

line. Yet commitment to a more holistic approach in the understanding of cultural questions has long been a central tenet of social anthropologists who are increasingly applying their skills in the gerontological sphere to address policy-related issues. And, if we need to know how to encourage people to exercise their political rights (Twine p. 174), it seems likely that they will have pertinent suggestions.

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Medicine in Society

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N. J. Dudley and E. Burns. The influence of age on policies for admission and thrombolysis in coronary care units in the United Kingdom. *Age and Ageing*, 21 (1992), 95–98.

This paper reports a national survey of the 175 consultants in charge of coronary care units in the United Kingdom at the beginning of 1991. Coronary care units are specially equipped hospital wards staffed by cardiologists and specially trained nurses and are responsible for looking after patients admitted with heart attacks. The 24 hours after a heart attack are the most dangerous and one of the most important functions of the coronary care unit staff is to prevent a patient's heart stopping and to restart it if necessary. Of the 134 units whose consultants responded to the survey, 19% operated an admissions policy which excluded patients above a specified age. Two units had an upper age limit at 65 years, 7 at age 70, 14 at 75 and 2 at 80. Recently it has been shown that injections of a drug that dissolves clots in the arteries to the heart, so-called thrombolytic therapy, increases the survival of people who have suffered a heart attack. At present the treatment has to be given early after the attack and in a specialist unit with skilled staff and continuous electronic monitoring of the heart beat. Fifty four units (40%) operated an upper age limit for thrombolytic therapy: two at age 65, eight at 70, 22 at 75, ten at 80, ten at higher ages and two at unspecified ages.

COMMENT

In 1991 the Royal College of Physicians published a report on cardiological interventions in elderly patients which stated that, 'arguments for restricting treatment because of age alone can no longer be sustained on clinical grounds'. There is nothing to suggest that older

people benefit less than younger from the attentions of a coronary care unit and one major trial suggested that older people benefit relatively more from thrombolytic therapy than younger patients. As Dudley and Burns state, 'the age limits used by many of these units are likely to exclude large numbers of patients who could benefit from cardiac monitoring and resuscitation as well as thrombolytic treatment'. The 'benefit' in this context is survival.

This is but one in a series of publications in recent years which show that older people in the United Kingdom have poorer access to the best of modern cardiological care than do younger. There are several reasons why elderly people have in the past been offered less than the best of modern medicine. One reason, and the most respectable is the idea that older people show poorer response and experience a higher incidence of undesirable side effects. This may be true, on average, for some interventions but it has nothing to do with age. The ability to respond to therapy is determined by physiological status, and although older people are likely, on average, to have more physiological impairments than younger people, this is not true of all individuals. In the field of intensive care it has been shown that when data on physiological status of individuals are fed first into the predictive equation age contributes only 3% to the variance in outcome. People should be assessed for medical interventions on their physiological merits not on their age. To make the point, patients of lower social class have, on average, more physiological impairments than people of upper social class and consequently, on average, do less well following medical interventions, but it has not yet been suggested that treatments should be withheld from them. Nor is the economic argument that it is not cost-effective to treat older people because they have on average fewer years of life to offer in return necessarily convincing. While it might save a hospital £2,000 to deny an older person heart surgery to cure her angina it might cost the taxpayer £50,000 to provide her with nursing home care because she has too much pain to manage in her own home – where she would rather be. More fundamentally, health care is a service not a business; it is the satisfaction of the customer not the profit of the purveyor that should determine policy. After all it is the customer who has paid for the service.

One of the reasons that older people may have poorer access to specialist cardiological care is because in many districts of the United Kingdom patients over a specified age coming to hospital are consigned to geriatric rather than cardiological or other specialist departments. This has the attraction to the administrators that geriatric care is thought to be cheaper, but the origins of this arrangement lie in

restrictive practices by the medical profession; there is no evidence that older people necessarily do better in geriatric than in other specialist units. No doubt, many geriatricians are highly skilled in cardiological care, but one wonders how many older people admitted to hospital with a heart attack would opt for care in a geriatric unit rather than a cardiology department if offered a choice.

While the evidence accumulates that discrimination on the basis of age rather than physiology has no more scientific than ethical justification, 'high technology' medicine is becoming less physically challenging. 'Keyhole surgery' for gall bladder disease causes much less morbidity than the traditional operation; coronary angioplasty is less traumatic than open-heart surgery. Modern treatments are becoming increasingly suitable for the physically frail of all ages. Unless the discriminatory practices unmasked by Dudley and Burns are eradicated older people will not share in the benefits of medical progress for which their taxes have paid.

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