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MEDICALIZATION OF AGING: THE UPSIDE AND THE DOWNSIDE

Winsor C. Schmidt*

INTRODUCTION AND DEFINITION OF MEDICALIZATION

The purpose of this article is to describe and assess the upside and the downside of the medicalization of aging.

The idea of medicalization was formulated to theorize about the expansion of medicine in people's lives.¹ Medicalization is

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1. Adele Clarke et al., *Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine*, 68 *AM. SOC. REV.* 161, 164 (2003) (citing Irving Zola, *Medicine as an Institution of Social Control*, 20 *SOC. REV.* 487, 487 (1972)); Peter Conrad & Kristin K. Barker, *The Social Construction of Illness: Key Insights and Policy Implications*, 51 *J. HEALTH & SOC. BEHAV.* S67, S74 (2010). See generally ADELE CLARKE ET AL., *BIOMEDICALIZATION: TECHNOSCIENCE, HEALTH, AND ILLNESS IN THE*

perceived to occur when a “morally problematic” social problem moves from the domain of law to the jurisdiction of medicine.² The morally problematic aspect of such medicalized social problems suggests irresolution in application of a legal paradigm or a medical paradigm, or in the continuum in between, and irresolution in application of legal values and medical values. Medicalization is defined as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders.”³

EXAMPLES OF MEDICALIZATION: MEDICALIZATION OF DEVIANCE

Early medicalization analyses addressed the medicalization of deviance, i.e., the movement from dealing with a social problem through law to dealing with a problem through medicine.⁴ Traditional social “deviants” transitioned from “bad” to “sick” included: those subject to divestment from the criminal law (e.g., incompetents to stand trial, insanity acquittees, incompetents to serve a sentence); the “mentally retarded”; the mentally ill; juvenile and “defective” delinquents; psychopaths; drug addicts; alcoholics; and the eugenically sterilized.⁵ More recent and continuing medicalized social deviance includes: mental illness; alcoholism; opiate addiction; delinquency; hyperactivity; child abuse; homosexuality; the born criminal (also, the redefinition of

U.S. (Adele Clarke et al. eds., 2010); IVAN ILLICH, *MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH* (Random House 1976) (1975).

2. Clarke et al., *supra* note 1, at 164.

3. PETER CONRAD, *THE MEDICALIZATION OF SOCIETY: ON THE TRANSFORMATION OF HUMAN CONDITIONS INTO TREATABLE DISORDERS* 4 (2007).

4. *See, e.g.*, PETER CONRAD & JOSEPH W. SCHNEIDER, *DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS* 17–18 (Temple University 1992) (1980).

5. *See* NICHOLAS N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* 2 (1971); KENT S. MILLER, *THE CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS: CONFLICT AND COLLUSION* 15 (1980). *See generally* TALCOTT PARSONS, *THE SOCIAL SYSTEM*, at vii (1951).

An earlier version of notes 5–8, 17–23, 104–12, 129–48, and accompanying text previously appeared in W.C. Schmidt, *Law and Aging: Mental Health Theory Approach*, in *THEORIES ON LAW AND AGEING: THE JURISPRUDENCE OF ELDER LAW* 121 (I. Doran ed., 2009).

violence as a public health or medical problem);⁶ AIDS; domestic violence; co-dependency; learning disabilities; eating disorders; compulsive gambling; transsexualism; menopause; premenstrual syndrome; infertility; suicide; impaired physicians; post-traumatic stress disorder; and obesity; as well as andropause; baldness; and erectile dysfunction;⁷ and genetic mutation, malfunction, and enhancement.⁸

MEDICALIZATION AND THE MEDICAL INDUSTRIAL COMPLEX

The machinery of medicalization has mushroomed from medical and allied health professionals, organizations, and social movements to consumers, biotechnology, and the insurance industry, as well as the pharmaceutical industry.⁹ Politico-economic developments in 1971 generated a medical industrial complex that begins to rival President Eisenhower's 1950s military industrial complex.¹⁰ If the military industrial complex is the "conjunction of an immense military establishment and a large arms industry,"¹¹ then the medical industrial complex is

6. *E.g.*, CONRAD & SCHNEIDER, *supra* note 4, at 34; Michael Fendrich, 358 N. ENG. J. MED. 2081, 2082 (2008) (reviewing CONRAD, *supra* note 3, and noting that Conrad inexplicably omitted the trend to redefine violence as a public health or medical problem).

7. CONRAD, *supra* note 3, at 5–6. *Cf., e.g.*, Barbara Marshall, *Science, Medicine and Virility Surveillance: 'Sexy Seniors' in the Pharmaceutical Imagination*, 32 SOC. HEALTH & ILLNESS 211, 211 (2009) (describing the emerging cultural consensus on maintenance of active sexuality as successful aging marker, including continued sexual activity across the lifespan, linkage of sexual function to overall health, and encouragement of increased self-surveillance and medical attention to late-life sexuality; calling for "continued critical inquiry into the biomedical construction of sex and age").

8. *See* Peter Conrad, *The Shifting Engines of Medicalization*, 46 J. HEALTH & SOC. BEHAV. 3, 7 (2005).

9. Conrad & Barker, *supra* note 1, at S74. *See generally* Anne E. Figert, *The Consumer Turn in Medicalization: Future Directions with Historical Foundations*, in HANDBOOK OF THE SOCIOLOGY OF HEALTH, ILLNESS, AND HEALING 291 (Bernice A. Pescosolido et al. eds., 2011) (highlighting "the role of individuals in the medicalization process and their redefinition from patients into consumers.").

10. *See* Clarke et al., *supra* note 1, at 167.

11. President Dwight Eisenhower, Farewell Address to the Nation (Jan. 17, 1960), available at <http://mcadams.posc.mu.edu/ike.htm>. President Eisenhower said:

In the councils of government, we must guard against the acquisition of

the conjunction of an immense medical establishment and a large medical/pharmaceutical industry.¹² Conrad and Barker highlight the increasing importance of commercial medicine, “especially the pharmaceutical industry,” in promoting their products through configuring and distributing “medical knowledge.”¹³

Harrington and Estes describe the medical industrial complex as including “private profit-making insurance companies, health maintenance organizations, hospitals, physician groups, pharmaceutical companies, medical supply companies, and other health-related businesses, all of which have a vested interest in maintaining the current social structure and health system.”¹⁴ In contrast, Dr. Relman in 1980 specified a “new” medical industrial complex that is “a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit —services heretofore provided by nonprofit institutions or individual practitioners. I am not referring to the companies that manufacture pharmaceuticals or medical equipment and supplies.”¹⁵ Public and non-profit medical entities, and manufacturers, arguably should not be excluded from the medical industrial complex any more than President Eisenhower excluded public and non-profit military entities, and

unwarranted influence, whether sought or unsought, by the military-industrial complex. The potential for the disastrous rise of misplaced power exists and will persist. We must never let the weight of this combination endanger our liberties or democratic processes. We should take nothing for granted. Only an alert and knowledgeable citizenry can compel the proper meshing of the huge industrial and military machinery of defense with our peaceful methods and goals, so that security and liberty may prosper together.

Id.

12. Cf. BARBARA EHRENREICH & JOHN EHRENREICH, *THE AMERICAN HEALTH EMPIRE: POWER, PROFITS, AND POLITICS* 29 (Vintage Books Ed. 1971) (first coining the term “medical industrial complex”).

13. Conrad & Barker, *supra* note 1, at S74.

14. HEALTH POLICY: CRISIS AND REFORM IN THE U.S. HEALTH CARE DELIVERY SYSTEM 153 (Charlene Harrington & Carroll L. Estes, eds., 5th ed. 2008).

15. Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963 (1980).

manufacturers, from the military industrial complex. Regarding a disquieting partnership of the military and medical industrial complexes, Clarke and Shim cite the emergence of the biomedicalization of defense with biomedical approaches to weaponry and warfare development including the technoscientific biological alteration of warriors and biosecurity.¹⁶

AGING, SOCIAL DEVIANCE, AND SOCIAL CONTROL

A critical view of law and aging, or elder law, sees growing old as a form of social deviance: “the elderly are punished by isolation and stigmatization for this ‘deviant’ act.”¹⁷ Devalued persons like the handicapped and the old are told they are normal and encouraged to act like they are normal while social organization precludes normalcy and acceptance.¹⁸ For example, while Social Security achieved a positive sea change in the incidence of poverty and quality of life for the elderly, its passage also authoritatively established the elderly as a new category of deviants.¹⁹

16. Adele E. Clarke & Janet Shim, *Medicalization and Biomedicalization Revisited: Technoscience and Transformations of Health, Illness and American Medicine*, in HANDBOOK OF THE SOCIOLOGY OF HEALTH, ILLNESS, AND HEALING, *supra* note 9, at 190. *But cf.* Tait R. Medina & Ann McCranie, *Layering Control: Medicalization, Psychopathy, and the Increasing Multi-institutional Management of Social Problems*, in HANDBOOK OF THE SOCIOLOGY OF HEALTH, ILLNESS, AND HEALING, *supra* note 9, at 139 (discussing increased “criminalization” of mental illness and increased medicalization of criminal behavior as demonstrative of layering institutional control and increasing multi-institutional management of social problems rather than medicine becoming more dominant than law and religion).

17. JOHN B. WILLIAMSON ET AL., AGING AND PUBLIC POLICY: SOCIAL CONTROL OR SOCIAL JUSTICE? 4 (1985). *See also* Carroll L. Estes & Elizabeth A. Binney, *The Biomedicalization of Aging: Dangers and Dilemmas*, 29 GERONTOLOGIST 587 (1989); Margaret Lock, *Licorice in Leviathan: The Medicalization of Care for the Japanese Elderly*, 8 CULTURE, MED. & PSYCHIATRY 121 (1984).

18. WILLIAMSON ET AL., *supra* note 17, at 29.

19. *Id.* at 105. Social Security is a social insurance program, a safety net of income support and maintenance, and of economic security. As the largest source of income for older persons, 88% of Americans over age 65 received benefits in 2005. Of these beneficiaries, 69% received over half their income from Social Security; 40% received over 90% of their income from Social Security; and for 25% Social Security is their only source of income. LAWRENCE A. FROLIK & ALISON MCCHRISTAL BARNES, ELDER LAW 151–61 (4th ed. 2007).

