Struck by cancer, killed by ageism

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Care of elderly cancer patients has improved over recent years; however, younger patients in Europe still survive longer than more elderly patients, and the difference cannot be accounted for by the higher likelihood of dying from all causes as you get older. Evidence suggests that there are a number of reasons why older people with cancer fare worse than their younger counterparts.

A recent study has shown that elderly patients are more likely to have their cancer diagnosed as an emergency, which compromises their chances of surviving. A variety of studies have demonstrated that, after controlling for patient choice, co-morbid conditions and pathological and biological factors, older patients are less likely to receive appropriate treatment than younger patients.

The worry is that clinical decisions are still being made on the basis of a patient's age, leading to significant under-treatment. Such decisions are often underpinned by ageist attitudes and stereotyping of older people. A survey of 155 British oncologists, cancer nurses and GPs, carried out late last year by the cancer charity Macmillan Cancer Support, showed that discriminatory practices persist. Nearly half the respondents indicated that they had been involved with a cancer patient who had been refused treatment because of their age.

In a sign that policy makers are beginning to recognise how serious this problem is, the UK Department of Health, together with Macmillan Cancer Support, have just published a joint report on cancer in the elderly. It noted that older people are becoming increasingly heterogeneous in terms of their life expectancy, their physical and mental well-being and their willingness to undergo aggressive cancer treatments, and it argued that treatment decisions should be based on an objective assessment of the patient's preferences, condition and circumstances, not on assumptions.

The report presents a series of recommendations, key among which are: we must act now because not acting will cost more money in the long term; cancer specialists and elderly care specialists must engage more effectively with one another in planning and delivering cancer services; treatment decisions must be tailored to individual patients using proven assessment methods that differentiate frail from fit elderly patients; and multi-agency working is essential to ensure that the needs of patients with more complex problems are effectively addressed.

Implementing these recommendations, not just in the UK, but all over Europe, could significantly improve the quality of care for many elderly patients. We also need to address the problem of late diagnosis: why are so many elderly patients being diagnosed in an emergency setting and what can we do about it? Discrimination has no place in modern cancer care and determined efforts are required to ensure that age is not a barrier to accessing high-quality diagnosis and treatment. ■