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REVIEW ARTICLE

ATTITUDES TO AGEING AND TO GERIATRIC MEDICINE

ABSTRACT

The ageing of populations across the developed and developing world is a consequence of success (better nutrition and sanitation, improved medical care, greater choice about whether and when to have children) but older people are not always viewed or portrayed in a positive light, either in the hospital setting or in wider society. Similarly, geriatric medicine is a low prestige specialty, facing problems with recruitment. Even the British Geriatrics Society debates changing its name since "geriatrics" has "acquired negative connotations".

Here, we briefly review the attitudes to geriatric medicine among medical professionals, including physicians, medical students and nurses. Societal attitudes to ageing are explored from different eras and across cultural perspectives. We consider how older people's own attitudes to their health may impact both their recovery from illness and life expectancy. We conclude that it is essential to consider the broader cultural milieu of medical schools, as this may have a greater influence than the formal curriculum on physicians' personality and conduct. Positive forces such as governmental edicts to abolish ageist practices may be undermined by what medical students hear and see on the wards. With the ageing of the inpatient population, it is critical that all physicians and nursing staff respect the ageing process and provide dignified and appropriate care to vulnerable older people.

Key Words: Attitudes; Ageing; Aged, 80 and Over.



DERLEME

YAŞLANMAYA VE GERİATRİK TIBBA YÖNELİK TUTUM

Öz

Gelişmiş ve gelişmekte olan ülkelerde nüfusların yaşlanması genel anlamda bir başarının sonucudur. Bu süreçte beslenme ve hijyen alanındaki gelişmeler, sağlık hizmetlerinin gelişmesi, çocuk sahibi olma konusunda ve zamanlamasında bireylerin seçim şansının artması gibi faktörler rol oynamıştır. Ancak gerek hastane ortamında gerekse daha geniş anlamıyla toplumda ileri yaş grubundaki kişiler her zaman pozitif bir şekilde algılanmamakta ve yansıtılmamaktadır. Benzer şekilde, geriatrik bilimler de istihdam sorunu yaşayan, bir anlamda itibarı düşük bir alan olarak algılanmaktadır. British Geriatrics Society dahi "geriatri" sözcüğünün negatif anlamlarından ötürü isim değişikliğine gitmeyi tartışmaktadır. Bu metnin amacı hekimler, tıp öğrencileri ve hemşireler gibi sağlık çalışanlarının geriatrik bilimlere karşı sergilediği tutumu gözden geçirmektir. Farklı çağların ve kültürlerin perspektifinden yaşlanmaya toplumun bakış açısı incelenmektedir. İleri yaştaki kişilerin kendi sağlıklarıyla ilgili tutumlarının, iyileşme süreçlerini ve yaşam sürelerini nasıl etkileyebileceği değerlendirilmektedir. Tıp okullarının geniş kültürel ortamının da bu anlamda göz önünde bulundurulması gerektiği sonucuna varılmıştır, zira bu ortamlar hekimlerin kişiliklerine ve davranışlarına resmi müfredattan daha etkili olabilir. Tıp öğrencilerinin farklı ortamlarda duydukları ve gördükleri olumsuz yargılara karşı, yaşa bağlı ayrımcılığı gidermeye yönelik yasal düzenlemeler pozitif yaptırımlar oluşturacaklardır. Hastanede yatan hastaların yaşlanmasıyla birlikte, tüm hekimlerin ve sağlık profesyonellerinin yaşlanma sürecine saygı duymaları ve korunmasız yaşlı hastalara gerekli bakımı onur kırıcı olmayan bir şekilde sunmaları çok önemlidir.

Anahtar Sözcükler: Tutumlar; Yaşlanma; Yaşlı; 80 Yaş ve Üzeri.

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Geliş Tarihi: 25/03/2013
(Received)

Kabul Tarihi: 07/08/2013
(Accepted)

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INTRODUCTION

The ageing of populations across the developed and developing world is a consequence of success (1). Improvements in living conditions and medical advances have enabled more people to survive to old age, and older people themselves are now living longer (2). However, older people and geriatric medicine are not always viewed or portrayed in a positive light, either in the hospital setting or in wider society.

Here, we briefly review the attitudes to ageing among medical professionals, including physicians, medical students and nurses. Societal attitudes to ageing are explored from different eras and across cultural perspectives. We consider how older people's own attitudes to their health may impact both their recovery from illness and life expectancy. We conclude with a summary of our findings and recommendations for future work.

