ORIGINAL

Ethical Imperatives and the New Physician: IV. Responding to the Aging Patient

Commencement Address By
C. Everett Koop. M.D., Sc.D.
Surgeon General
of the
U.S. Public Health Service
U.S. Department of Health and Human Services

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(GREETINGS TO HOSTS, GUESTS, FRIENDS, ETC.)

I AM DELIGHTED TO BE YOUR COMMENCEMENT SPEAKER THIS YEAR. AND IT'S A SPECIAL PLEASURE TO BE HERE IN KIRKSVILLE, WHICH YOUR CLASS PRESIDENT, MITCHELL ADAMS, REMINDED ME IS THE "HEARTLAND OF OSTEOPATHIC MEDICINE."

I FEEL A SPECIAL KINSHIP FOR OSTEOPATHIC MEDICINE BECAUSE OF ITS CONSISTENT AND ABIDING CONCERN FOR THE ROLE OF THE FAMILY IN THE CONTEXT OF GOOD PATIENT CARE.

I MIGHT ADD THAT FAMILIES AND CLOSE FRIENDS PLAY AN IMMENSELY IMPORTANT ROLE IN THE PREPARATION OF PHYSICIANS, ALSO. I AM SURE THAT THERE ARE MANY YOUNG MEN AND WOMEN AMONG THIS GRADUATING CLASS TODAY WHO SIMPLY WOULD NOT HAVE REACHED THIS HAPPY DAY, WERE IT NOT FOR THE LOVE ... THE MORAL SUPPORT ... AND THE HARD CASH THAT WAS FORTHCOMING FROM THE PEOPLE WHO LOVE YOU AND CARE ABOUT YOUR FUTURE.

SO FAMILIES AND CLOSE FRIENDS ARE PERSONALLY IMPORTANT, TO BOTH PATIENTS AND PHYSICIANS.

IN FACT, DURING MY 40-YEAR ASSOCIATION WITH PEDIATRIC SURGERY, I RELIED AS MUCH UPON THE PARENTS AND SIBLINGS OF MY PATIENTS AS I DID ON MY OWN MEDICAL AND TECHNICAL STAFFS. AND I ASSURE YOU THAT THOSE STAFFS WERE -- AND STILL ARE -- TOP-NOTCH AT THE CHILDREN'S HOSPITAL OF PHILADELPHIA.

BUT ODDLY ENOUGH, IN THE 7 YEARS SINCE I LEFT MEDICAL PRACTICE TO BECOME YOUR SURGEON GENERAL, I HAVE BEEN EVEN MORE CONSCIOUS OF THE IMPORTANT ADJUNCT ROLE OF THE FAMILY IN CONTEMPORARY HEALTH CARE.

HOWEVER, I'VE ALSO BECOME MUCH MORE AWARE OF THE MANY SUBTLE WAYS IN WHICH OUR EXCELLENT SYSTEM OF HEALTH CARE HAS BEGUN TO PUT CONSIDERABLE AND OFTEN UNREASONABLE STRESS UPON THE FAMILY UNIT AND UPON THE FAMILY-CENTERED PRACTITIONER.

AND DURING MY FEW MINUTES WITH YOU TODAY I'D LIKE TO TALK ABOUT THAT. MY PARTICULAR FOCUS, HOWEVER, WILL BE ON THE NATURE OF THE ETHICAL CHALLENGE BEING PRESENTED TO PHYSICIANS TODAY, ESPECIALLY TO THOSE WHO PROVIDE MEDICAL AND HEALTH CARE FOR OUR ELDERLY.

MY CHOICE OF TOPIC IS NOT ALL THAT ARBITRARY. EARLIER THIS YEAR, AS I LOOKED OVER MY SPRING SPEAKING SCHEDULE, I NOTED THAT I WOULD BE PRESENTING 6 COMMENCEMENT ADDRESSES TO GRADUATING CLASSES OF NEW PHYSICIANS. IT SEEMED LIKE A GOOD OPPORTUNITY TO DEAL WITH A VARIETY OF ETHICAL QUESTIONS IN THE COURSE OF THOSE 6 ADDRESSES.

