Ethical debate

Why are doctors ambivalent about patients who misuse alcohol?

It is not unusual for doctors to see patients who they strongly suspect are misusing alcohol. Should they ignore it or try to intervene? And what should they do if the patient's alcohol misuse puts other people at risk? In this ethical debate a lawyer, two psychiatrists, and an oral and maxillofacial surgeon give their views.

The case history and survey of doctors' attitudes

Ruth Dale, Roger Barton

Alcohol misuse is common, with 4% of adults being dependent.[1] Doctors have a duty not only to those patients but also to the wider community. Such patients may bring harm to others while driving a vehicle or while employed in a variety of occupations. There are clear guidelines on the actions medical practitioners should take with respect to such patients who drive motor vehicles,[1-3] but the advice with respect to patients in potentially dangerous occupations is less specific.[4]

Case report and survey

A 57 year old man with malaise was referred to the outpatient department. He was late for his appointment as he had crashed his car in the hospital car park. He had stigmata of chronic liver disease and was anaemic. He was admitted the following morning for transfusion, smelling heavily of alcohol but keen for early discharge as he wished to return to his post as captain of an oil tanker.

This patient and others prompted a heated debate on what action doctors should take when patients are obviously misusing alcohol and a survey of doctors' actions with respect to such patients. A questionnaire on the action a doctor would take was sent to 400 general practitioners and hospital physicians in the former Northern region. From 240 replies, 14% (32) of doctors said they would not ask their patients to inform the Driver and Vehicle Licensing Agency and 16% (33) would not ask them to inform the employer, and 31% (68) and 46% (95) would not check compliance. Therefore in up to 45% and 62% of cases the licensing agency and the employer might remain ignorant of the potential danger.

General practitioners were more likely than hospital doctors to ask the patient to inform the licensing agency and employer, to check compliance, to ask a defence society's advice, and to discuss the problem with a colleague.

Discussion

Despite clear guidelines from the Driver and Vehicle Licensing Agency, doctors' actions would vary considerably. Guidelines state that "Medical practitioners may be failing in their duty of care if they do not alert their patients to the need to notify the Licensing Centre .... Since many problem drinkers will not themselves notify the licensing agency, the doctor sometimes should do so if he feels the public are at risk."[2]

The General Medical Council's code states that doctors should "Explain to patients that they have a legal duty to inform the DVLA. If the patient refuses to accept the diagnosis or the effect of the condition you

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can suggest that the patients seek a second opinion You should advise patients not to drive until the second opinion has been obtained. If patients continue to drive … you should make every reasonable effort to persuade them to stop. This may involve telling their next of kin. If you do not manage to persuade patients to stop driving, or you are given or find evidence that a patient is continuing to drive contrary to advice, you should disclose relevant medical information immediately, in confidence, to the medical advisor at the DVLA. Before giving information to the DVLA you should inform the patient of your decision to do so. Once the DVLA has been informed, you should also write to the patient, to confirm that a disclosure has been made."[2]

In regard to patients who misuse alcohol undertaking hazardous occupations, the General Medical Council's guidelines state that "Disclosures [of information about patients] may be necessary in the public interest where failure to disclose information may expose the patient, or others, to risk of death or serious harm. In such circumstances you should disclose information promptly to an appropriate authority."[4]

Full details of the questionnaire, results, and statistics are available on request from Dr Barton. Grateful thanks to all colleagues who participated in yet another survey.

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Doctors have a community responsibility

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The implications of the General Medical Council's guidance may not yet have been understood fully by many doctors. It emphasises doctors' wider responsibilities and moves away from the assumption that community is just a voluntary association of individuals. A communitarian view holds that society is more than this, constituting a structured, enduring entity where people are bound together by shared needs, interests, and sensibilities.[1] Doctors' ambivalence may reflect beliefs that duties to individual patients and to the community usually conflict rather than, as is usually the case, complement each other.

