility. At first things

seemed fine but she became severely depressed after just a short time living there. It was hard for her to put her finger on what she didn't like initially. Finally she realized why she didn't like Longwood. The nurses were constantly watching and monitoring her every move. She didn't like having a nanny at her age and didn't like every aspect of her life controlled by someone else. The staff at Longwood House gave no consideration to what Alice wanted to do with her life. They took her life away from her before she was finished with it.

La Crosse Wisconsin

Medical professionals in the city of La Crosse Wisconsin banded together and decided that the care of the elderly was severely lacking and that with some effort, training and planning they could turn things around for their older citizens. One of the fundamental guidelines set out by these professionals was that end-of-life discussions needed to be held with each patient. The doctors and health care professionals at all La Crosse hospitals, nursing homes and assisted care facilities adopted the palliative care techniques decided on by the committee. Survey results indicated a greatly increased level of contentment and increased longevity among patients in La Crosse when compared with facilities in other cities.

Activities of Daily Living

Health professionals in the U.S. have a classification system for the functionality of an elderly person or disabled person. There is a checklist of tasks that if an individual cannot perform them by himself, he is considered unable to have basic independence.

Age Heaping

When the elderly were respected and considered the head of the family, some older folks actually added years on to their real age because of the respect it garnered. Demographers call this “age heaping.” Ironically, it is the opposite in modern times with the country's obsession with youth today compelling people to peel a few years off their real age. But in the past, the dignity of old age was an aspiration for everyone.

Falling

Falling is one of the biggest dangers that the elderly face. The three primary risk factors for falling are poor balance, taking more than four prescriptions and muscle weakness. When an elderly person begins to fall frequently, they cannot maintain their independence and must be closely monitored. It is a phase of aging that takes autonomy away from the elderly most of whom list it as a priority to maintain.

Hill-Burton Act

In 1946, the U.S. Congress passed the Hill-Burton Act which provided funding for hospital construction. Two years after the passage of the legislation, some 9,000 new medical facilities were financed and constructed across the nation. It was the first time that virtually every citizen had a hospital that was nearby. The industrialized world followed the lead of the U.S. and constructed hospitals across the globe.

The Three Plagues of Nursing Homes

In devising his plans to build a better nursing home or as he called them Green Houses, Dr. Bill Thomas isolated what had to be eradicated from nursing homes. The elderly suffered from boredom, loneliness and helplessness. He decided to attack what he termed the Three Plagues of Nursing Homes. Elderly people had full lives and have interests, experiences and talents that can be highlighted to help them have joy and satisfaction and feel that they have purpose at the end of life.

Assisted Suicide

Advocates of assisted suicide prefer to refer to the process as death with dignity. Doctors currently participate in lawful forms of assisted suicide. If a dying patient refuses to eat or drink, no effort is made to force them to have nourishment. When patients are removed from artificial machines, death is accelerated. Large doses of pain-killing narcotics also speeds up the process. The medical profession has to struggle to maintain the right balance between prolonging suffering and shortening life. The Netherlands, Belgium, Switzerland and the U.S. states of Oregon, Washington and Vermont allow physicians to write lethal prescriptions for dying patients. More movement toward this end-of-life choice is inevitable. However, assisted suicide should never replace efforts to provide medical care and effective treatment for the elderly and dying which can improve the quality of their final days.

Four Questions

As part of the palliative care that medical and nursing home facilities administered to patients in La Crosse, Wisconsin, four questions were asked of every patient: “1) Do you want to be resuscitated? 2) Do you want aggressive treatments such as intubation and mechanical ventilation? 3) Do you want antibiotics; 4) Do you want tube or intravenous feeding if you can't eat on your own?” (167)

With the answers to these questions in hand when the patient was in good condition, the staff had all the answers they needed about the patient's end-of-life desires when the patient became terminally ill.

Do Not Resuscitate Order

A terminally ill patient can opt to have a “Do Not Resuscitate” order attached to their records. This means that if the patient's heart or breathing stops, the medical staff will not attempt resuscitation and allow them to pass. The doctor would not order chest compressions or shock or a breathing tube. The order means to let the person die.

