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Focus

Dealing with the brain-damaged old—dignity before sanctity

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Author's abstract

The present and future rapid increase in the hospital population of geriatric patients is discussed with particular reference to the problem of advanced brain degeneration. The consequences of various clinical management options are outlined and it is suggested that extreme attempts either to preserve or terminate life are medically, morally and socially unacceptable. The preservation of life in senile patients has important economic consequences. In achieving a decision on the medical management of patients with advanced brain decay it is suggested that substantial help would be derived from: knowledge of the previously declared wishes of individual patients; improvements in geriatric assessments; broader consultation with relatives, and greater use of inter-disciplinary discussion in the preparation of criteria for terminating medical efforts to maintain survival.

Matters of ethical concern to medical practice often affect more than one specialty. Decisions on when and when not to treat, when and when not to resuscitate, when and when not to encourage dying, and when and when not to continue medical efforts to maintain survival are taken with such frequency that many doctors are frankly perplexed by the amount of media interest shown in isolated cases. However, it is becoming clear, and possibly somewhat alarming to the profession that advances in medical skills are creating a quite sudden increase in the number and complexity of legal, moral and ethical dilemmas.

To a busy clinician, experiencing difficulty in coping with his own specialist reading, the additional burden of examining the minutiae of ethical and legal argument may encourage simply the maintenance of the personal status quo; alternatively the commotion associated with broader press interest may encourage an uncritical attitude of 'playing safe'. Yet another reaction by doctors may be one of disenchantment and frustration caused by the very real tendency for the extremes of opinion, often highly articulate and carefully reasoned, to be given disproportionately large coverage in the columns of the lay and specialist press and in the wider media.

Key words
Geriatrics; senile dementia; stroke; euthanasia; voluntary euthanasia; medical ethics.

Although there has been full discussion in the wake of Leonard Arthur's trial and acquittal it would be prudent and relevant to examine areas other than neonatology that are likely to present clinicians with difficult ethical decisions about life and death. One such area is geriatrics.

The geriatric problem

Between now and the year 2000, although the total number of people over the age of 65 will decline, it is predicted that there will be an increase of over 50 per cent in the number of people over the age of 85 and a substantial increase in those aged 75–84 (1).

It may well be that the most effective means of generating interest in the growing geriatric problem is to focus attention upon the plight of a few individuals, but headlines such as 'Growing Old Disgracefully' (2) 'Who Killed Daisy Hamilton?' and 'Who is to Blame?' (3) are destined to stir an emotional reaction which may frustrate objective and rational assessment of the geriatric problem and what to do about it. Without a sensible, sensitive and compassionate medical response extreme viewpoints may be allowed to assume control of the discussion. Thus there are relatively frequent references in the press to the need to maintain the sanctity of life or, at the opposite extreme, to encourage active and voluntary euthanasia. The case for moderation, for which there seems to be a substantial demand by patients, relatives and doctors, tends to go unheard – possibly because it does not make exciting copy and possibly because there is genuine difficulty in defining what is meant by moderation in this context.

The changing pattern

Advances in the management of medical and surgical conditions affecting the elderly together with improvements in preventive medicine and community care have created a substantial growth in the numbers of elderly citizens who would otherwise have died or required extended medical or surgical care. This creates a much larger population at risk of developing

those diseases which are specific to old age, notably those involving the central nervous system – stroke and senile dementia. The excessive demands on geriatric beds have created pressure on domestic and community services. Old people's homes, instead of providing an alternative to living alone or within a family, are becoming an alternative to geriatric or psychogeriatric hospitalisation. One recent study showed that in a group of six old people's homes 50 per cent of the residents were probably demented (4); the consequences of a growth in this pattern, particularly with a spill-over effect into households, are of immense importance.

Recent newspaper accounts of life in geriatric hospitals and old people's homes (2, 3) may be merely disturbing glimpses into the future for the young and middle-aged but they are likely to instil into the elderly an immediate and considerable degree of fear and foreboding. The oft-heard plea, 'I hope I don't end up like that!' may mean that the elderly wonder if the matter of their own ageing and dying should remain totally beyond their control.

