Pomp's Highlights from Being Mortal by Atul Gawande

Introduction

1. The purpose of medical schooling was to teach how to save lives, not how to tend to their demise.
2. Modern scientific capability has profoundly altered the course of human life. People live longer and better than at any other time in history. But scientific advances have turned the processes of aging and dying into medical experiences, matters to be managed by healthcare professionals. And we in the medical world have proved alarmingly unprepared for it.
3. As recently as 1945, most deaths occurred in the home. By the 1980s, just 17% did.
4. Death, of course, is not a failure. Death is normal. Death may be the enemy, but it is also the natural order of things.
5. There's no escaping the tragedy of life, which is that we are all aging from the day we are born.
6. This is a book about the modern experience of mortality — about what it's like to be creatures who age and die, how medicine has changed the experience and how it hasn't, where our ideas about how to deal with our finitude have got the reality wrong.
7. Our reluctance to honestly examine the experience of aging and dying has increased the harm we inflict on people and denied them the basic comforts they most need. Lacking a coherent view of how people might live successfully all the way to their very end, we have allowed our fates to be controlled by the imperatives of medicine, technology, and strangers.

Chapter 1 — The Independent Self

1. My father's father had the kind of traditional old age that, from a Western perspective, seems idyllic. He was surrounded and supported by family at all times, and he was revered — not in spite of his age but because of it. He was consulted on all important matters — marriages, land disputes, business decisions — and occupied a place of high honor in the family.
2. Health professionals have a formal classification system for the level of function a person has. If you cannot, without assistance, use the toilet, eat, dress, bathe,

groom, get out of bed, get out of a chair, and walk — the eight “Activities of Daily Living” — then you lack the capacity for basic physical independence.

3. In contemporary societies, by contrast, old age and infirmity have gone from being a shared, multigenerational responsibility to a more or less private state — something experienced largely alone or with the aid of doctors and institutions.
4. The dignity of old age was something to which everyone aspired.
5. Age no longer has the value of rarity.
6. As for the exclusive hold that elders once had on knowledge and wisdom, that, too, has eroded, thanks to technologies of communication — starting with writing itself and extending to the Internet and beyond.
7. The fascinating thing is that, over time, it doesn’t seem the elderly have been especially sorry to see the children go. Historians find that the elderly of the industrial era did not suffer economically and were not unhappy to be left on their own.
8. Given the opportunity, both parents and children saw separation as a form of freedom. Whenever the elderly have had the financial means, they have chosen what social scientists have called “intimacy at a distance.”
9. Del Webb, an Arizona real estate developer, popularized the term “retirement community” in 1960 when he launched Sun City, a community in Phoenix that was among the first to limit its residents to retirees.
10. The veneration of elders may be gone, but not because it has been replaced by veneration of youth. It’s been replaced by veneration of the independent self.
11. Our reverence for independence takes no account of the reality of what happens in life: sooner or later, independence will become impossible.

Chapter 2 — Things Fall Apart

1. Increasingly large numbers of us get to live out a full life span and die of old age. Old age is not a diagnosis. There is always some final proximate cause that gets written down on the death certificate — respiratory failure, cardiac arrest. But in truth no single disease leads to the end; the culprit is just the accumulated crumbling of one’s bodily systems while medicine carries out its maintenance measures and patch jobs.
2. The progress of medicine and public health has been an incredible boon — people get to live longer, healthier, more productive lives than ever before.

