DOES PHILOSOPHY HAVE A PLACE IN SLOW MEDICINE?

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ABSTRACT: If one were to tour a museum showcasing images of how we (as a modern culture in the U.S.) tend to the changing needs of our elders, we would be hard-pressed to find a full-blown exhibit on Slow-Medicine or philosophy. This is unfortunate. In my paper, I examine the aforementioned and argue that we should strive to create new "philosophically-informed" and "attentive" pictures of aging and caring for those we love. In support of this I discuss what philosophy and Slow Medicine entail and discuss where, in the process of Slow Medicine, philosophy might play a role. In the end, I claim that there *is* a place for philosophy in Slow Medicine insofar as it contributes to the practice (and supports its aims), is applicable across all stations of late life, and has therapeutic and practical value in both personal and professional settings by virtue of what it brings to the caregiving (and receiving) process – the benefits of which have positive, complex and far-reaching implications. As such, an alteration in our museum layouts that reveal a dramatic change in landscape about late-life care and the import of philosophy is in order.

KEYWORDS/NAMES: aging, caregiving, care receiving, Dennis McCullough, ethics, elders, end-of-life care, geriatrics, healthcare, LBT, philosophy, philosophical counseling, qualitative living, Slow Medicine

INTRODUCTION[2]

If one were to tour a museum showcasing images of how we (as a modern U.S. culture) tend to the changing needs of our elders, we would (sadly) be hard-pressed to find a full-blown exhibit on Slow Medicine - an approach to late life care that "embraces the unsung work of daily attention" and "careful anticipatory 'attending'" to and of our aging loved ones.[3] We would likewise be hard-pressed to find any explicit images of philosophy in that galleries' annals, save perhaps exhibitions highlighting ethical quandaries surrounding end-of-life care, such as assisted suicide (for example). It is with this platform in mind, along with a sincere desire for the possibility of a different museum layout, that I cautiously and respectfully proceed.

In this paper, I examine how philosophy might be relevant to Slow Medicine. Beginning with the assumption that philosophy and Slow Medicine are positively correlated to well-being and quality of life, that both practices have intrinsic and extrinsic value, and that Slow Medicine is a practical approach to healthcare, I ask: *Does philosophy have a place in Slow*

Medicine? And if so, how? In order to answer this query, I first discuss what I mean by 'philosophy' and 'Slow Medicine,' and what, precisely, each entails. Then, I examine where, in the process of Slow Medicine, philosophy might play a role, focusing specifically on the questions: (a) How might Slow Medicine benefit from philosophy? (b) Is philosophy applicable across all "stations" of late life (a term used in Slow Medicine to signify "stages"), and (c) What sorts of therapeutic and practical value might obtain? In the end, I claim that philosophy *does* have a place in Slow Medicine insofar as it contributes to the practice (and supports its aims) via its methods, attributes, and fertile ground, is applicable across all stations of late life, and has therapeutic and practical value in both personal and professional settings[4] by virtue of what it brings to the caregiving (and receiving) process – the benefits of which have positive, complex and far-reaching implications. In light of this, we – our society and museums (metaphorically speaking) – should strive for new exhibits that reveal a dramatic change in landscape about late-life care and the import of philosophy, replete with "philosophically-informed" and "attentive" pictures of aging and caring for those we love.

EXHIBIT A: DEFINITIONS

Philosophy can be defined in a number of ways.[5] For the purposes of our discussion, what I mean by philosophy is that one approaches a topic of investigation in a way that honors critical thinking (or reasoning). This includes various methods commonly associated with philosophy, such as: (a) argument, (b) refutation, (c) systematic doubt, (d) dialectic, (e) justification (of beliefs), (f) logic, and so forth. It also means that one embrace several other attributes, including: a sense of wonder and imagination, open-mindedness, sincerity, humility, and dialectical justness, among others.[6] These methods and attributes perhaps best exemplify philosophy as *a thinking activity and way of life* and obtain regardless of one's conception of