AND THAT'S WHAT I'VE DONE. BEGINNING EARLIER THIS MONTH, AT THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES, AND ENDING IN MID-JUNE, AT THE UNIVERSITY OF HEALTH SCIENCES/CHICAGO MEDICAL SCHOOL, I AM SHARING WITH SOME 1,200 GRADUATES IN ALLOPATHIC AND OSTEOPATHIC MEDICINE THESE THOUGHTS ON THE RANGE OF "ETHICAL IMPERATIVES" FACED BY THE NEW PHYSICIAN.

SOMETIME THIS SUMMER I HOPE TO SEND EACH OF YOU A FINAL PUBLISHED COPY OF ALL 6 ADDRESSES.

HENCE, TODAY, I WANT TO RAISE WITH YOU SEVERAL OF THE ETHICAL QUESTIONS SURROUNDING HEALTH CARE FOR THE AGED.

I NEED NOT DWELL ON THE SIGNIFICANCE OF THE TOPIC BECAUSE I'M SURE YOU ALL KNOW THAT BY THE TIME YOU ARE AT YOUR PEAK IN YOUR OWN MEDICAL PRACTICES -- IN, SAY, 15 OR 20 YEARS -- A SUBSTANTIAL PORTION OF THE AMERICAN POPULATION, CLOSE TO 20 PERCENT, WILL BE OVER THE AGE OF 65.

AND WITHIN THAT GROUP, THE FASTEST-GROWING SEGMENT WILL BE THAT OF PERSONS WHO ARE AGE 85 OR ABOVE.

HENCE, A SUBSTANTIAL PORTION OF YOUR OWN PATIENT CENSUS WILL BE OVER THE AGE OF 65 ... AND EVEN OVER THE AGE OF 85.

THIS WILL BE A GRADUAL, AND EVOLVING DEVELOPMENT. I CERTAINLY DON'T ANTICIPATE -- NOR SHOULD YOU -- ANY SUDDEN "AGE SHOCK" IN YOUR PRACTICE.

ALSO, I WOULD ASSUME THAT ACCESS TO PHYSICIAN CARE WILL BE AS GENERALLY PROBLEM-FREE FOR OLDER PEOPLE IN THE NEXT CENTURY, AS IT IS TODAY.

THERE MAY BE SOME UNHAPPINESS AMONG PHYSICIANS WITH THE WAY THEY'RE REIMBURSED FOR THE MEDICAL CARE THEY DO DELIVER TO OLDER PEOPLE. WE HEAR ABOUT THAT TODAY, IN REGARD TO REIMBURSEMENT SCHEDULES UNDER MEDICARE ASSIGNMENTS.

NEVERTHELESS, IT IS GENERALLY ACKNOWLEDGED BY MOST OLDER PEOPLE AND THEIR ADVOCATES, AS WELL AS BY GOVERNMENT, THAT AN OLDER PERSON IN THIS COUNTRY WHO NEEDS MEDICAL CARE WILL GET IT.

THE RUB COMES WHEN THE ATTENDING PHYSICIAN MUST MAKE THE JUDGMENT -- AND IT'S AN ETHICAL AS WELL AS A MEDICAL JUDGMENT -- REGARDING THE NATURE AND THE EXTENT OF THE MEDICAL CARE TO BE GIVEN TO THE OLDER PATIENT.

IDEALLY WE WOULD RATHER MAKE OUR JUDGMENTS SOLELY ON THE BASIS OF WHAT IS GOOD MEDICINE. AND ESSENTIALLY I BELIEVE THAT'S STILL WHAT AMERICAN PHYSICIANS ARE DOING.

