Protecting elderly people: flaws in ageist arguments

Michael M Rivlin

Some form of rationing is necessary in medicine, and to use age as a criterion for rationing seems initially appealing. Many of the criteria currently being used for deciding the distribution of funds depend on subjective judgments. Age, however, is objective and therefore negates the need for value judgments. Justice and fairness, it is sometimes suggested, require that finite resources should be directed at young people, who have not had a chance to live their lives, rather than at elderly people, who have already lived most of theirs. The adoption of ageist policies, however, may not result in the implied savings unless care is also withdrawn. Furthermore, ageist policies, which deny elderly people treatment on the sole grounds of their age, are both unfair and discriminatory and should therefore be resisted.

The demographic explosion[1] that will take place as a result of an aging population poses enormous ethical and economic problems. An indication of the size of the problem is that in the United Kingdom the proportion of people over the age of 65 is expected to increase from 18% in the current population to 30% by 2030.[2] By the year 2050 in the United States an estimated 15 million people will be over the age of 85 alone, compared with 3 million in 1990.[3] The cost to society of dealing with an elderly population will be substantial. For example, Dworkin states that $80 billion was spent treating patients with Alzheimer's disease in the United States alone in 1991.[4] (Does Dworkin mean that the money was spent on treating or caring for patients, an important distinction as I shall argue later.) Hacker reports that in the United States "spending on hip fractures, for example, is projected to increase from $1·6 billion in 1987 to as much as $6 billion in the year 2040 (in constant US dollars)."[3] In view of these statistics, it is hardly surprising that there are increasing calls for age to be used as the principal criterion for rationing.

That ageist policies are already being implemented in some parts of medicine is indisputable.[5-7] Perhaps one of the reasons that these policies are under consideration is because of our mistaken perception of old people. Butler (who first used the term ageism in his book *Why Survive?*) suggested that we have "a deep and profound prejudice against the elderly."[8] Though this may be somewhat of an overstatement, I believe that people generally have an unfortunate (though perhaps understandable), prejudice against old people. This prejudice may not be based on malevolence but on the fact that elderly people are within sight of the end of their lives and facing death so it is perhaps pointless to use up resources on them. Elderly people, are, in some way, a lost cause.

Inconsistent arguments

Many other justifications are given for ageist policies. Some can be dismissed quite easily as being either inconsistent or fallacious. Included in these would be six common arguments.

ELDERLY PEOPLE WOULD WILLINGLY GIVE UP THEIR LIVES FOR YOUNG PEOPLE

In a recent article in the *Journal of Medical Ethics*, Shaw gives the example of a grandmother and her 20 year old granddaughter who are both drowning.[6] He suggests that the grandmother would want us to throw a lifebelt to the granddaughter in preference to herself. But the grandmother might want us to save the girl before herself because of emotional ties. The crucial test would be to find out what the grandmother would think if she did not know the younger woman. To give up your life for someone you do not know could be argued as stretching altruism to the limit, and I wonder how many of us are that altruistic. Evans gives evidence that elderly people value their lives more highly than others (their doctors, relatives, and young people) think that they do.[9] Much more research needs to be undertaken before it can be accepted that elderly people would willingly give up their lives in favour of younger people.

AGE IS ALREADY A CRITERION FOR REFUSING TREATMENT

Age is already used as a criterion for refusing treatment, which suggests that some people think that it is right that it should be. In many coronary care units, for example, age rather than medical considerations often determines whether a patient will be treated.[10] But the fact that a practice happens does not make it morally acceptable. Apartheid was, until recently, an accepted part of everyday life in South Africa, but the fact that this was the case does not make it justifiable. There is a danger that once something is seen to become an accepted form of medical practice its continued use will not be questioned; when this happens it is tempting, and too easy, to forget the moral implications of what is being done.

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JENNY MATTHEWS/FORMAT

Would this grandmother be willing to give up her life if the younger woman was a stranger to her?

ELDERLY PEOPLE GAIN LESS FROM TREATMENT

It is sometimes suggested that old people will not be able to gain as much benefit from treatment as young people because they may be physically, and mentally, unable to deal with the probems of old age.[5] In many cases, however, elderly people's response to treatment is as good as young people's. In referring to studies on how elderly people cope in intensive care units Brandstetter writes, "the percentage of survivors fully recovered, freely ambulatory, fully alert and productive, was the same in the elderly [over 65] compared with two other groups [under 41 and 41-65]."[11] Jecker and Schneiderman confirm this: "evidence is mounting that no significant age difference exists in mortality or morbidity outcomes associated with various interventions, including survival after CPR [cardiopulmonary resuscitation] . . . coronary arteriography and coronary bypass surgery, liver and kidney transplantation, other surgeries, chemotherapy, and dialysis."[12] Some elderly people might indeed not be able to cope with old age, just as some young people are not able to withstand modern day pressures, but it would be most odd to deny people treatment because they are unable to cope with their age. Many old people may thrive on being retired from work and free to occupy their days with things they enjoy doing. To suggest that elderly people do not benefit from treatment ignores research to the contrary and does not take account of the difference in people.

