Toward a Philosophy of Aging for the Public Health Professions

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Tearsheet requests to the Office of Public Affairs, Office of the Assistant Secretary for Health, Rm. 721H, HHH Bldg., 200 Independence Ave. SW, Washington, D.C. 20201.

NOT LONG AGO, while I was reviewing Public Health Service policies toward the aging, I had the pleasure of several long and valuable conversations with Dr. Robert Butler, then director of the National Institute on Aging, which has an excellent record of innovative intramural and extramural research in that field. I also had discussions with other National Institutes of Health directors; with experts at the Alcohol, Drug Abuse, and Mental Health Administration who have concerns related to the elderly; and with a number of people elsewhere in the Department of Health and Human Services—people who work in legislation, planning and evaluation, and social services.

Two things about these conversations particularly impressed me. First, just about everyone I talked with who worked in some aspect of the field of aging was genuinely concerned for the welfare of America's elderly population. Second, just about all the people I talked with came at the subject of aging from different perspectives, with differing, value-laden data, and with differing concepts of what they hoped to see Government achieve.

Drawing upon these conversations and my own reading, I would like to suggest some common ground for people who work in the field of aging. I certainly do not mean to be prescriptive—provocative, yes; prescriptive, no. But I hope that these words may in some way contribute to the building of a commonly accepted philosophy of aging for the public health professions.

I do not mean to suggest that people are now serving the aging without a scrap of philosophy to give them direction. What in fact we *do* have is the profession of health care applying its fundamental notions of compassion, of public service, and of human decency to the problems of the aged. And we ought to be rather proud of that.

However, I think a problem arises from the fact that, although the aging process begins in youth, the end stages of aging provide the ultimate, terminal experience. Therefore, I would say that the approaches we employ elsewhere in public health—that is, our methodologies, insights, and corporate responses—are not completely appropriate. We have been trained to identify opportunities for "linkage," "followthrough," and "followup"; for "cost effective" this and "technology intensive" that. But the aging experience leads to a known endpoint: death. Our usual methods do not translate well; they are designed to lead to something else.

The Final Stages of Aging

In our American culture, the age of 65 is usually considered a turning point. After 65, the aging person is generally retired. The road of life, from that point on, is often thought of as all downhill, the only variable among people being the steepness of the decline.

If I were to ask my friends who work in the field of aging to characterize this terminal period, they would probably say they would hope it would be a "good" time—one in which the aged person would enjoy reasonably good health; enough nour-

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ishment, prepared and presented with interest and care; the comfort of adequate clothing and shelter; and, at long last, a period of peaceful human relationships.

But a part of that time, indeed, may *not* be so "good." At some point the aged person enters a real and accelerated decline. Health deteriorates. Nourishment is reduced to just that, lacking any reason for interest. Discomfort becomes an around-the-clock norm, and the human relationship that absorbs most of the dying person's attention is the relationship with himself or herself.

I think it is clear that good medical and health care seeks to ensure to the fullest extent the "good" qualities of that terminal time in the aging process and to compress the downhill slide into as short a time as possible. But how do we prolong the "good" time, and how might we attempt to control the onset of the period of decline?

That question actually presents us with two problems:

1. If we recognize aging as being a "good" time followed by a difficult time, then we may begin to perceive the aging process as a series of self-fulfilling prophecies, and that is certainly a problem for anyone in health care.

2. If we recognize that there may be two qualitatively different periods of time, it is only natural that we would want to manipulate them in some way beneficial to the patient, as I have suggested, so as to prolong a person's "good" time and shorten the time of decline. The period of decline might be his or her "dying time," as it were, except that the two types of time are not neatly defined and separated for us.

Let's look at the first problem: the problem of self-fulfilling prophecies. The aging process is most often described as a chain of successive and anticipated events. A physician or a counselor will say, "You know, your father is getting on in years. You can expect *this* to happen. Then *that* will happen. And you should prepare your family for *this other thing.*" And superficially this sequence of events may indeed occur much as it was described.

We tend to accept these kinds of predictions—they are orderly and, therefore, comforting—although we know from our own personal hard experience that life really does not unfold that neatly. Events tumble in, one upon the other, and cause-and-effect is very often a shrewd guess at best. Other people, and the environment itself, trigger some events early and delay others, or prevent them from occurring at all.

When an aged person lives normally (that is, he or she is moved by events in a rather random fashion), we may become confused and even fearful. We conclude that "Something is wrong with Dad. *This* is happening way ahead of schedule, and *that* shows no sign of ever happening at all." Deviation from the anticipated norm—even if the deviation is healthful behavior—may be a cause for concern.

The aged person can actually be the victim of this kind of response. If we *expect* deterioration to take place, we may feed and medicate him or her as if deterioration were *in fact* taking place. As a result, the aged person may become malnourished and then indeed deteriorate, fulfilling the prophecy.

Overmedication is another dangerous outcome of this kind of behavior toward the elderly. We anticipate that the aging person will require certain drugs and medicines, we go ahead and administer them too soon, and then we witness the very decline we thought would take place, right on schedule.

The whole matter of aged persons' being erroneously judged "senile" is yet another aspect of the aging process seen as a sequence of anticipated events by the forewarned younger beholder.

The second problem in the development of a philosophy of aging is more delicate and complex: our lack of any neat definitions for the two qualitatively different periods in the terminal time of aging. Modern medical technology makes possible certain measures that can prolong life, at least for a time. When these measures are available to extend what I have called the "good" period within the terminal time, I think we would all agree that they should be carefully considered and probably used. (I'm speaking here of such things as pacemaker implants, colostomies, coronary bypass surgery, and motorized equipment for stroke victims.)

