In quest of justice? Clinical prioritisation in healthcare for the aged

R Pedersen,[1] P Nortvedt,[1] M Nordhaug,[1] Å Slettebø,[2] K H Grøthe,[3] M Kirkevold,[4] B S Brinchmann,[5] B Andersen[5]

[1] Department of General Practice and Community Medicine, Section for Medical Ethics, University of Oslo, Oslo, Norway; [2] Department of General Practice and Community Medicine, Section for Medical Ethics, University of Oslo and Faculty of Nursing, Oslo University College, Oslo, Norway; [3] Department of General Practice and Community Medicine, Section for Medical Ethics, University of Oslo and Faculty of Nursing Education, Akershus University College, Oslo, Norway; [4] Institute of Nursing and Health Sciences, University of Oslo, Oslo, Norway; [5] School of Professional Studies, Bodø University College, Bodø, Norway

Correspondence to:
R Pedersen, Department of General Practice and Community Medicine, Section for Medical Ethics, University of Oslo, PO Box 1130 Blindern, NO-0318 Oslo, Norway; reidar.pedersen@medisin.uio.no

Received 7 August 2006
Revised 9 January 2007
Accepted 31 January 2007

ABSTRACT

Background: A fair distribution of healthcare services for older patients is an important challenge, but qualitative research exploring clinicians' consideration in daily clinical prioritisation in healthcare services for the aged is scarce.

Objectives: To explore what kind of criteria, values, and other relevant considerations are important in clinical prioritisations in healthcare services for older patients.

Design: A semi-structured interview-guide was used to interview 45 clinicians working with older patients. The interviews were analysed qualitatively using hermeneutical content analysis and template organising style.

Participants: 20 physicians and 25 nurses working in public hospitals and nursing homes in different parts of Norway.

Results and interpretations: Important dilemmas relate to under-provision of community care and comprehensive approaches, and over-utilisation of certain specialised services. Overt ageism is generally not reported, but the healthcare services for the aged seem to be inadequate due to more subtle processes, for example, dominating considerations and ideals and operating conditions that do not pay sufficient attention to older patients' needs and considerations of justice. Clinical prioritisations are described as being dominated by adapting traditional biomedical approaches to the operating conditions. Many of the clinicians indicate that there is a potential for improving end of life decisions and for reducing exaggerated use of life-prolonging treatment and hospitalisations.

Conclusion: The interviews in this study indicate that considerations of justice and patients' perspectives should be given more attention to strike a balance between specialised medical approaches and more general and comprehensive approaches in healthcare services for older patients.

The improvement of public healthcare services for older patients has been heavily emphasised in Norwegian healthcare politics and by healthcare professionals' organisations for over a decade. However, inadequate healthcare services for the aged are still frequently reported and the challenges seem to be greater in community healthcare services than in hospital care services.[1] With a growing elderly population, limited healthcare budgets, and more expensive medical interventions, a fair distribution of healthcare services and just prioritisations are important challenges.

Prioritisations occur at all levels of healthcare and are common and complex phenomena which are not easily defined or demarcated. In general, prioritisations can be described as more or less conscious decisions to give some task or person priority. Prioritisations within healthcare may lead to postponed, reduced or shortened services for other patients, but may still be legitimate due to the need to distribute limited resources—for example, budgets, time, manpower, or competence—in a fair way. However, such a legitimatisation presupposes that the prioritisations result in a fairer allocation of available resources, and that the stakeholders reach some kind of agreement of what constitute a fair or just allocation.

