REFLECTION

The Old Duffers' Club

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ABSTRACT

As baby boomers move toward retirement and nursing home care, medicine can no longer ignore the daunting task of caring for the aged. The physical and emotional challenges are enormous—and shocking—especially for a culture that prefers to jump rather than wade into the experience of old age. A new book by Dennis McCullough, *My Mother, Your Mother,* offers "slow medicine" as a corrective to the quick, curative methods in which we were trained. A large part of the answer—as I was taught by the members of the Old Duffers' Club—lies simply in self-support, conversation and friendship, accepting our physical decay, and finding the inner gift of ourselves that never grows old.

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Ordinariness is the most precious thing we struggle for…the right to go on living with a sense of purpose and a sense of self-worth—an ordinary life.

Irena Klepfisz[1]

They come every 2 weeks, on snow-packed roads or under aquiline skies, often an hour early and sometimes a day late. But faithfully they come: the 6 founding members of the Elder Men's Education and Support Group. They gather with serious intent for friendship and conversation around a narrow circle of chairs in a tiny conference room at the far end of my office. They take a chance that to merely disclose their particular circumstance, their isolation and loneliness, will help them face their uncertain future.

The idea for what became known as The Old Duffers' Club sprang from the confluence of a week in practice: 5 elderly patients—retired teachers, businessmen, mechanics, pipe-fitters—confessed their feelings of uselessness and loss of direction. One gentleman, a wiry, soft-spoken, independent Mainer, struck a resonant chord:

"How are you, Harold? What's happened since the last time we sat down?"

"Well, Doc, I just returned from a moose hunt. I won a stamp in the lottery and shared it with my son and his friend. We got our moose, but [he glanced away] I wasn't much help in hauling it from the woods."

I could hear a crack in his voice, as he swallowed hard on his words and squeezed back tears. All the gentle coaxing, rephrasing, exploring of the logical angles could not flush out his feelings. Now, 5 minutes past our appointed time, I asked if he would return in a week to finish our conversation. He nodded yes, gathered himself up, and left without a word. When he returned a week later, he was still at a loss for what had washed over him.

"It's nothing, Doc. I've been a little teary since the stroke."

"Harold, whatever you are going through, you are not alone. I know there are others [soon to be discovered] who would sit down with you and see where it leads. Are you willing? Can I give you a call?"

During the next 2 weeks I jotted a list of potential candidates. Eleven men received my initial invitation, and 8 attended the first organizational

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meeting. A final 6 settled into the regular conversations that became, soon enough, the ODC.

SLOW MEDICINE

Long before, I had become aware of my failure to meet the needs of aging patients. The Old Duffers' Club provided a concrete corrective. But the larger gestalt required of our health care system is sweepingly outlined in Dennis McCullough's new book, *My Mother, Your Mother.*[2] Here he describes how "slow medicine" can help the elderly find or retain living conditions that will optimize the last years of their lives. Says McCullough, "Slow medicine is just this caring process of slowing down, being patient, coordinating care, and remaining faithful to the end. Families necessarily bear the greatest responsibility in surmounting [end of life] difficulties to create this bond of trust and security for their loved ones."

Contrast slow medicine with the brand of health care practiced in our emergency departments. Here a generation of specialists has been trained to react quickly, with increasing efficiency, using carefully constructed protocols, marshaling a mind-boggling array of resources to diagnose and intervene before a patient ever leaves their department. They have little or no foreknowledge of the individual; they have one chance to get it right. Because it is procedural, because it is crisis oriented, they have always enjoyed moral justification and reliable revenues for a system that, overall, produces underwhelming results. The problem lies neither in the training nor the protocol, but their application to all that inevitably floods the emergency department—too much of which is primary care.

McCullough's book is sprinkled with vignettes and powered by his personal experience as a geriatrician at Dartmouth Medical School and the Kendal-at-Hanover community of elders. He appeals to 2 groups of readers: doctors who are frustrated by the turnstile pace of ambulatory medicine, and families of the elderly who most of all need the ear, the patience, the clinical restraint, and careful watch of physicians who know them well. Rather than offer programmatic solutions, McCullough appeals to us personally. Kindness, he suggests, is the single most reliable ethical and practical guide to doing the work well. Preservation of function should be the priority of homes inhabited by the elderly so that their inevitable decline can be managed for as long as possible outside a nursing home.

