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Malcolm Gladwell

ATUL GAWANDE



BEING MORTAL

Illness, Medicine,
and What Matters
in the End

Being Mortal

ATUL GAWANDE is the author of three bestselling books:

Complications, a finalist for the National Book Award; *Better*, selected by Amazon.com as one of the ten best books of 2007; and *The Checklist Manifesto*. He is also a surgeon at Brigham and Women's Hospital in Boston, a

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Also by Atul Gawande

Complications: A Surgeon's Notes on an Imperfect

Science

Better: A Surgeon's Notes on Performance

The Checklist Manifesto: How to Get Things Right

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Being Mortal

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To Sara Bershtel

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I see it now—this world is swiftly passing.

—the warrior Karna, in the *Mahabharata*

They come to rest at any kerb:

All streets in time are visited.

—Philip Larkin, “Ambulances”

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Introduction

I learned about a lot of things in medical school, but mortality wasn't one of them. Although I was given a dry, leathery corpse to dissect in my first term, that was solely a way to learn about human anatomy. Our textbooks had almost nothing on aging or frailty or dying. How the process unfolds, how people experience the end of their lives, and how it affects those around them seemed beside the point. The way we saw it, and the way our professors saw it, the purpose of medical schooling was to teach how to save lives, not how to tend to their demise.

The one time I remember discussing mortality was during

an hour we spent on *The Death of Ivan Ilyich*, Tolstoy's classic novella. It was in a weekly seminar called

Patient-Doctor—part of the school's effort to make us more rounded and humane physicians. Some weeks we would practice our physical examination etiquette; other weeks we'd learn about the effects of socioeconomic and race on health. And one afternoon we contemplated the suffering of Ivan Ilyich as he lay ill and worsening from some unnamed, untreatable disease.

In the story, Ivan Ilyich is forty-five years old, a midlevel Saint Petersburg magistrate whose life revolves mostly around petty concerns of social status. One day, he falls off a stepladder and develops a pain in his side. Instead of abating, the pain gets worse, and he becomes unable to work. Formerly an "intelligent, polished, lively and agreeable man," he grows depressed and enfeebled.

Friends and colleagues avoid him. His wife calls in a

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series of ever more expensive doctors. None of them can agree on a diagnosis, and the remedies they give him

accomplish nothing. For Ilyich, it is all torture, and he

simmers and rages at his situation.

“What tormented Ivan Ilyich most,” Tolstoy writes, “was the deception, the lie, which for some reason they all accepted, that he was not dying but was simply ill, and he only need keep quiet and undergo a treatment and then something very good would result.” Ivan Ilyich has flashes of hope that maybe things will turn around, but as he grows weaker and more emaciated he knows what is happening. He lives in mounting anguish and fear of death. But death is not a subject that his doctors, friends, or family can countenance. That is what causes him his most profound pain.

“No one pitied him as he wished to be pitied,” writes Tolstoy. “At certain moments after prolonged suffering he wished most of all (though he would have been ashamed to confess it) for someone to pity him as a sick child is pitied. He longed to be petted and comforted. He knew he was an important functionary, that he had a beard turning grey, and that therefore what he longed for was impossible, but still he longed for it.”

As we medical students saw it, the failure of those around Ivan Ilyich to offer comfort or to acknowledge what is happening to him was a failure of character and culture.

The late-nineteenth-century Russia of Tolstoy's story seemed harsh and almost primitive to us. Just as we believed that modern medicine could probably have cured Ivan Ilyich of whatever disease he had, so too we took for granted

that

honesty

and

kindness

were

basic

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responsibilities of a modern doctor. We were confident that in such a situation we would act compassionately.

What worried us was knowledge. While we knew how to sympathize, we weren't at all certain we would know how to properly diagnose and treat. We paid our medical tuition to learn about the inner process of the body, the

intricate mechanisms of its pathologies, and the vast trove of discoveries and technologies that have accumulated to stop them. We didn't imagine we needed to think about much else. So we put Ivan Ilyich out of our heads.

Yet within a few years, when I came to experience surgical training and practice, I encountered patients forced to confront the realities of decline and mortality, and it did not take long to realize how unready I was to help them.

