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Pervasive Ageism and Bias Toward Older Adults in the Healthcare System

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December 20, 2021

The COVID-19 pandemic has brought to light insidious, long-standing ageist practices within the healthcare system (Inouye, 2021). These pervasive issues have been well documented within scientific literature and are an increasingly urgent topic given the rapidly aging population (Burnes et al., 2019).

Although older adults remain significant healthcare consumers, there are negative attitudes among medical professionals and ageist barriers within the healthcare system that make it difficult for older citizens to receive high-quality healthcare (Wyman et al., 2018). These ageist barriers negatively impact older individuals' physical and mental health, leading to worse health outcomes and increased mortality (Burnes et al., 2019; Inouye, 2021). To ensure older adults have equitable access to quality health services, the healthcare system must acknowledge the pervasive and systemic exclusion of older adults and dismantle outdated ageist attitudes through increased education, training, and interventions designed to combat age-related bias.

Ageism in the Healthcare System

Ageism is defined as discrimination or prejudice towards individuals solely based on their age (Burnes et al., 2019). This form of age-related ostracism, although often implicit and unconscious, can manifest in how individuals think, act, and feel about aging (Ayalon & Tesch-Römer, 2018). One of the primary drivers of this age-related prejudice is death anxiety and denial, where individuals associate aging with death, resulting in the need to dissociate and suppress thoughts about our finite time on earth (Ben-Harush et al., 2016).

Ageism is expressed in the age-related biases among healthcare providers, age-specific treatment cut-offs, and lack of education on the distinct health needs of older adults (Inouye, 2021; Wyman et al., 2018). The age-related bias and discrimination is also present in long-term care institutions where elders often fail

to receive high-quality care, resulting in unnecessary institutionalization and increased mortality risk (Gruneir et al., 2015)

In addition, the literature also demonstrates that ageist practices present significant barriers for seniors when trying to access healthcare, i.e., that age, rather than need, often dictates who will qualify for treatments or procedures (Inouye, 2021).

Aging is not an ailment or a disease but a gradual process that we all undergo– it is NOT synonymous with a decline in function but a natural progression of life (Hekmat-panah, 2019). Although comorbidities are often more common as age increases, not all cognitive, biological, or functional changes occur uniformly as aging is a highly variable process (Hekmat-panah, 2019). Ageist assumptions unfairly generalize co-morbidities for the entire ageing population, when many elderly people are quite able and productive their entire lives (e.g., Northrop Frye, Robertson Davies, Leonardo DaVinci and Buckminster-Fuller).

Ageist Barriers That Older Adults Face in the Healthcare System

Ageist Terminology and Discriminatory Communication

Long-standing ageist terminology and means of communicating with older adults continue to prevail in healthcare despite the growing aging population (Ben-Harush et al., 2016). A commonly used term in healthcare to refer to individuals over the age of 65 is "elderly." Although seemingly harmless, this term carries negative ageist connotations (Hekmat-panah, 2019). Describing a patient as "elderly" retracts from the individual's unique characteristics and conveys ageist biases that impact first impressions, demean communication, and ultimately affect the quality of care that older adults receive (Hekmat-panah, 2019; Burnes et al., 2019). To ensure care is provided based on facts rather than discriminatory practices, healthcare providers should simply mention a patient's name and age when communicating rather than using outdated, derogatory, and unnecessary terms (Wyman et al., 2018).

In conjunction with ageist terminology, another worrisome trend in healthcare is medical professionals not actively involving older patients in healthcare decisions (Ben-Harush et al., 2016). Decisions about older adults

should never be made without their involvement. When caring for older patients, physicians tend to show less respect and involve older individuals only minimally in decision making, retracting from person-centered care, and undermining the patient-physician relationship (Wyman et al., 2018). Even more concerning, when discussing care plans with older individuals in the presence of younger family members, medical professionals effectively ignore the individual by approaching family members instead, rather than the patient. Often, they make decisions without even consulting the older patient, thereby excluding individuals from their care (Ben-Harush et al., 2016).

