Journal of medical ethics 1994; **20: 188–191, 194**

In defence of ageism

A B Shaw *Bradford Royal Infirmary, West Yorkshire*

Author's abstract

Health care should be preferentially allocated to younger patients. This is just and is seen as just. Age is an objective factor in rationing decisions. The arguments against 'ageism' are answered. The effects of age on current methods of rationing are illustrated, and the practical applications of an age-related criterion are discussed. Ageist policies are in current use and open discussion of them is advocated.

If a twenty-year-old girl and her grandmother were both drowning most of us would throw a single lifebelt to the girl and most of the grandmothers would want us to do just that. The citizen would do it because the girl had a right to live the life which the older person had already enjoyed and the doctor to save more life. The health economist would do it to save more life-years for each unit-lifebelt cost. Justice is important to the public, maximum benefit to the doctor and cost-effectiveness to the economist. Health care must be distributed in a way that achieves maximum benefit and is seen to be just. Both considerations give the young priority.

Arguments for ageism

The British Medical Association (BMA) holds 'that no patient should be denied medical diagnosis and treatment just because of advanced age' (1). Others disagree. Callahan has long maintained that those near the natural term of life have a duty to forego expensive technological treatment in the interest of younger people (2). Veatch points out that the old have already enjoyed more community support than the young (3). Daniels believes the individual with a fixed-allocation of lifetime health care would use it all in earlier years to achieve old age (4). He would not risk premature death by refraining from using it until old age. Society is entitled to adopt the same approach.

The case for ageism is moral. Health care is a limited resource. It must be allocated in the way which achieves the greatest good for the greatest number. If all lives are of equal value more is effected by saving the one with more years left. Utilitarianism is necessary if not sufficient for ethical rationing decisions (5).

The right to treatment must be considered as well as the benefit gained. The moral quality of a society depends in part on the lowest standard of life it permits. There is a duty to afford all citizens lives of a minimum quality and duration but no duty to bestow extreme longevity on a few individuals. Bread for all before caviar for any. Ageism uses only the objective criteria of years lived and left to live to achieve this aim. Other assessments of right to treatment often involve subjective judgements of value we should not make, certainly not as individual clinicians (6).

The case for ageism is also economic. It would be foolish to let lifebelt-makers drown for who will make lifebelts for the next generation? Care costs money which can only be provided by a tax-paying working population. It is in the interest of the old people of the future to spend more keeping the young and the working healthy than the retired. The economic argument for ageism is not also an argument for 'middleageism' as this group has much to offer the economy (7).

Ageism is only one consideration in rationing. The girl can risk catching cold in the water while the older woman's life is saved. The cancer of the old man is more urgent than the hernia of the young man. Routine medical and nursing care is not in question. Inhumanity of any kind might temporarily benefit a majority but would change the nature of our society (5). It would also be wrong. We are considering the use of expensive technology as in dialysis and intensive care and the emphasis which government and health authorities should place on different types of health care. Ageism must also be enlightened. Aortic valve operations on the elderly are very cost-effective if the result is death or cure instead of prolonged illness (7).

Ageism already flourishes in British hospitals. It has long been operated openly and secretly by doctors (8) and administrators (9). At the time of writing my cousin tells me that a surgeon would not

Key words

Ageism; ageing; resource allocation; rationing.

repair the nerve to his finger because it was not worth it at 70. In Bradford there is a useful limited coronary care facility. Patients under the age of 65 with suspected myocardial infarction are routinely admitted there. Those over this age go to other wards and are transferred only if a clinical indication arises. Doctors have accepted this for many years as a just and effective method of using a limited resource. The public have never been consulted.

Objections and answers

NEED FOR RATIONING

Efficiency can abolish the need for rationing (10). However, no country can now give state of the art medical care to all its citizens (11). There will always be two drowning and one lifebelt, however well we target and however efficiently we deliver medical care. Technical innovation yearly widens the gap between the possible and the affordable. The public always wants to pay less tax and receive more medical care. Politicians rarely want to make clear that this is impossible. Clinicians are increasingly obliged to be the rationing agents.

ECONOMIC UNIMPORTANCE

The elderly are relatively few and little is saved by denying them high technology medicine (12). Health care is a precious commodity in short supply. It must all be used efficiently. In ten years from 1980 to 1990 the number of people over the age of 75 in England increased by 25 per cent from 2·7 to 3·4 million (13). The mean length of a stay in hospital is ten days for those aged 60 to 65 years and 25 days between the ages of 80 to 85 (14). It is not a small problem. In the US half the Medicare budget is spent on the last few months of life (15).

BIOLOGICAL AGE

The correlation between biological and chronological age is imperfect. The fit older person might derive more benefit from treatment than the unfit younger one. This is true but we see more often in hospital the fifty-year-old with a seventy-year-old body due to major chronic organ disease. The eighty-year-old in abnormally good condition is more rare. Fewer people reach advanced age and perhaps some die without medical help.