The options in geriatrics

The most controversial ethical issues in geriatrics arise in relation to those patients with such advanced disability that hospitalisation has become the only immediate answer, or in relation to those patients who cannot be accommodated in hospital and who remain under the care of a general practitioner.

Within this specific context some of the options in management are:

1) CONVENTIONAL MEDICAL AND NURSING CARE

This would apply to patients admitted with an identifiable condition who could be expected to improve significantly physically and/or mentally as a result of treatment. It is probably true to say that in medical and nursing care as presently practised in this context the patient tends to receive the benefit of any doubt. Thus conventional treatment may represent over – rather than under – treatment.

2) CARE BASED UPON THE CONCEPT OF THE SANCTITY OF LIFE

At its most extreme this involves the continuation of virtually all medical efforts to sustain life even in the presence of advanced disease with a limited prognosis. Although the fundamentals of the concept are largely based upon religious belief, the concept of the sanctity of life and religion are not necessarily interdependent. This does not in any sense alter the validity of the concept, but it makes for considerable difficulty in understanding on the part of those who profess little or no religious conviction.

The concept of the sanctity of life has the corollary that many elderly patients and many relatives will be subjected to distress and indignity in circumstances where they might expect doctors to intervene on humanitarian grounds. This is not to suggest necessarily that the alternative to the sanctity of life approach is euthanasia. However, failure to suppress distressing symptoms in senile dementia for example, may be seen as a dereliction of medical duty.

Thus the main argument against the concept of the sanctity of life is that its logical and rigid application will be seen by many as an unseemly interference in the natural process of dying, with no quantifiable or meaningful objective. Helga Kuhse puts it thus: 'We must drop the traditional sanctity-of-life ethic and embrace a quality-of-life ethic instead.' (5).

3) EUTHANASIA

Although meaning literally 'a good death' euthanasia is widely interpreted as having an active component. The case for what might be termed 'acute active euthanasia' has been made in a closely-reasoned discussion by Harris (6) not so much on the grounds of its obvious efficacy but because euthanasia in any other form, for example selective non-treatment, is essentially a deception which prolongs the very event (dying) which is the cause of concern. Doctors feel an instinctive abhorrence of active euthanasia because it is such a clear reversal of their normal role; so basic is this feeling that it can seem quite proper and reasonable and not at all cynical to camouflage the act of euthanasia. It may be equally reasonable to argue that 'selective non-treatment' plus or minus suppression of unwanted symptoms more accurately mimics natural dying than the active administration of drugs in lethal dosage.

The finality of acute active euthanasia would risk provoking complex psychological reactions in doctors, nurses and relatives as the result of assuming the position of executioner or executioner's assistant. It is inherently harsh and dangerous.

Passive euthanasia, or selective non-treatment, or the use of potent drugs with a 'double effect' are variants of euthanasia which may be criticised as lacking moral courage and being self-deceptive. However, self-deception may be a necessary component in the 'structuring' of death by medical people whereby as many as possible of its harsh aspects are softened in order to make the process tolerable. A system based upon redressing the balance in favour of 'nature's way' but without the extremes of indignity would instinctively seem to be right.

4) VOLUNTARY EUTHANASIA

The broad aim of the Voluntary Euthanasia Society, EXIT, is to encourage the relief of suffering in terminal (usually malignant) disease or severe physical disability. EXIT has been active in promoting the concept that such patients should be encouraged to terminate their own lives if they think the need has arisen. It should be a matter of some concern to the profession that many patients with terminal malignant disease appear to receive inadequate treatment of pain and

distress. However, the dissemination of details of drugs and dosages which would be fatal appears to be open to serious exploitation either by patients who are misguided as to their physical state or who are clinically depressed, or by the relatives of such patients. Furthermore, it is difficult to imagine the application of what might be termed 'self-induced euthanasia' – which is in effect suicide – within the context of acute or chronic cerebral disease in the elderly.

