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## The Role of Context in Clinicians' Decisions in Older Patients

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### Introduction

1. In UK, the solidaristic medical system funded 80% from taxation creates the ostensible inter-generational dilemma that Eric Matthews has discussed.
2. There are lots of examples in the UK of diminishing percentages of uptake of investigations and treatments with increasing age (especially in life-threatening conditions such as cancer and heart disease). The point of this talk is to discuss whether these differences are deliberately ageist or happen because other criteria when choosing whether or not to treat someone conservatively or aggressively are more common in older people.
3. The thesis is that reduction in uptake of interventions in later years should not necessarily be taken as ageism (defined as the application of bias against older people regardless of other factors). My main focus is on the influence of local/national culture on doctors' values about whether and when to be strongly interventionist.

### What underlies the differences in uptake of acute care with age?

4. Hard (explicit) rationing exists in the UK only if a service is not provided at all on the basis of evidence that it does not work. This is extremely rare and seldom upheld in court. So 'soft' (implicit) rationing by the clinician is the only way of doing anything other than first come first served.
5. Given that there is no explicit or even implicit government policy (which in UK NHS means both national and local) that older people should have less active acute care, what possible explanations are there?
6. Sources of doctors' values that influence their decisions are:
  - a. Primary medical education (at least 20 years before and has changed dramatically in respect of improved treatment outcomes of many killer diseases)
  - b. Their own clinical experience (not just selective but also historic, by definition). Cancer Research UK runs campaigns to remind doctors, and public, of improved survival rates in most cancers
  - c. Evidence-based medicine. In the UK this is the chosen route rather than explicit rationing (By the nature of the research process it also is 10 years out of date on precise survival rates, and historically omitted 65plus patients)
  - d. The Quality of Life and QALY loud debates. There are both economic and personal/family arguments about 'not striving officiously' to keep alive.

- e. Repeated reminders of the limits to local NHS resources, especially in the 90s during the Thatcher management years (if money was spent by December, clinics and beds closed until next financial year in April)
- f. The values of the society in which they live and work (the Protestant ethic is still alive and well in rural UK)
- g. Their own family experiences (original image of grandparents giving up at 65 or earlier, and current experience of grandparents still alive and not wanting to be)
- h. The wishes of individual patients (also influenced by their own society and family experiences), who have become used to a service free at the point of consumption and who are never told by government that their taxes are not enough to go round

### How do clinicians' decisions reflect these influences?

Alongside the project described by Eric Matthews, discussion were held with cancer clinicians and GPs, mostly local. What emerged (and there are similar findings from Sheffield):

- a. Awareness of acute resources shortages
- b. Concern to find a fair and acceptable way of managing their own time, skills and waiting lists
- c. Several examples of taking the currently published life expectancy as a rough guide to when to make 'heroic' interventions with surgery and chemotherapy
- d. But everyone quoted 'fitness' as the crunch criterion – fitness to withstand the treatment as much as other reasons to die sooner rather than later. But no one has a good measure of fitness!
- e. 'Quality of life' was a commonly used phrase. Specialists used it in considering the side effects of treatment but also in respect of desired outcomes. GPs reported their older patients as often 'not looking to live longer but rather to be independent for as long as possible'.

### Conclusion

1. Is there an identifiable societal position in UK on when not to do major surgery/treatments? No, UK is pluralistic. But, pushing impression to its limits,
  - a. There seems to be a perception of a difference between the under and over 75s (the 'third' and 'fourth' ages) that is at least sometimes shared by doctors and public
  - b. 'The Protestant Legacy' is still around; by no means universal, but still detectable in rural Britain and especially in Scotland. It contains a mainly subconscious belief in the importance of work (or contribution) as a means to health at all ages, in personal stoicism and in community solidarity. It is a background to
  - c. The 'Fair Innings' argument, which expects older people to deny themselves if there is a choice between them and a younger person. This may have no philosophical or ethical basis on which to run a state system but it exists, especially within families and personal rather than political judgements. Moreover, as a public health physician, I could argue that those who reach old age are the survivors and therefore have already done well (from the Welfare State, though not necessarily from the NHS).

- d. Since the personal is the only level at which limits to medical care are managed in the UK, is it fair that the effect (proportionately fewer acute interventions on older people) is judged as ageism?
- e. And should it be changed? In other cultures there is no such individual restraint on consumption, but does that mean that UK is 'bad'?