Age in years is a factor in treatment response. Asystolic cardiac arrest over the age of 70 is death, not an occasion for resuscitation (16). Age affects prognosis in the intensive care patient. It is true that young people are given expensive treatment which prolongs life for a very short time. This is more an argument for withholding such treatment from the young than for inflicting it on the old. If a treatment causes temporary incapacity or distress this results in damage to a greater proportion of the remaining life of an old person.

DISCRIMINATION

Why should the elderly suffer discrimination as a group? If the elderly are a group they are one which has enjoyed longer life than the rest as all men and women grow old or fail to do so. Diversion of care from the old would release resources to treat truly disadvantaged groups such as the handicapped. The old are indeed weak and need special protection. So are children, and both must have what is right, not more than is right. The dishonest and the powerful will certainly manipulate a rationing system. Food rationing in the last war was no less just and only slightly less successful because of the black market.

INJUSTICE

It is more just to give a little care to many old people who will die soon rather than a lot of care to a few young persons. This is relevant only to an expensive resource in constant use such as dialysis. Young people are transplanted and older patients spend more time in hospital so the argument is only partly correct. Also society owes bread to all but caviar to none.

A young person may have benefited from much medical care and an old one may never have seen a doctor before. Medicine is there for the present need of each person and the maximum future benefit of the people. Denial of treatment to those who have used up a fixed allocation would conflict with these principles.

One can turn the argument of fairness on its head and claim that the old deserve extra consideration because of the service they have given. They surely are owed love, gratitude and respect but in times of shortage most societies give the food to the babies. Drinkers and smokers pay high taxes but they have no greater right to care than abstainers. Need and benefit should determine the allocation of care not the economic contribution made so far.

It would be unfair to the first generation of elderly who have paid for treatment were they not to get it. Ageism is already widespread but erratic and often covert. It should be open and agreed.

VALUE OF THE OLD

All lives are of equal value. So claims a legitimate alliance of the old and their doctors (17). Society accepts this by awarding the same sentence for killing a young man and an old man (18). It also awards the same medal for saving the old lady or the young one. We are not assessing the moral value of acts. We are trying to distribute limited benefit fairly. When forced to choose we give the lifebelt to the young person who will live more years and has enjoyed less life.

The value of the old lies in their wisdom and their capacity for love which is as important as the economic value of the young. Ageism makes no assumption concerning the value of anyone. It measures years lived and left to live.

INDIVIDUAL RIGHT

Only the patient can decide if treatment is futile for him or her (19). Certainly patients have a right to request treatment with one chance in a million of success or which will prolong life by an hour. Society has a duty to refuse the request in favour of more reasonable claims.

The old are ends in themselves not the means of making a just society. Choice between these ends is imposed and it must be made in the way which creates the least injustice. It is dishonest to ask why when we need to say who. Hippocrates recognized the duty of the doctor to his patient alone but his oath would have been different if he had faced eight patients needing his four-bedded intensive care unit. The BMA recognizes a duty to the patient in the waiting room as well as the one in the consulting room (1).

INACCURACY OF AGEISM

Some refine the measurement of years by using 'QALYs'. The years of life left or saved are multiplied by a quality score derived from a value given to different disabilities (20). There are objections to basing medical decisions on unavoidably subjective valuations of human life (21). If it is arrogant for doctors to do this why should it be permissible for anyone else? Only the individual can decide what the value to him is of a life with various problems (22). For some a life of disability and pain might be filled with spiritual joy. We must avoid confusing decisions based on medical fact with those based on personal values (6).

It can be argued that someone who has had a long and miserable life has had less of a fair innings than one who has had a short and happy life. Yet it is just as arrogant to judge the value of the life someone has had as to judge the value of that which they will have. The healthy and wealthy may live in misery due to phobias and family traumas and the poor and disabled may be contented.

Dworkin points out that our grief at premature death is not greater for an infant than for a young adult (23). The investment made by each person in life is important as well as the years left. He agrees that grief is less for an old person whose life work is largely accomplished. This is an ageist view. I would also maintain that it is more important to improve the quality of the whole future life of a child than to achieve minor gains at the end of natural life. Temporary prolongation of the life of an infant at great expense is more questionable.

CRUELTY

Elderly patients admitted to hospital will fear neglect because their eightieth birthday fell the previous day. The Bradford coronary care model mentioned above should be copied. The care is targeted on the younger patients but none are denied treatment when need arises and benefit is substantial. All patients continue to be treated as individuals.

Methods of rationing

Health care distribution is affected by factors other than need and benefit and these factors are affected by age.