The functions of Social Security for stabilizing the social order and thus social control were many : unemployment was reduced, old people were to support the economy through consumption, they were to serve as both positive and negative role models for others, and the political steam they had gathered in working for change was to be diffused. Less obvious consequences of this process were solidification of age norms and the creation of numerous administrators, caretakers, and experts ["an aging enterprise"] who were to make their livings, their profits, and their reputations off of the elderly.²⁰

Instead of income support for all, Social Security, like Medicare later, achieved income support for some. "Social Security launched a process by which a primary deviation, old age, became a secondary deviation – one with definite role expectations, not the least of which was exit from the labor force."²¹ Loss of employment implies disability and moral deficiency.²² "[D]isability connotes an incapacity to perform role expectations and is very much in keeping with the medical model of social control."²³

Medicalization is "strongly evaluative," suggesting "how people ought to behave," and results in "policies that authorize social control."²⁴ Conrad and Barker observe: "[s]pecifically, medical sociologists point to the contingent processes by which certain behaviors and experiences come to be defined as medical conditions, and the way [in which] those definitions can function as a type of social control."²⁵ For medical social control, Conrad confirms that "the greatest social control power comes from having the authority to define certain behaviors, persons and things."²⁶ A key issue is definitional: "the power to have a

Regarding the role of Medicare in positively changing the incidence of poverty and quality of life for the elderly, *cf. infra* text accompanying footnotes 58–60.

20. WILLIAMSON ET AL., *supra* note 17, at 105, 109.

21. *Id.* at 110–11.

22. *Id.* at 111.

23. *Id.*

24. Conrad & Barker, *supra* note 1, at S75.

25. *Id.* at S68.

26. Conrad, *supra* note 3, at 8 (internal citations omitted).

particular set of (medical) definitions realized in both spirit and practice."²⁷

MEDICALIZATION OF AGING

In 1989, Estes and Binney documented the establishment of aging as a medical problem (a "pathology") viewed and managed as clinical phenomena.²⁸ The "biomedicalization" of aging fosters a public opinion tendency "to view aging negatively as a process of inevitable decline, disease, and irreversible decay" necessitating medical intervention.²⁹ "Medicine today is considered the right (and perhaps the only) tool for managing the problems of aging."³⁰ In the social environment, "[f]rom cosmetic surgery to knee and hip replacement, from hormone replacement therapy to the newest drugs for impotence, memory enhancement, and osteoporosis, the biotechnological practices—and promises—of slowing the aging process are ubiquitous."³¹

In 2004, Kaufman and colleagues reported the exponential growth of life-extending medical interventions in late-life (e.g., cardiac procedures, kidney dialysis, and transplants) and the difficulty of saying "no".³² Intensification of the biomedicalization of aging is associated with the overshadowing of choice by routine medical care; "the transformation of the technological imperative to a moral imperative; and [] the coupling of hope with the normalization and routinization of life-extending interventions."³³ In summary:

27. *Id.*

28. See ESTES & BINNEY, *supra* note 17.

29. *Id.* at 594. Cf., e.g., Richard J. Hodes & Megan J. Homer, *Aging Research: Translating Scientific Discovery into Clinical Intervention*, 2 WORLD MED. & HEALTH POL'Y, no. 4 at 7 (2010).

30. Sharon R. Kaufman et al., *Revisiting the Biomedicalization of Aging: Clinical Trends and Ethical Challenges*, 44 GERONTOLOGIST 731, 731 (2004).

31. *Id.* at 736 (citation omitted). See also Wendy Glauser, *Seniors Overmedicalized, Experts Say*, 183 CAN. MED. ASS'N J., no. 11 at E701 (2011); Marshall, *supra* note 7.

32. Kaufman et al, *supra* note 30, at 731–34.

33. *Id.* at 731.

Developments in the realms of biomedical science and geriatric clinical intervention, specifically, affect our understanding of the nature of late life, individual and societal decision making, and family and medical responsibility in ways that could not have been predicted, even 15 years ago. Medical interventions are reshaping norms of aging and standard clinical practice. The body seems open to unlimited manipulation, at any age, and the emphasis . . . is on the management and maximization of life itself. Medicine is producing a discourse of both senescence and life extension—that is, a framework for thinking about, speaking about, and understanding the arc, end, and prolongation of life.³⁴

ASSESSMENT OF THE MEDICALIZATION OF AGING

The definition, description, and history of the medicalization of aging provide at least implicit initial assessments of the downside of medicalization. Further assessment is gleaned from application to the medicalization of aging of the fundamental concerns in health law and policy: cost, quality, access, and personhood. What role does the medicalization of aging play “in promoting the quality of health care, . . . in assuring adequate control of the cost of health care, in promoting access to necessary health care, and in protecting the human rights of those who are provided care within the health care system”³⁵ and within the “aging enterprise”?³⁶ What role does the medicalization of aging play regarding cost, quality, access, and personhood in aging and health care, and in aging services?

34. *Id.* at 732 (internal citations omitted). Cf. John Albert Vincent, *Ageing, Anti-ageing, and Anti-anti-ageing: Who are the Progressives in the Debate on the Future of Human Biological Ageing?*, 1 *MED. STUD.* 197 (2009) (describing the anti-ageing movement as a route by which biologisation of old age inhibits people's achievement of a culturally valued final part of life). See generally Jennifer R. Fishman et al., *In the Vanguard of Biomedicine? The Curious and Contradictory Case of Anti-ageing Medicine*, 32 *SOC. HEALTH & ILLNESS* 197 (2010) (discussing that anti-ageing medicine is built on a technology of the self with the ultimate goal being an optimal self, not just a self free from illness).

35. BARRY FURROW ET AL., *HEALTH LAW*, at v (6th ed. 2008).

36. WILLIAMSON ET AL., *supra* note 17, at 109 (regarding the aging enterprise).

ASSESSMENT OF THE MEDICALIZATION OF AGING: COST

Conrad and colleagues have estimated the costs of medicalization generally.³⁷ Medicalized conditions in the medicalization cost estimate were selected on the basis of (1) identification of the condition as medicalized in any study published since 1950, and (2) the availability of “reasonably valid and current data on US . . . medical expenditures for that condition.”³⁸ Twelve medicalized conditions were selected: anxiety disorders; behavioral disorders; body image (cosmetic, not bariatric surgery); erectile dysfunction; infertility; male pattern baldness; menopause; normal pregnancy and/or delivery; normal sadness; obesity (bariatric surgery and weight loss medications); sleep disorders; and substance related disorders.³⁹ Of these twelve medicalized conditions, only infertility and normal pregnancy and/or delivery appear unrelated to medicalization of aging.

The estimated cost of U.S. medical spending on medicalized conditions was \$77 billion in 2005, which was 3.9% of the \$1.97 trillion in total national health spending (16% of gross domestic product (GDP)).⁴⁰ While “a relatively minor portion of medical care expenditures . . . is unlikely to be a key driver of spiraling health care costs,” the \$77 billion is more than the \$56.7 billion reportedly spent on heart disease and the \$39.9 billion reportedly spent on cancer in 2000, and greater than the estimated three percent of health spending allocated to public health in 2005.⁴¹ For 2009, 3.9% spent on medicalization is an extrapolated \$97.5 billion of the reported \$2.5 trillion (17.6% of

37. Peter Conrad et al., *Estimating the Costs of Medicalization*, 70 SOC. SCI. & MED. 1943, 1943 (2010).

38. *Id.* at 1943–44.

39. *Id.* at 1944.

40. *Id.* at 1943, 1946.

41. *Id.* at 1946. Cf. Glen P. Mays & Sharla A. Smith, *Evidence Links Increases in Public Health Spending to Declines in Preventable Deaths*, 30 HEALTH AFF. 1585 (2011) (finding that mortality rates declined between 1.1% and 6.9% for each 10% increase in local public health funding).

GDP) in U.S. health care spending.⁴²

There are other cost measures with some association to the medicalization of aging. Total Medicare spending in 2009 was \$502.9 billion for the eligible elderly and disabled beneficiaries, 20% of total national health spending.⁴³ Persons age sixty-five and over were only 12.9% of the national population.⁴⁴ Elderly and disabled beneficiaries were only about 14% of the national population.⁴⁵

Total federal and state Medicaid spending in 2009 was \$373.9 billion, 15% of national health spending.⁴⁶ The elderly were 10.2% of Medicaid enrollees⁴⁷ and accounted for 24.7% of Medicaid payments in 2007.⁴⁸ Medicaid paid for 48.9% of long-term care services in the U.S. in 2005; Medicare paid for 20.4%.⁴⁹

If aging includes the chronological passage of time, rather than just age sixty-five and over (i.e., a process rather than a category group), the disabled were 15.1% of Medicaid enrollees in 2007,⁵⁰ and accounted for 42.4% of Medicaid payments.⁵¹

However, compared to almost all other OECD

42. See Anne Martin et al., *Recession Contributes to Slowest Annual Rate of Increase in Health Spending in Five Decades*, 30 HEALTH AFF. 11, 11 (2011).

43. *Id.* Cf. NAT'L INST. FOR HEALTH CARE MGMT., UNDERSTANDING U.S. HEALTH CARE SPENDING 1, 6 (July 2011) (stating that five percent of the population is responsible for almost fifty percent of all spending; half of people in top five percent have hypertension, one-third have lipid disorders (high cholesterol), more than one-quarter have diabetes).

44. *State and County QuickFacts*, U.S. CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/00000.html> (last visited Oct. 16, 2011) (as of Oct. 19, 2011 *QuickFacts* page updated with 2010 census information).

45. See FURROW ET AL., *supra* note 35, at 776 ("Medicare covers nearly . . . one in seven Americans").

46. *National Health Expenditure Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_sheet.asp.

47. *Distribution of Medicaid Enrollees by Enrollment Group, FY2007*, KAISER STATE HEALTH FACTS, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=200&cat=4> (last visited Aug. 24, 2011).

