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Should cancer treatment stop at the age of 75?

Riccardo Audisio MD, PhD[1] | **Lodovico Balducci MD**[2] | **Silvio Monfardini MD**[3] | **Fedro A. Peccatori MD, PhD**[4] | **Siri Rostoft MD, PhD**[5] | **Barbara van Leeuwen MD, PhD**[6]

[1]Department of Surgery, Institute of Clinical Sciences, Sahlgrenska University Hospital, Göteborg, Sweden

[2]Moffitt Cancer Center, Tampa, Florida, USA

[3]European School of Oncology Program on the History of European Oncology, Milan, Italy

[4]Gynecologic Oncology Department, European Institute of Oncology IRCCS, Milan, Italy

[5]Department of Geriatric Medicine, Oslo University Hospital, Oslo, Norway

[6]University Medical Center Groningen, Groningen, The Netherlands

Correspondence
Siri Rostoft, Department of Geriatric Medicine, Oslo University Hospital, Oslo, Norway.
Email: srostoft@gmail.com

COMMENTARY ON AGEISM IN CANCER CARE

On March 29, 1984, Richard D. Lamm, governor of Colorado, stated that "Elderly ill people have a duty to die and get out of the way." An almost universal sense of horror reacted to this declaration that incensed physicians and medical ethicists throughout the globe. In a series of recent interviews released to the lay press, the world-renowned oncologist and medical ethicist Ezekiel Emanuel MD, seems to share Lamm's view. These interviews, the last of which was published this year in "*The Times*" of London,[1] spawn from an article Emanuel published in 2014 in the Atlantic.[2] In the article he expressed his personal wish to be dead at age 75. His current age is 65 years. As professionals who have dedicated our practice and research to the management of cancer in the older aged person, we would like to present a closer look at Emanuel's statement to prevent possible misinterpretations.

First of all, to his credit, Emanuel does not advocate any form of physician-aided death; in other words his position should not be interpreted as an invitation to "terminate" individuals aged 75 and older.[3]

The article and interviews provide an essential service to a society unwilling to face the problems related to the aging of the population and the growing number of older individuals in the community. These include: straining of medical and social resources; increased incidence and prevalence of chronic and disabling ailments including cognitive decline that Dr. Emanuel claims to dread more than cancer, burn-out, depression, unemployment, and marital discord for the caregiver of the older person. Problems that are made worse by a medical practice committed to prolonging life without regard to the meaningfulness of life. A corollary of this situation in the Western world is overcrowding of adult living facilities where older individuals are often neglected and abused due to a lack of personnel and resources.[4] The public should be thankful to Dr. Emanuel for this blunt but truthful exposition of a reality that has been impinged upon the citizens of developed countries.

Second, he emphasizes personal autonomy as the only reliable bulwark against the ordeal of a prolonged death. This point cannot be overrated as the autonomy of the older person is often undervalued, while autonomy should be presumed, even for individuals with cognitive impairment. As a physician, he is well aware that a number of medical interventions prolong death rather than life and make death more painful rather than life more enjoyable. With his own example, he makes a point that

the only way to prevent a nightmarish death for patients and their families requires precise advanced directives related to the provision of futile care. And these directives should be formulated when a person is in full possession of her/his mental faculties. Nevertheless, it is deeply problematic when healthcare professionals, such as Dr. Emanuel, argue that treatment should not be pursued if a patient is "faltering and declining," especially when discussing treatment for cancer. The core question for any physician who dedicates her/his medical profession to the care of patients with cancer, remains the following: What is the goal of cancer treatment?

Beyond any rhetoric, we feel that there is room for improvement here: the goal of cancer treatment is not to guarantee patients the longest lifespan possible, but to reach a shared decision where we support patients in identifying their goals, rank them according to their own preference, and assist them in reaching their goal with the administration of medications, surgical procedures, radiation treatments, and others. It is a common misconception that cure is the only goal, when in fact preserving independence or improving quality of life are equally common goals.

Well aware of these problems, we are a group of worldwide oncologists and geriatricians that have worked together for 30 years to design a personalized treatment trajectory for older patients with cancer, based on individual physical health, life expectancy, needs, and values. Since the year 2000, our action has been consolidated within the International Society of Geriatric Oncology (SIOG) that currently holds hundreds of members from around the world.

Together with the many colleagues who participate in SIOG activities we embrace well-established, clear, and firm principles related to the management of cancer in older patients.[5–7] First and foremost it is recommended that the functional age of each older person should be assessed given the well-known discrepancy between physiologic and chronologic age. The estimation of individual intrinsic capacity[8] and resilience[9] with a comprehensive geriatric assessment allows the practitioner to formulate an individualized plan of care based on life expectancy, risk of complications, and realistic expectations. In addition, we propose to incorporate patients' values[10] and alternative outcomes such as active life expectancy[11] into the decision-making. Personalized, value-based care of the older patient with cancer respects individual autonomy and at the same time allows effective utilization of always scarcer human, social, and economic resources.[12] Value-based care represents an ethical and humane response to the odious proposals to ration the medical care of older adults, emerging from budget-conscious politicians.

Given our mission, we feel the need to take issue with the suggestion of Dr. Emanuel to stop any life-prolonging treatment at age 75. Though it is presented as a legitimate and reasonable personal decision there is good reason to believe that it may be heeded by many older individuals given the authority and the expertise of the writer.

We strongly object to using chronologic age as a landmark of any medical decision. This is tantamount to using other physical landmarks including the color of the skin, the family history, or the presence of a disabling disease at any age. We observed during the pandemic caused by coronavirus disease 2019, where concerns about shortages of both healthcare professionals and supplies emerged, that some strategies misguidedly suggested to use age as an arbitrary criterium for prioritization. The American Geriatrics Society published a position statement which strongly opposed the notion of using age per se as a means for excluding anyone from care.[13,14] The shift toward patient-centered care is further elaborated in a recent publication about decision-making for older adults with multiple chronic conditions, which also emphasized the patients' own health priorities as a starting point, and the importance of aligning decisions and care with these priorities.[15] Age alone is not useful in this context. We are trusted with the management of human beings, each one endowed with an individual soul, that should represent the ultimate source of all medical decisions. It is unbecoming to our profession and a betrayal of our mission to label these individuals as "disposable" as a present for their 75th birthday! No age discrimination should be accepted when cancer treatment is involved, as dying of cancer is not the best cure for dementia.

In summary, we strongly disagree with Dr. Ezekiel Emanuel's principles, whose decision we certainly respect as far as it concerns himself, but not when a generalized statement is put forward.

AUTHOR CONTRIBUTIONS

All authors contributed equally to this article.

SPONSOR'S ROLE

None.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

ORCID

Siri Rostoft https://orcid.org/0000-0002-4277-8641

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