Joining GPs in the fight against ageism

A practical clinical guide

CARMELLE PEISAH MB BS(Hons), MD, FRANZCP, FPOA, Dip Fam Ther Institute Australia

Ageism leads to significantly worse mental and physical health outcomes, wellbeing, life satisfaction and longevity. To address ageism in clinical practice, GPs can adopt several practical strategies, such as fostering professionalism and self-awareness, identifying internalised ageism, offering targeted counselling, advocating for the rights and needs of older adults, minimising avoidable hospital admissions and staying alert to potential elder abuse.

KEY POINTS

- Ageism is rampant across society and health care and has been for some time, leading to significantly worse mental and physical health outcomes, wellbeing, life satisfaction and longevity.
- Factors that mediate the adverse effects of ageism include:
  - structural factors such as underdiagnosis and undertreatment of older people with reduced access to healthcare and treatment
  - individual patient factors including health-associated behaviours, such as failure to engage in preventive or health-promoting behaviours and nonadherence with healthcare treatment and recommendations
  - psychological factors such as integrating the negative stereotypes of ageing into self-image, which in turn affects both mental state and performance.
- Practical clinical strategies that GPs can use to battle ageism in practice include demonstrating professionalism and insight, screening for self-ageism, providing ageism counselling, advocating for older patients, avoiding acute hospitalisation and maintaining vigilance for elder abuse.

There is a global pandemic of ageism in health that merely echoes that of wider society.[1-3] To truly understand the pervasive impact of ageism, one needs to appreciate its broadest meaning; namely, ageism encompasses stereotypes (beliefs), prejudice (emotional responses) and discrimination (behaviour) based on age.[4-6] A World Value Survey showed that one in two people report holding ageist stereotypes and prejudice, whereas one in three people in Europe perceive age discrimination.[7,8] Most importantly, for the purposes of this article, a national survey undertaken in 2021 by the Australian Human Rights Commission found that 64% of older Australians reported experiencing ageism in its broadest sense in the previous five years.[9]

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Professor Peisah is Conjoint Professor at UNSW, Sydney; Clinical Professor at The University of Sydney, Sydney, NSW; Special Instructor at Chiang Mai University, Thailand; and President and Founder of Capacity Australia.

The consequences of ageism are well established. Ageism, particularly self-directed, internalised ageism (reported by 81% of adults), has negative effects on both mental health (specifically anxiety and depression) and physical health, as well as on general wellbeing and life satisfaction.[10-14] This has also been established in an Australian sample.[15] Remarkably, ageism is a life-or-death phenomenon, given that self-perceptions of ageing are also associated with longevity.[16]

Ageism is rampant across health care.[1,17] The most comprehensive global systematic review and meta-analysis to date found that ageism led to significantly worse health outcomes

1. SELECT SELF-SCREENING QUESTIONS FROM THE UNIVERSITY OF CALIFORNIA AT LOS ANGELES GERIATRICS ATTITUDES SCALE (UCLA-GAS)[33]

Item 3:	If I have the choice, I would rather take care of younger people than elderly ones.
Item 5:	Medical care for old people uses up too much human and material resources.
Item 8:	Taking a medical history from elderly patients is frequently an ordeal.
Item 10:	Old people in general do not contribute much to society.
Item 11:	Treatment of chronically ill old patients is hopeless.

across 11 health domains in all 45 countries included in the study. These domains included the following:

- denied access to health care and treatments
- exclusion from health research
- devalued lives (as assessed by age-rationing of social resources)
- lack of work opportunities
- reduced longevity
- poor quality of life and wellbeing
- poor social relationships
- risky health behaviours
- mental illness
- cognitive impairment
- physical illness.

