The Grandmother Gene

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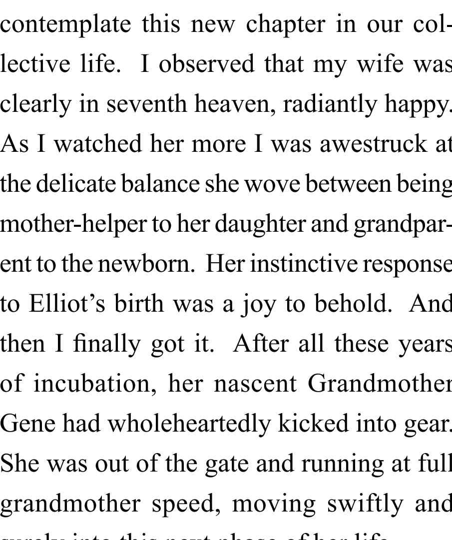

Our first grandchild, Elliot, was born in the Bay Area in June of 2014. I've been doing grandfather now for 14 months. On the other hand, my wife has been doing grandmother for 15 years, which I find perplexing. Having thought a lot on this state of affairs I'm just now starting to understand the phenomenon. I have come to believe that there exists deep in the X-chromosome a heretofore hidden gene that I now think of as the Grandmother Gene.

It all seemed to start shortly after my wife entered her fifth decade. Our daughters were growing up fine and dandy, and were in their mid-to-late teens. They had developed busy, increasingly independent lives of their own. Think "driver's license" and you'll get the picture. It was during this time that she started to take up knitting with a passion. She'd knitted a bit for years, but nothing like after she learned to find knitting stitch patterns on the internet. Within a few years her sewing nook hypertrophied from a little roomy workspace for occasional projects to a sweathouse of frenzied production. She had become a walking stitchionary. When her wrists and fingers got sore from too much knitting she'd make quilts. When the quilts were done she'd make clothing of all sizes. But she'd always return to the knitting.

And then came the baby caps, some with tassels, some with little ears, all the perfect size for a newborn. And I began to notice this distinct glow on her face whenever she finished one. I still didn't get it, for at the time neither daughter was displaying overt interest in childbearing. Soon her nook was filled with these little hats and she had to find hospital nurseries to donate them to. It is no exaggeration to note that a host of Northern California and southern Oregon newborns can trace their little heat-retention skullcaps to the emerging Grandmother Gene of my industrious wife.

The years flowed by with nary a son-in-law on the horizon. Her stitchery nook's cupboards were gradually filled to overflowing with handcrafted neonatal attire. Then, just when there was room for no more without renting a storage unit, stage two of the Grandmother Gene ignited.

Cameras had suddenly made the leap from the film-based "point-and-click" to the inner workings of the omnipresent mobile telephone. No more wasting film. Instant photographs were in. She learned she could take pictures to her heart's content and she proceeded to get very good at it. Digital photography had arrived!

To no one's surprise an auto-cycling digital photo frame soon presided over the kitchen and dining room, proffering a continuous dazzling display of current favorites. Little did I know that all this was subconscious preparation for the arrival of a yet-to-be conceived grandchild.

And then it happened. Our elder daughter's good friend morphed into her fiancée, then her husband, and then into the father of their child, our grandson Elliot. And our whole world changed.

On hearing of her daughter's labor, my wife drove 300 miles in the middle of the night to be at her side, arriving 40 minutes before the little fellow was born. The delivery went wonderfully well for all parties concerned.

I was out of the country teaching at the time, as the expected due date wasn't for another 2 weeks, and arrived early the next morning. I walked into the room and saw mother, father and son all healthy and happy (or sleeping), and my wife was glowing that glow again. At this point, as father, father-in-law, husband and physician, I relaxed, sat back and began to contemplate this new chapter in our collective life. I observed that my wife was clearly in seventh heaven, radiantly happy. As I watched her more I was awestruck at the delicate balance she wove between being mother-helper to her daughter and grandparent to the newborn. Her instinctive response to Elliot's birth was a joy to behold. And then I finally got it. After all these years of incubation, her nascent Grandmother Gene had wholeheartedly kicked into gear. She was out of the gate and running at full grandmother speed, moving swiftly and surely into this next phase of her life.