philosophy—i.e., philosophy as theoretical or applied.[7] While there has been much debate about what differentiates theoretical from applied philosophy, the distinction can roughly be characterized as follows. Theoretical philosophy is concerned with answering or clarifying matters of thought, while applied philosophy is concerned with answering or clarifying matters of action. But this distinction is muddled at best due in part to the interdependence of belief and action,[8] and with respect to what one feels the aims (and value) of philosophy consist. Some philosophers maintain that philosophy's primary aim is strictly conceptual analysis[9] whilst others claim that its practitioners must (in addition to such analysis) translate those concepts into practical terms, so as to "forge a coherent mode of living."[10] While I give no greater attention to this matter here, the points raised against the applied-theoretical division and in favor of philosophy's conceptual and practical aims, find particular agreement with my account of philosophy. That is, *if* (as *Plato's Dialogues* suggest), philosophy is: to live the examined life,[11] to follow reason where it leads,[12] and to do so "so that [one could] be better for the rest of [her] life,"[13] then at base, philosophy is both theoretical and applied. It is a thinking activity and a way of life. Not one or the other. Thus, I treat the two analogously (as inseparable or "intimately bound up"[14] components of what philosophy entails). My account of philosophy also finds agreement with Socrates' claim that: *philosophy is to live well, so that one can die well*.[15] In this way, philosophy is then also "intimately bound up" in the human condition and germane to our everyday experiences and understanding of life and death. As such, it is relevant on a grand scale and in a myriad of ways.[16]

With this conception of philosophy (or "approaching something philosophically") in mind, let us now turn our attention to Slow Medicine. Coined by geriatrician and family physician Dr. Dennis McCullough, M.D., Slow Medicine is an approach to late-life healthcare that is largely

shaped by common sense and kindness, and advocates for the careful anticipatory "attending" to and of our aging loved ones changing needs. The practice of Slow Medicine is not necessarily new in the annals of medicine, but it has (regrettably) taken a backseat to the more familiar "medicalized" form of care (or Fast Medicine) that has come to dominate our society, as witnessed in our hospitals, doctor's offices, nursing homes, and an overwhelming number of our assisted living communities.[17] In contrast to the focus and pace of Fast Medicine, in Slow Medicine daily attention shaped by habits of cooperation and coordination is recognized as the "greatest need and firmest foundation for longevity and quality of life at the farthest reach of age."[18] It "enacts the ancient Tibetan wisdom of 'making haste slowly,' that is, focusing on the central issues of human caring with patience and a sense of shared humanity…bending flexibility at times of need, and holding firmly to shared values and loyalties at other times."[19] The closest example to Slow Medicine we have in place at a formal level is hospice care, which, in fact, does (or can) play a role in Slow Medicine.[20] Like hospice, Slow Medicine is interested in the end stages of life and providing comfort and care. Unlike hospice, however, what constitutes one's 'end stages' differs insofar as Slow Medicine's end stages (or "stations") extend well beyond hospices' 6-month anticipatory window of "life left." As such, the type of care administered by Slow Medicine and the planning elements involved are much more complex, nuanced, and broad in scope than that of hospice and involve more than just comfort and care. It is also important to mention here that Slow Medicine is not necessarily opposed to Fast Medicine; it recognizes the many wonderful discoveries and forms of medical treatment that have evolved from the high-tech and specialized world of Fast Medicine and sees these as relevant and valuable forms of care. It does maintain, however, that despite the positive features of Fast Medicine, there are many legitimate concerns with this approach when it comes to elders.[21] Ultimately, for

McCullough, the compassionate and attention-based foundation of Slow Medicine "strengthens, rather than replaces, the selective use of high-tech care"[22] and necessitates intimacy and commitment on the part of many dedicated individuals. It is not a plan for dying but rather "a plan for understanding, for caring, and for living well"[23] – one that requires "thoughtful evaluation and reflection, attentive listening, looking, and hands-on participation."[24]

According to Slow Medicine there are eight stages (or "stations") of late life. These include the stations of:

(1) Stability
(2) Compromise
(3) Crisis
(4) Recovery
(5) Decline
(6) Prelude to Dying
(7) Death
(8) Grieving/Legacy

