

Ageist Behaviour and Health Care

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Abstract

Ageing populations worldwide present many issues for health services, not the least of which is the manner in which older people are treated by health care professionals. This paper examines national and international policies regarding attitudes of health care professionals when dealing with older people. The question is asked; is there an attitude of care and understanding or placation and dismissal and what could be the downstream health and wellbeing effects of such attitudes. Given the ageing pattern of many populations it becomes imperative to focus on health care professionals' attitudes and proposals are made for addressing this through policy and practice.

Introduction

Discrimination has been described as unfair or inequitable treatment; the derived beliefs of one socially defined group toward another (Krieger, 2001). It may be viewed as particularly insidious when targeted toward vulnerable populations such as the elderly. Social justice within the arena of aged health care should not only encompass fair and equitable access to resources but also the basic right to be treated in the same manner as any person regardless of age.

Rationalisation and distribution of health care has become an unavoidable factor in the management and treatment of illness for all strata of society and in itself may not be interpreted as evidence of an inequitable behaviour toward older people. However, when viewed in collusion with an attitude of dismissal by individuals responsible for the delivery of health care it is possible to understand how a correlation between the two may exist. Evidence suggests health care services may not be dispensed equitably to some groups viewed as less than worthy (Whitehead, 2000). Whitehead described possible manifestations of inequitable behaviour as the failure of health practitioners to apply the same professional expertise to older persons as in a lower likelihood of referrals to specialist care or shorter consultation times when compared to other social groups.

Defining age

When looking into the effects of attitudes toward older persons, it is useful to examine how old age is defined. Even though the term "old" is commonly utilised to describe a non-heterogeneous population it has been suggested that designations of age have become increasingly necessary as the human life span has lengthened (Nilsson, Sarvimaki & Ekman, 2000). Many international studies have utilised an age of 65 as the starting point for this definition while some others have used retirement to satisfy this criteria (World Health organization, ND 9). Often these are one and the same though a more detailed designation was discussed by Adelman, Greene & Charont, (1991) in which the older population was divided into three cohorts; those 65-74 as young-old, 75-84 as middle-old and 85 and older as old-old. All categories required different levels of care, assistance and progressively greater reliance on health services. A more basic delineation was suggested by Orimo, Ito, Suzuki, Araki, Hosoi, & Sawabi (2006) in which phases of old age were demarcated by the terms early and late elderly, categorised as 65 to 74 and people 75 and older, respectively.

Intuitively older populations are far from the homogeneous group often portrayed by society. Indeed the application of such age grading when viewed in such a wider societal context has been suggested

as a possible root cause for ageist behaviour creating an attitude of us and them (Hagestad & Uhlnberg, 2005). The manner in which humans age is affected by numerous determinants, including socioeconomic status, social support, personal relationships, resilience, autonomy, emotionality and education, not only across the lifespan but particularly in later years. For example, individuals with college or university education generally attained equivalence of age in death or disability a decade later than people with a lesser educational status (Larzelere, Campbell, & Adu-Sarkodie, 2011). What remains abundantly clear is that to impose an expectation on an individual's state of physical or mental condition on no other basis than chronological age is both inconsistent and unjust. Determinants which may affect the perception of ageing and being old are as varied as the individuals themselves. Therefore it is vital that expectations for non-ageist treatment relate to condition rather than uniformity of age.

A global perspective of health care and older people

Healthcare plays an important role in most lives, particularly within an older population. As international and domestic policies attempt to address inequality and prejudicial behaviour, the question remains how such policies influence the conduct of health care providers toward some of the most vulnerable members of our society. If health professionals harbour negative or discriminatory attitudes there may be significant psychosocial ramifications on the lives of their older patients. Globally, many health policies such as those which exist in the United Kingdom (UK) expressly forbid discrimination against age in the access to assessment and appropriate treatment (National service framework for older people, 2001). The United Nations Department for Economic and Social Affairs (2011) stated as an ultimate goal to "provide a system which ensures the health and wellbeing of all elderly citizens" (p.63). Synonymous terms for wellbeing are comfort, security, welfare, safety, health and happiness. Yet In spite of international accords such as the Ottawa (1986) and Bangkok charters (2005), espousing equality for all, discrimination against the aged continues to pervade societies within developed countries, devaluing older persons rights to equal treatment regardless of age (United Nations, 2011). Certainly there remains much doubt as to the efficacy of attempts to address ageist attitudes. Research indicates that discrimination, has been a persistent and seldom acknowledged characteristic of much clinical practice (Kapp, 1998) with narrative studies of the elderly recounting feelings of segregation, powerlessness and depersonalization during hospital stays in the United Kingdom (Miniciello, Browne & Kendig, 2000). A report on the British National Health Service stated there was a failure by the service to address older people with care, dignity and respect (Commission for Healthcare Audit and Inspection, 2007). It further reported that age discrimination complaints to the British Ombudsman for Health had reached an all-time high. Such evidence suggests that in the face of global policies and accords which clearly prohibit age discrimination, incidences of such events are continuing to rise. Should a comparable situation exist within the New Zealand (NZ) health service, what approach has the Government undertaken to mitigate the effects of similar ageist behaviour?

