

Older adults' attitudes to death, palliative treatment and hospice care

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Background: Cancer patients who receive care from specialist palliative care services in the UK are younger than those who do not receive this care. This may be explained by age-related differences in attitudes to end-of-life care. **Objective:** To determine the relationship between age and (i) attitudes to death and preparation for death; and (ii) knowledge about, and attitudes to, cancer and palliative care. **Design:** Interviews with older people, using a novel questionnaire developed using nominal groups. Main comparisons were made between people aged 55–74 with those aged 75 years and over. **Setting:** General practices in London. **Subjects:** 129 people aged 55–74 and 127 people aged 75 years or over on the lists of general practitioners. **Methods:** A cross-sectional survey to determine knowledge and experience of hospice care; preparation for end-of-life; and attitudes to end-of-life issues. **Results:** Participants were knowledgeable about specialist palliative care and almost half had some indirect contact with a hospice. People aged >74 were less likely than younger participants to want their doctor to end their life in a terminal illness. Although they believed death was easier to face for older people, they did not believe that younger people deserved more consideration than older people when dying, or that they should have priority for hospice care. Education, social class, hospice knowledge and anxiety about death had little influence on overall attitudes. **Conclusions:** The relative under-utilization of hospice and specialist palliative care services by older people with cancer in the UK cannot be explained by their attitudes to end of life issues and palliative care. *Palliative Medicine* 2005; 19: 1–9

Key words: aged; attitude to death; data collection; eighty and over; palliative care; primary health care

Background

There is evidence that cancer patients who receive care from hospice and specialist palliative care services in the UK are younger than those who do not receive this care. For example, the Regional Study of Care for the Dying, a population-based survey of a representative sample of deaths in 1990, reported that according to bereaved relatives, older people with cancer, particularly those aged 85 or over, were less likely than younger people to receive hospice in-patient care. Age remained a significant predictor of hospice in-patient use even when the effect of other variables, such as symptoms and dependency levels, were controlled for statistically.¹ Older people with cancer, in this case those aged 75 or above, were also less likely than younger people to receive care from community specialist palliative care nurses and

again, age remained a significant predictor of service use even when the impact of other variables was controlled for statistically.² Other studies and reviews in the UK and elsewhere have also found that cancer patients who use specialist palliative care services are younger than those who do not use the services.^{3–9}

The findings of these research studies are supported by figures provided by hospice information on the use of hospice and specialist palliative care services,¹⁰ combined with national statistics on the age of patients who die from cancer.¹¹ People aged <65 made up 35% of patients receiving specialist palliative care in 2000/1, but only 24% of cancer deaths; the figures for patients aged 65–84 are 56 versus 61%, and those for patients aged >85 are 9 versus 15%. Thus, although 65% of patients cared for by hospice and specialist palliative care services in the UK are aged 65 or over, the proportion of older cancer patients receiving care is lower than the proportion of younger patients doing so. The reasons for this age-related differential use of hospice and specialist palliative care services are poorly understood.

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It may be that older cancer patients, particularly the 'older old' have less need of these services than younger cancer patients. This is difficult to confirm, given the lack of clarity on what constitutes a 'need' for specialist palliative care, but has been suggested given the evidence that older cancer patients experience less severe symptoms and distress than younger patients.^{12,13} They are also thought to be less troubled by a cancer diagnosis than younger people,¹⁴ and are believed to be more accepting of death, although evidence here is conflicting.¹⁵ They may therefore be less in need of specialist physical, psychological and spiritual support than younger people. Evidence that need for specialist palliative care is related to age is, however, limited.

An alternative explanation for the age-related differential in access to hospice and specialist palliative care services is that attitudes to these services vary with age and that, as a consequence, older people are less likely to want these services. Knowledge of these services may also vary with age. Little is known about older peoples' attitudes to or knowledge of hospice care or, indeed, despite one recent paper about older people's views on resuscitation,¹⁶ about their attitudes to or knowledge of other contemporary issues related to death and dying, such as euthanasia and advance directives.

Our aim was to determine the relationship between age and (1) attitudes to and preparations for death and (2) attitudes to and knowledge of cancer and hospices and specialist palliative care services.