This ambivalence may, however, reflect difficulties with recognising important community issues. Taking into account all the factors associated with alcohol abuse by a particular patient takes time, and some of the risks may never be clear. There is a similar problem in relation to treating victims of violence, where estimating risk of future physical and psychological injury and the dangerousness of assailants still at large can be difficult.[2]

There is evidence from trauma centres that drunk drivers are rarely reported by doctors and that treatment for injuries tends to protect them from police charges.[3] Furthermore, since alcohol related injury not sustained in road accidents predicts driving impaired by alcohol, early intervention is likely to prevent road accidents.[4]

The Driver and Vehicle Licensing Agency takes disclosures seriously. In the year ending 31 March 1996, it received 31 536 notifications about concern with fitness to drive through alcohol misuse, mostly from license applicants themselves and mostly in relation to drivers designated as high risk offenders. Importantly, unless doctors specifically request information about outcome of disclosure, none is sent. This lack of feedback may help to explain any ambivalence generated by doubts about the effectiveness of disclosure.

Ambivalence on the grounds of uncertainty that alcohol interventions are effective or that compliance is low are now largely unjustified. A consistent finding of alcohol research is that treatment is better than no treatment and that "brief interventions" work. A review of 32 randomised trials of brief interventions has concluded that they are more effective than no counselling and often as effective as more extensive treatment.[5] In one study based in a general hospital, only 12% of 11 282 patients with untreated alcohol related illness refused their referral for treatment, and in 1991-2, 60% of 2424 patients offered intervention kept their appointment and entered treatment.[6]

There is a further reason for doctors to be vigilant, which relates to the increasingly recognised right of the NHS to recoup the costs of treating injuries from defendants. It seems likely that the Law Commission will recognise this right.[7] If it turns out in the future that appropriate advice was not given or that disclosure was not advised or carried out when appropriate then doctors may be laying themselves open to litigation initiated by aggrieved defendants on the grounds that their alcohol misuse should not have been neglected.

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The legal position

Andrew Burrows

From a legal perspective there are two main questions. Is a doctor in breach of the duty of confidence owed to a patient by disclosing information about the patient to a third party, such as the Driver and Vehicle Licensing Agency or the patient's employer? May a doctor be liable in negligence, to a person injured by a patient, for not having disclosed information about the patient to, for example, the licensing agency or the patient's employer?

As regards the first question, doctors have a legal duty to respect the confidence of a patient. But that duty is not absolute. Clearly, the information may be disclosed to a third party if the patient consents. Moreover, there is a defence where disclosure to the third party is in the public interest. What falls within this defence is a matter for the courts to determine on a case by case basis. It is clear, however, that a doctor who discloses information about a patient's alcohol abuse to the licensing agency or the patient's employer, with a view to avoiding injury to others, would have a public interest defence to a claim by the patient for breach of confidence. The interest in maintaining confidentiality is here outweighed by the interest in public safety.

In legal terminology, the central issue in relation to the second question is whether a doctor owes a "duty of care" to someone who it is reasonable to foresee may be injured by a patient. The tradition in Anglo-American tort law is that there is generally no duty of care to take steps to prevent a person causing harm to another.

Nevertheless, in one celebrated case in the United States, a psychiatrist was held to have a duty to warn a person who was named by his patient as his intended victim. In England the emphasis has often been on the need for the defendant to have control of the "dangerous" person—for example, the duty of care in guarding prisoners is owed by prison officers to those whose property is likely to be damaged by escaping prisoners. A doctor does not have control over a patient who is misusing alcohol and, at this stage in the development of English law, it seems very unlikely that a duty of care to those who may be harmed by a patient would be imposed on a doctor. But courts are influenced by the ethical standards of the medical profession. As the leading legal textbook on torts concludes: "Unless the profession itself starts to regard failure to warn as a breach of ethical standards, the courts are highly unlikely to impose a legal duty." [1]

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Doctors neglect their own alcohol problems as well as those of their patients

Deborah Brooke

The scenario set out by Dale and Barton is the stuff of sleepless nights. Assuming that the history, examination, and investigations all confirm the suspicions of alcohol dependency syndrome, then the patient's behaviour shows that he poses a risk to the safety of others, and to himself.

