SLOW MEDICINE: A PHILOSOPHICAL CONCEPTION FOR A HUMANIZED GERIATRIC PRACTICE

Slow medicine: uma concepção filosófica para uma prática geriátrica humanizada

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ABSTRACT

Expansion of the concept of health, care fragmentation, and technology overvaluation have fostered discussions about the limitations of the biomedical model. The post-COVID-19 era can be one of the largest and best windows of opportunity for implementation of interventions aimed at promoting health equity, particularly in geriatrics. The mission of Slow Medicine can be summarized in three keywords: measured, because it acts with moderation, gradually and without waste; respectful, because it seeks to preserve the dignity and values of each person; and equitable, because it is committed to ensuring access to appropriate care for all. Operationally, the Slow Medicine movement is known internationally for the "Doing more does not mean doing better" campaign, whose objective is essentially to reflect upon and try to engage physicians in reflective practices to avoid the overuse of medical resources, both diagnostically and therapeutically. In this article, we present a brief historical summary and the principles that guide the praxis of the Slow Medicine movement, and invite the reader to reflect on a "geriatrics without haste."

KEYWORDS: comprehensive health care; aged; health of the elderly; geriatrics.

RESUMO

A ampliação do conceito de saúde, a fragmentação do cuidado e a hipervalorização das tecnologias têm fomentado discussões acerca das limitações do modelo biomédico. A era pós-COVID-19 pode ser uma das maiores e melhores janelas de oportunidade para a promoção de intervenções destinadas à promoção da equidade em saúde, particularmente na geriatria. A missão da *Slow Medicine* pode ser sintetizada em três palavras-chave: sóbria, porque atua com moderação, gradativamente e sem desperdícios; respeitosa, porque zela pela preservação da dignidade e dos valores de cada pessoa; equitativa, porque tem o compromisso de garantir o acesso a cuidados adequados para todos. Operacionalmente, o movimento *Slow Medicine* é conhecido internacionalmente pela campanha "Fazer mais não significa fazer melhor", cujo objetivo é essencialmente refletir e tentar implantar entre os médicos práticas reflexivas que combatam a sobreutilização de recursos médicos, tanto diagnósticos como terapêuticos. Neste artigo, apresentamos um breve resumo histórico e dos princípios que pautam a práxis do movimento *Slow Medicine*, e convidamos o leitor a refletir sobre uma "geriatria sem pressa".

PALAVRAS-CHAVE: assistência integral à saúde; idoso; saúde do idoso; geriatria.

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Expansion of the concept of health has long fostered discussions about the limitations of the biomedical model.[1,2] As Barros[1] points out, there is no "intrinsic evil" in traditional medicine; overvaluation of the ordering of medications and tests, however, coincides with the dynamism of rushed health care providers and impersonal care delivery, which reinforces a mechanistic model that reduces the health-disease process to a strictly biological dimension. Health professionals seem to focus their attention mostly on technologies, while neglecting people's needs and the relationships with the family and social environment.

With the COVID-19 pandemic, the example of the United States has become quite illustrative. Despite all the technological investment in that country, their numbers of infections and deaths from COVID-19 are among the highest in the world, in contrast to nations that have fully implemented cost-effective public health measures — such as Japan, Taiwan, New Zealand, Hong Kong, and Iceland.[3] Although there are many potential explanations for these discrepancies, evidence supports the value of adopting soft and soft-hard technologies, such as stricter control of their borders, systematic wearing of masks, social distancing, and the continued practice of hygiene measures, such as hand washing and use of alcohol-based sanitizers.[4]

In principle, successful care should be based on the best available evidence, focusing on the patient and individual patient values within a concept of shared responsibility for diagnostic and therapeutic decisions. The effects of care fragmentation and technology overvaluation, however, have influenced an increasing number of health professionals, who are dissatisfied with this hegemonic model by realizing that "doing more does not always mean doing better."

The mission of Slow Medicine, as we will discuss later, can be summarized in three keywords:[5] *measured*, because it acts with moderation, gradually and without waste; *respectful*, because it seeks to preserve the dignity and values of each person; and *equitable*, because it is committed to ensuring access to appropriate care for all.

The Slow Medicine movement has its origins in Italy. In 1986, a group of protesters embraced the Piazza di Spagna, in the city of Rome, led by journalist and activist Carlos Petrini. The group protested the opening of a fast-food restaurant in that iconic site in the Italian capital city. This protest gave rise to the Slow Food movement, which proposed a new look at food consumption and production. Beyond commercial interests, the movement sought to rescue the Italian gastronomic culture: from the production of its traditional foods to the fair remuneration of the producers; from the very act of eating to the perception of the need for time to savor the food being consumed. In 1989, the Slow Food movement established its principles by proposing the concept of "good, clean, and fair" food. Its spread eventually generated other initiatives, including the *Cittá Slow* movement and, in 2011, the Slow Medicine movement, also in Italy.