BUT THEY ARE ALSO BEING PLACED UNDER GREATER AND GREATER PRESSURE TO SLOW DOWN -- IF NOT REVERSE ALTOGETHER -- THE RISING COSTS OF HEALTH CARE.

TAXPAYERS ... HOSPITAL ADMINISTRATORS ... THIRD-PARTY PAYORS ... GOVERNMENT OFFICIALS ... AND PATIENTS THEMSELVES ARE QUESTIONING THE HIGH COST OF MEDICAL CARE AND THEY ALL WANT TO SEE PHYSICIANS DO THEIR PART BY EXERCISING GREATER COST CONTROL.

THE ARGUMENTS, BY THE WAY, USUALLY CONCERN THE EXCESSIVE COSTS OF CARING FOR THE PATIENT IN THE NEXT BED ... NEVER ONE'S OWN.

IN ANY CASE, THE ELDERLY HAVE BECOME A RATHER CONVENIENT TARGET BECAUSE, NO MATTER HOW SUCCESSFULLY YOU CARE FOR AN ELDERLY PATIENT, HE OR SHE WILL HAVE THE POOR TASTE TO DIE WITHIN JUST A FEW YEARS --IF NOT A FEW MONTHS.

THIS RATHER OBVIOUS PHENOMENON HAS PROMPTED SOME CRITICS TO ADVISE OLDER PEOPLE TO SOMEHOW "GET OUT OF THE WAY," AS GOVERNOR LAMM OF COLORADO HAS SO DELICATELY PUT IT, IN ORDER TO CONSERVE PRECIOUS RESOURCES -- INCLUDING, OF COURSE, MONEY.

SUCH AN ARGUMENT REVEALS A FRIGHTENING OVER-SIMPLIFICATION OF A MAJOR HUMAN CONCERN. IT ALSO DEMONSTRATES A PROFOUND MISUNDERSTANDING OF THE HUMAN AGING PROCESS.

WHEN PEOPLE TURN 65, THEY AUTOMATICALLY DO NOT BEGIN TO DIE. THAT'S RIDICULOUS. EVEN AN OLDER PERSON WHO IS ILL IS NOT, IPSO FACTO, KNOCKING AT DEATH'S DOOR.

FOR SUCH PEOPLE, WHO CLING TO LIFE, DANIEL CALLAHAN OF THE HASTINGS CENTER HAS A SPECIAL LABEL: HE CALLS THEM "BIOLOGICALLY TENACIOUS." BUT THERE'S A LOT MORE AT WORK IN THE FIGHT FOR LIFE THAN JUST ONE'S OWN FERMENTING BIOLOGY.

THE PLAIN FACT IS THIS: WE DON'T KNOW PRECISELY WHEN A PERSON'S "TIME IS UP." THEREFORE, WE AS PHYSICIANS MUST OPERATE WITHIN AN ETHICAL SYSTEM THAT REQUIRES US TO GIVE A PATIENT ALL THE LIFE TO WHICH HE OR SHE IS ENTITLED.

WE SHOULD DO THAT FOR PATIENTS OF ANY AGE. BUT IT IS ESPECIALLY SIGNIFICANT FOR OLDER PATIENTS, WHO ARE ALREADY PERCEIVED BY YOUNGER PEOPLE AS BEING SO MUCH CLOSER TO DEATH AND THEREFORE ... VIRTUALLY DEAD.

SOME, WHO HAVE HEARD ME MAKE THIS ARGUMENT, HAVE COUNTERED THAT ALL I WANT TO DO IS PROLONG THE ACT OF DYING. I ACKNOWLEDGE THAT THERE IS SUCH A THING ... BUT I WOULD NOT ENGAGE IN IT.

I HAVE ALWAYS BELIEVED THAT THERE'S A VAST DIFFERENCE BETWEEN GIVING A PERSON AS MUCH LIFE AS HE OR SHE IS ENTITLED TO AND READY FOR ... AND MERELY STRETCHING OUT THE AGONY OF DEATH. I AM ALL IN FAVOR OF THE FORMER ... I DON'T CARE AT ALL FOR THE LATTER.

