I never gave much thought to end-of-life (EOL) care until a junior level course in geriatrics in my baccalaureate nursing program introduced me to disparities in the health care system at EOL. My dissatisfaction with the American cultural perspective on EOL care has made me reflect on what needs to change and how. I became convinced that there must be a more holistic, natural way to approach death and dying. My interest in this paradigm shift has led me to uncover a smoother path known as “slow medicine.”

Slow medicine is a holistic approach to EOL care that capitalizes on quality of life and preparation for the end (McCullough, 2008). It focuses on patients more than the illness and encourages providers to closely examine the most appropriate EOL care for each patient. At the core of slow medicine is the desire to balance what is beneficial to the patient and what is necessary for treatment (Radcliffe, 2015). Slow medicine is a concept that is undervalued in the current health care system.

The dichotomy of philosophy between fast and slow medicine has never been more apparent than it is now. Before this age of technology, people lived simple lives with simple endings. The current health care system has saved millions of lives but has also caused millions of problems. Slow medicine conflicts with the current perspective of medicine, providing a philosophy that supports patient transition from aggressive medical care to a meaningful end. Fast medicine creates a barrier on the bridge between holistic EOL care and a peaceful death (McCullough, 2008).

There are many reasons why slow medicine is not used in the medical system today. First, the American culture lacks patience. We are accustomed to receiving goods and services at the moment of purchase. The process of slow medicine is incompatible with this mindset. Western medicine is often an immediate transaction, whereas slow medicine is comparable to a 401(k): the account’s compounding interest will eventually pay off because slow medicine is a long-term investment (McCullough, 2008).

A second deterrent to slow medicine is denial. In a culture obsessed with staying young, we often deny the reality of aging and death. Many people confront the reality of mortality in the emergency department or at the receiving end of a devastating phone call. In contrast to facing sudden decisions at a moment’s notice, slow medicine creates a bridge to families and patients, facilitating awareness, planning, and readiness over time (McCullough, 2008).

Why concern ourselves with events in the distant future? Why scare mom and dad with thoughts about death? The intergenerational benefits of slow medicine are unassailable. When adult children spend time with their parents and have meaningful interactions, they develop deeper relationships. Before mass transportation, families stayed together and people often lived and died at home. Slow medicine hearkens back to a time when important relationships between generations were fostered by a shared participation in life transitions. There is also a pay-it-forward aspect to this principle (e.g., what was done for grandma will be done for me, and what was done for me will be done for my children) (McCullough, 2008).

Slow medicine is a common sense, yet somewhat revolutionary, take on EOL planning.
and care that can help patients and families prepare for challenging issues that arise during the last stages of life. After considering use of slow medicine, it can be seen that the process is less stressful and more meaningful than acute, traumatic EOL experiences. I believe slow medicine allows for a deeper respect of the previous generation. Moreover, it helps strengthen the family unit emotionally and relationally. For nurses, slow medicine will help them view the older adult population with empathy and respect, and see the road that they have traveled and have ahead as they walk alongside them to their next phase of life. In effect, the pace of medicine will slow and tear down the barrier on the bridge (McCullough, 2008).

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