In brief, these stations can be defined as follows. *Stability* involves routines – the patterns, things, or ways of interacting with the world that make-up our elders' day-to-day lives. At this station, things are relatively stable. *Compromise* involves an elder's daily routines interrupted and denotes their general vulnerability in changing circumstances. At this station, keen observation on behalf of the elder and family members is critical. In addition, balanced and pro-active planning, along with a support-oriented "mobilization of the troops" is key. The next station of late-life identified by McCullough is that if crisis. *Crisis* involves an acute change in an elder's health or circumstances. Here, damage control and preparation for inevitable future crises are the focus. *Recovery* involves recuperation and regaining of strength. While it is a difficult swim with numerous frustrations, this station typically involves a feeling of optimism and peace relative to the crisis overcome. In conjunction, it also involves anxiety and looming concerns – for recovery and rehabilitation are oft very near the shore of long-term chronic care. Unstinting emotional and logistical support as well as finely-tuned coordination of efforts across

caregiving teams and the elder are crucial at this station. The next stopover is decline. *Decline* involves what McCullough refers to as a "slow drift down a widening river."[25] During this drift of slow (and sometimes fast) separation, worldviews and perspectives shift and diverge. For the elder, the immediate details of living take on a particular significance – moments and reassuring gestures prevail. For family and friends, uncertainty about what might best be done to help slow or ease the separation increases. Active listening, mindful communication, and learning to become more comfortable with the unpredictable are imperative. *Prelude to Dying* is the next station identified by McCullough. Hospice care often comes into play here. Ailments lose their relevance in both care plans and caring, and medication and therapy become moot. At this station, glimpses of life's end are more predominant and feelings of isolation and aloneness for the elder more ever present. For family and friends, dedication and consistent "showing up" continue to be important. Honing one's ability to "soften in the presence of death" and recognize subtle forms of communication on behalf of the elder are also a central component. *Death* comes next. As one might surmise, this station involves the elder's "departing brushstrokes." Trust and acceptance that the circle of life must, by definition, always close are essential here, as are learning to navigate the language of death and being undauntingly present for the elder. Also critical at this juncture (and all other stations of late life care for that matter) are kind and unyielding emotional support. The concluding station of Slow Medicine identified by McCullough is *grieving/legacy*. At this station space and time are of utmost import. While grieving can certainly take place long *before* death occurs,[26] the grief that *follows* the loss of a loved one can be incapacitating – no matter how much one prepares for it. Allowing oneself and others time to grieve, each in their own way, is key. In addition, acknowledging covenantal

relationships, creating rituals and ritual space, engaging in legacy work, and finding room for forgiveness (as applicable) are vital.

Of final note, McCullough outlines five basic principles of Slow Medicine that can be used to help guide families, health professionals, caregivers, and other caring individuals in their efforts to enrich and support their aging loved ones.[27] These are:

(1) Endeavoring to understand parents and other elders deeply, in all of their complexity, while at the same time acknowledging both the losses and newly revealed strengths that come with aging
(2) Accepting the need for interdependence and promoting mutual trust
(3) Learning to communicate well and with patience
(4) Making a covenant for steadfast advocacy
(5) Maintaining an attitude of kindness no matter what

McCullough emphasizes the last principle – *kindness* – as the most important consideration underlying all of his assumptions about what constitutes good late-life care. "Although some families and caregivers may actually rise to extended acts of love (or simply loyalty, decency, respect, and gratitude)," he states, "*kindness is the single most reliable ethical and practical guide to doing this work well…*This is not always easy."[28] With the aforementioned definitions and principles in mind, let us now examine how philosophy might play a role in Slow Medicine.