Moreover, the prevalence of significant findings increased over the 25-year study period.[1] Some of these domains provide clues about the mechanisms – structural and individual – by which the adverse effects of ageism are mediated. Regarding structural or systemic mechanisms, it is well established that older people are provided less access to healthcare services and treatment. They face more limited provision of medical information and withholding of treatment options for a range of conditions, remaining frequently underdiagnosed and undertreated.[17-19] Moreover, inertia in response to acute deterioration in older patients possibly associated with ageism was one of the 'human factors' identified in a study of adverse serious events in health.[20] Finally, ageism has been reported across disciplines and stages of training in health, demonstrated in medical students, physicians and physicians-in-training, nurses and social workers.[12,21-26]

The individual patient factors that mediate the adverse effects of ageism can be divided into physiological, behavioural and psychological. The physiological mechanisms proposed include a physiological stress response that can affect multiple organ systems, particularly the cardiovascular system.[27] Behavioural responses include, at best, failure to engage in preventive or health-promoting behaviours or, at worst, risk-taking behaviours and nonadherence with healthcare treatment and recommendations. Finally, the psychological mechanisms are the most complex and involve integrating negative stereotypes of ageing (i.e. being a burden, being incompetent or lacking self-efficacy) into one's self-image (Stereotype Embodiment Theory), which in turn affects both mental state and performance.[27,28]

There have been several calls for action in response to this somewhat intractable and ubiquitous problem in health care, made only worse by the COVID-19 pandemic.[29-31] Who better to respond to this call than GPs, who are ideally placed to identify and address ageism in health? We should not miss the opportunity to mobilise this important frontline army in the battle against ageism. By focusing on some of these remediable structural and individual factors, this article aims to develop practical clinical strategies for GPs to utilise in this battle against ageism.

Strategies for GPs

Strategy 1: professionalism and self-awareness

It is suggested that avoiding an ageist stance as a healthcare professional is part of professionalism. Given what we know about the prevalence of ageism among healthcare professionals, some reflection on one's own attitudes towards older people and how they are treated is a good starting point. How does one reflect on the question 'Am I ageist?'? Although recourse to one of the myriad screening scales is neither practical (given their length) nor relevant (as they target community attitudes towards older people), an easy and practical, albeit unvalidated, approach might be to use select items from the 14-item University of California at Los Angeles Geriatrics Attitudes Scale (UCLA-GAS) for self-screening (Box 1).[32,33]

Two additional screening questions to identify nihilism or apathy regarding mental illness and cognitive impairment in older people are affirmation of either of the two following statements (which are often used in health education):

- 'it is normal to be depressed when you are old'
- 'it is normal to be confused when you are old'.[34]

Finally, reflection on your attitude to your own ageing might be useful here.

Strategy 2: screen for self-ageism among your patients

Just as there are a myriad of general ageism scales, there are equally a myriad of scales that measure self-directed, internalised ageism. These include:

- the Anxiety about Ageing questionnaire
- the Attitudes to Aging questionnaire
- the Expectations Regarding Aging questionnaire
- the Reactions to Aging questionnaire.[32]

Any one of these might be used in a general practice setting; however, efficiency and, more importantly, engagement with the patient and the doctor–patient relationship might be better served by simply looking out for manifestations of stereotype embodiment (i.e., negative, nihilistic self-deprecatory comments regarding being old and getting old as articulated by the patient).[27,28]

Strategy 3: consider ageism counselling

The key to this strategy is promoting realistic insight, adaptation and hope about ageing. It might be useful to draw upon Awareness of Age-Related Change (AARC), a theoretical, multidimensional construct encompassing health, physical, cognitive and social functioning; interpersonal relationships; lifestyle; and engagement. AARC provides a framework for facilitating individual awareness about how one's performance, behaviour and ways of experiencing life have changed as a result of growing older.[35,36] Although AARC encourages reflection on both positive and negative changes for each area, including gain- and loss-associated experiences, it is important to keep in mind that optimism about ageing buffers against the negative effects of ageism.[35,37] A practical example of this is when a GP challenges ageism-driven beliefs (e.g. 'I am too old to exercise' or 'that is not for me at my age') that act as barriers to healthcare. GPs might further challenge such beliefs by citing examples of other patients whose behaviours and outcomes dispel such myths (i.e. exemplifying the aforementioned optimism). An example of an ageist versus a nonageist approach towards screening and diagnostic procedures is illustrated in Box 2.[38]

