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Let's not turn elderly people into patients

PERSONAL VIEW **Michael Oliver**

Many older people, often retired, are summoned by their general practitioner for an annual health check. They may feel reasonably well, but the NHS does not always permit such euphoria. They may be told that they have hypertension or diabetes or high cholesterol concentrations; that they are obese; that they take too little exercise, eat unhealthily, and drink too much. The quality and outcomes framework (QoF), the scheme that rewards NHS general practitioners for good performance, awards points, with related payments, for each documentation. Many of these patients are told to have more investigations. Eventually, most are started on pills. Few seem to be considered not at risk for something. Thus, of those who thought themselves healthy, a number will return home as patients. And they may be scared and no longer comfortably aging.

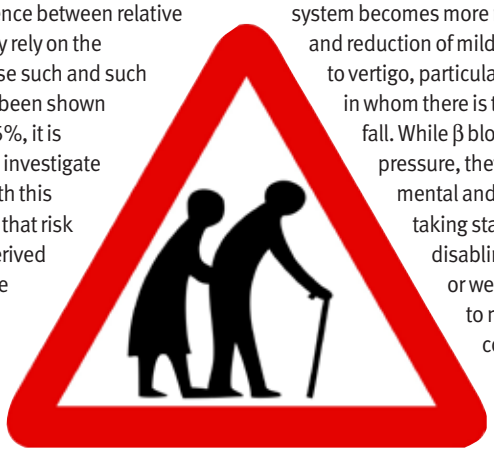
What kind of medicine is this? It is politics taking preference over professionalism, obsession with government targets superseding common sense, paternalism replacing personal advice. It seems that many Western governments regard all people aged over 75 as patients.

This trend has many causes. These include overenthusiastic and uncritical interpretation of various guidelines, the payment of GPs by NHS trusts for ticking boxes, the demands of government health economics and of insurance companies, and the relentless pressure from the drug industry.

Many busy family doctors seem not to understand the difference between relative and absolute risk. They rely on the reasoning that, because such and such a pill or way of life has been shown to reduce risk by 25-35%, it is mandatory for them to investigate and treat all people with this apparent risk. The fact that risk reduction is usually derived from comparison of the treatment in question with no treatment, placebo, or another pill (relative risk) is overlooked. The same treatment may have reduced the absolute risk by only 1% or 2%. This is not taken into account and is particularly relevant in advancing age, when longevity is limited. And the fact that the numbers necessary to treat in order to reduce either relative or absolute risk may be very high seems not to be widely understood. For example, about 75 mildly hypertensive elderly people may have to be treated to prevent one from having a stroke. Therefore, the other 74 will be committed to treatment for life. How many Department of Health economists comprehend this?

Guidelines should be regarded as just that. They are not commandments to investigate and treat. Some of these are so long winded that a busy GP does not have the time or the will to digest it all. The limits of supposed normality vary from one set of guidelines to another, and some derive from populations very different from that which the individual represents. For example, the isolated finding of a systolic blood pressure of over 140 mm Hg may be a warning sign in someone aged 40, but the evidence that it is bad news for a 75 year old is tenuous, and the finding should be assessed along with other features. Furthermore, the reliability of cuffs to measure blood pressure is often unchecked, and the optimum position of recording blood pressure is not heeded. Instead of making several measurements or investigating possible causes, the conclusion is to tell the person that he or she has raised blood pressure and that it must be treated.

Often, scant attention is paid to potential side effects. For example, the cardiovascular system becomes more rigid with advancing age, and reduction of mild hypertension can lead to vertigo, particularly in elderly people, in whom there is the added hazard of a fall. While β blockers may lower blood pressure, they can also slow activity, mental and physical. Many people taking statins seem to complain of disabling muscular discomfort or weakness, not amounting to myopathy. Of course, drug companies and their all pervading representatives do not encourage close consideration of minor side effects, even though they may be listed in the handout accompanying the pill package.



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Rigid interpretation of guidelines can lead to superficial diagnosis. Overinterpretation of the normal range of laboratory results is common. A raised fasting blood glucose concentration often seems to be sufficient to label someone as having diabetes. Often such individuals are later shown to have a normal HbA_{1c} (‹6.5%), but the diabetes box has been ticked, and they are stuck with the label. A total cholesterol concentration of ›4 mmol/l or an LDL cholesterol concentration of ›2 mmol/l is not a death sentence for elderly people. The actual evidence for the benefit of treating any risk factor in those aged over 75 needs much more careful consideration when applied to an individual. Are those people who have now been turned into patients warned sufficiently about side effects? Are minor side effects, which can be debilitating in this age group, reported to health authorities? More importantly, are doctors willing to discontinue treatment and permit these patients to return to their previously unencumbered and reasonably fit lives? The benefits and risks of treatment and of remaining untreated need to be explained fully to individuals, as it is they who should make the final choice. It may be difficult for doctors when individuals decline to be treated, but this is their right.

Primary prevention among young and middle aged adults should be encouraged and supported. But should this apply equally to fit elderly people? Few elderly people are allowed to enjoy being healthy. A bureaucratic demand for documentation can lead to overdiagnosis, overtreatment, and unnecessary anxiety. Preventive action may be irrelevant and even harmful in elderly people. More than 30 years ago Ivan Illich called this trend "the medicalisation of health."

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