

# Perspectives on ageism: understanding and combatting age discrimination in healthcare

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## ABSTRACT

Ageism is prevalent in Canadian healthcare settings. On average, Canadian seniors spend less time talking to their healthcare providers (HCPs) than any other age group. However, even when seniors are allowed to see an HCP, they can be subjected to discrimination based on age. This can lead to blunders in care such as undertreatment and/or overtreatment, misinterpretation of cognitive impairments such as functional impairments, and ineffective communication that is, ultimately, patronizing. Combating ageism requires implementing training for HCPs, revising institutional procedures, and addressing ageist attitudes amongst HCPs and older patients.

## RÉSUMÉ

L'âgisme est très répandu dans les établissements de soins de santé canadiens. En moyenne, les personnes âgées canadiennes passent moins de temps à parler à leurs prestataires de soins de santé (PSS) comparé aux autres groupes d'âge. Cependant, même lorsque les personnes âgées sont autorisées à consulter un professionnel de la santé, elles peuvent faire l'objet de discrimination fondée sur l'âge. Cela peut conduire à des gaffes dans les soins telles que des traitements insuffisants et/ou excessifs, à une mauvaise interprétation des troubles cognitifs tels que des troubles fonctionnels, et à une communication inefficace qui, en fin de compte, est condescendante. La lutte contre l'âgisme nécessite la mise en place d'une formation pour les professionnels de la santé, la révision des procédures institutionnelles et la lutte contre les attitudes âgistes des professionnels de la santé et des patients âgés.

American psychiatrist, Dr. Robert N. Butler, first coined the term “ageism” in 1969; since then, it has become one of the greatest impediments to modern medicine. Defined as the systematic stereotyping and discrimination against people because of their age, ageism is ubiquitous throughout Canadian healthcare settings (1).

In 2018, seniors were the fastest-growing age group in Canada with an estimated 4.8 million people aged 65 and older (2). This number is expected to double in the next five years (2). With just over 300 geriatricians in Canada, experts say another 500 are needed to provide effective medical care to the elderly (3). The lack of geriatricians

makes access to healthcare resources much harder for seniors. A report from the Canadian Institute for Health Information (CIHI) revealed that Canadian seniors endured a longer waiting period to see their doctors in comparison to those in 10 other high-income countries (4). Older adults are likely to have a greater number of, and more pressing, health concerns than the average Canadian (4). Seniors often present with multiple comorbidities, be it urinary tract infections, cardiovascular complications, osteoporosis, or dementia (4). If not given immediate medical attention, their health may rapidly deteriorate. Alternatively, while numerous factors affect one's decision to match to a specialty, inadequate exposure to caring for the elderly and the negative connotation associated with it may explain the unmatched geriatric residencies (5).

Even when seniors are able to see an HCP, they may still find themselves subject to discrimination based on age. For instance, ageism can take place behind closed doors when the physician refuses to differentiate age-related changes from pathognomonic findings (6). In some cases, a physician may avoid treating a certain pathology by merely labeling it as a feature of "old age" (6). This lack of homogeneity in treating patients may result in undertreatment and, in severe cases, medical negligence. A cross-sectional study by Davis et al. found that 64% of primary care providers (PCPs) agreed that "having more aches and pains is an accepted part of aging," while over half deemed it normal to experience forgetfulness (7). If HCPs solely attribute these symptoms to increasing age, conditions such as chronic pain, anxiety, depression, and cognitive impairment may go unnoticed. In the long run, age-based clinical decision-making will drain healthcare resources rather than save them.

Ageism is starkly apparent in encounters between patients and physicians. On average, Canadian seniors spend less time talking to their HCPs than any other age group (8). Once inside the room, the situation is no better. Elderly patients are usually accompanied by a companion to their medical visits. Doctors often take advantage of this by directly communicating with the family member, even if the patient in question is fully competent (9). While having a third person in the room can be beneficial, it may also affect the group dynamic. Seniors accompanied to their medical visits are less likely to raise topics with their doctors and are less assertive during the discussion (10). If patients do

not fully disclose their concerns to the HCP, this may result in an inaccurate medical diagnosis and may, ultimately, compromise the quality of care they receive. Therefore, when consulting with an elderly patient, it is important for HCPs to give their undivided attention. Doctors may also speak with the patient privately if they feel that this will strengthen the patient-physician rapport.