Palliative Care

Aetna Insurance developed a program that they referred to as concurrent care which was a blending of typical medical treatment and hospice services. The success of the program was due in part to the patient satisfaction with their ability to discuss their conditions and concerns with palliative care nurses who are most concerned with preventing pain and suffering. Many patients who were under typical medical care reported that they rarely had such conversations with their physicians. A study out of Massachusetts General found that patients with advanced lung cancer under the care of a physician benefited greatly with the addition of visits from palliative specialists. In this study, those with palliative care lived 25 percent longer than those under just a doctor's care.

Death Panels

The “R” word that strikes fear in the heart of some individuals is “rationing” – rationing of health care which has famously been referred to collectively as death panels. This process, another alternative to end-of-life issues although arguably a very heartless one, would involve challenges by insurance companies on treatment decisions made by doctors and hospitals especially in the cases of terminally ill patients. The insurance companies would of course be trying to protect their bottom line. However, this process is unpopular and unacceptable to the vast majority of the public and has not gained any ground.

Themes

Priorities

One of the oft repeating points that is made in “Being Mortal” is the quality of life at its end. Dr. Gawande frequently made the important point that “quality of life” has different definitions depending on one's perspective. A dynamic triumvirate often develops in the hospital room of a very sick or dying patient. The three sides that have different opinions of what quality care is are the doctor, the patient's family and the patient.

Physicians are trained to cure people. But that's impossible with a dying patient. Most physicians are not trained in geriatrics and are often reluctant to provide the family and patient with the real hard facts, the prognosis, the length of time the person has left. The family is sure the patient will recover with the right treatment. And the patient who is in pain mainly wants relief. When a physician does provide some hard facts, like the patient has a year to live, the family and often the patient interprets that as 10 or 20 years.

Dr. Gawande emphasizes that the turmoil at the end of life is not necessary and that a much smoother conclusion to a long life is possible through the techniques provided by palliative care. Many important questions are answered about end of life desires but palliative care goes a step further. These specialized practitioners get to know the patient and find out what is important to him at the end of life. Terminally ill patients are most interested in maintaining their independence as long as possible; staying mobile; keeping their senses; avoiding pain; and, enjoying the time they have left with family and friends.

Rather than a frenzy at the end of life, a transition that limits pain and optimizes pleasure is the trend that is being embraced by medical professionals across the nation and world.

The Evolution of the Nursing Home

In 1913, Mabel Nassau, a Columbia University grad student conducted a survey of 100 elderly people living in Greenwich Village. Women outnumbered men two to one. All of those in the study were poor and only one-fourth could support themselves. Most were too ill or debilitated to work. The establishment of pension systems was thought to put an end to poorhouses but the problems persisted. The elderly wound up in poorhouses because they were poor but also because they were sick.

As hospitals became more plentiful, it was considered a much more satisfactory place for the infirm. Throughout the 1950s, the poorhouses closed their doors. Hospitals couldn't solve the problems of aging and they became crowded with people they couldn't fix but who had nowhere to go. In 1954, Congress provided funding for

separate custodial units to be established as wings of the main hospitals which was the beginning of today's nursing homes.

Nursing homes weren't created to help the elderly; they were created to get them out of the way and free up beds for people who could be treated and cured. In 1965, the Medicare law for the elderly and disabled was enacted. One of his regulations was that pay would only be provided for care that met basic health and safety standards. Hospitals in the south had difficulty meeting those standards. The law was changed to allow funding for facilities that were close to those standards. That ambiguous language made the way for nursing homes that operate with sub-standard conditions. Free-standing nursing homes were built over the next few years and with them complaints of neglect and abuse were on the increase.

Remembering vs. Experiencing

The brain provides two ways to look at things – before and after. These these views can be quite contradictory. When one is experiencing a traumatic or pleasurable experience, he has certain feelings and opinions about that experience while he's going through it. However, just like the armchair quarter back on Monday morning, after the event is concluded the individual can have a completely different view of what had just transpired.