I BEGAN WRITING when I was a junior surgical resident, and in one of my very first essays, I told the story of a man whom I called Joseph Lazaroff. He was a city administrator who'd lost his wife to lung cancer a few years earlier. Now, he was in his sixties and suffering from an incurable cancer himself—a widely metastatic prostate cancer. He had lost more than fifty pounds. His abdomen, scrotum, and legs had filled with fluid. One day, he woke up unable to move his right leg or control his bowels. He was admitted to the hospital, where I met him as an intern on the neurosurgical team. We found that

the cancer had spread to his thoracic spine, where it was compressing his spinal cord. The cancer couldn't be cured, but we hoped it could be treated. Emergency radiation, however, failed to shrink the cancer, and so the neurosurgeon offered him two options: comfort care or

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surgery to remove the growing tumor mass from his spine. Lazaroff chose surgery. My job, as the intern on

the neurosurgery service, was to get his written confirmation that he understood the risks of the operation and wished to proceed.

I'd stood outside his room, his chart in my damp hand, trying to figure out how to even broach the subject with him. The hope was that the operation would halt the progression of his spinal cord damage. It wouldn't cure him, or reverse his paralysis, or get him back to the life he had led. No matter what we did he had at most a few months to live, and the procedure was inherently dangerous. It required opening his chest, removing a rib, and collapsing a lung to get at his spine. Blood loss would be high. Recovery would be difficult. In his

weakened state, he faced considerable risks of debilitating complications afterward. The operation posed a threat of both worsening and shortening his life. But the neurosurgeon had gone over these dangers, and Lazaroff had been clear that he wanted the operation. All I had to do was go in and take care of the paperwork.

Lying in his bed, Lazaroff looked gray and emaciated. I said that I was an intern and that I'd come to get his consent for surgery, which required confirming that he was aware of the risks. I said that the operation could remove the tumor but leave him with serious complications, such as paralysis or a stroke, and that it could even prove fatal. I tried to sound clear without being harsh, but my discussion put his back up. Likewise when his son, who was in the room, questioned whether

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heroic measures were a good idea. Lazaroff didn't like that at all.

"Don't you give up on me," he said. "You give me every chance I've got." Outside the room, after he signed the form, the son took me aside. His mother had died on a

ventilator in intensive care, and at the time his father had said he did not want anything like that to happen to him.

But now he was adamant about doing “everything.”

I believed then that Mr. Lazaroff had chosen badly, and I still believe this. He chose badly not because of all the dangers but because the operation didn’t stand a chance of giving him what he really wanted: his continence, his strength, the life he had previously known. He was pursuing little more than a fantasy at the risk of a prolonged and terrible death—which was precisely what he got.

The operation was a technical success. Over eight and a half hours, the surgical team removed the mass invading his spine and rebuilt the vertebral body with acrylic cement. The pressure on his spinal cord was gone. But he never recovered from the procedure. In intensive care, he developed respiratory failure, a systemic infection, blood clots from his immobility, then bleeding from the blood thinners to treat them. Each day we fell further behind. We finally had to admit he was dying. On the fourteenth

day, his son told the team that we should stop.

It fell to me to take Lazaroff off the artificial ventilator that was keeping him alive. I checked to make sure that his morphine drip was turned up high, so he wouldn't suffer from air hunger. I leaned close and, in case he

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could hear me, said I was going to take the breathing tube out of his mouth. He coughed a couple of times when I

pulled it out, opened his eyes briefly, and closed them.

His breathing grew labored, then stopped. I put my stethoscope on his chest and heard his heart fade away.

Now, more than a decade after I first told Mr. Lazaroff's story, what strikes me most is not how bad his decision was but how much we all avoided talking honestly about the choice before him. We had no difficulty explaining the specific dangers of various treatment options, but we never really touched on the reality of his disease. His oncologists, radiation therapists, surgeons, and other doctors had all seen him through months of treatments for a problem that they knew could not be cured. We could never bring ourselves to discuss the larger truth about his

condition or the ultimate limits of our capabilities, let alone what might matter most to him as he neared the end of his life. If he was pursuing a delusion, so were we. Here he was in the hospital, partially paralyzed from a cancer that had spread throughout his body. The chances that he could return to anything like the life he had even a few weeks earlier were zero. But admitting this and helping him cope with it seemed beyond us. We offered no acknowledgment or comfort or guidance. We just had another treatment he could undergo. Maybe something very good would result.

We did little better than Ivan Ilyich's primitive nineteenth-century doctors—worse, actually, given the new forms of physical torture we'd inflicted on our patient. It is enough to make you wonder, who are the primitive ones.

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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 health care professionals. And we in the medical world have proved alarmingly unprepared for it.

This reality has been largely hidden, as the final phases of life become less familiar to people. As recently as 1945, most deaths occurred in the home. By the 1980s, just 17 percent did. Those who somehow did die at home likely died too suddenly to make it to the hospital—say, from a massive heart attack, stroke, or violent injury—or were too isolated to get somewhere that could provide help.