5) 'DIGNITY NOT SENILITY FOR THE ELDERLY' (7)

Of the various options in geriatric care for patients with stroke or senile dementia, 'conventional medical and nursing care' is the most widely practised. It is also the line of management which is legally and morally least contestable. It may be seen as 'defensive' medicine, practised because of its legal and moral safety without thought for its possible consequences to patients, relatives or society. In a proportion of patients there is likely to be no reasonable alternative because no clinical event arises which threatens life. In others, an event may occur which, often with hindsight, is seen as an opportunity to allow a patient to die without intervention.

The decision on the immediate management of patients with severe stroke or senile dementia is critical in the sense that it indicates a particular level of commitment in the minds of medical and nursing staff. Possibly the greatest single cause of protracted and often inappropriate treatment of elderly patients with severe cerebral disease is inadequate initial assessment. In some cases, because of inadequate early assessment, the initiation of treatment may be seen with hindsight to be inappropriate and to represent a missed opportunity to allow natural dying to occur. The avoidance of inappropriate commitment to treat thus becomes a potentially important means of reducing the risks of indulging in long-term hospital care of those patients who are going to be most demanding in terms of medical and nursing care and ancillary services. Furthermore, the early rescue of patients from an illness from which there is no hope of meaningful recovery may well cause distress to relatives. As McCall Smith, writing about 'Dignity and medical procedures' (8), has said: 'prolongation of life can in itself be seen as an inherently undignified procedure where it involves the use of extreme measures which cannot possibly retrieve the patient from inevitable death'. And he adds that an important part of such an assessment is judgment of the pointlessness of the patient's suffering.

Patients who subject themselves to serious indignities such as persistent shouting or screaming represent a further group who merit more rational, and at the same time more compassionate, management, even if the necessary sedative treatment promotes the development of a life-threatening condition. The 'double effect' of sedative drugs may clearly create the opportunity to allow dying without indignity but the primary intention should be the control of symptoms, not the hastening of death, just as the primary intention in terminal cancer is the control of pain.

Thus, without invoking anything resembling active euthanasia it is possible to perceive in the process of senile brain decay a series of opportunities to allow natural or near-natural dying.

To reject such opportunities will certainly be costly in financial terms and in a health care system with finite resources it is neither harsh nor unethical to accept the consequences, within the component parts of the hospital service, of a financial limit. It means that some kind of value judgment may have to be made on one individual life compared with another. There are several areas of practice, such as renal transplantation, renal dialysis and certain types of cardiac surgery in which the selection process has been in operation for many years and it is accepted that a proportion of patients, physically and mentally otherwise perfectly sound, will die while on waiting lists for these facilities purely because of economic reasons. Similarly the economics of an expanding demand for geriatric care will dictate the need for a 'value-of-life' factor to be incorporated into an already complex equation. Mooney has presented the financial facts of life quite bluntly (9): 'Every decision on resource allocation in the health sector involves a judgment on whether it is worth paying X to achieve Y'.

The differential expenditure of greater sums of money on the elderly might not be supported by public opinion if it became known that younger lives were lost because of inadequate finance and that the misapplication of increased expenditure might increase the frequency and duration of undignified behaviour in old age.

There are aspects of acute surgical care which perhaps allow the problems of senile dementia and major stroke to be viewed from yet another standpoint. For example, those involved in the care of severe head injuries in children and young adults develop a pragmatism which does not pretend that some good can be done for all patients. A similar attitude can usually be discerned in those involved in managing the late stages of malignant disease.

In these examples the need for a humane approach exists not only for the sake of minimising the patient's suffering but also to minimise distress within a family. Viewed within this wider context, efforts at maintaining life in elderly patients with severe brain disease appear all the more misplaced, pointless and distressing.

The difficulties for the geriatrician are, nonetheless, augmented in certain respects – the time-scale of senile dementia is relatively long, evaluation of the likely outcome of a stroke is complex, the wishes of relatives may be conflicting or suspect, and finally the wishes of the patient are not known.

Making a decision

A decision on the extent to which the elderly with

severe acute or chronic cerebral disease should be treated is immensely difficult. However, the preceding discussion may permit speculation upon these factors which should introduce a greater degree of objectivity into the decision-making process.

