In the vanguard of biomedicine? The curious and contradictory case of anti-ageing medicine

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Abstract

The rise of anti-ageing medicine is emblematic of the current conditions of American biomedicine. Through in-depth interviews with 31 anti-ageing practitioners, we examine how practitioners strive for—and justify—a model of care that runs counter to what they see as the ‘assembly line’ insurance-managed industry of healthcare. Their motivation, however, is not merely a reaction to conventional medicine. It is derived from what they see as a set of core beliefs about the role of the physician, the nature of the physician-patient relationship, and the function of biomedicine. We analyse this ideology to underscore how anti-ageing medicine is built on a ‘technology of the self’, a self in need of constant surveillance, intervention, and maintenance. The ultimate goal is to create an optimal self, not just a self free of illness. A fundamental irony is that, despite their self-presentation and the perception of the public, anti-ageing providers do not use practices that are especially ‘high-tech’ or unconventional. Instead, the management of ageing bodies rests on providers’ perceived knowledge of their patients, tailored treatments, and a collaborative pact between the provider and patient.

Keywords: anti-ageing, biomedicalisation, technogenarian, surveillance medicine, preventative medicine

Introduction

Anti-ageing medicine, a specialty in which healthcare providers typically see patients in stand-alone clinics, has grown exponentially over the last five years. Anti-ageing medicine is difficult to characterise in uniform terms, but its essential mission, as expressed by the American Academy of Anti-Aging Medicine (A4M), is ‘to detect, prevent, and treat aging-related disease and to promote research into methods to retard and optimise the human aging process. ... [D]isabilities associated with normal aging are caused by physiological dysfunction which in many cases are open to medical treatment, such that the human lifespan can be increased, and the quality of one’s life enhanced as one grows chronologically older’
(American Academy for Anti-Aging Medicine 2008). In this paper, we argue that the rise of anti-ageing medicine, as an early indicator of an emerging model of healthcare, is emblematic of the current condition of American biomedicine. Anti-ageing medicine has developed as a response to the perceived problems of biomedicine while at the same time retaining many of biomedicine’s underlying ideologies.

The still largely ideological concepts of consumer-directed healthcare, personalised medicine and preventive health have found strong footing in the specialty of anti-ageing medicine. Through interviews with 31 US-based anti-ageing practitioners, we examine how practitioners incorporate a personalised, individualised approach to their work as an attempt to move away from what they see as the ‘assembly line’ insurance-managed healthcare industry in the United States. They are more reluctant than conventional practitioners to use mass-market pharmaceutical drugs and more likely to rely on seemingly ‘old-school’ medical techniques, such as in-depth interviewing and repeated laboratory tests. However, their motivation is not merely a reaction to conventional medicine, but it is also derived from philosophical beliefs about the role of the physician, the nature of the physician-patient relationship, and the function of biomedicine to create an optimal self, not just a self free of illness. Our analyses examine how this supposedly new area of biomedicine fits into contemporary practice and discourse in the field.

In one of the first published articles to use the term ‘biomedicalization’, Estes and Binney (1989) describe how ageing has come to be seen as a biomedical problem—that is, as a problem of individual physiological pathologies—and how the growing biomedical ageing industry has been manufactured to treat these problems. In the 20 years that followed, ageing became fully biomedicalised and biomedicine itself changed dramatically. Besides turning ‘normal’ processes of ageing into pathological ones, all aspects of life are now heavily affected by biomedicalisation (Clarke et al. 2003). For example, improving one’s quality of life is considered a perfectly worthwhile motivation for seeking biomedical attention. Relatedly, Nikolas Rose describes ‘the politics of life itself’ as

neither delimited by the poles of illness and health, nor focused on eliminating pathology to protect the destiny of the nation. Rather it is concerned with our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures (2006: 3).

These concepts form the ideological backdrop of biomedicine that anti-ageing medicine both replicates and to which it responds. Ultimately, anti-ageing providers embrace the notion of the ‘vital self’ and address it through discourse about optimisation and balance. Yet, they simultaneously wish to reject other aspects of ‘vital politics’ that look like more traditional ‘surveillance medicine’ (Armstrong 1995), such as efficiency and evidence-based medicine and a one-size-fits-all form of care. Anti-ageing providers see themselves as the antithesis of the impersonal, routinised, insurance-managed care offered by other physicians. Above all, anti-ageing medicine is construed as something drastically different from what is now the ‘conventional’ practice of medicine. These providers hope to deliver personalised care that is tailor-made for each patient. This is marked by in-depth appointments, careful monitoring of a wide range of biomarkers, concern with the patient’s broader quality of life, and a specialised programme of health and wellness.