3. In a sense, the advances of modern medicine have given us two revolutions: we've undergone a biological transformation of the course of our lives and also a cultural transformation of how we think about that course.
4. Why we age is the subject of vigorous debate. The classical view is that aging happens because of random wear and tear. The newest view holds that aging is more orderly and genetically programmed.
5. I spoke to Felix Silverstoe, who for twenty-four years was the senior geriatrician at the Parker Jewish Institute, in New York, and who has published more than a hundred studies on aging. There is, he told me, "no single, common cellular mechanism to the aging process." Our bodies accumulate lipofuscin and oxygen free-radical damage and random DNA mutations and numerous other microcellular problems. THe process is gradual and unrelenting. I asked Silverstone whether gerontologists have discerned any particular reproducible pathway to aging. "No," he said. "We just fall apart."
6. "Eating alone is not very stimulating."
7. 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.
8. Decline remains our fate; death will someday come.
9. Until that last backup system inside each of us fails, medical care can influence whether the path is steep and precipitate or more gradual, allowing longer preservation of the abilities that matter most in your life.
10. Researchers at the University of Minnesota identified 568 men and women over the age of seventy who were living independent but were at high risk of becoming disabled because of chronic health problems, recent illness, or cognitive changes. Researchers randomly assigned half of them to see a team of geriatric nurses and doctors — a team dedicated to the art and science of managing old age. The others were asked to see their usual physician, who was notified of their high-risk status. Within eighteen months, 10% of the patients in both groups had died. But the patients who had seen a geriatrics team were a quarter less likely to become disabled and half as likely to develop depression. They were 40% less likely to require home health services. These were stunning results. It was just geriatrics. What they did was to simplify medications.
11. The dismal finances of geriatrics are only a symptom of a deeper reality: people have not insisted on a change in priorities. We all like new medical gizmos and demand that policy makers ensure they are paid for. We want doctors who promise to fix things. But geriatricians? Who clamors for geriatricians? What

geriatricians do — bolster our resilience in old age, our capacity to weather what comes — is both difficult and unappealing limited. It requires attention to the body and its alterations. It requires vigilance over nutrition, medications, and living situations. And it requires each of us to contemplate the unfixables in our life, the decline we will inevitably face, in order to make the small changes necessary to reshape it. When the prevailing fantasy is that we can be ageless, the geriatricians's uncomfortable demand is that we accept we are not.

12. Creating geriatric specialists takes time, and we already have far too few. In a year, fewer than three hundred doctors will complete geriatrics training in the United States, not nearly enough to replace the geriatricians going into retirement, let alone meet the needs of the next decade.
13. The risk of a fatal car crash with a driver who's eighty-five or older is more than three times higher than it is with a teenage driver.

Chapter 3 — Dependence

1. It is not death that the very old tell me they fear. It is what happens short of death — losing their hearing, their memory, their best friends, their way of life.
2. As Felix put it to me, "Old age is a continuous series of losses." Philip Roth put it more bitterly in his novel Everyman: "Old age is not a battle. Old age is a massacre."
3. In time, poorhouses passed from memory in the industrialized world, but they persist elsewhere. In developing countries, they have become common, because economic growth is breaking up the extended family without yet producing the affluence to protect the elderly from poverty and neglect.
4. Prosperity has enabled even the poor to expect nursing homes with square meals, professional health services, physical therapy, and bingo. They've eased debility and old age for millions and made proper care and safety a norm to an extent that the inmates of poorhouses could not imagine. Yet still, most consider modern old age homes frightening, desolate, even odious places to spend the last phase of one's life. We need and desire something more.
5. Our old age homes didn't develop out of a desire to give the frail elderly better lives than they'd had in those dismal places.
6. Instead we said, "this looks like a medical problem. Let's put these people in the hospital. Maybe the doctors can figure something out." The modern nursing home developed from there, more or less by accident.

7. From World War II onward, doctors became heroes, and the hospital transformed from a symbol of sickness and despondency to a place of hope and cure.
8. Communities could not build hospitals fast enough. In America, in 1946, Congress passed the Hill-Burton Act, which provided massive amounts of government funds for hospital construction. Two decades later the program had financed more than nine thousand new medical facilities across the country. For the first time, most people had a hospital nearby, and this became true across the industrialized world.
9. Pensions provided a way of allowing the elderly to manage independently as long as possible in their retirement years. But pensions hadn't provided a plan for that final, infirm stage of mortal life.
10. This has been the persistent pattern of how modern society has dealt with old age. The systems we've devised were almost always designed to solve some other problem.
11. The sociologist Erving Goffman noted the likeness between prisons and nursing homes half a century ago in his book *Asylums*. They were, along with military training camps, orphanages, and mental hospitals, "total institutions" — places largely cut off from wider society.
12. Nursing homes have come a long way from the firetrap warehouses of neglect they used to be. But it seems we've succumbed to a belief that, once you lose your physical independence, a life of worth and freedom is simply not possible.
13. This is the consequence of a society that faces the final phase of the human life cycle by trying not to think about it. We end up with institutions that address any number of societal goals — from freeing up hospital beds to taking burdens off families' hands to coping with poverty among the elderly — but never the goal that matters to the people who reside in them: how to make life worth living when we're weak and frail and can't fend for ourselves anymore.