Method

Questionnaire development

We developed a novel questionnaire to measure attitudes to and preparations for death, and attitudes to and knowledge of hospice and specialist palliative care services. The content of the questionnaire was informed by the findings of nominal groups conducted to establish older people's priorities for end of life care, combined with themes described in the literature. Full details are provided elsewhere.¹⁷

Quantitative survey

General practice selection. In order to recruit a representative sample of older people in London, we approached older people on general practice lists. We used Jarman scores,¹⁸ (a measure available at general practice level) to select general practices across London. The Jarman scores are derived from census information and are based on the weight of eight separate variables; the greater the Jarman score then the greater the social deprivation. Five bandings were applied (0–9, 10–19, 20–29, 30–39, 40+), with two practices recruited in each band.

Recruitment of sample. Older people registered with GPs in north and south London, including people in residential homes, who were (a) aged between 55 and 74 or (b) aged 75 and over, were randomly sampled from practice lists. Sampling was set up to achieve equal numbers of participants in the age bands 55–74 and 75 and over. A quota of 25 patients in each of the two age bands was set as a target for recruitment from the ten general practices. Exclusion criteria were: inability to read English, severe physical or mental illness (including severe dementia) and recent bereavement. GPs also excluded patients they considered too personally or physically vulnerable to participate.

Participant recruitment. Patients were contacted by post and those who did not reply were telephoned one week later or sent a reminder letter if a telephone number was not available.

Interviews. Interviews took place in the participant's home or general practice. Fully informed consent was obtained from all participants. The 30–60 minute interview covered: socio-demographic details including the Registrar General's classification of social class; social network status; religious and spiritual beliefs; fear of death as measured by the Revised Death Anxiety Scale (RDAS),¹⁹ where the greater the score then the greater the anxiety the subject feels about death and dying; quality of life (QoL) using the Euroqol,²⁰ a standardized measure where lower score represents better quality of life but which also has a visual analogue scale of a 'thermometer' (0–100), where higher score indicates better quality of life; depressive symptoms using the Geriatric Depression Scale (GDS);²¹ questions on knowledge and experience of hospice care and preparation for end-of-life such as a will or advanced care directive; and attitudes to end-of-life issues using the questionnaire our group developed. We used a Likert scale for each available response, ranging from 'strongly agree' to 'strongly disagree'. We collected medical notes data on consultation rate over the previous two years, major diagnoses and current prescribed medications.

Ethical issues. Ethical approval was obtained from the North Thames Multisite Regional Ethical Committee and the Local Research Ethical Committees involved.

Sample size. Few data were available to assist in determining the required sample size for this study. Our power calculation was based on Bruce-Jones *et al.*¹⁶ who reported that 60% of older physically ill, in-patients would choose an acute intervention when confronted with a life-threatening episode. We assumed that this represented a fundamental divide in attitudes between people who seek acute interventions and those who

prefer supportive care. In order to detect a substantial disparity in such opinion (20% in either direction) between the age groups at 80% power and 5% level of significance, we needed at least 107 interviews in each age-group. Thus, we aimed to recruit up to 25 patients in each of the ten general practices.

Analysis. Univariate comparisons between the two age-groups were made by χ^2 test for categorical variables and independent *t*-test for continuous variables; all tests are two-tailed unless otherwise stated. We used logistic regression in three separate analyses to examine: (i) variation in attitudes between age groups, after controlling for the presence of all other attitudes; (ii) influence on attitudes of potential confounding variables; and (iii) influence of these potential confounding variables on the attitude differences between the age groups. We analysed the data using SPSS for Windows Version 9.0.²²

Results

Responses rates

A total of 793 potential interviewees were identified within general practices of whom 223 (28%) could not be contacted. Of the remainder, 256 (129 aged 55–74 and 127 aged 75 years or more) agreed to participate and 28 were excluded after contact (Table 1). People we were unable to contact were significantly more likely to be in the younger age group than those who returned a reply ($\chi^2 = 15.5$, *df* = 1, *P* = 0.000). There was no significant difference in gender or Jarman band scores between these two groups. The only significant difference between those participating and those refusing from amongst all we

successfully contacted was that of those in Jarman band, 40 were relatively more likely to decline ($\chi^2 = 11.1$, *df* = 4, *P* = 0.025) (Table 1).