From a ‘technogenarian’ perspective (see Introduction of this issue), we examine how anti-ageing medicine is a ‘technology of the self’ (Foucault 1988), as evident in the labels and practices noted above. The ageing body is in need of constant surveillance,
intervention, maintenance, and management. Yet a fundamental irony is that anti-ageing providers, in delivering personalised medicine, claim to offer a return to the ‘art’ of medicine. Instead of working with pre-designed or prescribed treatment plans, these providers are concerned with the creation of medical care that is specific to the individuals they are treating, countering the trends of evidence-based medicine. In their minds, this makes a return to what they refer to as ‘patient-centred care’ more like the care given before the current era of managed healthcare. Many work outside traditional insurance arrangements, and many accept only out-of-pocket payments and offer off-label treatments, such as hormone therapies, that are not approved by the US Food and Drug Administration for anti-ageing purposes. Anti-ageing providers therefore employ rhetoric about a return to an earlier form of medicine, even though their approach may also embody some of the hallmark features of 21st century biomedicine. In the end, their approach represents an amalgamation of new and old forms of medical practice in order to appeal to patients who are looking for alternatives to conventional medicine, both in terms of the desired doctor-patient interactions and the kinds of services and therapies they seek. Anti-ageing medicine puts into practice a contorted and modified type of surveillance medicine, one that embraces a biomedicalisation of ‘life itself’ but in unconventional ways—through ‘low tech’ and ‘holistic’ approaches.

David Armstrong first described his concept of surveillance medicine in an article published in 1995 as a way of describing the historical shift from ‘hospital medicine’ in which the ill are the targets for medical intervention to a more general ‘problematisation of the normal’ that implicates the population at large (Armstrong 1995). By transforming signs and symptoms into risk factors for illness, everyone can be placed under surveillance. With everyone ripe for medical intervention, surveillance medicine turns ‘increasingly to an extracorporeal space—often represented by the notion of ‘lifestyle’—to identify the precursors of future illness’ (Armstrong 1995: 401). Foucauldian theorists have similarly identified the expansion of the medical gaze to healthy, ‘at risk’ populations.

One of the unintended outgrowths of surveillance medicine has been the rise of evidence-based medicine, where knowledge about risk factors for illness is compiled in meta-analyses, turned into practice guidelines, and used to make medical decisions about diagnosis and intervention. Although evidence-based medicine was designed in part as a professionalising strategy to reduce medical uncertainty, it developed a reputation as achieving just the opposite, because of its purported potential for routinised care based on cost-effectiveness rather than individual need (Armstrong 2007). Polemicists might, for instance, pit evidence-based medicine against ‘patient-centred care.’ In fact, in the United States, rhetoric about evidence-centred medicine became conflated with health maintenance organisations’ attempts to create efficient and cost-minimising care by reducing the number of ‘unnecessary’ diagnostic tests.

Anti-ageing providers are responding to this rhetoric and, moreover, to the rationalised and insurance-driven healthcare system in the US by rejecting the ideology behind evidence-based medicine, yet simultaneously embracing much of the ideology of surveillance medicine. In fact, we argue that they push the boundaries of surveillance medicine beyond just trying to treat risk factors for illness to improving and optimising one’s health regardless of one’s current health status. There is always room for improvement. ‘Life itself’ is a continually moving target for intervention. Yet, contrary to other forms of biomedicine that use the newest technologies for intervention, anti-ageing providers have turned to low-technological solutions—solutions that in their minds hark back to an earlier era of medicine which they associate with patient-centred care.
Methods

We interviewed a sample of 31 US-based anti-ageing providers drawn from the online directory of the American Academy for Anti-Aging Medicine (A4M) through which consumers can identify anti-ageing physicians, clinics, spas and products in their communities. The A4M is a professional organisation that claims to represent more than 28,000 physicians and scientists interested in anti-ageing. It organises and sponsors conferences all over the world to educate people and promote anti-ageing medicine and considers itself a ‘global resource for anti-aging medicine’ (American Academy for Anti-Aging Medicine 2008). It also has a fellowship and certification program for physicians to get training in anti-ageing medicine. It is in many ways one of the more public faces of anti-ageing medicine. Its website also has a directory of clinicians that anyone can search through and is the first hit in a google search of ‘anti-aging medicine’ (search conducted September 13, 2008). A total of 122 potential participants were identified within the category ‘anti-aging health professionals’ in the United States.