The 2001 NZ Government Positive Ageing Strategy (PAS) (Dalziel, 2001) acknowledged the need for society in general to attend to pervasive ageist attitudes. Indeed three of the four planning recommendations within the strategy involved improving the levels of expertise of those charged with caring for older individuals; at the forefront of which was the recommendation for an up skilling of any health practitioners such as general medical, nurses, therapists, social workers and public health professionals whose work included association with older people. The document however, appeared to focus on wellbeing of older people being coupled to economic benefit, i.e. to be productive is to be happy. The view that the positive discourse used in this and counterpart documents from Australia and the UK would lead to a happier healthier old age came under criticism (Davey & Glasgow, 2009). The PAS endorsed the rights of older people to contribute in useful and productive ways going so far as to actively discourage retirement at 65 years of age, whilst endorsing the fiscal benefits of promoting active contribution. The document, however, paid scant attention to the existence of

barriers to these objectives such as societal attitude, illness or mobility. Davey & Glasgow suggested that frailty, as a reality for some, meant that such idealistic goals of healthy ageing were not achievable. The intent of the PAS was clearly to promote healthy active ageing however in doing so it underplayed many of the barriers; indirectly suggesting that being healthy and active in old age were self-modifiable factors and within the control of older people.

Certainly, this situation indicates that policy may not necessarily reflect the reality of lived experiences. Policy makers, with good intentions, may view the promotion of equity in health care as a means of ultimately improving productivity of an ageing population. In practice however there appears to be a lack of participatory consultation when drafting such metaphorical wish lists. Taking into account the patient perspective, such as the manner in which health services provide for those with ever increasing needs, surely must begin by acknowledging in the first instance that those needs exist. Wellbeing when defined is not merely the absence of disease or illness; it is also an expression of a state of mind and it is important for health care not to be viewed solely as physiological in nature but also psychological to fulfil the full scope of the term. The manner in which older persons are treated when seeking health care may well reflect either an environment of care and dignity or placation and dismissal.

It is accepted that some level of physiological and psychological decline is inevitable with advancing age and will impact on the majority of people. (Stewart, Chipperfield, Perry & Weiner, 2011). Ageist paradigms have persisted however, which gratuitously portray older people as frail, ineffective; a burden on health resources and highly reliant on social services (Bowling, 1999). But how warranted really are epithets such as burden?

The World Health organization in 2005 approximated that 80% of deaths correlated to modifiable factors of stroke and heart disease were not a result of old age, yet the beliefs of these illnesses' association to old age endure (Stewart, Chipperfield, Perry, & Weiner, (2011). As such, older persons are frequently treated with ageist overtones and in a manner which though sometimes intended to be compassionate is often characterised by a condescending demeanor (Binstock & Post, 1991). Clearly, to entirely dismiss age as a factor in some conditions would be unreasonable however it then falls to the clinician to remain aware that to accurately treat older people one should resist preconceptions based on age.

It has been proposed that harmful stereotypical characteristics attributed to the aged as adopted in later life prime an individual to behave in a self-fulfilling manner (Levy, 2003). The activation by triggers of self-stereotypes as suggested by Levy, Ashman & Dror, (2000) may indeed produce adverse effects on the quality of life of older individuals. The potential to direct attitude regarding life and survival, through the influence of those held in high regard such as doctors becomes of critical importance. Acceptance of the effects of multiple chronic conditions in older people has been shown to occur in conjunction with a resignation of "just becoming old" and a concomitant acquiescence to reduced function and mobility (Clarke & Bennett, 2012). Should this become further reinforced by those with a perceived ability to heal, the effects of decline may well become magnified. It is therefore befitting of health professionals to become aware that their attitudes or negatively primed expressions may have unintended and unfortunate health effects on older patients.