Results in a study conducted by Daniel Kahneman, a Nobel Prize winner in research and included in his book, “Thinking, Fast and Slow,” indicated that a painful experience is remembered by a peak point of pain within the experience and by the pain felt at the end. If the end is not painful, then the pain during the entire experience is greatly diminished in retrospect in the person's mind. Contrarily, the entire process is remembered as painful if the final minutes are wrought with pain even though the beginning and middle part of the episode was not particularly painful.

There are two selves within the human psyche – the “remembering “ self and the “experiencing” self. Since the “remembering” self and the “experiencing” self will undoubtedly have diverse opinions about an experience, the question lingers as to which one most closely represents what actually occurred and in the case of pain or pleasure, which version was more unbearable or more satisfactory.

It is natural for an individual whose life has been his story to end it with a happy ending. Kahneman wrote that the mind is wired to remember peak moments of pleasure and peak times of pain during a lifetime – the rest, the mundane and the ordinary – just kind of fades to black.

Courage

While there is much to be DIScouraged about in the aging process when frailty and lack of mobility and pain set in, medical professionals like Dr. Atul Gawande and Dr. Bill Thompson along with ancillary experts like Keren Brown and palliative specialists feel

there is also much to ENcouraged about relative to the treatment of the aging and dying. It takes dedicated medical professionals like these doctors and experts to view each person like the unique individual she or he is and prescribe the treatment that is fitting for that person taking into consideration his physical condition but also his personal needs and wants. How a patient who has lived a long life wants to spend his last days should certainly be part of the conversation.

The patient isn't free of responsibility about his final time on earth. He must take to heart the root word from “discourage” and “encourage” and have the courage to face his reality and what limitations and restrictions he has. He has to have the courage to face himself as he is and recognize that some of the things he longs to do are not possible. Most of all, the terminally ill patient must the courage to face his own mortality. Everyone will get to that point in life although the young feel that it won't happen to them. By showing courage under fire, the elderly can be role models for others who will one day face the same circumstances.

The book references a play that Plato wrote in 380 BC entitled, the “Laches.” The play is about Socrates and two Athenian generals, Laches and Nicias, who seek to answer the question: What is courage? The generals came to Socrates to solve a debate: If the ultimate purpose of training is to instill courage, what is courage? Laches answered that it is endurance of the soul but Socrates did not agree. He believed that while it takes courage to attack, it also takes courage to retreat and flee. Nicias said that courage was “knowledge of what is to be feared or hoped.” Again Socrates did not completely agree. One can have courage without perfect knowledge of the future and one must often have courage in the face of the unknown.

Socrates's perfect reasoning can be applied to the treatment of the elderly and dying. It takes courage on the part of the patient to acknowledge that there is little that a doctor can do for him, that he can't recover and can't be cured and that he does not have knowledge of the future. It also takes courage on the part of the physician to be honest about a patient's prognosis and not give false hopes to the patient or family. The family exhibits courage by listening to the medical professionals and not insisting that there must be a cure for their loved one when the medical field has exhausted all possibilities.

Two kinds of courage are essential for aging and sickness. One must have the courage to face his own mortality and secondly, one must have the courage to act on that reality. A decision has to be made on whether one's fears or one's hopes are most important.

New Approaches to Care of the Elderly and Infirm

Before mid-century 20th century, the elderly and dying usually wound up in what was aptly called the “poorhouse.” It was a very descriptive term in that the people who landed there were poor. The level of “care” that was received in these facilities was minimal at best. After the popularity of hospitals grew and were constructed in most neighborhoods, the dying and elderly were deemed not to be a good fit in a system that focused on care and recovery. This revelation through a series of transitions resulted in

what is popularly known as the nursing home. Most elderly patients would rather die that be confined in a nursing home. Its reputation has been sullied by its lack of appropriate and advanced care, indifferent staffs and even neglect and abuse.