According to the Norwegian law of patients' rights every citizen has an equal right to healthcare services independent of the citizen's age, gender, and residence.[2] At the same time, the national guidelines for healthcare prioritisation in Norway assert that chronological age, if influencing the effect or risk involved in the medical treatment, could be a legitimate criterion.[3]

Earlier research indicates that old age may have more influence over clinical prioritisations than is legitimate, taking older patients' level of co-morbidity and potential risks into account.[4–9] Reports of overt ageism are rare, but many articles indicate covert ageism.[7 10–13] Quite a few studies explore attitudes on age as a criterion for healthcare rationing when confronted with hypothetical situations and scenarios. For example, a Finnish study shows that the proportion of physicians willing to refer the patients to surgery was inversely related to the patient's age, even when there were no purely medical contraindications. However, comorbidity, patients' lifestyle, and institutionalisation had even greater effect on referrals than age.[6] In a European study 70% of the physicians answered that they were more likely to refrain from using expensive interventions if the patient was over age 85.[14] In a Dutch study, half of the physicians interviewed wanted to use expensive life-prolonging treatment primarily to save the life of people younger than 75 years. Two thirds of the oncologists interviewed agreed on this, while two thirds of the nursing home physicians disagreed.[15] Other studies have explored the inclusion or exclusion of older patients in different kinds of healthcare services. Within cardiology it is reported that older people are less likely to be offered thrombolytical treatment and angiography.[7] Another study concluded that transient ischaemic attack and minor stroke in older patients are underinvestigated, something which results in undertreatment.[16] In Norway, older patients suffering from stroke are reported to be less likely to be admitted to stroke units and rehabilitation units than younger patients, although there is no difference in medical benefit from medical

rehabilitation between younger and older patients.[13] Furthermore, older people are more often excluded from clinical research considering medical treatment and investigation.[13] A review of treatment and investigation of cancer concluded that older patients are more likely to be offered medical treatment of lower quality, which can only partly be explained by increased comorbidity.[9] In a cohort study of about 9000 patients in the USA, older age was found to be associated with higher rates of withholding life-sustaining treatments such as ventilator, surgery, and dialysis.[17] One recent editorial stated that whenever a clinical stone is turned over, ageism is revealed.[18]

However, there is scarce qualitative research addressing the considerations that dominate clinicians' daily clinical prioritisation in healthcare services for older patients. This paper attempts to fill some of this gap.

METHOD

The present study is a part of a larger study—consisting of a qualitative part and a quantitative part—of clinical prioritisation in healthcare services for older patients. The quantitative sub-study (a survey) is presented elsewhere.[1]

In the qualitative part 20 physicians and 25 nurses from different wards were interviewed during spring 2005. The wards represented were dialysis and renal medicine (nine interviews), internal medicine (11 interviews), surgery wards—predominantly orthopaedics (12 interviews) and nursing homes (13 interviews). There were 15 male and five female physicians, and two male and 23 female nurses, working in the east, west or northern part of Norway. The physicians were aged 32–63 with 3–35 experience as physicians, with a median of 19 years. The nurses were aged 26–59 with 1–34 years experience as nurses, with a median of 12 years. All informants were interviewed once (approximately one hour). The interviews were taped and transcribed verbatim.

The semi-structured interview-guide that was used started with an open question inviting the informants to describe prioritisation dilemmas in their clinical work with older patients. Furthermore, the interview-guide focused on what kind of criteria, values, and other relevant considerations, that were important when making clinical prioritisations. In the end we asked how the interviewees documented prioritisation decisions and who participated in the decision making process when deciding on prioritisation dilemmas. Key terms in the interview guide—for example, ''old'', ''prioritisations'' and ''dilemmas''—were not predefined, allowing the interviewees to answer what they believed to be relevant without demanding a strict use of terminology.

The study was permitted through the Norwegian Social Science Data Services after reviewing the recruitment, information, consent, data sampling and data storage procedures. The informants were healthcare personnel, thus the study was not within the mandate of the Norwegian Regional Ethics Committees.

Analysis

Data were analysed qualitatively using hermeneutical content analysis and template organising style.[19 20] As a result of the first readings an analysis guide with the most central themes in the interviews was developed by the research group. The analysis guide was used to condensate and to structure the findings. In addition, the interviews were analysed using predefined templates, that is, three criterias developed for priority setting in Norwegian healthcare, seriousness, utility and cost-effectiveness,[3] and four common medical ethics principles, respect for patient autonomy, beneficence, nonmaleficence, and justice.[21]

This paper presents an overview of the dominating considerations and values in clinical prioritisation in healthcare services for older patients reported by the 45 interviewees and display relevant differences and similarities across the wards included. Other articles will explore other themes that emerged in the interviews.