Three features are central to risk management: security, supervision, and support[1]. This patient may agree to notify the Driver and Vehicle Licensing Agency and engage with alcohol treatment services, accepting their recommended period of sick leave and notifying his employer. I would make every effort to persuade him. This would include an account of my likely actions if he refuses help. I would try to involve his family in the discussion.

If he refuses to follow this course, then I would follow the guidance from the General Medical Council. I would consult with my defence society about the advisability of notifying his employer or the Lloyd's agent dealing with his ship in the United Kingdom. I would write to inform him of my actions and would repeat my offer of help in that letter. (In the present Mental Health Act, alcohol and drug problems are not grounds for detention.)

The results of the survey raise wider issues, described in the title as doctors' ambivalence. Many respondents adopted a passive approach to this man's difficulties. Almost a third of medical and surgical admissions to hospital are for problems related to alcohol, and the profession has been poor at detecting and addressing these problems.[2] A main cause is insufficient training in recognising and treating substance misuse at undergraduate and postgraduate levels. This leads to uncertainty about management, accompanied by gloomy prognostications.

This attitude has extended to neglect of colleagues' alcohol (and drug) problems. A number of agencies offer help to sick doctors. The GMC has dispelled any confusion about the limits of confidentiality by advising that it is unethical for a doctor to fail to disclose information about a colleague who is putting patients at risk. The profession is edging towards a culture in which our own use and misuse of mood altering agents can be examined, with the knowledge that the prognosis is not necessarily hopeless. I hope that we can therefore be clear about the management of our patients' alcohol problems.

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1 Gunn J, Taylor P. *Forensic psychiatry: clinical, legal and ethical issues.* Oxford: Butterworth-Heinemann, 1993:635.
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Whose secret is it anyway?

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Why is there a duty to keep confidences? Most commentators claim that if doctors did not have such a duty, patients would not trust their doctors with clinically relevant material, and this would have bad consequences. There is nothing about the duty of confidentiality which implies absolute secrecy; it is a commitment to treating the patient's information with respect. Privacy might be a better word than confidentiality, so that patients are protected from gossip (usually by health care professionals).

Confidentiality is not an absolute principle, as the established exemptions make clear. Harm to others is a time honoured justification for inroads into personal liberty (including privacy), and there is clear professional consensus that when doctors perceive a strong likelihood of harm to others, they are justified in acting on that information. Action may include not only breaches of confidentiality but also using appropriate civil or criminal sanctions, such as the use of the Mental Health Act or the involvement of the police.

One difficulty with limiting the scope of confidentiality is that the patients are often not aware that such limits exist. There seems to be ambivalence in patients, too: some believe that they will get total secrecy from their doctors, and others expect that nothing is private. Practically, what people object to most is the spreading of information behind their backs.

Although disclosing patients' information may mean that doctors may have to handle angry confrontations with patients, such confrontations are also part of the doctor-patient relationship and will have to be survived by both parties. An empathic responding to the patient's concerns is important here. In my experience, patients who have disclosed that they are "risky," in whatever sense, are often relieved that someone is going to act in a way to reduce the risk. It is often illuminating to ask oneself why a patient has chosen to disclose their "risk" situation.

The American courts have clearly perceived doctors to have duties to protect others. Dale and Barton, too, assert that doctors have duties to "the wider community." I am not so sure. Traditionally, doctors' duties have been to protect their patients' interests. Who will protect these interests if the doctor decides that others' interests come first? There is a danger that patients who are perceived to pose a risk to others (and Dale and Barton make it clear how diverse such people are) will be treated with less respect than others.

If doctors are to have duties to the wider community, then the profession must be involved in deciding what the scope of these duties should be. In this case, it might be argued that doctors have duty to be politically active to restrict sales of alcohol and reduce the numbers of addicts. I suspect that political interference, and our own ambivalence to alcohol abuse, might make this difficult.

