Emotional ties may mean that that is the case, *but the crucial test would be to find out the view of the grandmother if she did not know the young woman or girl*. Professor Evans gives evidence of research that shows that elderly people value their lives more highly than both their doctors, and the young, think they do (2).

There are flaws in some of Dr Shaw's other arguments. On page 188 he writes: 'Health care must be distributed in a way that achieves maximum benefit'. This is a surprising statement for a practising physician to make. If doctors decided treatment only on the basis of maximum benefit there would be some very strange decisions made. Those with a poor prognosis, or with an illness that may be expensive to treat would not be treated (as opposed to cared for).

On page 189 Dr Shaw writes: 'Health care is a precious commodity in short supply. It must be used efficiently'. Here he is implying that to treat the elderly would be to use scarce funds inefficiently. However, in 'Age as a criterion for rationing' (3), an article that Dr Shaw quotes from, the author writes: 'Contrary to conventional wisdom, the savings will be small if we eliminate intensive, high-technology care for the aged. ... For substantial savings we must withhold routine medical care from the elderly'. But as we have seen, Dr Shaw is not suggesting that the elderly should be denied routine treatment, or even more expensive treatment such as aortic valve operations if the benefits to the patient would be 'substantial'. If, as it seems, Dr Shaw is only advocating that the elderly should not be given *very expensive high-tech treatment*, then it is not a policy of ageism that Dr Shaw is recommending, it is something very different. Whether anyone, young or old, should be given treatment that uses up large amounts

of finite resources is a different debate and not the point at issue.

We are living in a society with an increasing elderly population. There will undoubtedly be pressures to discriminate against the old in terms of the use of scarce resources. Dr Shaw does not satisfactorily explain why we should discriminate in this way. An ageist policy, far from being fair, would be both very unfair and discriminatory.

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Lifestyles and allocation of health care resources

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Calman's overview of the ethics of allocating resources for health care (1) illustrates well the difficulty of overview. One of his central issues is 'the basing of decisions on the outcomes of health care and on their subsequent economic evaluation' but this is incompatible with his description of the General Medical Council's ruling that 'all patients should be treated

equally, regardless of lifestyle'. The second statement muddies the first: is the cost-benefit of liver transplantation to include the transplanting of scarce donor livers into alcoholics who will not give up alcohol?

Most people's sense of justice would argue that unreformed alcoholics should not be given liver transplants, whatever the ethical inequity. Calman rightly stated that those who supported the physicians in the debate about smoking and heart surgery, which includes myself (2), did so because of considerations of outcome. If outcome is measured with no consideration of pre-existing factors, this might be more fair to the smokers, but is less fair to non-smokers because it increases the overall cost and decreases the overall benefit of the procedure.

Lifestyles must be important in the allocation of health care resources whatever consensus bodies - who are more ruled by political expediency than logic - might say. The only question is which lifestyles: 'If we want the right to society's resources we have a duty to respect them and must be prepared sometimes to have resources refused if we ignore those duties' (2).

References

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