Across not just the United States but also the entire industrialized world, the experience of advanced aging and death has shifted to hospitals and nursing homes.

When I became a doctor, I crossed over to the other side of the hospital doors and, although I had grown up with two doctors for parents, everything I saw was new to me.

I had certainly never seen anyone die before and when I did it came as a shock. That wasn't because it made me think of my own mortality. Somehow the concept didn't occur to me, even when I saw people my own age die. I

had a white coat on; they had a hospital gown. I couldn't quite picture it the other way round. I could, however, picture my family in their places. I'd seen multiple family members—my wife, my parents, and my children—go through serious, life-threatening illnesses. Even under dire circumstances, medicine had always pulled them through. The shock to me therefore was seeing medicine

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not pull people through. I knew theoretically that my patients could die, of course, but every actual instance

seemed like a violation, as if the rules I thought we were playing by were broken. I don't know what game I thought this was, but in it we always won.

Dying and death confront every new doctor and nurse.

The first times, some cry. Some shut down. Some hardly notice. When I saw my first deaths, I was too guarded to cry. But I dreamt about them. I had recurring nightmares in which I'd find my patients' corpses in my house—in my own bed.

"How did he get here?" I'd wonder in panic.

I knew I would be in huge trouble, maybe criminal

trouble, if I didn't get the body back to the hospital without getting caught. I'd try to lift it into the back of my car, but it would be too heavy. Or I'd get it in, only to find blood seeping out like black oil until it overflowed the trunk. Or I'd actually get the corpse to the hospital and onto a gurney, and I'd push it down hall after hall, trying and failing to find the room where the person used to be. "Hey!" someone would shout and start chasing me. I'd wake up next to my wife in the dark, clammy and tachycardic. I felt that I'd killed these people. I'd failed. Death, of course, is not a failure. Death is normal. Death may be the enemy, but it is also the natural order of things. I knew these truths abstractly, but I didn't know them concretely—that they could be truths not just for everyone but also for this person right in front of me, for this person I was responsible for.

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The late surgeon Sherwin Nuland, in his classic book *How We Die*, lamented, "The necessity of nature's final victory was expected and accepted in generations before

our own. Doctors were far more willing to recognize the

signs of defeat and far less arrogant about denying them.”

But as I ride down the runway of the twenty-first century, trained in the deployment of our awesome arsenal of technology, I wonder exactly what being less arrogant really means.

You become a doctor for what you imagine to be the satisfaction of the work, and that turns out to be the satisfaction of competence. It is a deep satisfaction very much like the one that a carpenter experiences in restoring a fragile antique chest or that a science teacher experiences in bringing a fifth grader to that sudden, mind-shifting recognition of what atoms are. It comes partly from being helpful to others. But it also comes from being technically skilled and able to solve difficult, intricate problems. Your competence gives you a secure sense of identity. For a clinician, therefore, nothing is more threatening to who you think you are than a patient with a problem you cannot solve.

There's no escaping the tragedy of life, which is that we are all aging from the day we are born. One may even

come to understand and accept this fact. My dead and dying patients don't haunt my dreams anymore. But that's not the same as saying one knows how to cope with what cannot be mended. I am in a profession that has succeeded because of its ability to fix. If your problem is fixable, we know just what to do. But if it's not? The fact that we have had no adequate answers to this question is

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troubling and has caused callousness, inhumanity, and extraordinary suffering.

This experiment of making mortality a medical experience is just decades old. It is young. And the evidence is it is failing.

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. As I pass a decade in surgical practice and become middle-aged myself, I find that neither I nor my patients find our current state tolerable. But I have also found it unclear what the

answers should be, or even whether any adequate ones are possible. I have the writer's and scientist's faith, however, that by pulling back the veil and peering in close, a person can make sense of what is most confusing or strange or disturbing.

You don't have to spend much time with the elderly or those with terminal illness to see how often medicine fails the people it is supposed to help. The waning days of our lives are given over to treatments that addle our brains and sap our bodies for a sliver's chance of benefit. They are spent in institutions—nursing homes and intensive care units—where regimented, anonymous routines cut us off from all the things that matter to us in life. 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.

I wrote this book in the hope of understanding what has happened. Mortality can be a treacherous subject. Some will be alarmed by the prospect of a doctor's writing about the inevitability of decline and death. For many, such talk, however carefully framed, raises the specter of a society readying itself to sacrifice its sick and aged. But what if the sick and aged are *already* being sacrificed—victims of our refusal to accept the inexorability of our life cycle? And what if there are better approaches, right in front of our eyes, waiting to be recognized?