48. *Distribution of Medicaid Payments by Enrollment Group (in millions), FY2007*, KAISER STATE HEALTH FACTS, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=858&cat=4> (last visited Aug. 24, 2011).

49. *National Clearinghouse for Long-Term Care Information*, U.S. DEPT. OF HEALTH AND HUMAN SERVS. http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/ Costs_Of_Care/ Costs_Of_Care.aspx (last visited Sep. 3, 2011).

50. *Distribution of Medicaid Enrollees by Enrollment Group*, *supra* note 47.

51. *Distribution of Medicaid Payments by Enrollment Group*, *supra* note 48.

(Organisation for Economic Co-operation and Development) countries, the U.S. has one of the smallest proportions of population over age sixty-five and the highest percentage of GDP spending on health care.⁵² While per capita U.S. spending for people age sixty-five and older is three to five times higher than for younger Americans, population age is not the major driver of health care cost.⁵³ The principal factors responsible for growth in health care spending include:

[R]ising per capita incomes, the availability of promising but costly new medical technology, workforce shortages that can drive up the unit cost of health care, and the asymmetric distribution of market power in health care that gives the supply side of the sector considerable sway over the demand side. These other factors will be the dominant drivers of health spending in the future as well. Blaming Medicare's future economic pressures mainly on demographic factors beyond policymakers' control is an evasion of more important challenges.⁵⁴

Half of the annual per capita health care spending growth in 2002 "is accounted for explicitly by technology (here called 'utilization' and defined to include the 'quality and mix of services'). Moreover, some of the second-largest component, medical price increases, almost surely includes some changes in the nature of the product."⁵⁵

52. Joseph White, *(How) Is Aging a Health Policy Problem?*, 4 YALE J. HEALTH POL'Y L. & ETHICS 47, 50 (2004).

53. Uwe E. Reinhardt, *Does the Aging of the Population Really Drive the Demand for Health Care?*, 22 HEALTH AFF., Nov. 2003 at 27, 27. See also Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States is So Different from Other Countries*, 22 HEALTH AFF., May 2003 at 89, 91; Cynthia X. Pan et al., *Myths of the High Medical Cost of Old Age and Dying*, 38 INT'L J. HEALTH SERVS. 253, 254 (2008); Peter Zweifel et al., *Ageing of Population and Health Care Expenditure: A Red Herring?*, 8 HEALTH ECON. 485, 485 (1999).

54. Reinhardt, *supra* note 53, at 37.

55. Mark V. Pauly, *Competition and New Technology*, 24 HEALTH AFF. 1523, 1524 (2005).

But *cf.*, e.g., Kenneth E. Thorpe & David H. Howard, *The Rise in Spending Among Medicare Beneficiaries: The Role Of Chronic Disease Prevalence and Changes in Treatment Intensity*, 25 HEALTH AFF. W378, W385 (2006) ("Virtually all of the growth in spending from 1987 to 2002 can be traced to the twenty-percentage-point increase in the share of Medicare patients receiving medical treatment for five or more conditions during a year."); *id.* at W379 (Areas giving rise to chronic disease

On the upside of the medicalization of aging, as well as the medicalization of persons with disabilities, "Medicaid [and Medicare] [are], in a very real sense, the cost that we pay as a society for valuing the lives of these persons."⁵⁶ This cost is a tangible, economic value of personhood. There are other personhood measures: "the moral test of government is how [it] treats those who are in the dawn of life, the children; those who are in the twilight of life, the [aged]; and those in the shadows of life – the sick, the needy and the handicapped."⁵⁷

Before Medicare, only fifty-six percent of the elderly were insured for hospital care, and nonwhite and poor elderly received less health care than white and wealthier elderly.⁵⁸ With Medicare, more equitable access to medical care is available to beneficiaries otherwise probably uninsured. Sixty percent of elderly beneficiaries have Social Security for the majority of their income, and fifty percent of Medicare beneficiaries have incomes equal to or less than 200% of the federal poverty level.⁵⁹ Medicare and Medicaid provide health insurance for virtually all Americans age sixty-five and older.⁶⁰ Medicare reduces racial

prevalence include "metabolic syndrome" and "more aggressive use of medication to treat asymptomatic or mildly symptomatic patients. Metabolic syndrome [includes] three of the following five conditions: abnormal levels of glucose, low high-density lipoprotein (HDL) cholesterol, elevated blood pressure, high triglyceride levels, and abdominal obesity.")

56. Furrow et al., *supra* note 35, at 830.

57. 123 CONG. REC. 37287 (1977) (remarks of Hubert Humphrey at the dedication of the Hubert H. Humphrey Building).

58. FURROW ET AL., *supra* note 35, at 777.

59. *Id.* Cf. Sandro Galea et al., *Estimated Deaths Attributable to Social Factors in the United States*, 101 AM. J. PUB. HEALTH 1456, 1462 (2011) (Approximately 133,000 deaths in the U.S. in 2000 were attributable to individual-level poverty and 39,000 to area-level poverty compared with 192,898 deaths from acute myocardial infarction, and 155,521 from lung cancer. The relative risk of mortality associated with poverty was less for individuals sixty-five and older than for individuals aged twenty-five to sixty-four years.).

60. Arloc Sherman, *Public Benefits: Easing Poverty and Ensuring Medical Coverage*, CTR. ON BUDGET AND POL'Y PRIORITIES, Aug. 17, 2005. Cf. Amy Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year* (Nat'l Bureau of Econ. Research, Working Paper No. 17190, 2011) (randomized controlled experiment finds group of uninsured low-income Oregon adults selected by lottery for chance to apply for Medicaid is after one year twenty-five percentage points more likely to have insurance, has higher health care utilization, lower out-of-pocket medical expenditures and debt, and better self-reported physical and

and income disparities in health care utilization by seniors (and is instrumental in documenting remaining disparities).⁶¹ Medicare's administrative overhead is 3.6% compared with other administrative costs that account for 31% of overall U.S. health care expenditures.⁶²

On the downside of the medicalization of aging, and of persons with disabilities, Medicare and Medicaid costs are significant and disproportionate compared with non-old and non-disabled persons, and at the expense of such opportunity costs as education of individuals and society, and of more investments in noninstitutional care, preventive care, increased access to health insurance for the uninsured, and the like.

ASSESSMENT OF THE MEDICALIZATION OF AGING: QUALITY

The problem of medical error, or patient safety, is significant.⁶³ More people die annually from medical errors in U.S. hospitals (between 44,000 and 98,000) than from AIDS (16,516), cancer (42,297), or motor vehicle accidents (43,458).⁶⁴ Adverse incidents and deaths are ten times more likely in physician offices than in ambulatory surgery centers.⁶⁵ The quality chasm in the health care system is documented in at least four different states, four different decades, and seven different

mental health than control group that was not selected to apply for Medicaid).

61. STUDY PANEL ON MEDICARE AND DISPARITIES, NAT'L ACAD. SOC. INS., STRENGTHENING MEDICARE'S ROLE IN REDUCING RACIAL AND ETHNIC HEALTH DISPARITIES 1, 9 (Bruce Vladeck et al. eds., 2006), available at http://www.calendow.org/uploadedFiles/strengthening_medicares_role.pdf.

62. Steffie Woolhandler et al., *Costs of Health Care Administration in the United States and Canada*, 349 NEW ENG. J. MED. 768, 771-72 (2003).

63. See, e.g., COMMITTEE ON QUALITY OF HEALTH CARE IN AM., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn et al. eds., 2000).

64. *Id.* See also Troyen K. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 NEW ENG. J. MED. 370, 373 (1991); Winsor C. Schmidt et al., *Factors Associated with Medical Malpractice: Results from a Pilot Study*, 7 J. CONTEMP. HEALTH L. & POL'Y 157, 160 (1991) (There were an "estimated 6,860 deaths from negligent medical injury in New York in 1984," while 1,777 New Yorkers were murdered and 2,064 died in car accidents.)

65. Hector Vila, Jr. et al., *Comparative Outcomes Analysis of Procedures Performed in Physician Offices and Ambulatory Surgery Centers*, 138 ARCHIVES SURGERY 991, 993 (2003).

countries.⁶⁶

Rates of adverse events increase with age (persons age sixty-five and older have more than double the risk of persons age sixteen to forty-four), and the elderly have a significantly higher percentage of adverse events from negligence even after standardizing for DRG (Diagnosis-Related Group) risk category.⁶⁷ "Presumably, this rate means that care for the elderly less frequently meets the standard expected of reasonable medical practitioners."⁶⁸

Drug-related adverse events account for over half of adverse events in hospitals, with patients age sixty-five and older having the highest age-specific adverse drug event rate.⁶⁹ Potentially inappropriate medication use in the U.S. nursing home, board and care, and community-dwelling elderly is a significant patient safety and cost issue.⁷⁰ Pressure ulcers are not

66. See, e.g., four states: Brennan et al., *supra* note 64 (New York); Don Harper Mills, *Medical Insurance Feasibility Study*, 128 W. J. MED. 360 (1978) (California); Eric J. Thomas et al., *Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado*, 38 MED. CARE, no. 3 at 261 (2000). See, e.g., seven countries (U.S. plus six): G. Ross Baker et al., *The Canadian Adverse Events Study*, 170 J. CAN. MED. ASS'N 1678 (2004); Peter Davis et al., *Adverse Events in New Zealand Public Hospitals I: Occurrence and Impact*, 115 N. Z. MED. J., Dec. 13, 2002, available at <http://journal.nzma.org.nz/journal/115-1167/271/content.pdf>; John D. Hamilton, *The Quality of Australian Health Care Study: Implications for Education of Failure in Quality and Safety of Health Care*, 13 EDUC. HEALTH 27, 29 (2000); Thomas Schiøler et al., *The Incidence of Adverse Events in Hospitals*, 163 UGESKRIFT FOR LÆGER 5331 (2001) (Denmark); Michael Soop et al., *The Incidence of Adverse Events in Swedish Hospitals*, 21 INT'L J. QUALITY HEALTH CARE 285 (2009); Charles Vincent et al., *Adverse Events in British Hospitals*, 322 BRIT. MED. J., Mar. 3, 2001 at 517 (2001). See also David C. Classen et al., 'Global Trigger Tool' Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured, 30 HEALTH AFF. 581, 584 (2011) (adverse events occur in one-third of hospital admissions).