RESULTS

In this section, after giving a short presentation of common prioritisation dilemmas reported in this study, we present the dominating professional considerations and values, then the template analysis, and finally, economic considerations and operating conditions.

Prioritisation dilemmas related to withholding or withdrawing life-prolonging treatment were frequently described, and many interviewees were concerned about the overuse of life-prolonging treatment and the dilemmas related to avoid meaningless treatment.

> *Nurse (internal medicine)*: …we have had many examples of them [the older patients] being treated into death … until they lie there and die with the antibiotics in their hand … we see a tendency towards … over-treating … older patients, often dying patients.

Most interviewees reported prioritisation dilemmas arising due to the operating conditions (see below: Economic considerations and operating conditions). Many of the interviewed nurses and physicians regarded comprehensive care, general medical approaches, and clinical communication as some of the most important in healthcare services for the aged. However, many reported an under-provision of such services, mainly due to the operating conditions. Among the interviewees working in hospitals it was generally stated that all patients who need admission, regardless of age, are admitted, and that they do not have to select which patients are to be given a treatment when indicated. In contrast, the nursing home interviewees frequently described that the number of patients in need exceed the number of beds available in the nursing homes. Both hospital interviewees and nursing home interviewees believed that the greatest lack of resources and competency is found within the nursing homes and community care, and that this can also contribute to exaggerated use of specialised services and hospitalisation.

Dominating professional considerations and values in clinical prioritisations in healthcare for the aged

In general the interviewees in this study described clinical prioritisations as medical decision making within the given operating conditions, rather than resource allocation based on explicit criteria for priority setting. Often, there were no clear distinctions between scientific and moral criteria, but in general the focus was on medico-scientific considerations rather than moral considerations. Furthermore, both physicians and nurses generally described that medical services are given highest priority in their work.

Professional considerations and values frequently mentioned in the interviews are given in box 1.

Also, more subjective or contextual aspects were emphasised by most of the interviewees—for example, degree of pain or other symptoms, the patient's coping and mental abilities, lack of competence in the nursing home, staff available, professional competency and interests, keeping the patient alive for the relatives to arrive from a journey, discomfort due to transport

Box 1: Frequently mentioned professional considerations and values

- Avoiding meaningless or exaggerated treatment, especially when patients are terminal.
- Dignified death - when patients become terminal, they are generally given high priority, for example, single room, time for communication with patient and relatives, palliation and continuous care.
- The most acute and serious conditions and those patients with greatest needs, are generally given highest priority, rather than—for example, prevention, screening, regular check-ups and quality assurance.
- Medical indications; for example, diagnosis and seriousness of the condition, prognosis and effect of treatment and care (eg, life-prolonging or improving quality of life), potential for rehabilitation.
- Medical contraindications; for example, co-morbidity (eg, heart disease or far gone cancer), risks (eg, possible complications and side-effects).
- The patients' general functional abilities (eg, to assess the patient's needs and potentials).

and hospitalisation, or lack of adequate hospital care for old and frail patients:

> *Physician (nursing home)*: As a point of departure we investigate and treat what we can inside here [in the nursing home]. As a point of departure we don't want to hospitalise any patient. Then you get the question, why is that? One thing is that the elderly easily get confused when they have to change place of living for some days, secondly the elderly are more susceptible to hospital infections. Furthermore, they often return with bedsores….

Many nurses reported that the patients with the most extensive care needs have to wait until the "easier" patients have been given their care. This often results in more patients getting out of their bed early, but the frailest, older patients are often stuck in their beds until late in the morning, or even most of the day during the weekends.

Life-prolonging treatment is often given to be on the safe side, or in cases of clinical uncertainty. Many physicians reported that they prefer to attempt active treatment, and then possibly withdraw the treatment, since it is more difficult to estimate the effect of the treatment in advance.

