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The Graying of America: Challenges and Controversies

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Keywords

Bioethics; Ethics; Health Care Disparities; Advanced Dementia; Physician-Assisted Death

Growth of the world's population is accelerating. It reached 1 billion people in 1800, and added the next billion by 1930—130 years. The population reached 3 billion by 1960—only 30 years—and ever since then, a billion more people have been added every 12-13 years. The world's population now stands at nearly 7 billion and epidemiologists project that it will rise to 9.3 billion by 2050. The majority of that population, 61%, lives in Asia, mostly China and India, and only 4.5% live in the United States—those proportions will change little by 2050. (Figure 1) In developing countries, the populations frequency distribution by age is heavily weighted toward youth, while in developed countries such as the US, the bulk of the population is in the 30-60 year age group.¹

In the US, the expanding population is reaching old age more rapidly than in most of the rest of the world, largely because the baby boom of 1946-1964 produced a large bump in population, and the first of the baby boomers reached age 65 in 2010. Between 1900 and 2010, the proportion of the population age 65 and older increased at an average rate of 0.74% per decade, but over the next 2 decades, the rate of increase in the elderly population will be over 3% per year. (Figure 2) By 2030, the rate of population growth related to the baby boom will level off, and by then, about 20% of the US population, 72 million people, will be over the age of 65 years. (Figure 3).

This aging of the US population has brought to the fore a number of ethical issues that will grow in importance as the elderly population expands. The 16th Annual Thomas A. Pitts Memorial Lectureship in Medical Ethics addressed several of these issues, including the idea of rationing health care based on age; disparities in health care of the elderly; caring for the growing number of persons with advanced dementia; and physician-assisted death for terminally ill individuals with unremitting suffering. Some of the nation's leading authorities in these areas were brought together for this conference.

Daniel Callahan has been one of the foremost proponents of rationing health care for the elderly since the publication of his 1987 book, *Setting Limits: Medical Goals in an Aging Society*. His argument has focused on using public funds—mostly Medicare—for palliative treatment of the elderly rather than curative care. In his contribution to this symposium,

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“Must We Ration Health Care for the Elderly?”, he continues to argue that the rising cost of care is unsustainable and requires explicit instead of hidden rationing. He no longer believes in using age as an arbitrary determinant of withholding curative care, however; rather, he contends that a better way to ration public funds is by setting limits independently of age by using one a new technology such as quality adjusted life year calculations to establish a line beyond which only palliative care will be offered.²

David Gruenewald addresses the same issue in his paper, “Can Health Care Rationing Ever Be Rational?” He argues that physicians generally do a poor job of sharing decision making with patients because they do not seek information from the patient or listen carefully enough to determine the real desires of their elderly patients, many of whom prefer comfort care to complex and expensive technologies intended to extend life. He approvingly describes the idea of “slow medicine” as a strategy aimed at improving the quality of life while avoiding inappropriate, potentially harmful care. By adopting measures such as genuine shared decision making and slow medicine, he argues, progress can also be made toward reducing the costs of health care for the elderly.³

Using Alzheimer's disease as an example, Peggy Dilworth-Anderson examines the interactions between disparities in health care outcomes in minority populations, social justice, and differences in cultural appreciation of illness. In her contribution, “Social Justice, Health Disparities, and Culture in the Care of the Elderly,” she argues that research into health care disparities requires understanding of disparities arising from 2 different sources: economic and structural barriers to access, diagnosis, and treatment, and barriers related to cultural interpretations of disease. The way to reduce disparities in health care outcomes in the elderly, she says, is to apply ideas of justice, fairness, and equity to the care of both individuals and communities.⁴

In his paper, “Looking for Better Health in All the Wrong Places: The Road to ‘Equality’ Hits a Dead End,” Thomas Miller takes a different view of how to approach health care disparities in the elderly. He provides extensive citation of work in this area that shows that measuring health outcomes rather than expenditures and processes is more likely to be effective. Nonmedical factors are critically important as determinants of health, but have a long latent period before the beneficial effects are manifested: exercise, nutrition, health related behaviors, and especially education level. Interventions in childhood may be relatively inexpensive medical investments that produce large dividends late in life, in the health of the elderly.⁵

Addressing the problems associated with dementia in his paper, “Testing the Medical Covenant: Caring for Patients with Advanced Dementia,” William May argues that the medical covenant with a patient is not the same thing as a contract. Reaching beyond the specificity of contract, covenant requires the physician to attend to the whole patient rather than specific aspects of her care. He discusses six different ways that withholding of treatment in cases of medical futility can be understood, ultimately focusing on physicians responsibilities to the patient and the patient's family. He concludes by rejecting the idea of treating medical futility as a contest between competing sources of power. Rather, as the end-of-life approaches for elderly patients who suffer from dementia, the physician should

recognize the strength of the bonding between family members and patients as they work together to discover the course that best suits the needs of the patient and her family.⁶