AN ADDITIONAL COMPLICATION IN ALL OF THIS IS THE FASCINATION WE ALL HAVE WITH THE WORD "QUALITY." I USED IT JUST A FEW MOMENTS AGO, IN THE PHRASE "QUALITY MEDICAL CARE." I THINK I KNOW WHAT "QUALITY MEDICAL CARE" MEANS, ALTHOUGH I ADMIT IT'S LARGELY INTUITIVE ON MY PART ... VERY SUBJECTIVE AND VERY PERSONAL.

AND THE SAME IS TRUE OF THE PHRASE "QUALITY OF LIFE." EACH OF US HAS AN INTUITIVE UNDERSTANDING OF WHAT "QUALITY OF LIFE" MEANS ... BUT ONLY FOR ONE'S SELF. I CAN ASSURE YOU, AS A 71-YEAR-OLD WHITE MALE IN THE GOVERNMENT, THAT MY IDEA OF "QUALITY OF LIFE" IS PROBABLY QUITE DIFFERENT FROM THE IDEAS IN THE HEADS OF ANY YOUNG GRADUATE HERE TODAY.

I'M NOT WRONG, OF COURSE. AND NEITHER ARE YOU. BUT OBVIOUSLY I CAN'T DECIDE WHETHER OR NOT TO EXTEND YOUR LIFE BY A FEW MONTHS ON THE BASIS OF ITS "QUALITY" FOR YOU ... NOR SHOULD YOU MAKE ANY JUDGMENTS ABOUT THE "QUALITY OF LIFE" FOR ME.

THIS IS A NAGGING CONCERN OF MINE, SINCE I HEAR THE PHRASE USED MUCH TOO OFTEN NOT ONLY IN THE CONTEXT OF MEDICAL CARE FOR THE AGED, BUT ALSO IN THE CONTEXT OF EMERGENCY MEDICAL CARE FOR HANDICAPPED NEWBORNS.

ODDLY ENOUGH, SOME PHYSICIANS -- WHO PROFESS SOME CONCERN ABOUT THE "QUALITY OF LIFE" -- HESITATE GIVING THEIR OLDER PATIENTS GOOD ADVICE REGARDING THE PREVENTION OF DISEASE AND THE PROMOTION OF GOOD HEALTH.

MAYBE THAT'S PART OF OUR PREOCCUPATION WITH HIGH-TECH MEDICINE. FOR EXAMPLE, WE SEEM TO BE MORE INTERESTED IN TRANSPLANTING DISEASED HEARTS AND LUNGS THAN WE ARE IN TEACHING PEOPLE NOT TO SMOKE IN ORDER TO PREVENT HEART AND LUNG DISEASE FROM OCCURRING IN THE FIRST PLACE.

BUT OLDER PEOPLE SHOULD GIVE UP CIGARETTES, SHOULD WATCH THEIR DIET, HAVE A ROUTINE REGIMEN OF EXERCISE, SHOULD GO EASY ON THE ALCOHOL, AND SHOULD WEAR SEAT-BELTS ... JUST LIKE YOUNGER PEOPLE.

THE AGING PROCESS, AFTER ALL, IS A LIVING PROCESS. IT IS NOT AN ILLNESS AND, THEREFORE, IT'S NEITHER TREATABLE NOR REVERSIBLE.

BUT HUMAN AGING CAN BE SICKNESS-FREE, DISEASE-FREE, JUST LIKE ANY OTHER PERIOD IN ONE'S LIFE. AND IF YOU UNDERSTAND THAT -- TO REPEAT WHAT I SAID EARLIER -- THEN YOU UNDERSTAND THE DIFFERENCE BETWEEN LIVING AND THAT SEPARATE AND SPECIAL EXPERIENCE CALLED "DYING."