A patient who changed my practice

A unique free lunch

In 1973 I was appointed as the only consultant physician in the elderly in an area with a population of 200 000, 10% of whom were over the age of 65. In those days a consultant for the elderly was hailed as a messiah by the public, as well as by the general practitioners. I soon discovered that I was inundated with requests for home visits. Many of these cases were so called long stay, who needed continuous care in hospital. They needed assessment and placing on a long stay waiting list. I therefore devised an idea of dividing the catchment area into five sections. I charted them on a wall map. I visited each area in rotation from Monday to Friday, so that the general practitioners knew exactly the day of my visit.

One afternoon, I went to visit an elderly lady of 90, who lived with a very caring daughter. The request for the visit had come five days earlier. The daughter ushered me straight to the dining table for a snack lunch. It seemed as if the rest of the family was anxiously waiting for me to start. I said that I had a packed lunch in my car but the daughter would not let me go unfed. When I finished my lunch I asked her politely if I could see the patient. She was equally polite in answering me. "For 90 years of age she did very well, doctor." She was buried that morning. I should have taken note of the men dressed in black ties. She added: "Perhaps, doctor, you would be kind enough to look after me when I am old."

I learnt my lesson that day. From then on I have tried to finish my domiciliary visits within 24 to 48 hours of the request.

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We welcome filler articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk.

Women's health

The childbearing years and after

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This is the last of three articles exploring the impact of women's health on the international community

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Summary points

- Over half a million women die each year from causes related to pregnancy and childbirth, mostly in the developing world
- Reproductive health is linked with the economic and cultural environment, and improvements are not limited to interventions by the health sector
- Women live longer than men but often after a lifetime of social disadvantage, and their old age may be characterised by disabilities, chronic ill health, poverty, loneliness, and alienation
- The UN conference on population and development held in Cairo in 1994 witnessed a major shift in the way that governments approach population control, moving away from coercive attempts to achieve demographic goals to a position that emphasises women's reproductive health and puts women's health into a broader economic and social context

Each year more than 150 million women become pregnant, and more than 15%—23 million women—develop complications needing skilled treatment.[1] Each year, over half a million women die from causes related to pregnancy and childbirth.[2] The risk of dying varies from country to country: the lifetime risk of dying from causes related to pregnancy and childbirth in Africa is 1 in 23, compared with 1 in 4000 in North America.[3]

The risks of childbirth are higher when there are other health problems such as high blood pressure, heart disease, malaria, and diabetes. Pregnancy also carries a higher risk for relatively young and old women and for women who have many babies in a short space of time.

Improving the health of pregnant women

The dramatic falls in maternal mortality in developed countries over the past 100 years have largely been attributed to the move towards having babies in hospital.[4] But women have been increasingly unhappy with the medicalisation of childbirth. In response to this, the British government set up the Cumberledge Committee, which reported in 1993. The committee found no evidence to support the medical paradigm for maternity care for most women and recommended that all the care for pregnant women should be provided by midwives.

Most of the deaths from causes related to pregnancy and childbirth occur in the developing world, and almost all of these deaths are preventable with existing knowledge and technology. In response to this challenge, the international health community, including the World Bank, the World Health Organisation, the United Nations Population Fund, and agencies in 45 countries, launched the Safe Motherhood Initiative in 1987. The initiative aimed to halve the number of maternal deaths by the year 2000 by providing programmes focusing on the provision of services in three areas:

- Information and education, designed to create demand for clinical services, alert women and others to possible complications, and help develop transport links with obstetric units in district hospitals;
- Community based obstetrics with trained nurse-midwife staff to provide prenatal care, supervise normal deliveries, and refer women who develop complications;
- District hospital facilities to provide essential obstetric services, including neonatal resuscitation.

There has been a disappointing lack of improvement in maternal health in the past decade despite the efforts of the Safe Motherhood Initiative, possibly because of its failure to tackle the wider social and political context of women's health. Factors underlying the continuing risk to women include persistent malnutrition, anaemia, and female genital mutilation, which predispose to obstetric complications. Dealing with these issues involves delving into some deeper economic and sociocultural issues, including poverty and gender inequality.[5]

Improving nutrition

Pregnant women in the developing world can be at risk from complications due to poor nutrition. Iron deficiency anaemia affects 458 million adult women but only 238 million adult men.[6] This is because menstruation and childbearing increase the body's requirement for iron. About 43% of all women and 51% of all pregnant women have iron deficiency anaemia, most of these being in the developing world.[1] Iron deficiency increases women's susceptibility to illness, complications in pregnancy, and death.

