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ETHICAL DILEMMAS FACING THE PRACTISING GERIATRICIAN*

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A doctor's working life is full of dilemmas and controversies which persist even when medical practice is evidence- or research-based: the clinical situation is not always black or white, it is frequently grey. Personal views and attitudes, not only of the doctor but also of patients, their relatives and of society at large, make such 'grey' areas even more cloudy and complex. This is perhaps more acute in dealings with elderly patients. While the process of ageing is universal and inevitable, attitudes towards it vary widely, and it would be inappropriate to seek to set uniform and rigid social standards of practice to be applicable equally to all societies, not to base moral judgement on them.

Ian Kennedy once said that 'Medicine is too important to be left only in the hands of the Medical Profession'. Indeed, medicine has many faces and broad political, social and ethical dimensions. It is the ethical dilemmas in medicine practised in relation to the aged which this paper will identify and analyse.

With increasing ageing of the population, the impact of the frail elderly on the total health care burden is likely to increase significantly in coming years. Society at large requires to be more sensitive and responsive to their special needs. This would entail providing support to their family, aim at achieving financial independence and stability in physical and mental health.

AGEISM

Like racism and sexism, ageism is a prejudice commonly prevalent in our society, but while the victims of the first two usually campaign to counter them, the elderly, quite often, curiously perpetuate and paradoxically augment ageism. Thus common utterances from an old person may include 'it is all because of my age', 'I am old, that is why it happens to me', 'what more can I expect at my age?' Instead of society being educated in an attempt to change such attitudes, it appears to exploit such views, especially in the context of health care.

Ageism can be expressed differently. Denial of effective treatment, on the grounds of old age, is the classic example of 'primary ageism'. Flimsy excuses for treatment denial are offered. These may be overemphasis on the possible risks involved in treatment (which are certainly increased because of the age of the patient) until the elderly patient submits to 'treatment refusal'. Adequate information regarding possible options may not always be provided and this, together with inherent anxiety about other personal and social changes related to chronological age, distances the patient from the appropriate intervention. This can easily be considered as a form of tacit health care rationing.

'Secondary ageism' is collective discrimination and denial of opportunity to older people as a 'client group'. Their social status is undermined, their voice is not heard and their life is undervalued. It is not uncommon to find the budget for a hospital

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upgrading programme is exhausted just before the wards earmarked for elderly care are due to be refurbished. When there is a shortage of specialised staff, for example physiotherapists, it is the elderly care-service which is the first to have its quota reduced. How many NHS Trust or Health Authority Board Members regularly visit the elderly post-acute rehabilitation wards or understand the functioning of a geriatric day hospital?

'Tertiary ageism' occurs when professionals interested in and devoted to caring for older people are underrated by their colleagues and ignored professionally. The unexpressed feeling is that it does not matter how well-qualified or how good one is but any association and/or commitment to Geriatric Medicine, must represent 'failure' and 'incompetence'.

Ageism is learned from our own experiences and, to address it, our own private feelings about ageing and the elderly must be examined and reviewed.

HOW DOES THE CARE OF THE ELDERLY DIFFER FROM OTHER AREAS OF CARE?

Principles of medical care of the elderly are not significantly different from those which apply to any other adult age group. Even at a young age, physiological parameters vary significantly around mean values, and maturation and development proceed at variable rates from individual to individual. This applies to ageing and to the development of degenerative pathological processes. The practice of medicine and the delivery of care to the elderly needs to take these factors into account.

Most older patients presenting with a single complaint are usually dealt with by their General Practitioners and, if necessary, by an organ/system specialist. Specific complaints are thus dealt with in isolation, and often no enquiries or assessments are made about the rest of the functioning capability of the patient. A basic principle of geriatric care should, however, be a functional holistic approach: in addition to effecting a 'cure' or control of the presenting complaints, the specialist properly trained in the care of the elderly will seek a much wider assessment of function to prevent the most serious complications in old age - disability and dependency. The involvement of a specialist geriatrician in the acute phase of any illness in an elderly patient is thus extremely important. When such an approach is not made or is not available, elderly patients may accrue pathologies and problems which gradually lead to the development of a complex clinical picture and a progressively increasing level of disability and dependency.

