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A conversation with Nortin M. Hadler, M.D.

Author of *Rethinking Aging:*

Growing Old and Living Well in an Overtreated Society

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Q: In your introduction to *Rethinking Aging*, you express hope that “a new institution of medicine will soon supersede one that is ethically bankrupt.” In your opinion, what steps need to be taken for this to happen?

A: The *status quo* underwrites an enormous industry: insurance, pharmaceutical, hospitals and clinics, extended care facilities and nursing homes, manufacturers of devices, many “providers,” and all sorts of suppliers. None suffer assaults on their *raison d’être*, let alone their profitability, passively.

However, nearly all these “stakeholders” have the same tailor. Once we, the people, are informed adequately, we will recognize their new clothes. All that is required is that we learn to ask two questions: “Is this a disease or just a predicament of life?” and “Will this really advantage me?” My earlier books teach working-age adults how to ask such questions and how to actively and effectively listen to the answers. *Rethinking Aging* teaches this relevant to life after sixty.

Q: How can patients maintain control of the diagnostic and therapeutic processes? And is our obsession with our numbers (BMI, blood pressure, cholesterol, blood sugar, etc.) ultimately hurting or helping us?

A: Our “obsession with numbers” is an object lesson. There is nothing wrong with the numbers themselves. However, all too often people do not understand how to interpret their numbers. All of the examples you list are discussed in detail in *Rethinking Aging*. Let’s just take cholesterol measurement in the general population as an example. Cholesterol is not a “disease.” It is an essential component of normal biology, and we don’t feel differently because it is higher or lower. It is a “risk factor” meaning the higher your LDL-cholesterol (and the lower your HDL-cholesterol), the more likely you are to suffer a cardiovascular event ahead of others. However, the risk one can impute is not that great. The highest LDL-cholesterol we come across on rare occasion places a year or two of life at risk, i.e., you are more likely to die a year or two sooner than others like you in every way but their LDL-cholesterol. That doesn’t mean you will die sooner, just that you are more likely to die sooner. Furthermore, most of you who are told that you have “high” cholesterol don’t have extreme values; you usually have months, not years, at risk.

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Is that worth knowing? Studies show that knowing changes one's sense of self; you will feel flawed and will likely adjust your diet and acquiesce to taking medicines designed to alter your cholesterol risk profile. Before you do either, you must ask, "Will these interventions that alter my risk profile also alter my risk?" There is a science that speaks to these queries. If you've never had a heart attack, you'll be on a fool's errand. If you have had a heart attack, there is measurable benefit but it is far from dramatic and worth discussing in detail before embarking on the interventions.

Q: What is the difference between a screening and diagnostic test, and why is it so important to understand the difference?

A: A *screening test* is done because some august body of experts deems it advisable based on their interpretation of the relevant science. You do not have the test for any symptom; you have it because it is time to have it. This asks a lot of the screening test. It must find the disease you care about and not anything you could care less about. And it must find the disease whenever it is present and early enough to do something important about it. Hence, you never have a screening test unless the test is accurate, the disease is important, and there is meaningful recourse if it is positive. In *Rethinking Aging*, I discuss in detail why many of the commonly advised screening tests fall off this tightrope.

A *diagnostic test* is a test performed in response to a symptom. You may undergo colonoscopy because you have suffered rectal bleeding. In that context colonoscopy is not a screening test, it is a diagnostic test. You may undergo mammography because you feel a lump. Likewise, in that context mammography is a diagnostic test. A diagnostic test is designed to answer the question, "What is the cause of (this symptom)?" The yield of a meaningful result, either a positive or a negative, goes way up.

Most of the controversies regarding screening need to be influenced by this distinction. When one says that a screening has too little yield to be advocated, that does not exclude the use of the same test for diagnostic purposes. Furthermore, when the large trials of screening are designed, the screening procedure is offered in one population and the results compared with "usual care" in another population. "Usual care" includes diagnostic testing.

Q: You advise readers to "Find a physician with clinical judgment while you are well and in your Golden Years." How should one go about finding such a doctor?

A: It's not hard to find a physician who is prepared to foster informed medical decision making. Western medical school curricula have focused on such for a generation. Clinical judgment is a combination of such education and ability to establish a trusting relationship that keeps the patient the captain of the ship and the physician the navigator. That takes time and proclivity. The systems of medicine have evolved to defund and denigrate both. One needs to find the rare physician who can work in the system and not lose its ethic.

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Q: You say that “longevity is not heritable” and that those who live beyond a ripe old age are “lucky statistical outliers.” This seems counterintuitive. Could you please explain?

A: That’s what the science says. Get over it.

Q: I was struck by your assertion that “You should be fully informed that participation in *any* program, regimen, or other intervention purporting to enhance your health will change you forever—even if you are disappointed by the outcome.” Please discuss this further.

A: It is not possible to turn to any provider of health care without investing emotional energy in the encounter. Before the first contact, everyone casts about for the means and the information that might render the encounter unnecessary or point one in the right direction. We carry our preconceived notions into the encounter. In explaining the reason for seeking care, one is displaying the degree to which one tried to sort out the problem and failed. What follows is instructional. The “provider,” regardless of ilk, will listen actively to your symptoms attempting to reframe them in a fashion that conforms to whatever preconceptions are customary for that provider. If the symptoms are multifaceted, say fatigue+achiness+abdominal distress+headache, I can assure you that the diagnostic synthesis that emerges will differ if the diagnostician is a gastroenterologist or chiropractor or acupuncturist or general physician. Furthermore, you will learn the jargon that the provider is most comfortable employing along with all the implications of the jargon. Everyone leaves the encounter changed. That’s true if the encounter results in the diagnosis of a destructive disease, like Crohn’s disease, or a disease with no destructive potential, like chronic fatigue syndrome.

Q: Many readers will take heart in your pronouncement that “It’s OK to be overweight” and will be surprised to hear that you have no idea what you weigh because you never weigh yourself. But you do offer advice on weight control and staying and getting fit. Very briefly, what’s your prescription for a healthy lifestyle?

A: There are extremes and outliers in lifestyle that are to be avoided, and that I discuss. There is every reason to maintain the degree of fitness that facilitates function through the aging process. There is every reason to have perspective about life course and about healthfulness. Beyond that it is advisable that you learn to make living as self-fulfilling as you can. For most that requires engagement and community.

Q: You open *Rethinking Aging* with a remembrance of your father—who was also a physician—and learning gerontology at his knee. You close the book with your granddaughter’s musings on wanting to stay a kid “because kids don’t die.” This is by far your most personal book to date. Why did you decide to put so much of yourself into this work?

A: I tried not to; this is not about me. But more of me managed to insert itself. Perhaps this is because I am living *Rethinking Aging* along with the readers.

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This interview may be reprinted in its entirety with the following credit: A conversation with **Nortin M. Hadler, M.D.** Author of *Rethinking Aging: Growing Old and Living Well in an Overtreated Society* (University of North Carolina Press, Fall 2011). The text of this interview is available at www.ibiblio.org/uncp/media/hadler/.

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