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Ageism's Influence on Health Care Delivery and Nursing Practice

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Abstract

Ageism is defined as the intentional and/or subconscious discrimination against elderly people. Despite the prevalence of ageism, nurses are able to offset prejudice against the elderly and improve the quality of health care for older patients by educating patients, families, and health care providers about the effects of ageism and by advocating for the delivery of unbiased care. In order to discuss the extent to which ageism affects the quality of health care and nursing practice, this paper reviews the published literature pertaining to ageism. Elderly cancer patients are even more affected by ageist attitudes and beliefs, and as a result experience poorer health outcomes. Future research should continue to explore the effects that ageism has on the health of the elderly so that changes to nursing practice and health care policy can be made, thereby providing all patients with high-quality health care.

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The faculty sponsor of this paper is Sarah Kagan, PhD, FAAN, RN.

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Abstract

Ageism is defined as the intentional and/or subconscious discrimination against elderly people. Despite the prevalence of ageism, nurses are able to offset prejudice against the elderly and improve the quality of health care for older patients by educating patients, families, and health care providers about the effects of ageism and by advocating for the delivery of unbiased care. In order to discuss the extent to which ageism affects the quality of health care and nursing practice, this paper reviews the published literature pertaining to ageism. Elderly cancer patients are even more affected by ageist attitudes and beliefs, and as a result experience poorer health outcomes. Future research should continue to explore the effects that ageism has on the health of the elderly so that changes to nursing practice and health care policy can be made, thereby providing all patients with high-quality health care.

In its broadest definition, ageism is “prejudice toward, stereotyping of, and/or discrimination against any person or persons directly and solely as a function of their having attained a chronological age which the social group defines as *old*” (Penson, Daniels, & Lynch, Jr., 2004, p. 347). While attitudes and beliefs often reflect ageism, such bias is also evident in language, behaviors, and policies (Penson et al., 2004; Tsuchiya, Dolan, & Shaw, 2003). Ageism is a significant problem because it directly influences patient mortality. A study by Levy, Slafe, Kunkel and Kasl (2002) suggests that positive self-perceptions of aging have a greater effect on lengthening lifespan than do either low systolic blood pressure or cholesterol. Furthermore, patient outcomes are indirectly affected by ageism. For example, providers’ biases towards the elderly often result in the exclusion of older patients from clinical trials and a reluctance to pursue aggressive treatments, especially with geriatric cancer patients (Muss, 2003; Penson et al., 2004).

Ageism is a widespread form of discrimination that has both direct and indirect detrimental effects on the elderly population, especially in older patients with cancer. Nevertheless, it is possible to counteract ageism and to improve the quality of life and health care delivery for elderly patients. Nurses are in a position to lead this movement because the reduction of ageism is an educational issue. Greater patient, family, and provider awareness of ageism will lead to decreased prejudice toward the elderly and have a positive impact on gerontological health care.

This paper will review the current research and existing literature pertaining to ageism. After a more thorough analysis of the articles discussed, the feasibility of implementing suggested interventions will be explored.

Finally, this paper will discuss nursing implications related to ageism.

Method

The articles selected for review concentrated on one of the following three areas: ageism, ageism and health care practice, or ageism and cancer. Using the online Cumulative Index to Nursing and Allied Health Literature (CINAHL), a search for “age discrimination” limited to articles published in English from 2001-2007 was combined with a search for “nurse” and then for “cancer,” both of which were run with the same limitations.

Age Favoritism

Tsuchiya, Dolan, and Shaw (2003) go beyond acknowledging that the elderly are discriminated against in an attempt to discover why young people are favored. In their empirical study, Tsuchiya et al. conducted two rounds of interviews with adults of all ages to determine the order in which the subjects would treat hypothetical patients aged 5, 20, 35, 55, and 70 years, and the motivations behind their decisions. The results support the hypothesis that health care providers often favor younger people over older adults when providing care because they are perceived as being more productive and as having greater potential to live longer and healthier lives (Tsuchiya et al., 2003).

Limitations of this study include a small sample size and a homogenous population. Only 31% of the people invited to participate responded. All participants were voters of unknown ethnicity in one English city; this likely well-educated sample may or may not be representative of the local population at large. Additionally, almost all of the participants in both interviews were non-smokers and there was an overrepresentation of parents in the participant population. Finally, the methods of measurements are

questionable. Participants were forced to make hypothetical choices without having the option of ranking any of the ages equally, so the results may not accurately reflect their perceptions (Tsuchiya et al., 2003). While elderly people were not the target subjects of this particular study, the results suggest a pervasiveness of ageism among younger members of society. The next article discusses research findings that are directly applicable to all elderly patients.