67. Brennan et al., *supra* note 64, at 372.

68. *Id.* at 373-74.

69. See, e.g., Urmimala Sarkar et al., *Adverse Drug Events in U.S. Adult Ambulatory Medical Care*, 46 HEALTH SERV. RES. 1517, 1518 (2011); David M. Studdert et al., *Beyond Dead Reckoning: Measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado*, 33 IND. L. REV. 1643, 1660, 1680 (2000); Thomas et al., *supra* note 66, at 265; Eric J. Thomas et al., *Costs of Medical Injuries in Utah and Colorado*, 36 INQUIRY, Fall 1999 at 255.

70. See, e.g., Mark H. Beers et al., *Inappropriate Medication Prescribing in Skilled-Nursing Facilities*, 117 ANNALS INTERNAL MED. 684, 684, 686 (1992); Alex Z. Fu et al., *Potentially Inappropriate Medication Use and Healthcare Expenditures in the US Community-Dwelling Elderly*, 45 MED. CARE 472, 472 (2007); Denys T. Lau et al., *Polypharmacy and Potentially Inappropriate Medication Use Among Community-Dwelling*

uncommon and are associated with high treatment costs and adverse health outcomes.⁷¹

The role that the medicalization of aging plays in the quality of health care does not appear favorable. The more medicalization, the more there is opportunity for error and challenges to patient safety. 'First do no harm' seems an important priority.

ASSESSMENT OF THE MEDICALIZATION OF AGING: ACCESS

The traditional problem of access to health care is the number and population of the uninsured and underinsured. With Medicare, older persons have less of an access problem than other population demographics. Nevertheless, there are problems for older persons with such issues as prescription drug coverage,⁷² home health care,⁷³ hospice care,⁷⁴ and mental health benefits and parity.⁷⁵

Elders with Dementia, 24 ALZHEIMER DIS. & ASSOC. DISORD. 56 (2010); Seema D. Dedhiya et al., *Incident Use and Outcomes Associated with Potentially Inappropriate Medication Use in Older Adults*, 8 AM. J. GERIATRIC PHARMACOTHERAPY 562, 563, 569 (2010); Diana L. Spore et al., *Inappropriate Drug Prescriptions for Elderly Residents of Board and Care Facilities*, 87 AM. J. PUB. HEALTH 404, 406 (1997).

71. See, e.g., Dan R. Berlowitz et al., *Are We Improving the Quality of Nursing Home Care: The Case of Pressure Ulcers*, 48 J. AM. GERIATRICS SOC'Y 59, 61 (2000); Dan R. Berlowitz et al., *Effect of Pressure Ulcers on the Survival of Long-Term Care Residents*, 52A J. GERONTOLOGY: MED. SCI. M106 (1997); Madhuri Reddy et al., *Preventing Pressure Ulcers*, 296 J. AM. MED. ASS'N 974 (2006).

72. See, e.g., James J. Kennedy et al., *Cost-Related Nonadherence in the Medicare Program*, 49 MED. CARE 522, 522 (2011); William H. Shrank & Niteesh K. Choudhry, *Time to Fill the Doughnuts — Health Care Reform and Medicare Part D*, 364 NEW ENG. J. MED. 598, 599 (2011).

73. See, e.g., Christina Bielaszka-DuVernay, *The 'GRACE' Model: In-Home Assessments Lead To Better Care for Dual Eligibles*, 30 HEALTH AFF. 431, 431–432, 434 (2011); Harris Meyer, *A New Care Paradigm Slashes Hospital Use and Nursing Home Stays for the Elderly and the Physically and Mentally Disabled*, 30 HEALTH AFF. 412, 412 (2011).

74. See, e.g., Bridget Candy et al., *Hospice Care Delivered at Home, in Nursing Homes and in Dedicated Hospice Facilities*, 48 INT'L J. NURSING STUD. 121, 122 (2011).

75. See, e.g., Stephen J. Bartels, *The US System of Geriatric Mental Health Care: Financing and Future Challenges*, in PRINCIPLES AND PRACTICE OF GERIATRIC PSYCHIATRY 770, 771 (3d. ed. 2010); Joan K. Davitt & Zvi D. Gellis, *Integrating Mental Health Parity for Homebound Older Adults Under the Medicare Home Health Care Benefit*, 54 J. GERONTOLOGICAL SOC. WORK 309, 314 (2011); Margaret Knight, *Access to Mental Health Care Among Older Adults*, 37 J. GERONTOLOGICAL NURSING, no. 3 at 16, 20 (2011).

Upsides to medicalization of aging regarding access issues include the appearance of need and more successfully addressing the extent of unmet need. Addressing such access issues carries cost and opportunity cost implications, as well as potential quality trade-offs.

Downsides to medicalization of aging for such access issues include overutilization and the provision of unnecessary care.⁷⁶ On balance, demedicalization of aging seems a higher priority regarding access to care.

ASSESSMENT OF THE MEDICALIZATION OF AGING: PERSONHOOD

The important personhood questions for medicalization of aging include: when as a matter of law is a person no longer a person at the end of life? And when as a matter of law is a person no longer a person because of legal incapacity?

The medicalization of aging includes medicalization of death and dying.⁷⁷ Legal definitions of death have historically

76. Cf., e.g., Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273, 273 (2003) (more inpatient-based and specialist-oriented patterns of practice in higher spending regions); Elliott S. Fisher, et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288, 296 (2003) (increased mortality risks for regions with greater end-of-life care intensity); Jack Hadley et al., *Medical Spending and the Health of the Elderly*, 46 HEALTH SERV. RES. 1333, 1357 (2011) (greater medical spending is associated with better health status for Medicare beneficiaries; search for Medicare inefficiencies should focus on effectiveness of specific treatment and care patterns, such as multiple chronic conditions, terminal illnesses near end of life, and fraudulent spending for durable medical equipment, home health, and hospice care); Mathew Mercuri et al., *An Even Smaller Area Variation: Differing Practice Patterns Among Interventional Cardiologists Within a Single High Volume Tertiary Cardiac Centre*, HEALTH POL'Y (forthcoming) (manuscript at 1, 3-4), available at <http://www.sciencedirect.com/science/article/pii/S0168851010003386#FCANote> (last visited Oct. 16, 2011); John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, 3 HEALTH AFF., May 1984 at 6, 30 (systematic and persistent differences in standardized rates for common surgical and other medical services).

77. See, e.g., Suzanne Ost, *The De-Medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward?*, 18 MED. L. REV. 497 (2010); Stephen J. Ziegler, *Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process*, 37 J. L. MED. & ETHICS 318 (2009).

adopted medical definitions.⁷⁸ The law has attempted to enhance individual autonomy and personhood with rights to refuse medical treatment even if the consequence is death.⁷⁹ Some states (Montana,⁸⁰ Oregon,⁸¹ Washington⁸²) and countries (e.g., Belgium, Columbia, Netherlands, Switzerland)⁸³ have provisions for aid in dying and “death with dignity,” sometimes medicalized as physician-assisted death or physician-assisted suicide.

Even though there are perceptions that the cost of dying is high, available research suggests that such perceptions are not necessarily warranted. For example, a 2001 study found that one-quarter of Medicare outlays occur in the last year of life, but this percentage was unchanged from the previous twenty years and reflects care for multiple severe illnesses typically present.⁸⁴ Even though half of people with a serious chronic illness would prefer to die at home, thirty-eight percent of Medicare beneficiaries spend some time in a nursing home in the last year of life, while half of Medicare cancer decedents and nineteen percent of Medicare decedents overall use hospice.⁸⁵

78. See, e.g., FURROW ET AL., *supra* note 35, at 1380–89 (defining death).

79. See, e.g., *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278–79 (1990) (“The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. . . . [W]e assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”)

80. *Baxter v. State*, 224 P.3d. 1211, ¶ 117 (Mont. 2009).

81. OR. REV. STAT. §§ 127.800–.897 (2009).

82. WASH. REV. CODE §§ 70.245.010–.904 (2009).

83. See, e.g., FURROW ET AL., *supra* note 35, at 1567.

84. Christopher Hogan et al., *Medicare Beneficiaries’ Costs of Care in the Last Year of Life*, 20 HEALTH AFF., July 2001 at 188, 189–192 (also, unexpectedly finding that African Americans have higher end-of-life costs than others). Accord Cynthia X. Pan et al., *Myths of the High Medical Cost of Old Age and Dying*, 38 INT’L J. HEALTH SERV. 253 (2008). Cf. DAVID C. GOODMAN ET AL., DARTMOUTH ATLAS PROJECT, TRENDS AND VARIATION IN END-OF-LIFE CARE FOR MEDICARE BENEFICIARIES WITH SEVERE CHRONIC ILLNESS (Kristen Bronner, ed., April 2011) (chronically ill Medicare patients spent fewer days in hospital and received more hospice care in 2007 than 2003, but increased intensity through intensive care growth and medical specialist capacity for patients hospitalized; patients seeing ten or more doctors in last six months of life).

85. Hogan, *supra* note 84, at 191–94.

Scitovsky examined the cost of dying in 2005.⁸⁶ She found that 5.9% of Medicare enrollees who died accounted for 27.9% of Medicare disbursements.⁸⁷ Seventy-seven percent of decedents' expenses occurred in the last six months of life, forty-six percent in the last sixty days, and thirty percent in the last thirty days.⁸⁸ Seventy-nine percent of all inpatient hospital days occurred for aged beneficiaries in the last twelve months.⁸⁹ There was a medicalization shift to dying in hospitals and institutions from thirty-seven percent of all deaths shortly after 1937 to sixty-three percent by 1980.⁹⁰ Scitovsky concludes that sick people who die are given the same expensive medical care generally given to all sick people, and that predicting imminent death, or death in three to twelve months is "well-nigh impossible."⁹¹ In summary, "the data from the studies conducted to date do not provide a basis for a policy of singling out one group of patients for cost-containment strategies."⁹² The key factors responsible for the rapid growth in health care spending include rising per capita incomes, costly new medical technology, workforce shortages, and the asymmetric distribution of market power in health care, not Medicare's demographic challenges.⁹³

In any event, relative demedicalization through advance

86. Anne A. Scitovsky, "The High Cost of Dying": What Do the Data Show?, 83 MILBANK Q. 825, 836-37 (2005).

87. *Id.* at 831.