Commonly a geriatric patient will (1) be frail, (2) have disorders of multiple systems, often with atypical presentations, (3) probably have some underlying cognitive impairment, (4) be socially isolated and deprived, (5) not have been properly assessed functionally and (6) be prescribed a large amount of medication. She - as the majority are women - resides in accommodation which, although reasonably modern and clean, will not have been designed to cater specifically for her special needs. She will have disabilities relating to mobility, eyesight and hearing, and will often suffer from some degree of pain, breathlessness, urinary incontinence, constipation and listlessness. She will also be fearful of asking for help as, if she does, she is likely to be advised to give up her own home being deemed to be unable to cope, and required to go into an institution. If she is courageous enough to ask for help, she is likely to have her worst hopes fulfilled: 'It's your age, Gran - nothing can be done to get you better. We haven't enough staff to look after you in your own home, you are at risk of falling or may even set your house on fire - you need to go into a care home'.

Although it is suggested that the elderly patient can be treated adequately by any clinician, the management of old people does require special knowledge, skill and

understanding. It is unthinkable nowadays for an ill or disabled child to be handled by nurses or Health Visitors without any specialised training and experience in child care. How often are the credentials of someone caring for an older patient, whether a nurse, social worker or even a doctor, checked as regarding their formal training, experience and qualification in the care of the elderly?

A geriatric patient needs: (1) experienced and specifically trained clinicians to disentangle the complexities of health-related problems and this requires considerable time and patience, (2) a lengthier period to respond to treatment and to recover from even a relatively minor disability of recent onset, (3) detailed planning for future care at home with appropriate services, support and respite for carers, if necessary, which also takes time, and (4) continuing supervision by properly-trained and interested professionals. It may be considered unprofessional, and perhaps even unethical, not to appreciate that there are specific and substantial differences in relation to the medical care of elderly patients; this understanding is essential to meet their special needs.

One must also remember that not all elderly people fall into this category and some can cope adequately with no additional care resources. The 'typical' elderly patient described above is the sort that is usually referred to a geriatrician for his special expertise. Medical mismanagement of an elderly patient may *per se* lead to serious long-term problems of care.

EVIDENCE-BASED MEDICINE (EBM)

As with all the practical disciplines, clinical practice is replete with fallacies which are either deeply embedded in tradition or have been influenced by prevailing fashions and fads; ideally, practice should be based on knowledge arising from research or the persistent witness of effectiveness. Difficulties faced by clinicians often reflect a dearth of research-based information with a bearing on management. Individual practice tends to be guided by a 'gut feeling', arising from the physician's own experiences. However, while the principles of medicine must be based on science, there is 'art' in the application. In this respect the doctor-patient relationship and inter-communication are important and necessary factors which influence the patients' response to treatment. Most individuals in need of clinical care, and as relatives or carers in a supporting role, expect the doctor to be a decent, caring, human being while being professionally competent.

Within geriatrics there flow currents of scepticism and concern, the main anxiety being that EBM may be used to generate guidelines which define the treatment of diseases too rigidly for practical application to the individual aged patient. Such evidence-based guidelines may provide standards and outcomes which satisfy the purchasers of health care in the short term. In the long term, they may inhibit research into treatment options and could stifle clinical practice;[2] furthermore, many of the problems a geriatrician encounters in his everyday clinical practice have never been, and probably never will be, the subject of randomised clinical trials.

Such common presentations as vague confusion, dizziness, 'funny turns', 'going-off the legs' and unsteadiness are too diffuse and have too many variables to allow focused scientific study. Furthermore, studies undertaken on selected subgroups with rigid inclusion and exclusion criteria could well result in conclusions inappropriate to extrapolate to all patients. Some studies on the aged are possible in well-defined clinical groups.[3] Evidence derived from subjects studied in general trials may not be relevant to geriatric patients, since most trials do not encompass the frail elderly.[4]

It is possible that conclusions based on trials may be used to justify unpopular

decisions reached by health purchasers suggesting a somewhat spurious shift of the responsibility.

