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Address

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When I presented this address, I had been talking frequently on the “Graying of America” and indeed, everything we talked about, internally, concerning the future of public health took into account the fact that we were facing huge public health challenges as the population shifted in age. Life expectancy had been extended and we could look forward to the “Baby Boomer” cohort being the largest aged cohort that had ever been dealt with in the history of public health.

I started this off not by giving statistics, but reminding the audience that over half of all the people who had ever lived beyond the age of 65 in this country...were alive that day. And that there were 2.5 million Americans in the country that were already over the age of 85 and that number would double by the year 2000. And finally I reminded the audience that a good number of them would celebrate their own 100th birthday.

The question before us was how do we prepare ourselves for the impact of the “Graying of America”, which had been underway for some time? What kind of thinking did we have to do? This was the first time I had ever addressed the subject of “older Americans” and acknowledged to the audience that I was indeed one of the seniors. At the time this talk was given, I was in my seventy-second year, which might not have broken records for government employees, but it certainly did for Surgeons General.

I suggested the first thing to do would be to get rid of myths and outworn stereotypes regarding the elderly. We had always tended to confuse the aging process with certain specific disease conditions that happen to be found most often in the elderly. Biomedical research now tells us that there is such a thing as a disease-free aging in which all systems of the human body and mind function quite well. Scientific literature indicates that people do not just “run-down” as they get older. Things do change, that’s true, but most natural functions continue and do not naturally deteriorate as part of the process.

Specifically, cardiac research has shown that about half the elderly subjects in the study conducted by the Gerontology Research Center of Baltimore had some evidence of coronary artery disease, and showed a decline in cardiac output. But there were also a fair number of elderly subjects in the same age cohort who had no signs of coronary artery disease and no signs

of a decline in cardiac output. In other words, this kind of research showed that, a decline in cardiac function is related to disease and is not an inevitable result of aging.

I then cautioned, that when it came to the aging process, we are still on the threshold of learning about it. However, that didn't prevent me from venturing to this dangerous territory to make some general observations:

First, aging itself, is not a disease condition and it is not necessarily accompanied by a disease condition. Second, each person grows older in a way that is individual and unique to that person. It is different from the way that anyone else grows older. I drew on Boswell's biography of Dr. Samuel Johnson, who had said. "There is a wicked inclination in most people to suppose an old man decaying in his intellect. If a young or middle aged man, when leaving a company, does not recollect where he laid his hat, it is nothing; but if the same inattention is discovered by an old man, people will shrug their shoulders and say, 'His memory is going.'" Johnson knew yesterday by intuition what we are finding to be true today through science.

The best studies were done in the State of Washington, where over a twenty-year period, the subjects were given a battery of intelligence tests. It was discovered that 80 per cent of the subjects showed no real change in mental performance over that period of time.

Strange as it may seem to the user, looking at this archive now, even back in 1988, one heard almost nothing about Alzheimer's disease compared to what one hears today (2003). I mentioned we were getting to know more about Alzheimer's and I pointed out that natural changes in cognition that take place over time, are not, in themselves, a disease condition, nor do they seem to be precursors of a disease such as Alzheimer's.

Today's working adults are generally in good health. In fact, the overall health status of adult Americans was better at the time of this lecture, than it ever had been before. They were benefiting from better diet, regular exercises, and a noticeable and continuing decline in alcohol intake and cigarette smoking.

Inasmuch, as the Surgeon General is always keenly aware of health promotion and disease prevention, I then pointed out the fact that many terminal illnesses among the elderly are totally or substantially the consequences of certain patterns of living. And I used smoking as a case in point.

I also hit something else that the pundits seems to have discovered and bothered me considerably, and that was the last year of a person's life is the most expensive medically. What did one expect? He real question was, were we spending money properly? This seemed to be an appropriate time to quote Governor Lamm of Colorado (that I was later to debate on this subject, on the Green in Hanover, New Hampshire) when he said concerning older people: "They ought to die more quickly" and "get out of the way". I made it clear that that phrase bothers me, especially with people who say it is the choice of the older folks. I know so much by personal experience that it frequently is not the older person's choice, but someone else's. Various living wills and medical powers of attorney were being doubted, in the days of this lecture, as being the kind of documents that express an individual's personal choice for a so-called "Death with

dignity”. But when push comes to shove, and a patient faces the choice of the type of life he or she is living or a “death with dignity”, a patient very often chooses life over death. I find no fault with any old person who does not agree with Governor Lamm.

This was a natural entrée to a discussion about euthanasia. I thought then, and I think now that one of the most important things I could say on this issue was: “There is a great deal of difference between giving the patient all the life to which she or he is entitled or prolonging the act of dying.”

It is true that many of the expenditures made in the last year of a person’s life are in the futile pursuit of prolonging the patient’s act of dying. On the other hand, having been a clinician for many years, I know there are many patients for whom there is a high expectation of recovery. These two types of patients need to be separated in our minds.

I confess to a worry that America will decide such great ethical issues of life and death exclusively in terms of “cost containment”.

It certainly is sensible to imply that the possibility exists that the overall health costs of tomorrow’s elderly may be substantially lower, per capita, than it is today, thanks to a popular commitment to health promotion and the prevention of disease and disability, by both the individual and society. This however, has proven to be an illusive goal. I think largely because Americans who are preoccupied with health tend to focus on the glamorous things like baboon hearts and titanium knees and don’t think there is much glamour in just saying “no”.

I closed with the notion that we could not duck these issues, because they are inconveniently difficult. My parting shot was: “If you do duck them, they will only come back to haunt you, when you, too, are old...and ill...and in need of compassionate health care to ease you through your final years.”