Professionals in the medical field and other experts in ancillary fields began to recognize that the care provided to the elderly was not at the standard they would want their loved ones or indeed themselves to receive in their last days. Aging isn't just a condition of the elderly; aging begins the moment a baby is born. To look at aging as an experience shared by all, places a difference emphasis and urgency on improving care and changing the approach to treating people in their last days.

It was the personal experience of Keren Wilson Brown and the agony that her mother experienced in nursing homes that compelled her to begin the development of assisted living facilities which are somewhere between being completely independent and being confined to a nursing home. She recognized in her own mother's struggle the importance of allowing the elderly to maintain their autonomy and independence as long as possible. She learned that medical and elderly care professionals can do much to make this happen for their patients.

Dr. Gawande who is a general surgeon learned more about the treatment of the elderly from his father's experience with end-of-life issues as he did at medical school. It made him keenly aware of the suffering that can and cannot be avoided and as a physician how he can help his patients. Physicians like Dr. Gawande are understanding that they have to treat the elderly patient as a whole and unique individual who they cannot fix but who they can help in making their final days more comfortable and satisfying.

Dr. Bill Thomas created Green Houses for the elderly. He brought life to nursing homes by introducing birds, dogs, cats, live plants, vegetable and flower gardens and even playgrounds for visiting children into the homes. The medical professionals of La Crosse, Wisconsin, banded together and adapted palliative care techniques that have proven to have a very positive impact on the residents of the hospitals, nursing homes and assisted living facilities of that city and even has on the average prolonged satisfying and comfortable life.

There is speculation about health care rationing – death panels to some – which have been roundly shouted down. Proponents of assisted suicide have increasingly loud voices. Dr. Gawande cautions that the medical profession should look at these drastic alternatives under only rare circumstances. Good medical care and the input of palliative care specialists should never be replaced by these easy ways out.

Styles

Structure

“Being Mortal” by Atul Gawande is a non-fiction work that delves into the care of the elderly and dying past, present and future. Since there is not a story being told per se, there is no chronological order to the structure because it is not necessary. Dr. Gawande makes his case about the health care industry as it relates to the terminally ill by presenting his personal experiences and opinions, anecdotal evidence that shines a light on various aspects of care of the elderly and opinion and raw data that he has amassed from other experts in the medical and clinical research fields.

In the first chapter he describes the need for the elderly to maintain their own identity and independence and have purpose for as long as possible. He begins with this element because it remains important throughout his work. He stresses this point repeatedly because it plays such an important role in enabling the sick and dying to have the easiest and most comfortable transition possible.

Dr. Gawande explains the aging process and its inevitability no matter how healthy the person is. He cites cases, including that of his own father, when death can come swiftly – fine one day and “falling apart” the next. He then describes a person's difficult journey from independence to assisted living and then finally dependence. He then describes the innovative approaches to help the elderly and dying navigate through their final days. One trend that is catching on within the medical field is the practice of palliative care techniques which places the emphasis on what the patient needs and wants in his final days.

Dr. Gawande pulls no punches and describes how physicians who are not geriatric specialists have difficulty dealing with the elderly – a group of patients that they cannot “fix.” However, physicians are learning the importance of palliative care and having “hard” conversations with patients and their families about their longevity.

Perspective

“Being Mortal” by Atul Gawande is written in the third person narrative from the perspective of the author. In this book about the ailing, the aged, and the dying Gawande who is a physician and award-winning author is the perfect choice for the telling of this subject matter. He has based much of the book on his education, training and background as a surgeon/physician and as well as on his personal experience with his aging father. He also draws from many other resources in this account about the care and housing the ailing elderly and the dying.

Gawande came to America with his immigrant parents. He had the benefit of having knowledge of two separate cultures that have diverse approaches with the treatment of their elderly. In his native India, the first choice is to bring an aging parent into a

relative's home. The elderly in India are considered wise and someone to be revered and respected. He contrasts that with the US which relies largely on nursing homes to care for their elderly.

Over time and through his experiences Gawande came to recognize that the elderly are not getting the satisfactory life that the could during their final years. He discusses prolonging life while also prolonging pain and misery. He broaches the subject of “assisted suicide” which, he says, should not replace the effort to provide quality “assisted living.”