We returned home a few days later, but clearly a huge portion of her mind and heart remained firmly focused down south. The intensity of her inner longing was undeniable and irresistible. We found ourselves arranging trips every 4 to 6 weeks to spend time with them, and we kept in phone or Skype contact almost daily. We found a computer app called Moment Garden that allowed Elliot's life adventures to be transmitted digitally into our lives on a daily basis. The stitchery nook's contents were gradually distributed and the photographs of our grandson's life began to fill our home. I now count at least seven Elliot photos visible from anywhere in the kitchen or dining room.

My wife's need to frequently make the journey south gradually exceeded my own and the next few months found her heading that direction more often than I, drawn by her intense longing to fulfill this deep-rooted calling. I mentioned this phenomenon to the

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other fellows in my Grandfather's Support Group and found it to be a common experience delicately referred to as "The Missing Wife Syndrome."

This pervasive captivating preoccupation with grandmotherhood has turned out quite all right, I've realized. My wife returns from such grandmother intensives beaming with life and radiant love. I've noticed that in many ways she seems younger and even more beautiful now. The joy of our grandson's presence in her life and her touchingly refreshed relationship with our daughter have evoked an abundant happiness.

As you can see, I've thought a lot about this Grandmother Gene thing. I can't help but wonder how it is that my wife has twice as much draw to spend time with the little tyke at this stage in his life as I do. I mean, he's a really cute kid, but somehow I can't relate to newborns anywhere nearly as unhesitatingly as she can. Maybe that's because this is truly an X-chromosome related happening. After all, all my cells only have one of those and hers have two. No wonder she's twice as good at it!

But just wait until the little tyke can handle a fishing rod or play card games. Then you'll see the Grandpa Gene really kick in! I can feel it happening… §

"Dietary", Continued from Pg 6

change among adults. Therefore, healthier dietary habits need to be implemented in school aged children. Family nutrition counseling sessions for patients with metabolic disorders and diabetes will help "catch them young," as well as promoting parental support for healthy eating for the entire family. §

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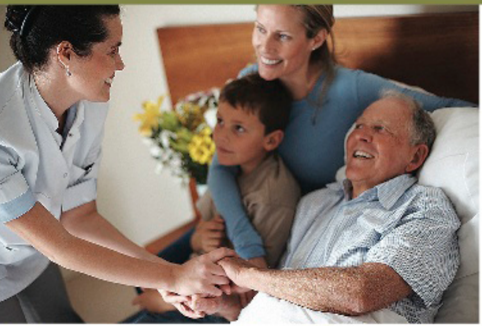

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Primary Care Continues Fall

In 2010, the American Association of Medical Colleges (AAMC) noted that by 2025, there would be a 70,000 primary care physician shortage in the United States. However, with all the hoopla surrounding Obamacare, nothing was done to ease this pending crisis in healthcare.

One counterweight we thought we had was that the number of Osteopathic Medical Schools was rapidly increasing, and the DO (Doctor of Osteopathy) schools have a real commitment to increasing the number of primary care physicians.

However, the June 1, 2015, edition of American Family Physician notes that the number of DO grads going into primary care has fallen since 1985, when 53% of Osteopathic Grads were opting to go into primary care after graduation. In 2008 (the last year we have figures for) the number has fallen to 42% of grads going into primary care. The good news is that the number of osteopathic medical schools has increased from 19 to 34, so the total number of grads going into primary care has actually risen from 700 in 1985 to 1100 in 2008.

While the increased number of grads going into primary care is good, there is a disturbing trend as the actual percentage decreases. (Of note: the percentage of MD's going into a primary care specialty is about 24%, and that number has been pretty consistent for the last 20 years or so.) If this trend continues, it will be harder and harder to find a doctor.

In our current medical milieu there are a tremendous number of disincentives for choosing primary care as a specialty. The amount of debt medical students, especially osteopathic students, is soaring to astronomical heights. Osteopathic medical schools are generally much more expensive than allopathic (MD) schools, and the average DO grad is more than $200,000 in debt upon graduation. The pay for primary care physicians is far and away the lowest of all medical specialties, and this pay difference shows up in residency training continuing all the way through practice. Primary care physicians are being asked to take on more paperwork responsibility, with no increase in pay.