EQUITY, ACCESS AND RATIONING OF CARE

Because of equally valid yet conflicting claims on limited resources, there is no agreed ethically satisfying principle of health-care distribution. In a state-funded system such as Britain's, health care is also inextricably linked with politics. Although clinicians working at the 'coal face' often receive the blame for the inadequacies of the service, it is politicians who have taken the decisions which influence the priorities. A level of rationing has always been practised and will always remain an integral part of the clinical decision-making process. However, the use of chronological age alone as a discriminating criterion in determining priorities, would be controversial and hazardous.

As an example consider an individual, aged 75 years, whose disability is limited to chronic heart failure with incapacitating breathlessness as a consequence of a leaky heart valve. He is referred to a cardiac centre and is refused surgery as being too old for intervention. This micro-rationing may be interpreted as the assumption that a 75-year-old does not deserve the same level of health care as a 50-year-old.

This example may be too simplistic but many elderly people do become victims of socio-political attitudes. Should age *per se* be a factor in any health care decision? One could argue against the delivery of care of equivocal, unproven or uncertain benefit to an individual of any age, but what about measures of proven value being withheld from one subset of the population? Does it not compromise one's professionalism to an extent? It has been suggested that expensive treatment should preferentially be withheld from the elderly as the so-called 'health gain' in this age group is less; after all, the older patient is no longer economically productive and has had a 'good innings' anyway.[5,6] Yet an elderly individual may happen to be the president of a country, or royal, or an eminent politician; is then the individual clinician and society at large to take a similar view? Rationing policies apply to the average elderly citizen, possibly impoverished and weak. A different set of rules would then appear to apply for those who can afford to pay for their own care and those who are unable to do so.

When 'Child B' or Laura Davies were refused treatment of unproven benefit by an NHS Trust, a massive outcry was recorded in the media. Little is heard, however, when hospitals refuse to accept patients above a certain age suffering from myocardial infarction into their CCU to enable them to receive thrombolytic therapy, though this is of proven benefit.[7] The attitude may be gradually changing: in 1994 the case was publicised of a 73-year-old who was refused physiotherapy, and more recently, when a London Hospital Accident and Emergency Department closed its doors to all over 75, on the basis of rationalisation of emergency services. Various nationally-conducted surveys have demonstrated significant problems of access by older and frailer patients to services such as chemotherapy for malignant disease, renal replacement therapy, and surgical treatment of cardiac disease, ischaemic and valvular.

A report published in 1991 by the Royal College of Physicians of London identified a general inequity in the provision of both non-invasive and invasive diagnostic and therapeutic cardiological services to older people, and recommended better access with a view to improving their health and overall quality of life.[8] Although this report has been widely studied, it has failed to influence and change the routine practice of cardiology or cardiac surgery.[9] Twenty-three per cent of cardiologists in a survey admitted that, against the background of inadequate resources, patients above 65 years, even if suitable for and likely to benefit from surgery, would be rated as a low priority.

Encouragingly, between 1988 and 1993 there has been some increase in the number of invasive cardiac procedures, for example CABG, angioplasty and valve replacement, especially among the 65-74 age group.[9]

The situation with bronchial carcinoma is similar. A recent study[10] from Liverpool revealed that of all the elderly patients with a chest X-ray diagnosis of neoplasm, only nine per cent were referred to oncologists and two per cent to radiotherapists: none, ultimately, received any treatment. The British Thoracic Society has admitted major deficiencies and some inequities in existing lung cancer services for older patients, in particular a failure of early diagnosis and lack of provision of adequate and appropriate treatment of proven value.[11]

