Commentary

Cardiac surgery in the elderly

Three papers in this issue show good results for cardiac surgery in the elderly.5,6,7 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”.6 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 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 wish to live out the rest of our lives, however long that turns out to be.

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.

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.

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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.

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