Published in final edited form as:
Gerontologist. 2004 December ; 44(6): 731–738.

Revisiting the Biomedicalization of Aging: Clinical Trends and Ethical Challenges

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Abstract

Developments in the realms of medical innovation and geriatric clinical intervention impact our understanding of the nature of late life, the possibilities for health in advanced age, medical decision making, and family responsibility in ways that could not have been predicted 15 years ago. This essay begins to map new forms of biomedicalization in the U.S. and to underscore their emergence in a new ethical field. We suggest that a new kind of ethical knowledge is emerging through "routine" clinical care, and we offer examples from the following interventions: cardiac procedures, kidney dialysis, and kidney transplant. This new ethical knowledge is characterized by the difficulty of saying "no" to life-extending interventions, regardless of age. We explore the intensification of the biomedicalization of old age through a discussion of three features of the new ethical field: (a) the ways in which routine medical care overshadows choice; (b) the transformation of the technological imperative to a moral imperative; and (c) the coupling of hope with the normalization and routinization of life-extending interventions. We argue that societal expectations about longevity and standard medical care come together today in a shifting ethics of normalcy, with unexplored sociocultural ramifications.

Keywords

Medical ethnography; Biotechnologies; Life extension

Since the 1989 publication in these pages of "The Biomedicalization of Aging: Dangers and Dilemmas," by Carroll L. Estes and Elizabeth A. Binney, the rapid pace of developments in the biomedical sciences and in geriatric medical care continues to shape knowledge about the aged body and expectations about medical intervention in late life. That landmark article drew attention to two trends. The first was the way in which aging is constructed as a medical problem or "pathology" and thus is viewed substantially by means of clinical phenomena and the management of clinical problems. The second trend was the growing power of the biomedical model in shaping a national research agenda focused increasingly on basic biological processes and the study of the etiology and treatment of diseases at cellular or subcellular levels.

Estes and Binney also pointed out the influence of the biomedicalization of aging on public opinion, "fostering the tendency to view aging negatively as a process of inevitable decline, disease, and irreversible decay" (p. 594) for which medical intervention is normalized as necessary and appropriate. Medicine today is considered the right (and perhaps the only) tool for managing the problems of aging. Other ways of defining aging and conceptualizing its problems and solutions are muted or are inconceivable. "Convinced that only biomedical science can save them [i.e., older people], the solutions to the problems of aging appear

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resolvable by the purchase and consumption of more and more high-cost medical services and technology” (p. 594).

The trends that Estes and Binney documented in 1989 have become more evident and pronounced in recent years. It can be argued that “public acceptance of the authority and legitimacy of medicine” (p. 594) has never been greater, despite the fact that a sizable minority of older persons use alternative modalities (Foster, Philips, Hamel, & Eisenberg, 2000). Developments in the realms of biomedical science and geriatric clinical intervention, specifically, affect our understanding of the nature of late life, individual and societal decision making, and family and medical responsibility in ways that could not have been predicted, even 15 years ago. Medical interventions are reshaping norms of aging and standard clinical practice. The body seems open to unlimited manipulation, at any age, and the emphasis of the health professions is on the management and maximization of life itself (The President’s Council on Bioethics, 2003; Rose, 2001). Medicine is producing a discourse of both senescence and life extension—that is, a framework for thinking about, speaking about, and understanding the arc, end, and prolongation of life (Cole, 1992; Katz, 1996; Kaufman, 1994; Rose 2001). The ways in which this discourse is made manifest in clinical activities today and the ways in which it is reshaping the social and ethical landscape of old age in the United States could only be hinted at by Estes and Binney and has not been sufficiently explored in gerontology and geriatrics.

This article begins to map the forms of intervention, responsibility, and care that exist now and to underscore their emergence in a new ethical field. Once the idea—of extending the oldest lives with the plethora of interventions now available—has been conceived, expressed, and made available to others (Strathern, 1992), it becomes a normal part of the socioethical landscape. The rightness, necessity, and inevitability of the interventions themselves remain mostly unexamined, though the scope of individual, familial, and societal obligation is forever altered.