Ageism in clinical practice

It would appear intuitive that those involved in health care should be by nature of a sympathetic, tolerant disposition (Herdman, 2001). Such altruistic temperaments may not preclude however, an unintentional or benign over accommodation toward older people and may stem from a lack of training and preparation for dealing with the complex health needs associated with this population. Furthermore, an unintended consequence of insufficient training in the area of elder health care is the failure to generate the same interest as other areas in spite of reporting the highest rate of job satisfaction for any medical subspecialty (Adelman, Capello, LoFaso, Greene, Kpnopasek & Marzuk,

2007). Turcotte (2003) discussed the tendency of clinicians to misdiagnose health complaints of older persons citing training as a major determinant. Only three of 145 medical schools in the United States provided dedicated geriatric departments and as few as ten percent of the remaining 143 requiring any course work at all in gerontology. Indeed it was observed that medical graduates were exceedingly unlikely to specialise in careers involving older adults (Weir, 2004). The resultant shortfall of clinicians who were adequately prepared to work with older people is of serious concern. Given that pervasive social attitudes toward older individuals may be the subjective frame of reference for many professionals, it seems likely that accessing suitably trained health providers becomes in the least problematic. Turcotte (2003) further reported that clinicians poorly educated in geriatric needs not only tended to misdiagnose but were more inclined to offer fewer treatment options opting to focus on symptomatic aspects only. Some evidence has suggested that when compared to younger patients, not only was the standard of care poorer for older individuals but consultation times were also routinely shorter (Fernando, Arora & Chrome, 2011). Moreover, combined with reduced consultation times a paternalistic approach to making decisions about health care options with older patients may have contributed to misdiagnoses, exacerbating the issues associated with poly-pathology (Stewart, Chipperfield, Perry & Weiner, 2011). Certainly it has been acknowledged for many years that the co-existence of a variety of medical conditions in addition to altered tolerance to polypharmacy in older individuals necessitates considerable proficiency. Many geriatricians have conceded that multiple visits are often required to satisfactorily assess a patient (Adelman Greene & Charont, 1991) with anecdotal evidence often suggesting that clinicians may choose to assess a given medical condition differently if at all. Furthermore, options for treatment or ongoing investigation may also be limited for older patients. The Alliance for Ageing Research (2003) discussed five areas of concerns for older individuals when seeking health care, these were: inadequately trained health professionals; less preventative care; failure to administer preventative treatment including referral for screening; exclusion from established medical interventions and finally exclusion from clinical trials. Thus it appears evident that clinicians may obtain varying outcomes when treating an older patient.

It may be possible that a solution lies in the manner in which elder health is introduced to upcoming future health professionals. Wilkinson & Sainsbury (1998) examined the effect of gradual exposure of medical students to older patients in a Christchurch teaching hospital over three years. Year one commenced with predominantly well patients culminating in year three and advanced degrees of illness. The authors demonstrated that exposure and instruction in geriatric care was able to alter positively the attitudes of medical students toward older patients. Results such as these are supported by similar studies which highlight the importance of exposure and preparation for managing older health (Bernard, McAuley, Belzer & Neil, 2003). However, a search of leading medical teaching institutions in New Zealand indicates that study of the needs associated with older people remains the domain of elective course work or post graduate specialisation. A danger exists that in the absence of the appropriate skills with which to manage older health, some health professionals may resort to what has been described as the fair innings argument as a measure of value (Weir, 2004) which refers to the prioritisation of care based on the crude equation of years lived versus years likely to live.

Conclusion

Within a doctor patient relationship, decisions surrounding the allocation of resources should be undertaken in an informed, compassionate manner, reflecting that any decisions are made in the patient's best interests as an individual rather than being correlated to their age. For the promotion of health to older persons to be effective, beliefs surrounding the homogeneity of this sector of the population must be amended with health providers at the forefront of any such attitudinal change (Stewart, Chipperfield, Perry & Weiner, 2011).

It is hoped that through future research, the attitude of health professionals may be fashioned in such a way as to encourage open, unbiased communication with older people so that they may engage freely with their providers unencumbered by any societal constraint associated with becoming old.

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