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

George S Robertson

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.