EXHIBIT B: PHILOSOPHY & SLOW MEDICINE

The journey of caring for an aging loved one can be an extremely rewarding experience. It can also be extremely trying – physically, emotionally, and mentally. Rumi's insightful claim that "love is the work of warriors" reflects this point superbly, I think, and sheds significant light on the nature of love and what it means (and takes) to truly BE with someone through thick and thin; beautiful and tender aside, love is *not* for the meek or timid. Slow Medicine brings with it similar aspirations of mindful presence and unyielding perseverance, as evidenced by its five basic principles. But even in the most ideal of situations – where, for example, communication styles and worldviews of the elders and their family and friends are healthy and in sync, the network of caring and able-bodied individuals is deep, and the elders passage through the

stations of late life are relatively smooth – the path of Slow Medicine is still a uniquely challenging one. In addition to the practical realities and challenges of time and/or conflicting obligations, energy level, and finances, at its core, Slow Medicine is challenging because it speaks to the human condition; we are mortal and so are our loved ones (despite whatever pedestals of perpetuity we might place them on). Be it our own "drift down a widening river" or the irrepressible drift of another, facing mortality is, without a doubt, among the most arduous and emotionally demanding tasks we will ever face. With this in mind, and assuming that Slow Medicine has both intrinsic and extrinsic value and is a practical approach to healthcare, is there anything that might play a role, contribute to its practice and aims, and add value to the dialogue of what it means "to understand, to care for, and to live well"? Yes! *Philosophy*.[29] And here's how.

Recall our discussion about the definition of philosophy as a "thinking activity" and "way of life." Recall also my claim that philosophy is "intimately bound up" in the human condition and germane to our experiences and understanding of life and death. To paraphrase Socrates: *philosophy is to live well so that one can die well*. What might this mean in terms of Slow Medicine? First, philosophy and Slow Medicine share similar aims – both endeavor to improve our level of understanding, both strive for well-being (on an individual and collective level), and both embrace and encourage active participation and engagement in dialogue (of life and death). Of course, just because philosophy and Slow Medicine share similar aims, it does not follow that the former will benefit the latter.[30] What it does mean, rather, is that both share a common space and grapple with similar questions. What does it mean to live well? What do kindness and compassion entail? What do I do and how do I do it well? How philosophy can benefit Slow Medicine – what it has to offer in this regard – is experience. While Slow Medicine might ask

questions that don a less classically philosophical tone – e.g., How do I know when its time to take the keys from grandma? ("She loves them wheels, man! But I can only replace the mailbox so many times!") – these sorts of questions hinge on pivotal philosophical inquiries about human nature, responsibility, identity, and notions of justice and fairness (to name a few), that have been going on for hundreds of years in the philosophical community. As such, the sorts of existential and practical queries with which Slow Medicine wrestles can gain valuable insight from philosophy. And it can do so at every level. That is to say, all stations of late life care – from *stability*, *compromise*, *crisis*, and *recovery* to *decline*, *prelude to dying*, *death*, and *grieving/legacy* – involve significant questions about thoughts and behavior that are deeply rooted in philosophical grounds. Thus, by looking at past and present philosophical discussions (as well as engaging in philosophical dialogue),[31] Slow Medicine can gain a profoundly robust perspective on what it means to understand, care for, and live well with our aging loved ones.

In addition to its inexhaustibly fertile ground, philosophy can also benefit Slow Medicine via its unique approach. While the two fields wade in the same pools (so to speak) and are concerned with similar queries, taking a philosophical approach requires that certain methods and ways of engaging with the world obtain. Recall that philosophy entails that one approaches a topic of investigation in a way that honors critical thinking (or reasoning). This includes such methods as: (a) argument, (b) refutation, (c) systematic doubt, (d) dialectic, (e) justification (of beliefs), (f) logic, and so forth. It also means that one embrace several attributes, including: a sense of wonder and imagination, open-mindedness, sincerity, humility, and dialectical justness, among others. As it concerns Slow Medicine, these sorts of methods and attributes may seem irrelevant. But this is not the case. Why? Philosophy provides a unique and valuable vantage point – one that grants its "investigators" a unique sort of relationship with its subject matter and