All potential participants were mailed recruitment packets that included information on the study, how to schedule an interview, and a small gift card for coffee. We conducted a total of 31 interviews, stopping after we met our goal for the sample size. Of the 31 participants, 19 (61%) were men and 12 (39%) were women. The majority (23, or 74%) reported themselves as White/Caucasian, three as Hispanic (10%), two as Black (6%), and one as Asian (3%). (Two respondents did not report their race and/or ethnicity.) Interviewees ranged from 33 to 71 years of age. Most (71%) reported a medical degree (MD) as their primary credential, with the remaining participants being Doctors of Naturopathy (ND), Doctors of Philosophy (PhD), Doctors of Osteopathic Medicine (DO), or Nurse Practitioners.

Semi-structured interviews were conducted by phone between March and August 2008 and ranged from 41 minutes to over two hours. Our inquiry draws heavily on sections of the interview that probe whether and how the term anti-ageing reflects the work of these providers, how their approach is similar to or different from ‘conventional medicine’, and what typical appointments and patients are like.

All interviews were fully transcribed and imported into Atlas.ti, a software program for qualitative data analysis. Codes were developed by drawing on existing scholarship and by building directly from the transcript text. First-level coding was done for particular questions (e.g. a reference to the provider’s work as ‘functional medicine’ as a specific type of terminology), and similar first-level codes were collapsed into higher-order ‘interpretive codes,’ to use Huberman and Miles’s (2002) term (e.g. references to specific terms were included in a larger code, ‘objections to anti-aging’). Both types of codes were then applied to the entire interview. Using this ‘grounded theory’ approach (Charmaz 2006), codes were further sorted into broader conceptual categories and incorporated into the theoretical foundation of this project.

The transcripts were divided among three coders who had also conducted the interviews. A coding manual was developed in collaboration with the full research team. The manual included a specific definition of each code and how to apply them. A common set of interviews was initially coded by all three coders to establish reliability. Coded transcripts were also reviewed and discussed by the whole team. As new codes were developed, coders followed the same process to ensure consistent decisions and to fine-tune existing codes.
Framing their work: the significance of language

The majority of providers express some reservations about using the label ‘anti-ageing’ to describe their work. ‘Anti-ageing’ is viewed as ‘a term that people get on a visceral level’—one that has meaning to the average person. It is not seen as an accurate descriptor of the daily work of most providers. Yet one of the most common objections of providers to the term ‘anti-ageing’ is that it is largely understood by the public to be aimed at making people look younger. Providers are quick to emphasise that aesthetic services are only a small part of what they do, if at all. One provider argues that ‘anti-ageing’ was once an accurate label for his work and the field, but its meaning had changed:

In say ‘96 or ‘97, yes. Today, no. Anti-ageing, the term ‘anti-ageing’ has really been taken over by Oil of Olay and all sorts of not necessarily bad things, but it’s really cosmetic. It’s having people like chase the fountain of youth, things that I do not feel are part of our specialty at all (P21).

Regardless of whether providers offer aesthetic services, the ‘anti-ageing’ label is generally viewed as failing to reflect the breadth of their practices. One provider says: ‘[I’m] not just...balancing someone and their, you know, human growth hormone or whatever needs replacing, but [I'm] also spending a lot of time with emotional, you know, fostering spirituality, nutrition, and so yes, [anti-ageing] plus’ (P4). This notion of ‘anti-ageing plus’ is important because it symbolises their work as far bigger than ‘anti-ageing’ alone.

For this reason, most providers opt for alternative labels, the most common being ‘preventative medicine’. In positioning their work as preventative medicine, providers attempt to distance themselves from longstanding perceptions of anti-ageing providers as peddlers of the ‘fountain of youth’ or, worse still, as quacks or charlatans (see also Binstock 2003, Fishman et al. 2008). ‘Functional medicine’ (Settersten et al. 2008), another frequently used term, promotes the notion that these providers seek to optimise function, not merely maintain it—which also has the effect of preventing triggers of disease and age-related decline.

‘Age-management medicine’ is a term that seems to be gaining significant momentum as a replacement for ‘anti-ageing medicine’. As one provider explained, ‘age management tends to be a more muted way to say anti-ageing’ (P10)—it is a safer way to describe the practice of anti-ageing medicine without carrying the same negative connotations. As we will later show, the ‘management’ descriptor is critical because it signals that ageing is a process that can and should be managed by providers and patients. Furthermore, it highlights the idea that the majority of anti-ageing patients are not the very old, but are, rather, middle aged, ‘45 and older’ (P5).