A GOOD PHYSICIAN, IN MY BOOK, RECOGNIZES THE ETHICAL IMPERATIVE TO ASSIST HIS OR HER PATIENTS TO TAKE ADVANTAGE OF ALL THE LIFE THEY CAN.

I REALIZE, OF COURSE, THAT WHAT I JUST SAID HAS SOMETHING OF A ROMANTIC RING TO IT. IT IS THE IDEALIZED PHYSICIAN-PATIENT RELATIONSHIP, IN WHICH ALL YOU HAVE TO WORRY ABOUT IS THE SUCCESS OF YOUR DIAGNOSIS AND TREATMENT.

BUT THE REAL WORLD OF MEDICINE IS NOT QUITE THAT NEAT. YOUR ELDERLY PATIENTS MAY HAVE THOUGHTFUL, CARING ADULT CHILDREN. OR THEY MAY BE ABANDONED BY THEIR CHILDREN AND GRAND-CHILDREN.

WHEN THEY LEAVE YOUR OFFICE, THEY MAY GO BACK TO THEIR GROUP HOUSE, WHERE THEY LIVE ALONG WITH OTHER SUPPORTIVE MEN AND WOMEN THEIR OWN AGE. OR THEY MAY RETURN TO A ONE-ROOM FLAT WHERE THEY LIVE ALONE IN ISOLATION AND DEPRESSION.

THEY MAY BE SWEET PEOPLE WHO DESERVE THE BEST POSSIBLE CARE. OR THEY MAY BE CRANKY AND SELFISH PEOPLE -- BUT DESERVING OF THE BEST POSSIBLE CARE ANYWAY.

OF COURSE, YOU MAY NOT KNOW ENOUGH ABOUT YOUR ELDERLY PATIENTS TO MAKE EVEN THESE KINDS OF JUDGMENTS.

CHANCES ARE THAT MANY OF YOU -- MAYBE EVEN A MAJORITY OF YOU -- WILL HAVE ELDERLY PATIENTS IN THE FINAL STAGES OF TERMINAL ILLNESS ... AND YOU WILL WANT TO SERVE THEM AS BEST YOU CAN, EVEN THOUGH YOU WILL KNOW LITTLE OR NOTHING ABOUT THEM ... THEIR FAMILIES ... THEIR OUTLOOK ON LIFE ... OR THEIR ATTITUDE TOWARD DEATH.

THAT'S QUITE DIFFERENT FROM WHAT THE SITUATION USED TO BE. YOUR GREAT-GRANDPARENTS -- AND MAYBE YOUR GRANDPARENTS AS WELL -- VERY LIKELY DIED IN THEIR OWN HOMES WHILE UNDER THE CARE OF A PHYSICIAN THEY HAD KNOWN FOR YEARS ... PERHAPS MOST OF THEIR ADULT LIVES.

I LIKE TO CALL THAT "PRACTICING WITHIN THE REALM OF TRUST BETWEEN PATIENT AND PHYSICIAN."

YOU AND I, ON THE OTHER HAND, ARE MORE LIKELY TO DIE IN A HOSPITAL IN THE CARE OF A PHYSICIAN WE MAY HAVE KNOWN FOR JUST A FEW YEARS ... OR EVEN JUST A FEW HOURS. WE ARE -- AS OSCAR WILDE WROTE -- BORN AS KINGS AND DIE IN EXILE.

LET'S HOPE THAT MANY OF YOU WILL BE BLESSED BY CARING FOR YOUR PATIENT-KINGS AND -QUEENS WHILE THEY STILL WEAR THEIR CROWNS AND YOU ARE THEIR PHYSICIAN AND THEIR FRIEND.

IN THIS REALM OF TRUST, WHERE AN ILLNESS IS TERMINAL AND NO CURE WILL WORK, THEN CARE CERTAINLY WILL. AND THAT MEANS LETTING THE PATIENT KNOW THAT YOU RECOGNIZE AND APPRECIATE HIS OR HER WORTH AND THAT YOU WILL BE BOTH PHYSICIAN AND COMFORTER.