Mental impairment

Severe cognitive impairment, was reported by some interviewees, as making it less difficult to withhold or withdraw life-prolonging treatment. Some nursing home interviewees said that it is more difficult to get a patient admitted to the hospital if the patient suffers from dementia. Many interviewees, both in hospitals and nursing homes, stated that moderate or severe mental impairment in older patients is a relative or absolute contraindication—for example, for long-duration dialysis—due to lack of cooperating abilities. However, to what degree cognitive impairment influences clinical prioritisations seems to vary. While some stated that this warrants that the healthcare professionals unilaterally withhold treatment, others stated that cognitive impairment necessitates a more thorough assessment of the treatment indication, closer collaboration with relatives and more extensive support and follow-up if treatment is given. These variations were also present among interviewees working in the same type of clinical ward.

Old age as a criterion

Most interviewees defined patients above 70–75 years as old, while some described 65 or 80 years as an appropriate limit to describe the patient as old. Age was generally not reported as a relevant consideration when making clinical prioritisation, but some interviewees did mention that children are generally given higher priority. It was sometimes specified that symptomatic treatment is never held back because of old age. Some reported that one may give in earlier when the patients are old and frail, or that with very old patients one is more reluctant to start extensive investigations, surgery, or life-prolonging treatment, or that such treatment requires more extensive evaluations before starting if the patient is old. Some nursing home interviewees reported that referral to specialist services is more difficult for older patients, especially if the patient lives in a nursing home. A hospital physician admitted that operating conditions and work pressure often make one think that nursing home patients should not have been treated in the hospital. Furthermore, long travel distances to hospitals and lack of adjustments to older patients' needs in the hospital wards, make the nursing home interviewees more reluctant to refer the patients. Another challenge reported by some nursing home nurses, is to get a medical assessment and sometimes the doctor on call does not know the patient and initiates exaggerated treatment regimes.

Many reported that it is easier now than ever before to get older patients admitted to specialised hospital treatment, and sometimes too easy:

> *Physician (dialysis)*: When I began working it was extremely difficult, for example, to get [an older patient] admitted to the hospital … and I feel that this has changed to the almost diametric opposite, and I feel that we practically have a kind of open door policy … in the hospitals … I generally think this is positive. I react sometimes, when patients who have been lying in nursing homes for years are being transferred from the nursing home to hospitals if they get pneumonia, for instance. Because then I think that they may have been better off in the nursing home, and that maybe it was time to ship the oars. But that is not put into practice, because it is very often a doctor on duty who comes and sees the patient and who doesn't know them, and then they are referred to the hospital.

Some hospital interviewees stated that overuse of healthcare services is a greater problem than down-prioritising.

The templates

Norwegian prioritisation criteria: Seriousness, utility and cost-effectiveness

Utility and seriousness were mentioned by many interviewees, but in general to assess the need of the particular patient, rather than to distribute limited resources in a fair way. The two criteria are used to assess individual needs in line with a traditional clinician-patient relationship shielded from any third party, rather than to prioritise the need of an individual patient in a context that also includes other patients' needs. Cost-effectiveness was rarely mentioned as a relevant consideration (see below; Economic considerations and operating conditions). However, there were some exceptions. Some physicians, the

orthopaedics and a few nephrologists, reported use of systematic evaluations of utility and cost-effectiveness—to be able to use the cheapest intervention when the different alternative interventions are equally effective (eg, to compare different types of prosthesis or peritoneal dialysis versus hemo-dialysis). None of the interviews indicated that the development and partial implementation of the three criteria for prioritisations in the Norwegian healthcare services has made healthcare services for the aged more fairly distributed.

The principle of justice

Many of the interviewees believed that the healthcare services for older patients are not fairly allocated and distributed, but the principle of justice is by and large not reported as a relevant consideration in the clinical prioritisation processes described. Rather, some physicians conveyed rather narrow-minded ideals—for example, that one's duty as a physician is to fight for one's own patients and another physician stated that no professional would admit having too many resources available in their work. One physician mentioned that such ideals may work in combination with "strong" administrators or politicians making up for the clinicians' narrow focus, but added that administrators with such strength are non-existent.

