Family medicine, fast and slow

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If everything seems under control, you're not going fast enough.

Mario Andretti

Late last autumn in my office I saw Barbara, a 63-year-old woman who a year earlier had been diagnosed with an aggressive form of pancreatic cancer. The cancer had recently spread to her liver and her oncologist had recommended that she enrol in a clinical trial of a new chemotherapeutic regimen. Overwhelmed with fear and uncertainty while at the oncologist's office, she had booked the appointment with me, her family physician for many years, to discuss her options. A few days earlier she had e-mailed a copy of the treatment protocol, allowing me the time to consider the risks and benefits and to think about the questions I should ask to help her make the right decision.

Later that same day I saw David, a 54-year-old man, for his periodic health examination. He was particularly concerned about being screened for prostate cancer, as an office colleague had recently been diagnosed with the disease.

As a young family physician running a family medicine inpatient service at a busy downtown teaching hospital and building a practice and an academic career while juggling the responsibilities and roles of raising 3 young children, Mario Andretti's quotation was one of my favourites. I wore it like a badge of honour. For the first 15 years of my career things were rarely under control.

When I look back, in my professional life every working hour was divided into 15-minute pieces that made it feel like I sprinted through each day. In large part this was driven by a fee-for-service model of payment that was arbitrarily determined by insurance service codes based on diagnostic complexity—a capitalistic model where money is tied to a clock.[1] The effect of this was "one visit, one problem" thinking and a lack of attentiveness that is now epidemic in our society.[2] This worked out well enough if the presenting problems were simple—a rash, an ear infection, or a sore throat—but for most of the patients I saw each day it was likely not enough.[3]

Almost a decade ago, with the establishment of family health teams in Ontario and the move to a capitation model of payment that coincided with the implementation of the electronic medical record in our clinic, I was serendipitously forced to begin to practise what I called *slow medicine*—reducing the number of patients that I saw in the course of the day in order to adapt to the considerable change in our model of care. It turns out that, like most good ideas, someone else had thought about it long before it occurred to me. Like the "slow food" movement, slow medicine also has its origins in Italy, heralded by the publication of a paper in the *Italian Heart Journal* calling for a more considered approach to cardiac interventions.[4] The slow medicine movement has grown, especially in Europe, and has as its tenets making time for listening and understanding, individualizing care, practising shared decision making, and focusing on "positive health," among others.[5,6]

As a family physician with an aging practice, faced daily with patients with complex and interacting health problems,[7] being able to practise slow medicine when it is needed has been a boon. The benefits of slow medicine have been manifold, for both my patients and me. These include being more attentive and fully present at each encounter, increasingly using a narrative[8-10] and trauma-informed approach to the care that I provide,[11] and having the time to help my patients navigate important medical decisions—whether it is to enrol in a clinical trial of chemotherapy or to fully engage in shared decision making for preventive care, such as the choice to be screened for prostate cancer (**page 502**).[12]

There is so much at stake when we inappropriately practise fast medicine and fail to slow down when needed: regret on the part of the person, regret on the part of the doctor, and the failure to savour the meaningful work that we do.

References

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