Description of the sample

There were no differences between the age groups on gender, ethnicity and social class (Table 2). More of the older age group had left school at or before the age of 14 years and were widowed, lived alone and retired. Medical records data revealed that the older age group suffered more health problems than the younger group (Table 3). Thirty-five (13.7%) scored in the abnormal range on the GDS but there were no significant differences in prevalence of depressive symptoms between the two age groups (Table 4). Despite lower, overall quality of life, the older group perceived themselves to be in at least as good a health on the self-assigned health state dimension of the EuroqoL as the younger group (Table 4). Death anxiety scores revealed that the older group was significantly less anxious than their younger counterparts (Table 4).

Knowledge/experience of hospice care and preparation for death

Experience of hospice care in this population was quite common and participants in the two age groups held similar perceptions about it (Table 5). Mean scores for the questions on knowledge about hospice care were similar in the younger (4.4, *SD* = 1.5) and older groups (4.3, *SD* = 1.6). Nearly 70% of the younger group and 76% of the older group had made a will. Only two (1.6%) people in the younger age group and seven (5.6%) in the older group had drawn up a living will.

Table 1 Description of total sample approached in terms of age, sex and GP practice Jarman Score

Characteristics	Responders: 570 (72% of total approached)		Uncontactable 223 (28% of total approached)	
	Yes* 256	No 286	Unsuitable/ excluded 28	
Total number approached = 793				
55–74 years, <i>n</i> = 388 (49%)				
≥75 years, <i>n</i> = 405 (51%)				
Male, <i>n</i> = 340 (43%)				
Female, <i>n</i> = 453 (57%)				
Age (years)				
55–74	129	122	3	134
≥75	127	164	25	89
Sex				
Male	116	113	7	104
Female	140	173	21	119
Deprivation (Jarman band)				
0	43	35	2	42
10	50	60	4	34
20	54	68	6	36
30	59	43	7	55
40	50	80	9	56

*A total of 5/256 (1.9%) of responders who consented to an interview refused access to their medical records.

Table 2 Sample characteristics of gender, ethnicity, education, social class, marital status, living arrangements and employment status according to age category 55–74 ($n=129$) ≥ 75 ($n=127$)

Characteristics	Age (%)		χ^2	P
	55–74 $n=129$ (50.4)	≥ 75 $n=127$ (49.6)		
Total $n=256$				
Gender				
Male	60 (46.5)	56 (44.1)	0.15	0.7
Female	69 (53.5)	71 (55.9)		
Ethnicity				
White UK	101 (78.3)	107 (84.3)	1.5	0.2
Other	28 (21.7)	20 (15.7)		
Education (years)				
Left at <14	16 (12.4)	52 (40.9)	27.84	0.00
Left at 15–16	54 (41.9)	40 (31.5)		
Left at 17–18	40 (31)	23 (18.1)		
Left >18	15 (11.6)	8 (6.3)		
Social class (registrar general's classification)				
I	15 (11.6)	8 (6.3)	7.4	0.2
II	53 (41.1)	39 (30.7)		
IIIN	25 (19.4)	28 (22)		
IIIM	17 (13.2)	24 (18.9)		
IV	13 (10.1)	16 (12.6)		
V	6 (4.7)	11 (8.7)		
Marital status				
Married	78 (60.5)	55 (43.3)	23.1	0.00
Widowed	21 (16.3)	55 (43.3)		
Divorced	15 (11.6)	6 (4.7)		
Single	9 (7)	8 (6.3)		
Living arrangements				
With spouse or partner	82 (64.1)	57 (44.9)	9.1	0.01
Alone	35 (27.3)	50 (39.4)		
Other	12 (8.6)	20 (15.7)		
Employment status				
Retired	84 (65.1)	121 (95.3)	37.4	0.00
Employed	40 (31)	4 (3.1)		
Other	5 (3.9)	2 (1.6)		

Age differences in attitudes to death and dying

The age groups were strikingly similar in their attitudes toward death and dying (Table 6). In only five out of the 27 questions were statistically significant differences demonstrated. Three of these five significant differences were in the strength of the attitude held rather than its 'direction'; while significant differences in the remaining two were a matter of opinions being expressed in 'opposing' directions between the two age groups.

Multivariate analyses

A full model and backwards stepwise logistic regression was performed to explore the independent predictive power of each attitude score. This confirmed the results of the univariate analyses presented in Table 6. Attitudes 3, 10, 12 and 26 demonstrated robust differences between the two age groups.