LET YOUR PATIENT KNOW THAT WHEN THE FEAR OR PAIN BECOMES TOO GREAT, YOU WILL TREAT IT AS EFFICIENTLY AND AS EFFECTIVELY AS YOU CAN.

AND IF YOUR PATIENT DOES NOT WANT EXTRAORDINARY LIFE-SUPPORT MEASURES TO BE TAKEN, LET THAT PERSON KNOW YOU WILL ABIDE BY THAT DECISION.

YOU AND YOUR TERMINALLY ILL PATIENT SHOULD UNDERSTAND -- TOGETHER -- THAT THE TIME MAY COME WHEN THE ONLY USEFUL THING A PHYSICIAN CAN DO IS TO STAND BACK AND ALLOW NATURE TO TAKE ITS COURSE. AND THAT IS NOT EUTHANASIA, EITHER ACTIVE OR PASSIVE. THAT IS SOUND, COMPASSIONATE MEDICINE.

IN ORDER TO ACHIEVE SOMETHING THAT EVEN MIGHT APPROXIMATE SUCH A "REALM OF TRUST BETWEEN PATIENT AND PHYSICIAN," YOU'LL NEED TO DIG DEEP WITHIN YOURSELF TO COME UP WITH THE RIGHT ANSWERS.

THAT KIND OF INTROSPECTION IS NOT EASY, BUT IT'S ESSENTIAL FOR YOUR DEVELOPMENT AS AN INTELLIGENT AND ETHICAL PHYSICIAN SERVING THE HEALTH NEEDS OF OLDER PATIENTS.

AND YET, THIS ISN'T A MATTER THAT CONCERNS ONLY YOUR OLDER PATIENTS. IN FACT, THERE IS NOTHING AGE-SPECIFIC ABOUT ETHICAL BEHAVIOR. IF YOU DEAL ETHICALLY WITH YOUR OLDER PATIENTS, YOU WILL DO SO WITH PATIENTS OF ALL AGES.

AND THE REVERSE IS ALSO TRUE: THAT IS, IF YOU DO NOT UNDERSTAND THE SIGNIFICANCE OF THE ETHICAL ISSUES SURROUNDING HEALTH CARE FOR THE ELDERLY, CHANCES ARE YOU WON'T UNDERSTAND THE ROLE OF ETHICS IN YOUR MEDICAL PRACTICE GENERALLY.

I WAS TAUGHT THAT PARTICULAR LESSON 40 YEARS AGO. I WAS NOT LONG OUT OF MEDICAL SCHOOL AND POST-GRADUATE TRAINING MYSELF, WHEN, IN 1948, I CAME UPON AN ESSAY IN THE NEW ENGLAND JOURNAL OF MEDICINE WRITTEN BY A DR. LEO ALEXANDER.

A NATIVE OF AUSTRIA, BUT BY THEN A RESIDENT OF BOSTON, MASSACHUSETTS, DR. ALEXANDER TAUGHT PSYCHIATRIC MEDICINE AND HAD SERVED AS AN EXPERT WITNESS AT THE NUREMBERG WAR CRIMES TRIALS RIGHT AFTER THE SECOND WORLD WAR.

HIS 1948 ESSAY DREW NOT ONLY UPON HIS EXPERIENCE AS A WITNESS BUT ALSO UPON MATERIALS HE COLLECTED DURING HIS LONG INTERVIEWS -- IN GERMAN -- WITH THE NAZIS WHO WERE BEING PUT ON TRIAL.

THE RECORD OF HORRORS THAT UNFOLDED IN THE COURSE OF THOSE TRIALS HAUNTS MANKIND RIGHT UP TO THE PRESENT DAY. HOWEVER, SAID DR. ALEXANDER...