The attempts to achieve better value for money, to extract more from available resources and to become more efficient, lead to measures for the reduction of wastage and the termination of activities of proven ineffectiveness.[12] Ironically, the government is not providing enough resources to deliver and implement care measures which have been proven to be effective. Methods of reconsidering or rationing care provision, involving deference, delay, dilution and discharge, are becoming more overt and are disadvantaging the elderly more than any other client group.[13]

The cost-effectiveness of any intervention for health gain can be measured in terms of useful life, expressed as Quality Adjusted Life Years (QALY).[14,15] Rigid application of this measurement denigrates equity and fairness, and leads medicine to a formula-based practice.[16] If one considers other suggestions, such as treating only those who are most ill, or treating only when intervention will produce long-term gain, one finds that the practice of medicine becomes riddled with dilemmas. In the case of the elderly, perhaps the maximum benefit which can be defined is the attainment of a useful independent life of reasonable quality. Treating only the most seriously ill and denying treatment to those where intervention is unlikely to be of maximum long-term gain could, for the elderly, restrict management to only critical illness and emergencies which may have no intrinsic lasting benefit. While discrimination on racial grounds is strictly illegal, age discrimination in health care delivery is not and exists despite the official position and peer group guidelines.[18]

If some kind of health-rationing is necessary, it should be done with caution, and as explicitly and as transparently as possible.[19] In the United Kingdom, there can be no valid justification for rationing purely on financial grounds as this country is one of the lowest spenders on health care among the industrialised developed nations. But health care is inadequately funded because we, through our elected politicians, make this choice.

THE DILEMMAS AND PRESSURES INDUCED BY RECENT CHANGES

A market approach to health care encourages quick turnover of patients, and in many instances this is attainable. Day surgery, for example, has been a success for many easily treatable conditions. Unfortunately, this approach cannot be applied to all circumstances, particularly to the frail elderly. In the current climate, doctors prevailed upon to complete treatment within a target number of days of hospital stay, and clinicians keeping patients in for longer periods may be considered incompetent or weak. The victims at greater risk of such target practice are the elderly who often have concurrent complex socio-medical problems and multiple pathologies. I consider it grossly unethical to push an 80-year-old frail patient from one ward to another, three or four times during a short stay in hospital, and then to discharge her before her condition becomes stable. Such thoughtless turnover has the potential to produce either some disaster at home or an early re-admission.

The distinction between 'providers' and 'purchasers' was put forward to improve health-care delivery on the basis of health needs and health gain. Although such principles are laudable in application, the whole procedure has become a mere financial exercise. Care in the community makes sense, but what may not always be appreciated is that good quality care in a patient's own home does need at least the same amount of resourcing as hospital care, if not more. A good fundamental principle of care is being impeded by financial stringency and bureaucratic dogma, and many older persons are denied much-needed specialist care, which is unfair and unethical. The fund-holding general practitioner purchaser system has benefited some elderly patients in need of specific procedures, e.g. hip surgery, cataract extraction, but fast-tracking particular groups of patients raises ethical issues. Unscrupulous fund-holders might abuse the free emergency services offered for elderly patients, instead of arranging an earlier referral to the Outpatient Clinic or the Day Hospital in order to avoid the charges.

The emergency attendance/admission rates in our hospitals are steadily increasing and the increase is proportionally higher for the elderly. It is unethical to let an emergency situation arise in an elderly individual when an earlier, more appropriate intervention might have prevented it. Furthermore, subsequent to such an admission, the elderly patient does not always receive the full range of multi-disciplinary assessment and rehabilitation. Ever-increasing integration of single-organ specialties with General Medicine is marginalising rehabilitation.[20] The special approach of Geriatric Care is gradually losing its identity and threatens to compromise the care of the elderly which cannot be ethical.

