Editor's view

On reviewing the contents of this issue of Age and Ageing, I noted that four papers and one book under review included the word ‘elderly’ in the title, compared with two editorials, one commentary and 10 papers, which used the alternative term ‘older’. In a Personal View published in the British Medical Journal (2007: 2007: 316), Marianne Falconer and Desmond O’Neill described the results of a Europe wide survey, where older people expressed a clear preference for the use of the adjective ‘older’ or ‘senior’ to describe their age group, rather than terms such as ‘elderly’, ‘aged’ and ‘old’. Falconer and O’Neill also highlighted that this view was reflected by the Human Rights Commission of the United Nations in the International Covenant on Economic, Social and Cultural Rights, which outlined why the term ‘older’ should be used. They went on to provide a number of cogent arguments, to justify the use of the term ‘older’ rather than ‘elderly’. Professor O’Neill subsequently published a comparison of the use of the terms ‘elderly’ and ‘old’ in four General Medical and three Gerontological journals (JAGS, 2008; 56: 1983-1984). They reported that all but one of these journals used the term ‘elderly’ more than ‘older’, but this was particularly marked in the General Medical journals. As I consider my own ageing, I admit that I would prefer to be described as ‘older’ rather than ‘elderly’, particularly as the latter is often used to infer frailty, which is not an inevitable consequence of ageing. Readers will be used to debate about the use of terms like ‘Geriatric Medicine’, ‘Care of the Elderly’ and ‘Medicine for the Elderly’, but I would welcome their views on the use of ‘elderly’ and ‘older’ in Age and Ageing, through the e-letters facility.

Although proportion of older people in the developed and developing world is increasing, the design of the man made environment fails to reflect this. In a cross-sectional observational study, Rose Anne Kenny’s group have measured walking speed in 355 community-dwelling people aged 60 years and compared with the minimum walking speeds needed to negotiate standard pelican crossings in Ireland (pp. 80–86). They report a strong inverse correlation between advancing age and walking speed, such that many pedestrians above the age of 80 years would be unable to negotiate a pelican crossing on a wide road in the time available. It is clearly essential that town planners and those involved in traffic management are aware of the functional abilities of older pedestrians, to prevent social isolation and avoid unnecessary road traffic accidents.

Vitamin D is essential for the maintenance of bone health and muscle function, but may also play an important role in the prevention of cancer, cardiovascular disease, immune disorders and infectious disease. Although there is no universal consensus on what constitutes vitamin D repletion, previous studies have shown that sub-optimal status is common in older people. A Research Paper in this issue provides further information on vitamin D status in older people in England, presenting the results of serum 25 hydroxyvitamin D [25(OH)D] measurements in 2,070 people aged 65 years and above taking part in the Health Survey for England (HSE) in 2005 (pp. 62–68). The prevalence of vitamin D deficiency, as defined by a serum 25(OH)D <25 nmol/l was 13% in women and 8% in men, whereas 57% of women and 49% of men had a serum 25(OH)D <50 nmol/l. Compared with the results of the HSE in 2000, there has been no improvement in vitamin D status. Having again confirmed that impaired vitamin D status is common in older people, how should this be addressed at a public health level? Concern about the risks of skin cancer has made people wary of sunlight exposure. The Department of Health only recommends a Reference Nutrient Intake of 400 IU vitamin D in people above the age of 65 years, who are at risk of vitamin D deficiency, such as those who are housebound. Even if a policy of widespread vitamin D supplementation was adopted, most preparations also contain calcium, which has an adverse effect on compliance with supplementation. Ideally we need an appropriate preparation of vitamin D and a regimen that is convenient, safe and effective at ensuring vitamin D repletion.

Finally, a Research Paper reports the findings of a national survey of the experiences of bereaved relatives of older adults in the community, dying from cancer and non-cancer causes (pp. 86–91). In both groups less than half of the participants reported that their relatives received treatment which completely relieved their symptoms some or all of the time, but relatives of people dying of cancer reported greater satisfaction with the support received. With the increasing interest in allowing people choice of where they choose to spend the end of their life, it is important that the quality of medical, nursing and social care is good across all care settings, irrespective of underlying medical conditions.

Professor R. M. Francis
Editor, Age and Ageing