‘Can You Prescribe Something?’

It’s tough to convince family when exercise, not pills, is the medicine they need.

by Audrey Young

My mother telephones me on my day off. “Can you prescribe something for your grandmother?” she asks. She is talking about her Chinese-born mother, who lives in Indonesia and who seems to me in the half-dozen times we’ve met only remotely related to my family. I admire my grandmother greatly. She chain-smokes, wears Escada suits and bright jewels; she speaks loudly, like a Chinese soap opera matriarch. She once owned a textile factory that grossed millions, until workers burned it down and she sold it at a loss. Before I started medical school, she told my mother, “Forget that. She won’t be a good doctor. Send her to me, and I’ll teach her business.”

Grandmother is eighty now and jets between Hong Kong, Singapore, and Indonesia, making social visits among her extensive family. She’s weighing a business venture with a computer scientist in mainland China, where everyone is getting rich, she says.

Mom calls to tell me that Grandmother feels weak. She’s lost weight and doesn’t feel like getting out of bed. She’s consulted a Chinese herbalist and applied various poultices to her tired muscles, but it hasn’t helped. Mom gets right to the heart of the matter: Do I know of medicine that will improve Grandmother’s strength?

Mom often asks me for medication. To her and Dad, prescribing drugs is a filial obligation; they footed my medical school bill, after all. I don’t like it, but I know Mom’s in a tough spot. In an extended Asian family, she’s the only one who became an American; she’s the eldest and most responsible of a tribe of siblings who are preoccupied with how Grandmother’s numerous properties will soon be dispersed. And so, as a daughter who happens to be a general internist, I feel she’s owed a sympathetic ear.

“What did the doctors find?”

“I guess there’s nothing wrong. They did all sorts of tests. But it’s Indonesia. They are not very advanced.”

“Medicine can’t help when you don’t know what’s wrong,” I responded. “Sometimes it can make things worse. If the problem is that she’s weak, she should start using her body. If she doesn’t get some kind of exercise, nothing can replace that. Maybe she should see a physical therapist.”

Audrey Young (auyoung@u.washington.edu) is a general internist at Harborview Medical Center in Seattle, Washington, and the author of What Patients Taught Me: A Medical Student’s Journey (Sasquatch Books, 2004). [Health Affairs 25, no. 1 (2006): 226–230]
“Isn’t there a medication to increase strength?” Mom sounds disappointed.
“Not that I know of. Sorry.”
Realistically, I recognize that my grandmother is not going to exercise, that what I’m advocating is entirely hypothetical. Exercise just isn’t practiced in my grandmother’s culture, where physical activity signals poverty. Grandmother doesn’t even drive—her chauffeur does that—and the cook walks to the markets and does the shopping.

I suppose I’m making the point for Mom’s benefit. I’m trying to tell her that there aren’t miracle compounds to bring back youth and energy. In my specialty—general internal medicine—the best medications can only combat disease. But I think that health is more than just the absence of disease, more than just the status quo. To my mind, health is a state of regular physical and mental activity. Use it or lose it, as the geriatricians say.

“She doesn’t want to eat, either,” Mom says.
“Can she get another opinion?”
“Maybe she can go to Singapore.”

Naturally, Grandmother refused to go to Singapore. The last thing she wanted was to spend her little time left seeing doctors.

**A Counter Of Pills**

Some years later, the grandmother on Dad’s side of the family complains of feeling weak. “Can you visit her?” Dad asks me. This grandmother lives just twenty miles from me, in a suburban townhouse filled with orchids. She loves doctors, and her medical complaints and doctor visits have increased since her husband died. I insist that she see her regular physician before I visit. Not long afterward, Dad calls to say, “There’s nothing more for them to do”—as though she was in the throes of dying. So I telephone my grandmother to tell her that I’m coming over. When I arrive, she’s on the couch waiting for me. She certainly doesn’t look sick. She’s dyed her hair jet black. She stands and goes immediately to the kitchen counter where all of her nutritional supplements are arranged, an amassed set of purchases intended to improve her eyesight, her urinary tract, her heart. I’ve seen and commented on some of these bottles before.