In addition to barring older individuals from decisions regarding their care, discriminatory communication exists in the interactions between healthcare providers and older patients. For example, Wyman et al. (2018) found that nurses are more likely to only engage in care-oriented conversation, have shorter discussions, and use condescending language when dealing with older adults. Adding insult to injury, patronizing tones and infantilizing language are also often used by healthcare professionals with older adults (Ben-Harush et al., 2016), thereby perpetuating the ageism that older individuals face and decreasing the quality of communication,

Rationing Healthcare and Age-Related Cut-Offs

Arguably the most worrisome bias older individuals face within the healthcare system is the rationing of resources and services based on ageist policies and procedures. The deeply unjust process of healthcare rationing involves utilizing age as the primary if not sole determinant of resource allocation and the foundation for clinical decision making rather than the risk of mortality, functional status, or prognosis (Farrell et al., 2020; Hekmat-panah, 2019).

Although these discriminatory practices have long existed, they have become much more evident during the COVID-19 pandemic as healthcare systems worldwide utilized age-based rationing in response to ventilator shortages (Inouye, 2021). The lack of support and safeguards in long-term care institutions during the pandemic is a glaring example.

We can see that it is explicit and implicit ageist policies which drive healthcare rationing through arbitrarily using age cut-offs as rationale to exclude older adults from accessing services necessary to prevent and treat disease (Farrell et al., 2020). Discriminatory age cut-offs within the healthcare systems pose

significant barriers for seniors when trying to access services, compromise the quality of care provided, and ultimately put them at risk (Wyman et al., 2018; Burnes et al., 2019). Solely denying care based on age is unfair and unethical as there are means to determine the risk and benefit of medical procedures regardless of age (Hekmat-panah, 2019). Finally, the allocation of healthcare resources should not be dictated solely on the basis of age, but rather on strictly based on age but instead prognosis, risk of mortality, and functional status. Increased age is not synonymous with increased risk (Inouye, 2021).

Lack of Education of Health Care Professionals on Older Adults

A significant driver of many of the ageist attitudes and practices within the healthcare system is the lack of education of healthcare providers on the biological, psychological, and social needs of older adults. According to Wyman et al. (2018), many educational programs for healthcare professionals do little to confront and correct ageist attitudes or entice new graduates to pursue careers in eldercare. Further adding to this issue, in most medical schools, students spend three hours learning about pediatrics for every 1-hour learning about gerontology, and in some cases, new doctors do not complete any official training on the health and emotional needs of older adults (Inouye, 2021).

Without the knowledge to help maximize the health of individuals as they age, there is an increased risk of adverse drug reactions as a result of polypharmacy and a greater likelihood of delayed or inaccurate diagnoses due to a lack of understanding of atypical disease presentation commonly seen in older adults, both of which can lead to serious injury or death (Inouye, 2021). In addition to this lack of education, there is also an overall shortage of physicians specializing in geriatrics. According to Glauser (2019), there are only three hundred geriatricians practicing in Canada, and in some provinces, there is only one qualified professional who can provide specialized eldercare.

This lack of adequate education and ageist attitudes drive the prevailing belief among the medical profession that frail older adults should be institutionalized (Buttigieg et al., 2018). This profoundly flawed bias increases the already lengthy wait times for long-term care (LTC). It also places unnecessary strain upon a system that does not have the capacity or funding to meet the basic needs of older adults (Ontario Health Coalition 2019). Furthermore, the Canadian Institute for Health Information (2020) highlights that from 2018-2019 one in nine

older adults living in LTC institutions could have aged from the comfort of their own home if only they had access to necessary home care support. Demonstrating that the Canadian healthcare system has failed not only to create the infrastructure required to support older individuals to age in their own homes but has also failed to equip novice medical professionals with knowledge of alternatives to LTC institutions.

How can Ageist Practices within Healthcare be corrected?