Gawande who is an active general surgeon has written three other bestsellers, “Complications,” “Better,” and “The Checklist Manifesto,” which all deal with the medical field and health care. He also finds time to be a contributing writer for “The New Yorker,” and perform his duties as a professor at Harvard Medical.

Tone

“Being Mortal” by Atul Gawande is written in a straight forward manner with minimal use of technical and medical words which makes for the unencumbered reading of a book that involves the medical field. Dr. Gawande is a general surgeon so he is on solid ground with the topics covered in the book.

Dr. Gawande is also a very successful author have written three previous bestsellers before this bestseller and is a contributing writer for The New Yorker magazine. His writing credentials are above reproach and therefore he is obviously a very good communicator with the written word. It is easy to follow the descriptions, arguments and case studies that he presents because of his command of the language and ease of expression. The book is a teaching book as it enlightens the reader about the current state of care for the elderly and dying. Since Dr. Gawande is also a professor at Harvard Medical his talents in instruction are obvious from the clarity he brings to difficult topics.

The kindness of Dr. Gawande shines through throughout the book and in the accounts he provides about his own experiences with elderly and dying patients. The chronicle of his own father's decline in health is genuine and poignant. He has a tender heart which compelled him to write this book to point out the good, bad and ugly of the current care available to those at the end of their lives and the trend in the medical field to focus on positive end-of-life experience.

Quotes

He was surrounded and supported by family at all times, and he was revered – not in spite of his age because of it.
-- Dr. Gawande (Chapter 1 paragraph Page 15)

Importance: Atul embraced American life but could not believe how Americans abandoned their elderly. By contrast, Atul recalls visiting his grandfather when he was 100 years old and had the full support of his loved ones.

The body's decline creeps like a vine. Day to day, the changes can be imperceptible. You adapt. Then something happens that finally makes it clear that things are no longer the same.
-- Dr. Gawande (Chapter 2 paragraph Page 41)

Importance: Atul explains how aging is a long process that is irreversible and ultimately results in the end to independence and the reliance on others for survival.

Old age is not a battle. Old age is a massacre.
-- Philip Roth (Chapter 3 paragraph Page 52)

Importance: The author captures the aging process in a few sentences in his book,”Everyman.” Atul Gawande describes that aging is an on-going process that seems to sneak up on us and suddenly leaves us helpless.

Doctors became heroes, and the hospital transformed from a symbol of sickness and despondency to a place of hope and cure.
-- Dr. Gawande (Chapter 3 paragraph Page 66)

Importance: Prior to World War II, hospitals were seen as a place to go and die. After the advancements in surgical procedures and life-saving pharmaceuticals, the hospital became a place where lives were saved.

I was willing to be rejected. That's what allows you to be a good salesperson. You have to be willing to be rejected.
-- Bill Thomas (Chapter 5 paragraph Page 105)

Importance: Bill Thomas was a good salesman all his life and understood both the upside and downside of sales. As a physician he applied his salesmanship to innovative ideas to bring life into the nursing home.

It was the perfect demonstration of this theory about what living things provide. In place of boredom, they offer spontaneity. In place of loneliness, they offer companionship; and in place of helplessness, they offer a chance to take care of another being.
-- Dr. Gawande (Chapter 5 paragraph Page 116)

Importance: Dr. Bill Thomas brought life to the Chase Nursing Home by putting a plant and parakeet in every patient's room. Having something alive and needing care gave many of the people a reason for living.

By nature, I am a sort of meeting place of countless streams of ancestral tendency. From moment to moment, I am a collection of impulses. We cannot see the inner light. Let us try the outer one.
-- Josiah Royce (Chapter 5 paragraph Page 118)

Importance: Harvard philosopher Josiah Royce wrote in his 1908 book, “The Philosophy of Loyalty,” made the point that in order to feel satisfaction and purpose in life, man must be dedicated to something or someone beyond himself. He must look for the outer light.