88. *Id.*

89. *Id.* at 834.

90. *Id.* at 833-34.

91. *Id.* at 826.

92. *Id.* at 837. See also Birgit Gielen et al., *Patterns of Health Care Use and Expenditure During the Last 6 Months of Life in Belgium: Differences between Age Categories in Cancer and Non-Cancer Patients*, 87 HEALTH POL'Y 53 (2010) (public expenditures for oldest old lower than younger decedents; recommend more allocation to palliative care at home); Allan Kellehear, *Dementia and Dying: The Need for a Systematic Policy Approach*, 29 CRITICAL SOC. POL'Y 146 (2009) (laments medicalized and professionalized approach to end of life care that overemphasizes pharmacological management and health services, including clinical palliative care attending to the physical and psychological more than the social or spiritual); Johan J. Polder et al., *Health Care Costs in the Last Year of Life—The Dutch Experience*, 63 SOC. SCI. & MED. 1720 (2006) (expenditure on hospitals and medical services in the last year of life declines with increasing age at death, an inverse relationship between age at death and health care costs at the end of life).

93. Reinhardt, *supra* note 53, at 37.

directives and hospice can save twenty-five to forty percent of health care costs in the last month of life, ten to seventeen percent in the last six months of life, and up to ten percent of health care costs in the last twelve months of life.⁹⁴

While there are some demedicalizing trends in death and dying, excessive medicalization of death and dying seems the prevailing and problematic paradigm.

The medicalization of aging is also manifest in personhood questions about legal incapacity. The extent of unmet need for legal guardianship of persons with legal incapacities is substantial and growing.⁹⁵ This reflects individual and demographic medical realities as well as the service of third party interests, especially medical interests.⁹⁶ The criteria and

94. See Ezekiel J. Emanuel, *Cost Savings at the End of Life: What Do the Data Show?*, 275 J. AM. MED. ASS'N 1907, 1907 (1996). Cf. GOODMAN, *supra* note 84, at 2 (change in end-of-life care is not always in the direction toward improved chronic illness care that patients may prefer allowing them to remain safely out of the hospital).

95. See David Hightower et al., *Elderly Nursing Home Residents' Need for Public Guardianship Services in Tennessee*, 2 J. ELDER ABUSE & NEGLECT 105, 120 (1990); Winsor C. Schmidt & Roger Peters, *Legal Incompetents' Need for Guardians in Florida*, 15 Bull. Am. Acad. Psychiatry & L. 69 (1987); Pamela B. Teaster & Karen A. Roberto, *Living the Life of Another: The Need for Public Guardians of Last Resort*, 21 J. APPLIED GERONTOLOGY 176 (2002) (extent of need in Virginia).

96. See, e.g., Comm'n on the Mentally Disabled & Comm'n on Legal Problems of the Elderly, Am. Bar Ass'n, *Guardianship: An Agenda for Reform*, 13 MENTAL & PHYSICAL DISABILITY L. REP. 271, 277 (1989) ("Too often guardianships are initiated to meet the primary needs of parties other than the proposed ward, such as hospitals, nursing homes, service provider agencies, the families, commercial enterprises, group homes and the state.") See also GEORGE J. ALEXANDER & TRAVIS H. D. LEWIN, *THE AGED AND THE NEED FOR SURROGATE MANAGEMENT* 135 (1972):

Under the present system of "Estate Management by Preemption," we divest the incompetent of control of his property upon the finding of the existence of serious mental illness whenever divestiture is in the interest of some third person or institution. The theory of incompetency is to protect the debilitated from their own financial foolishness or from the fraud of others who would prey upon their mental weaknesses. In practice, however, we seek to protect the interests of others. The state hospital commences incompetency proceedings to facilitate reimbursement for costs incurred in the care, treatment and maintenance of its patients. Dependents institute proceedings to secure their needs. Co-owners of property find incompetency proceedings convenient ways to secure the sale of realty. Heirs institute actions to preserve their dwindling inheritances. Beneficiaries of trusts or estates seek incompetency as an expedient method of removing as trustee one who is managing the trust or

procedures for legal incapacity have theoretically evolved from heavily medicalized criteria to more functional criteria for legal incapacity and more legal due process.⁹⁷ Yet determination of legal incapacity, restoration of capacity, and management of and guardianship outcomes for people with legal incapacities remain heavily medicalized.

Thirty states and the District of Columbia statutorily require a clinical evaluation of capacity during guardianship proceedings, fifteen states leave a clinical evaluation to the discretion of the court or a motion by the respondent, and five states have no statutory provision regarding the conduct of a clinical evaluation.⁹⁸ The Uniform Guardianship and Protective Proceedings Act provides that “the court may order a professional evaluation of the respondent and shall order the evaluation if the respondent so demands.”⁹⁹ The National Probate Court Standards advise that “The imposition of a guardianship by the probate court should be based on competent evidence of the incapacity of the respondent.”¹⁰⁰

One study finds that physicians almost always sign clinical evaluations for guardianship in Massachusetts (ninety-eight percent) and Pennsylvania (eighty-eight percent).¹⁰¹ Another

estate in a manner adverse to their interests. All of these motives may be honest and without any intent to cheat the aged, but none of the proceedings are commenced to assist the debilitated.

97. See, e.g., WINSOR C. SCHMIDT ET AL., PUBLIC GUARDIANSHIP AND THE ELDERLY 61–62 (1981) (compilation of state guardianship statutes); PAMELA B. TEASTER ET AL., PUBLIC GUARDIANSHIP: IN THE BEST INTERESTS OF INCAPACITATED PEOPLE? 17 (2010) (includes updated compilation of guardianship statutes).

98. Michael Mayhew, *Survey of State Guardianship Laws: Statutory Provisions for Clinical Evaluations*, 27 BIFOCAL 1, 14 (2005).

99. Uniform Guardianship and Protective Proceedings Act § 306 (1997). A professional evaluation was mandatory under the 1982 Act. *Id.* at cmt.

100. COMMISSION ON NAT'L PROBATE COURT STANDARDS, NAT'L COLLEGE OF PROBATE JUDGES & NAT'L CTR. FOR ST. CTS., NATIONAL PROBATE COURT STANDARDS, NO. 3.3.9 (Oct. 1993).

101. Jennifer Moye, *Clinical Evidence in Guardianship of Older Adults Is Inadequate: Findings from a Tri-State Study*, 47 GERONTOLOGIST 604, 608, 610 (2007) [hereinafter Moye, *Clinical Evidence in Guardianship*]. Guardianship orders for older adults are generally based on inadequate clinical evidence. Much clinical evidence is incomplete. The mean length of written clinical reports for guardianship of older adults ranges between 83 words in Massachusetts (with two-thirds of the written

study finds that physicians complete the clinical evaluation of the alleged incapacitated person ninety percent of the time in Pennsylvania and West Virginia.¹⁰² In Colorado, physicians (fifty-seven percent), psychologists (twenty-seven percent), other professionals (nine percent), or a multidisciplinary team (six percent) submit the clinical reports.¹⁰³

The outcomes of guardianship for people with legal incapacities also reflect the medicalization of aging. There is a general lack of systematic studies in guardianship and adult protective services,¹⁰⁴ but the few outcomes studies in guardianship are instructive and important.

Blenkner and associates performed one of the first such studies through Cleveland's Benjamin Rose Institute. In a quasi-experimental research design, the experimental group receiving enriched protective services, including guardianship, not only failed to have deterioration or death averted, it also had a higher rate of institutionalization (a medicalized disposition) and death than the control group.¹⁰⁵

evidence illegible) and 781 words in Colorado (one to three pages) compared to 24 pages for the mean length of child custody evaluations. *Id.* at 604, 610. *Accord* Kris Bulcroft et al., *Elderly Wards and Their Legal Guardians: Analysis of County Probate Records in Ohio and Washington*, 31 GERONTOLOGIST 156, 157, 160 (1991); Roger Peters et al., *Guardianship of the Elderly in Tallahassee, Florida*, 25 GERONTOLOGIST 532, 537-38 (1985). *See also* Jennifer Moyer et al., *A Conceptual Model and Assessment Template for Capacity Evaluation in Adult Guardianship*, 47 GERONTOLOGIST 591 (2007) (model and template for capacity evaluation in guardianship assessing medical condition, cognition, functional abilities, values, risk of harm and level of supervision needed, and means to enhance capacity); Jennifer Moyer et al., *Empirical Advances in the Assessment of the Capacity to Consent to Medical Treatment: Clinical Implications and Research Needs*, 26 CLINICAL PSYCHOL. REV. 1054 (2006) (clinical judgment for capacity determination can be unreliable; no consensus regarding reliability and validity of instrument-based consent capacity assessment).

102. Kenneth C. Dudley & R. Turner Goins, *Guardianship Capacity Evaluations of Older Adults*, 15 J. AGING & SOC. POL'Y 97, 105 (2003). Evaluation thoroughness is substandard. Guardianship inefficiency is rampant in the guardianship system in Pennsylvania and West Virginia. *Id.* at 97, 111.

103. Moyer, *Clinical Evidence in Guardianship*, *supra* note 101, at 608.

104. *See, e.g.*, Kathleen H. Wilber, *Choice, Courts, and Competency: The Coming of Age of Protective Services Research*, 37 GERONTOLOGIST 272, 272 (1997).