1) PATIENT'S PREVIOUSLY EXPRESSED WISHES

People should be encouraged to declare their own wishes in writing before reaching senility (7). If they do so, individuals may be able to spare themselves and their families the extremes of indignity which the elderly can suffer and inflict as a result of senile brain disease. It is contended that a substantial proportion of those approaching old age – for example on retirement or on reaching pensionable age – would welcome the chance to influence events, if a ready opportunity could be provided. A signed statement would have legal standing in the sense that it would be drafted within a legal framework to exclude the influence of any person who might have an interest in the early demise of the patient. However, it would not be legally binding upon any future clinician – it would be a statement of wish which would not necessitate any reciprocal commitment. It could take the form of a declaration such as this:

'It is my express wish that if, beyond the age of (say) 65 years, I develop an acute or chronic cerebral illness which results in a substantial loss of dignity, and the opinions of two independent physicians indicate that my condition is unlikely to be reversible, any separate illness which may threaten my life should not be given active treatment. It is also my wish that if, during such cerebral illness, my condition deteriorates without reversible cause to the extent that my behaviour becomes violent, noisy or in other ways degrading these symptoms should be controlled immediately by appropriate drug treatment regardless of the consequence upon my physical health.'

Such a statement would be used only as an adjunct to decision-making and not necessarily as a major factor in its own right. It would certainly be no less valid than, say, the opinion of a parent in decisions concerning a child.

There is no question here of attempting to push geriatricians or general practitioners into legally dangerous positions, but the written wishes of a particular patient might discourage over – or under – treatment, as the case may be, in situations in which the most appropriate form of management is uncertain on evaluation by conventional means.

A *Lancet* editorial (10) referring to Kennedy's challenge of the right of doctors to determine their own code of conduct (11) states that many medical decisions are not technical or clinical but moral and ethical and that doctors may not be competent to decide upon such issues. Reference is made to the need for the profession to initiate a move to involve the public. In relation to the pressing problems of geriatrics a positive start could be made by assessing the acceptability of a signed declaration of future wishes. This might best be done through the offices of a body such as the British Medical Association.

2) IMPROVED GERIATRIC ASSESSMENT

Just as the management of late malignancy is determined by assessment of current status and likely prognosis in the individual patient, so the course of action in the geriatric patient will depend upon assessment of the likely course of a brain illness. Whilst clinical assessment may remain the foundation of predictive capacity in over 80 per cent of cases (12), there has been increasing evidence of the value of computerised tomography (ie a computerised scanning of successive sections of the brain, examined by x-rays) in the evaluation of acute and chronic brain failure in old age (13). The ability to achieve something approaching 90 per cent accuracy in predicting the outcome of senile illness should allow much greater rationalisation of management with morally and legally justifiable criteria for deciding on a particular course of action.

3) CONSULTATION WITH RELATIVES

Better assessment will make it simpler to explain to relatives the various options for the geriatric patient, and to explore their attitude to a line of management founded upon good basic nursing care but no attempt at prolongation of life. Alterations in public opinion towards the problems of senility may create an environment in which there is clear encouragement to geriatricians to pursue the aim of greater dignity and less distress in the ageing process. In the absence of relatives, or when they are unwilling to be involved, an early report from a social worker would provide information on the extent to which a given patient's immediate social circumstances might contribute to or detract from the chances of successful rehabilitation outwith a geriatric hospital.

4) INTER-DISCIPLINARY COMPARISONS

Reference has already been made to the possibility that judgments concerning quality of life and the economic value of life may be determined largely by the particular specialty within which these judgments are made. Resource allocation tends to favour younger patients with a relatively good prospect of re-integration into family and society.

Viewed in a comparative manner, in which factors such as staffing, finance, future prospects, family disturbance and social acceptability are taken into account, geriatric patients would not and should not expect priority over younger patients. Indeed it has already been argued that the pursuit of survival in older patients with the same vigour as in younger cases would act contrary to the best interests of patients, staff, relatives and society.

