HEART

Commentary

Cardiac surgery in the elderly

Three papers in this issue show good results for cardiac surgery in the elderly.^{1–3} These papers remove one objection to the practice of according to the elderly an equality of concern, respect, and protection in the care afforded by a public health care system, namely that such treatment is futile or the next best thing to futile.

An important question that must be settled before anything useful can be said about such surgery is the question of whether people's legitimate moral claims are age related in any way? There are three obvious ways in which it might be thought that moral claims could be age related.

One is that the strength of the claims might be thought to vary with elapsed time, that they might diminish (or increase) in proportion to the amount of lifetime an individual had experienced or "consumed".

The second concerns not lifetime lived, but lifetime in prospect. It is often thought that moral claims vary with life expectancy, in proportion to the amount of life an individual has left or (more likely) is reasonably expected to have left. This will always be related to elapsed time but may also arise through illness, injury or indeed genetic constitution.

Finally many think that moral claims are legitimately varied by quality of life considerations—for example, that people with very poor quality of life are not worth (or are worth less) the expenditure of health care resources.

It is perhaps some or all of these considerations that lie behind Rudolf Klein's recent suggestion in the *BMJ* that "it might not be too difficult to get widespread agreement that the elderly should have less priority than the young in getting lifesaving cardiac surgery".⁴ Of course the ethical issue is not what people would agree to, but what they ought to agree to.

I have for many years defended an age neutral approach to the allocation of scarce resources which may be expressed thus: So long as we each wish to live out the rest of our lives, however long that turns out to be, then if we do not deserve to die, we each suffer the same injustice if our wishes are deliberately frustrated and we are cut off prematurely.⁵

An important element of an age or life expectancy neutral position expressed in this way is that it links discrimination on the basis of elapsed lifetime, to discrimination on the basis of life expectancy. These are not of course necessarily linked. Some people have defended what might be termed a "fair innings argument", which suggests that people are entitled to every opportunity to live a fair lifespan—perhaps the traditional three score years and ten. Up to that point they have equal entitlement to health care, beyond the fair innings they are given very low priority. However, the fair innings argument has a number of defects. It assumes that the value of a life is to be measured in units of lifetime, the more the better up to a certain point but thereafter extreme discounting begins. The problem with such an approach is that people value particular events within their life disproportionately to the time required to

experience those events. Although the fair innings argument gives great importance to a life having shape and structure, these things are again not necessarily only achieved within a particular timespan. On the fair innings argument Nelson Mandela's entitlement to lifesaving care from the community was over long before he left prison. It is not only for such as Mandela that the most important part of their life might well begin after a so called "fair innings" has been achieved.

Without the vast detail of each person's life and their hopes and aspiration's within that detail, we cannot hope to do justice between lives. The only sensible alternative is, arguably, to count each life for one and none for more than one, whatever the differences in age and in other quality considerations.

It is this outlook that I believe is the only one tenable for a public health care system. It also explains why murder is always wrong, and wrong to the same degree, whatever the age of the victim. When you curtail (or decline to extend) someone's life, you take from them not only all they have but all they will ever have, it is a difference in degree so radical that it makes for a difference in the quality of the act. Those who believe in discriminating in favour of the young or against the old must believe that in so far as murder is an injustice, it is less of an injustice to murder the old than the young; it is clear that in robbing people of life you take less from them the less life expectancy they have. This is of course directly contrary to the way in which the common law tradition has viewed the wrong of ending life prematurely. As Mars Jones J has said in his judgment in a recent case: However gravely ill a man may be . . . he is entitled in our law to every hour . . . that God has granted him. That hour or hours may be the most precious and most important hours of a man's life. There may be business to transact, gifts to be given, forgiveness to be made, 101 bits of unfinished business which have to be concluded.⁶

The age indifference principle

If we try to derive from this an appropriate guiding principle, perhaps the following has some plausibility: An individual's entitlement to the concern, respect and protection of the community, as expressed in its public health care system does not vary with age or life expectancy.⁷

I believe this principle is the only one consistent with justice and with the principles that animate our public health care system.^{8,9} Acting consistently with this principle in the case of cardiac surgery in the elderly has been shown to be useful and efficient, which is certainly a bonus. But we should be clear that doing right is important even when we have to make sacrifices in terms of cost and efficiency. Although there may still be a consensus that the young should get priority in receiving lifesaving cardiac surgery, that consensus needs to be justified. I do not believe that there is any way of providing that justification consistent

with treating people as equals and with regarding human rights as applying to all, regardless of race, sex, nationality, belief, etc, and age or life expectancy.

J HARRIS

*Sir David Alliance Professor of Bioethics,
Research Director of The Centre For Social Ethics & Policy,
Humanities Building, University of Manchester,
Oxford Road, Manchester M13 9PL, UK
email: CSEP@man.ac.uk
Professor Harris is a Director of The Institute of Medicine Law and Bioethics
© John Harris 1999*

- 1 Zaidi AM, Fitzpatrick AP, Keenan DJM, *et al.* Good outcomes from cardiac surgery in the over 70s. *Heart* 1999;82:134–7.

- 2 Bouma BJ, van den Brink RBA, van der Meulen JHP, *et al.* To operate or not on elderly patients with aortic stenosis: the decision and its consequences. *Heart* 1999;82:143–8.
- 3 Gilbert T, Orr W, Banning AP. Surgery for aortic stenosis in severely symptomatic patients older than 80 years: experience in a single UK centre. *Heart* 1999;82:138–42.
- 4 Klein R. Puzzling out priorities [editorial]. *BMJ* 1998;317:959–60.
- 5 Harris J. *The value of life*. London: Routledge, 1985:89.
- 6 R v Carr. *The Sunday Times*, 30 November 1986.
- 7 Harris J. Ethical issues in geriatric medicine. In: Tallis RC, Fillit HM, Brockelhurst JC, eds. *Textbook of geriatric medicine and gerontology*, 5th ed. Edinburgh: Churchill Livingstone, 1998:1611–23.
- 8 Harris J. The rationing debate: maximising the health of the whole community. The case against: what the principal objective of the NHS should really be. *BMJ* 1997;314:669–72.
- 9 Harris J. “What is the good of health care?” *Bioethics* 1996;10:269–92.

STAMPS IN CARDIOLOGY

Foundations and institutions

The 75 peso stamp from Uruguay was issued in 1974 to commemorate the Uruguayan “Pro Cardias” Heart Foundation. It was cleverly designed adapting the map of Uruguay to form the illustration of the heart and is inscribed “protect your heart”. The 1 peso Dominican

Republic stamp was the highest value stamp (for use on airmail) in a set of three issued in 1979 to commemorate the Dominican Cardiology Institute. The institute building is shown with the stylised heart overlaid in red and blue.

M K DAVIES
A HOLLMAN