Other commonly referenced terms include ‘integrative medicine,’ which providers describe as the integration of ‘conventional’ medicine with ‘anti-ageing’ practices; and ‘longevity medicine,’ which suggests that providers seek to extend the human lifespan—or at least the healthy portion of it (or ‘health span’). Other terms that are raised by providers, but much less often, include ‘complementary and alternative medicine’, ‘regenerative medicine’, ‘rejuvenating medicine’, ‘wellness medicine’, and ‘natural medicine’.

In the vanguard of biomedicine?

When providers are asked to compare their practices to ‘conventional medicine’, an almost uniform response results: that what they are doing is conventional medicine. This shocks the
rhetoric of anti-ageing medicine as a cutting-edge and technologically-driven specialty of medicine. Most of our interviewees emphasise that they are not opponents of conventional medicine and, indeed, that the diagnostic techniques they use in their practices are staples of conventional medicine.

The major difference that sets them apart from conventional medical providers, in their estimation, has to do with the basic philosophy of their practices: they strive to deliver *personalised* and *individualised* care. This is a benefit for the provider as much as it is for the patient:

> Every physician, I think, should have his own practice, his own preferences, and in my understanding the patients should choose a physician according to his philosophy, rather than going to the McDonald-type physician which actually gives you the same product just in a different location (P2).

The scientific *methods* they use are consistent with conventional medicine, but *how* they deliver medicine is not—at least as they see it. In fact, the majority of providers say that they moved to anti-ageing medicine because the ethos and constraints of contemporary clinical medicine prevented them from delivering the type of care to which they are committed.

The emphasis on individualised care is evident from the first visit, with providers reporting that they spend between two and five hours with new patients. Providers take extensive histories that include things ‘not stressed in traditional medicine’, such as nutrition, exercise, sleep habits, supplements, and assessments of ‘antecedents, triggers and mediators’. As a result, providers are less concerned about assigning a disease label to a patient’s problems than they are about uncovering its etiology or underlying process:

> We look at the whole person, not necessarily a holistic approach, but we’re looking at the entire person, all of the disease processes put together and trying to find out what is the core reason and the causative factors, whereas in conventional medicine we all work in a silo. I mean the orthopedists do theirs, and somebody’s got a foot specialist and a hand specialist and an ear specialist, and right now the current medicine is just fragmental and everybody has their own thing. We try to put all those pieces of the puzzle together (P5).

The majority of providers stress the importance of taking an ‘open-minded’ approach that not only focuses on physical health, but also mental, emotional, sexual, and spiritual aspects:

> We spend more time with our patients. We dig a little deeper. We’re looking at the whole person…. A lot of conventional doctors would say ‘Well it’s in range. You’re fine’, and we have narrower ranges of what we consider normal. So we’re kind of focused more on optimal health, versus just normal and, let’s see, treating the underlying cause instead of just matching a drug with the bug, focus a lot on nutrition, lifestyle, which you know a lot of that is anti-ageing medicine anyway, supplements and the whole thing really. Just like basically it’s your personal doctor (P4).

This provider’s emphasis on ‘optimal health, versus just normal’ draws attention to a key way that anti-ageing providers see themselves as being in the vanguard of medicine (see also Mykytyn 2006). Their goal is to create optimal functioning, and not be satisfied when functioning falls within ‘normal’ ranges. Shrinking the range of ‘normal’ is a classic type of medicalisation—it makes pathological a set of parameters that were once normal and acceptable. In the case of anti-ageing medicine, the narrowing of an acceptable norm is a
direct attempt to define (and strive for) an optimal state of being. It reflects one of the hallmark of new forms of biomedicalisation in the 21st century: a movement away from the classification of diseases and towards the construction of an ever-improvable self (Clarke et al. 2003). Closely related to creating an optimal self is the emphasis that anti-ageing providers place on the goal of improving whole ‘quality of life’. Their explicit attention to the spiritual, emotional, and physical aspects of their patients’ lives is the full instantiation of a biomedicalisation of lifestyle. ‘Life itself’, following Rose (2006), is a worthy biomedical endeavour and part of the rhetoric of biomedicine—and anti-ageing providers are trying to fully implement this ideal.