Self-Perceptions

Because of the all-encompassing nature of ageist stereotypes, Levy, Slade, Kunkel, and Kasl (2002) argue that older people have more difficulty protecting themselves from age discrimination and will often subconsciously internalize the negative perceptions. By superimposing data from an aging and retirement study onto data from the National Death Index, the authors deduced that people with positive self-perceptions related to aging live years longer than people with negative outlooks, either because of this optimism alone or by channeling positive thoughts through a “will to live” mechanism (Levy et al., 2002, p. 267).

While the findings are remarkable, the study has one clear limitation: the study from which the authors obtained their data was conducted in the 1970s, and all data were gathered in one small Midwestern town. Matching limited data from 30 years ago with current data may not provide an accurate assessment of today’s elders’ perceptions. Finally, the data may not be representative of ethnically diverse older patients from urban and minority backgrounds.

Nurses’ Perceptions of Elderly Patients

Nurses, like the general public and even the elderly themselves, discriminate against older patients (Cooper & Coleman, 2001). Cooper and Coleman (2001) explored the extent to which society influences hospital nurses’ perceptions and examined how the demands of the profession influenced nurses’ opinions about elderly patients. They found evidence that nurses prefer patients who defy society’s negative ageist stereotypes: notably, patients who are mentally intact.

An Alternate Perspective

Not all research supports the idea that ageism influences nursing practice. In an open-ended survey of nursing students, Herdman (2002) provides nursing students with the opportunity “to position themselves within the discourses of elderly care” (p. 108) and reflect upon the relationship between nurses and elderly patients. Herdman refers to “the dysfunctional image of nurses as ageist” (p. 107) and states that the nursing students’ responses do not reflect ageist attitudes, although less than 9% of the 96 students who volunteered to be surveyed were

considering a career in geriatric nursing after graduation.

A limitation of the Herdman (2002) study is the small sample size made up of volunteers, which may not be representative of all nursing students. Also, it is impossible to generalize these findings to all elderly patients; because the study was conducted in Hong Kong, the results may be affected by cultural influences. Furthermore, it seems the data do not support the conclusions drawn by the author throughout the article.

A Specific Example

Peake, Thompson, Lowe, and Pearson (2003) performed a national questionnaire-based study of lung cancer patients divided into three groups: under 65 years, 65-74 years, and 75 years and older. Quite simply, Peake et al. found that “older patients were less likely to receive active treatment of any sort,” (p. 174) even though other studies have suggested that elderly patients respond to surgery and chemotherapy as well as their younger counterparts with the same functional status. While ageism among clinicians is one possible explanation, families may also see older relatives as “too ‘frail’” (Peake et al., 2003, p. 175) for treatment, and it is possible that the elderly are more likely to decline treatment when offered (Peake et al., 2003).

Like two of the previous studies, this research focused on patients in the United Kingdom (UK), where lung cancer mortality rates are higher than those in the United States (Peake et al., 2003).

Numerous flaws in experimental design further limited the results: nearly 2/3 of the participants were male, smoking statuses and causes of death were not recorded, and radical and palliative radiotherapy were not separated from one another, restricting the validity of the data supporting this particular treatment (Peake et al., 2003).

Ageism and Cancer: A Case Study

An article by Penson, Daniels, and Lynch, Jr. (2004) begins with a dialogue between medical professionals who reflect upon their own ageism while discussing a case study of an elderly woman with lung cancer. The authors then present a general discussion of cancer therapies and ageism, arguing that health care professionals “must treat their patients based on physiologic, rather than chronologic, age” (Penson et al., 2004, p. 350).

After a discussion about how “age is not a disease” (Penson et al., 2004, p. 345) and how the medical treatment of the elderly--especially older cancer patients--is grossly inadequate, the authors express their own prejudice by opening their conclusion with an assumption that although “we all hate getting older, aging is inevitable” (Penson et al., 2004, p. 350). Despite this one limitation, the main

ideas of the article can effectively be applied to the care of geriatric patients.

Cultural Difference

An editorial by Muss (2003) explores the cultural differences between medical care in France and the United States. After 320 French and American cancer outpatients between the ages of 70-95 were surveyed, the author described ageism as “a cultural bias” (Muss, 2003, p. 3189) that puts older people at a medical disadvantage. Muss (2003) addresses an interesting cultural conflict as well. Unlike patients in France, those in the United States are encouraged to take sole responsibility for their health. However, many older Americans prefer to have their physicians make treatment decisions for them. Consequently, elderly American patients are less likely to choose aggressive treatments for themselves, resulting in poorer health outcomes when compared to their French counterparts, whose physicians often encourage the use of aggressive treatments (Muss, 2003).

“The Enemy Within”

Levy (2001) considers ageism a form of abuse “largely ignored by our society” (p.578) that goes beyond elders’ subconscious internalization of stereotypes to include active self-stereotyping, or conscious beliefs about the elderly population in general. Levy (2001) also states that the above forms of discrimination are “mutually reinforcing” (p. 579) and may occur simultaneously.