On a regional hospital basis there may be considerable merit in encouraging a regular exchange of views between representatives of neonatology, paediatrics, intensive care, nephrology, surgery, medicine, geriatrics and the social services with the objective of establishing criteria for discontinuing medical efforts at maintaining life. If such criteria could be rendered fairly uniform it might enable each specialty to see its ethical problems in better perspective. Discussion and recommendations concerning these criteria could come within the remit of existing ethical committees (currently dealing mainly with ethics in relation to research) or separate committees could be established solely to debate ethics in relation to severely retarded, brain-damaged and terminal patients.

Despite the apparent need to clarify the process of decision-making for reasons of dignity, morality, priority and finance, it is likely that the LIFE organisation would object to any policy which declared the need to choose between one life and another or between life and death. In addition to the several reasons given for rationalisation it must be accepted that such decisions are already being taken and the alternative of endless striving for survival in all patients would be contrary to the wishes of the vast majority of patients and doctors and is nonsensical on social and economic grounds.

5) MEDICAL EDUCATION

It has recently been reaffirmed that the desirability of teaching ethics to medical students increases in line with the complexities of medical care (10). The broad interdisciplinary over-view suggested under 4) above applies equally to undergraduates. In certain respects they are in an ideal position to see the advantages of uniformity of approach in dealing with very ill patients.

Conclusion

Recent debate on the ethical issues raised by severely retarded newborns, together with rapid expansion in the demand for geriatric services, make the present a particularly opportune time to evaluate those factors which should be considered in making decisions on management which may have moral, ethical, economic and social consequences. There would appear to be considerable merit in interdisciplinary discussions on policy, together with the promotion of legally-prepared declarations from future patients who may choose to assert their wish for greater emphasis on dignity in their care should they eventually develop irreversible brain damage.

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Commentary

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It is a source of wonder to one who qualified in 1938 how much the care of the elderly has improved during one's professional lifetime. Geriatric medicine is a part of the enormous advances in general medicine, and its provision of better investigation and management in the elderly and contributions to research is still underestimated. It has, of course, benefited from advances in surgery, especially in orthopaedics, and they, in their turn, from better anaesthesia. It is sad to have to admit that some of one's colleagues in the specialty of geriatric medicine still feel defensive and that one can still meet the occasional clinician who is prepared to refer to elderly patients in terms which are disparaging, if not actually contemptuous, and to the geriatric department as a superfluity that any decent hospital would be better without. However, there are undoubtedly problems of care which Dr Robertson does well to discuss in such moderate terms. Advances are still being made in the medicine of old age and well run departments are increasingly offering good prospects for the elderly when the problem is one of physical illness.

The question of where to stop is well put in this paper. I would like to look at the history of the National Health Service (NHS) first. I can just recall visiting local authority hospitals which were mainly

Key words
Geriatrics; senile dementia; stroke; terminal care; medical ethics.

repositories for the 'chronic sick'. As a matter of fact (and this was where pioneers of geriatric medicine like Marjory Warren began) many of these would not have been inmates had modern attitudes existed at that time. I can recall the chloral hydrate and bromide in Winchester bottles which as far as I remember were replenished automatically from the dispensary and dished out fairly haphazardly by the ward staff. It may not have been as bad as that; we have come a long way since then. What is astonishing now, and a point that is seldom discussed, is what the planners – medical, lay professional and political – were doing in the 1940s in, it seems, ignoring the statistics then available. It does not seem to have been considered that if the large population cohort in their forties lived to 65 and thereafter survived as they would have done in 1900, the NHS would have very considerable problems in due course. Bearing in mind the little that was then done for the elderly and disabled, and indeed for degenerative illness in general, it is surprising that the Beveridge Report envisaged a declining demand for health care in the long run because everyone would be so well, or words to that effect. This is now history, but the present problem was foreseeable and it exists at least in part because of inadequate provision of services. The Department of Health and Social Security (DHSS) norm for geriatric facilities is still not being met everywhere, either in active treatment and rehabilitation or continuing care, and Professor Arie has pointed out that there has even been a fall in provision of psychogeriatric care. Further, the norms should not be regarded as the Laws of the Medes and Persians, altering not, because of the rise in population of the very old which Dr Robertson points out. There is the additional complication that 90 per cent or more of the elderly in their own homes are cared for in part by the next generation who are growing old too. Indeed, when I was in practice I found, not very infrequently, the relatively hale nonagenarian unable to cope with an ill daughter in her seventies.