The principles of beneficence and non-malificience

Interpreting the interviews from a principled medical ethics framework, the interviewees in general seem to emphasise beneficence and non-malificience, and use their professional judgment to assess what is in the best interest of the patient within the given operating conditions.

> *Nurse (dialysis)*: I do try to consult with the patient as far as possible … but sometimes one has to act counter to the patient's wishes, but we do try to explain that if we don't do that then *that* [ie death] can happen … so it may get even worse, and most [patients] probably understand that, even if they don't want to understand it …. And another thing is that they phone us and are ill and don't want to come, but they have to come, so it is likely that some may feel that there is a bit of coercion, that they have to come—and that they must; it may be that they have become so ill precisely because they did not come for dialysis.

Patient autonomy and persistent relatives

Respect for patient autonomy was mentioned as important by many interviewees. The interviewees in this study were generally conscious that many problems could be avoided if communication is given priority. However, time for communicating with patients and relatives were generally described as scarce, and it was reported that scarce communication makes it more difficult to know the needs of the patients, especially if they are cognitively impaired. Some interviewees reported that lack of time causes insufficient communication about end of life decisions and that this sometimes leads to conflicts or overuse of life-prolonging treatment:

> Physician (internal medicine): We just recently had, it was last week, a lady who was not that old, who had a … far gone … cancer … I didn't know her from before and I didn't have time to get to know her either because she got a [cardiac] arrest and she was resuscitated … something which she perhaps shouldn't have been. But none had talked with her about such matters … one had not had the time to get to know her … go in and get a feeling with her, something which resulted in that she was resuscitated … and died.

Many interviewees reported that "clearheaded" patients do partake in clinical prioritisation, but it is often difficult and time-consuming to assess what the older patients really want. The patients' participation is predominantly described as getting the opportunity to accept or refuse the treatment judged as indicated or to be in the patient's best interest by the clinicians. However, quite a few of interviewees said that the patients are often not asked directly what they want, or that the professionals' judgment of the patients' best interests limit patient autonomy too much:

> *Nurse (dialysis)*: …what I may have been missing mostly is quite simply to ask the patient directly "what do you think about going to dialysis treatment? How are you actually?" … Because I have the impression that some feel that this is something that they have to do…

It was often mentioned that time for assessing the patients' perspectives and needs are insufficient, and that those patients or relatives who speak up loudest, get most healthcare services and most attention.

> *Nurse (nursing home)*: … we have a patient who is ill and her way of reacting is to get anxiety attacks … and we can see when she has received too little attention from us for a long time—her way of reacting is to get attacks. Then she gets attention and then the staff run to her … the other [patients] do not tell, so the less you shout the less attention you get

One physician reported that when the relatives pay close attention or show great interest in the care of the patient, he becomes more thorough and always checks twice when treating the patient. Powerful or persistent relatives are also reported to influence whether a patient is accepted into the nursing home, sometimes more than is legitimate. Some interviewees stated that relatives have become more demanding than before and that the patients' relatives sometimes pressure to obtain futile treatment. To comply with the relatives' wishes, some of the interviewees reported that futile treatment is sometimes given counter to the professionals' judgment of the patient's best interest.

Economic considerations and operating conditions

Economic considerations, especially treatment costs, were generally reported as irrelevant in clinical prioritisations and some reported that economy ought not to be taken into considerations and this tendency was stronger in the hospital interviews.

> *Nurse (dialysis)*: If we think that the patient should have a treatment and that this is right for the patient, then economy is a "non-issue" …. We are not that pressured, we are not in the situation where treating one patients excludes treating another patient. For instance, if we do not have enough space for treatment then we have to treat the patient through working overtime.

However, most interviewees indicated—implicitly or explicitly—that operating conditions do influence clinical priorities and the content and quality of healthcare services for older patients. Frequently emphasised examples of operating conditions were lack of time, staff, competence and services available

(eg, physicians in nursing home, geriatricians, physiotherapists, rehabilitations services), number of beds and rooms, and economic incentives.