The structure of the health care system critically affects the professional ethics of those working within it. The commercial market is a far more serious threat to ethical behaviour than the differences in the personal ethics of individual health professionals.[21]

PRACTICAL CLINICAL DILEMMAS

The key objectives of Geriatric Medicine are relief of suffering and avoidance of dependence; these are interlinked and crucial for a good quality of life. While 'cure' is more beneficial and cost-effective than care, a balance has to be struck between a purely therapeutic approach and a palliative one. In most instances a frail elderly patient will have a combination of problems, some of which will benefit from well-established therapeutic intervention, while others will warrant wider supportive prosthetic measures. Unfortunately, the eventual outcomes in each individual patient cannot always be anticipated. The clinical approach, therefore, will remain full of uncertainties and consequently subject to dilemmas, controversies and ethical conflicts. When failure to take measures will result in death with pain and suffering, and as quality of life cannot be any lower than actual culmination of life, perhaps it would be more ethical to proceed with the measures and accept anticipated risks.

From the point of view of everyday practice, two questions highlight the clinical dilemma and the ethical implications:

1. How far should the clinician proceed with investigations to obtain a correct diagnosis?
2. How should medical treatment/intervention be pursued in an apparently irreversible situation?

In any clinical situation, a correct diagnosis is essential. The options for various forms of care, whether medical or social, can only be discussed sensibly and decided upon and the prognosis can only be fully explored and its implications considered when the

diagnosis is ascertained. Frequently both patient and relatives wish to know the diagnosis and to express a view on any possible treatment. The special difficulties with the elderly are (1) the concomitant presence of multiple disorders, each of which may warrant different (2) the limited ability to tolerate invasive diagnostic procedures which may be a necessary pre-requisite to achieving a diagnosis.

Measures to alleviate suffering and to relieve symptoms must not be withheld; for example, the amputation of a severely painful gangrenous limb even if the ultimate life gain is likely to be very modest.

Table 1 sets out relatively common situations faced by a practising clinician treating the elderly in which there are no easy, universally-agreed solutions. One needs to ponder and discuss these situations with departmental colleagues; the discussion may have to be widened to involve the patient himself or a close relative or carer. It is also known that irrespective of the outcome and subsequent quality of life, the intricacies of the procedure itself and the existing health status of the individual, nearly three quarters of elderly patients awaiting discharge from hospital wards wish to be resuscitated 'just to live'.[22] The dilemma, therefore, is to whether there should also be a third key objective of Medicine in Old Age, i.e. avoidance of death or preservation of life.

Sometimes individuals wish to live a bit longer for a specific reason. A 99-year-old patient, decrepit and with advanced disability, may wish to score a century and receive a telegram from Her Majesty the Queen - her life's ambition. An 85-year-old riddled with disseminated malignancy and terminally ill, may have an intense desire to see a great grandchild due to be born in a few months' time.

The various ethical and moral dimensions of the 'Do not resuscitate' policy have been a subject of debate for a long time. Such debates usually generate guidelines but individual clinicians will always remain responsible for their actions; guidance may help, providing an agreed peer-reviewed framework to work on, but each patient and every situation must be handled with utmost sensitivity in the light of the prevailing individual factors, the respective background and the wishes of the patient.

In a complex disorder without a clear-cut established diagnosis, when it is felt that any further investigation is unlikely to provide any answer, an autopsy may be the only way to arrive at the diagnosis. The rate of routine autopsy examination in the United Kingdom is much lower than that in the United States and even the dead elderly are discriminated against as a clinical irrelevance. At the same time, it would be equally wrong to undertake intimidatory measures just to squeeze out consent to an autopsy examination from a bereaved relative.

LONG-TERM CARE

Older people differ from the younger section of the community in two main respects: they receive a pension from the State and a greater proportion of them are chronically sick and disabled, thus needing long-term care; both represent fiscal costs which are substantial: the increasing number of the very dependent elderly and the concurrent reduction in the younger population in employment has contributed to the major socio-economic challenge faced by the health service. Clinicians can do little about the burden of pension costs; this is a matter for experts in Social Welfare and economists. In relation to the burden of long-term care, health care professionals do have a responsibility: it is not only financially and socially unsound, but professionally and ethically wrong to prescribe inappropriate long-term care or even indirectly to condone it. If health authorities decide not to purchase any long-term care, it may be to their initial financial advantage. This would soon be outweighed by the enormous cost

TABLE 1
Other dilemmas with ethical implications.