Strategy 4: facilitate access to care and treatment and be an advocate

Noting the aforementioned structural factors, such as reduced access to healthcare services and treatment, and a lack of treatment zeal that mediate ageism, it is incumbent upon us to act as advocates for our older patients. However, this is easier said than done given the trickle-down effect on GPs of a chronic, increasingly under-resourced healthcare system and waitlist crises.[39] Contacting specialists directly is the natural first step, but this often leads to frustration both on the part of the GP and the patient. Although this places enormous pressure on GPs, some find heart in managing the delays by supporting patients while they wait, keeping track of patients on waiting lists, working collaboratively with advice from the specialist, upskilling and increasing their scope of practice. Nonetheless, there are risks, both medicolegal (from being forced to manage conditions beyond their skillset) and emotional (from exhaustion and dispiritment) in being an advocate in these times.

Strategy 5: hospital avoidance

Many of the structural factors that mediate the negative effects of ageism on health are at play in acute hospitals, where age rationing of health resources is the most prominent. The adverse experiences of older people, particularly those with frailty or dementia, in emergency departments and acute hospitals are well known.[40-44] There are a range of acute 'hospital in the home' services, which go by various names (e.g. 'flying squads'), usually provided by local acute public hospital geriatric services that are available to support the efforts of GPs to manage older patients in the community.[45]

2. CASE VIGNETTE: AN AGEIST VERSUS A NONAGEIST APPROACH TO SCREENING AND DIAGNOSIS

Case vignette

A 73-year-old patient with a strong family history of bowel cancer has just undergone colonoscopy. A single benign polyp was found.

Ageist response

'There is no need to keep monitoring your colon because of your age.'

More appropriate response with comment

Rather than allowing the doctors' perception of the patient's age to exclude the patient from being offered this procedure, the usual informed consent procedure should proceed. The patient must be offered the procedure with the standard national screening advice, with the nature of the procedure, advantages and risks based on age, as well as alternatives explained. The patient can then decide based on this information. Ongoing screening and surveillance should be a shared decision-making process between the doctor and patient based on multiple factors, including the patient's morbidity and mortality risk, comorbidities, functional status and preferences for screening,[38] rather than on age alone.

Strategy 6: eyes wide open for elder abuse

The Ageism-Elder Abuse hypothesis is that elder abuse results from the conflation of sociocultural inequality with internalised ageism, mediated by exclusion or isolation, devaluation, depersonalisation, infantilisation, powerlessness and blame. The theory is that systemic norms, values, policies, behaviours and laws create an environment conducive to elder abuse.[46] Failure to act in response to elder abuse is a corollary to this theory. This is exemplified by turning a blind eye to elder abuse in clinical practice.[47] Instead, it is important to understand the role of GPs in detecting abuse and participate in the Eyes Wide Open for Elder Abuse global campaign.[48,49] Not knowing what to do or being embroiled in and daunted by a complex medicolegal matter are some of the understandable reasons for inaction in healthcare. To remedy this, there are elder abuse hotlines in every state and territory. The elder abuse phone line (1800 ELDERHelp [1800 353 374]) is a free call phone number that automatically redirects callers seeking information and advice on elder abuse to the appropriate phone service in their state or territory.

Conclusion

Ageism is everywhere one looks. That is the point; we should look and act. We have a duty to do so as health practitioners, as identification and awareness raising are key to tackling this insidious, wicked problem. This is more so for GPs, the healthcare practitioners at the frontline of the battle against ageism. It is high time we took up the baton in health. MT

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A list of references is included in the online version of this article (www. medicinetoday.com.au).

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