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Practitioner's blog

Is it age before beauty?

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I have an extraordinary friend. When I first came to know her, I was doing research and she was running one of the UK's foremost human rights organisations. I would sit in her office, clutching my notebook as she fielded calls from public figures and prepared for select committee briefings. That was 10 years ago, when she was 74. Today, she still works seven days a week, defending the vulnerable, and inspiring individuals all over the world who shower her with honorary degrees and fight to come and work with her. Recently I asked this woman, who set up her first charity at the age of 67, if she had ever considered retirement. She laughed, shaking her improbably red hair. 'Don't be ridiculous', she said, 'What would I do?'

She worries me. Now in her mid-80s, her punishing 70-hour week is beginning to take its toll. Sometimes she takes Sundays off in reluctant deference to her age. The time will come when her indomitable spirit will be failed by her body, or when, just like the rest of us, she is involved in an accident or develops an acute illness.

Unlike me, a less than sprightly 44-year-old, her status will change the moment she is admitted to a hospital bed. Her age, lit as if by neon over her head, will determine the kind of treatment that she will receive. Unlike me, when she falters, stumbles over a word or gets muddled, she will instantly be regarded as *cognitively impaired* rather than tired, scared, or both. If she deteriorates, the onus will be on her to prove that she qualifies for intensive care. She will have to convince strangers, in her hour of greatest need and when she is at her most vulnerable, that she is in some way worthy of further treatment because of an accident of birth, namely the date of hers. It is a far cry from the ageless care that was promoted in the National Service Framework for Older People (Department of Health, 2001).

Recently, I looked after a woman of the same age, and maybe more or maybe less marvellous than my amazing friend. I have no idea, because when I first met her, she was already beneath a continuous positive airway pressure (CPAP) mask. I do know that, when we took off the mask and gave her a drink, she smiled and whispered her thanks. I know that she had a son, and that she lived alone but had a wide circle of friends. I know that she was a person, with all the aspirations, desires, interests and hopes that everyone has. I know, too, that she was deteriorating.

I was involved because she was at the centre of a bitter three-way fight. She had been on the CPAP, which is likened to the experience of flying in a jet fighter plane, for 4 hours and was not stabilising. The nurses on the critical care outreach team wanted her to be transferred to the intensive-care unit for ventilation, but the ITU registrar on call refused the referral because he felt that she did not qualify for ventilation, and he suggested a referral to the respiratory team. The respiratory team refused to see her, and said that the ITU registrar should take over her care.

Meanwhile she continued to gasp and struggle to breathe beneath her CPAP mask. After an hour the geriatric registrar tried calling the medical registrar, hoping for back-up, but he also declined to become involved. Another hour passed and the ITU registrar was called again. Once more he refused to see the patient until she had been seen by the respiratory team. The on-call Director of Operations was called and the head of intensive care was asked to see the patient. Another hour of waiting ensued before he saw her. All the time she gasped and smiled her thanks and weakened.

When she was finally seen, 8 hours into her CPAP, she was deemed unfit for transfer. When we asked why she could not be stabilised on the ward and then transferred to the ITU, we were told that she still did not qualify for ventilation and that it would be better to wait and see how she got on. She laboured for another 12 hours before she stopped breathing and therefore qualified for ventilation. She died 2 hours after her admission to intensive care.

Afterwards, in the post-event review, which was resisted at first, the reason for the reluctance to ventilate this patient earlier seemed to stem from a comment that 'I wouldn't want to die that way.' It seemed that from the moment her grey hair and wrinkled skin had been noted, there was an assumption that she was going to die anyway regardless of the fact that she was being treated quite aggressively. I don't think that the patient thought she was going to die; I think that she fought and gasped on CPAP for 20 hours because she wanted to live.

The doctors who engaged in this turf war are not bad people, and would probably be appalled if they were accused of being discriminatory. They will have convinced themselves that fobbing her off on to someone else was in her best interests, and that refusing her ventilation was kinder really. One of them even said 'She probably wouldn't have survived anyway.' Maybe not, but had she been 20 years younger, she would have been given the chance.

I appreciate that hard choices often have to be made when a person becomes very ill. Sometimes the decision to persist with treatment when a patient is extremely frail and has a poor quality of life is morally ambiguous. However, so often this is not the case. Treatment is not even considered because the attitude which persists towards people in their eighties is that they are at the end of their life, and that illness, however acute and however reversible, is just an inevitable consequence of the years.

We work so hard to avoid value judgements in clinical decision making. We all know just what a slippery slope that would be. We believe that we treat everyone without discrimination, regardless of who they are or what they might become. We treat tomorrow's murderers and thieves as well as tomorrow's scientists and writers, and that is absolutely right. However, we still look at someone in their 80s and think 'end' rather than 'beginning.' It is a hopelessly outdated paradigm based on the notion of 'threescore years and ten', and is consistent with the findings of a recent report from the Centre for Policy on Ageing which suggested that the key to eliminating age discrimination in the NHS will be about raising awareness of ageist attitudes (Lievesley *et al*, 2009). The majority of the evidence suggests that age discrimination mainly disadvantages older people (Carruthers and Ormondroyd, 2009). However, the world and medicine in particular have moved on, and attitudes need to catch up. We must embrace the reality of our future, which is a world with older people in it, older people who will live longer, work longer and will rightly expect the same clinical commitment from us as a younger person receives. Were we to fail in this for any other reason, for example, on the basis of colour, religion or disability, there would be an outcry.

REFERENCES

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