

Fast to Slow Medicine

By Dr Tan Poh Kiang, Editorial Board Member

While living in an era where everything fast is deemed better, it caught my attention when our Prime Minister Lee Hsien Loong advocated “slow medicine” in his National Day Rally Speech 2009. No one ought to be surprised that he needed to raise the subject in view of our changing demographics – our average life expectancy is now 79.3 years and the number of those aged above 65 years of age will rise from 8% (2004) to nearly 20% (2020). The demands on our health system are also shifting due to the older folks with chronic medical conditions requiring longer in-patient care than our acute hospitals can provide. Hence, the introduction of the concept of step-down care.

The process of moving from “fast medicine” in an acute tertiary hospital where the medical condition is stabilised, to a community hospital or nursing home where the “slow medicine” of rehabilitation and in-patient care is administered, and finally

to home care where home care nurses and community general practitioners contribute to the care-givers’ efforts, makes economic sense.

PM Lee indicated the government’s commitment to make step-down care a reality by strengthening the basics (building new hospitals in HDB heartland; recruiting and training more healthcare professionals; increasing the health budget; enhancing the existing 3M model – Medisave, MediShield, Medifund) as well as implementing specific measures (twinning of acute hospitals with community hospitals eg. Changi General Hospital-St. Andrew’s Community Hospital, Tan Tock Seng Hospital-Ren Ci Hospital and Medicare Centre, Jurong General Hospital-St. Luke’s Hospital; increasing the number of home care nurses and upgrading their skills, and professional training of family care-givers and maids).

I was asked to comment on this subject of step-down care and “slow medicine”. It had taken me three weeks of mulling before I could even form a response. I kept asking myself, “What

good is ‘slow medicine’?” Besides new structures and policies, what does “slow medicine” provide that is not already there? My answers were revealed through the lives of my regular patients – all of them having lived more than three score and ten years.

Mr Tan is my oldest patient. He is 92 years old and lives merely three blocks away from my clinic. However, it takes two kind neighbours (in their seventies) and a two-minute taxi ride to get to my clinic. He tells me he likes me because we share the same surname and dialect. I find it a real challenge to keep track of his list of medical conditions, his medications and his never-go-away symptoms. To give you an idea how inadequate I feel, among his other complaints is this lethal combination: he can’t eat (no appetite), he can’t sleep (chronic insomnia), he can’t pass motion (his stools are rock hard) and he can’t pass urine (his pee comes out in dribbles and takes forever). And he has no money.

“Do you have children?”

His tears flowed easily as he told me that he had married late (in his fifties)

and only has two step-sons from his wife's first marriage. After his wife died ten years ago, they come by to see him sporadically.

"Do they give you money?"

"Sometimes \$50, sometimes \$100. I see them only once every few months." Usually each step-son would take turns to accompany him to Bukit Merah Polyclinic for his three-monthly check-ups and re-supply of his medications.

"How do you get your meals?"

"My neighbours usually cook extra and scoop some rice and food for me. If they didn't take pity on me, I'll have starved to death a long time ago."

His latest visit to see me was because he had run out of three of his nine drugs from the polyclinic and there was nobody to bring him there. He still took a long time to release his urine and he had not passed motion for more than three days.

I resupplied his chronic medications and gave him more medicine for his constipation and his BPH (benign prostatic hypertrophy). It is good that he carries the CDMP-PCPS (Chronic Disease Management Programme – Primary Care Partnership Scheme) blue card that grants \$18.50 per visit to the card holder by the government. Unfortunately that does not quite cover a month's supply of aspirin, Omeprazole, Isosorbide Dinitrate (which the polyclinic usually supplies) plus two week's supply of Lactulose and generic Terazosin.

I suppose "slow medicine" will be able to address this need: elderly folks who live alone and have multiple medical conditions requiring polypharmacy, but are unable to physically get to the polyclinic where all the subsidised drugs can be obtained. This issue has obviously surfaced on MOH's radar and since 1 January 2009, the PCPS has been extended to chronic diseases (hypertension, diabetes, and hyperlipidaemia). If the patient

qualifies, he is granted up to \$360 per year that he can use at his GP clinic for his disease management. Unfortunately since the GP's medications are not subsidised, the \$360 grant is grossly inadequate for the large number of pills a typical elderly patient requires. The scheme assumes that the rest of the GP's bill can be paid by the patient's or his children's CPF accounts (up to 10 accounts!). The harsh reality is that most of my elderly patients have no money in their Medisave accounts, and none of the children are available to volunteer theirs.

Wrestling with the question, "What's the right thing to do for mom or dad?" many of us become unwillingly caught up in the new "death by intensive care" epidemic in which the "care" is often more destructive than the disease. We want to do the best thing, but are overwhelmed with the staggering choices we face.

Mr Lim is 78 years old. He has two sons and two daughters, all of whom are doing well in their careers and businesses. He is very proud of them. Unfortunately, since his wife died three years ago, he stays in a two-room HDB flat, with an Indonesian domestic helper to assist him in activities of daily living. He has a CDMP-PCPS card and he loves to visit me every week – I suspect, often times just to say hello.

Recently, he developed a significant problem: no matter how much Lactulose and Senokot he took,

he had not been able to pass motion for nearly a week. He grimaced and pleaded with me to help him. I told him he might need to be admitted to SGH for bowel evacuation. But he told me he really dreaded the hospital as he was admitted to SGH a few months ago for five weeks, when he was diagnosed with stage 4 lung cancer after bouts of haemoptysis.