But what about the period of decline? That is the time when the public tends to speak of anything the physician does as "taking heroic measures" to save the patient's life. If we accept the philosophical principle that we should work to make the true "dying" period as brief but as comfortable as possible, then we can commit ourselves to a rational, compassionate course lying between "heroic measures," on the one hand, and the callous mind-set expressed in that dreadful and inaccurate term "pulling the plug" on the other.

Let me interject that I never use the terms "extraordinary" and "heroic." What was extraor-

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dinary yesterday is ordinary today; what is extraordinary today will be ordinary tomorrow—and I do not know how to define "heroic" in this context. Nevertheless, each of us has some intuitive and operational understanding of these gradations of meaning, and this understanding should help us deal openly and candidly with patients.

When we counsel a patient and his or her immediate family about a developing crisis during the "dying" period, we need to clarify what our medical alternatives will accomplish. Will this or that procedure enable the patient to enjoy some additional "good" time, or will it only prolong the period of dying? Will doing nothing shorten the period of dying? Does the patient consider this to be a desirable alternative?

It is at this point that we have to deal with all three aspects of the human experience: the state of the body, the state of the mind, and the strength of the patient's spirit. Physicians and other health professionals often want to steer clear of this triangle. They profess not to have the training to deal with matters of the spirit, for example, and that is probably true. But they still need to recognize that such matters are of profound concern to the patient and need to be addressed *somehow*.

I would suggest that the way all three aspects—physical health, mental health, and spiritual health—are handled will probably determine the nature of the medical care given to the elderly patient in the final stage of approaching death. Here again, we cannot be prescriptive in defining our philosophical base. Instead, we may simply need to accept that, as a part of our treatment philosophy relative to the aged, we will give substantial attention to the patient's spiritual health during the final phase of the terminal period of life.

This is not very revolutionary talk; it is the kind of thinking that underlies the hospice movement. We know that at some point during their final period of decline, many patients are more concerned about the spiritual quality of their remaining time than about any further repair work on their bodies or minds. An act of heroism—either by their physicians or by themselves—just may not be very impressive or useful any more. They want dignity. Above all, they want peaceful human relationships. Hospice care is organized to provide that kind of experience, whether in an institution or in the dying person's own home.

The Search for Understanding

I have spoken of the end of the aging process as a finite period that has some "good" time, but then closes with a time of decline—we would want it as brief as possible—that ends in death. But when and how does the process begin?

As I mentioned earlier, our culture has more or less determined that the beginning point of the aging process follows one's 65th birthday. But some orthopedists tell patients that the aging process begins around age 30, when their shoulders and back begin to stiffen and some signs of arthritis become common. And some psychiatrists believe that the aging process begins when the infant first cries out in the delivery room and begins to breathe air. Unfortunately, there is more poetry in all this than good science.

At the National Institute on Aging, one of the key questions researchers keep turning to is, When does the aging process *really* begin: biomedically . . . behaviorally . . . from a neurophysiological, cardiorespiratory, or musculoskeletal standpoint? I'm afraid we are some distance from a scientific answer.

Nevertheless, that very lack of precision may be the most important thing for us to know right now.

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It means that we have to take into account a great deal of behavioral and biomedical information because we dare not leave anything out. And it obliges the health professional to work with professionals in many other disciplines in dealing with the problems of the aging process.

If we as professionals can arrive at some consensus about what our philosophy of aging ought to be, what would be the impact upon the people we serve?

I firmly believe that, with the help of a coherent philosophy, we will be better able to provide care to all older people, including those who are in the final period of decline. I also believe that our efforts to develop such a philosophy will stimulate clearer thinking about the aging process among the very people we serve. With the help of a philosophic approach, we can gain the mastery of that basic information about aging that would help us—and through us help others—make informed choices and decisions.

I think we need such a philosophy not only for our own work in public health but also as a contribution to society's understanding of aging in general. Before very long, young people in American society will have to make some difficult decisions about the role of older people in American life—decisions that could affect public policies toward pensions and retirement, job seniority and security, home ownership, insurance coverage, medical benefits, and so on. When they make these decisions, they should be comfortable with the idea that, whatever their youthful age, they may already be part of the aging process. They need to understand and accept the eventual terminal nature of aging. They need to evaluate the nature of the "good" time for an elderly person. And they need to participate in, or somehow influence, the decisions made during the very difficult period of final decline.

It is estimated that by the turn of the century 50 million persons in the United States—about 20 percent of the population—will be over the age of 65. The impact on all our services—but especially public health services—will be considerable.

Today's "middle-aged" persons are already ambivalent about the effects of this evolving demography: they know that decisions about care for the aged that are made and ratified today may determine how they themselves are cared for not too many years hence. Yet they are not keen on putting forward any position, however reasonable, that might "raise the hackles" of their juniors.

This raising of the hackles has already happened in organized labor. Older workers have wanted certain basic retirement and pension guarantees written into new contracts and have been willing to discuss larger payroll deductions or employer-employee contributions. But younger workers have often voted them down. Without a good basis of common understanding between young people and middle-aged people, our society could face several more decades of deep division over the issues of aging and the position of the aged.

Certainly, we should look to philosophy as a way of healing divisions and overcoming barriers, real or imagined. At least that is my intent in pursuing this idea of a philosophy of aging for public health professionals. And I see no conflict in the idea of bundling a word like "philosophy" together with a phrase like "public health." I am reminded of the lesson taught by the late James Bryant Conant, who wrote that "Any attempt to draw a sharp line between common-sense ideas and scientific concepts is not only impossible but unwise."

I hope that in the field of aging we will continue to progress in seeking the unity of common sense with science—possibly gaining that sense of unity with the help of a touch of philosophy. If so, our achievement will count as another small victory for older people in our society.