Discussion

Strengths and limitations of the study

This survey is the biggest contribution in the UK on this subject since qualitative work carried out 20 years ago.²³ Although our response rate is low, it is not atypical,²⁴ with older women,^{25,26} and those from poorer areas, the least likely to participate. Many of the older people we could not contact were likely to be 'ghost' patients on the practice list, who had either moved or died and record keeping had not kept up with these changes. A strength of the study is our selection of general practices based on Jarman scores that ensured a sample with characteristics commensurate with the general population.²⁷

Our respondents are not representative of all older people in the study area, which limits the conclusions that can be drawn on the attitudes of older people to issues of death, dying and palliative care. However, the sensitivity of the subject matter makes it difficult to collect

Table 3 Medical health status according to age category 55–74 ($n=126$) and ≥ 75 ($n=125$)

Total $n=251$ Diagnosis	Age		χ^2 or Fisher exact (P)
	55–74 $n=126$ (%)	≥ 75 $n=125$ (%)	
Cancer	13 (10.3)	22 (17.6)	0.1
Potentially life-threatening	9 (7.1)	20 (16)	0.03*
Cardiovascular			
Angina	3 (2.4)	6 (4.8)	0.2
Hypertension	33 (26.2)	35 (28)	0.75
Myocardial infarction	6 (4.8)	12 (9.6)	0.14
Stroke	2 (1.6)	9 (7.2)	0.02*
Heart failure	4 (3.2)	12 (9.6)	0.02*
Chronic respiratory	19 (15.1)	24 (19.2)	0.4
Chronic neurological	6 (4.8)	4 (3.2)	0.5
Musculoskeletal	62 (49.2)	59 (47.2)	0.75
Gastrointestinal	20 (15.9)	27 (21.6)	0.2
Endocrine	19 (15.1)	30 (24)	0.07
Psychological	19 (15.1)	27 (21.6)	0.2
Other	62 (49.2)	69 (55.2)	0.3
Total number of diagnoses			
0	16 (12.7)	1 (0.8)	0.000*
1–3	91 (72.2)	86 (68.8)	0.6
≥ 4	19 (15.1)	38 (30.4)	0.004*

χ^2 or Fisher exact test to examine differences, where * are statistically different at $P=0.05$ or below.

information from representative samples and thus our findings make a contribution to the relatively poor knowledge base in this area.

Although our respondents were similar to the general population in terms of socio-demographic characteristics, those who chose to participate are likely to have differed from those who did not on characteristics related to the subject topic; we speculate for example that people with high death anxiety may have been particularly unlikely to participate and that this may also have been true of those in poor health, particularly given evidence that death anxiety and poor health are related in older people.²⁸ Participants may have been more familiar with and more supportive of hospice and palliative care.

Main findings

Older people are knowledgeable about, and familiar with, the type of care offered by hospices. They also show considerable preparation for death in that up to three-quarters had made a will. However, very few had made a living will, which may reflect the relatively good physical health of the sample, or a lack of awareness about such a facility. When it came to attitudes and beliefs about hospice care and dying, people in the two age groups held similar views. They seldom disagreed about the nature of palliative care, the main differences lying in the strength of belief held. Their attitudes were unaffected by their position in society, level of education or fears of death. We cannot rule out the possibility that attitudes change

Table 4 Psychological profile according to age category 55–74 ($n=129$) and ≥ 75 ($n=127$)

Total $n=256$ Factor	Age		t-value	Sig.
	55–74 $n=129$ Mean (SD)	≥ 75 $n=127$ Mean (SD)		
QoL total score	8.26 (1.75)	8.98 (2.2)	-2.95	0.004*
Self-assigned health state (QoL thermometer)	76 (17.6)	74 (16.9)	0.82	ns
RDAS (revised death anxiety scale)	41 (8.7)	38.73 (9.1)	2.00	0.047*
GDS total score	1.8 (2.2)	2.0 (2.3)	-0.72	ns
GDS	Number (%)	Number (%)	χ^2	
GDS 'caseness' (cut-off $<5/5^+$)				
Not depressed	115 (89.1)	106 (83.5)	1.75	ns
Depressed	14 (10.9)	21 (16.5)		

Quality of life (QoL) is measured using the EuroqoL and its 'thermometer', anxiety about death using the RDAS and depression using the GDS total score and 'caseness' with a cut-off at five and above. *Denotes significant at $P \leq 0.05$.