The value of autonomy... lies in the scheme of responsibility it creates: autonomy makes each of us responsible for shaping his own life according to some coherent and distinctive sense of character, conviction and interest. It allows us to lead our own lives rather than be led along them, so that each of us can be, to the extent such a scheme of rights can make this possible, what he has made himself.
-- Ronald Dworkin (Chapter 5 paragraph Page 131)

Importance: The philosopher discusses the importance of maintaining autonomy throughout life and shaping one's life, allowed to be the authors of our own lives.

The simple view is that medicine exists to fight death and disease, and that is, of course, its most basic task. Death is the enemy. But the enemy has superior forces. Eventually, it wins. And in a war that you cannot win, you don't want a general who fights to the point of total annihilation. You don't want Custer. You want Robert E. Lee, someone who knows how to fight for territory that can be won and how to surrender it when it can't...
-- Dr. Gawande (Chapter 6 paragraph Page 174)

Importance: The author makes the point that a good doctor will not prescribe treatment or medications for a dying patient just to assuage family or patient demands. A responsible doctor will discuss the reality of the patient's chances and not give the patient or family false hope.

You agree to become a patient, and I, the clinician, agree to try to fix you, whatever the improbability, the misery, the damage, or the cost. With this new way, in which we together try to figure out how to face mortality and preserve the fiber of a meaningful life, with its loyalties and individuality, we are plodding novices. We are going through a societal learning curve, one person at a time. And that would include me, whether as a doctor or as simply a human being.
-- Dr. Gawande (Chapter 7 paragraph Page 179)

Importance: The author makes the point that doctors who formerly did everything possible to save a life even when it was impossible just to alleviate the agony of the

patient or family are learning to accept the death of a patient, be honest with the family and make the end of a patient's life as comfortable and stress free as possible. He acknowledges that doctors are learning this process along with their patients and patient families.

Trouble was coming. Today was the first day I really grasped what it would mean for him to become paralyzed. It meant difficulty with the basics – standing up, getting to the bathroom, getting bathed, getting dressed – and my mother wasn't going to be able to help him.
-- Dr. Gawande (Chapter 7 paragraph Page 207)

Importance: Atul captures the moment that he realized that his father was becoming paralyzed and the ramifications of that reality. Even though Atul and both his parents were physicians they had been in denial about his father's condition.

... One can have courage without perfect knowledge of the future. Indeed, one often must.
-- Dr. Gawande (Chapter 8 paragraph Page 215)

Importance: The author paraphrases Socrates who admired courage in the pursuit of an unwise cause. Medical professionals generally didn't like treating the elderly because they couldn't be fixed. But bringing comfort and peace of mind to one's end of life is not an “unwise cause” although it can take courage.

Topics for Discussion

Topic 1

How has the view of the elderly changed by doctors and by family members? What life style is preferred by most of the elderly?

Topic 2

Why has the care of the elderly by physicians become a concern? What are the two leading concepts about why we age?

Topic 3

What does the author mean by the “natural redundancy” that is built into our bodies? What are signs of the condition commonly known as “frailty?”

Topic 4

How was treatment and care of the elderly changed during the decades? What was the initial purpose of a hospital and how did that purpose change over the years?

Topic 5

What are the pros and cons of having an elderly and sick relative move into another relative's home? What stresses do both sides of the equation experience?

Topic 6

What shift occurs as people age? Why is it important for family members and medical professionals to understand this shift?

Topic 7

Why did Dr. Bill Thomas bring animals, living plants into the Chase Nursing Home and why did he build a playground in the backyard of the home? How did Dr. Thomas' approach to elderly care compare with that of other nursing homes?

Topic 8

What was Harvard philosopher Josiah Royce's philosophy on loyalty? What need must caregivers for the elderly and dying recognize about their patients' needs?

Topic 9

How can doctors make a dying person's life more miserable? Why must doctors treat an elderly or dying patient as a whole individual?

Topic 10

What palliative care techniques did Dr. Gawande apply to Jewell Douglass and how was it helpful. What information was helpful to Atul and his family from the information he received from his father about his end-of-life needs?