In 2002, Italian cardiologist Alberto Dolara suggested that some of the principles of the Slow Food movement could be incorporated into medical practice, particularly to slow down the decision-making process in specific situations.[6] For example, hospitalized frail older patients should not be "rushed" to be discharged early without an established care transition process: while respecting the available local resources, this process should be widely discussed and shared with patients, families, and caregivers.[7]

Currently, there is evidence that transitional care programs reduce readmission rates and the risk of older patients being unnecessarily subjected to repeated, harmful, or ineffective interventions.[8] Likewise, in end-of-life situations, many interventions have proven to be less impactful (sometimes they add not only risk but also suffering to the patient). A careful and compassionate attitude to maximize comfort and quality of life should be the goal of health professionals.[9]

In 2008, American geriatrician and family physician Dennis McCullough published a seminal work: "My mother, your mother: embracing 'slow medicine': the compassionate approach to caring for your aging loved ones".[10] Based on his experience of more than three decades as a physician, he takes a look at aging that, once again, challenges evidence-, protocol-, and technology-based medicine, and proposes a more cautious and humanistic care. The book's propositions include the education of family members and caregivers about what he called "the eight stations of late life." McCullough's book is a small masterpiece that should be a must-read for all geriatricians, gerontologists, and anyone involved in the care of older people. McCullough was undoubtedly the great thinker of Slow Medicine when it comes to geriatric practice.

Overuse of technology in the face of the finitude of life and inexorability of death was the focus of an article published by journalist Katy Butler in The New York Times in 2010, entitled "What broke my father's heart".[11] The journalist was particularly concerned with the overvaluation of advanced technologies for cardiac support and questioned the fact that, when assessing a sick heart, many health professionals seem to forget that behind it there is an older person with a history of life, values, decisions, and expectations. In her next book, "The art of dying well: a practical guide to a good end of life," Butler established parallels

and practical, medical, and spiritual guidelines to define what a "good death" could be in the setting of chronic illness.[12] As we can see, the view of Slow Medicine mingles with palliative care strategies and manages to demonstrate how much this philosophy can be of value in addressing finitude-related issues.

The particular view developed by Californian physician Victoria Sweet contributed to the development of the Slow Medicine movement. She wrote two works based on her personal experiences: "God's hotel: a doctor, a hospital, and a pilgrimage to the heart of medicine"[13] and "Slow medicine: the way to healing".[14] In an interesting analogy, her work describes an eleventh-century Benedictine nun, musician, philosopher, and healer who saw the "health care provider" (there were no physicians at that time) as a gardener, who seeks to offer plants the best conditions to heal and grow, rather than as a mechanic, who "fixes and repairs things."

The Italian side of the movement is represented by the Italian Slow Medicine Association (AISM), established in 2011 in Turin. It was at the first AISM congress that the manifesto that proposes a "measured, respectful, and equitable" medicine was drafted.[5] An exponent of the AISM is Dr. Marco Bobbio, who has had two books translated and published in Brazil: *The Imagined Sick Person*[15] and *Too much medicine: overuse can be harmful to health*.[16]

Operationally, the movement is known for the "Doing more does not mean doing better" campaign, similar to the "Choosing Wisely" campaign in the United States, which aims to improve clinical appropriateness by reducing unnecessary tests and treatments. The Choosing Wisely campaign, which started in the United States, is coordinated by the American Board of Internal Medicine Foundation and conducted in Italy by the AISM. Its objective is essentially to reflect upon and try to engage physicians in reflective practices to avoid the overuse of medical resources, both diagnostically and therapeutically.

In Brazil, the Slow Medicine movement is in a clear process of consolidation. Most of the group's publications are available online, especially at the group's website (https://www.slowmedicine.com.br/). The Brazilian movement has an important presence on social media, producing a Slow Medicine with a national accent — the "Medicine without Haste."

The discussion on aging covers a broad spectrum of topics and formats, from the dissemination of McCullough's ideas and reviews of books and films with themes relevant to old age to reflections on finitude, palliative care, and their intertwining with Slow Medicine, including comments on articles whose themes encompass deprescribing and issues related to medicalization among older patients.

From an academic perspective, the emergence of academic Slow Medicine leagues in higher education institutions in Brazil is a healthy movement. Also worth mentioning is the initiative of professors Afonso Carlos Neves and Dayse Machado, from the Neurology Department at Escola Paulista de Medicina, who implemented an elective Slow Medicine course at this university.

Slow Medicine can contribute to geriatrics through a vast range of elements and reflections: the thoughtful use of technology; end-of-life care; the systematic adoption of deprescribing strategies; the provision of multidisciplinary care; and, eventually, in line with the principles of disease prevention and health promotion, the use of integrative practices that, whenever possible, improve the quality of life of older people.