Higher numbers of hospital admissions were reported to increase the workload on the ward and the pressure to discharge patients, sometimes more than is professionally defensible. Some nursing home clinicians reported that when there is an increased demand for nursing home admissions—for example, because of more patients arriving from the hospitals—patients on temporary admission are discharged earlier (to home based care). Older patients were reported to be especially vulnerable to busy wards and increased throughput. Furthermore, many hospital clinicians emphasised the lack of adequate healthcare services or institutions available for older patients considered ready for discharge. These patients often end up waiting in beds placed in the hospital corridors without any rehabilitation services or adequate care services, and are sometimes looked upon as pariah patients by the hospital staff. Among the nursing home interviewees premature discharges from the hospitals and lack of adequate rehabilitation services within the nursing homes, were frequently mentioned. Some nursing home clinicians reported that dying patients are sometimes discharged to the nursing home and promptly die. This is especially challenging if the patient has not been admitted to the nursing home before.

Another tendency described was that lack of staff, competency and resources in the nursing homes sometimes causes unnecessary hospitalisation:

> *Physician (nursing home)*: So the workload is heavy, and that implies that I have to ration the time I have to the individual patient. So that is a dilemma. I can't go as deep into every individual's problem as I may like. Another dilemma is that I have to push some tasks to the hospital. In principle, we could take care of more tasks if we had the resources—for example intravenous treatment … And this is primarily due to resource considerations.

Some of the interviewees indicated that operating conditions, clinical competence and local professional cultures may influence the standards of care developed at the ward. Many interviewees stated that operating conditions make one focus more narrowly on the most pressing medical tasks. Some nurses described that the healthcare services resemble an assembly line when the days are busy, which is not uncommon. Both physicians and nurses feared that lack of time and staff—especially lack of physicians in the nursing homes—may undermine proper assessment, treatment, care, and follow up. When days are busy, more peripheral or less necessary tasks are sometimes not taken care of, overlooked or believed to be others' responsibility without knowing if anyone really assumes that responsibility. Examples of such tasks are clinical communication, psychosocial needs, wound care, nutrition, incontinence treatment, pain therapy, general care, physical activities, rehabilitation, patient education, and coordinating and planning the hospital discharge. Thus, patients that do not match with the assembly line services, and in particular many older patients, do not get adequate services. Some interviewees said that the patients who fit best with the assembly line are given highest priority, since they are most lucrative due to economic incentives. One hospital nurse stated that basic care has been given lower priority the last years, maybe because the hospitals' economic incentives are predominantly related to medical diagnosis and interventions, and less to care tasks.

Quite a few of the interviewees expressed that the care given to older patients does not fit with their professional ideals, or that it is hard to carry the weight of the operating conditions, which sometimes cause indefensible practices and serious consequences for older patients, who often don't complain. Some of the interviewees reported that for many years they have used their spare time to cover for a lack of staff, and some feared growing cynicism or burn-out syndromes due to cutbacks:

> *Nurse (nursing home)*: … I just have those days when there are many [patients] who call and want contact, but you are in the middle of something and can't come. That does something to you, that an old lady sitting in a wheelchair wants to talk to you and asks you to come. But that you can't, because you know you have a task that takes a while and that you won't get the opportunity for a long time. You have to be quite callous for those things not to affect you. It is then that you bend over backwards—that is how the personnel describe it—and then you fall, and you may be down for a long time.

DISCUSSION

This is a qualitative study based upon interviews with 45 physicians and nurses working within selected contexts (internal medicine and surgical hospital wards and nursing homes) in Norway—a relatively wealthy state where healthcare services are by and large publicly funded. The study did not include home care services and mental health services, and did not include patients or administrators as informants. The interviews were performed without any strict use of terminology, and prioritisations are delicate matters which may trigger politically correct answers. Thus, interpretations and generalisations have to be made with care. The strength of this study is the rich and concrete descriptions of clinical prioritisations coming forward from a relatively large number of qualitative interviews from both hospital and nursing home wards. Furthermore, eight researchers with various backgrounds and institutional affiliation have contributed to a broad analysis and interpretation process.

