Help Stamp Out Ageism

By Monique Camerlain, MD, FRCPC; and Geneviève Myhal, PhD

"There is to my mind something inhuman in senility. Something crouching and atavistic; the human qualities seem to drop from old people, insensibly day by day." - H.G. Wells, "The Red Room", *The Idler*, 1896.

Ageism is a pervasive form of discrimination entrenched in modern North American culture and known to influence the provision of medical care, as demonstrated by a Senate Special Committee on Aging.[1] It is a negative bias or stereotypic attitude toward aging and the aged. According to Dr. Robert Butler, a Pulitzer Prize winner and past head of The International Longevity Center, it reflects a deep-seated uneasiness, a personal revulsion to, and distaste for growing old, diseased and disabled. It also reflects a fear of powerlessness, uselessness, and death.[2]

With the rising age wave of 80 million baby boomers, 70% of whom do not plan to retire but wish to go on serving their values, the perspective on aging is changing in North America. Life expectancy has increased by 28 years in the last century. The "old age 65" marker is out-dated. It was selected in the 1930s by President Roosevelt for the Social Security Act. Life expectancy was 61.8 years at the time.[3] A 65-year-old woman can now expect to live 19 more years and men of this age can expect to live another 14. As stated by Dr. Butler, combating ageism is now considered "a matter of civil and human rights."[2]

Four factors contribute to the negative image of aging, according to Traxler.[4] They are: fear of death, the emphasis on the youth culture in North America, the emphasis on productivity and the manner in which medicine originally researched aging in long-term care institutions. Institutionalized elderly amount to only 5% of the aged population and cannot be considered representative of the group.[4]

The MacArthur Foundation has added two more factors to this list: the focus of the geriatric literature also on the more fragile and disabled elderly and the disengagement theory. According to this questionable theory, the elderly withdraw from others and from the world to make their ultimate departure less disruptive.[5]

There are two forms of ageism: one directed against others and one against the self as the susceptible individual mirrors and accepts cultural values. This may lead to depression and even suicide as part of a social disintegration syndrome.[6]

Known consequences of ageism in patient care include less prevention, less screening and diagnostic testing, and care gaps leading to insufficient and possibly even inappropriate treatment.[6] While older Americans are the biggest users of prescription drugs, between 1991 and 2000, 40% of clinical studies excluded participation of people over 75. Our research has furthermore demonstrated an ageist bias in 58% of healthcare providers in Canada.[7]

Care gaps in the treatment of elderly patients have been documented in rheumatology in chronic pain,[8] osteoporosis,[9] and rheumatoid arthritis (RA).[7] Less than 35% of the 756,000 Canadian osteoporotic women are diagnosed and treated, and current real-life management strategies in RA of the elderly may be based more on assumptions than evidence. Older patients receive lower doses of methotrexate (MTX). They are less likely to be treated with disease-modifying antirheumatic drug (DMARD) combinations, more likely to be taking prednisone, and are less often treated with biologics.[10]

How then can we as rheumatologists help to stamp out ageism? How can we help our patients on the road to healthy aging? First, through education, we must increase awareness of this prejudice among our peers and among our patients. Though the risk of complications is higher among elderly patients, no class of medication should be excluded,

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a priori, without a thorough evaluation of the patient's global needs and condition. We must stress equality of care for all based on evidence and on an unbiased evaluation of the

risk:benefit ratio.[11] We must also help patients to become active participants in their care and compliant to their treatment.

The Mayo Clinic website states that "healthy aging is a hot topic for boomers everywhere." It describes the ongoing activities and behaviors people undertake to reduce the risk of illness and disease and increase their physical, emotional and mental health. It also means combating illness and disease with some basic lifestyle realignment that

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can result in a faster and more enduring recovery. And yet, a study of 17,354 Canadians over 60 has demonstrated that a large proportion of these individuals do not meet the required criteria for preventive medical visits and diagnostic testing; 63.2% had made no effort to improve their health in the preceding year and 66.7% did not deem it necessary.[12]

Three elements characterize the essence of the clinical transaction between patient and physician: technology, caring and values. The most neglected of the three is values, despite their importance in governing the quality of the medical encounter on the personal level, and the social contract of healthcare on the political level.[13]

In our culture of the disposable and of planned obsolescence, the wisdom and experience of elders is given little attention or importance. In ancient China, the third age of man was considered to be the purpose of his life. Having fulfilled his family and social responsibilities he could now seek enlightenment. The Hindus added a fourth age where the enlightened elder's duty was to share his learning and discoveries. Perhaps we can learn from the perspective of these other cultures and improve the quality of our interaction with our older patients through adding new values to quality technology and caring.[7]

Educational effort on ageism for elders by the Arthritis Society in Quebec.

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