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1 • *The Independent Self*

Growing up, I never witnessed serious illness or the difficulties of old age. My parents, both doctors, were fit and healthy. They were immigrants from India, raising me and my sister in the small college town of Athens, Ohio, so my grandparents were far away. The one elderly person I regularly encountered was a woman down the street who gave me piano lessons when I was in middle

school. Later she got sick and had to move away, but it didn't occur to me to wonder where she went and what happened to her. The experience of a modern old age was entirely outside my perception.

In college, however, I began dating a girl in my dorm named Kathleen, and in 1985, on a Christmas visit to her home in Alexandria, Virginia, I met her grandmother Alice Hobson, who was seventy-seven at the time. She struck me as spirited and independent minded. She never tried to disguise her age. Her undyed white hair was brushed straight and parted on one side, Bette Davis-style. Her hands were speckled with age spots, and her skin was crinkled. She wore simple, neatly pressed blouses and dresses, a bit of lipstick, and heels long past when others would have considered it advisable.

As I came to learn over the years—for I would eventually marry Kathleen—Alice grew up in a rural Pennsylvania town known for its flower and mushroom farms. Her father was a flower farmer, growing carnations, marigolds, and dahlias, in acres of greenhouses. Alice and

her siblings were the first members of their family to attend college. At the University of Delaware, Alice met

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Richmond Hobson, a civil engineering student. Thanks to the Great Depression, it wasn't until six years after their

graduation that they could afford to get married. In the early years, Alice and Rich moved often for his work.

They had two children, Jim, my future father-in-law, and then Chuck. Rich was hired by the Army Corps of Engineers and became an expert in large dam and bridge construction. A decade later, he was promoted to a job working with the corps's chief engineer at headquarters outside Washington, DC, where he remained for the rest of his career. He and Alice settled in Arlington. They bought a car, took road trips far and wide, and put away some money, too. They were able to upgrade to a bigger house and send their brainy kids off to college without need of loans.

Then, on a business trip to Seattle, Rich had a sudden heart attack. He'd had a history of angina and took nitroglycerin tablets to relieve the occasional bouts of

chest pain, but this was 1965, and back then doctors didn't have much they could do about heart disease. He died in the hospital before Alice could get there. He was just sixty years old. Alice was fifty-six.

With her pension from the Army Corps of Engineers, she was able to keep her Arlington home. When I met her, she'd been living on her own in that house on Greencastle Street for twenty years. My in-laws, Jim and Nan, were nearby, but Alice lived completely independently. She mowed her own lawn and knew how to fix the plumbing. She went to the gym with her friend Polly. She liked to sew and knit and made clothes, scarves, and elaborate red-and-green Christmas stockings for everyone in the

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family, complete with a button-nosed Santa and their names across the top. She organized a group that took an annual subscription to attend performances at the Kennedy Center for the Performing Arts. She drove a big V8 Chevrolet Impala, sitting on a cushion to see over the dashboard. She ran errands, visited family, gave friends rides, and delivered meals-on-wheels for those with more

frailties than herself.

As time went on, it became hard not to wonder how much longer she'd be able to manage. She was a petite woman, five feet tall at most, and although she bristled when anyone suggested it, she lost some height and strength with each passing year. When I married her granddaughter, Alice beamed and held me close and told me how happy the wedding made her, but she'd become too arthritic to share a dance with me. And still she remained in her home, managing on her own.

When my father met her, he was surprised to learn she lived by herself. He was a urologist, which meant he saw many elderly patients, and it always bothered him to find them living alone. The way he saw it, if they didn't already have serious needs, they were bound to develop them, and coming from India he felt it was the family's responsibility to take the aged in, give them company, and look after them. Since arriving in New York City in 1963 for his residency training, my father had embraced virtually every aspect of American culture. He gave up

vegetarianism and discovered dating. He got a girlfriend, a pediatrics resident from a part of India where they didn't speak his language. When he married her, instead of letting my grandfather arrange his marriage, the family

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was scandalized. He became a tennis enthusiast, president of the local Rotary Club, and teller of bawdy jokes. One

of his proudest days was July 4, 1976, the country's bicentennial, when he was made an American citizen in front of hundreds of cheering people in the grandstand at the Athens County Fair between the hog auction and the demolition derby. But one thing he could never get used to was how we treat our old and frail—leaving them to a life alone or isolating them in a series of anonymous facilities, their last conscious moments spent with nurses and doctors who barely knew their names. Nothing could have been more different from the world he had grown up in.