The interviewees in this study described various prioritisation dilemmas in the healthcare services for older patients related to under-provision of some services and overuse of others. In some circumstances under-provision was reported to contribute to over-utilisations of more expensive services. For example, inadequate community care and professional staff in nursing home—in particular physicians—is reported to contribute to overuse of referrals and hospitalisations. Medical treatment, and in particular specialised treatment, acute and serious conditions, and those patients and relatives who speak up loudest, are reported to be given highest priority. The services are reported to be focused in a way that does not pay adequate attention to important needs for older patients—for example, nursing home admissions, time for communication, rehabilitation, physiotherapy, physical activity, nutrition, minor illnesses, "silent" psychiatric problems, general medical approaches, and basic nursing care. "Soft" dilemmas (eg relative neglect of psychosocial and care needs) are reported as more dominant than "harder" dilemmas (eg letting older patients die because of lack of resources). However, the "soft" dilemmas—for example, deficient clinical communication or lack of comprehensive approaches—sometimes result in "harder" problems—for example, grave consequences for older patients, a need for more

recourse intensive treatment, more challenging end-of life decisions and sometimes over-utilisation of life-prolonging treatment. The challenges related to clinical prioritisations are not only a question of patients' health. Some of the interviewees feared growing cynicism or burn-out syndromes due to cut-backs. In the survey part of this project 79% of physicians and 92% of nurses responded that lack of resources and clinical prioritisation put the staff under great strain.[1]

Of the patients in Norwegian nursing homes, 70–80% are mentally impaired.[22] Some research indicates that decisions to withhold life-sustaining treatments are more common among patients with dementia.[17] Our study indicates that mental impairment can be given unequal weight in clinical prioritisations, but overt ageism was generally not reported. The healthcare services for older patients seem to be inadequate due to more indirect or subtle processes—for example, dominating considerations and ideals, and operating conditions that do not pay sufficient attention to older patients needs. This may be described as covert or indirect age discrimination.

By and large the vocabulary, principles and criteria developed within medical ethics and the resource allocation discourse, and in particular the principle of justice, seem to be rather remote for most of the interviewees. In general, the interviewees indicated that clinical prioritisations in healthcare services for older patients are performed through accommodating traditional biomedical approaches to the operating conditions, rather than distributing limited resources or healthcare services in a way that is considered just by the stakeholders or the general public. Biomedical criteria seem to outrun ethical considerations. This may contribute to hiding moral evaluations inherent in clinical prioritisations—for example, in futility judgments and considerations of co-morbidity (eg, mental impairment). Furthermore, we are concerned that the extensive use of biomedical criteria may reinforce the dominance of specialised medical approaches over more comprehensive approaches in the healthcare services to older patients.

Many of the challenges described may best be dealt with at an organisational or political level. For example, both the hospital and nursing home clinicians in this study and in the survey part of this project[1] indicate that there is an under-provision of comprehensive approaches and community services, possibly resulting in over-utilisation of other services. Another organisational challenge is the potential institutional age-discrimination indicated by some of the interviewees, due to economic incentives and the way the healthcare services accommodate to these incentives. To address these challenges appropriately one also has to include the citizens and hospital administrators and their perspectives on healthcare prioritisations, as well as other methodological approaches.

However, clinical and professional ethics are also challenged by narrowly focused medical approaches largely devoid of considerations of justice. Furthermore, the distributions of services described and the dominance of biomedical criteria may not be the best way to realise older patient's autonomy and dignity. Many of the interviewees believe that healthcare services for older patients are not fairly allocated, but the principle of justice is rarely considered in the clinical prioritisation processes described. Thus, it seems like the most absent principle may be the most needed.

Acknowledgements: We thank all the interviewees for their participation. We also thank Dr J Bjørnson, Dr A H Ranhoff and Professor B Vandvik for their valuable contributions in the design of this study.

Funding: This research is funded by the Norwegian Directorate for Health and Social Affairs.

Competing interests: None.