105. *See* Margaret Blenkner et al., *A Research and Demonstration Project of Protective Services*, 52 SOC. CASEWORK 483, 498 (1971); MARGARET BLENKNER ET AL., BENJAMIN ROSE INST., FINAL REPORT: PROTECTIVE SERVICES FOR OLDER PEOPLE 107, 134, 138 (1974). A later reanalysis by other researchers suggested that the findings

The issues of the use of adult protective services, including pursuit of guardianship, and nursing home placement were not "revisited in an epidemiologically rigorous fashion" until thirty years later.¹⁰⁶ Linking the New Haven Established Population for Epidemiologic Studies in the Elderly cohort with catchment area adult protective services records and data from the state long-term care registry, Lachs and associates explore "whether APS use for abuse and self-neglect is an independent predictor of [nursing home placement] after adjusting for other factors known to predict institutionalization (e.g., medical illness, functional disability, and poor social support)."¹⁰⁷ The Lachs study finds that "the relative contribution of elder protective referral [including 'pursuit of guardianship'] to [nursing home placement] is enormous [—'4- to 5-fold risk conferred by elder

on death came from initial group differences not controlled by the random sampling, but confirmed the strong effect of membership in the experimental group on the institutionalization tendency. Raymond Berger & Irving Piliavin, *The Effect of Casework: A Research Note*, 21 SOC. WORK 205, 207 (1976). Cf., e.g., ROBERT C. DAVIS & JUANJO MEDINA-ARIZA, NAT'L INST. JUSTICE, RESULTS FROM AN ELDER ABUSE PREVENTION EXPERIMENT IN NEW YORK CITY 3 (Sept. 2001) ("[N]ew incidents of abuse were more frequent among households that both received home visits and were in housing projects that received public education.") But cf. Ruth E. Dunkle et al., *Protective Services Reanalyzed: Does Casework Help or Harm?*, 64 SOC. CASEWORK 195, 195 (1983) (criticizes flaws in Blenkner study design and questions study conclusions). See also Winsor C. Schmidt, *Adult Protective Services and the Therapeutic State*, 10 L. & PSYCHOL. REV. 101, 121 (1986) ("We should identify, segregate, and victimize the victimizer, rather than the victim . . ."); Winsor C. Schmidt et al., *A Descriptive Analysis of Professional and Volunteer Programs for the Delivery of Public Guardianship Services*, 8 PROB. L. J. 125 (1988) (compares Florida professional and volunteer guardianship programs by client assessment forms, guardianship plans, and guardian activity reports; includes cost analysis); Pamela B. Teaster et al., *Staff Service and Volunteer Staff Service Models for Public Guardianship and "Alternatives" Services: Who Is Served and With What Outcomes?*, 5 J. ETHICS, L. & AGING 131 (1999) (compares Virginia professional and volunteer public guardianship programs by client assessment instruments, client care plans, and work activity logs; includes cost analysis).

106. Mark S. Lachs et al., *Adult Protective Service Use and Nursing Home Placement*, 42 GERONTOLOGIST 734, 734 (2002). Cf. JOHN B. WILLIAMSON, *supra* note 17, at 33 ("Nursing homes present an unusually graphic example of bureaucratic, medical, profit-oriented, and labeling control mechanisms in operation . . .").

107. Lachs, *supra* note 106, at 735. See also S. L. Reynolds & L. D. Carson, *Dependent on the Kindness of Strangers: Professional Guardians for Older Adults Who Lack Decisional Capacity*, 3 AGING & MENTAL HEALTH 301, 301 (1999) (explaining that it was more likely for wards with family guardians to be living in the community than wards with professional guardians).

mistreatment and self-neglect’—] and far exceeds the variance explained by other variables such as dementia, functional disability, and poor social networks.”¹⁰⁸ While the Lachs clinicians “observed that often nursing home placement resulted in dramatic improvements in quality of life that was apparent to all observers—including [adult protective services] clients themselves,” the authors note: “[i]t is remarkable that controlled studies of differential outcomes of [adult protective services] have not yet been conducted. A review of the literature shows no systematic attempt to evaluate program outcomes or to examine unintended consequences of [adult protective services] intervention.”¹⁰⁹

Such adult protective services and guardianship outcomes research is consistent with the earliest descriptive research and conclusions about guardianship.¹¹⁰ A legal services advocate concluded: “When examined in the larger context of social programming through which we purport to help the less advantaged, involuntary guardianship emerges as an official initiation rite for the entry of the poor and the inept into the

108. Lachs, *supra* note 106, at 737–38.

109. *Id.* at 738.

110. See, e.g., ALEXANDER & LEWIN, *supra* note 96, at 136. See also George J. Alexander, *Who Benefits from Conservatorship?*, 13 TRIAL, May 1977 at 30, 32 (“In short, then, the present California law and the law in most of the United States applies conservatorship: for inappropriate reasons (petitioner’s unstated motives); according to invalid standards (old age, designing persons); under the dubious pretense of medical expertise; and without seeing to the representation of the proposed ward.”). Cf., e.g., Joseph A. Rosenberg, *Poverty, Guardianship, and the Vulnerable Elderly: Human Narrative and Statistical Patterns in a Snapshot of Adult Guardianship Cases in New York City*, 16 GEO. J. POVERTY L. & POL’Y 315 (2009) (case study suggests guardianships adversely affect vulnerable elders by causing dislocation, diminished autonomy, and privacy infringement; hospitals may use guardianships to facilitate disproportionate discharges to nursing homes); Jennifer L. Wright, *Guardianship for Your Own Good: Improving the Well-Being of Respondents and Wards in the USA*, 33 INT’L J. L. & PSYCHIATRY 350 (2010) [hereinafter Wright, *Guardianship*] (questioning the presumption that guardianship is in best interests of incapacitated adults by empirical research on role of internal locus of control and autonomy on human well-being, and finding current statutes fail to achieve underlying values justifying adult protective proceedings); Jennifer L. Wright, *Protecting Who from What, and Why, and How?: A Proposal for an Integrative Approach to Adult Protective Proceedings*, 12 ELDER. L. J. 53 (2004) [hereinafter Wright, *Protecting*] (arguing that adult guardianship and parens patriae civil commitment should be integrated).

[medically] managed society."¹¹¹ In short,

Recognize guardianship for what it really is: the most intrusive, non-interest serving, impersonal legal device known and available to us and as such, one which minimizes personal autonomy and respect for the individual, has a high potential for doing harm and raises at best a questionable benefit/burden ratio. As such, it is a device to be studiously avoided.¹¹²

Another example of the medicalization of aging in personhood issues about legal incapacity is the practice of physicians serving as de facto guardians. Despite the legal requirement that non-emergency medical treatment occurs only with patient or surrogate consent, there is a significant incidence of unconsented medical service to patients who lack both decision-making capacity and a surrogate decision-maker. At least 16% of patients admitted to medical intensive care units (ICU) of hospitals lack capacity and a surrogate while accounting for 5.5% to 27% of ICU deaths.¹¹³ Compared with other ICU patients, these patients are more likely white, male, and age sixty-five or older.¹¹⁴ An estimated one-third of incapacitated nursing home residents do not have a surrogate

111. Annina M. Mitchell, *Involuntary Guardianship for Incompetents: A Strategy for Legal Services Advocates*, 12 CLEARINGHOUSE REV. 451, 466 (1978).

112. Elias Cohen, *Protective Services and Public Guardianship: A Dissenting View*, Address at 31st Annual Meeting of the Gerontological Society, Dallas (Nov. 20, 1978).

Guardianship represents a failure to execute appropriate planning and advance directives. *Cf., e.g.*, Patient Self-Determination Act of 1990, 42 U.S.C. §§ 1395 et seq. (requiring hospitals, skilled nursing facilities, home health agencies, hospice programs, and health maintenance organizations receiving Medicare and Medicaid to provide each patient with information about rights to accept or refuse treatment, to formulate advance directives, to document whether an advance directive is signed, to assure related state law is followed, and provide for education of staff and public about advance directives); MARSHALL B. KAPP, *THE LAW AND OLDER PERSONS: IS GERIATRIC JURISPRUDENCE THERAPEUTIC?* 143–56 (2003) (discussing Patient Self-Determination Act).

113. Douglas B. White et al., *Decisions to Limit Life-Sustaining Treatment for Critically Ill Patients Who Lack Both Decision-Making Capacity and Surrogate Decision-Makers*, 34 CRITICAL CARE MED. 2053, 2055–56 (2006) [hereinafter White, *Decisions*]; Douglas B. White et al., *Life Support for Patients Without a Surrogate Decision Maker: Who Decides?*, 147 ANNALS INTERNAL MED. 34, 36 (2007) [hereinafter White, *Life Support*].

114. White, *Decisions*, *supra* note 113, at 2054.

available to make DNR order decisions.¹¹⁵ Contrary to law, physicians make many important medical decisions for incapacitated patients without surrogates and without judicial review.¹¹⁶ Physicians not only rarely receive training in legal competence evaluations,¹¹⁷ they also rarely receive training or certification in guardianship.¹¹⁸

115. See Andrew M. Fader, *Implementing a "Do-Not-Resuscitate" (DNR) Policy in a Nursing Home*, 37 J. AM. GERIATRIC SOC'Y 544, 547 (explaining that 45% of incapacitated nursing home residents' surrogates did not respond within three months when asked about the DNR wishes of their wards, but the authors intended to follow up after the study was published).

116. See Robin J. Bandy et al., *Medical Decision-Making During the Guardianship Process for Incapacitated, Hospitalized Adults: A Descriptive Cohort Study*, 25 J. GEN. INTERNAL MED. 1003, 1006 (2010); White, *Decisions*, *supra* note 113, at 2053; White, *Life Support*, *supra* note 113, at 34. Cf., e.g., University of Louisville Hospital Policy, No. 600-140, Informed Consent (rev. Dec. 2010), available at <http://www.uoflhealthcare.org/Default.aspx?tabid=526> (last visited Aug. 25, 2011).

If it is not possible to obtain a timely court order, then two attending physicians (one of whom is *not* involved in the patient's care) will confer and based on their best medical judgment, determine what care is in the patient's best interests. **Note:** the determination regarding treatment in the patient's best interests shall be made in coordination with Social Services' efforts to address the patient's guardianship needs.