Table 5 Experience and knowledge of hospice care according to age category 55–74 ($n=129$) and ≥ 75 ($n=126$)

Factor	Age	
	55–74 $n=129$ (%)	≥ 75 $n=126$ (%)
Total $n=255$		
Have visited a hospice	54 (41.9)	56 (44.4)
Have had family/close friend cared for in a hospice	61 (47.3)	67 (53.2)
Have volunteered/worked in a hospice	7 (5.4)	3 (2.4)
Able to name their local hospice◆	61 (48)	52 (43)
Believe a hospice is for care of the dying◆	107 (82.9)	98 (77.8)
Believe you do not have to be a Christian to receive hospice care◆	111 (86)	106 (84.8)
Believe hospice care is about pain and symptom control◆	114 (88.4)	103 (82.4)
Believe hospices care for all age groups◆	116 (89.9)	114 (91.2)
Believe hospices depend entirely on voluntary contributions	56 (43.4)	66 (52.8)
Believe hospice care is not only for people with cancer◆	105 (82)	90 (72)

◆ Denotes the items used as a scale to test knowledge of hospice care.

as people become more seriously ill, but at least in this sample, attitudes were not related to quality of life or physical health.

Younger people and hospice care

Participants were moderately anxious about death and believed that it is more difficult for younger than older people to come to terms with dying. Hospice and specialist palliative care services promote open communication about death and dying and have expertise in providing psychological and spiritual support for dying people. It might, therefore, be appropriate for such care to be focused on those dying prematurely. However, despite believing that it is easier to die in old age, respondents did not agree that hospice and specialist care services should give priority to younger patients nor that younger people deserved more consideration than older people when dying. Thus, from the perspective of people aged over 55, the potentially greater psychological and spiritual needs of younger patients do not justify their greater use of hospice services. Participants agreed that spiritual or religious support would be important to them when dying, and the greater emphasis hospices place on such support will be important. They did not want to be kept alive at all costs, did not want to die alone (particularly those in the younger group) and considered quality of life as paramount when seriously ill with no hope of recovery.

Pain control

Both groups did not consider that pain is inevitable at the end of life, however if they were to be in pain they wanted pain relief even if this left them confused. The strength of these attitudes was not related to age. Age-related differences in attitudes to pain and pain control do not therefore appear to explain the apparent under-usage of hospice and palliative care services by older people.

Place of care

When asked where they would want to be cared for if seriously ill with no hope of recovery, participants generally preferred hospice to home. Both groups preferred hospice to hospital, with the younger participants holding this view more strongly. Older participants tended to prefer hospital to home whilst younger participants did not. The finding that respondents – particularly those aged 55 to 75 – would prefer to be cared for in a hospice than a hospital is not surprising, given continued concerns about the quality of palliative care in hospitals.²⁹ What is more surprising given the apparent consensus that people would prefer to die at home,³⁰ is the finding that both groups preferred hospice to home, and that the oldest group preferred hospital to home. These findings run contrary to the increasing emphasis of many in-patient hospices and specialist palliative care units on short-admissions for symptom control rather than longer-term admissions for nursing and terminal care,³¹ and to the increasing policy emphasis on promoting care and death at home. Further work is needed to investigate preferences for place of care, particularly as our participants were not in the main facing a life-threatening illness. What is important in the context of this study is that our findings suggest that differential access to (in particular) in-patient hospices is not explained by older people holding negative views of this care.

Euthanasia

Specialist palliative care is underpinned by a philosophy that aims to enable patients 'to live until they die' and promote quality of life in the face of physical dependency. Many, if not most palliative care professionals, oppose euthanasia.³² The older respondents were less likely than younger respondents to want to end their life when seriously ill with no hope of recovery. They were opposed to physician-assisted suicide, in contrast to younger respondents who supported it. Thus, older people's views of end of life care concur with the ethos of palliative care and do not suggest any reluctance on their part to be involved.

