Ageism in medicine: a problem for all

Ageism was first coined as a term by an American physician, Robert N Butler, who defined it as: 'A deep and profound prejudice against the elderly which is found to some degree in all of us. Ageism allows the younger generations to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings'.

The subject has become a popular topic among politicians and in the popular press. This has lead to the health-care system also coming under scrutiny and numerous articles and editorials have examined the existence, or otherwise, of ageism in health care.

One thing is certain, the UK population is living longer and the older population is steadily increasing. This will affect all areas of society and impact on the health service's existing caseloads.

Evidence that ageist attitudes among health workers does exist was shown in a study by Kearney et al (2000) who found that oncology health-care professionals displayed negative attitudes towards elderly people, regardless of clinical experience, specialist education or professional groups.

Ageism in cancer patients

Approximately 65% of all cancer patients are aged 65 years and older and yet management is often based on research findings in younger patients, as only 25% of patients included in clinical trials are in this older age group. This exclusion of older patients is perhaps most marked for breast carcinoma. Only 9% of those recruited to clinical trials were older than 65 years but this group represents 49% of those affected by breast carcinoma (Hutchins et al, 1999).

Screening for various cancers is also less exhaustive in the elderly and this has been noted in various countries and for various cancers, including breast, colon and melanoma. With breast cancer screening, it has been argued that the health gain for younger women is vanishingly small, but there is no rationale for having an upper age range as breast carcinoma becomes increasingly common in older patients.

Once identified, do older patients receive equitable treatment? It would seem not. A retrospective study from a database of 200 000 patients in the US showed decreased odds of receiving cancer-directed surgery in older patients (60–90 years) with lung, liver, breast, pancreas, oesophageal, gastric and rectal cancers. However, this appeared not to include colon cancer (O'Connell et al, 2004).

Although colon cancer surgery may not be affected by age, Mahoney et al (2000) showed that older patients who had undergone surgery for colon cancer were less likely to receive subsequent chemotherapy. This was either because it was not offered, was refused by the patient, because of concomitant disease or because the medical staff thought the patient too old.

Negative attitudes towards elderly people among health-care professionals can result in practical differences in the management of younger and older patients.

Ageism in Parkinson's disease

Parkinson's disease is a progressive neurological disorder, which becomes increasingly prevalent with advancing age, affecting 2% of the population at 80 years and over. Non-motor manifestations such as depression, constipation and neurobehavioural problems are increasingly recognized as intrinsic features of the disease. However, in an article in the British Geriatric Society newsletter, consultant physician Doug MacMahon referred to a survey conducted by the Parkinson's Disease Society which noted that many GPs are reluctant to refer older patients with Parkinson's disease to a specialist.

Unfortunately, this is the very group in whom specialist advice is necessary to clinch the diagnosis since concurrent common morbidity may often confound the diagnosis. In addition, such patients are often treated with polypharmacy and a number of drugs such as neuroleptics may cause drug-induced parkinsonism. Other commonly used drugs may also be associated with parkinsonism in the elderly, e.g. lithium, amiodarone and sodium valproate. Some of the reluctance to refer may have stemmed from previously extended neurology waiting lists, but now many care of the elderly physicians have specific expertise and will organize multidisciplinary services to best meet the needs of these patients.

Previous guidelines have suggested the use of age as a criterion for initial treatment choice. In contrast, the recent National Institute for Health and Clinical Excellence (NICE) (2006) guidelines recognize the need for tailored drug choice taking into consideration patient and family preferences following provision of appropriate information, education and review of comorbidities, particularly cognitive and neurobehavioural problems.

For the older patient who is deemed suitable, commencement of dopamine agonist treatment has clear advantages in delaying the evolution of motor complications and dyskinesias with levodopa (Rascol et al, 2000). Traditionally this has been felt to be less applicable to older patients because of a reduced life expectancy. However, on average a 70-year-old woman has a life expectancy of 15 years and a 70-year-old man a life expectancy of 12 years. Although motor complications may be less prevalent in older Parkinson's disease patients they are still significant and treatment plans need to reflect a potential lengthy disease duration.

