Ms Jones: Reflections on Aging, Illness, and Medicine

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Ms Jones sighed to me, with some resignation, “I’m falling apart.” She’s referring to her body. Clearly, her mind remains sharp. In bed for most of the day, Ms Jones has most of her necessities within arm’s reach. She is surrounded by walls covered with pictures of her youth, of her parents’ youth, of her children’s youth, and of her grandchildren’s youth. These images stand in stark contrast to her current reality. The quality of her life has been severely impacted by severe COPD, an obstructive lung disease that, in her case, is due to emphysema caused by smoking. Specifically, she suffers from a decrease (<35%) of forced expiratory volume of her lungs.

As a third-year medical student, I came to know Ms Jones, a 72-year-old woman, through the Area Agency on Aging. The building of a relationship with Ms Jones created a dialogue and connection between us that enhanced my appreciation of the diverse issues of an elder’s experience in health care. For years, I have approached aging with a passion from the laboratory bench. I’ve aggressively investigated therapeutics for degenerative diseases of aging with a sincere, but distant, hope that our findings will somehow improve the quality of life in our aging population. To catch a glimpse, for a few days, of one woman’s quality of life dramatically raised my focus and awareness from the cellular level to the personal level.

Now I was confronted by a new set of questions. How is Ms Jones personally impacted by this disease for which we memorized laboratory and anatomical characteristics in pathology last year? She is weak, dependent on continuous oxygen therapy, extremely vulnerable to infections, and chokes on tiny crumbs. She has stock supplies of antibiotics and steroids and a new supply of diabetes medications; her new-onset diabetes is a likely outcome of her high-dose corticosteroid therapy for COPD. Unfortunately, just as we were taught in pathology, her heart has become weak as it tires of forcing blood into her lungs; there are more medications for this, too. Beginning at the level of her biological disease, I began to contextualize the classic “textbook case” of COPD into the body of a unique and spirited elderly woman.

Ms Jones, afflicted with the biological dysfunctions of COPD and comorbid conditions, is aging in a family structure very different from that of her grandparents. Her paternal grandparents lived in Frankfort, Ky, in a large and extended family system. Many families and their children lived together in one home. Ms Jones indicates that the result of everyone being together was that “everyone pitched in,” particularly in the care for the elders. Thus, Ms Jones’ grandmother, who lived into her 80s, was always surrounded by family. In contrast, Ms Jones, a grandmother who is nearing her 80s, lives alone.

The two disparate family systems in Ms Jones’ experience demon-
strate two distinct family structures; each carries unique implications for the quality of life in the elderly. How is this relevant and important to Ms Jones? Ms Jones, in her own words, was “a liberated woman before anyone knew what that was” and relished her autonomy and personal freedoms. She traveled to Europe as a young woman, lived in many places in the United States, and succeeded as a social worker helping women to empower themselves. In the United States, the nuclear family is currently the dominant paradigm of living and reflects our deep cultural emphasis on personal autonomy and independence. We have idolized rugged individualism and personal freedoms. This dominant value is not compatible with an extended family system, in which individuals relinquish some autonomy and play a more communal, familial role.

Maintaining personal independence was and still is crucial to Ms Jones’ livelihood. She states that she hopes never to burden her children with caretaking. Thus, the Area Agency on Aging has been invaluable to her in providing services (daily bath, grocery shopping, house cleaning) that allow her to preserve autonomy and to live a quality of life that is in keeping with her values, even in the face of chronic illness.

Though Ms Jones has managed to maintain some autonomy, with help from the Area Agency on Aging, the quality of her life is directly impacted by the health care she receives. Ms Jones insists, “If we made every doctor stay in the hospital and stay in the wheelchair for a week to see what it’s like, treatment would change considerably.”

Her firsthand experiences in the health care community reflect a delusional attitude toward the elderly termed ageism. Ageism involves stereotypes of the elderly such as being incapable of understanding, being childlike, suffering from hopeless conditions, and remaining lost without “doctor’s orders.” These attitudes are exemplified during her visits when physicians and other health care professionals (1) ignore her concerns and questions, (2) do not speak directly to her and, instead, address the person with her, (3) joke with each other at her expense as if she were invisible, and (4) do not involve her, or even disrespect her input, in decision making.

Our dominant culture highly values, or even obsesses over, youth and the avoidance of aging. It has been demonstrated that negative attitudes toward the elderly have been developed in students even before they begin medical school. It is essential that training during medical school and residency is geared toward developing positive attitudes toward the elderly. It was a unique opportunity for me to engage closely in a dialogue with Ms Jones, celebrate the patient as the teacher, and learn about her world as it looks to her. This exposure and opportunity to learn from the lived wisdom of an elderly patient has imprinted an awareness and sensitivity to the important issues that directly impact the health care and lives of our aging population.

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