A New Ethical Field: The Impossibility of Saying “No” to Medical Interventions

The ever-mutable nature of old age is being transformed today, in large part through the clinical practices and medical innovations that lie at the heart of biomedicalization in the United States (Clarke, Shim, Mamo, Fosket, & Fishman 2003). In our own anthropological investigation of the expanding use of life-extending medical intervention among those aged 70 and older, we are concerned with the effects, over the past 15 years, of the transformation of old age on ethical arrangements in society. We suggest that a new kind of ethical knowledge is emerging through “routine” clinical care. We are not referring here to bioethics and the well-known strategies and parameters of that philosophically based discipline for clinical decision making in individual situations. Instead, we mean a new ethical field, located throughout the social fabric and characterized by the difficulty or impossibility of saying “no” to life-extending interventions. This ethical field is constituted by the following three features:

1. The purported choices clinical medicine now provides to patients, prospective patients, their families, and doctors regarding whether and when to use life-extending procedures, and whether and when to stop them, are not really choices at all. Rather, choice elides into routine treatment.
2. The nature of caregiving and love have changed so that expressions of care (both medical and familial), affection, and value are explicitly tied to clinical acts that either extend life in advanced age or allow “letting go.”

3. The availability of interventions as therapeutic choices elicits hope and expectations for cure, restoration, enhancement, and quality of life. In turn, the boundaries between medicine's focus on cure, life enhancement, and life prolongation are increasingly blurred in the desire to maximize life.

Doctors, other health professionals, patients, and families now live in a world that is shaped by these three arenas of unavoidable conceptual framing and responsibility. The broadening of medicine's scope over the management of old age as well as illness per se (Clarke et al., 2003; Kaufman, 1994; The President's Council on Bioethics, 2003) reinforces and sustains these three features of the ethical field. This new ethical field is like the air we breathe—it is mostly background to the daily activities of health care practitioners and consumers, yet it is the basis through which we come to understand the value of medical care, our connections to one another, and the social worth of the oldest lives in our society. Each practitioner, patient, and family must "work out" an ethic of care in the course of unfolding events, active and tacit decision making, and reflection. That ethic of care is rarely premeditated, autonomous, or deliberate as conventional bioethics would have us believe. Rather, it emerges during social interaction and is shaped by the structural features and pressures of medical practice and institutions, changing notions of "standard of care," and negotiations (always influenced by power relations) about what to do and when.

Not only is the power of biomedical science and clinical medicine shaping the way we understand aging (as Estes and Binney, 1989, noted, p. 587) but also the multiple (and even contradictory) ways we understand aging and old age are changing clinical practices. In our research, we have become aware of the dialectical manner through which biomedicalization operates in the clinical realm today. To begin to explore new developments in the relationship among clinical medicine, aging, and old age, we have three goals in this article. Using findings from the medical literature and our ongoing research, our first goal is to illustrate some areas of clinical intervention in late life that have grown enormously over the past decade and a half. Our second goal is to describe what has recently become "normal" and "natural" about old age and its treatments and to begin to scrutinize the reciprocal effects of clinical medicine and conceptions of old age. Our third goal is to open a discussion of the sociocultural, ethical impacts of these developments. It is our contention that the implications for an aging society of interventions already routine in late life, or becoming so, should be a recognized topic for the multidisciplinary gerontological community.