It is still necessary to mention how far decent and progressive geriatric care is removed from the 'dump' hospital of the 1940s, and a tragedy that well-meaning persons have so blackened the word 'geriatrics' that even today some patients will refuse admission to the geriatrics assessment unit because of the workhouse image that the subject acquired at the outset and which is still difficult to shed. Unhappily, the media have not been very helpful and the word has pejorative overtones. The matter is, of course, in part economic and it is reasonable to suggest that the NHS should at least provide the resources it has set itself to provide and not reduce its service or that provided by the local authorities. More research is needed in the medicine of old age and on preventive medicine, especially on vascular disease. The net result of stroke rehabilitation is nothing to be satisfied about so far, and surely more can be done to find out *why* strokes occur and thus reduce the incidence of this illness. I cannot accept that we need to regard cerebral vascular accidents as an insoluble and growing problem, and even senile dementia may not be quite as inevitable as it seems at present. It is commendable in Dr Robertson's comments on assessment that he accepts the value of full investigation, especially of computerised tomography. Even now, not all doctors are aware of the need for accurate diagnosis of dementia and the exclusion of treatable physical or mental illness which may mimic it.

I feel that it is necessary to go very carefully in proposing any measure that withdraws health care from the elderly, who, despite the development of geriatric care and other services, have not been exactly privileged to date and whose 'dignity' should not be founded on economic issues alone. It is arguable that conventional care may develop into over-treatment in certain cases, and it does not appear to me that there need be any debate on undue prolongation of life in the case of somebody with, say, a myocardial infarction, together with advanced carcinoma or severe dementia. Burdensome treatment need not be forced on a patient already seriously ill and with a limited life expectancy. There does seem to be a real difficulty about modifying any further the 'sanctity of life' concept. If it is conceded that this general principle be modified to a 'quality of life' ethic, it would seem to me that it is possible to develop a logical basis for not allowing quite a lot of people to live – not that this is in Dr Robertson's mind. One is grateful for his point about active euthanasia and the problem created by the ideas, not to mention activities of EXIT.

There is no need nowadays for terminal malignant disease to be inadequately treated, though there may still be some ignorance on this matter in our profession. Hospice care and its extension into home care of terminal cases is excellent today and we need more of it. Here at least there should be no argument about priorities and no hospital district should be unable to find some way of providing this level of attention.

It has in the past been argued by psychiatrists that there is a limited prognosis in established dementia: this is only partly true but there is no doubt that progressing dementia over a long period is a considerable problem though it can be contained more than is realised. There is no reason why a proportion of mild ambulant cases should not be manageable in local authority residential homes, though whether this should be done by segregating them into 'designated' homes or by providing special accommodation (in view of their wandering tendency) in ordinary homes, is debatable. But with sympathetic supervision and a co-operative psychiatric service which has access to a day hospital, the problems of a lot of these cases are not unsurmountable. Similarly, home care with day-hospital support *and* (this is absolutely essential) holiday relief, can be possible for long periods, but there will come a time when in-patient care may be the only solution, and there certainly may not be enough of that.

Dr Robertson's views on dignity and senility merit

some consideration. Initial assessment, of course, can work either way: it is as easy to write off a stroke case too soon as it is to decide on a course of protracted and ultimately inappropriate treatment. It is surprising how often it is possible to feel 'it was unfortunate we were not in at the onset of the illness', after having waited to do an assessment either until a colleague needed the use of the patient's bed or the family, having misguidedly 'rested' a CVA into unnecessary immobility, have had enough. The prospects of meaningful recovery are difficult to assess until one has tried. Having said this, I agree that there is a point at which to stop. It is reasonable to assume that opportunities to allow a natural or near-natural death will be accepted.

