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Ethical Imperatives and the New Physician
IV. Responding to the Aging Patient

Commencement Address by
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I began by acknowledging that I knew I was in the heartland of osteopathic medicine for which I felt a special kinship because of its consistent and abiding concern for the role of the family in the context of good patient care. The more practiced I become, the more I am aware of the many subtle ways in which our system of health care has put considerable and often unreasonable stress on the family unit. And that means also on the family-centered practitioner. However, my major concern in this address was the reaction of young physicians with the aging population. That should have made sense to the graduating class because in fifteen or twenty years a substantial portion of the American population, close to 20 per cent, would be over the age of 65. The fastest growing segment would be over the age of 85.

I assumed that access to physician care would be generally problem-free for older people in the next century, as it was at the time of the commencement talk. That has turned out to be the case, except that managed care did cause a little blip on the screen and the cost of prescription drugs – now a political football, at the time of this writing, 2003 – has put many oldsters in the position of taking their medications only half as frequently as prescribed, or cutting out food in order to take it all the time.

We, as physicians, would always like to make our judgments solely on the basis of what is good medicine, but physicians are being asked more and more to slow down or reverse altogether the rising costs of health care. Those arguments usually are for the patient in the next bed, never one's own. This means that the elderly have become a rather convenient target, complicated by the fact that elderly patients sooner or later will die, perhaps in a few years, or even in a few months.

I felt it proper to mention Governor Lamm of Colorado and his admonition that older people should. "Get out of the way" – a frightening oversimplification of a major human concern. When people turn 65, they automatically do not begin to die. Daniel Callahan calls these people the "Biologically tenacious", but there is a lot more to it than just one's own fermenting biology.

Just because we do not know precisely when a person's "time is up", we have to work within an ethical system that requires us to give a patient all the life to which he or she is entitled. I believe in that for patients of any age, but not if it just means prolonging the act of dying.

The term "Quality of Life" is used a great deal these days and I presume each of us has an intuitive understanding of what that means. However, I contend that it is only for oneself. The fact is that you can't make any assessments of my "quality of life" for me and neither can I, for you.

This seemed a good time to talk a little about prevention and point out that we are preoccupied with high-tech medicine, more interested in transplanting diseased hearts and lungs than in teaching people, for example, not to smoke to prevent heart and lung disease in the first place.

The aging process is a living process not an illness and therefore, it is neither treatable, nor reversible, but one can do things on the way up the hill to lessen concerns going down the hill. The elderly can be sickness free and disease free. A lot of the decisions have to be made, of course, on the basis of who else is in the picture; elderly patients may have thoughtful, caring adult children, or they may have already been abandoned by them. Your patients may leave your office and go back to a group house where they live with support of other men and women, or they may return to a one-room flat where they live alone in isolation and depression. They may be sweet people, who deserve the best possible care, or they may be cranky and selfish people who deserve the best possible care anyway.

I took this opportunity to compare the doctor-patient relationship of yesteryear with elderly patients with today's relationship, which is much more superficial than it used to be. It was great in the days of my youth that my parents and grandparents had a physician who could practice within the realm of trust between patient and physician. You and I, on the other hand, are more likely to die in a hospital in the care of a physician who may not have known us a few years, or a few hours, but just a few minutes.

Never forget in this realm of trust that an illness might be terminal and no cure will work, but care is certainly still possible. And, you must let your patient know that you recognize and appreciate his or her worth, and that you will be both physician and comforter. Be sure that your patient knows that they will die without undue pain and if they do not want extraordinary life-support, you will abide by that decision.

One of the toughest things to teach is that in a terminal illness, one of the more sensible things to do at the time – and only at the proper time – is to stand back and let nature take its course. I hope some of you will have the pleasure of practicing in the realm of trust between patient and physician, but I'm reminded that if you do, you will need to dig deep within yourself to come up with the right answers.

By talking, as I am, about the aging, I do not wish to imply that there is anything age-specific about ethical behavior. But if you don't understand the significance of the ethical issues surrounding health care for the elderly, the chances are you won't understand the role of ethics in medical practice generally.

In 1948, I read an essay by Dr. Leo Alexander, whom I have admired ever since. He served as an expert witness at the Nuremberg war crime trials and conversed with many on trial in long interviews in their native tongue. The record of horrors that unfolded in the course of those trials haunts mankind to the present day. At that time Dr. Alexander said: “Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were a subtle shift in emphasis in the basic attitude of physicians.” The new attitude, said Dr. Alexander, was that “There is such a thing as a life not worthy to be lived.” That reminds me of term I hate – “the non-rehabilitable sick”. Individuals are more frail than societies and potentially more destructive – one-on-one – than whole nations. Don’t ever forget that it is possible for a physician to become too aware of the economics of health care...too calculating about treatment priorities...and too impatient with those in his or her care who are among “the non-rehabilitable sick”.

I closed with six lines from Robert Browning’s poem, Rabbi ben Ezra.