McCullough resists the call for more professionals and better checklists to aid the war on aging. Instead, he encourages us to slow down and enlist families as we struggle to understand and address the needs of elderly neighbors and parents.

Mrs McGreavey lives up the street. Sitting on her rotting back porch with a yappy terrier leashed to the clothesline, she often waves to me as I jog past. Her son and daughter-in-law recently escorted her to an appointment with concerns about her memory. Indeed, she had not been seen in our office for over 3 years, a lapse in my memory, too. She complained of sleeping poorly, fearful that a 7- or 8-year-old boy had been entering her house and stealing cookies.

"Did you lock your door?"

"Of course, but he made an extra key."

"Could you change the lock?"

Her son hangs his head in frustration, having engaged the locksmith 3 times in the last 6 months.

"Why does he take only cookies, when there are other valuables in the home?"

"Truth be known, Dr Loxterkamp, he also steals my new brooms and leaves me with old, ragged ones."

She is so convincing, so sincere in her telling that I wonder if this mysterious boy is my son, a lover of cookies but decidedly allergic to dust and brooms.

"Have you seen the boy?"

"No."

"Then how do you know he is 7 or 8?"

"Because I know his mother. She's a nurse who lives across the street."

"Then why don't ask her to give her son a stern talking to?"

"I don't know her name."

There is no dissuading her; the story rises above her inconsistencies. Dr McCullough is right: our worries for the patient often hover below the thresholds of the Mini Mental State Exam and depression inventory. Because this is Mrs. Greavey's annual exam, I order tests and set a time to review the results. Meanwhile, the son and I plan to enlist the community's resources and commit to closer surveillance in hopes of keeping my neighbor in her cozy house with the yappy dog for as long as possible.

Al and Roberta Pendleton have been my patients since I moved here a quarter-century ago. They are dead ringers for the couple in Grant Wood's famous painting *American Gothic*: silent, stoic, and standing by each other's side for more than 70 years. On the occasional home visit, one is always "doing fine" but "worried to death" about the other. Twenty years ago they might have moved out of their rambling farmhouse which—like themselves—was in need of repair. But the window of opportunity closed. The children anxiously shored up support. The son designed an expensive new addition and synchronized a rotation of home health aides that kept his parents at home a few months more before they died.

Despite our prayers for a quick and painless death,

it will likely come by another route. We will follow that well-worn path from home to clinic, ambulance cot to hospital bed, rehabilitation facility to home care, and round the base paths again. Most of the crises that turn the wheel are predictable but unpreventable; many of the obvious safety nets choke the freedoms and desires of those we are trying to help. Denial is the preferred bullet for besting change. It thwarts children who otherwise exert their firm upper hand. It stymies doctors who think that clinical realities should dictate the better course. This long and uncertain drama requires time, tolerance, family allegiance, and an unbending desire to discover and place the patient's needs before our own.

SLOW CHANGE

How can we accomplish this in our own practices? I am not sure, and I am not there—yet. Here are ways we might begin:

• Individualize the ordering of mammograms, prostate cancer screening tests, Papanicolaou smears, or colonoscopies for anyone older than 80 years. Why measure cholesterol levels or bone density if the results don't alter our treatment? Increasingly, we do so to gild the quality assurance report and payment for performance, though there is little evidence that these tests matter in the elderly. For most, an annual breast examination, digital rectal examination, and stool occult blood test will suffice.

• Be attentive to the safety concerns of driving, balance, and memory loss. Inquire about alcohol consumption, daily nutrition, sleep habits, and regular exercise. McCullough believes that compromised mobility is one of the most sensitive indicators of a person's well-being because it affects so many systems, from digestion, circulation, balance, and strength to overall emotional health.

• Advocate for necessary changes in the health care system that would reimburse us for unrushed office visits and family meetings. Reclaim our leadership role in home care, rather than relinquish it to agencies and aids. Fund research that specifically recruits the elderly and tests the intuition that less is more. Train hospitalists with a strong primary care orientation for the courage and wisdom to share important management decisions with patients and their physicians in the settings where they live.