At least a quarter of adolescent girls in developing countries are iodine deficient.[7] In a developing fetus and infant, iodine deficiency can irreversibly delay psychomotor development. Hypothyroidism due to iodine deficiency affects about 5.7 million people and is the world's leading preventable cause of intellectual impairment.[6]

Strategies for improving nutrition include controlling infectious diseases and intestinal parasites and educating women about food. Nutrition tends to be affected by who in the household controls the money—women's income is more likely than men's to be spent on better nutrition. Strategies to improve nutrition on a national basis include fortifying food with micronutrients and subsidising the cost of basic foodstuffs. The World Bank says that governments should invest in intervention programmes that provide food supplements sparingly and combine them with behavioural

change and health care. It argues that some interventions have been wasteful because they have failed to improve families' knowledge and capacity to feed themselves adequately.[6]

Improving access to family planning services

Women tend to delay childbirth where they have a choice, but it is men who initiate most major fertility and reproductive decisions, including use of contraception.[8-10] Many projects are addressing this issue through education.

Constraints on the availability of birth control, says the 1993 world development report, include "excessively restrictive medical screening requirements, unnecessary or duplicative approval procedures, packaging and labelling requirements that perform no useful function but increase costs and import restrictions or tariffs." [6] The report recommends that governments help couples by promoting family planning as a socially acceptable practice; providing information on the health effects of fertility regulation; teaching couples about effective methods of contraception; and removing restrictions on the marketing of contraceptives. It also says that family planning services should be distributed through the community to reach rural and low income populations who may otherwise have no access to family planning, and young people should be targeted through "family life education" in schools and other venues.

At the United Nations' conference on population and development in Cairo in 1994, governments moved away from coercive attempts to achieve demographic goals to a position that emphasised women's reproductive rights.

The risks of abortions

Regional estimates by the World Health Organisation suggest that worldwide there are 52 million abortions each year, of which 21 million are performed in countries where the procedure is not legal.[2] At least 70 000 women die as a result of illegal abortions.[2]

Abortion is legal throughout most of the industrialised world, in China, and in some smaller developing countries; it is also legal in India, but difficult to obtain. In Bangladesh, menstrual regulation (vacuum aspiration performed at less than two months' gestation) is permitted.

RON GILLING/PANOS PICTURES

Agricultural cooperatives, as here in Niger, improve nutrition through improving food production

In a Colombian programme using food supplements and "maternal tutoring," the effects of education on children's height and weight were as large as the effects of extra food.[6]

In countries where abortion is virtually prohibited the procedure is frequently performed illicitly. In these countries, incomplete abortions are common and the risk of complications is high. Women who need postoperative treatment are unlikely to attend hospital, either because they are poor or afraid that their illicit abortion will be discovered or because there are no accessible hospitals. Longlasting consequences, such as infertility, may affect those women who survive.

Lesley Doyal, professor of health and social care at the University of Bristol, writes that "the legal status of abortion is the single most important factor determining its impact on women's health. In the United States its legalisation led to a decline in mortality from 30 to 5 per thousand terminations between 1970 and 1976. In contrast, mortality in Romania rose from 21 to 128 per 100 000 live births between 1965, when abortion was made illegal, and 1984." [11]

But as Professor Doyal notes, the legal status of abortion is not the only factor which influences health outcomes—interpretation of the law, levels of public funding, and modes of professional practice can all exert a powerful influence. For example, in the United States, federal funding for abortions is prohibited, affecting young, poor, black and minority ethnic women in particular.