CHANCE

It would be acceptable to spin a coin for the lifebelt only when there was no other way of deciding priority. Few would accept that medical care should be awarded by lottery. However, chance takes a hand in most human transactions. The need for fertility treatment is similar everywhere. Its availability depends on the presence of an able local specialist or the views of local general practitioners (24). It is unfortunate but unavoidable that care should depend on proximity to specialised units. Uniform availability could be achieved only by suppressing innovation and centres of excellence. The old may suffer because travel is more exacting for them.

QUEUING

The lifebelt should go to the first person seen, if other things are equal. Queuing is more acceptable in the United Kingdom than elsewhere, as anyone who has boarded a bus in Europe will know. It is reasonable to repair hernias in the order in which the patients appear but not to let patients die in the queue for cardiac surgery. Need is more important than time of arrival. The older person is more likely to die in a queue. Unless death is due to the condition requiring treatment the delay will save him from pointless disturbance shortly before death.

MARKET FORCES

The lifebelt should not go to the highest bidder but people are entitled to pay for a personal lifeguard. Why should the individual not be free to choose between tobacco and private health care? Private care is an acceptable addition to an ethically based health service. Older people can often buy private care more easily than young parents. In Britain where most care is free at the point of delivery 20 per cent more is spent on children than on adults but in the United States only a third as much (8).

COST EFFECTIVENESS

Lifebelts must be placed where they will save most lives. Maximum benefit must be obtained from limited resources. More attention has been given to the economic appraisal of treatments than to the study of the benefits to the patients who receive those treatments (11).

PUBLIC OPINION

The public acts through its elected legislature and also by creating the atmosphere in which we all work.

The public gives priority to dread disease, visible disease such as haemophilia and emergency treatment (8). Pressure groups also advance the claims of specific diseases.

Who should take which decisions? In Oregon the public indicated the type of health care which should have priority (15). A professional committee decided which specific interventions should be funded, influenced by the public philosophy. The public did not exclude the elderly specifically from care but it gave priority to maternity care and to preventive care for children. It also gave priority to acute fatal conditions where treatment prevented death and led to full recovery. Need, benefit and cost were therefore emphasized. Care followed by full recovery is cheap because its duration is short. In Hackney the public gave preference to dread disease and high technology (25). Interestingly, the doctors voted according to their special interests.

In such surveys, well designed questions must be put to a representative sample of citizens who understand the consequences of their choices, a combination difficult to achieve. It is as useful to ask an uniformed public to assess the value of medical interventions as to ask the man in the street which is the best antibiotic for his mother's pneumonia.

Ageism in practice

I base my approach on the attitude of the Oregon public and the practice of the Bradford coronary care unit. The government and the health authorities should have some ageist emphasis when resources are allocated to doctors. Efforts are concentrated on younger people but the needs of the old are not neglected. Research into the prolongation of life should not be funded (2). To improve life for the young elderly is laudable but to prolong life for the very old is antisocial. In this world of disease and deprivation we do not need more of us able to remember the last century but not yesterday. How useful is screening in the elderly? In those who are younger it often creates anxiety, expense, inconvenience and even risk, with little compensatory benefit. Is there evidence that it is better for the old?

Why should clinicians discuss ageism if most practise it already? We must discuss it so that a philosophy can be agreed and perhaps a code developed. As rationing becomes stricter ageism may increase and doctors will need guidance. Doctors should have complete freedom to give each patient their best advice. They need help with their new freedom to select which patient should benefit from that advice.

Callahan believes that doctors need an imposed age limitation on different treatments (2). I oppose this on three grounds. Biological age is not the same as chronological age. Women live longer than men and different age limits might create problems. Fear might be generated by strict limits. Increasing age should be accepted as an increasingly important factor in some clinical decisions but actual age limits should be advisory. The application of any code depends on circumstances and judgement. There can be no absolutism at the bedside.

Dialysis units treat increasing numbers of patients by reducing dialysis hours or using peritoneal instead of haemodialysis. This reduces well-being and survival. Should fewer patients receive better treatment? Should older patients or those with non-renal life-shortening diseases be excluded? When patients are selected for high technology treatments doctors must consider not only how much prolongation and what kind of life are likely, but also at whose expense the prolongation and 'quality' of life are obtained.

Selection should be made on the basis of agreed guidelines rather than subjective views. Objective criteria such as age are useful. Where there is disagreement with patients the views of colleagues are helpful but a single unit may have a single approach. These painful decisions may be best arbitrated by small ethical committees derived from trained members of the research ethics committees already in being.

If the limited medical care available is to be used to best advantage age must be taken into account. Because ageism is officially condemned as unethical it flourishes unregulated in secret. Open discussion of its application would be better.

Summary

Older people have enjoyed more life and have less life left to enjoy. Age is an ethical, objective and cost-effective criterion for rationing health care. Ageism flourishes in secret. Open discussion would make its application more just.