Id. (emphasis in original); University of Louisville Hospital Policy, No. 600-158, Recognizing Patient Autonomy Decision Making (rev. Feb. 2003), available at <http://www.uoflhealthcare.org/Default.aspx?tabid=526> (last visited Aug. 25, 2011) ("If the patient requires urgent care or treatment and the health care decision maker is absent or unavailable, two (2) licensed attending physicians not involved in the patient's care" may consent to treatment.) Medical treatment may occur in Kentucky on the authority of: (a) a valid informed consent, KY. REV. STAT. ANN. § 304.40-320(1) (West 2011); (b) "an emergency situation where consent of the patient cannot reasonably be obtained before providing health care services," § 304.40-320(3); (c) authorized responsible parties (not including an attending physician), § 311.631(1) (2011); or (d) by a court exercising the powers of a limited guardian, or appointing an individual or agency to exercise such powers if "there is danger of serious impairment to the health or safety of the respondent," § 387.740(1).

117. Dudley & Goins, *supra* note 102, at 112.

118. Fifteen states have some provision for professional guardian licensing, certification, or registration, almost all with some provision for guardianship training or examination. Winsor C. Schmidt et al., *Study Finds Certified Guardians with Legal Work Experience are at Greater Risk for Elder Abuse than Certified Guardians with Other Work Experience*, VII NAELA J. 171, 178 (2011). The state of Washington's Professional Guardian Certification Program training requires completion of three courses offered by the University of Washington and consisting of fifty-six classroom hours and forty-four online distance education hours. Professional Guardian Certification Program, WASH. CTS., http://www.courts.wa.gov/committee/?fa=committee.display&item_id=845&committee_id=115 (last visited Oct. 16, 2011).

The problems with surrogate decision-making for patients by physicians in ICUs, general hospital wards, and skilled-nursing facilities are myriad. Such decision-making by physicians (a) is inconsistent with the *Ethics Manual* of the American College of Physicians;¹¹⁹ (b) does not provide “adequate safeguards to [assure] that decisions for these patients [(critically ill patients lacking decision-making capacity and surrogates)] are fair and consistent”;¹²⁰ (c) is erroneously based on “problematic” subjective criteria, “such as the patients’ anticipated quality of life, [the physician’s] own perception of what was in the patients’ best interest, and concerns about appropriate resource allocation”;¹²¹ (d) assesses patient quality of life systematically lower than patient assessment;¹²² (e) chooses less aggressive treatment for homeless or marginally housed patients than the patients choose;¹²³ (f) presents potential physician conflict of interest, and presents absence of patient due process;¹²⁴ and (g) “may result in similarly situated patients receiving different levels of treatment” because of wide variation in physician beliefs about limiting life-sustaining treatment.¹²⁵

Also, (a) considering that the medical literature¹²⁶ documents potential physician conflict of interest when a physician renders a surrogate consent decision for his or her own patient, or a colleague’s patient, or for the physician’s hospital’s patient, and (b) considering that the medical literature documents the “concern that, depending on the reimbursement structure of the . . . hospital, there may be a systematic bias in

119. See White, *Life Support*, *supra* note 113, at 34; Lois Snyder & Cathy Leffler, Position Paper, *Ethics Manual: Fifth Edition*, 142 ANNALS INTERNAL MED. 560, 567 (2005).

120. White, *Decisions*, *supra* note 113, at 2058.

121. *Id.* at 2057.

122. *Id.* (citing Robert A. Pearlman & Richard F. Uhlmann, *Quality of Life in Chronic Diseases: Perceptions of Elderly Patients*, 43 J. GERONTOLOGY: MED. SCI. M25, M30 (1988)).

123. See Wendi M. Norris et al., *Treatment Preferences for Resuscitation and Critical Care Among Homeless Persons*, 127 CHEST 2180, 2181 (2005).

124. White, *Decisions*, *supra* note 113, at 2058.

125. *Id.*

126. *E.g., id.*

favor of either overtreatment or undertreatment of these patients,"¹²⁷ there may be legal risk regarding "false claims" for Medicaid (and Medicare) reimbursement under the various federal civil and criminal statutes, and regarding risk under the Stark Law (governing physician self-referral) and federal and state "fraud and abuse" statutes.¹²⁸ Depending on the reimbursement claims in these cases, there may be problems, at least conceptually, with financial benefit that occurs from conflict of interest, or from either overtreatment or undertreatment of patients who lack a legally authorized consent.

While some demedicalization has occurred in statutory criteria for legal incapacity, excessive medicalization of guardianship seems to prevail, as with the other important medicalization of aging personhood issue, death and dying.

ASSESSMENT OF THE MEDICALIZATION OF AGING: THERAPEUTIC STATE

A critical view of law and aging, or elder law, sees a dramatic historical shift of public policy about aging from concerns about equity and social justice to preoccupation with efficiency and cost containment.¹²⁹ While Social Security, Medicare, and Medicaid achieved a sea of change in the reduced incidence of poverty and improved quality of life for older persons, the preoccupations with cost containment in the late twentieth century arguably changed the function and political economy of elder law and policy from social justice to social control.

Probably the most important point made by theorists of social control is that the nature or face of control has changed over the past 100 years; not only are targets told they are responsible for their plight, they are also

127. *Id.* at 2057.

128. See generally C. Dean Furman, Special Article, *The Federal False Claims Act: The Dangers of Ignorance*, 105 KY. MED. ASS'N J. 23 (2007).

129. See WILLIAMSON, *supra* note 17, at 38.

led to believe that their loss of autonomy and relegation to others' care is for their own good. Essentially, social control mechanisms have been altered in two major, yet overlapping ways. First, enlightened bureaucratic management, through the use of policy and law, has replaced informal controls of the primary group and overtly coercive powers of the state as the most pervasive sources of control.

....

Second, the major agents of control are no longer sweatshop employers or law enforcement agents. Rather the benign bureaucratic model overlaps with a medical model of control, and psychiatrists and other medical personnel play a major part in defining people's possibilities in life. . . . [M]ental hygiene is not so much a science for preventing mental disorder as a science for the prevention of moral delinquency.¹³⁰

Kittrie identified a "new hybrid system of social controls" which he designated as the therapeutic state.¹³¹ The therapeutic state is distinct from the welfare state, which includes aid to the poor, public education, housing assistance, retirement benefits, medical care, and possibly guaranteed income (not to mention corporate welfare).¹³² "The welfare state makes services available to voluntary consumers; the therapeutic state assumes that its clients are too incompetent to be voluntary or to realize the beneficence of the proffered assistance and therefore attempts to administer its services involuntarily."¹³³

Dangers of the therapeutic state lie in the conditioning of society to consider those with a label of deviance, like the elderly, as "'different,' rarely considering the possibility that deviance could easily be broadened to encompass many unsuspecting candidates."¹³⁴

The danger . . . exists that in the implementation of the

130. *Id.* at 32 (internal citations omitted). Williamson at al. account for the extent of social control experienced by older persons from historical, cultural, and social perspectives. *See id.*

131. KITTRIE, *supra* note 5, at 40.

132. *Id.* at 10, 41. *See generally* GUNNAR MYRDAL, *BEYOND THE WELFARE STATE* (Bantam Books 1967) (1960).

133. SCHMIDT et al., *supra* note 97, at 9. *See* KITTRIE, *supra* note 5, at 41.

134. KITTRIE, *supra* note 5, at 361.

rehabilitative ideal, the social-defense role will gain ascendancy, leaving the individual with little or no protection from the powers of the therapeutic state. . . . More and more persons will find themselves subject to compulsory treatment for the well-being of society in general with little or no protections offered against error, abuse, oversights, or untoward infringements of privacy. At that time we would truly be near the Brave New World.¹³⁵

With the Brave New World of the therapeutic state and the medicalization of deviance like aging, constitutional safeguards and individual rights are circumvented or lost in the name of health.¹³⁶

ASSESSMENT OF THE MEDICALIZATION OF AGING: THERAPEUTIC JURISPRUDENCE

One of the more recent manifestations of the therapeutic state is therapeutic jurisprudence. Therapeutic jurisprudence, “the role of the law as a therapeutic agent,”¹³⁷ studies “the use of the law to achieve therapeutic objectives.”¹³⁸ Therapeutic jurisprudence is an “antidote” to the judicial-opinion-based “doctrinal, constitutional, and rights-oriented” approach reached by mental health law.¹³⁹ Traditional mental health law extended rights in constitutional criminal procedure to the mental health system, but allegedly grew “sterile” with increased social conservatism and changes in composition of the U.S. Supreme Court.¹⁴⁰ Therapeutic jurisprudence examines “the

135. *Id.* at 401.

136. See CONRAD & SCHNEIDER, *supra* note 4, at 257; see generally KITTRIE, *supra* note 5. See also Special Issue, *Challenging the Therapeutic State: Critical Perspectives on Psychiatry and the Mental Health System*, 11 J. MIND & BEHAV. 247 (David Cohen, ed. 1990).

137. DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 8 (1991).

138. DAVID B. WEXLER, *THERAPEUTIC JURISPRUDENCE: THE LAW AS A THERAPEUTIC AGENT* 4 (1990).

139. WEXLER & WINICK, *supra* note 137, at 3, 7.

140. *Id.* at 4–5. Cf. Bruce J. Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101 (1971) (standards and procedures for involuntary confinement for mental illness should be no less than for criminal defendants).

extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences."¹⁴¹ Therapeutic jurisprudence has produced a considerable literature in mental health law, as well as in such other fields of law as criminal law, tort, and contract.¹⁴² Elder law is subject to therapeutic jurisprudence analyses.¹⁴³

While the founders of therapeutic jurisprudence deny (intentions) that therapeutic jurisprudence supports or calls for a return to the therapeutic state,¹⁴⁴ significant criticisms of

141. WEXLER & WINICK, *supra* note 137, at ix.

A 9-cell matrix with Therapeutic, Neutral, and Antitherapeutic on the vertical axis, and Substantive Law, Legal Procedure, and Legal Role on the horizontal axis encourages therapeutic jurisprudence conclusions about whether any particular law, procedure, or role is therapeutic, antitherapeutic, both, or neither. Wexler, *supra* note 138, at 4–5. *Cf.*, John Monahan & Laurens Walker, *Social Science in Law*, at v (6th ed. 2006) (describing the 4-cell matrix for social science in law with Law and Social Science on the horizontal axis and Substance and Method on the vertical axis; social science in law jurisprudence is a tool in law for analysis of the resulting four subtopics: substantive law (“the legal rules which make the involvement [of social science in law] relevant”); legal method (“the process of managing the involvement [of social science in law]”); social science findings (“the relevant research results”); and social science method (“the techniques of carrying out and analyzing that research”). *Id.* From a social science in law perspective, conceptual challenges for therapeutic jurisprudence include: legal method issues about the legally appropriate methods of using social science; social science method issues about research design (e.g., causation, internal and external validity); issues about the admissibility of social science findings at trial and on appeal as “adjudicative facts” or “social authority”; social science findings as “legislative facts”; and, social science findings as context or “social framework” for predicting future facts, determining present facts, and determining past facts. *See generally id.* Social science in law jurisprudence may provide a more objective, neutral, or even determinative perspective than therapeutic jurisprudence.