Sexually transmitted infections and AIDS

An estimated 315 million sexually transmitted diseases occur globally every year, most of them in developing countries.[12] Close to 20 million men, women, and children worldwide have been infected with HIV, most in the developing world (table), and the epidemic is still expanding at the rate of about 6000 new infections a day.[13]

All the available information suggests that the rate of infection in women is rising faster than in men. Women are biologically more vulnerable to sexual transmission of HIV,[12] partly because as the receptive partner, women have a larger mucosal surface exposed during sexual intercourse and because semen contains a far higher concentration of HIV than vaginal fluid. Women are more likely than men to receive blood transfusions and other blood products because of their role in childbearing.

In Africa, men are supposed to prefer a hot, dry vagina to a warm and moist one, which is perceived as cold and watery.[14] Many women use drying agents: local applications of herbs mixed with porridge or tea. These lotions cause inflammation, including mucosal erosion and then constriction. Some men use herbal aphrodisiacs for enhanced performance and have sex four to seven times a night. The vaginal wall can, through this combination, become badly damaged and vulnerable to infection.

Estimated minimum numbers of adults infected with HIV, late 1970s/early 1980s until late 1994[12]

Area	No of adults infected	No (%) women infected
North America	1 000 000	150 000 (15)
Western Europe	500 000	75 000 (15)
Eastern Europe and central Asia	50 000	7 500 (15)
North Africa and the Middle East	100 000	15 000 (15)
East Asia and the Pacific	50 000	25 000 (50)
Latin America and the Caribbean	2 000 000	440 000 (22)
Sub-Saharan Africa	11 000 000	5 500 000 (50)
South and south east Asia	3 000 000	1 350 000 (45)
Australasia	25 000	3 700 (15)

The sexual and economic subordination of women in many countries has fuelled the HIV/AIDS pandemic. Even a woman who knows that her partner is infected with HIV may not be able to refuse intercourse.

Reducing the risks of sexually transmitted infections

Strategies to reduce the incidence of HIV infection in women need to tackle social and cultural inequalities. This can be difficult, as Henriette Meilo from the Society for Women and AIDS in Africa described: "We started talking with the male programme managers about polygamy and they said: 'Oh no, you can't touch that. It is our culture.' There are several areas of our tradition and culture men are frightened of exploring, because they are ways of keeping women under submission in communities." But there have been successes. Thailand has established the world's most comprehensive national HIV surveillance system and has enforced a policy of 100% condom use in brothels. Preliminary evidence shows an increase in condom use, from 10 million a year to about 120 million a year, and a reduction in the incidence of sexually transmitted infections.[6]

Smoking and alcohol

Smoking kills over half a million women each year in the industrialised world.[15] The proportion of smokers is rising most rapidly among young women in many countries; in Western societies over a quarter of 18-22 year olds are smokers.[16 17] As well as causing lung cancer and cardiovascular diseases, smoking poses specific risks to women. It increases the risk of cervical cancer and the risks of taking the contraceptive pill and affects women's reproductive health, increasing the risk of early menopause, miscarriage, and low birthweight babies. In response to restricted opportunities and declining markets in Western societies, the tobacco industry has concentrated its efforts on less developed countries, in which smoking related diseases are on the increase.[18]

Alcohol use among women has also risen. Women who drink heavily are more likely than men to develop complications such as cirrhosis of the liver.

Methods to control the use of tobacco, alcohol, and other addictive substances—through information campaigns, taxes, bans on advertising, and possibly import controls, can help substantially to reduce chronic lung disease, heart disease, and cancer.

Mental illness

Depression is the most common mental disorder among women in developed countries, and although there are not many data, this seems to also be true in developing countries. A multicountry study coordinated by the WHO showed that depression is twice as common in women as in men. Possible reasons include the increased incidence surrounding childbirth which may have a neurophysiological or social basis.[19] In some cultures, for example in Nepal, mental illness is a sign of witchcraft, and attempts to drive out evil spirits can result in horrific injuries, such as burns, being inflicted.[20] Future initiatives in mental health need to focus on gaining a better understanding of the origins of psychiatric illness in women and developing more effective treatments.

Cancer

Cancer is a leading cause of death in women, especially those aged 35-55, in both the developed and developing world.[15] Women most commonly develop breast, cervical, colorectal, and stomach cancer.