A survey from Huse et al (2006) demonstrated that the use of dopamine agonist therapy becomes increasingly rare with advancing age. Certainly many older patients will have concurrent comorbidity which contraindicates the use of dopamine agonists but many patients appear excluded from agonist treatment because of custom rather than tailored clinical care. This underscores the importance of specialist assessment to ensure that patients are not deprived of treatments that are useful in maintenance of quality of life and preservation of activities of daily living. Even if patients are not suitable for agonist therapy, it is reassuring for the patient and carers to know that they have been appropriately assessed by specialist services.

Information on the tolerability of dopamine agonists in the very oldest population is scant but limited trials suggest

that with judicious introduction, careful titration and regular monitoring many older patients can benefit from these agents (Shulman et al, 2000) not only as monotherapy but as adjunctive treatment.

What of younger Parkinson's disease patients? Will they be 'disenfranchised' as a result of increased focus on the elderly? We must guard against this and ensure that they have access to all appropriate treatments, particularly the benefits of a multidisciplinary specialist service as recommended in the NICE guideline. Additionally, care of the elderly physicians should champion the need for multidisciplinary services for all Parkinson's disease patients irrespective of age.

Ageism in cardiovascular disease

In cardiovascular diseases, older patients are also the most numerous. Patients over 70 years of age account for approximately 40% of all patients with acute myocardial infarction admitted to hospital (and perhaps a higher proportion of those not admitted to hospital) and 80% of deaths from acute myocardial infarction occur in those over 65 years.

With cardiovascular diseases, older patients are also under-represented in clinical trials, despite this being the leading cause of death in such patients. No patient over the age of 75 years was recruited to any of the major statin trials in the 1990s despite over 45 000 patients being recruited. It is therefore no surprise to find under-investigation and possible under-treatment of elderly patients (De Wilde et al, 2003).

But the differences are more than just prevention. Bowling et al (1999) showed that people diagnosed with cardiovascular disease are less likely to be referred for a specialist opinion or to receive cardiologist intervention with increasing age. This was not explained by the presence of co-morbidities.

Age has also been shown to be the variable most predictive in deciding the likelihood of angiography and revascularization post-myocardial infarction. And older people, more likely to have severe disease, are paradoxically more likely to be treated medically rather than surgically.

In a related area of vascular disease, but perhaps more surprisingly, it has been shown that there is substantial under-treatment with appropriate medical therapy of stroke and transient ischaemic attack in patients over 80 years (Fairhead and Rothwell, 2006).

Much of the above could be construed as ageism, although it could be argued that lack of evidence of optimum management in older people is responsible. However, the lack of evidence stems directly from low recruitment of older people into clinical trials, particularly when older people are those in whom the condition is most prevalent. More trials need to avoid age-related exclusions.

Conclusions

Ageism in medicine, as in society, exists in many forms. It encompasses attitudes, research, investigation, treatment and the end of life. This needs to be tackled from medical school to postgraduate education and in all departments, clinical and non-clinical.

Decisions must be based on the individual patient and not on their age. There is often a debate about biological *vs* chronological age, but there are no good measures of an individual's 'biological' age. Research must include patients within the older age group, which will provide some evidence for decision making. However, decisions on investigation and treatment must be individualized for each patient. It is much more difficult to follow standardized guidelines in patients who have multiple pathologies and are on numerous drug therapies. This is true for all age groups, but is more common in older patients.

We must involve older patients more in the planning of their investigations and treatment, allowing the patient to assess the risks and benefits of the various options open to them.

With better education, research, individual assessment and effective communication, older people would be less likely to suffer discrimination. This should be the goal for all of us, not least because, some day, we may be that patient. **BJHM**

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KEY POINTS

- Ageist attitudes affects the management of older patients.
- Research should include greater numbers of older patients.
- Clinical decisions should not be based on age alone.
- Older patients should be treated as individuals.