**Low-tech answers in high-tech times**

Providers reject the traditional ‘disease model’ of medicine—one that focuses on standardised measures and tests and on uniform diagnoses—in favour of strategies that allow them to gain a deeper perspective on why patients have particular symptoms. It comes as no surprise, then, that the modes of treatment they choose are preventative ones, which they also say are not part of the repertoire of contemporary clinical medicine:

There is minimal emphasis on prevention in medical school. … [N]o one cares about it and doctors don’t know much about it, and it’s also not very exciting. [They] are a lot more interested in learning how to do a bypass than they are in, you know, what the optimal dose of calcium is to prevent osteoporosis or, you know, things along those lines. … [T]he high tech stuff that’s now available is much more interesting, so medical students and residents tend to gravitate towards the more interesting things (P8).

The fact that providers categorise anti-ageing medicine as a specialty that does not embody innovative high-tech developments is especially noteworthy, for anti-ageing providers do see themselves—and are promoted by the A4M—as being in the vanguard of medical knowledge and technology.

In an era in which high tech medical practices are touted as being synonymous with high-quality care, anti-ageing providers spend a great deal of time on decidedly less tech-heavy methods of treatment. They tend to rely on in-depth medical interviewing, repeated laboratory tests of hormone levels and other biochemical measurements, dietary and exercise regimens, supplements, and hormone replacement. And it is for this very counterintuitive reason that providers see themselves as ‘revolutionary’. Even providers who rally to the cry that anti-ageing medicine is on the cutting edge of technology suggest that their principles are rooted in solid, traditional medicine:

I think anti-ageing medicine is more on the edge. It’s at the leading edge of medicine, okay, and it’s like everything else in society. You have a subset of the population that’s at the edge. You know they define science. They come up with methods, you know, technology, and then you have everybody else in the back. All right, the medical world, I look at it the same way. You have a set of doctors that are willing to leap that edge, you know, where it comes to anti-ageing. All it is is endocrinology, okay, and there’s so much technology and new medications and things that you can do (P12).

Careful not to depict anti-ageing medicine as ‘just endocrinology’, this provider, unlike many of the providers we interviewed, does see anti-ageing as being ‘on the edge’, especially
because of advances in endocrinology and hormonal treatments. All the providers we interviewed report using some form of hormone level assessment in their daily practice, and those who provide hormone replacement therapy use only bioidentical hormones. Yet bioidentical hormone synthesis is, on the face of it, neither new nor flashy. What is noticeably absent from these practices are advances in genetic science, particularly epigenetics. Only a few providers report that they use genetic testing, even when they acknowledge the significance of genetic predispositions for age-related diseases.

That a new medical specialty could arise without strong ties to new technology is peculiar—and an important commentary on the present state of biomedicine. Many social theorists have linked the turn in biomedicine to technologies of enhancement (e.g. Elliott 2003, Parens 1998) and optimisation (e.g. Rose 2006, Franklin 2003), but the emphasis there is primarily on biotechnologies that are part of the ‘hybrid assemblages’ of a regime of living (Rose 2006). Anti-ageing medicine embodies a regime that features an ever improvable and modifiable self, yet it does not carry with it the concomitant new technological developments that are present in other emergent fields of biomedicine. The representation of anti-ageing medicine by the A4M, the major professional organisation, however, capitalises on images of ‘high tech’ interventions: a DNA double helix; scientists in lab coats; magnified images of blood cells and neurons that are belied by what providers are actually telling us about daily clinical practice.

Anti-ageing practices are not only surprisingly low-tech. Providers are also reluctant to prescribe traditional pharmaceuticals, which they see as a key problem of mainstream medicine:

I feel that there is a bias among conventional doctors to do a very sloppy job of prevention and instead just wait for disease to occur and then write a prescription. So rather than, you know, when someone comes in and their blood pressure is high or high normal, rather than reaching for the prescription pad right away, I will instead try to implement, you know, the lifestyle strategies that would bring that person’s blood pressure down, like weight loss, exercise, stress management, diet, etc., rather than just giving them a prescription right off the bat (P8).

The use of pharmaceuticals in their own practices poses a dilemma: they are reluctant to use the same pharmaceutical drugs as conventional providers because those doctors and treatments represent the homogenised and routinised care that anti-ageing providers denounce. Given their mission of delivering individualised and personalised treatment, anti-ageing providers do not want to resemble ‘ready made’, factory-line medicine. They do use other synthetic pharmaceuticals in the form of bioidentical hormones, but these need to be compounded especially for the patient, which is consistent with their emphasis on customisation:

Well, everybody has different hormonal differences. Everybody is absolutely different. Everybody is unique. So everybody is going to need a different level to get them where they need to be. So it’s not a ready-made, it’s not a pre-made dosage from a pharmaceutical company. It’s going to be an individualised dose. The dose has to be compounded for that particular patient. So the usual idea is to start low and go slow. You start on the lower end of the dosage and slowly give it to them and recheck it, see it slowly kind of creeping up until their symptoms and, you know, their blood tests and saliva tests are over their optimal range (P10).
The above quote illustrates not only the resistance to ‘ready-made’ medicine driven by the pharmaceutical industry, but it again points to the goal of pursuing the ‘optimal’ over ‘normal’.