In contrast to the “analogical reasoning” of traditional legal doctrinal analysis, the typical “creative/analytical process” for therapeutic jurisprudence includes an introduction, a description of the pertinent law, a section on the pertinent psychology, an integrative section applying or “relating the psychology to the law,” and a conclusion. WEXLER & WINICK, *supra* note 137, at 13–14.

142. *See, e.g.*, references cited by MICHAEL L. PERLIN, 1 MENTAL DISABILITY LAW: CIVIL AND CRIMINAL, 534–44, *supp.* 136–47 (2d ed. 1998 & *Supp.* 2009); Wright, *Guardianship*, *supra* note 110, at 357; *see* Wright, *Protecting*, *supra* note 110, at 73.

143. *See, e.g.*, KAPP, *supra* note 112; Daniel C. Marson et al, *Testamentary Capacity and Undue Influence in the Elderly: A Jurisprudent Therapy Perspective*, 28 L. & PSYCHOL. REV. 71 (2004); Dennis P. Stolle, *Professional Responsibility in Elder Law: A Synthesis of Preventive Law and Therapeutic Jurisprudence*, 14 BEHAV. SCI. & L. 459 (1996). *But see, e.g.*, Schmidt, *supra* note 5, at 125–26 and 133–37 for critical assessments of The Law and Older Persons.

144. *See* WEXLER & WINICK, *supra* note 137, at xi (“Let us, at the outset, emphasize that therapeutic jurisprudence does not embrace a vision of law or even

therapeutic jurisprudence at least keep the concern alive.¹⁴⁵

Petrila criticizes therapeutic jurisprudence: (1) for assuming that therapeutic outcomes should have a dominant, or any, role in judicial decision making; (2) for representing that therapeutic jurisprudence is a new approach to mental health law issues; (3) for ignoring the “consumer/survivor movement” in assuming “general agreement that, *other things being equal*, mental health law should be restructured to better accomplish therapeutic values;” and (4) for significantly failing to question “*who decides*” whether there is a therapeutic outcome and largely

of mental health law as serving exclusively or primarily therapeutic ends. We do not call for a return to the ‘therapeutic state’ or extol what Wexler once called ‘therapeutic justice.’”); David B. Wexler, *New Directions in Therapeutic Jurisprudence: Breaking the Bounds of Conventional Mental Health Law Scholarship*, 10 N.Y.L. SCH. J. HUM. RTS. 759, 762 (1993) (“Therapeutic jurisprudence in no way supports paternalism, coercion, or a therapeutic state. It in no way suggests that therapeutic considerations should trump other considerations such as autonomy, integrity of the fact-finding process, community safety, and many more.”).

145. Joel Haycock, *Speaking Truth to Power: Rights, Therapeutic Jurisprudence, and Massachusetts Mental Health Law*, 20 NEW ENG. J. CRIM. & CIV. CONFINEMENT 301, 315 (1993–94) (“But if therapeutic jurisprudence is construed as a shift from, or an alternative to, rights-based perspectives, then real risks exist.”); John Petrila, *Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence*, 10 N.Y.L. SCH. J. HUM. RTS. 877, 890 (1993) (reviewing WEXLER & WINICK, *supra* note 137):

First, . . . the authors assume “general agreement that, *other things being equal*, mental health law should be restructured to better accomplish therapeutic values.” This assumption on its face is highly questionable. Criticisms of the “therapeutic state” are common in both popular and professional literature; the views of people who do not share the belief that law should be devoted to accomplishing therapeutic values should not simply be discounted.

(internal citations omitted). Cf. Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL., PUB. POL’Y & L. 193, 211–214 (1995) (Under the “‘Internal’ Balancing” dilemma, while Wexler has asserted that therapeutic jurisprudence “in no way supports paternalism, coercion, or the therapeutic state,” the logic of therapeutic jurisprudence “may obscure any values encapsulated in the Constitution not connected with therapeutic results,” and, “[i]n short, . . . could undermine the normative premises of the legal system.”). *But cf.* David B. Wexler, *Reflections on the Scope of Therapeutic Jurisprudence*, 1 PSYCHOL., PUB. POL’Y & L. 220, 230 (1995) (“[M]icroanalytic therapeutic jurisprudence has in no way sought to construct a Therapeutic State: Therapeutic jurisprudence has been playing at the fringe of the mental health care tapestry and has not been designing the larger pattern.”); David B. Wexler & Bruce J. Winick, *Patients, Professionals, and the Path of Therapeutic Jurisprudence: A Response to Petrila*, 10 N.Y.L. SCH. J. HUM. RTS. 907 (1993).

ignoring the people subjected to therapeutic jurisprudence.¹⁴⁶ “Therapeutic jurisprudence as it has been conceptualized to date is a conservative, arguably paternalistic, approach to mental disability law.”¹⁴⁷ Petrla found no federal or state court cases using the term “therapeutic jurisprudence.”¹⁴⁸

From a medicalization of aging perspective, realization of therapeutic jurisprudence seems to enhance medicalization. Do therapeutic means or consequences achieve just ends? Should Lady Justice practice medicine? Should law strive for therapy or justice? Elder law should arguably refocus on constitutional safeguards and individual rights.

CONCLUSION

The purpose of this article is to describe and assess the upside and the downside of the medicalization of aging. The medicalization of aging seems to unnecessarily increase health care costs, unnecessarily increase opportunity for medical error, unnecessarily increase inappropriate utilization, needlessly medicalize death and dying, needlessly medicalize legal incapacity, and threateningly facilitate enhancement of the therapeutic state, including the therapeutic jurisprudence of the therapeutic state.

Regarding the favorable aspects of medicalization of aging, there are arguable benefits to *medicalizing general social deviance* and *transferring morally problematic general social problems* from law to medicine. Medicine can appear more scientific and objective. Morally problematic social problems may receive a more sympathetic and less judgmental hearing from physicians and medicine than from law. Medical treatment of social

146. Petrla, *supra* note 145, at 877, 881, 891 (quoting WEXLER & WINICK, *supra* note 137, at xii).

147. *Id.* at 881.

148. *Id.* at 878 n.6.

For further analysis of responses to Petrla by Wexler and Winick, and Slobogin's examination of five conundrums challenging therapeutic jurisprudence see, e.g., Schmidt, *supra* note 5, at 127–28. See generally Slobogin, *supra* note 145; Wexler & Winick, *supra* note 145.

problems may cost less than social control systems like jails and prisons and offer the possibility of rehabilitation and cure. The sick role exempts individual social responsibility and provides exemption from normal social responsibilities.¹⁴⁹ Medicalizing social problems may reduce the need for law to successfully retribute, deter, incapacitate, and otherwise achieve and maintain social control. If war is merely politics by other means,¹⁵⁰ then medicalization of general social deviance is merely law and social control by other means.

Favorable aspects to *medicalizing the social deviance of aging* and *transferring morally problematic social problems of aging* from law to medicine are not so clear. Nonetheless, the morally problematic social problems of aging subject to medical ethical requirements¹⁵¹ of nonmaleficence, beneficence, autonomy, and justice¹⁵² (e.g., fair, equitable distribution) may receive a more sympathetic and less judgmental hearing from physicians and medicine than from law. Medicine and physicians can appear more scientific and objective about elder and disabled patients. The “arc, end, and prolongation of life”¹⁵³ with medicalization are subject from ethical requirements to erring on the side of medical diagnosis, treatment, and life extension seemingly regardless of cost. Individual and community medical treatment of social problems in aging may cost less than social control systems like mental institutions and long term care facilities, and offer the possibility of rehabilitation and cure. The sick role in aging exempts individual social responsibility for successful planning and implementation, and provides exemption from normal social responsibilities of healthy people. Medicalizing

149. See PARSONS, *supra* note 5.

150. CARL VON CLAUSEWITZ, 1 ON WAR 23 (J. J. Graham trans., new & rev. ed., 5th impr. 1949) (“We see, therefore, that War is not merely a political act, but also a real political instrument, a continuation of political commerce, a carrying out of the same by other means.”).

151. See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (6th ed. 2009); BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS (4th ed. 2009).

152. See, e.g., BEAUCHAMP & CHILDRESS, *supra* note 151, at 241.

153. Kaufman et al., *supra* note 30, at 732.

social problems in aging may reduce the need for law to successfully achieve and maintain social control. If war is merely politics by other means, then medicalization of aging is merely law and social control by other means.

Regarding drawbacks to *medicalizing the social deviance of aging* and *transferring morally problematic social problems of aging* from law to medicine, medicine is not necessarily scientific and objective. There is much art and discretion to medicine that escapes accountability in law. The morally problematic social problems of aging subject to medical ethical requirements of nonmaleficence, beneficence, autonomy, and justice may get no hearing from law. The "arc, end, and prolongation of life" with medicalization err on the side of medical diagnosis, treatment, and life extension seemingly regardless of cost, and with significant challenges to individual autonomy and individual and social preference to not medicalize life, to not needlessly prolong life, and ultimately to end life in a demedicalized manner. A medicalized sick role in aging makes the person a patient, a disease, illness, sickness, disorder, or syndrome, with less personhood and less of a person. Choice, planning, implementation, and responsibility are diminished. Normal social responsibilities are excused. Medicalizing social problems in aging reduces law and rule by law and substitutes rule by medicine. If medicalization of aging is law and social control by other means, it may constitute the moral equivalent of war as merely politics by other means.