Given the profoundly troubling age-related discrimination in the current healthcare system, there is a clear need for system-wide change to safeguard the health of older adults. Ageism is a vicious cycle that has become embedded in how society and healthcare systems communicate, react, and respond to older adults (Ayalon & Tesch-Römer, 2018). Although ageist barriers within the healthcare system are highly complex, *the first step to resolving this insidious issue is quite simple; the healthcare system must acknowledge ageism and decisively work to eliminate it* (Wyman et al., 2018).

Since it is not possible to address a problem without first acknowledging it, healthcare systems must first recognize that ageist practices and policies exist at all levels of care provided to older adults (Wyman et al., 2018).

Second, individuals of all ages working in the healthcare industry need education on ageism and the negative impact their prejudiced behaviour has on older adults' health and quality of care (Inouye, 2021).

Third, in conjunction with acknowledging this bias and providing education to actively combat ageism within the current model of care, *targeted interventions must also be deliberately incorporated into an eldercare system* (Burnes et al., 2019). A person-centered approach uniquely responsive to older individuals should be used (Wyman et al., 2018).

Utilizing an age-appropriate, person-centered approach is especially important when healthcare providers support and plan with vulnerable older adults. To support autonomy and respect while empowering elders to make informed decisions, healthcare professionals must consider patient preferences and be aware of alternatives to LTC institutions (Ebrahimi et al., 2021). By using age-appropriate communication techniques, involving older patients in decisions,

considering their preferences, and eschewing offensive "baby-talk" approach, healthcare providers can help lessen the impact of ageism (Inouye, 2021).

Fourth, the healthcare system must also make radical changes within the context of the COVID-19 pandemic and beyond to halt healthcare rationing and instead allocate health resources based on suitability rather than age. Healthcare providers and researchers must work together to develop and disseminate evidence-based clinical guidelines that outline the equitable allocation of health resources based on functional status and prognosis (Wyman et al., 2018).

To end discriminatory practice, *there must also be transformation within eldercare to focus on increasing capacity within preventative home and community care rather than providing health services in long-term care institutions* (National Research Council Canada, 2021).

Finally, to start to resolve the long-standing ageist practices that have prevailed in medical education, *there is a clear need to build capacity within the workforce to prepare novice healthcare providers to meet the health needs of older adults.* To enable this, universities and colleges need to redesign their curriculum to include required content on ageism and the health needs of older adults both physically and emotionally, increase the number of faculty specializing in geriatric care and create programs that allow for advanced training in this increasingly relevant field (Institute of Medicine, 2008). Academic institutions must also provide better education for healthcare providers on community-based care options for older individuals and the benefits they provide, which will help to decrease unnecessary LTC admissions (Siegler et al., 2015; Ontario Health Coalition, 2019). By increasing capacity through education, physicians and other medical professionals will be better prepared through their medical education to provide care based on the needs of an individual and not on their age.

Although deeply tragic, the COVID-19 pandemic has irrevocably exposed the extent of current ageist practices within healthcare systems worldwide. One of the most disturbing examples is the COVID-19 mortality rates seen in LTC institutions across Canada, which made up 80 percent of virus-related deaths, doubling the average of other OECD nations (Ritts, 2020). With this discriminatory practice more evident than ever to the public eye, the pandemic has prompted an unprecedented opportunity to push for system-wide changes within

the healthcare industry and eldercare to protect and preserve the health of older adults (Inouye, 2021).

Conclusion

The current ageist practices and attitudes that exist in healthcare which perpetuate the ideology that older adults are disabled, unproductive and so expendable must be dismantled (Inouye, 2021). Older adults have made and continue to make an invaluable contribution to society through their knowledge, experience, and expertise. By acknowledging current ageist practices in the system, providing education to medical practitioners on this unjust prejudice, and implementing alternative approaches in eldercare that combat discrimination against older adults, ageism can be identified, corrected, and brought to an end (Wyman et al., 2018; Burnes et al., 2019). The ageist practices of discriminatory communication, exclusion of older adults from healthcare research, healthcare rationing, and limited education of medical professionals on the health needs of older individuals must be acknowledged, addressed, and corrected to safeguard the current and future health of us all.

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