The Exponential Growth of Medical Interventions in Late Life

The age of patients who undergo surgery and other medical interventions that save and extend life is rising rapidly in the United States (The Interdisciplinary Leadership Group of the American Geriatrics Society, 2000; Solomon, Burton, Lundebjerg, & Eisner, 2000). Indeed, octogenarians comprise the most rapidly growing group of surgical patients in the United States (Deviri, Merin, Medalion, & Borman, 1995; Olshansky & Carnes, 2001), and there is a growing literature on the justification and benefits for performing many kinds of surgical procedures on persons over the age of 80 (Christenson, Simonet, & Schmuziger, 1997; Coffman et al., 1997; Craver et al., 1999; Hricik, 1991; Sollano et al., 1998). Our research focuses on three groups of medical procedures that are already routine, or are becoming so, for the oldest adults in American society: cardiac procedures used to reduce pain, the chance of heart attacks, or sudden death—angioplasty, coronary artery bypass graft, stent, and the automatic implantable cardioverter defibrillator (AICD); kidney dialysis; and kidney transplant. This brief summary encompasses only these procedures. We do not address, for example, the growing use of chemotherapy and other cancer treatments in older age groups, other kinds of surgical interventions, or the use at older ages of drug interventions. The kinds of treatments we are investigating are, however, emblematic of the rising age for medical interventions of all kinds.

Cardiac Bypass, Angioplasty, Stent, and AICD

Coronary artery bypass graft surgery, together with angioplasty and stent procedures, are now commonplace for persons in their 80s and not unusual for persons in their 90s (Glock et al., 1996; Schmitz, Welz, & Reichart, 1998; Stemmer & Aronow, 1998). A 2003 review of outcomes of cardiac bypass surgery in nonagenarians concludes that successful outcomes can be obtained for a select group of patients aged 90 or older, though hospitalization may be longer and morbidity may be higher than for younger patients (Bachetta et al., 2003). The oldest cardiac surgery patient we could document was 98 years old at the time of his double coronary artery bypass and aortic valve replacement. He lived to be 100 (Riverview Medical Center press release, 2002).

Changes in health care financing arrangements reinforce the “normal” use of procedures at ever-older ages and, importantly, determine value in prolonging old lives. In March 2003, Medicare expanded its coverage to include the AICD. Thousands of additional older Medicare patients now qualify for the device (approved by the FDA in 1985) under expanded medical criteria developed during clinical trials (Buxton, 2003; Ezekowitz, Armstrong, & McAlister, 2003). The device is now implanted routinely for patients in their eighth decade, even though we have been told repeatedly by clinicians that sudden cardiac death, when it occurs in late life, is a “good” way to die.

Renal Hemodialysis

Since 1972, when Medicare benefits were extended to all persons with end-stage renal disease (ESRD), the earlier stringent criteria for dialysis selection have largely fallen away. In recent decades, physicians have become more successful at dialyzing patients with complicated conditions, including many older patients. Today doctors may claim that it is morally unjustified *not* to offer dialysis to any patient with ESRD. Between 1977 and 1995, the numbers of new ESRD patients in the United States ballooned from 16,000 to 72,000. In 2001, 50,000 U.S. citizens aged 75 or older were living with ESRD (Brown, 1999). The population receiving renal dialysis has grayed proportionately. Currently, approximately 20% of all U.S. dialysis patients are over the age of 75 and 13% are over the age of 80 (Transpacific Renal Network, 2002).

Kidney Transplant

The number of kidneys transplanted to people over the age of 70, both from live and cadaver donors, has increased dramatically over the past two decades. Transplants are routine in the seventh decade of life and sometimes performed into the early part of the eighth decade. Cadaver kidneys are sought, now, from donors over the age of 60 so that they can ease the shortage of kidneys for older recipients. In addition, live kidney donation is on the rise for all age groups (United Network for Organ Sharing, 2000). The growing phenomenon of live kidney donation for older recipients opens up new dimensions of family relationship and medical responsibility, as yet unexplored. Adult children (primarily in their 30s and 40s) are donating kidneys to their parents (currently, those who are in their 60s and 70s). Nephews and nieces, spouses, other relatives, friends, and strangers are donating kidneys to older persons as well. There is little, if any, public knowledge or discussion of the transfer of organs from younger to older people, yet the phenomenon is affecting more and more families (Dowd, 2003; Grady, 2001).

