



AGEISM IS GETTING OLD!

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Introduction

Older adults, typically defined as over the age of 65, make up approximately 17% of the population in Canada.(1) StatsCan predict that this trend will continue with older adults comprising an estimated 24–28% of Canada's population by 2036.(2) This is particularly relevant as health care spending for individuals over the age of 65 years in Canada is at least 4.4 times higher than for individuals between 15–64 years of age.(3) Individuals aged 65 years and older also accounted for 21% of ER visits in Canada in 2014–2015, representing 2.2 million visits. Of all age groups, those 65 and older were more likely to spend longer in the ER, and were more likely to be admitted.(4) This same population group makes up a disproportionate use of paramedic resources, accounting for approximately 40% of 911 calls (US data).(5) These demographic changes will

compel policy makers and health care providers to consider the ways older adults interact with, and are supported by, our health care system and explore ways to enhance the level of care provided to them.

Ageism

With the increasing focus on issues surrounding sexism and racism in our everyday lives, it is perhaps easy for us as health care providers (HCPs) to forget the most commonly tolerated form of social prejudice “-ism” that exists in Canadian society today: ageism.(6) Ageism is defined as a systemic bias towards older adults because of their age. It is found across the spectrum of health care from a macro policy level down to the individual interactions of HCPs towards their patients.(7) At the individual level, ageism has been reported

across a number of disciplines and although less studied, paramedics are not immune to these biases.(8,9) Many of these biases are believed to initially be formed by societal conception of older adults as more frail, unproductive, cognitively impaired, and less independent than younger adults.(8)

Attitudes towards older adults and well-intentioned efforts

These attitudes continue to develop during clinical training and reflect the environments that older adults are encountered in such as interfacility transfers and long term care homes. This leads to cases involving older adult cases being seen as more involved but less technically challenging and less rewarding.(8,9) Although a bias towards chronic and non-emergent patient encounters exists,

it is not supported in the literature. Dickinson and colleagues (1996) reported that older adults who call 911 were more likely to require advanced life support interventions than younger patients (54% vs 33%).(10) As the health care system continues to work towards elimination of macro level ageist policy, unconscious bias towards older adults can still have a significant impact on the clinical care that older adults receive.(7)

These biases and attitudes towards older adults can lead to under and overtreatment situations and put older adult patients at risk for negative outcomes.(9) Many HCPs are prone to assuming that fatigue, aches and pains, cognitive decline, and anxiety are a natural part of aging. HCPs may perform less investigation and assessment if they believe that symptoms can be explained by aging. Pain management is often a therapeutic goal that older adults have, it is often under- or ineffectively treated, and older adults are left with chronic pain that is explained away as a consequence of aging.(11)

Even the way that HCPs speak with older adults can be grounded in our stereotypes. 'Elderspeak' is a simplified pattern of speech, similar to "baby talk", used by younger individuals while communicating with older adults.(12) Phrases like 'dear' and 'young lady' although well intentioned can be interpreted as demeaning by the older adult. Elderspeak is also associated with negative perception of the patient experience as well as more resistance to care.(9) This style of speech is believed to be grounded in the same stereotypes previously discussed. Although commonly used, many older adults report associating elderspeak with feelings of incompetence. These feelings can lead to internalization and the development of dependency.(12)

Not all attitudes towards older patients are negative. The idea that older adults are fragile and require gentle treatment may lead to a "benevolent ageism", HCPs trying to protect older adults.(7) HCPs may attempt to make decisions which they feel are the best for the patients without involving them in the decision process. Higashi and colleagues (2012) report that physicians were more likely to provide less information to older adults about the care they are receiving at the expense of reassuring them that they are "going to be ok".(13) These experiences can cause frustration in older adults who feel a loss of choice and independence.(9) When patients have family members or caregivers present it is often reported that the HCP will explain most of the medical information to the other individual and focus on reassuring the patient.(13) By removing the opportunity for choice from the older adult patient we can reinforce these same stereotypes in them and

lead them to develop a dependency on their caregivers.

Independence and choice

As people age, independence plays a large role in the feeling and perception of dignity and self-esteem.(14–17) Older adults typically expect a level of independence and autonomy with their lives. If someone reduces or changes this level of independence it can result in feelings of lowered self-worth.(15) As care providers, it is important that we maintain an older adult's independence and autonomy during care whenever possible in order to reduce any potential negative impact on their dignity and quality of life.(15–19) HCPs, including paramedics, often attempt to control the autonomy and activities of older adults in order to keep them safe.(18) According to a recent study, 46% of older Canadians (77 years +) and 49% between the ages of 68–76 years, were of the opinion that people viewed them as being less independent as they aged.(6)

For many older adults, maintaining independence, especially in their Activities of Daily Living (ADLs) which includes things such as dressing, showering, and toileting, is a major motivation for seeking help within the health care system.(20) Independence plays an important role in an older adult's mental, physical, and emotional health and as older adults continue to age they increasingly value independence.(20) Lee (2000) found that an older adult's perception of a loss of independence was a strong predictor of actual loss of functioning in their activities of daily living.(21) This was true even when the loss of independence was only a perception. During surgical recovery a loss of independence was the strongest factor associated with death after discharge and readmission.(22) As paramedics who interact with these older adults when they may be at their most vulnerable, it is important that we work to maintain this independence. Paramedics should strive to involve older adults in decisions regarding their health care. We are also in a position to advocate for our patients and their desires for independence-based goals for their health care. Going forward paramedics (as caregivers) should consider how their actions may impact their patients independence while providing care to older adults, as this can ultimately reduce functional decline, improve self-worth, dignity, and quality of life.

Incorporate ageism education into curricula

Educational interventions such as courses focused on older adults, interactions with older adults, and workshops that simulate certain aspects of aging have demonstrated development of positive attitudes in students towards aging (23–27). These positive attitudes toward older people developed through increased knowledge and experience have been associated with improved patient care (28,29). Ross & Williams demonstrated that exposing a group of paramedic students to an elderly population improved their pre-conceived attitudes towards the elderly population, from one of feeble to strong and capable.(26) It is thought that the student's pre-conceived attitudes before the study could be due to a lack of interactions with elderly patients, or from limited interactions with only ill and frail patients. They concluded that there is a need to increase the exposure of paramedics during their training to elderly people who are not living in long term care type facilities.(26) Fostering intergenerational relationships, and giving students the ability to gain personal experience of the demands of a medical condition can also aid in the development of empathy. Clinical outcomes have been shown to improve when patients perceive their health care provider to be empathetic. (30) This approach aligns well with "Aging with Confidence: Ontario's Action Plan for Seniors", released by the Ontario provincial government on November 7, 2017, which highlights increasing access to geriatric care through training for health care providers as an important strategy to support older adults living in the community.(31)

Conclusion

The biases that are developed by clinicians can be insidious and under-recognized. They do however have significant impacts on the care that these patients receive. Paramedics are in a position to be champions and advocates for their patients and must work to overcome these biases to better care for older adults. Helping paramedics to recognize and acknowledge their own implicit biases or ageist practices, and demonstrating how well-intentioned efforts may result in loss of independence and choice are an ideal starting point to address ageism in paramedic delivered care. 

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