allows its participants to "observe" and "experience" the subject matter more completely. This, in turn, allows for increased levels of understanding and awareness. Consider McCullough's station of grieving/legacy, for example, in conjunction with philosophical counseling[32] and Logic-Based Therapy (LBT) – a dynamic form of Rational-Emotive Behavior Therapy that aims to help individuals overcome irrational thinking/behavior via uniquely philosophical methods so that they may live healthier, happier lives.[33] While certainly not the only way to approach grief,[34] doing so philosophically is (I feel) particularly advantageous insofar as it affords one the ability to "see and feel" grief (i.e., to grapple with the concept *and* the experience of grief) in ways that appeal to and increase one's objective and subjective understanding of it.[35] Metaphorically, philosophy arms its cognizers with a set of oars and a looking glass and provides a means by which to approach, recognize and navigate the vicissitudes inherent in life (death & grief being among those). And it does so in a way that honors the critical art, value and function of both "diving in" and "floating above." More precisely, philosophy (and philosophical modalities such as LBT) offer its participants systematic methods for understanding the world and our experiences within it. Considering the complexity and emotionally-charged nature of the experiences and challenges faced in late life care, such techniques are compelling. What is more, they have therapeutic and practical import and can be of value to Slow Medicine by virtue of what they bring to the caregiving (and receiving) process. This includes clarity, direction, well-being (and relief) – all of which are critical to successful[36] late-life care in personal and professional settings.[37] For example, with the clarity that philosophy provides better decision-making can obtain.[38] This can lead to more appropriate and efficient (or well organized) action, which – from an economic[39] and therapeutic standpoint – has positive benefits with complex and far-reaching implications.[40] In the end, philosophy's rich history/experience, methods, and

attributes can assist Slow Medicine by helping elders and all those involved in the journey of late life care to better navigate the ebbing and flowing tides of living and dying and the decisions made within those oft mercurial and fickle waters.

CONCLUSION

This paper was interested in establishing a place in Slow Medicine for Philosophy. First, I advocated for an (metaphorical) alteration in lay-out to our cultural museums – one that, in contrast to modern U.S. culture, contained full-blown exhibits on Slow Medicine and Philosophy, replete with "philosophically-informed" and "attentive" pictures of aging and caring for those we love. This visual served as an initial platform for my primary discussion about Slow Medicine and philosophy and was used to make a larger, implicit statement about what sorts of things we ought to strive for on an individual and societal scale. Then I laid out my three primary assumptions: (1) that philosophy and Slow Medicine are positively correlated to well-being and quality of life, (2) that both practices have intrinsic and extrinsic value, and (3) that Slow Medicine is a practical approach to healthcare. From here I explored the question *Does Philosophy Have a Place in Slow Medicine? And if so, how?*

In order to answer this query, I first discussed what I meant by 'philosophy' and 'Slow Medicine,' and what, precisely, each entailed. According to my interpretation, philosophy entails that one honor critical thinking (reasoning), enlist in her approach various methods commonly associated with philosophy, and engage in philosophical investigation in ways consistent with the Socratic "method," inclusive of several character-related attributes. Insofar as an individual embraces these components, she is participating in a way consistent with philosophy (as a thinking activity and way of life). Further, philosophy is concerned with thought and action. Not one or the other. As such, it is theoretical and applied in its essence. It is also in line with Socrates' claim that: *philosophy is to live well, so that one can die well* and, as such, is

"intimately bound up" in the human condition and germane to our experiences and understanding of life and death. It is thus, relevant in a myriad of ways. Next I appealed to McCullough's interpretation of Slow Medicine who defines the practice as an approach to late-life healthcare that focuses on the central issues of human caring with patience and a sense of shared humanity, is largely shaped by common sense and kindness, and which advocates for the careful anticipatory "attending" to and of our aging loved ones changing needs. I then discussed the eight stations of Slow Medicine and the five basic principles to which the practice adheres, kindness being the most important consideration relative to what constitutes good late-life care.

Then, I discussed where, in the process of Slow Medicine, philosophy played a role, focusing specifically on how philosophy benefitted Slow Medicine, why philosophy was applicable across all "stations" of late life, and what sorts of therapeutic and practical value obtained. In the end, I claimed that philosophy *does* have a place in Slow Medicine insofar as it contributes to the practice (and supports its aims) via its methods, attributes, and fertile grounds, is applicable across all stations of late life, and has therapeutic and practical value in both personal and professional settings by virtue of what it brings to the caregiving (and receiving) process, the benefits of which have positive, complex and far-reaching implications. In light of this, I urged that we (our society and museums) strive for new exhibits that revealed a change in landscape about late-life care and the import of philosophy to life, death, and the inevitable drift down a wide river that we all face.