MY FATHER'S FATHER had the kind of traditional old age that, from a Western perspective, seems idyllic. Sitaram Gawande was a farmer in a village called Uti, some three

hundred miles inland from Mumbai, where our ancestors had cultivated land for centuries. I remember visiting him with my parents and sister around the same time I met Alice, when he was more than a hundred years old. He was, by far, the oldest person I'd ever known. He walked with a cane, stooped like a bent stalk of wheat. He was so hard of hearing that people had to shout in his ear through a rubber tube. He was weak and sometimes needed help getting up from sitting. But he was a dignified man, with a tightly wrapped white turban, a pressed, brown argyle cardigan, and a pair of old-fashioned, thick-lensed, Malcolm X-style spectacles. 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

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family. When we ate, we served him first. When young people came into his home, they bowed and touched his feet in supplication.

In America, he would almost certainly have been placed

in a nursing home. 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. If you cannot shop for yourself, prepare your own food, maintain your housekeeping, do your laundry, manage your medications, make phone calls, travel on your own, and handle your finances—the eight “Independent Activities of Daily Living”—then you lack the capacity to live safely on your own.

My grandfather could perform only some of the basic measures of independence, and few of the more complex ones. But in India, this was not of any dire consequence. His situation prompted no family crisis meeting, no anguished debates over what to do with him. It was clear that the family would ensure my grandfather could continue to live as he desired. One of my uncles and his family lived with him, and with a small herd of children,

grandchildren, nieces, and nephews nearby, he never lacked for help.

The arrangement allowed him to maintain a way of life that few elderly people in modern societies can count on.

The family made it possible, for instance, for him to continue to own and manage his farm, which he had built up from nothing—indeed, from worse than nothing. His

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father had lost all but two mortgaged acres and two emaciated bulls to a moneylender when the harvest failed

one year. He then died, leaving Sitaram, his eldest son, with the debts. Just eighteen years old and newly married, Sitaram was forced to enter into indentured labor on the family's two remaining acres. At one point, the only food he and his bride could afford was bread and salt. They were starving to death. But he prayed and stayed at the plow, and his prayers were answered. The harvest was spectacular. He was able to not only put food on the table but also pay off his debts. In subsequent years, he expanded his two acres to more than two hundred. He became one of the richest landowners in the village and a

moneylender himself. He had three wives, all of whom he outlived, and thirteen children. He emphasized education, hard work, frugality, earning your own way, staying true to your word, and holding others strictly accountable for doing the same. Throughout his life, he awoke before sunrise and did not go to bed until he'd done a nighttime inspection of every acre of his fields by horse. Even when he was a hundred he would insist on doing this. My uncles were worried he'd fall—he was weak and unsteady—but they knew it was important to him. So they got him a smaller horse and made sure that someone always accompanied him. He made the rounds of his fields right up to the year he died.

Had he lived in the West, this would have seemed absurd. It isn't safe, his doctor would say. If he persisted, then fell, and went to an emergency room with a broken hip, the hospital would not let him return home. They'd insist that he go to a nursing home. But in my grandfather's

premodern world, how he wanted to live was his choice, and the family's role was to make it possible.

My grandfather finally died at the age of almost a hundred and ten. It happened after he hit his head falling off a bus. He was going to the courthouse in a nearby town on business, which itself seems crazy, but it was a priority to him. The bus began to move while he was getting off and, although he was accompanied by family, he fell. Most probably, he developed a subdural hematoma—bleeding inside his skull. My uncle got him home, and over the next couple of days he faded away. He got to live the way he wished and with his family around him right to the end.

FOR MOST OF human history, for those few people who actually survived to old age, Sitaram Gawande's experience was the norm. Elders were cared for in multigenerational systems, often with three generations living under one roof. Even when the nuclear family replaced the extended family (as it did in northern Europe several centuries ago), the elderly were not left to cope with the infirmities of age on their own. Children typically left home as soon as they were old enough to

start families of their own. But one child usually remained, often the youngest daughter, if the parents survived into senescence. This was the lot of the poet Emily Dickinson, in Amherst, Massachusetts, in the mid-nineteenth century. Her elder brother left home, married, and started a family, but she and her younger sister stayed with their parents until they died. As it happened, Emily's father lived to the age of seventy-one, by which time she was in her forties, and her mother

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lived even longer. She and her sister ended up spending their entire lives in the parental home.

As different as Emily Dickinson's parents' life in America seems from that of Sitaram Gawande's in India, both relied on systems that shared the advantage of easily resolving the question of care for the elderly. There was no need to save up for a spot in a nursing home or arrange for meals-on-wheels. It was understood that parents would just keep living in their home, assisted by one or more of the children they'd raised. 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. How did this happen? How did we go from Sitaram Gawande's life to Alice Hobson's?