Evidence suggests that healthy aging is more directly influenced by the presence (or absence) of social and economic resources and opportunities over the life course (which influence the power to make healthy choices, for example) than by the availability of advanced technologies.[17] The concept of intrinsic capacity, for example, is strongly influenced by the environments in which people have lived throughout their lives.[17] In this context, the proposition "less is more" may have a special meaning in old age, with the appreciation of art and the ability to not intervene and to observe the natural course of events and phenomena that can affect old people — remembering that untimely interventions can be more harmful than the disease itself.

As Spanish bioethicist Diego Gracia[18] proposes, health professionals should be encouraged to form strong bonds with their patients and family members and to establish respectful and trusting relationships, using *shared decision-making* as a rudder and relying on ethical and trustworthy information. This relationship should be based on the *time* required for these relationships to consolidate and on the *reasonable use of technology* so that older people can receive more humane and compassionate care. A "geriatrics without haste" can increase the satisfaction of physicians with their work and of older people with the attention they receive.

The post-pandemic era can be one of the largest and best windows of opportunity for implementation of interventions aimed at promoting health equity. This may be a new paradigm to be recognized and spread among geriatricians, who will have their practice enriched and will certainly provide more sensitive care to their patients. After all, what is our major role if not caring?

CONFLICT OF INTERESTS

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REFERENCES

1. Barros JAC. Pensando o processo saúde doença: a que responde o modelo biomédico? Saúde Soc. 2002;11(1):67-84. https://doi.org/10.1590/S0104-12902002000100008
2. Fertonani HP, Pires DEP de, Biff D, Scherer MDA. Modelo assistencial em saúde: conceitos e desafios para a atenção básica brasileira. Ciênc Saúde Coletiva. 2015;20(6):1869-78. https://doi.org/10.1590/1413-81232015206.13272014
3. Atzrodt CL, Maknojia I, McCarthy RDP, Oldfield TM, Po J, Ta KTL, et al. A Guide to COVID-19: a global pandemic caused by the novel coronavirus SARS-CoV-2. FEBS J. 2020;287(17):3633-50. https://doi.org/10.1111/febs.15375
4. Teslya A, Pham TM, Godijk NG, Kretzschmar ME, Bootsma MCJ, Rozhnova G. Impact of self-imposed prevention measures and short-term government-imposed social distancing on mitigating and delaying a COVID-19 epidemic: A modelling study. PLoS Med. 2020;17(7):e1003166. https://doi.org/10.1371%2Fjournal.pmed.1003166
5. Bonaldi A, Vernero S. Italy's Slow Medicine: a new paradigm in medicine. Recenti Prog Med. 2015;106(2):85-91. https://doi.org/10.1701/1790.19492
6. Dolara A. Invitation to "slow medicine". Ital Heart J Suppl. 2002;3(1):100-1.
7. Lima MADS, Magalhães AMM, Oelke ND, Marques GQ, Lorenzini E, Weber LAF, et al. Care transition strategies in Latin American countries: an integrative review. Rev Gaúcha Enferm. 2018;39:e20180119. https://doi.org/10.1590/1983-1447.2018.20180119
8. Weeks LE, Macdonald M, Martin-Misener R, Helwig M, Bishop A, Iduye DF, et al. The impact of transitional care programs on health services utilization in community-dwelling older adults: a systematic review. JBI Database System Rev Implement Rep. 2018;16(2):345-84. https://doi.org/10.11124/jbisrir-2017-003486
9. Bauer JL. Slow medicine. J Altern Complement Med. 2008;14(8):891-92.
10. Hickey MH. My mother, your mother: embracing "slow medicine": the compassionate approach to caring for your aging loved ones By Dennis McCullough. Educ Gerontol. 2009;35(3):277-8. https://doi.org/10.1080/03601270802660049
11. Butler K. What Broke My Father's Heart. The New York Times [periódico eletrônico] 2020 [cited in 2020 Dec 16]. Available at: https://www.nytimes.com/2010/06/20/magazine/20pacemaker-t.html.
12. Butler K. The Art of Dying Well: A Practical Guide to a Good End of Life. Nova York: Scribner; 2019.
13. Sweet V. God's Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine. Nova York: Riverhead Books; 2012.
14. Sweet V. Slow Medicine: The Way to Healing. Nova York: Riverhead Books; 2017.
15. Bobbio M. Il Malato Immaginato: I Rischi Di Una Medicina Senza Limiti. Torino: Einaudi; 2010.
16. Bobbio M. Troppa medicina. Un uso eccessivo può nuocere alla salute. Torino: Einaudi; 2017.
17. World Health Organization. Decade of Healthy Ageing 2020–2030. Genebra: World Health Organization; 2020.
18. Gracia D. Moral deliberation: the role of methodologies in clinical ethics. Med Health Care Philos. 2001;4(2):223-32. https://doi.org/10.1023/a:1011445128427