SOCIETY GAINS LITTLE FROM TREATING ELDERLY PEOPLE

Society as a whole will not gain from the treatment of elderly people as they are likely to be both non-productive and even perhaps a drain on resources.[5] But many groups of patients might be considered to be non-productive, why therefore discriminate against elderly patients? Elderly people are not alone in having medical conditions that require long term treatment and in which the outlook is poor. It is legitimate to ask, for instance, why funds should be used on a younger person with a poor prognosis instead of an elderly person who could benefit far more from treatment. It must also be remembered that young patients with chronic illness may be more of a drain on resources than elderly patients as they may have more non-productive years to live. Imagine the outcry—and rightly so—if a young paraplegic patient or a patient with a mental illness were to be refused treatment on this basis. If it is fair to refuse treatment to old people because they cannot work, consistency would dictate that other groups of "non-productive" people should be refused treatment.

MARION MARSHALL

Something pricked my foot, and Grandad has time for a full inspection

Just because people are old it does not mean that they cannot contribute to society. I am thinking here not only of a Picasso or a Bertrand Russell but also of the value of personal relationships between, for example, a grandparent and grandchild. Simply observing such relationships in practice shows how valuable they can be.

TREATMENT SHOULD ACHIEVE MAXIMUM BENEFIT

"Health care must be distributed in a way that achieves maximum benefit."[6] This is a surprising argument. If doctors decided treatment only on the basis of maximum benefit some strange decisions would be made. Many of those with chronic illness, a condition with a poor prognosis, or with an illness that may be expensive to deal with would not be treated at all.

AGE IS AN OBJECTIVE CRITERION

Age is objective and is not therefore subject to the value judgments that other forms of rationing depend on. If there were to be a policy based solely on age then presumably there would have to be an age after which treatment would be denied. Assume that this cut off point was 65. Does this then mean that a heart bypass operation that might give a patient 25-30 years of good quality life be refused if the patient was a day past his or her 65th birthday? To those who might say that an ageist policy would allow for this by permitting some exceptions I would argue that this would negate the central tenet of the policy. Once exceptions are allowed, then objectivity, presumably the main force supporting ageism, is removed from the equation.

Slippery slope

Another important point must be raised about using a specific age as a cut off point for the access to treatment and about ageist policies in general. Economic pressures, the raison d'être behind ageism, coupled with slippery slope arguments, would inevitably ensure that the age chosen would soon be revised downwards. If it were established that substantial sums could be saved by denying treatment to those over a certain age it could, and probably would, then be argued (correctly) that by lowering that age further, even greater sums would be saved. The pressures for this to happen would be overwhelming.

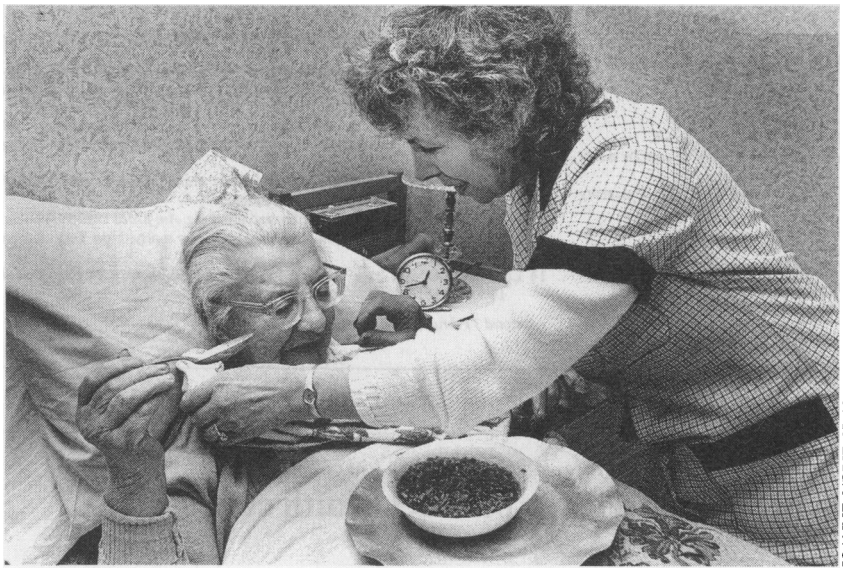
Of course society does not allow people to undertake certain activities until they have reached a particular age—driving and voting for instance. It could therefore be argued that age is an acceptable way of limiting people's freedom to act as they might wish. However, I can think of no examples in which age effectively condemns a person to an early death—as an ageist policy undoubtedly would.