To reduce ageism, Levy (2001) encourages health care workers to become aware of the subtle forms of ageism inside of themselves. Limitations (i.e. the population studied for this article) are unclear, as this article is a general overview of previously accumulated knowledge.

One Hospital's Campaign

To make hospital staff members more aware of the subtle impacts of ageism, one hospital in the UK launched a poster campaign to remind health care workers that elderly patients must be treated with respect (Moore, 2005). Nurses were especially targeted by this effort because of their close relationship with patients and their potential “to really make a difference to the hospital experience,” and the effects of the intervention (while not discussed in detail) have been described as “very positive” (Moore, 2005, p. 26).

Suggested Approach to Geriatric Care

Nurses are not the only members of the health care team that need to reflect on their ageist perceptions. A review in support of a research report from Scotland targets physicians and patients as well, supporting a “teamwork” approach to geriatrics and encouraging older people to remain active and healthy (Rochon, Bronskill, & Gurwitz,

2002). Rather than targeting a select population of patients, this article focuses on promoting a model of care for geriatric patients (Rochon et al., 2002). The review only promotes the original study, whose limitations are not discussed (Rochon et al., 2002).

Analysis

The research and literature articles selected for review discussed many of the same principles. Six of the ten articles directly state that ageism is a problem in modern society (Levy, 2001; Levy et al., 2002; Moore, 2005; Peake et al., 2003; Penson et al., 2004; Tsuchiya et al., 2003). Several of the articles use examples of cancer research to illustrate the tremendous impact that ageism has on health care delivery; the discussion of the dialogue between various medical professionals even cited the cancer-related research article reviewed independently in this paper (Muss, 2003; Peake et al., 2003; Penson et al., 2004). The violation of the ethical principle of patient autonomy occurs frequently in the literature and is usually seen as a result of clinicians’ biases toward the elderly interfering with appropriate care delivery (Cooper & Coleman, 2001; Muss, 2003; Penson et al., 2004). Most of the articles explore how ageism affects patient care, but only two (Penson et al., 2004; Rochon et al., 2002) mention how the exclusion of the elderly from medical research and clinical trials indirectly harms elderly patients.

Despite numerous similarities, there were some important differences in the ideas, findings, and recommendations presented by the various authors. Herdman (2001) dismissed the notion of ageism’s potential impact on the nursing profession completely, stating that her research revealed “no clear link between career preferences and attitudes towards elderly patients” (p. 112) among nursing students. One article (Penson et al., 2004) stated that age-related assumptions are often necessary in order to provide physiologically-appropriate care to elderly patients, and another (Levy, 2001) argued that positive aging stereotypes can actually improve patients’ cognitive functioning. Ethnic differences, which are discussed in the literature, also seem to affect how societies and individual patients view older adults, with less evidence of ageism found in Asian cultures as compared to those in Europe and the United States (Cooper & Coleman, 2001; Herdman, 2001; Levy, 2001; Levy et al., 2002; Moore, 2005; Muss, 2003; Peake et al., 2003; Penson et al., 2004; Rochon et al., 2002; Tsuchiya et al., 2003). From these findings, the authors make several recommendations for terminating ageism including working to change ageist societies, altering clinicians’ perceptions of the elderly, using health care teams to treat geriatric patients more effectively, and

encouraging “meaningful intergenerational contact” (Levy, 2001, p. 579) between the young and old to improve elderly patients’ spirits. However, one author argues that ageism is an inherent part of human nature and does not propose any suggestions for reducing its occurrence (Cooper & Coleman, 2001; Levy et al., 2002; Moore, 2005; Peake et al., 2003; Penson et al., 2004; Rochon et al., 2002; Tsuchiya et al., 2003).

Problems with generalizing findings to the United States and conflicts over specific issues related to patient care are prevalent throughout the literature. Only half of the articles reviewed included research performed on elderly Americans, so the extent to which the findings can be applied to patients in the United States is uncertain (Levy, 2001; Levy et al., 2002; Muss, 2003; Peake et al., 2003; Penson et al., 2004). One author found that elderly patients tend to rely on their doctors and their families to make health care decisions on their behalf (Muss, 2003), while another (Moore, 2005) cited examples of elderly people being offended by such practices. Penson et al., (2003) even suggested that caregivers and patients engage in “collusions,” (p. 349) or purposely deceitful conversations, during verbal interactions so that they will not have to discuss painful and/or emotional topics.