REFERENCES

1. **Førde R,** Pedersen R, Nortvedt P, *et al*. [Care for the elderly still suffers from lack of resources.] *Tidsskr Nor Laegeforen* 2006;126:1913–6. (In Norwegian)
2. **The Ministry of Health and Social Affairs**. [The Patients' Rights Act. Circular letter 1–60/2000.] Oslo: The Ministry of Health and Social Affairs, 2000.
3. Norges offentlige utredninger 1997:18 [*Priority settings anew*] Oslo: Statens forvaltningstjeneste, 1997. (In Norwegian)
4. **Lamping DL,** Consantinovici N, Roderick P, *et al*. Clinical outcomes, quality of life, and costs in the North Thames Dialysis study of elderly people on dialysis: a prospective study. *Lancet* 2000;**356**:1543–50.
5. **Mendelssohn DC,** Toh Kua B, Singer P. Referral to dialysis in Ontario. *Arch Intern Med* 1995;**155**:2473–8.
6. **Ryynänen OP,** Myllykangas M, Kinnunen J, *et al*. Doctors' willingness to refer elderly patients for elective surgery. *Fam Pract* 1997;**14**:216–19.
7. **Collinson J,** Bakhai A, Flather MD, *et al*. The management and investigation of elderly patients with acute coronary syndromes without ST elevation: an evidence-based approach? Results of the prospective registry of acute ischaemic syndromes in the United Kingdom (PRAIS-UK). *Age Ageing* 2005;**34**:61–6.
8. **Penson RT,** Daniels KJ, Lynch Jr TJ. Too old to care? *Oncologist* 2004;**9**:343–52.
9. **Dale MJ.** Poor prognosis in elderly patients with cancer: the role of bias and undertreatment. *J Supp Oncol* 2003;**1**(suppl 2):11–17.
10. **Melberg T,** Thoresen M, Hansen JB, *et al*. [Management of acute coronary syndromes in Norway.] *Tidsskr Nor Laegeforen* 2005;125:2925–8. (In Norwegian)
11. **Arnesen KE,** Eriksen J, Stavem K. Factors influencing physicians' assessment of urgency for inpatient surgery. *J Health Serv Res Policy* 2001;**6**:214–19.
12. **Yong PFK,** Milner PC, Payne JN, *et al*. Inequalities in access to knee joint replacements for people in need. *Ann Rheum Dis* 2004;**63**:1483–9.
13. **Senter for Medisinsk Metodevurdering**. Rapport Nr 11/2003 [*Health care services and the elderly – what is the knowledge basis?*]. Oslo: Lobo Media AS, 2003. (In Norwegian)
14. **Hurst SA,** Slowther AM, Forde R, *et al*. Prevalence and determinants of physician bedside rationing: data from Europe. *J Gen Intern Med* 2006;**21**:1138–43.
15. **van Delden JJM,** Vrakking AM, van der Heide A, *et al*. Medical decision making in scarcity situations. *J Med Ethics* 2004;**30**:207–11.
16. **Fairhead JF,** Rothwell JF. Underinvestigation and undertreatment of carotid disease in elderly patients with transient ischaemic attac and stroke: comparative population based study. *BMJ* 2006;**333**:525–7.
17. **Hamel MB,** Teno JM, Goldman L, *et al*. Patient age and decisions to withhold life-sustaining treatments from seriously ill, hospitalized adults. *Ann Intern Med* 1999;**130**:116–25.
18. **Young J.** Ageism in services for transient ischaemic attack and stroke. *BMJ* 2006;**333**:507–8.
19. **Malterud K.** [*Qualitative methods in medical research: an introduction*.] Oslo: Universitetsforlaget, 2003. (In Norwegian).
20. **Crabtreee BF,** Miller WI. Using codes and code manuals: A template organizing style of interpretation. In: Crabtreee BF, Miller WI, eds. *Doing qualitative research, second edition*. Thoasand Oaks: Sage Publication, 1999:163–77.
21. **Beauchamp TL,** Childress JF. *Principles of biomedical ethics, 5th edition*. Oxford: Oxford University Press, 2001.
22. **Engedal K,** Kirkevold Ø, Eek A, *et al*. [Power and powerlessness: Limitations of rights and use of coercion in institutions and houses for elderly]. Sem: Nasjonalt kompetansesenter for aldersdemens, 2002. (In Norwegian)