The long innings argument

Having dealt with what I consider to be the weaker arguments used by those who advocate ageism, I will discuss in more detail two arguments that I believe deserve more attention.

The first is fairness, or the long innings argument, and is simple. As elderly people have lived most of their lives it is only fair that those who are younger are given preference in the distribution of scarce resources so that they have a better chance of living theirs.

But why is it considered fair that an old person who has worked and paid taxes all his life and has never smoked be denied treatment just because he is old, while a heavy smoker, who may have already used considerable medical resources, be given treatment instead? Many would argue that it is both fairer and more rational to discriminate against the smoker. Is it



JOANNE O'BRIEN/FORMAT

Elderly people need care rather than high tech treatments

fair to spend huge amounts of limited resources on treating illness caused by smoking—illness that is, in the main, self inflicted? Smokers, by polluting the atmosphere, may also harm others. Age is not self inflicted and neither does it harm others. (I accept that it may inconvenience others in terms of them having to look after elderly people but that would be a selfish reason to deny old people treatment.) Therefore if we are to discriminate against any group of people then it might be argued that it is fairer to deny treatment to those who smoke rather than those who are old. I am certainly not proposing that smokers should be denied treatment just because they smoke, only asking why, if there is a group of people to be discriminated against, it should be those who have done themselves, and society, no harm?

I would also question the idea that, as the old have had their lives, fairness dictates that the young should be given the chance to have theirs. What is so special about young people, and in particular, all young people? Let me give an example.

A young joyrider who has just killed three people in a car crash is brought into accident and emergency critically ill. At the same time the remaining survivor of the car he hit arrives in the department. The survivor is known to the hospital staff as a leading consultant oncologist, aged 68, who is working on important research. Those who advocate an ageist policy argue that the distribution of treatment must be seen to be just, and that health care must be distributed in a way that achieves maximum benefit. On both these counts some might ask why the young joyrider be given preferential treatment over the elderly physician. I emphasise that I am not for one moment advocating that we should give, or deny, treatment based on our views of a person's worth—the consequences of doing so are morally abhorrent and far too dangerous. Ageist policies imply that the allocation of funds should be distributed in favour of young people. But what is there about being young that entitles young people to preferential treatment—just the fact that they are young?

Expense of treating elderly people

The second argument is that it is expensive to treat old people and the large amounts of money and resources that are spent looking after them could be better utilised elsewhere. There is a big misunderstanding by those who put forward this argument. The main costs of treating elderly people are not in the use of sophisticated technology, but in routine treatment, and particularly, caring. Callahan dealt with ageism in depth.[13] He suggested that expensive and high tech treatment should be denied to elderly people and the money saved could be used instead on better care, which would result in old people having a more meaningful life. An opposite view is given by Levensky, who writes, "Contrary to conventional wisdom, the savings will be small if we eliminate intensive, high-technology care for the aged. . . . For substantial savings we must withhold routine medical care from the elderly."[14] Patients with severe Alzheimer's disease can be in hospital for many years. They are not subject to high tech treatment, but it is expensive to look after them. Routine care and less expensive treatments take up most of the funds that are used in looking after old people. Levensky shows that research in the United States indicated that "probably no more than 1 or 2 percent of the national health care expenditure for the elderly is devoted to high-cost medical admissions."[14]

I hope that nobody is suggesting that elderly people should be denied routine treatment or care. However, whether anyone, young or old, should be given expensive treatment that uses up large amounts of finite resources is a different debate and not the point at issue.

One of the large problems facing doctors is that they are being forced to make rationing decisions on behalf of the government, sometimes against the best interests of their patients. These decisions are usually made covertly and without the patient being informed that treatment is being denied because of lack of resources. (How can patients protest about something they are unaware of?) If society decides that age should be the factor determining whether a person is denied treatment then this must be made explicit by the government, not left to the medical profession to disguise, by way of euphemisms, that it is happening. Only when it is admitted that an ageist policy exists, and an extension of it is being considered, will it be possible to have a meaningful debate about the subject.

Conclusion

How do we justify funds spent on a population that is dying and not economically productive? It is the mark of a civilised society to look after its most vulnerable members. In addition, elderly people lack the assertiveness of young people, which is another reason why they should not be taken advantage of or discriminated against. I am not suggesting that all elderly people receive treatment, irrespective of their prognosis, any more than I would argue that all young people should be treated irrespective of theirs. My submission is only that age should not be the principal criterion used to gain, or deny, access to medical facilities. Obviously sometimes the medically correct decision is to refuse a person treatment because he or she will not be able to benefit from it. However, I strenuously argue that treatment should be denied only if it is medically inappropriate and not because of a patient's age. The inevitable consequence of an ageist policy would be to consider elderly people expendable —surely morally unacceptable. Age related rationing demeans our society. Unless, and until, better arguments for an ageist policy are proposed elderly people should not be discriminated against and ageism as a policy should not be given further credibility.