One answer is that old age itself has changed. In the past, surviving into old age was uncommon, and those who did survive served a special purpose as guardians of tradition, knowledge, and history. They tended to maintain their status and authority as heads of the household until death. In many societies, elders not only commanded respect and obedience but also led sacred rites and wielded political power. So much respect accrued to the elderly that people used to pretend to be older than they were, not younger, when giving their age. People have always lied about how old they are. Demographers call the phenomenon “age heaping” and have devised complex quantitative contortions to correct for all the lying in censuses. They have also noticed that, during the eighteenth century, in the United States and Europe, the

direction of our lies changed. Whereas today people often understate their age to census takers, studies of past

censuses have revealed that they used to overstate it. The dignity of old age was something to which everyone aspired.

But age no longer has the value of rarity. In America, in 1790, people aged sixty-five or older constituted less than 2 percent of the population; today, they are 14 percent. In Germany, Italy, and Japan, they exceed 20 percent. China is now the first country on earth with more than 100 million elderly people.

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. New technology also creates new occupations and requires new expertise, which further undermines the value of long experience and seasoned judgment. At one time, we might have turned to an old-timer to explain the world. Now we consult Google, and if we have any trouble with

the computer we ask a teenager.

Perhaps most important of all, increased longevity has brought about a shift in the relationship between the young and the old. Traditionally, surviving parents provided a source of much-needed stability, advice, and economic protection for young families seeking pathways to security. And because landowners also tended to hold on to their property until death, the child who sacrificed everything to care for the parents could expect to inherit the whole homestead, or at least a larger portion than a child who moved away. But once parents were living

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markedly longer lives, tension emerged. For young people, the traditional family system became less a source

of security than a struggle for control—over property, finances, and even the most basic decisions about how they could live.

And indeed, in my grandfather Sitaram's traditional household, generational tension was never far away. You can imagine how my uncles felt as their father turned a hundred and they entered old age themselves, still waiting

to inherit land and gain economic independence. I learned of bitter battles in village families between elders and adult children over land and money. In the final year of my grandfather's life, an angry dispute erupted between him and my uncle with whom he lived. The original cause was unclear: perhaps my uncle had made a business decision without my grandfather; maybe my grandfather wanted to go out and no one in the family would go with him; maybe he liked to sleep with the window open and they liked to sleep with the window closed. Whatever the reason, the argument culminated (depending on who told the story) in Sitaram's either storming out of the house in the dead of night or being locked out. He somehow made it miles away to another relative's house and refused to return for two months.

Global economic development has changed opportunities for the young dramatically. The prosperity of whole countries depends on their willingness to escape the shackles of family expectation and follow their own path—to seek out jobs wherever they might be, do

whatever work they want, marry whom they desire. So it was with my father's path from Uti to Athens, Ohio. He

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left the village first for university in Nagpur and then for professional opportunity in the States. As he became

successful, he sent ever larger amounts of money home, helping to build new houses for his father and siblings, bring clean water and telephones to the village, and install irrigation systems that ensured harvests when the rainy seasons were bad. He even built a rural college nearby that he named for his mother. But there was no denying that he had left, and he wasn't going back.

Disturbed though my father was by the way America treated its elderly, the more traditional old age that my grandfather was able to maintain was possible only because my father's siblings had not left home as he had. We think, nostalgically, that we want the kind of old age my grandfather had. But the reason we do not have it is that, in the end, we do not actually want it. The historical pattern is clear: as soon as people got the resources and opportunity to abandon that way of life, they were gone.

THE FASCINATING THING is that, over time, it doesn't seem that 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. Instead, with growing economies, a shift in the pattern of property ownership occurred. As children departed home for opportunities elsewhere, parents who lived long lives found they could rent or even sell their land instead of handing it down.

Rising incomes, and then pension systems, enabled more and more people to accumulate savings and property, allowing them to maintain economic control of their lives in old age and freeing them from the need to work until

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death or total disability. The radical concept of "retirement" started to take shape.

Life expectancy, which was under fifty in 1900, climbed to more than sixty by the 1930s, as improvements in nutrition, sanitation, and medical care took hold. Family sizes fell from an average of seven children in the

mid-1800s to just over three after 1900. The average age at which a mother had her last child fell too—from menopause to thirty or younger. As a result, vastly more people lived to see their children reach adulthood. In the early twentieth century, a woman would have been fifty when her last child turned twenty-one, instead of in her sixties a century before. Parents had many years, easily a decade or more, before they or their children had to worry about old age.

So what they did was move on, just like their children. 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.”

