

A special kind of realism

Samia Hurst

A 1952 issue of JAMA contains an article «prepared from the viewpoint of the general practitioner», in which the author Edward J. Stieglitz remarked that:

«In diseases of senescence the physician deals with subtle, insidious changes, which demand the highest diagnostic acumen for their detection, identification, and evaluation, and the greatest therapeutic skill individually applied. Geriatric medicine is no area for those who are intellectually lazy.» [1]

He added, again in a style that would not be out of place today, that «the burdens of chronic disease, both individually and collectively, are the source of greater tragedy than death from acute illness».

Fast forward to the present and to recent papers on, for example, the need to reassess our hierarchy of cardiovascular risk factors in old age [2]: clearly, we are still speaking of adapting medical interventions *to* old age. We are also still concerned about how to define the proper aims of medicine *in* old age. Critiques of «agism», that we are doing too little, and proponents of «slow medicine», who are concerned that we are doing too much, both do seem to have a point. Shall it be, then, medicine tailored to old age? Perhaps we should even have medicine *against* old age itself. [3] In practice we may sometimes need medicine *despite* old age, at a time when resource constraints meet rising needs, and where voices raised against the risk of discrimination become more important. [4] We may also need somewhat-more-than-medicine in old age, integrating a more clearly relevant concern for the socio-economic determinants of health. [5] In this issue, Laura Di Pollina proposes that we should integrate loneliness «into the traditional medical model of disease» [6]; a proposal which is certainly close to the current needs of many patients. But there are certainly different ways of opening the scope of medicine in such ways, and some will be more justifiable than others.

To examine Medicine in Old Age, as this issue of *Bioethica Forum* attempts to do, is to explore a field of constant concerns about doing *too much*, or *too little*, or in any case *not right*. In the care of patients, where «the greatest therapeutic skill individually applied» requires

more of some things and less of others. In the full scope of medicine, we are constantly uncertain about the proper boundaries between medical and social interventions. In our stance towards old age, we are divided on whether to embrace or combat old age as one of the limits of our lives. It is crucial, however, to realise that the terrain on which these issues play out is one where the very notion of old age shifts. Stieglitz marks «the senescent period of life» as beginning at 40 (he himself died at 59) and his concern was associated with the rise of life expectancy to all of over 71 years for baby girls born in 1951. [1] So yes, this is a field where realism can translate into adaption, restraint, expansion, even utopia. It should, however, include something more: the realisation that the limits on which our opinions are divided tend to move along with us, as it were; along with the length and structure of what we may call «a typical human biography», something which might now realistically shift within a single lifetime.

Correspondence

Pr. Samia Hurst
Institut d'éthique biomédicale
CMU/1 rue Michel Servet
CH-1211 Genève 4

e-mail: samia.hurst@unige.ch

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