Ironically, some of the largest technological advances in anti-ageing treatment are designed for cosmetic and aesthetic medicine, often in the form of pharmaceuticals. Several of the providers in our sample reported that they offer a variety of cosmetic procedures in their practice, ranging from hair and skin care (e.g. chemical peels, laser treatments) to wrinkle removal/filling (using injections of Botox or hyaluronic acid) to cosmetic surgery. For one provider, the aesthetic component of his practice is in addition to the ‘anti-ageing’ aspect of the practice:

Again, my practice again does do, like I said earlier on, it’s not just anti-ageing medicine. I also have an extent which is not particularly anti-ageing in the respect of a physiological level, but we’re talking care of the outside, for instance. So we do laser treatments for skin care, also for skin conditions: Rosacea, sun damage, *et cetera, et cetera* (P1).

For others, aesthetic treatments are merely one option that anti-ageing providers can decide they want to provide:

Anti-ageing is pretty broad-based. There’s a lot of, in today’s world, there’s a lot of cosmetics, aesthetics in anti-ageing. I don’t do those. I used to do facial cosmetic surgery for 15 years. I enjoy that. I like to do it. We used Botox for 30 years, but I’m not doing any aesthetics. I’m focusing primarily on comprehensive medicine. I don’t do any mesotherapy. I don’t do any acupuncture, don’t do any massage. There’s a lot of different… You know, anti-ageing is so multifaceted that you sort of have to pick out what you want to do, and so I’m primarily in the regenerative area (P5).

Clearly, cosmetic and aesthetic treatments are highly profitable. But they can also cast a long shadow on the professional legitimacy of providers. As a result, it is common for most anti-ageing physicians to distance themselves from dermatologists and plastic surgeons, whose work is restricted to improving ‘the outside’ of the human body without attention to ‘the inside’:

There is this aesthetic component, aesthetic medicine component. Now aesthetic medicine in itself is not anti-ageing medicine, and any primary care doctor or dermatologist or plastic surgeon can throw up a sign on their door, say ‘We practice anti-ageing medicine’, because they do Botox and facial fillers and laser therapies. That’s *not* anti-ageing medicine. That’s skin care. Anti-ageing medicine, you know this concept, is all about balancing of the physiology. Now you have the skin changes based on this, or it’s based on the physiologic changes of the body, and most of that is endocrine, the loss of the hormones as we age. The hormones generally decline whether there’s a medical issue or, you know, a non-medical issue. They’re going to decline as we age, and along with decline of our supportive hormones, that’s where we have enzyme failure, tissue failure and disease development (P6).

Here again, we see the provider alluding to the idea that anti-ageing medicine is about uncovering underlying etiologies rather than merely treating symptoms of ageing.

The lengths to which some anti-ageing physicians go to exempt themselves from, or at the very least de-emphasise, these more superficial modes of treatment only serve to elevate their
personal sense of legitimacy as professionals. These dynamics are similar to what we have elsewhere identified as ‘boundary work’ in anti-ageing science and medicine, where in an emergent field of questionable credibility those within it feel the need to clearly demarcate themselves from those seen as less reputable (Fishman et al. 2008).

The collaborative management of ageing bodies

The emphasis on prevention, in particular, means that the prime targets for anti-ageing therapies are not individuals who are already old. Anti-ageing medicine is, ironically, mostly for middle-aged people—as one provider explains, ‘generally speaking’, anti-ageing medicine is for ‘men and women ages 45 and older’ (P5). Why this threshold? Because as individuals cross this threshold, they begin to experience significant bodily changes and become worried about growing older. Midlife patients come to anti-ageing practices because they have a growing awareness of not being ‘up to speed’, as one provider (P5) puts it, or of ‘losing one’s edge’ and ‘needing a hand up, not a push off a cliff’, in the words of another (P3). Repeatedly, providers say that the most common reasons that patients seek their services are a ‘pervasive sense of fatigue’ and an associated desire to increase ‘libido’, ‘energy’, and ‘cognition’ (P10).