Ageism presents in a myriad of ways throughout the healthcare system. Stemming largely from the assumption that all members of a given group are alike, ageism inherently manifests within the attitudes of HCPs. It is so deeply rooted within our system that it enables common blunders in individualized care, such as the potential for the misinterpretation of cognitive impairments including functional impairments, and ineffective communication that is often patronizing (11). Combating it will require implementing a strategy that mandates geriatric training for HCPs, revisits institutional procedures, and addresses ageist attitudes amongst HCPs and older patients.

A critical place to begin is by developing an awareness of the inequalities that persist between age groups and to appreciate the diversity that exists amongst older adults. They differ in health and functional status, educational background, and cultural upbringing. Labelling older adults with descriptions such as disease, disability, and decline reinforces our current discriminatory perceptions of what aging entails. According to Ashton Applewhite, a renowned author and activist for ageism, it is essential that we attempt to reshape negative thoughts concerning aging in order to build a society that does not isolate older adults by allowing them to contribute to it (12).

An additional necessary step to fight internalized ageism is to foster intergenerational collaboration. Interaction between HCPs and older adults is imperative to changing our current misconception that older individuals are dependent and frail. The goal in any healthcare setting with the elderly should focus on individualized treatment plans that enable patients to remain independent, healthy, and outside of hospital settings. Williams et al. emphasized that healthcare outcomes depend on the physical health of a patient in addition to the HCP's ability to attend to their patient's psychosocial and biomedical needs (13). Effective patient-physician communication not only facilitates the exchange of health information, but it also

builds interpersonal relationships that encourage decision making and patient satisfaction. We can change the way practitioners interact with older adults by encouraging the use of age-friendly language, as well as refraining from associating the elderly with labels (12). This will allow for patients to be empowered to use both their skills and confidence to take responsibility for their health and wellness.

Better education is part of the solution to combat ageism (9). Those who work with the elderly in healthcare settings should receive training that dispels negative assumptions and attitudes towards the elderly and serves to increase awareness of how to appropriately respond to the aging process. Educational initiatives should include enhanced training in gerontology, care-giving skills, and communication techniques (14). Improved training for doctors, nurses, physician assistants, nurse practitioners, psychologists, and social workers, as well as paramedics, firefighters, and other first responders who work directly with older persons is a necessary starting point. With the aging of the population and longer life expectancies, HCPs need to become more familiar with the aging process and the needs of older adults (15). Since family physicians are often the first point of entry into the healthcare system, it is important that they receive more comprehensive training in caring for older adults than is currently offered (16). Besides HCPs, education must also be aimed at older persons so that they can identify if and when they are experiencing age-based discrimination in addition to knowing what recourses are available to address it (17). Keeping the elderly informed about ageist practices empowers them to take part in changing current healthcare practices.

The healthcare system has an obligation to actively address ageism. The task remains to define the approach to healthcare for older adults in a way that is not ageist. What does this look like? One possible advance is to develop healthcare services for older persons that moves away from standardizing assessment and treatment procedures across the age spectrum. Healthcare equity for older adults refers to equality, rather than uniformity, in the case-appropriateness of diagnosis and treatment (18). It means establishing care that respects the unique needs of the elderly, which achieves success in reaching desired health outcomes (18). Quality medical treatment is relative to what is required and what is adequate for that

particular patient. It requires an individualized, person-centered approach to care (19), and is in keeping with the anti-ageist ideology inherent in the principles of modern geriatric practice (20). It supports the potential for geriatric medicine to not only treat health conditions and reduce suffering in the elderly, but to also reconstruct ageist conceptions regarding patients' own aging and health (20).

We are all united by the natural process of aging, and it is important that we aim to challenge our ageist perceptions to create an accepting society. Becoming advocates for older adults means that we need to choose our words with care. Avoiding stereotypes and discrimination commonly associated with older age will allow us to positively affect both implicit attitudes and explicit actions. Supporting funding for clinical and educational research within the field of geriatrics is another prerequisite to gaining knowledge regarding how to build communication models that combat ageist language. Finally, it is critical to invest more in training qualified individuals who have an interest in providing healthcare to older adults. With the aging population growing rapidly, addressing the lack of HCPs with geriatric knowledge will aid our healthcare system in supporting all stages of life equally.