Most of the current literature is limited to exploring the prevalence of ageism in hospitals and among the general public, and to explaining how this discrimination affects the care of elderly patients with cancer. Other environments, diseases, and chronic conditions do not seem to be well-researched. Although the literature suggests that reformation of health care providers’ attitudes toward elderly patients is necessary, more research is needed to identify specific ways in which clinicians should change their approach to geriatric care.

Implementation

Ageism is a widespread form of discrimination that not only affects the self-esteem of older people, but also compromises patients’ autonomy. Some research even suggests that patient age and providers’ beliefs directly impact how “caregivers communicate with, impart information to, and treat their patients” (Penson et al., 2004, p. 348). Thus, health care providers have an ethical obligation to reduce ageism—in themselves and in others—whenever possible in order to provide appropriate care. Nurses are in an ideal position to lessen the impact of ageism on elderly patients because they work as health care team coordinators and have the responsibility of educating patients, families, and other team members.

Ideally, nurse leaders would be able to decrease the incidence of societal ageism by influencing legislation

and advocating for policy changes. While this is an important long-term goal to ensure protection of elders’ rights, immediate solutions are needed as well. As the care providers with the most direct patient contact, nurses are in a position to provide continual emotional support and positive reinforcement while encouraging patients to remain active and healthy. Nurses should assess patients for any signs of loneliness or depression that may reflect some of the harmful effects caused by ageism in the past and pursue the treatment of such conditions. As health care team leaders, nurses must go beyond encouraging communication between the professionals involved with a patient’s care to include advocating for *unbiased* care as one of their priorities for each individual patient. In order for the nurse to do this successfully, he or she must be consciously aware of his or her own biases towards the elderly and manage them appropriately.

All clinicians could potentially benefit from increased self-awareness, provided via conferences or meetings in any clinical setting (i.e., hospitals, assisted-living facilities, and nursing homes). It would be helpful to integrate ageism awareness and bias reduction into curriculums of medical and nursing schools so that future clinicians will be able to approach *every* elderly patient with an awareness of ageism and the harmful effects that result from this form of discrimination. Some medical schools already have programs that pair new students with “elderly mentors” (Penson et al., 2004, p. 349) for a few years so that young physicians have the opportunity to learn directly from older patients.

Another nursing intervention includes frequent interaction and ongoing communication with patients and their families, who may need to be educated about the dangers of ageism as well. When appropriate, friends and family members of all ages should be encouraged to visit the patient, since “benign neglect” (Levy, 2001, p. 578) often fosters ageism. It is important to note, though, that culture often influences how elderly people are perceived within family structures. Therefore, nurses must strive for cultural competence in order to uphold a trusting relationship and provide high-quality, individualized health care based on each patient’s values and preferences.

If nurses make an effort to lessen the impact of ageism on each elderly patient during either acute or prolonged care periods, patient satisfaction will almost certainly improve. In addition to developing a more trusting working relationship with clinicians, elderly patients may also experience an increase of positive self-perceptions that could then result in more elevated moods and better functional health status. More research is needed to

determine if such interventions would have these effects.

Conclusions

Almost all of the reviewed literature supports the idea that ageism is prevalent in modern society and that this form of discrimination has a negative impact on the quality of life and of health care provided to elderly patients. Cancer patients seem to be disproportionately affected by health care providers' ageist beliefs, which is significant because 60% of all cancers occur in people aged 65 and older and the elderly population will soon comprise almost 20% of the entire population of the United States (Penson et al., 2004). Thus, cancer-related ageism will become an even more significant issue in the future (Penson et al., 2004).

While researchers like Levy (2001) and Tsuchiya et al. (2003) suggest that ageism is subconsciously distributed throughout the entire population, older patients seem to have a greater awareness of ageism in acute care settings. One elderly patient said, "I used to be someone...people used to listen to me but now, when I am in [the] hospital, people seem to look though [*sic*] me" (Moore, 2005, p. 25). Another interviewee expressed a desire for health care providers to "stop using age as an excuse for not giving proper treatment" (Rochon et al., 2002, p. 1232).

The implementations of the findings are directly related to nursing practice, which should be refocused to emphasize the fundamentals of nursing theory in the clinical setting. Health care ethics, team coordination, patient advocacy, and patient and family education would consciously shift to the forefront of the nursing process while caring for the elderly. Such evidence-based practice would ensure that patient needs are met to a greater degree, as the literature suggests that an increased awareness of ageism would result in greater patient satisfaction and improved outcomes.

To further improve the quality of health care provided for the elderly, future ageism research should expand beyond hospitals and cancer patients to include other chronic diseases and elder care settings (independent housing, nursing homes, and assisted-living facilities) in order to determine if ageism affects patients in all environments equally. The reasons why it exists to such an extent in society should then be explored. With this knowledge, it would be possible to research ways for nurses and other health care providers to improve the quality of care provided to the elderly and to ultimately oppose this subtle form of discrimination.

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