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[1] *Merlin MCC* is a small non-profit organization in Helena, MT aimed at helping people *find their way with philosophy.* It offers philosophical counseling services (for challenges related to loss, change, grief, death, dying, and quality of life) and philosophical consult services (academic editorial, research/writing, and lecture coordination) in the fields of philosophy and psychology, especially related to quality of life, elder interests, and thanatology. To learn more visit www.merlinmcc.org.

[2] This paper was presented in Philadelphia, PA at the 2014 American Philosophical Association (Eastern Division Conference), *National Philosophical Counseling Association* meeting.

[3] Dennis McCullough, M.D., *My Mother, Your Mother: Embracing "Slow Medicine," The Compassionate Approach to Caring For Your Aging Loved Ones* (New York: HarperCollins, 2008), xxi.

[4] Personal settings might include ones household or caregiving on a personal level. Professional settings might include hospitals, doctor's offices, assisted living facilities, psychological/counseling arenas.

[5] For a more complete rendering of philosophy and what "approaching something philosophically" entails see, Marisa Diaz-Waian, "How Philosophy Can Help Us Grieve: Navigating the Wake(s) of Loss," *International Journal of Applied Philosophy* 28:1 (2014): 20-24.

[6] These desiderata of philosophy are discussed in detail (in the context of the Platonic Question) by J. Angelo Corlett in his book *Interpreting Plato's Dialogues* [J. Angelo Corlett, *Interpreting Plato's Dialogues* (Las Vegas: Parmenides, 2005), 45-57]. According to Corlett, "Although there is no formalized Socratic Method, it is nonetheless helpful to take a close look at how. Socrates is portrayed doing philosophy in Plato's dialogues. In so doing, we might gain a better understanding into the nature and value of philosophy itself, and better appreciate what is truly fundamental to it" (47). See also: Marisa Diaz-Waian & J. Angelo Corlett, "Kraut and Annas on Plato," *Epoché: A Journal for the History of Philosophy* 16, no. 2 (2012); Diaz-Waian, "Excavating Plato's Cave" (http://sdsu-dspace.calstate.edu/handle/10211.10/2034).

[7] "[P]hilosophical thinking activities employed by pure philosophers are, in general," avows Elliot D. Cohen, "the same as those employed by applied philosophers. Both attempt to build logical arguments, engage in logical analyses of arguments, examine assumptions of such arguments, and define key terms" [Elliot D. Cohen, "The Activity of Philosophy," in *Philosophers at Work: Issues and Practice of Philosophy* (Belmont, CA: Harcourt, 2000), 8].

[8] According to Dr. Elliot D. Cohen, to separate applied and theoretical philosophy into two distinct species is to create a false impression as each area of focus bears substantially on one another; beliefs have an effect upon actions and vice-versa (Cohen, "The Activity of Philosophy," 8). Consider also the parallel between thanatology and thanatology practice. Specifically, Luciana Mascarenhas Fonseca and Ines Testoni assert: "[R]eflecting upon thanatology and discussing the application of death studies in various environments is *fundamental* to adapting practice to different realities. Thanatology theory took shape as death studies and research, whereas thanatology practice manifests primarily as formal death education, end-of-life care, and bereavement counseling" [Luciana Mascarenhas Fonseca and Ines Testoni, "The Emergence of Thanatology and Current Practice in Death Education," *Omega* 64, no. 2 (2011): 163]. Emphasis added.

[9] Historically speaking, this view seems to be dominated by twentieth century Anglo-American philosophers from the analytic tradition. See Louis I. Katzner, "Applied Philosophy and the Role of the Philosopher," *International Journal of Applied Philosophy* 1, no. 2 (1982): 32.