We do not take an ideological stand on whether, when, or to what extent life-extending medical procedures should be used in late life. Rather, our task as social scientists is to map the kinds of changes taking place in the delivery of medical care to older persons and to analyze the ways in which these changes are affecting knowledge about old age, expectations about interventions at ever-older ages, and the nature and quality of individual and social experience. Effective clinical treatments for ever-older persons have led to an interesting turn in the biomedicalization of aging. Medical practice in the past 15 years, especially, promotes the notion that aging is not inevitable (in the United States). Treatments already in use, together with the prospects for medical treatments that may retard aging, lend credence to the idea that aging is, in fact, reversible, or, at least, that it can be held in abeyance through the application of restorative and replacement procedures. There are no longer steadfast clinical assumptions about technological or biological limits to what can be done, medically or surgically, for older persons.

Moreover, intervention leads to more intervention because natural age limitations for procedures are no longer thought to be inevitable. It is well known that geriatricians (and other clinicians as well) understand chronological age to be merely one factor among medical, functional, and social variables when they are assessing treatment options. “One 80-year-old is not like another” and “Age alone should never be a deterrent to specific medical interventions, including surgery” are statements we have heard often that are supported by the medical literature (Solomon et al., 2000). Thus, although one cultural tendency continues to be, as Estes and Binney (1989) pointed out, to view aging as a process of inevitable and irreversible decline, that tendency, we suggest, has been muted by another phenomenon that exists in the clinical realm and has a profound impact on physicians, patients, and families: Age, per se, is frequently “disappeared” from view in the context of life-extending medical procedures. That is, age is denied as the factor most relevant to clinical decision making about the uses and “success” of various life-extending technologies.

As the age for certain procedures moves up beyond 70, 80, and 90, widespread consideration of an “appropriate” time to die moves up as well. Thus, it now seems almost unnatural—wrong—for someone to die at the age of 70 or 75. This perception of unnaturalness, reinforced by the fact that something can be done to prolong life at any age, is historically unprecedented.

Choice Elides to Routine Treatment

When procedures are “tried out” on older populations and shown to be effective at ever-older ages, they become “routine” (Koenig, 1988) and thus expected and desired by clinicians and patients. When techniques become less invasive and associated with lower mortality risk, consumer demand for them and ethical pressure to make them available both increase. Finally, procedures that are relatively low risk (angioplasty, stents, and dialysis) quickly become standard practice. Actual clinical choice about them is thereby eliminated. Together, these features of procedure-driven medical care contribute to the difficulty—for patients, families, and health professionals alike—of saying “no” to treatments, even at very advanced ages.

Physicians form understandings of, and thus approaches to, patient populations through their own clinical experience with the technological tools at their disposal. They work in a socioeconomic context in which the organization of clinical medicine and chain of subspecialty referrals promotes the use of high-technology procedures (Kaufman, 1997). In interviews conducted between 2002 and 2004, 16 physicians in the cardiac fields shared with us the ways their knowledge about old age has emerged through clinical practice. They all spoke about the incremental creep upward, not only in the acceptable, “normal” age range of patients for cardiac and other kinds of procedures but also in the increased aggressiveness and invasiveness of what physicians are willing to do at later ages. They spoke about how the clinical–ethical line for cardiac interventions advances in ever-older lives. Though that line is negotiable in theory and in individual situations, its overall movement upward is an unquestioned sociomedical phenomenon:

> That line is advancing. We are more willing to do things—me, and I’m more conservative than some—more willing to do things on a 70-year-old and people in

> their eighth decade than I was 25 years ago. We are doing more, and we’re getting much better results than we were in the old days. (Interventional cardiologist)
>
> I remember, in training, being confronted with the notion of putting a defibrillator in an 80-year-old patient, and thinking that that was just the most extreme circumstance. How could we justify preventing sudden death in an 80-year-old person? And now, it’s commonplace. I don’t flinch as much now about the 80-year-old. Now, I have an incredulous reaction to someone who may be over90. So, regarding my own threshold, that’s a real change that you can quantify. (Electrophysiologist)

As patients go through the process of seeing specialists and subspecialist consultants, they get put on a “train” of aggressive interventions that is very difficult to stop. Diagnostic tests “confirm” the need for interventions. Procedures become “appropriate” by default in this organizational scheme.