Grandmother plucks one from the counter and says, “How is this one?” She’s spent thirty dollars on a special fish oil. I study the label.

“It’s probably good for you.” I pick out the bottles of calcium and vitamin D and push aside the rest. “These are important. Take three of the calcium every day, and one of the vitamin D.”

“OK,” she says, reaching for the pushed-aside bottles and moving them back.

“Are you getting out of the house? Are you walking?” I ask.

“I’m too tired. I have no power.”

“You have to walk, Po Po.” I use the Chinese phrase for “grandmother.” “You have
to use your muscles and get strong. Medicine can’t make you stronger.” She lives in a planned neighborhood with gardens and lovely, leafy trees. I’d planned ahead, and my dogs wait strategically in the car. I suggest that we all take a walk together.

“I can’t,” she says.

“Why not?”

“I’m too weak.”

“It’s beautiful outside today.”

“You go ahead,” she says.

Fine. How is it that her husband, who walked five miles a day until just before his death at age ninety, never took her along with him? If they had gone out for a stroll now and then, perhaps she’d be more inclined to now? Even if exercise probably won’t lengthen her life or prevent catastrophic disease, it would build muscle, stimulate her appetite, improve her fitful sleep. Exercise would help her feel well.

Later Mom asks, “Did you write her a prescription?”

“She’s got to walk, Mom,” I say. “More medicine is not what she needs.”

Some weeks later, after we all have lunch in the city, Dad offers to bring the car around to pick up Po Po.

“I’ll walk with her to the car,” Mom says.

“I can come get her,” Dad counters.

“She needs some exercise,” Mom says.

“It will make her tired,” Dad points out.

“Good,” I say.

It’s Complicated

D O N T B E Y O U R O W N F A M I L Y ’ S D O C T O R : I t is one of the inviolable rules. Everybody knows stories of unnecessary procedures performed on doctors’ relatives that end with bad or complicated outcomes or, alternatively, of diagnoses that wouldn’t have been missed with routine medical care. Leave the doctoring to someone who can be objective.

I’m happy to adhere to this rule. I couldn’t be more pleased that Mom’s doctor orders her mammogram and colonoscopy, then counsels her about their necessity when she refuses. Her doctor can check her cholesterol, talk about osteoporosis risk, encourage a multivitamin. I don’t want that kind of relationship with Mom. When Mom asks for a prescription, I ask her to go through her primary care doctor unless the circumstances seem especially urgent. What I can do, though, is check in with her regularly about her health—about what she’s reading, what she’s eating, and how she exercises. I try to provide her with lots of support, as any responsible family member does, plus some medical knowledge to back things up.

It’s considerably different from what I do for patients in the office or on the hospital wards at the county hospital where I practice. My clinic patients are refu-
gees, and most of the hospital patients are homeless or underserved in one fashion or another. Disease brings them to see me. Most often I treat their diseases with medications, sometimes a dozen at a time. I blunt chest pain, lower blood sugars, control blood pressures. Sometimes I help my patients return to their status quo; occasionally I lengthen their lives by years. And I talk with my patients about exercise because I believe that the evidence is convincing. Exercise can prevent the onset and complications of both diabetes and heart disease, two of the major diseases of our time. Exercise improves backaches, joint pain, and problems sleeping, both in controlled studies and with patients I care for. For many of these common conditions, regular exercise plus medication is the most potent therapy.

But frequently I find that counseling exercise brings a less-than-satisfactory response. My patients live in neighborhoods where the streets are dangerous and there isn't access to an open space appropriate for exercise. Most can barely pay for housing, transportation, and food; health club fees would be an unaffordable luxury, and so it's unusual that I can convince a patient to give exercise a serious chance. When I do, I know I'll need to devote precious minutes of subsequent office visits to following up and that the benefits of the exercise program I recommend are often not apparent to the patient. So my patients and I talk about exercise, and we keep talking, but often I revert to treating disease with just medication. Medication is easy. Medication works quickly; a single pill can bring down blood pressure, cause heartburn to subside. All that's needed is a pill in the mouth, a sip of water, and the patient feels better.