The economics of health care do impose value judgments. It would be unfortunate if it were true that young lives could be lost because of better care for their seniors. This is a difficult point, and it could be argued that the cost of intensive care in terms of nursing ratio and elaborate equipment may, in some cases, operate in the reverse direction to 'the greatest good of the greatest number'. This country does not spend enough of its Gross National Product (GNP) on health care and I would be reluctant to settle now for the assumption that the elderly have enough resources and that the next step is to divert any resources left elsewhere.

As regards 'making a decision': I am not entirely convinced by the well presented case for letting people who are alive and well take decisions that may be binding later on when they are unable to express themselves. There is an expression of intent, 'the Living Will', in the USA which is variously interpreted in different States, and EXIT have an 'Advance Declaration' to prevent unreasonable prolongation of life. This is a matter of great importance, and Dr Robertson is to be thanked for making it clear that he does not want to push colleagues into legally dangerous positions. I think more advice is needed on this and, as he says, the British Medical Association (BMA) might be a proper body to ascertain the status of such documents.

On the question of discussion on a regional hospital basis, there would indeed appear to be merit in encouraging the serious exchange of views on establishing criteria for discontinuing efforts at maintaining life. It is to be hoped, however, that these will be free from outright discrimination on the grounds of age alone.

Response

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There is no means of knowing if Dr Hebbert's thoughtful commentary is representative of the current views of most geriatricians. If it is, one is encouraged by the general support for moderation in the management of the brain-damaged elderly. One is discouraged by those details which appear to perpetuate the impression that geriatricians are eternal optimists: '. . . it is easy to write off a stroke case too soon', and, '. . . even senile dementia may not be as inevitable as it seems to be at present'. The latter may have some future in the field of preventive medicine, but it is an immediate problem which represents increasingly the way in which the health of old people will decline because diseases such as pneumonia, cancer and heart ailments are curable or containable.

Central to the argument concerning dignity in old age is the seeming inevitability that the brain is the ultimate 'target organ' if other organs can be cured of disease or replaced. Certainly, if brain degeneration can be held at bay, meaningful life will be prolonged, but in broad terms, reasonable cerebral function is the key to the quality of survival in the elderly.

Dr Hebbert, while acknowledging that a time may come to cease 'burdensome treatment', is unwilling to admit that modern diagnostic methods should now permit that degree of objectivity which would point to a quite hopeless outlook in a sizeable proportion of cases. This should not be seen as an admission of defeat, but should be an opportunity to stop medical efforts at obtaining survival, with the double pay-off of allowing the dignity of natural dying and the diversion of resources to those elderly patients in whom the prognostic indices are unequivocally favourable.

The principal differences between the views of Dr Hebbert and the author reflect emphasis rather than fundamentals, but the singular danger of a moderate consensus is that it may perpetuate the status quo. One is anxious to press the need for dignity in old age to the point of promoting 'moderation with teeth'. While we shun the extremes we must show that moderation needs to be defined and sharpened by interdisciplinary discussion. Although doctors may need to give an active lead in the concept of dignity in old age, it may well transpire that public opinion will dictate that moderation should not be a soft option.

Dr Hebbert rightly acknowledges the difficulty of apportioning relative value to the various forms of intensive care, but the emotive nature of senile dementia and its social consequences have possibly forced political decisions on resource allocation which do not reflect broad medical opinion.

Finally, one would wish to allay fears of 'outright discrimination on the grounds of age alone' in establishing criteria for discontinuing efforts at maintaining life. As an anaesthetist dealing frequently with elderly patients, one has learned to categorise patients by physiological age rather than chronological age. It is a pleasure to help a mentally alert 90-year-old through the resection of a bowel cancer; it is quite unrewarding to witness the often stormy post-operative course of a dementing 65-year-old. The over-zealous treatment of those with advanced brain degeneration will serve only to hasten the re-emergence of the 'dump' hospitals of the 1940s whose passing Dr Hebbert so rightly celebrates.