Whereas in early-twentieth-century America 60 percent of those over age sixty-five resided with a child, by the 1960s the proportion had dropped to 25 percent. By 1975 it was below 15 percent. The pattern is a worldwide one. Just 10 percent of Europeans over age eighty live with their children, and almost half live completely alone,

without a spouse. In Asia, where the idea of an elderly parent being left to live alone has traditionally been regarded as shameful—the way my father saw it—the same radical shift is taking place. In China, Japan, and

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Korea, national statistics show the percentage of elderly living alone rising rapidly.

This is actually a sign of enormous progress. Choices for the elderly have proliferated. 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. It was a controversial idea at the time. Most developers believed the elderly wanted more contact with other generations. Webb disagreed. He believed people in the last phase of their lives didn’t want to live the way my grandfather did, with the family underfoot. He built Sun City as a place with an alternate vision of how people would spend what he called “their leisure years.” It had a golf course, a shopping arcade, and a recreation center, and it offered the prospect of an

active retirement of recreation and dining out with others like them to share it with. Webb's vision proved massively popular, and in Europe, the Americas, and even Asia, retirement communities have become a normal presence.

For those who had no interest in moving into such places—Alice

Hobson,

for

instance—it

became

acceptable and feasible to remain in their own homes,

living as they wanted to live, autonomously. That fact

remains something to celebrate. There is arguably no

better time in history to be old. The lines of power

between the generations have been renegotiated, and not

in the way it is sometimes believed. The aged did not lose

status and control so much as share it. Modernization did

not demote the elderly. It demoted the family. It gave

people—the young and the old—a way of life with more liberty and control, including the liberty to be less

beholden to other generations. 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.

THERE REMAINS ONE problem with this way of living.

Our reverence for independence takes no account of the reality of what happens in life: sooner or later, independence will become impossible. Serious illness or infirmity will strike. It is as inevitable as sunset. And then a new question arises: If independence is what we live

for, what do we do when it can no longer be sustained?

In 1992, Alice turned eighty-four. She was in striking health. She'd had to make a transition to false teeth and undergo removal of cataracts in both eyes. That was all. She'd had no major illnesses or hospitalizations. She still went to the gym with her friend Polly and did her own shopping and took care of her house. Jim and Nan offered her the option of turning their basement into an apartment for her. She might find it easier to be there, they said. She

wouldn't hear of it. She had no intention of not living on her own.

But things began to change. On a mountain vacation with the family, Alice didn't turn up for lunch. She was found sitting in the wrong cabin, wondering where everyone was. We'd never seen her confused like that before. The family kept a close eye on her for the next few days, but nothing else untoward happened. We all let the matter drop.

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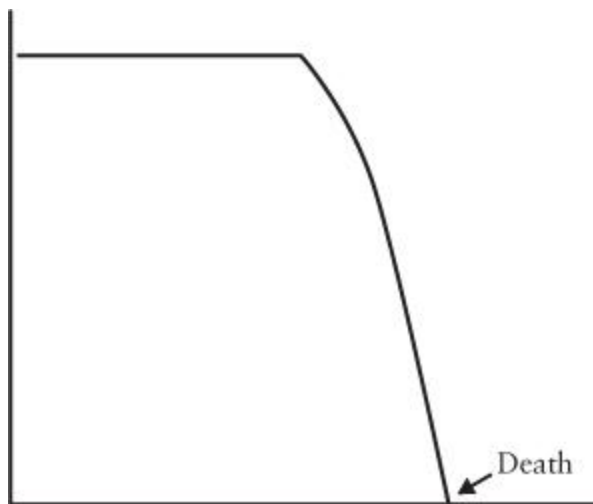
Then Nan, visiting Alice at home one afternoon, noticed black-and-blue bruises up and down her leg. Had she fallen?

No, Alice said at first. But later she admitted that she'd taken a spill going down the wooden basement stairs. It was just a slip, she insisted. It could have happened to anyone. She'd be more careful next time.

Soon, however, she had more falls, several of them. No broken bones, but the family was getting worried. So Jim did what all families naturally do nowadays. He had her see a doctor.

The doctor did some tests. He found that she had thinning bones and recommended calcium. He fiddled with her medications and gave her some new prescriptions. But the truth was he didn't know what to do. We were not bringing him a fixable problem. Alice was unsteady. Her memory was slipping. The problems were only going to increase. Her independence would not be sustainable for long now. But he had no answers or direction or guidance. He could not even describe what to expect would happen.