CODA

Some people might say that if you argue against ageism you should offer other forms of patient selection. I do not believe, however, that it is incumbent on critics of the policy to propose an alternative form of

rationing. It can presumably be acceptable to show the flaws in an argument without having to suggest what to put in its place.

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South Africa's Health

Traditional healers in South Africa: a parallel health care system

Rajendra Kale

This is the second in a series of five articles reporting on health care in South Africa

"Traditional healers are a very caring people, and extraordinarily skilled in psychotherapy and counselling. Some of them do a damn good job. Of course there are certain horrible ones who poison their patients at every turn," said Professor Ralph Kirsch of the Department of Medicine in the University of Cape Town Medical School. Traditional healers existed in South Africa before its colonisation by the Dutch in the 17th century. They have flourished in the face of competition from modern medicine. About 200 000 traditional healers practise in South Africa, compared with 25 000 doctors of modern medicine; 80% of the black population use the services of traditional healers.[1] Traditional healers are enshrined in the minds of the people and respected in their community, and they are often its opinion leaders.

Traditional medicine

The theory underlying traditional medicine in the several black ethnic groups of South Africa is essentially similar.[2] Disease is a supernatural phenomenon governed by a hierarchy of vital powers beginning with a most powerful deity followed by lesser spiritual entities, ancestral spirits, living persons, animals, plants, and other objects. These powers can interact, and they can reduce or enhance the power of a person. Disharmony in these vital powers can cause illness. Thus, ancestral spirits can make a person ill. Ingredients obtained from animals, plants, and other objects can restore the decreased power in a sick person and therefore have medicinal properties.

Types of healers

Inyangas are herbalists and possess extensive knowledge about curative herbs and medicines of animal origin (table I). Ninety per cent of inyangas are male.

Isangomas are diviners; they determine the cause of illness by using ancestral spirits, and 90% of them are female. A person cannot choose to become a diviner. Only a person "called" by the ancestors can become one. An individual who has been summoned behaves like a person with mental illness, and only a skilled diviner can differentiate this behaviour. The duration of training for a traditional healer varies from a few weeks to up to 10 years and depends on the ability of the apprentice. The fee for training is not fixed.

Umthandazi are faith healers who are professed Christians. They belong to one of the independent African churches and heal by prayer, by using holy water or ash, or by touching a patient.

Traditional birth attendants are usually elderly women and are respected in society for their skills. The conditions for becoming a traditional birth attendant include having had at least two babies of your own and an apprenticeship lasting up to 15-20 years. Birth attendants do not charge for their services but may accept gifts. If a complication occurs, the birth attendant seeks the advice of an *inyanga*. There are no data on the number of deliveries in South Africa that take place under the supervision of the birth attendants, but presumably they carry out most deliveries in rural areas.

Patients visit traditional healers for treatment of various illnesses including sexually transmitted

TABLE I—*Traditional healing agencies in South Africa*[1]

Agent	Skills	Method of service	Nature of service	Accessibility
Isangoma:				
High grade	1 Lower and middle grade qualifications a prerequisite 2 "Call" by spirits 3 Apprenticed to an expert 4 Medical skills acquired as in inyanga	1 Essentially diagnostic 2 Contact with patient not needed for diagnosis 3 History, symptoms, and nature of problem not revealed by patients	1 Conflict resolution 2 Revelation of misfortune and illness 3 Recommends solution 4 Provides expertise and leadership	Access given to relatively few
Middle grade	1 Lower grade qualification a prerequisite 2, 3, and 4 as above	1 As above 2 Throws and reads "bones" 3 As above	1, 2, 3, and 4 as above	Relatively accessible compared with above
Lower grade	1 First entry point to divination 2, 3, and 4 as above	1 As above 2 Divination through trance 3 As above 4 Cooperation of clients sought	Confirms patient's beliefs	Much more accessible
Inyanga	1 Individual choice to become one 2 Apprenticed to an expert	1 Knowledge of symptoms and patient's history necessary 2 Contact with patient necessary	Comprehensive, curative, prophylactic, ritualistic, and symbolic	Freely accessible
Specialist	Usual family prerogative	Essentially curative	Consultant, special skills	Fewer in number
Spiritual healer	Trances and contact with spirits	Essentially diagnostic	Lays on hands, prays, provides holy water and other symbols	Freely accessible

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