In identifying these ‘symptoms’ as part of ageing, providers and patients jointly engage in another aspect of surveillance medicine. Yet, they are neither interested in linking symptoms to illness categories nor trying to biomedicalise ageing. Rather, they use the language of maintenance, restoration, and optimisation to think broadly about the functioning of the whole body and the interconnectedness of systems, and to identify targets and treatments, which typically involve major changes in lifestyle. This is consistent with the growing legitimacy of improving lifestyle as an explicit goal of biomedicine (see e.g. Mamo and Fishman 2001, Marshall and Katz 2002).

The joint collaboration of providers and patients is based on the premise that ageing bodies can be effectively managed if a few conditions are met. One necessary ingredient for success is that individuals must have the right attitude and be truly desirous of change. One provider even opens his consultation by presenting a 10-point rating scale in which the patient must evaluate ‘How ready are you to make changes in your life?’ Effective treatments rest on the serious commitments of patients and of the people around them who must provide support. Lifestyle changes, in particular, do not occur in a vacuum, but involve spouses and partners, households, and extended families.

By the time patients end up in the waiting rooms of anti-ageing practices, their levels of commitment are generally high, they are informed, and they have specific concerns in mind:

Well, I think one of the nice things about, you know, not being [in an] HMO [health maintenance organisation] and everything else, whenever you walk in a room, the patient already knows where they are. ….I mean they know sort of what to expect. They’ve heard about it. You know they’ve been on the website or they’ve talked to a friend or something. They kind of know what kind of office they’re walking into, and so right from the beginning they’ve got the idea (P13).

The magnificent thing about ‘age management medicine’ is that it’s patient-driven. The patients want it. I do workshops and seminars throughout the year, and people who are interested in finding out about anti-ageing practices in medicine will come to those and they basically refer themselves …So it tends to be driven by the patients (P20).
These patients have often reached the point where they realise it is their responsibility, even duty, to take personal control over their health, echoing the neo-liberal framework that has enveloped contemporary biomedicine. But they need help. Enter the provider, who becomes a guide or coach to facilitate it and has the knowledge and skill to do so. ‘After all,’ as one provider says, ‘I’m a physician first, and an anti-ageing physician second’ (P2). The first part (the physician) is the core part of the provider’s knowledge and skill base:

My approach is integrative, you know, ‘Let’s bring everything in that I can possibly bring in to help the patient,’ and so all [of the] traditional medicine that I’ve learned is fair game. … [B]asically it’s like going to war, okay? It’s like as being a doctor you’re in a strange war because you’re going to lose. Everybody is going to die, so your job I think is to win as many battles as you can, and so the idea is use every weapon that’s at your disposal. Now since I was able to actually go to medical school I’ve been given the legal right to use every weapon in the world, and that’s what I’m going to do, you know (P13).

The second part (the anti-ageing specialist) is surprisingly much less about additional knowledge and skill and much more about the return to older ideals of medicine. The neo-liberal approach to health, in which one’s health is a project to be constantly tended, is juxtaposed to older traditions that emphasise the doctor-patient dyad. Now the language has shifted, however, to reflect an emergent construct of doctor-patient collaboration. Altering the traditional medical paternalism, the anti-ageing provider takes on a new role as guide and mentor—just as the patient, too, must take on a new role as active participant and their own caretaker.

Founded on Foucault’s analysis of the medical project, Armstrong (1995) described the ‘new’ regime of biomedicine as ‘surveillance medicine’. Prescient of the hallmarks of anti-ageing medicine, Armstrong argued that preoccupations with diet, exercise, stress, sex, and the like, become ‘vehicles for encouraging the community to survey itself,’ and that the ‘ultimate triumph of Surveillance Medicine would be its internalization by all the population’ (1995: 399).

This sentiment is echoed in our interviews with providers, who say they do not simply ‘tell’ a patient what to do, but instead actively ‘help’ the patient do it and keep them on course. To be effective in this role, the provider must have intense personal knowledge about a patient and both provider and patient must spend significant time together—conducting full physical examinations, running many lab tests to create baseline data and monitor changes thereafter, and having follow-up meetings to discuss results and devise and revise treatment plans. This is, above all, a ‘joint process between the physician and the patient’ (P20). This process rests not only on the patient’s willingness to submit themselves to the battery of tests, but to take responsibility for making significant lifestyle changes. The surveillance happens not only in the presence of the clinician’s office, but thereafter in all aspects of the patient’s life.