[10] Pure philosophy tends to reflect the former view, while applied philosophy the latter. But, as Louis I. Katzner notes, "that 'philosophy' was not always understood in this way can of course be seen from even the most cursory readings of works such as Plato's *Republic*. And that not all . . . philosophers [accept] this view can be seen by attending [for example] to the writings of pragmatists, Marxists, and existentialists" (Katzner, "Applied Philosophy and the Role of the Philosopher," 32).

[11] Plato, *Plato: Complete Works*, ed. J. M. Cooper and D.S. Hutchinson (Indianapolis: Hackett Publishing Company, 1997), *Apology*, 29b; 38a. All references to Plato's works herein are taken from this source.

[12] Plato, *Euthyphro*, 14c; *Phaedo*, 82d; *Laws*, 667a.

[13] Plato, *Euthyphro*, 16. This latter point – that philosophy can help one be better for the rest of her life – entails both an individual and collective notion of well-being and responsibility. For more detail see Diaz-Waian, "Excavating Plato's Cave" (http://sdsu-dspace.calstate.edu/handle/10211.10/2034).

[14] Cohen, "The Activity of Philosophy," 8.

[15] Implied here is the positive correlation between philosophy, well-being, and quality of life (and death).

[16] As a thinking activity and way of life, philosophy is also a *psychologized* activity. That is to say, "psychological processes infiltrate all cognitive activities and human relations, including philosophical rumination" (Jon Mills, "Philosophical Counseling as Psychotherapy: An Eclectic Approach," *International Journal of Philosophical Practice* 1.1 (2001): 3).

[17] McCullough, *My Mother, Your Mother*, 48.

[18] McCullough, *My Mother, Your Mother*, xxi.

[19] McCullough, *My Mother, Your Mother*, 3.

[20] Technically, hospice and palliative care can play a role in Slow medicine. Hospice care *provides* palliative care but is not itself palliative care. While the two are similar in terms of aim (i.e., care), they differ the most in regard to care location, timing, payment, and eligibility for services. For example, typically you must be considered terminal or within six months of death for hospice care, whereas with palliative care, there are no time restrictions. Palliative care can be received by patients at any time, at any stage of illness regardless of whether they are terminal or not. As such, palliative care is not exclusively interested in late-life or end-stage care, though it can be a component of it.

[21] First, there are well-documented cases of significant danger for elders in acute hospital settings. They acquire more infections in hospital settings, are exposed to treatment protocols typically reserved for younger more resilient patients, fall more often during hospital stays, and are more likely to be readmitted due to complications related to hospital care. McCullough states, "Large 'industrial-scale' environments like hospitals focus on disease and tend to lose sight of the complexity of an older person. Speed is at a premium, and slower-moving, slower-responding elders don't fit well with the pressured environment of fast medical care" (*My Mother, Your Moth*er, 48). Second, in acute hospital settings, elders are subject to the rapid discharge time frames established for young and middle-aged patients; this often results in a chain of unfortunate events for the elder and his/her family. Finally, in Fast Medicine environments, decision-making is vastly different. Families are often viewed as "in the way." As such, they are less likely to be included in discussion about an elder patient's health care.

[22] McCullough, *My Mother, Your Mother*, xxii.

[23] McCullough, *My Mother, Your Mother*, xxii.