So I agreed to perform the evacuation in my clinic. After I had Mr Lim lie on his right side, I put in a Fleet enema. The nozzle went in easily and I emptied the contents. No problem, I thought to myself. But I had spoken too soon for within the next two minutes, almost all of the enema flowed out over his thighs and my examination couch. I realised to my horror when I put in my finger to check his rectum, that it was completely filled with hard-rock faecal material. I spent the next few unpleasant minutes breaking up the hard faeces and digging them out. Even through my 3M N95 mask, I had a hard time tolerating the stench. It must have wafted to the dispensing area, for soon my two clinic assistants popped in their heads to see what I was doing. Behind their masks, their eyes told me this – thank goodness Dr Tan did not ask for assistance in this horrid procedure.

The experience of having to digitally evacuate an old person's impacted rectum was not new to me; I had done it a few times before. What was new was that Mr Lim's problem re-surfaced twice more in the next six days. In total, I dug Mr Lim's rectum three times in that period. It took at least 20 to 25 minutes to serve him each visit, as time was also needed to spray the room with Lysol air freshener and to air it before the next patient was asked to enter.

I look forward to slow medicine – when it becomes a reality – where home care-givers are properly trained to prevent severe constipation leading to faecal impaction. I am convinced that there is a large number of elderly

folks who are all by themselves or at best, only in the accompaniment of a foreign domestic helper. This is not a reality that will go away; it will only increase in prevalence. Home care has to be enhanced so that many preventable medical complications (falls, pressure sores and so on) do not happen.

I don't know how old Mdm Wong is. Her identity card says she is born in 1932 but she looks like she was born before 1922. She comes in her wheelchair, usually slumped over and drooling. Needless to say, she has more medical issues than I can resolve but her main preoccupation and misery is her tongue. She seems to suffer from a chronic glossitis that manifests with shooting pain down her tongue to her left cheek. When it relapses, she will be crying with her tongue stuck out constantly and drooling. It is causing her much pain even though neuropathic drugs like Neurontin and Lyrica have been prescribed.

"*Kua loh chan!*", she screams. I am not Cantonese but her son tells me that means she wants to die. This mantra comes out every visit. She offers to pay me for lethal injection. I tell her I can't perform assisted death. She tells me she will keep it a secret between us. In her most agonising moments, she would beg pitifully and then curse violently (in Cantonese, something about my mother's anatomy). I soothe her pains when they are bad with a shot of Tramadol and a dose of mist morphine. But the pain never goes away.

Her son and I know that getting her admitted is not an option. She gets so violent towards healthcare workers she does not like that she has scratched and bitten some. She pulls off every intravenous canula and as such she often is discharged with linear bruise marks from the heavy restraints.

Mdm Wong has 12 children but is only cared for by one. This youngest son works 13-hours a day and thus depends on his maid to provide for all

the needs of his mother.

"Why don't you get your siblings involved?"

"Let's put it this way – my mom was not exactly a fantastic mother when we were young and now that she is old, no one wants to care for her."

"Does she rest well at night?"

"Even with Dilantin, Remeron and Diazepam, she wakes up every two hours demanding all kinds of things. I can't cope with that so it's the maid who has to suffer. I've got to work the next day."

I am at my wit's end regarding how to help a patient like Mdm Wong. I know she likes me because she has never scratched or bitten me. The maid tells me that she is visibly calmer after a visit to the clinic. Her son quips that she is addicted to my clinic. All I know is that the optimal care for such an elderly requires a system of many providers in the community. My dream is that when "slow medicine" is fully developed as a system, GPs like me will be able to communicate and collaborate with other community professionals like home nurses, counsellors, physiotherapists, social workers, nutritionists and even volunteer befrienders of the elderly shut-ins.

Elsewhere in the USA, I read that the term "slow medicine" was coined by Dennis McCullough, a Dartmouth geriatrician, Kendal's founding medical director and author of *My Mother, Your Mother: Embracing 'Slow Medicine', the Compassionate Approach to Caring for Your Aging Loved One*, to counter a rising phenomenon where elderly patients are routinely admitted into the acute tertiary hospitals when a 911 ambulance call is placed. This then triggers a cascade of medical investigations and treatments (all of them expensive) and still the medical problems are often unresolved or aggravated, and may even result in what they call "death by intensive care". In a New York Times report by Jane Gross (May 5, 2008), a glimpse of how "slow

medicine" is practised is given through the care provided by Kendal, Hanover – a retirement community affiliated with Dartmouth Medical School.

In every ageing society, it has become inevitable that at the other end of the spectrum of medical care, "slow medicine" has to evolve to meet needs that are unmet by our existing infrastructure and practices. I learn much from Dr McCullough when he says:

"Thanks to advances in medicine, the lives of the elderly and the infirmed can be significantly prolonged. But at what cost? Wrestling with the question, 'What's the right thing to do for mom or dad?' many of us become unwillingly caught up in the new 'death by intensive care' epidemic in which the 'care' is often more destructive than the disease. We want to do the best thing, but are overwhelmed with the staggering choices we face. Shaped by common sense and kindness, grounded in traditional medicine yet receptive to alternative therapies, 'Slow Medicine' is a measured treatment of 'less is more' that improves the quality of patients' extended late lives without bankrupting their families financially or emotionally. Expensive state-of-the-art medical interventions do not necessarily deliver superior outcomes. Gentle, personal care often yields better results, not only for elders in late life, but for the families who love them."

I am thus understandably excited about what lies ahead as we make the necessary shifts toward a more holistic approach to provide good healthcare to those at the final stations of their life's journey. SMA



Dr Tan Poh Kiang (MBBS, 1990) is a family physician who practices in a public housing estate in the heartland of Singapore. He is privileged to practise the art of healing and enjoys writing in his free time. He can be contacted at email: liejoan@singnet.com.sg.