"WHATEVER PROPORTIONS THESE CRIMES FINALLY ASSUMED, IT BECAME EVIDENT TO ALL WHO INVESTIGATED THEM THAT THEY HAD STARTED FROM SMALL BEGINNINGS. THE BEGINNINGS AT FIRST WERE A SUBTLE SHIFT IN EMPHASIS IN THE BASIC ATTITUDE OF PHYSICIANS." THE NEW ATTITUDE, SAID DR. ALEXANDER, WAS THAT "THERE IS SUCH A THING AS A LIFE NOT WORTHY TO BE LIVED."

AT FIRST, SUCH LIVES WERE THOSE OF THE SEVERELY AND CHRONICALLY ILL, BUT LATER, SAID DR.ALEXANDER, THIS CATEGORY INCLUDED THE "SOCIALLY UNPRODUCTIVE, THE IDEOLOGICALLY UNWANTED, AND FINALLY ALL NON-GERMANS. BUT," HE CONCLUDES, "IT IS IMPORTANT TO REALIZE THAT THE INFINITELY SMALL WEDGED-IN LEVER FROM WHICH THIS ENTIRE TREND OF MIND RECEIVED ITS IMPETUS WAS THE ATTITUDE TOWARD THE NONREHABILITABLE SICK."

AS I SAY, I READ DR. ALEXANDER'S ESSAY IN 1948 AND IT HAS REMAINED BURNED INTO MY CONSCIOUSNESS TO THIS VERY DAY. AND THAT EXTRAORDINARY PHRASE IN PARTICULAR ... "THE NONREHABILITABLE SICK."

THE UNITED STATES IS NOT -- AND I'M SURE WILL NEVER BE -- A SOCIETY SUCH AS THE ONE THAT HELD SWAY IN GERMANY UP TO AND THROUGHOUT WORLD WAR II. THAT'S UNTHINKABLE.

BUT INDIVIDUALS ARE SOMETHING ELSE AGAIN. WE ARE MORE FRAIL THAN SOCIETIES ... AND POTENTIALLY MORE DESTRUCTIVE -- ONE-ON-ONE -- THAN WHOLE NATIONS.

IT IS POSSIBLE FOR A PHYSICIAN TO BECOME TOO AWARE OF THE ECONOMICS OF HEALTH CARE ... TOO CALCULATING ABOUT TREATMENT PRIORITIES ... AND TOO IMPATIENT WITH THOSE IN HIS OR HER CARE WHO ARE AMONG "THE NONREHABILITABLE SICK."

AND CHIEF AMONG THOSE, WE MUST ADMIT, ARE THE ELDERLY.

THESE, THEN, ARE SOME OF MY THOUGHTS ON THE ETHICAL CONCERNS OF THE PHYSICIAN WHO SERVES THE ELDERLY. AND SINCE THE ELDERLY WILL BECOME A MORE SIGNIFICANT POPULATION AND PATIENT GROUP AT THE VERY TIME YOU ARE BUILDING YOUR OWN CAREERS IN MEDICINE, I CHOSE THIS TOPIC FOR MY ADDRESS.

NOW, I WILL CLOSE MY REMARKS WITH A LITTLE BIT OF POETRY ... SOMETHING YOU MIGHT WISH TO HAVE HANDY TO TELL YOUR PATIENTS, AS THEY CONTEMPLATE THEIR OWN AGING PROCESS ... AND THEIR OWN MORTALITY.

THE FEW LINES ARE FROM THE POEM, RABBI BEN EZRA, BY ROBERT BROWNING, AND THEY GO LIKE THIS:

"GROW OLD ALONG WITH ME!
THE BEST IS YET TO BE,
THE LAST OF LIFE FOR WHICH THE FIRST WAS MADE:
OUR TIMES ARE IN HIS HAND
WHO SAITH, 'A WHOLE I PLANNED,
YOUTH SHOWS BUT HALF; TRUST GOD: SEE ALL, NOR BE AFRAID!'"

THANK YOU.

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