Table 6 Distribution of replies to the attitude questions by age group 55–74 ($n=126$) and ≥ 75 ($n=129$)

Attitudes	55–74 years $n=126$		≥ 75 $n=129$		t-tests	
	Mean	SD	Mean	SD	t	Sig.
1 If I were severely ill with no hope of recovery, I would prefer the doctors to make all the decisions about my care	3.42	1.14	3.14	1.10	1.96	0.051
2 If I were severely ill with no hope of recovery, I would want to be kept alive at all costs	3.84	0.92	3.83	1.01	0.10	0.922
3 If I were severely ill with no hope of recovery, I would like to die alone	3.74	0.80	3.37	1.02	3.23	0.001*
4 If I were severely ill with no hope of recovery, I would like a drug at my disposal to end my life when I chose	2.82	1.22	3.11	1.26	-1.86	0.064
5 If I were severely ill with no hope of recovery, I would want treatment to completely control my pain, even if it left me muddled	2.81	1.02	2.69	1.09	0.87	0.383
6 If I were severely ill with no hope of recovery, I would rather be cared for in a hospice than at home	2.90	1.06	2.70	1.10	1.48	0.140
7 If I were severely ill with no hope of recovery, I would still want to try the latest treatments whatever those involve	2.44	0.95	2.74	1.21	-2.17	0.031
8 By law, doctors should have to follow the instructions in a living will	2.38	0.82	2.53	0.96	-1.36	0.176
9 If I were severely ill with no hope of recovery, I would like to be in control of my pain medication rather than relying on doctors and nurses to give it to me	2.45	0.94	2.82	1.08	-2.90	0.004
10 If I were severely ill with no hope of recovery, I would rather be cared for in a hospital than a hospice	3.70	0.89	3.23	1.12	3.67	0.000*
11 If I were severely ill with no hope of recovery, spiritual or religious support would be important to me	2.84	1.18	2.94	1.29	-0.64	0.523
12 I wish that death and dying were more openly discussed in our society	2.26	0.80	2.68	0.95	-3.86	0.000*
13 I believe older people are last on the list when it comes to receiving medical care	2.83	1.10	3.08	1.19	-1.74	0.083
14 If I were severely ill with no hope of recovery, I would not need a living will as my loved ones know what to do when the time comes	2.91	1.08	2.55	1.01	2.78	0.006
15 If I were severely ill with no hope of recovery, I would rather be cared for in hospital than at home	3.22	0.98	2.92	1.10	2.34	0.021
16 Younger people who are dying deserve more consideration than older people who are dying	3.69	1.04	3.49	1.13	1.49	0.139
17 A person should never take their own life	2.74	1.23	2.69	1.19	0.30	0.762
18 If my loved ones thought it better for me to die because I was severely ill with no hope of recovery, doctors should be allowed to help me to die	2.71	1.13	2.90	1.13	-1.40	0.163
19 If I were severely ill with no hope of recovery, I would like a living will so that the doctors and nurses knew exactly what care I wanted	2.84	1.04	3.25	0.96	-3.20	0.002*
20 I believe most people are in pain as death approaches	3.53	0.80	3.56	0.74	-0.30	0.768
21 If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted	1.99	0.78	2.08	0.91	-0.83	0.410
22 I fear being helpless and dependent more than I fear death	2.02	0.77	2.02	0.93	0.07	0.945
23 Hospice care should give priority to young people who are dying	3.67	1.00	3.62	1.03	0.38	0.708
24 I find the idea of making a living will too gloomy	3.57	0.90	3.40	0.92	1.45	0.149
25 It is more difficult for a younger person to come to terms with death than an older person	2.32	0.78	2.22	0.80	0.97	0.335
26 If I were severely ill with no hope of recovery, my doctor should be allowed to help me to end my life	2.74	1.19	3.29	1.24	-3.55	0.000*
27 If I were severely ill with no hope of recovery, it would not matter how many health professionals I saw as long as I was getting the latest treatment	2.84	1.06	2.68	1.11	1.14	0.255

*Significant at $P \leq 0.002$ level (adjusted for multiple comparisons). On the attitude scale a score of 3 = neutral opinion, <3 suggests agreement and, >3 suggests disagreement.

Conclusion

Our findings suggest that the relative under-utilization of hospice and specialist palliative care services by older people with cancer in the UK cannot be explained by their attitudes to end-of-life issues and palliative care. It may be the consequence of lower levels of need for these services amongst older people.¹ Further research is needed both to establish what are perceived by health professionals to be 'palliative care needs' and to investigate the impact of varying definitions of need on older peoples' use of these services. Our findings also indicate that we now need to examine the attitudes and practices of referral agencies, and the admission policies of the services themselves.

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