## REFERENCES

1. Achenbaum WA, Robert N, Butler, MD. Visionary Leader. *J Gerontol.* 2013;54:6-12.
2. Priest L. Canada's seniors: The doctor will see you now [Internet]. *The Globe and Mail*; 2011 [cited 2020 Apr 3]. Available from: <https://www.theglobeandmail.com/life/health-and-fitness/canadas-seniors-the-doctor-will-see-you-now/article576256/>.
3. Glauser W. Lack of interest in geriatrics among medical trainees a concern as population ages. *CMAJ.* 2019 May 21;191(20):E570-E571.
4. The Canadian Press. Seniors wait longer for doctor care in Canada than in other countries: report [Internet]. *CTV News*; 2015 [cited 2020 Apr 23]. Available from: <https://www.ctvnews.ca/health/seniors-wait-longer-for-doctor-care-in-canada-than-in-other-countries-report-1.2211748>.
5. Sinha S. Aging in the 21st Century: the Triumph and the Challenge [Internet]. *Western University*; 2019 [cited 2020 Apr 9]. Available from: [https://www.schulich.uwo.ca/rapport/2019/features/aging\\_in\\_the\\_21st\\_century\\_the\\_triumph\\_and\\_the\\_challenge.html](https://www.schulich.uwo.ca/rapport/2019/features/aging_in_the_21st_century_the_triumph_and_the_challenge.html).
6. Seegert L. Doctors are ageist - and it's harming older patients [Internet]. *NBCNews.com*. NBC Universal News Group; 2019 [cited 2020 Apr 9]. Available from: <https://www.nbcnews.com/think/opinion/doctors-are-ageist-it-s-harming-older-patients-ncna1022286>.
7. Davis MM, Bond LA, Howard A, Sarkisian CA. Primary Care Clinician Expectations Regarding Aging. *J Gerontol.* 2011 Dec;51(6):856-66..
8. The Royal College of Physicians and Surgeons of Canada. A Study of How Physicians Care for Seniors [Internet]. *Royal College*; 2016 [cited 2020 Apr 23]. Available from: <http://>

- www.royalcollege.ca/rcsite/health-policy/senior-care-e.
9. Senger E. Ageism in medicine a pressing problem. *CMAJ*. 2019 Jan 14;191(2):E55-E56.
  10. Ben-Harush A, Shiovitz-Ezra S, Doron I, Alon S, Leibovitz A, et al. Ageism among physicians, nurses, and social workers: findings from a qualitative study. *Eur J Ageing*. 2016 Jun 28;14(1):39-48.
  11. Dionigi RA. Stereotypes of Aging: Their Effects on the Health of Older Adults. *J Gerontol*. 2015;30:1-9.
  12. Applewhite A. What is Ageism? [Internet]. This Chair Rocks; 2020 [cited 3 July 2020]. Available from: <https://thischairrocks.com/>.
  13. Williams B, Anderson MC, Day R. Undergraduate Nursing Students Knowledge of and Attitudes Toward Aging: Comparison of Context-Based Learning and a Traditional Program. *J Nurs Educ*. 2007 Mar;46(3):115-20.
  14. Ouchida KM, Lachs MS. Not for Doctors Only: Ageism in Healthcare [Internet]. American Society on Aging; 2015 [cited 2020 Apr 9]. Available from: <https://www.asaging.org/blog/not-doctors-only-ageism-healthcare>.
  15. National Research Council (US) Panel on a Research Agenda and New Data for an Aging World. *Preparing for an Aging World: The Case for Cross-National Research*. Washington (DC): National Academies Press (US); 2001. PMID: 22787685.
  16. Gordon JE. Updated Survey of the Geriatric Content of Canadian Undergraduate and Postgraduate Medical Curricula. *Can Geriatr J*. 2011 Jun;14(2):34-9.
  17. Stankov G. Overcoming Ageism through education for the Third age [Internet]. ResearchGate; 2017 [cited 2020 Apr 3]. Available from: [https://www.researchgate.net/publication/327972020\\_Overcoming\\_Ageism\\_through\\_education\\_for\\_the\\_Third\\_age](https://www.researchgate.net/publication/327972020_Overcoming_Ageism_through_education_for_the_Third_age).
  18. Wyman MF, Shiovitz-Ezra S, Bengel J. Ageism in the Health Care System: Providers, Patients, and Systems. *Contemporary Perspectives on Ageism* 2018;19:193-212.
  19. Breslau ES, Gorin SS, Edwards HM, Schonberg MA, Saiontz N, Walter LC. An Individualized Approach to Cancer Screening Decisions in Older Adults: A Multilevel Framework. *J Gen Intern Med*. 2016 May;31(5):539-47.
  20. Coupland J, Coupland N. "Old Age Doesn't Come Alone": Discursive Representations of Health-in-Aging in Geriatric Medicine. *Int J Aging Hum Dev*. 1994;39(1):81-95.