SITUATIONS	POSSIBLE REASONS	POSSIBLE ETHICAL IMPLICATION
Delayed referral.	• Patient did not report. • Relatives did not bother. • GP did not consider it relevant. • GP felt he could personally manage the patient's complaint.	• Is there an overall education problem here? • Is it ageism? • Is it rationing?
Referred to the wrong department.	• GP did not think otherwise. • Neither patient or GP wanted to involve a geriatrician.	• Lack of knowledge in the management of an elderly patient. • Tertiary ageism.
Patient refuses investigation for a correct diagnosis.	• Scared of invasive and painful procedure. • Thinks diagnosis is unnecessary as nothing more can be done at that age.	• Lack of explanation with the assumption that the elderly patient will not understand.
Patient refuses treatment.	• Nature (invasive?) of treatment. • Poor motivation/depression. • Lack of understanding.	• Lack of explanation • Recognition and treatment of depression. • Is it proper to let a patient suffer or deteriorate when safe and effective methods of treatment are available? • Is it right to go against a patient's wishes?
Patient wishes to return home too early.	• Unhappy/dissatisfied with treatment. • Misses own environment. • Lack of insight into own illness disability.	• Is it proper to let a patient return to an unsafe environment or situation? • Is it right to go against a patient's wishes?
Refusal by other specialists to accept the patient for other procedures.	• Risk outweighs benefit. • Chances of minimal improvement only. • Lack of courage/competence.	• Do you tell the patient about this refusal? • Lack of understanding of the problem/primary ageism. • Rationing of care.
Refusal by patient/ relatives of rehabilitation.	• Lack of motivation. • Fear of living alone or becoming independent resulting in withdrawal of support services.	• Poor communication. • Waste of resource in provision of unnecessary institutional care.
Intervention in terminal situation. (Patient/relatives refusal).	• Lack of understanding that symptom-control does not prolong life.	• Is it right to let someone suffer?
Relatives do not want the patient to know the diagnosis of a fatal condition, yet patient wants to know.	• Fear of ill-effects and anxiety.	• Lack of knowledge about one's own illness may cause more anxiety - is it right to let the patient suffer that way? • Is it right to go against a patient's wishes?

imposed on the Social Services and other stake-holders, including the patients and their families. It is unethical to 'sentence' an elderly individual to long-term institutional care, no matter how apparently good the physical facilities are in such establishments, when the real need of the patient is related to their health, i.e. a correct diagnosis and appropriate restorative intervention. It is unethical for an elderly individual to be placed in institutional long-term care without exploring to the fullest the rehabilitation outcome possibilities. A significant number of nursing home residents are inappropriately located therein as their genuine needs can only be met by specialist medical care.[23] Furthermore, should all patients in this category, even after being vetted by multi-disciplinary and specialist medical teams, be looked after entirely by non-specialist staff in the independent sector? While most of these patients can be looked after most of the time entirely adequately in this way, there will always be a hard core of very disabled patients with complex needs who require regular specialised medical or nursing input. The HSG(95)8[24] has defined the position with firm recommendations that a proportion of long-term care should be purchased from Health Service providers with specialist medical knowledge in the field. Regular specialist supervision and input would still be required concurrently for a number of patients cared for in the independent sector on a longer-term basis. It is hoped that such an input would at least rectify some of the present clinical inadequacies, e.g. inappropriate prescribing of medication to the residents. One recent study from Scotland has shown that as many as 88 per cent of the prescribed drugs in residential care homes could be considered inappropriate.[25]

The dilemma here is how a specialist in the field employed by the NHS can remain involved in the care of patients within the independent sector. Should geriatricians and psycho-geriatricians have a regular role here? The practice of Geriatric Medicine is a continuum of seamless service, commencing with acute care, going right through to the end. Is it ethical, therefore, to abandon our most dependent and vulnerable patients partway through, with crisis intervention only on an intermittent basis? We need to address this urgently within the profession.