Reasoned choice about using specific interventions is obfuscated by the need to treat, the routinization of intervention, the specter of future risk, regardless of age, and the perceived opportunity to prevent future disease:

> One of the scenarios that troubles me the most is that the patient that arrives in the hospital with a heart attack, they’re rushed to the operating room, the blockage is identified, they have an appropriate intervention with a stent. They then have a discussion about the need or role for bypass. They go to bypass surgery. They then have some extra beats noted on the heart monitor because they’re monitored. They do have a weakened heart muscle. They’re felt to be at risk for future dangerous arrhythmias. And then I get called, and I’m just part of this 2-week extravaganza of cardiology…. And the person leaves, having had three separate types of intervention, ending with a device that is very expensive and of proven benefit and value. And sometimes we do all of this for someone who’s very old…. We definitely convince 80-year-olds to go through all this. (Electrophysiologist)

These physicians’ understandings of the shifting imperative to treat at older ages contribute, pragmatically, to the elimination of any deliberation about treatment options for an individual case, and thus standard practice replaces choice. The idea that medicine can be expected to intervene, always, even in very late life, is therefore strengthened. That idea is one of the most potent “truths” of the contemporary era.

Patient and family expectations about the ability of medicine to extend life, restore function at any age, and make people feel younger are fueled by clinical successes at ever-older ages. “I feel 10 [or 20 or 30] years younger since my bypass [or transplant]” is a common statement. Most patients and families want to “do something” to alleviate symptoms, restore function, and extend life, regardless of age. Most will not say “no” to routine treatments. Moreover, a great deal of guilt accompanies the choice to forego medical intervention, and thus that choice is not often actively made (Kaufman, 1998, in press). Twenty-eight cardiac patients interviewed between 2002 and 2004 informed us that “no treatment” was almost never an option provided by physicians. In addition, patients and their families are always hopeful that interventions will relieve painful symptoms and restore quality of life. Of 43 hemodialysis patients aged 70 or older, 40 told us they felt no choice about starting and continuing this treatment. If one were to stop dialysis, then death would come in about 2 weeks. In that case choice is replaced by treatment.

Expressions of Care and Love Are Tied to Life Extension

The second feature of the new ethical field is the way in which the technological imperative of medicine has become a moral imperative for families as well as clinicians. Families have always been implicated in medical care and its social ramifications, but the fact that older lives are routinely extended today complicates the nature of familial obligation. For patients the normalization of intervention in advanced age is accompanied by the dual obligation of being treated and staying alive—regardless of complicated, debilitating medical conditions and increased frailty. The press to treat and the need to stay alive have both become expressions of family obligation and love (as has the ambivalent desire to allow death). In the case of heart attacks, shortness of breath, and cardiac failure, nonintervention is almost unthinkable (Kaufman, 1998, in press). In the case of renal dialysis, some older patients say they continue to stay alive, by means of dialysis, because their spouses or children want them to. In the case of kidney transplant, our interviews with recipients and donors document the near impossibility of *not* offering to donate one's kidney to a relative, and the concomitant difficulty of not accepting a donation (Fox & Swazey, 1992; but see Gordon, 2001). In these cases, choice is overshadowed by family obligation and concern.