Globally there are 460 000 new cases of cervical cancer a year, most occurring in developing countries, where only 5% of the global resources for cancer control are available.[12 15] Early detection and screening have reduced the morbidity and mortality due to cervical cancer in some but not all developed countries. According to a recent WHO report, this uneven coverage is due to "poor management and the implementation of inappropriate policies, such as screening mainly young women without sufficient coverage of older women." In developing countries most cases are detected at an advanced and incurable stage, due to "lack of knowledge among women of the symptoms of the disease, a fatalistic attitude towards cancer generally; a lack of awareness of the possibility of a cure; lack of, or disorganised, screening programmes; and a lack of health care facilities in the rural areas, combined with a low priority for women's health issues." [12]

The postreproductive years

All over the world, women tend to live longer than men. The average life expectancy is 79 years for women and 73 years for men in western Europe, North America, Australia, and New Zealand—but 54 years for women and 51 years for men in sub-Saharan Africa.[3] By 2015 the number of women aged over 65 will have increased to 600 million (from 330 million in 1990). Most will live in the developing world.[1]

PETER BARKER/PANOS PICTURES

Family planning talk in a Calcutta slum

LIBA TAYLOR/HUTCHISON LIBRARY

Numbers of elderly women are increasing, and old age is being seen as a female issue

Living longer

Many women, particularly in developing countries, who reach old age will have experienced a lifetime of social disadvantage. Even where women live longer, their last few years may be characterised by disabilities, chronic ill health, poverty, loneliness, and alienation.

Alienation is not a global phenomenon. Only 2% of those aged 60 and over live apart from their families in Fiji, Korea, and the Philippines. However, nearly a third of elderly Americans live alone. In the United Kingdom, 80% of elderly people living alone are women.[1]

Cardiovascular diseases

In the developed world, cardiovascular diseases are the major cause of death among women aged 50 years and over.[15] The health problems of aging women in developing countries may not be given as much attention as communicable diseases and maternal mortality. As life expectancy and the standard of living in developing countries improve, cardiovascular diseases and the disability they cause are set to become more important..

Most of the research about cardiovascular disease is based on long term studies of men. Experience is showing that the findings do not apply to women. For example, half of all women who have a heart attack die within a year compared to only 31% of men.[12] Despite evidence that established treatments for coronary heart disease should be used in women, the medical profession has been slow to apply them.[21] In the United States in the 1980s, angiography, angioplasty, and bypass surgery were much less likely to be offered to women than to men.[22]

Though many-studies sensitive to gender are now being undertaken, the WHO predicts that women will be some 20 years behind men in getting answers to some pressing questions about their health.[16]

Summary

Health and development planners have tended to see women primarily in context of their reproductive role. As a result, solutions to women's health needs have been restricted to expanding and improving maternal and child health systems. There has recently been a major shift in direction, largely because of the influence of the world conference on population and development held in Cairo in 1994. Dr Guiseppe Benagiano, director of the special programme of research, development and research training in human reproduction based at the WHO, says, "We need to remind ourselves constantly that reproductive health is not simply a biomedical issue but one with serious implications for our general health and by extension, for all our efforts in human social and economic development." [23]

The 1993 world development report on health identified the lack of a clear strategy for engaging women in health care and suggested that child health services, prenatal care, treatment of sexually transmitted diseases, and family planning services should be provided jointly at convenient times.[6] In an example of this, the Chilean Institute of Reproductive Medicine now offers integrated family planning services at the same time as child health services, and Thailand is experimenting with mobile health clinics to reach women in their homes.

As the proportion of elderly women increases, old age is increasingly being seen as a female issue. With the impact of urbanisation and industrialisation, more of these women are living isolated lives, often suffering from chronic debilitating diseases. In his opening statement to the global commission on women's health in April 1995 which focused on health conditions of women in old age, Dr Hiroshi Nakajima, the WHO's director general, said: "Our goal should not be solely to extend lives in the physical sense, but to ensure that the added years are worth living."

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