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2 • *Things Fall Apart*

Medicine and public health have transformed the trajectory of our lives. For all but our most recent history,

death was a common, ever-present possibility. It didn't matter whether you were five or fifty. Every day was a roll of the dice. If you plotted the typical course of a person's health, it would look like this:

Life and health would putter along nicely, not a problem in the world. Then illness would hit and the bottom would drop out like a trap door—the way it did for my grandmother Gopikabai Gawande, who'd been perfectly well until the day she was struck by a fatal case of malaria, not even thirty years old, or for Rich Hobson, who had a heart attack on a business trip and then was gone.

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Over the years, with medical progress, the bottom has tended to drop out later and later. The advent of sanitation

and other public health measures sharply reduced the likelihood of death from infectious disease, especially in early childhood, and clinical advances dramatically reduced the mortality of childbirth and traumatic injuries.

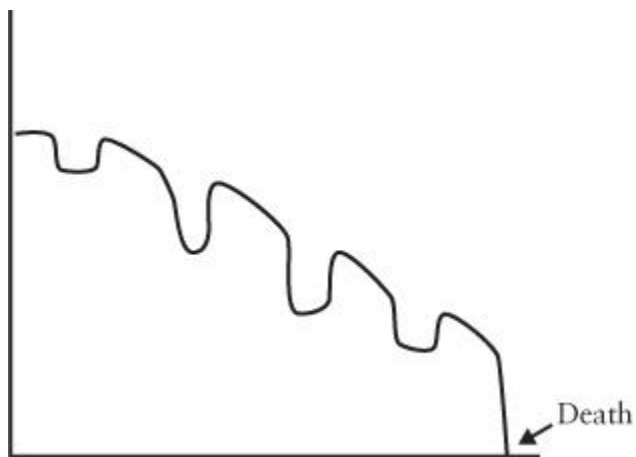
By the middle of the twentieth century, just four out of every hundred people in industrialized countries died

before the age of thirty. And in the decades since, medicine found ways to cut the mortality of heart attacks, respiratory illnesses, stroke, and numerous other conditions that threaten in adult life. Eventually, of course, we all die of something. But even then, medicine has pushed the fatal moment of many diseases further outward. People with incurable cancers, for instance, can do remarkably well for a long time after diagnosis. They undergo treatment. Symptoms come under control. They resume regular life. They don't feel sick. But the disease, while slowed, continues progressing, like a night brigade taking out perimeter defenses. Eventually, it makes itself known, turning up in the lungs, or in the brain, or in the spine, as it did with Joseph Lazaroff. From there, the decline is often relatively rapid, much as in the past. Death occurs later, but the trajectory remains the same. In a matter of months or weeks, the body becomes overwhelmed. That is why, although the diagnosis may have been present for years, death can still come as a surprise. The road that seemed so straight and steady can

still disappear, putting a person on a fast and steep slide down.

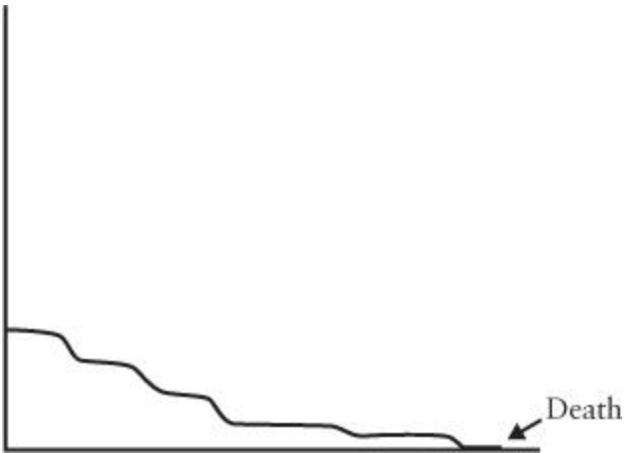
The pattern of decline has changed, however, for many chronic illnesses—emphysema, liver disease, and

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congestive heart failure, for example. Instead of just delaying the moment of the downward drop, our treatments can stretch the descent out until it ends up looking less like a cliff and more like a hilly road down the mountain:

The road can have vertiginous drops but also long patches of recovered ground: we may not be able to stave off the damage, but we can stave off the death. We have drugs, fluids, surgery, intensive care units to get people through. They enter the hospital looking terrible, and some of what we do can make them look worse. But just when it looks like they've breathed their last, they rally. We make it possible for them to make it home—weaker and more impaired, though. They never return to their previous baseline. As illness progresses and organ damage worsens, a person becomes less able to withstand even minor problems. A simple cold can be fatal. The ultimate course is still downward until there finally comes a time when there is no recovery at all.



The trajectory that medical progress has made possible for many people, though, follows neither of these two patterns. Instead, 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