• Focus on the little things that occupy our patients' lives, known by their acronym ADL, or activities of daily living. Advanced ADLs are the social skills that allow active participation in community life, including the ability to drive. Intermediate ADLs let us live independently in an apartment, requiring the ability to cook, houseclean, use the telephone, and pay bills. Basic ADLs are the skills of personal care—eating, dressing, bathing, and using the toilet. We sometimes forget that as a person's universe narrows, these simple tasks occupy monumental importance. I am reminded of this importance in the words of a Holocaust survivor, Irena Klepfisc, speaking on the 45th anniversary of the uprising of the Warsaw Ghetto:

> What we grieve for is not the loss of a grand vision, but rather the loss of common things, events and gestures.… Ordinariness is the most precious thing we struggle for, what the Jews of the Warsaw Ghetto fought for. Not noble causes or abstract theories. But the right to go on living with a sense of purpose and a sense of self-worth—an ordinary life.[1]

This what is at stake for the elderly as friends die, functions fail, and independence slips away or is forced from their grasp.

SLOW TALK

Which brings me back to the Old Duffers' Club. What have we actually accomplished by our meetings? None of us claims to be working on a Master's of Duffer (MD) degree. A lucky few will realize the more elusive prize of *Duffer Ordinaire* (DO). This is, in fact, our ticket for admission: that we are willing to acknowledge our age, commonality, and need for friendship. No group is smart enough, accomplished enough, or popular enough to please those who ride in on the high horse of pride.

At the first meeting, I asked each member what had drawn him there. Nearly all reported that they had lost a sense of direction and purpose. Two were widowers. One recently sold his life-long stamp collection; another gave up the clarinet. Each meeting began with a check-in, where we could discuss any event that involved us in the previous 2 weeks. There was one fellow, a retired professor, who uneasily confessed that he had done nothing except pass his empty hours in the recliner.

With time, the group began to talk of their activities. One wrote a letter to an old classmate, a best friend with whom he had lost contact. Another was planning a tour of the Western national parks. Still another came to terms with his eventual move out of state, where his younger wife had family and needed more of Grandma's time. It had now become their mutual decision, made for a hard but higher cause. And in recent weeks, the professor talked of taking his wife out to lunch, returned for lectures at Senior College, and suggested that the ODC meet at a restaurant for our final gathering before summer break. At that meal, I gave them each a gift, a T-shirt with the printed letters ODC and an image of the compass rose: symbol of their search for direction.

One of the Duffers caught me off guard recently when he asked, "Are you doing this group as much for yourself as for the rest of us?" Of course, I realized! Life is messy, purposes oblique, endings in doubt, and companionship essential. We are all looking more mercifully at our lives, knowing that many circumstances will not improve. Robin Sarah, in her poem "Tickets," provides insight on how people come embrace the string of accidents that constitute a life. We are in a theater watching an unfamiliar play. When it is almost over, we realize that it was not the play we had purchased tickets for. We could leave—"some people do"—but feel compelled to stay "all through the tedious denouement to the unsurprising end—riveted, as it were; spellbound by our own imperfect lives, because they are lives."[3]

What I have learned from the old duffers? They are a grateful lot. They have no schemes for getting ahead, nor do they dwell in a photo-album past. They have only the present at their disposal and, in their vulnerability and loneliness, have learned to share it. Lack of direction and loss of purpose can be the price we pay for defaulting on society's standards of success. When wealth, fame, and productivity sift away, what remains is friendship. What remain are conversation, honesty, kindness, and affection. These are the tools well-used and well-kept by average people, the ones that William Stafford praises in his poem "Allegiances." While the hero travels to the mountaintop to capture his dreams, the rest of us can find comfort in the routines he left behind. In our doubts and restlessness, "we ordinary beings can cling to the earth and love where we are, sturdy for the common things."[4]

Ordinary lives are made extraordinary by this awareness. It is a lesson learned late, often too late for the likes of Mrs McGreavy. It is not too late for her family, Harold, the other members of the ODC, and their doctor. Slow medicine allows physicians to be a helpful part of end-of-life transitions. It makes it more likely that our patients will negotiate them successfully. There is only one club, claimed by all: why pretend otherwise? Let's toast our membership in the universal ODC. Teaching by example, let's slow down to a conversational pace, enjoy our simple dreams, and appreciate ordinary patients in need of the most ordinary brand of medicine, which is our primary care.

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