Discrimination of the elderly: how guilty are you?

M-J. de Boer

In the Netherlands a recent discussion on 'the right to die' and premature ending of life for people over the age of 70 has only highlighted one side of the story. The tale of a situation of bad health, depression and physical ailments, which progresses to, worst of all, a painful and loveless ending of life, has often been told and scares us literally to death. It may distract us from a far bigger and more complex problem. Old and very old people have a serious risk of not being treated properly and not receiving adequate medical care. I would like to refer to this as 'discrimination of the elderly'. For instance, I am old enough to have lived in the time when patients older than 70 were not considered to be candidates for haemodialysis, whereas nowadays they represent a very large group, living decent and satisfactory lives. Also, very old people are often not treated according to guidelines or with advanced medical technology. Hospital administrations and doctors have sometimes refused to treat very old people, because of fear for high expenses, high mortality leading to bad numbers for quality monitoring, and simply less commitment and devotion to the very old. Recently it was even suggested that elderly patients were being allowed to die in order to relieve pressures on hospital beds.¹ This is a serious threat for good clinical cardiology practice. Very old people are very special and deserve our respect and good care. Old people are more vulnerable and are less well informed or equipped to defend themselves and to be assertive, when it comes down to receiving optimal medical care. Hospitals often have an intimidating effect and an undignified approach of doctors and nursing staff towards old people is common. Awareness of these phenomena may prevent misunderstanding and improve the needs of the very old. Most randomised clinical trials (RCT) in cardiology have been conducted in patients, excluding older and very old people. Reliable data on old patients are not available and are often derived from RCT results from their younger counterparts. It may very well be that clinical results of optimal treatment of acute myocardial infarction (AMI) yield relatively more clinical benefits in the elderly. The ageing heart becomes more vulnerable to ischaemia and age itself is a risk factor for morbidity and mortality following AMI, independent from other and confounding variables.² In the ageing population, degenerative aortic valve disease is a rapidly progressive phenomenon and should be treated with surgery (with very good results) or maybe by percutaneous valve replacement (with promising results.) So, treating old people is often very rewarding but it should always be considered in relation to their age. If in doubt, in my view the secret word should be: dignity. Try to treat your old or very old patients with dignity and understanding. Listen very carefully to their often very interesting stories, take some extra time because they are often less well equipped: it takes them longer to enter your practice room, to express their feelings, to undress themselves, or to adjust their hearing aid. Take your time to check their extensive medication list, a source of much iatrogenic damage and harm. Make an extra telephone call to the GP or attending nursing home doctor to check their vital status in daily life. Do not disqualify them from high-level clinical care or interventions on the basis of their age alone.

And remember: one day you may be very old yourself. ■

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References

- 1 <http://news.bbc.co.uk/2/hi/health/711627.stm>
- 2 de Boer MJ, Ottervanger JP, Suryapranata H, et al. Old Age and outcome after primary angioplasty for acute myocardial infarction. J Am Geriatr Soc. 2010; in press.