Honour your father and mother:
ageism in medicine

Ageism, a negative bias or prejudice based on age, has long been prevalent in Western societies where older people are commonly perceived as having low value, and placing a high economic burden on society. Age has been used as a criterion for rationing scarce healthcare resources (for example, kidney transplantation), and has been justified on the basis of the greater good versus the individual: that older people have a shorter duration of benefit from treatment and they have had a 'fair innings'.[1] If resources are scarce, it is assumed that they should be assigned to younger people.

Preferential treatment for younger people may have made sense in 1948, when 40% of people died before they reached 65 years of age, compared with the current 7%. It is less defensible now, given the improvement in longevity, the effectiveness of medical interventions for older people which is apparent in clinical practice, and the compression of morbidity into the last years, or even months, of long and active lives.[2] The National Service Framework for Older People[3] aimed to ensure that older people are not discriminated against because of their age when in need of health or social care. However, there is a consistent body of evidence in Europe and the US that older people are less likely than younger people to receive a range of indicated treatments. Heart disease provides some rich examples of how discrimination by age might operate, from prevention to investigation and intervention. Receipt of cardiac interventions has been reported to vary with patients' age, sex, ethnicity, and socioeconomic status.[4–8]

Arber *et al*[9] reported that GPs were more likely to ask about smoking and alcohol consumption habits, and more likely to give advice about smoking to 55 year olds than to otherwise identical 75 year olds presented to them on video clips. Similarly, Harries *et al*[10] presented 72 electronic, hypothetical patients with angina to 29 cardiologists, 28 care of the elderly physicians, and 28 GPs. Each doctor was asked to search for information about the patients on a computer and to make decisions on their treatment. Almost half the doctors in each speciality treated patients aged over 65 years differently from those aged younger than 65 years, independent of clinical indications, comorbidity, and sex. Overall, older patients were less likely to be given a cholesterol test, lipid-lowering drugs, exercise tolerance testing, angiography, revascularisation, or to be referred to a cardiologist. They were more likely to have their prescriptions changed and just given a follow-up appointment. In follow-on interviews, while doctors referred to old age being a risk factor for cardiovascular disease, it was also viewed as leading to greater risk of complications from treatment. NHS rationing was also cited as an excuse for under treatment of older patients. The interesting thing about ageist decisions in this study was that doctors were prepared to justify them explicitly.

The NICE guidelines on Social Value Judgements[11] supported decision making based on age: 'where age is an indicator of benefit or risk, age discrimination is appropriate'. The difficulty is that the evidence base about risk and benefit in the older population is still limited. Bartlett *et al*[12] argued that there has been over-generalisation of evidence from trials (particularly of angioplasty and stenting) to the older population at risk, who are largely excluded from such trials. This generalisation has sometimes led to caution in treating older people, despite the population at risk of most chronic disease being aged over 65 years.[13]

There is insufficient research into the full extent of age-related inequities in primary care. It remains to be seen whether the introduction of the new GP contract, including the Quality and Outcomes Framework (QOF), which sets standards of care for targeted conditions including cardiovascular disease, will offset the apparent trend towards excluding older people from some treatments. Exceptions to applying the QOF are permitted (for example, inappropriateness due to terminal illness, frailty, or supervening condition; patient intolerance of medication; and service unavailability). It is possible that these 'exceptions' may result in continuing inequalities in access to services. High exception rates have so far been documented for diabetes,[14] and recordings for stroke showed inequities by older age and female sex.[15]

More systematic knowledge of patients' perspectives on age discrimination are needed (Box 1).[16] The (admittedly limited) body of evidence in cardiology shows no evidence that older people prefer less invasive approaches than younger ones. Most patients apparently 'would choose treatment based on the extent of benefits', and 'would accept any treatment, no matter how extreme, to return to health'.[17]

Box 1. Comments on ageism by the general public in response to the question 'Are the elderly less deserving of medical care?'[16]

- *'"Honour your father and mother." That's one of the Ten Commandments. I take that to mean that the elderly are to be looked after. To discriminate against them is outrageous. Anyone who disagrees should bear in mind that they too are likely to be old one day.'* (posted by MP Telkman 14 February 2007)
- *'… as the NHS does not have available funds, then unfortunately you must prioritise. If you are 20 years old, then the medication or an operation is likely to allow you to live for another 60 years. If you are 60 years old then* [it] *will allow you to live for another 20 years. The majority of people will therefore say the operation should be given to the younger person. It may not be fair but unfortunately it is the best decision.'* (posted by Rachel Jones 15 February 2007)

Age discrimination is a political issue which has many sides. For example, eligibility for the NHS breast screening programme has an upper age limit, which is clearly 'ageist'. On the other hand, in this issue Evans *et al*[18] reported that some older people in good health regard the policy of offering people aged over 65 years the influenza vaccination as ageist. In some cases this may be because they feel healthy, and not 'at risk' or 'old', and do not wish to be perceived differently from people aged younger than 65 years; or it may be a reaction to the institutionalised ageism of health services, in which older people are cared for separately by geriatricians, and which is a specialty widely perceived to have more limited resources. In an era in which 'active ageing' and employment beyond existing retirement ages is being encouraged,[19] these different perspectives raise a separate question of how to target services to the groups most at risk without appearing 'ageist'. The challenge for health services is to develop a consistent approach, based on an understanding and communication of risk on a case-by-case basis. There is a need to explain why 'age 65 and over' is a risk factor for complications of influenza, and why vaccination is offered to this age group. There is a similar need to explain the rationale of offering screening programmes to different age groups (for example, the NHS breast screening programme age ceiling of 70 years). GPs and practice nurses are best placed to provide these explanations, but first must be sure that their own judgments are evidence based whenever possible, and that prioritisation decisions are transparent. The Harries study[10] suggests that there is some way still to go.

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We need a chronic disease management model for depression in primary care

The treatment of depression as described by steps 3 and 4 in the NICE guidelines for the management of depression are a particular challenge for primary care.[1] There is now an increasing body of evidence that suggests depression, for a lot of people, is a chronic illness that leads to ongoing suffering and disability. Between 50 and 70% of patients with depression treated in the primary care setting with antidepressant medication showed a response. In a recent review of treatment for depression, a meta-analysis comparing antidepressants with placebo showed a relative risk for improvement on