Acknowledgements

I am grateful to S A Shaw, M Ward and R L Woodhead for helpful discussion.

A B Shaw, MD, FRCP, is Consultant Physician to Bradford Hospitals, West Yorkshire.

References

(1) BMA. *Medical ethics today.* London: BMJ Publishing Group, 1993.
(2) Callahan D. *Setting limits: medical goals in an aging society.* New York: Simon and Schuster, 1987.
(3) Veatch R M. *Justice and the economics of terminal illness.* Hastings Center report 1988; 18, 4: 34–40.

Please turn to page 194

great variation in the extent to which local medical institutions or national policy-makers have implemented prevention activities to reduce the sexual harassment of female medical students, residents and other health trainees. Medical and public health professionals have much expertise to offer to religious as well as secular organizations in the systematic surveillance, management and prevention of sexual assault. But before we can lead in this effort, surveillance and preventive education systems within our own profession need to be models in concept and practice.

The ethical contradiction of pointing out and documenting sexual assault in other professions and social sectors is not unique to medicine. But medical practitioners are hardly in a position to cast stones in this regard, as data increasingly indicate a serious problem in our own profession and the absence of a systematic effort to acknowledge the varied influences of sexuality on medical training and practice. While medicine and public health continue to promote consciousness and prevention of child sexual abuse external to the profession, a serious and consistent effort must be made to establish surveillance mechanisms and interventions on behalf of patients and female colleagues within medicine. Only then can the contribution and leadership of physicians to child abuse detection and prevention have credibility and integrity.

Reference

(1) Taylor E. The secrets of St. Lawrence: a Capuchin school provides Catholicism's latest sex abuse scandal. *Time* 1993 Jun 7: 44.

GEORGE A GELLERT, MD, MPH, MPA
Project HOPE Health Sciences Education Center, Millwood, VA 22646 USA
MICHAEL J DURFEE, MD
Child Abuse Prevention Program, Los Angeles County Department of Health Services, Los Angeles, CA 90012 USA

Continued from page 191

(4) Daniels N. *Am I my parents' keeper? An essay on justice between the young and the old.* New York: Oxford University Press, 1988.
(5) Campbell A V. *Moral dilemmas in medicine* [3rd ed]. Edinburgh: Churchill Livingstone, 1984.
(6) Kennedy I. *The unmasking of medicine.* London: George Allen and Unwin, 1981.
(7) Forster P. The fortysomething barrier: medicine and age discrimination. *British medical journal* 1993; 306: 637–639.
(8) Aaron H J, Schwartz W B. In: Aaron H J, Schwartz W B. *The painful prescription: rationing health care.* Washington DC: The Brookings Institute, 1984: 36–37.
(9) Sims J. *Rationing comes in by stealth.* Healthcare management. 1993; 1: 23–26.
(10) Relman A S. Is rationing inevitable? *New England journal of medicine* 1990; 332, 25: 1809–1810.
(11) Buxton M. Economic appraisal and prescribing choices. *Prescribers' journal* 1993; 33, 3: 133–138.
(12) Levinsky N G. Age as a criterion for rationing health care. *New England journal of medicine* 1990; 322, 25: 1813–1815.
(13) Department of Health. *Health and personal social services statistics for England, 1992.* London: HMSO.
(14) Department of Health and Social Security. Office of Population Censuses and Surveys. *Hospital in-patients enquiry, 1985.* London: HMSO.
(15) Kitzhaber J A. Prioritising health services in an era of limits: the Oregon experience. *British medical journal* 1993; 307: 373–377.
(16) O'Keeffe S, Redahan C, Keane P, Daly P. Age and other determinants of survival after in-hospital cardiopulmonary resuscitation. *Quarterly journal of medicine* 1991; 81: 1005–1010.
(17) Fletcher A. In: Hopkins A, ed. *Measures of the quality of life.* London: Royal college of physicians, 1992: 115.
(18) Kilner J F. *Who lives? who dies?* London: Yale University Press, 1990.
(19) Truog R D, Brett A S, Frader J. The problem with futility. *New England journal of medicine* 1992; 326: 1560–1564.
(20) See reference (13): 21–34: Williams A, Kind P. The present state of play about QALYs.
(21) Solomon M. 'Futility' as a criterion in limiting treatment. *New England journal of medicine* 1992; 327: 1239.
(22) See reference (17): 107–116: Evans J G. Quality of life assessments and elderly people.
(23) Dworkin R. *Life's dominion.* London: Harper Collins, 1993.
(24) Redmayne S, Klein R. Rationing in practice: the case of *in vitro* fertilisation. *British medical journal* 1993; 306: 1521–1524.
(25) Ham C. Priority setting in the NHS: reports from six districts. *British medical journal* 1993; 307: 435–438.