There is one other requirement that is not expressed explicitly (or at least voluntarily) in our interviews: most of the time, patients must be able and willing to pay on a cash-only basis—and given the intensity of these services, the price tag is high. Financial resources, therefore, become a significant barrier and only those who have resources can seek these services. When patients take control of their health, and are successful in their efforts, both patients and doctors are left with the sense that they are doing something of great import. Their joint work becomes what Williams (1998) calls a ‘moral performance’.
Conclusion

Optimising health through individualised attention and manipulation is a hallmark of 21st century biomedicine, where the focus is less on norms and more on the customisation of care (Clarke et al. 2003). With its emphasis on small-scale practices and intimate knowledge of the patient, anti-ageing medicine embodies many of these ideals. In fact, much of anti-ageing medicine is an example of ‘boutique medicine’ and an instantiation of a backlash to corporatised, insurance-run American biomedicine.

These providers are, however, not necessarily setting the medical world on fire with the latest genomic or other cutting-edge technologies. In our study of anti-ageing medicine, practitioners use primarily ‘low-tech’ versions of technologies of the self. In contrast to popular images of anti-ageing medicine utilising the latest available technological advances, anti-ageing medicine, as described by our practising clinicians, relies on strategies that are surprisingly simple yet still reflective of the contemporary era of biomedicine through heightened surveillance, vigilance, and health management. This includes the emphasis on collaboration and co-operation between physicians and patients.

Anti-ageing providers consider their approaches cutting edge because they strive for personal and individualised treatment, with one eye on prevention and the other on optimisation. The rhetoric of customisation and optimisation are indeed part of the ideal practice of conventional medicine, and therefore considered an important part of healthcare in the 21st century. Its importance, however, stems in part from the idea that this is what patients want, and fulfilling consumer demand has become an integral part of healthcare delivery in the United States—at least for those who can afford it. The turn towards thinking of healthcare as a commodity and of patients as consumers is the crucial backdrop for thinking about the emergence of anti-ageing medicine.

In describing their practice as ‘conventional’ and their philosophy as ‘medicine as an art’, it is clear that practitioners are also trying to legitimise their work in the face of criticism. Anti-ageing medicine, with its dependence on hormonal supplementation, and the move away from the established insurance-based healthcare payment arrangements, is at great risk of condemnation and question. By positioning their work as a return to the ‘golden age’ of medicine based on intimate relationships between physicians and patients, anti-ageing practitioners effectively depoliticise their work through an appeal to medical professionalism.

The assembly-line approach to medicine that conventional providers describe is also what patients dislike. Anti-ageing providers attempt to meet consumer demand by returning to a practice of treating the patient as an individual. This is predicated on the need for an intimate provider-patient relationship that rests on collaboration and trust. The only way they see to ensure this is to take the time to ‘get to know’ patients, understand their particular circumstances, and develop an elaborate treatment program tailored to them.

In the end, responsibility for managing the ageing body is put in the hands of patients and providers themselves, particularly those of the patients who do all the work of adhering to the regimen. But anti-ageing medicine serves a set of larger social goods: As patients change their lives in these ways, and as providers deliver medicine in these ways, patients enact practices that serve medical institutions (in reinforcing norms of personal responsibility), society (in improving the health of the population), and individuals and families (in increasing lifespan and ensuring that those years are healthier).

The neo-liberal emphasis on individual responsibility for one’s own health takes on a particular tone when it comes to preventing the diseases and disabilities of old age.
Historically, the ideology for a civil society was that the welfare of older people was a state responsibility. Whether or not this was ever actualised is debatable, but the idea that the elderly should be cared for through state support has long been part of public discourse. Now, however, even the notion of public welfare for older people cannot be taken for granted, especially in the United States. With questions about the long-term viability of Social Security and Medicare, devolution of responsibility for care falls to older people themselves. And with sky-rocketing healthcare costs and the recent economic downturn that has drained stock market-based retirement accounts, individuals have good reason to worry about their ability to provide for themselves in old age, especially in the face of serious or chronic illnesses. Anti-ageing medicine patients are responding to this call and worrying early and often, with many patients seeking anti-ageing treatments while in their forties and fifties. The American backdrop for this analysis is clearly important. The practitioners we interviewed raised the issue of healthcare organisation in the US as an important consideration for their move to anti-ageing medicine. We would encourage other empirical studies of anti-ageing medicine in other national and cultural settings.

The impetus to stay healthy in middle and later life may indeed reflect new discourses about the presence and role of biomedicine in all aspects and periods of life. But we should also consider the other pragmatic, structural, and material reasons why individuals might seek out a medical specialty which, on the surface, seeks to control human ageing and stave off the challenges of old age. In societies that place a premium on staying as healthy as possible for as long as possible, the desire and demand for anti-ageing medicine is clearly rational, even if it comes with an equally premium price tag.

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