Chapter 4 — Assistance

1. The key word in her mind was *home*. Home is the one place where your own priorities hold sway. At home, you decide how you spend your time, how you share your space, and how you manage your possessions. Away from home, you don't.
2. With "assisted living," the goal was that no one ever had to feel institutionalized.

3. Reality is more complex, though. People readily demonstrate a willingness to sacrifice their safety and survival for the sake of something beyond themselves, such as family, country, or justice. And this is regardless of age.
4. Our driving motivations in life, instead of remaining constant, change hugely over time and in ways that don't quite fit Maslow's classic hierarchy. In young adulthood, people seek a life of growth and self-fulfillment, just as Maslow suggested.
5. When people reach the latter half of adulthood, however, their priorities change markedly. Most reduce the amount of time and effort they spend pursuing achievement and social networks. They narrow in.
6. Studies find that as people grow older they interact with fewer people and concentrate more on spending time with family and established friends. They focus on being rather than doing and on the present more than the future. Understanding this shift is essential to understanding old age.
7. Far from growing unhappier, people reported more positive emotions as they aged. They became less prone to anxiety, depression, and anger.
8. If we shift as we age toward appreciating everyday pleasures and relationships rather than toward achieving, having, and getting, and if we find this more fulfilling, then why do we take so long to do it? The common view was that these lessons are hard to learn. Living is a kind of skill. The calm and wisdom of old age are achieved over time.
9. What if the change in needs and desires has nothing to do with age per se? Suppose it merely has to do with perspective — your personal sense of how finite your time in this world is.
10. A hypothesis: How we seek to spend our time may depend on how much time we perceive ourselves to have. When you are young and healthy, you believe you will live forever. When horizons are measured in decades, which might as well be infinity to human beings, you most desire all that stuff at the top of Maslow's pyramid — achievement, creativity, and other attributes of "self-actualization." But as your horizons contract — when you see the future ahead of you as finite and uncertain — your focus shifts to the here and now, to everyday pleasures and the people closest to you.
11. "Socioemotional selectivity theory" - the simpler way to say it is that perspective matters.
12. When, as the researchers put it, "life's fragility is primed," people's goals and motives in their everyday lives shift completely. It's perspective, not age, that matters most.

13. This simple but profound service — to grasp a fading man's need for everyday comforts, for companionship, for help achieving his modest aims — is the thing that is still so devastatingly lacking more than a century later.
14. We have no good metrics for a place's success in assisting people to live. By contrast, we have very precise ratings for health and safety.
15. Assisted living isn't really built for the sake of older people so much as for the sake of their children.
16. In the absence of a vast extended family constantly on hand to let him make his own choices — our elderly are left with a controlled and supervised institutional existence, a medically designed answer to unfixable problems, a life designed to be safe but empty of anything they care about.

Chapter 5 — A Better Life

1. Bill Thomas believed that a good life was one of the maximum independence. But that was precisely what the people in the home were denied.
2. Attack what he termed the Three Plagues of nursing home existence: Boredom, Loneliness, and Helplessness.
3. Every place has a deep-seated culture as to how things are done. "Culture is the sum total of shared habits and expectations," Thomas told me.
4. "Culture has tremendous inertia," he said. "That's why it's culture. It works because it lasts. Culture strangles innovation in the crib."
5. To combat the inertia, he decided they should go up against the resistance directly — "hit it hard." He called it the Big Bang.
6. Researchers studied the effects of this program over two years, comparing a variety of measures for Chase's residents with those of residents at another nursing home nearby. Their study found that the number of prescriptions required per resident fell to half that of the control nursing home. Psychotropic drugs for agitation, like Haldol, deceased in particular. The total drug costs fell to just 38% of the comparison facility. Deaths fell 15%. The study couldn't say why. But Thomas thought he could. "I believe the difference in death rates can be traced to the fundamental human need for a reason to live."
7. The most important finding of Thomas' experiment wasn't that having a reason to live could reduce death rates for the disabled elderly. The most important finding was that it is possible to provide them with reasons to live, period.