ADVANCE DIRECTIVES

A further dimension to medical ethics faced by practising clinicians respects the treatment of patients who are unable to make decisions or participate in the decision-making process. Individuals are entitled to compile an instruction-directive written before any such unfortunate situation befalls them. It is on the strength of such instruction that any medical intervention intended to sustain and/or to prolong life can be withheld or withdrawn, provided the declarant (the patient) has no longer the mental capacity to make and communicate a treatment decision and is terminally ill or permanently unconscious.

Such 'advance directives' (or living wills) were developed in North America. In Britain there is as yet little reported evidence of their routine application in clinical practice. It is presumed that any such advance directive on one's individual future care continues to represent the wishes of the individual, unless this is revoked formally. No legal requirement for expert certification of mental capacity is needed at the time of the writing of an advance directive, and there is no safeguard to ensure the lack of any possible coercive measures against the subject. The application of an advance directive, if in existence, should be made with caution only after fullest possible consultation with the next of kin. Growing concern exists amongst some clinicians that these directives, drawn up perhaps without careful consideration of all factors, possibly at a

much earlier, active and healthier stage of life, might be made legally binding by the State with a view to saving money by the withdrawal of treatment to individuals whose lives are deemed irrelevant and wasteful. Subsequently, the directive could act against the best interest of the patient. [26]

To counter such possibility, the Terrence Higgins Trust (a UK AIDS patients' support group) has drawn up its own guideline with the option that 'the declarant be kept alive for as long as reasonably possible using whatever forms of medical treatment are available'. The United Kingdom Law Commission, whilst accepting the principles of advance directives, clearly wish to retain the provision of basic care, such as nutrition and hydration, despite any directive on withdrawal of specific treatment.[27]

The pragmatic approach should perhaps remain somewhere in between. Some form of earlier written instruction by the patient may be regarded as extremely helpful as a guideline to the clinician and to the relatives in making the correct decision in such difficult circumstances.[28]

NEED FOR TRAINING AND RESEARCH IN ELDERLY CARE

The recent changes in specialist training programmes *(Calman)* provide an opportunity for better quality training for junior doctors. The Royal Colleges of Physicians and the Post-Graduate Deans are expected to ensure that the prescribed curricula are adhered to with regular appraisals and rectifying actions. Henceforth in Britain, only a properly trained doctor will be acceptable as a specialist in Old Age Medicine, which has hitherto not been the case. Some concern is still expressed about the training of SHOs in Geriatric Medicine - the emergency workload is overwhelming and in many instances compromising their training in Elderly Medicine, especially in rehabilitation and continuing care.

Research into topics relevant to the practice of Elderly Medicine, such as age-related disorders, parmacokinetics, delivery of care and so on, are essential to modern day practice; these applications tend to lose out in funding bids as there still exists a widespread ambivalence towards research on the afflictions of later life.[29] Some may also consider that the use of the elderly as research subjects is 'cruel'. It is somewhat disheartening and paradoxical that whilst the practice of medicine as a whole is being encouraged to be based on research evidence, little enthusiasm exists for furthering the knowledge-base in the medicine of old age. Not to advance knowledge is as unethical as not to provide an effective service.

CONCLUSION

The increasing number of elderly people with complex problems at different stages of illness will lead to debatable issues, ethical concerns and dilemmas. The elderly of tomorrow are likely to be much better informed of their rights, and they will expect and demand a greater participation in the medical decision-making process that affects them personally. Whether this will increase or minimise the burdens of clinical dilemmas is uncertain.

Irrespective of what the future holds, as part of their training every clinician should be fully exposed to discussions on ethical controversies. Ethical views will always reflect the clinician's own personal values, beliefs and upbringing. Regular nurturing of these by participation in intelligent well-informed exchange of opinions and debates would make a good doctor a better one.

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