[24] McCullough, *My Mother, Your Mother*, 2.
[25] McCullough, *My Mother, Your Mother*, 134. Or in some instances, I might add, a fast and ferocious drift down a widening river.
[26] Anticipatory grief is an example.
[27] A complete rendering of the five principles outlined here can be found on pages 3-13 (McCullough, *My Mother, Your Mother*).
[28] McCullough, *My Mother, Your Mother*, 12. One should note here, that this this also means (with respect to caregiving) "kindness to oneself."
[29] Other disciplines might also be of benefit to Slow Medicine.
[30] Or vice-versa.
[31] With oneself and others.
[32] While a general consensus exists among philosophical practitioners that philosophical counseling "aims toward philosophical examination and understanding through the guidance of a professional trained philosopher," there is less agreement on what specific methods apply and as it concerns its relationship to psychotherapy (or psychology). My interpretation of philosophical practice finds particular agreement with John Mills' conception that, among other things, philosophical counseling is a *form of psychotherapy that is differentiated from other forms of psychotherapy by its philosophical emphasis and the unique theoretical and methodological considerations born from such emphasis* [See Jon Mills, "Philosophical Counseling as Psychotherapy: An Eclectic Approach" *International Journal of Philosophical Practice* 1.1 (2001): 2].
[33] Logic-Based Therapy (LBT) is the leading modality of a breed of philosophical counseling advanced by Dr. Elliot D. Cohen, which is perhaps best described as a hybrid discipline that combines psychology and philosophy; a form of counseling that uses philosophical methods and theories; and a type of applied philosophy that, in its specific application, becomes psychological (i.e., *philo-psychotherapy*). LBT is a dynamic, philosophical form of cognitive-behavior therapy (CBT), or more precisely, a variant (or philosophically evolved version) of Albert Ellis's Rational-Emotive Behavior Therapy (REBT). LBT shares with REBT: (a) the hypothesis that many (though not all) behavioral and emotional problems (troubles, disturbances) are rooted in irrational thinking, (b) a belief in the positive correlation of rational thought and health and happiness, (c) a strong alliance with empirical science, (d) the provision of instructive measures relative to the identification and avoidance of fallacies (i.e., errors in reasoning), (e) a belief in willpower and the importance of partaking in willpower strengthening exercises, (f) the provision and encouragement of "homework assignments" (e.g., biblio-therapy, humor), emotive techniques (e.g., role playing, rational-emotive imagery), and behavioral techniques (e.g., relaxation protocols, self-monitoring), and (g) the same three-pronged concept of emotion, according to which emotions consist of cognitive, behavioral and physiological components. LBT differs from REBT in its *explanation* of emotions and behavior (i.e., LBT offers a justification-based versus a casual explanation), the increased magnitude of fallacies with which it works, and with respect to its provision of 'transcendent virtues' (i.e., a set of positive values in which to aspire in overcoming fallacies). In addition, LBT claims that emotion and behaviors are decisions (conclusions) and, in light of this, we are largely responsible for them. In this connection, we are also largely responsible for and capable of (in theory) addressing and overcoming unhealthy emotions and behaviors to live healthier, happier lives. The five steps of LBT are: (1) identify the client's emotions, (2) identify and/or find (if suppressed) the premises of the client's emotional reasoning, (3) refute any irrational premises, (4) find antidotes to the refuted premises, and (5) assign exercises aimed at strengthening willpower. For greater details see, Diaz-Waian, "How Philosophy Can Help Us Grieve," 19-48. A more recent clarification of LBT's steps is offered by Dr. Cohen and recasts the above five steps as follows: (1) Identify the emotional reasoning, (2) Check for fallacies in the premises, (3) Refute any fallacy, (4) Identify the guiding virtue for each fallacy, (5) Find a philosophy for the guiding virtue, and (6) Apply the philosophy.
[34] The nature of grief has been conceived of in numerous ways. For the purposes of our discussion, I shall appeal to the general notion of 'grief' (or 'grieving') offered by Thomas Attig, according to which grief is characterized as an active and choice-filled response and a relearning of sorts that involves "problem-solving, addressing definable tasks, [and] life-long projects of adjustment in the most fundamental dimensions of our being" (Thomas Attig, "Meanings of Death Seen Through the Lens of Grieving," *Death Studies* 28 (2004): 359).
[35] A philosophical understanding of x involves both "seeing and feeling" X.
[36] By 'successful' I mean healthy/harmonious, beneficial, well-organized, etc.
[37] As well as the success of countless other enterprises.
[38] Of course, just because someone has clarity about a matter, it does not necessarily follow that she will make a better decision. Other factors come into play here. However, it is reasonable to suggest that without clarity, the probability of making a "better" decision (insofar as it is at least adequately informed) is significantly decreased.
[39] This point was brought to light by Andrea Houchard (Director of Philosophy in the Public Interest, *NAU*) during a discussion about the economic value of philosophy. Thank you for your valuable insight.
[40] For example, appropriate and well-organized action can result in better (more aptly fit) administration and allocation of resources/services.