From our ethnically diverse sample of 35 kidney transplant recipients aged 70 or older, we heard a broad range of ethical opinion, from the moral obligation not to ask anyone for an organ to the individual responsibility of finding one's own donors. We heard, "I would never ask anyone to donate, my children or my friends. I'll wait for a cadaver." We also heard, "You have to be proactive. You can't just sit around or you'll die waiting. I lined up 3 [or 9 or 23] donors." However, from people who received a kidney from an adult child, we heard, at first, a negative injunction against asking one's children to donate. That initial refusal to consider one's child as a donor in order to protect one's child from risk or harm often gives way to acceptance: "The children talked me into it." Some patients expressed the following:

> I didn't want to take a kidney from her, but she was determined, adamant, insistent. It didn't feel like it was the right thing to do—help should go the other way, from parent to child. But finally [or after weeks, months, years on dialysis, feeling lousy] I went along with her [less often, him]—and with the doctors.

From 10 adult children who donated to a parent, we learned that "He [or she] was dying, or might have died, and I wanted him [her] to live," or, "The moment he started dialysis, I offered. 'Dad, you need a kidney.'" We also heard, "It was the obvious thing to do. There was no decision to make," "We were watching him die. I could prevent his death," "I wanted him around many more years. It was, in part, self-interest," and "I offered immediately, no doubts whatsoever in my mind about what to do. I volunteered before he raised the subject at all."

Maximizing Life: The Lure of Restoration and the Hope of Growing Older Without Aging

The routinization and normalization of interventions elicits hope. Hope for restoration, survival, and increased quality of life, together with the proven life-extending benefits of cardiac treatments, dialysis, kidney transplantation, and other therapies, legitimates medical interventions at ever-older ages. The coupling of hope with the normalization of life-extending interventions affects our understandings of a "normal," and therefore desired, old age and constitutes the third feature of the new ethical field.

No Normal Aging

Daniel Callahan (1987) noted two decades ago that American society, including the institution of medicine, has lost a sense of the normal or natural life span. He, along with others, urged members of American society to rediscover the naturalness of the life course and to select or reject, accordingly, medical intervention that would stave off death yet not prolong meaningful life. Current trends in the biomedicalization of aging negate the possibility of recovering a sense of natural aging and the end of life, if there ever was one; today, medicine's jurisdiction over life itself, its ability to transform life, complicates the natural biology of aging, the relationship of aging to disease, natural death, and the relationship of culture to biology in old age (Caplan, 1992; Elliott, 2003; Kaufman, 2000a; Rose, 2001; Rubinstein, 1990).

Gerontologists and social scientists have shown that conceptions of “normal” and “pathological” aging, like all scientific knowledge, are not objective, natural, or given (Cole, 1992; Holstein, 1997; Katz, 1996; Lock, 1993). Those concepts are constituted in particular social and political contexts and are elaborated over time as scientific knowledge changes. The clinical preoccupation of disentangling pathology from normal decline in late life, the blurring of normal and pathological, and the impact of both on patients, their families, and medical decision making provides a second reason why Callahan’s wish cannot be realized (Blumenthal, 2003; Kaufman 1994, 1997, 2000b).

These issues have been and will continue to be questioned and debated. Though the terms of the debate have shifted over the past century with the growing sophistication of biological knowledge, the debate itself is ongoing and pervasive in American society (Hayflick, 2003; Holstein, 1997; Moody, 2003). Knowledge of aging and disease today, like knowledge of life itself, is intrinsically linked to interventions (Rose, 2001). In addition, norms about aging and old age are being reshaped by clinical treatments.

Growing Older Without Aging

The boundaries between medicine’s focus on cure and its concern with life enhancement are increasingly blurred at every age (Nuland, 1998; The President’s Council on Bioethics, 2003). The practices of the biomedical sciences continue to move beyond the confines of disease entities and whole individuals to investigate life itself rather than disease. In doing so, they are ushering in a new genre of medicine, called by some *regenerative medicine*, which is part cure, part prevention, and part experimental science. Awareness of and desire for the malleability of the body and self well into late life underlies and characterizes this new kind of medicine (The President’s Council on Bioethics; Rose, 2001; Rowe, 1998). A major effect of biomedicalization today is that the aged body tends to be viewed now as simultaneously a diseased entity, a site for restoration, and a space for improvement.

