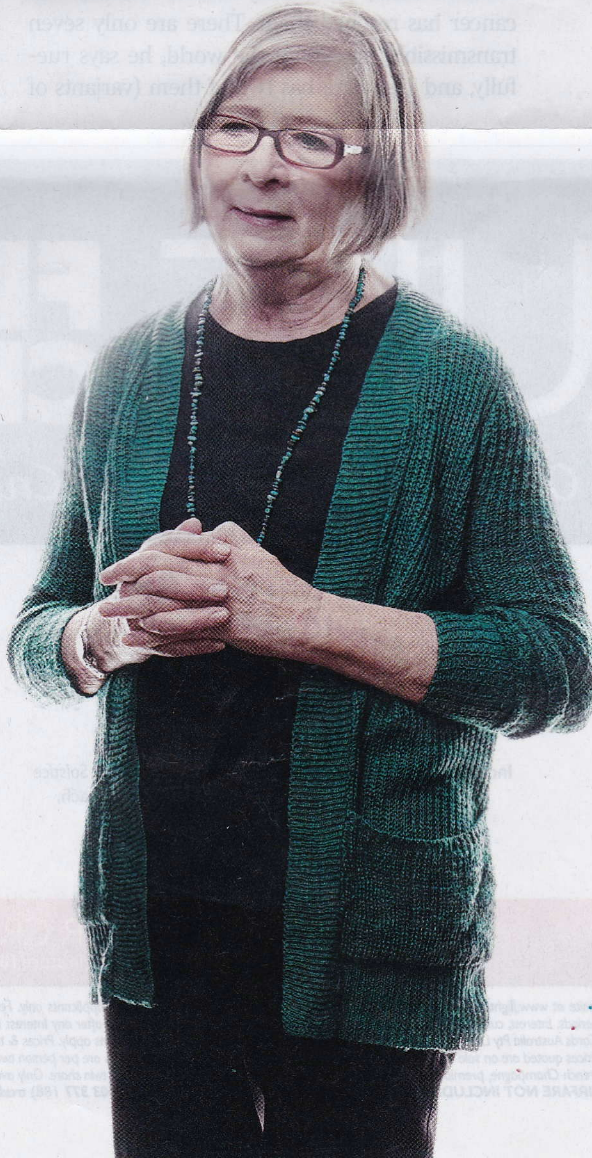
At 76, author Barbara Ehrenreich steps off the preventive care treadmill – and revels in her newfound freedom

OLD ENOUGH TO DIE



my own experiences
my solution
experiences of individuals

Old Enough to Die

Barbara Ehrenreich steps off the preventive care treadmill – and revels in her new found freedom.

n the last few years I have given up on the many medical measures – cancer screenings, annual exams, Pap smears, for example – expected of a responsible person with health insurance. This was not based on any suicidal impulse. It was barely even a decision, more like an accumulation of micro-decisions: to stay at my desk and meet a deadline or show up at the primary care office and submit to the latest test to gauge my biological sustainability; to spend the afternoon in the faux-cozy corporate environment of a medical facility or to go for a walk. At first I criticised myself as a slacker and procrastinator, falling behind on the simple, obvious stuff that could prolong my life. After all, this is the great promise of modern scientific medicine: you do not have to get sick and die (at least not for a while), because problems can be detected "early" when they are readily treatable. Better to catch a tumour when it's the size of an olive than that of a cantaloupe.

I knew I was going against my own longstanding bias in favour of preventive medical care as opposed to expensive and invasive high-tech curative interventions. What could be more ridiculous than an inner-city hospital that offers a hyperbaric chamber but cannot bestir itself to get out in the neighbourhood and test for lead poisoning? From a public health perspective, as well as a personal one, it makes far more sense to screen for preventable problems than to invest huge resources in the treatment of the very ill.

I understood that I was going against the grain for my particular demographic. Most of my educated, middle-class friends had begun to double down on their health-related efforts at the onset of middle age, if not earlier. They undertook exercise or yoga regimens; they filled their calendars with upcoming medical tests and exams; they boasted about their "good" and "bad" cholesterol counts, their heart rates and blood pressure. Mostly they understood the task of ageing to be self-denial, especially in the realm of diet, where one medical fad, one study or another, condemned fat and meat, carbs, gluten, dairy, or all animal-derived products.

I had a different reaction to ageing: I gradually came to realise that I was old enough to die, by which I am not suggesting that each of us bears an expiration date. There is of course no fixed age at which a person ceases to be worthy of further medical investment, whether aimed at prevention or cure. The military judges that a person is old enough to die – to put him or herself in the line of fire at age 18. At the other end of life, many remain world leaders in their 70s or even older, without anyone questioning their need for lavish continuing testing and care.