Last year the Robert Graham Center called for a 22% increase in the number of primary care residency slots to help stave off the impending shortage. However, with our current climate subliminally and overtly pushing students away from primary care, the 22% increase won't mean much.

As the US population ages, it will be even more critical to turn out good, well trained primary care physicians. If we can't figure out some way to alleviate the disincentives for students to choose primary care, we all may wind up without a doctor in the future.

Are We Shortchanging the Elderly?

Everybody agrees that we are spending too much money on peoples' health during the last six months of life. Currently, 25% of Medicare dollars are spent for the last year of peoples' lives. This translates into $170 Billion out of a total Medicare expenditure of $554 Billion in 2011.

However, how are we doing with elderly patients who are not in the last six months to one year of life? There is increasing evidence that this rapidly growing group of people is being seriously underserved. A 2004 study showed that elderly patients were less likely than younger patients to get life-extending care, such as surgery and dialysis, even after patients who refused that care were excluded.[1]

This issue was brought to a head in late 2014, after an essay in the October issue of The Atlantic by Ezekiel Emanuel, MD, chair of the Department of Medical Ethics and Health Policy at the University of Pennsylvania, set off a firestorm of debate on this topic, in which he stated that he would decline medical treatment after age 75.

Many physicians don't recommend preventative measures for their elderly patients. In fact, the US Preventative Health Task Force recommends that we stop colon and breast cancer screening after age 75.[2]

It is true that even the "healthy" elderly often suffer from multiple chronic illnesses, including cognitive difficulties, arthritis, cardiac, pulmonary and renal problems. However, except

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for severe dementia, this doesn't necessarily preclude them from leading productive fulfilling lives.

Many physicians don't like taking care of the elderly; they move more slowly, and take more medications that need to be reviewed with each visit. Both of these facts are antithetical to our current mode of getting patients in and out of exam rooms as quickly as possible. Most practicing geriatricians feel that at least a half-hour appointment should be dedicated to elderly patients, but we're only given 10-15 minute appointments, so physicians don't like the slow down.

Many elderly patients, due to physical and/or cognitive disability, make it "difficult" for a physician to get a good handle on what's going on with them. Physicians have little training for dealing with elderly patients, and they feel that their care is non-rewarding. We are conditioned by advertising that seems to show that every elderly person requires incontinence supplies or automatic stair climbers.

This is especially true since we, including the elderly, live in youth oriented culture. Caught up in a youth culture, aging women get face-lifts; aging men ride Harleys. These youth oriented attitudes are being carried into our aging years. How many of us aging Baby Boomers are still listening to Classic Rock stations and singing "I hope I die before I get old"?

And speaking of aging Baby Boomers–they are becoming the Silver Tsunami as they enter into their 60's and 70's. The first Boomers turned 65 in 2011, and by 2030, the over-65 population will be triple the size it was in 1980. This is a generation that has always carried a sense of entitlement, and this will not change as they age. They will rightfully demand better services tailored for their particular needs.

Medicine needs to get a handle on we take care of our rapidly aging population. We need more and better geriatric training in medical school. We need to encourage more of our med school grads to go into geriatrics. This means we need to make it both financially and emotionally rewarding to take care of the elderly.

We need to instill in our physician (and general) population the concept of functional age rather than chronological age. I have taken care of patients in their 70's and 80's that are much younger and healthier than many of my patients in their 30's and 40's. Even those older patients of mine that do suffer from chronic arthritis or cardiac disease or other diseases often maintain an attitude of "youth" that gets them out and about, allows them time to spend with others, contribute meaningfully to our community, and give us the benefit of their long years of experience. We should be celebrating them; not shortchanging them on their medical care.

1. Sunderland A. "Older patients get less aggressive treatment, regardless of health status or their own preferences, study finds." Robert Wood Johnson Foundation. September 10, 2004. http://www.rwjf.org/en/research-publications/find-rwjf-

2. Emanuel EJ. "Why I hope to die at 75: an argument that society and families—and you—will be better off if nature takes its course swiftly and promptly." The Atlantic. October 2014. http://www.theatlantic.com/features/archive/2014/09/why-i-hope-to-die-at-75/379329/ Accessed December 22, 2014.

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