Providing a physician's point of view of advanced dementia, Muriel Gillick starts by describing the huge scope of the problem in her essay, "Doing the Right Thing: a Geriatricians Perspective on Medical Care for the Person with Advanced Dementia." Over 5 million Americans currently suffer from Alzheimer's disease, and this number could rise to 16 millions in the next 4 decades. She identifies the goal of care when loss of cognition progresses for most individuals both with and without advance directives: limitation of interventions in favor of comfort care—prevention of suffering, promotion of dignity and facilitation of caring—in the presence of severe cognitive impairment. In the uncommon instances when the patient clearly desires life-extending interventions, the physician's should help surrogate decision-makers understand how this goal can be achieved.⁷

As the first speaker in a debate between 2 of the nation's foremost proponents of opposing views of physician-assisted death, Timothy Quill reviews the settings in which requests for assisted death take place, the variety of options of last resort for dying patients who are severely suffering, and answers to frequently asked questions about assisted death, using data from the Oregon experience. In his paper, "Physicians Should 'Assist in Suicide' When It is Appropriate," he gives several reasons why open, legally permitted assistance in death is to be preferred over secret practices: the problem is substantial and should be acknowledged; patients and families are encouraged by physician's open admission of medicine's limitations and their search for effective solutions; moreover, it permits a (rarely-needed) final option for physicians to continue their foundational ethical obligation to care for their patients through to the end of their lives, without the use of secrecy and ambiguity.⁸

The distinguished constitutional scholar, Yale Kamisar, has written and spoken in opposition to physician-assisted death for over 50 years. He continues to oppose it in his contribution to this symposium, "Are the Distinctions Drawn in the Debate about End-Of-Life Medical Decision Making 'Principles'? If Not, How Much Does It Matter?" He agrees with Quill that dying patients should not be abandoned and that a reasonable goal of medicine is to help terminally ill patients to achieve the best possible death. He disagrees, however, that the law should be changed to permit physicians to prescribe or administer lethal drugs. In support of his position, he reviews pertinent contributions from the bioethics literature and from the law as it has developed over the last few decades, including the findings of various courts in the Cruzan case, the Glucksberg and Quill cases, and *Baxter v. Montana*. He concludes by pointing to the dangers of legalizing assistance in death, while at the same time emphasizing the variety of assistance that can be provided to terminally ill patients short of intentionally causing death.⁹

The ethical and public policy problems associated with the rapid growth of the elderly population are not likely to diminish over the next two decades—quite the opposite, in view of the rapid growth of the population over age 65 years. Many more discussions and debates such as those presented in this symposium will be needed to light the way to better care for those who have contributed much to our society and are now in their declining years.

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Biography

Robert M Sade, MD, is Professor of Cardiothoracic Surgery and Director of the Institute of Human Values in Health Care at the Medical University of South Carolina. He currently chairs the Ethics Committee of the American Association for Thoracic Surgery, chairs the Standards and Ethics Committee of the Society of Thoracic Surgeons, and serves on the ethics committee of the United Network for Organ Sharing. He was a member of the American Medical Association's Council on Ethical and Judicial Affairs for seven years, and retired as chair of the Council in 2007. He is Associate Editor (Ethics) for the Annals of Thoracic Surgery.

About This Symposium

This symposium issue consists of papers presented at the 16th Annual Thomas A. Pitts Memorial Lectureship. The endowed lectureship, held annually since 1993, is funded by the Medical University of South Carolina Foundation through a bequest from Dr. Pitts, who served on MUSC's Board of Trustees for 36 years and as its chair for 25 of those years.

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Figure 1.

Graphic representation of the world's population in 2010 and 2050, by region. The population of Asia is concentrated in China and India and, although it will grow at a lower rate than Africa and Latin America, Asia is now and will remain by far the largest population center in the world. Adapted from L. Roberts, "9 Billion?" *Science* 333, July 29 (2011): 540-543. Based on data from the U.N. Population Division, 2011.

Figure 2.

Percent of US Population 65 and over and 85 and over: 1900 to 2050. The proportion of the US population 65 and older increased from 4 percent in 1900 to 13 percent in 2010 and is projected to be 19 percent in 2030 and 20 % in 2050. The proportion of the US population 85 and older increased from 0.2 % in 1900 to 1.9 % in 2010 and projected to be 2.3 % in 2030 and 4.3 % in 2050. Based on data from Population by Age and Sex for the United States: 1900 to 2000, Part A, F. Hobbs F and N. Stoops, U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4, Demographic Trends in the 20th Century, 2002; and G.K. Vincent and VA. Velkoff, "The Next Four Decades: The Older Population in the United States: 2010-2050," Current Population Reports, US Census Bureau, May 2010.

Figure 3.

US Population Age 65 and over and 85 and over by Age: 1900 to 2050. Large increases have occurred in the population 65 years and older, from 3.1 million people in 1900 to 35 million in 2000, projected to 72 million in 2030 and nearly 90 million in 2050. Based on data from Table 12. Based on data from Population by Age and Sex for the United States: 1900 to 2000, Part A. Number, F. Hobbs F and N. Stoops, U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4, Demographic Trends in the 20th Century, 2002; and Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12), Population Division, U.S. Census Bureau, Release Date: August 14, 2008.