8. What more is it that we need in order to feel that life is worthwhile? The answer, he believed, is that we all seek a cause beyond ourselves. This was, to him, an intrinsic human need.
9. Royce called this dedication to a cause beyond oneself loyalty. He regarded it as the opposite of individualism.
10. In fact, he argued, human beings need loyalty. It doesn't not necessarily produce happiness, and can even be painful, but we all require devotion to something more than ourselves for our lives to be endurable.
11. The only way death is not meaningless is to see yourself as part of something greater: a family, a community, a society.
12. As our time winds down, we all seek comfort in simple pleasures — companionship, everyday routines, the taste of good food, the warmth of sunlight on our faces. We become less interested in the rewards of achieving and accumulating, and more interested in the rewards of simply being.
13. Medical professionals concentrate on repair of health, not sustenance of the soul.
14. For more than half a century now, we have treated the trails of sickness, aging, and mortality as medical concerns. It's been an experiment in social engineering, putting our fates in the hands of people valued more for their technical prowess than for their understanding of human needs. That experiment has failed.
15. They were both pursuing the same idea: to help people in a state of dependence sustain the value of existence. Thomas's first step was to give people a living being to care for; Wilson's was to give them a door they could lock and kitchen on their own.
16. Making lives meaningful in old age is new. It therefore requires more imagination and invention than making them merely safe does.
17. There are people in the world who change imaginations. You can find them in the most unexpected places.
18. The amount of freedom you have in your life is not the measure of the worth of your life. Just as safety is an empty and even self-defeating goal to live for, so ultimately is autonomy.
19. The battle of being mortal is the battle to maintain the integrity of one's life — to avoid becoming so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be.
20. The terror of sickness and old age is not merely the terror of the losses one is forced to endure but also the terror of the isolation. As people become aware of

the finitude of their life, they do not ask for much. They do not seek more riches. They do not seek more power. They ask only to be permitted, insofar as possible to keep shaping the story of their life in the world — to make choices and sustain connection to others according to their own priorities. In modern society, we have come to assume that debility and dependence rule out such autonomy.

Chapter 6 — Letting Go

1. People with serious illness have priorities besides simply prolonging their lives. Surveys find that their top concerns include avoiding suffering, strengthening relationships with family and friends, being mentally aware, not being a burden on others, and achieving a sense that their life is complete.
2. Dying used to be accompanied by a prescribed set of customs.
3. People believed death should be accepted stoically, without fear or self-pity or hope for anything more than the forgiveness of God. Reaffirming one's faith, repenting one's sins, and letting go of one's worldly possessions and desires were crucial, and the guides provided families with prayers and questions for the dying in order to put them in the right frame of mind during their final hours. Last words came to hold a particular place of reverence.
4. For most people, death comes only after long medical struggle with an ultimately unstoppable condition.
5. In all such cases, death is certain, but the timing isn't.
6. The trouble is that we've built our medical system and culture around the long tail. We've created a multitrillion-dollar edifice for dispensing the medical equivalent of lottery tickets — and have only the rudiments of a system to prepare patients for the near certainty that those tickets will not win. Hope is not a plan, but hope is our plan.
7. People who had substantive discussions with their doctor about their end-of-life preferences were far more likely to die at peace and in control of their situation and to spare their family anguish.
8. The lesson seems almost Zen: you live longer only when you stop trying to live longer.
9. Swedish doctors call it a "breakpoint discussion," a series of conversations to sort out when they need to switch from fighting for time to fighting for the other things that people value — being with family or traveling or enjoying chocolate ice cream.

10. 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.

Chapter 7 — Hard Conversations

1. Scholars have posited three stages of medical development that countries go through, paralleling their economic development. In the first stage, when a country is in extreme poverty, most deaths occur in the home because people don't have access to professional diagnosis and treatment. In the second stage, when a country's economy develops and its people transition to higher income levels, the greater resources make medical capabilities more widely available. People turn to health care systems when they are ill. At the end of life, they often die in the hospital instead of the home. In the third stage, as a country's income climbs to the highest levels, people have the means to become concerned about the quality of their lives, even in sickness, and deaths at home actually rise again.
2. A monumental transformation is occurring. In this country and across the globe, people increasingly have an alternative to withering in old age homes and dying in hospitals — and millions of them are seizing the opportunity. But this is an unsettled time. We've begun rejecting the institutionalized version of aging and death, but we've not yet established our new norm.
3. We want information and control, but we also want guidance.
4. The amount of freedom you have in your life is not the measure of the worth of your life. Just as safety is an empty and even self-defeating goal to live for, so ultimately is autonomy.