Exercise is more complicated. If our society is serious about creating healthy patients, we all—doctors and patients alike—need some serious help. Creating safe public spaces where people can exercise, indoors and out, should be the first step. Contiguous sidewalks in housing developments, for example, would facilitate exercise.

Every day in Seattle, where I live, public trails in upscale neighborhoods fill with walkers, joggers, roller bladers, and bikers. The sight of hundreds of people exercising is a constant reminder to get outside and get moving. Open public space has made exercise part of the culture. But public trails, and gyms such as the YMCA, need to be accessible in all neighborhoods, not only the most fashionable.

Another step toward a national culture of physical activity would be support for exercise counseling in primary care clinics. In its current form, exercise is a vast and vague concept for both patient and doctor. A recommendation to exercise “thirty minutes a day, most days of the week” contains very little that is useful to a patient. My own conversations with patients could be streamlined if there were structured guidelines to follow, crisp goals to aim at, or, better yet, a consultant (such as a personal trainer) who could follow patients' progress closely. I grasp for something to measure, something numerical such as duration and frequency of exercise, number of steps walked each day, heart rate goals—anything to help my patients and me recognize that their effort is leading to some gain.
Expectations for providers and clinics should be considered thoughtfully and tested in real practice situations. In my clinic, I talk about exercise during brief health maintenance visits, where it competes with cancer screening, smoking cessation questions, a glance at the day's blood pressure reading, and whatever is continuing to ail the patient. I have a difficult time counseling adequately about exercise in the three-to-five-minute office-visit window that the U.S. Preventive Services Task Force suggests. I like to assess the patient's environment, help select walking or bicycling or yoga, recommend a nearby pool, set goals, then later review the patient's performance, help troubleshoot, and motivate. All of this takes time. If we are really serious about having exercise counseling in primary care clinics, we need to pay for it. A CPT code and Medicare reimbursement would get the message across.

**Moving Toward Health**

Mom and Dad exercise regularly now. Mom swims most evenings at the club once they clear the kids out and rope off lap lanes. Dad won't get near the water; he acts as if he'll drown if he gets in deeper than his waist. He prefers playing tennis with his hitting partners of many years. He's tried running, but what he likes better is walking home from the courts along wooded trails. I've coaxed Mom to walk with him. Something to toughen the bones, I tell her. She's a small Asian woman and could use the weight-bearing exercise. She gives me that forget-about-it look and says, “I like to swim.”

Exercise is just about the only thing my parents do separately. They eat their meals together, watch business news shows together, shop at Costco together. But Mom's not interested in tennis and doesn't feel like socializing while she exercises. Dad won't swim. It makes me realize how intensely personal exercise is.

Exercise forces an awareness of one's living, sweating, imperfect body. It's nothing like the simple relationship between a person and a pill. I know that exercise can be unpleasant, can sometimes actually feel like illness. When I run, my stomach cramps and I become short of breath. I notice my troublesome right ankle, the noises that my lungs make, the soft rapid pulse at my wrist, my sinews and bones. But I also know the upside. I love the sensation of moving effortlessly along the trails near my home. I love feeling strong.

It's not a mental stretch to imagine how Mom feels when she pulls her swim goggles down over her eyes and eases underwater, the four-count rhythm of kick-pull-kick-breathe returning her to a more intuitive state of being. It's not a mental stretch to imagine Dad's satisfaction with a well-hit tennis ball, placed deep in a corner. Once they got into their individual rhythms, they've kept up their exercise routines.

Maybe I'm a bit surprised, but then again maybe I'm not. In the end, exercise ceases to feel like work and starts to feel, finally, like health.