Once I realised I was old enough to die, I decided that I was also old enough not to incur

any more suffering, annoyance or boredom in the pursuit of a longer life. I eat well, meaning I choose foods that taste good and that will stave off hunger for as long as possible, like protein, fibre and fats. I exercise – not because it will make me live longer but because it feels good when I do. As for medical care: I will seek help for an urgent problem, but I am no longer interested in looking for problems that remain undetectable to me. Ideally, the determination of when one is old enough to die should be a personal decision, based on a judgment of the likely benefits, if any, of medical care and – just as important at a certain age – how we choose to spend the time that remains to us.

At the same time I had always questioned whatever procedures the healthcare providers recommended; I am part of a generation of women who insisted on their right to raise questions without having the word "uncooperative", or worse, written into their medical records. So when a few years ago my primary care physician told me that I needed a bone density scan, I asked him why: what could be done if the result was positive and my bones were found to be hollowed out by age? Fortunately, he replied, there was now a drug for that. I told him I was aware of the drug, both from its full-page magazine ads as well as from articles in the media questioning its safety and efficacy. Think of the alternative, he said, which might well be, say, a hip fracture, followed by a rapid descent to the nursing home. So I grudgingly conceded that undergoing the test, which is non-invasive and covered by my insurance, might be preferable to immobility and institutionalisation.

The result was a diagnosis of "osteopenia", or thinning of the bones, a condition that might have been alarming if I hadn't found out that it is shared by nearly all women over the age of 35. Osteopenia is, in other words, a normal feature of ageing. A little further research revealed that routine bone scanning had been heavily promoted and even subsidised by the drug's manufacturer. Worse, the favoured medication at the time of my diagnosis has turned out to cause some of the very problems it was supposed to prevent – bone degeneration and fractures. A cynic might conclude that preventive medicine exists to transform people into raw material for a profit-hungry medical-industrial complex.

My first major defection from the required screening regimen was precipitated by a mammogram. I'd been fairly dutiful about mammograms since having been treated for breast cancer at the turn of the millennium and now, about 10 years later, the gynaecologist's office reported that I'd had a "bad mammogram". It turned out, after I'd been through a sonogram and fought panic in a coffinlike MRI tube, that the "bad mammogram" was a false positive resulting from the highly sensitive new digital forms of imaging. That was my last mammogram. Lest this seem like a reckless decision I was supported by a high-end big-city oncologist, who viewed all my medical images and said that there would be no need to see me again, which I interpreted as ever again.

After this, every medical or dental encounter seemed to end in a tussle. Dentists – and I have met a number of them in my moves around the country – always wanted a fresh set of X-rays, even if the only problem was a chip in the tip of a tooth. Why should I routinely expose my mouth to high annual doses of roentgens [radiation]? If there was some reason to suspect underlying structural problems, OK, but just to satisfy the dentist's curiosity or meet some abstract "standard of care"? No.

In all these encounters, I was struck by the professionals' dismissal of my subjective reports – usually along the lines of "I feel fine" – in favour of the occult findings of their equipment. One physician, unprompted by any obvious signs or symptoms, decided to measure my lung capacity with the new handheld instrument he'd acquired for this purpose. I breathed into it, as instructed, as hard as I could, but my breath did not register on his screen. He fiddled with the instrument, looking deeply perturbed, and told me I seemed to be suffering from a pulmonary obstruction. In my defence, I argued that I do at least 30 minutes of aerobic exercise a day, not counting ordinary walking, but I was too polite to demonstrate that I was still capable of vigorous oral argument.

It was my dentist, oddly enough, who suggested, during an ordinary filling, that I be tested for sleep apnea. How a dentist got involved in what is normally the domain of ear, nose, and throat specialists I do not know, but she recommended that the screening be done at a "sleep centre" where I would attempt to sleep while heavily wired to monitoring devices, after which I could buy the treatment from her: a terrifying skull-shaped mask that would supposedly prevent sleep apnea and definitely extinguish any last possibility of sexual activity. But when I protested that there is no evidence I suffer from this disorder – no symptoms or detectable signs – the dentist said that I just might not be aware of it, adding that it could kill me in my sleep. This, I told her, is a prospect I can live with.

As soon as I reached the age of 50 physicians had begun to recommend – and in one case even plead – that I have a colonoscopy. As in the case of mammograms, the pressure to submit to a colonoscopy is hard to avoid. I put this off from year to year, until I finally felt safe in the knowledge that since colon cancer is usually slow-growing, any cancerous polyps I contain are unlikely to flourish until I am already close to death from other causes.

Of course all this unnecessary screening and testing happens because doctors order it, but there is a growing rebellion within the medical profession. Overdiagnosis is beginning to be recognised as a public health problem, and is sometimes referred to as an "epidemic". It is an appropriate subject for international medical conferences and books such as *Overdiagnosed: Making People Sick in the Pursuit of Health* by H. Gilbert Welch, Lisa