At the same time that the relevance of age for individual medical decision making is muted and denied by clinicians, the urgency about age—especially the desire to thwart its advancement by means of medical interventions—permeates the social environment. From cosmetic surgery to knee and hip replacement, from hormone replacement therapy to the newest drugs for impotence, memory enhancement, and osteoporosis, the biotechnological practices —and promises—of slowing the aging process are ubiquitous (Elliott, 2003; Katz & Marshall, 2003). The blurred boundaries between management, enhancement, and staving off the effects of age lead toward the acceptance of life-extending medical procedures, regardless of age.

New ways of thinking about the aged body and current and potential interventions accompanying those ideas have implications for personal, societal, and clinical responsibility that are only beginning to be explored. In its 2003 report, “Beyond Therapy: Biotechnology and the Pursuit of Happiness,” the President’s Council on Bioethics warns against the pursuit of “ageless” bodies and further temptations of life extension because those desires deflect us from realizing other human aspirations, aspirations that have nothing to do with becoming “better than well.”

Clinical medicine in consumer society contributes to “the stretching of middle age into later life” (Katz & Marshall, 2003, p. 4), yet, at the same time, it makes the risks of old age insistently relevant well into midlife. The well-analyzed “age-irrelevant” society that characterized late-20th-century American social life and distinguished it from earlier historical periods (Cole, 1992; Featherstone & Hepworth, 1991; Neugarten, 1982, 1988) has been joined, at the end of the 20th and early 21st centuries, by an additional cultural phenomenon: biomedicalized life. That is, we now have the opportunity and the (impossible) burden of “*growing older without aging*” (emphasis added; Katz & Marshall, p. 5). “The extension of medical jurisdiction over health itself” (Clarke et al., 2003, p. 162) and, we would add, over life itself, renders medical intervention natural and normal, especially in late life.

The Future of Care

It is through an ethics of normalcy that expectations about long lives and expectations about routine medical treatment come together. It is unacceptable to die at 71, or 81, or 91 if one can utilize routine medical care to stave off death and restore health. Things can be done, and the family is involved. Love is actualized often through the commitment to a longer life and by doing things to prolong life. The ancient question—what are our obligations across generations?—has not disappeared. As ever, we must demonstrate the ways in which we care for the oldest members of our families and our society. We are demanding and being asked to share in those lives in unprecedented ways through the range of medical procedures now available.

Biomedical technique provides the most powerful logic, the most pervasive method, to show our care. Demonstrating care and love for the oldest generation outside the frame of medical treatment, and then outside the rhetoric of rights and entitlement, is nearly impossible in American society. An alternative rhetoric, of nonabandonment, for example, is rarely articulated. If, as Rose (2001) and others suggest, the body has become one of the most important sites for ethical judgments about life, what other framings are possible when an old body can “benefit,” unequivocally, from medical intervention? Are there ways, beyond the body and its medical treatment, to demonstrate worth and love?

A price is paid for hope and expectation invested in biomedical technique. We are only beginning to discover this price in terms of life extension in late life. As yet, the long-term ramifications, for our relationships with one another—of extending life and postponing death—are entirely unknown. In this regard we are all the subjects of a medicoethical experiment taking place on a broadening social scale. As more and more individuals and families become involved in the stakes here, simply because we face the prospect of longer lives, one thing is certain: What we are willing to accept, in terms of interventions and obligations to those in late life, will change. We invite the gerontological community to begin to explore these issues with us.

Acknowledgements

The study on which this article is based was funded by the National Institute on Aging under Grant AG20962 (to Sharon R. Kaufman, principal investigator). We are indebted to the more than 100 health professionals, patients, and family members who took the time to speak with us about life-extending medical procedures. This article, and the research on which it is based, represents a collaboration among the three authors, all of whom gathered ethnographic data and contributed to the content (Dr. Kaufman drafted this paper, incorporating suggestions from Drs. Shim and Russ). We thank Meredith Minkler for her suggestions on an earlier draft.

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