MEDICAL ATTITUDES

Physicians

Older, dependent patients with rehabilitation need are not confined to Care of the Elderly units but are scattered throughout intensive care, medical and surgical wards (3). All doctors looking after adult patients therefore need the skills to work with older people. Yet the list of knowledge deficits in geriatric medicine identified by physicians encompasses many essential domains, including medication prescribing, urinary incontinence and falls and ethical issues (4). Knowledge deficits result in greater medical uncertainty and feelings of inadequacy and frustration for the physician (5). This frustration may manifest as negative stereotyping and suboptimal care.

Some physicians openly question the need for geriatric medicine. Increasing numbers of older complex inpatients and the positive results achieved by non-geriatricians supervising multi-disciplinary teams have both been used as arguments to abolish the specialty (6). It is hard to imagine similar debates about the existence of cardiology ("we all manage patients with ischaemic heart disease") or endocrinology ("we too use oral hypoglycaemics to lower blood sugar") being countenanced by leading medical journals.

Perceptions of prestige may contribute to negative attitudes. In one survey, junior and senior doctors consistently ranked neurosurgery and cardiothoracic surgery as the highest prestige specialties (7). Only dermatovenerology rivalled geriatric medicine for the lowest prestige rating. Highest

prestige conditions, such as myocardial infarction, leukaemia and brain tumour, seem to share an acute onset, definitive diagnostic strategies, high-tech interventions and the possibility of complete cure. They reinforce the doctor's role as healer. Low prestige conditions, such as fibromyalgia and anxiety neurosis, often require a shift in philosophy from cure to care and demand communication skills rather than procedural finesse. Indeed, the knowledge and skills required to manage such conditions are the very ones that physicians report most difficulty in mastering (4).

Nurses

It can be challenging to provide optimal care to patients with dementia and delirium, particularly in the acute care sector. One study of nursing staff reported that being younger and working as an assistant nurse were factors associated with negative attitudes to older people with cognitive impairment (8). The authors suggested that targeted support and education for younger staff and nursing assistants may promote more positive attitudes. A recent meta-analysis of nurses' attitudes towards older people yielded 25 papers published in English or Chinese since 2000 (9). Positive, negative and neutral attitudes were noted. Perhaps unsurprisingly, those preferring to work with older people had more positive attitudes but there was no consistent relationship between results and nurses' age, gender or years of experience.

Medical Students

Most medical students do not consider pursuing a career in geriatric medicine (10 – 12). Students not interested in geriatrics rate performing procedures, technical skills and not managing chronically ill patients as important practice characteristics (10). Some students feel older people are "to blame" for their illnesses through life-style choices (12). A more positive attitude to older people increases the likelihood of choosing a career in geriatric medicine (10) and students with more experience of older people, both positive and negative, are less likely to resort to stereotype and show more interest in geriatric medicine as a career (12).

Early exposure to geriatric medicine has been advocated (11) yet a systematic review looking at teaching interventions to improve knowledge, skills and attitude reported mixed results: only 10 of the 19 studies described had a positive impact on attitude to older people (13). Interestingly, from a qualitative perspective, Bagri et al.'s work (14) demonstrates that there are numerous negative themes that medical students still associate with geriatrics. In fact, some of the



themes seem to imply a lack of interest (“I don’t think it is super exciting”); a sense of frustration (“...have so many problems that just accumulate with age”); time consuming (“very hard to stay focused for every patient”) and unrewarding (“you can’t really cure most of..”) when managing the older person. However, in this study, the sample size was small and the data collection was not described consistently or in detail in the author’s paper. There is currently a paucity of qualitative studies in the literature. There is a role for more qualitative studies as they can present a more comprehensive evaluation with a personalised perspective.

SOCIETAL ATTITUDES

In 2005, a UK survey of 2000 adults aged over 16 years reported that one third of people thought that the demographic shift towards an older society would make life worse in terms of standards of living, security, health, jobs and education and one in three respondents viewed the over 70s as incompetent and incapable. From age 55 onwards, people were nearly twice as likely to have experienced age prejudice as any other form of discrimination (15). Charities that work with older people in the UK report difficulties generating financial support, with a quarter of the total income of charities that work with children and adolescents and half that of animal charities (16).

Ageism, like other forms of discrimination, is built on stereotypes. A stereotype can be defined as “a widely held but fixed and oversimplified image or idea of a particular type of person or thing” (17). Stereotypes detrimentally affect individuals by denying them the attributes that make them unique. Stereotypes of older people imply that they become increasingly similar as they get older, despite evidence to the contrary that older adults are less like each other than those in other age groups across physical, psychological and sociological measures (18).

In her treatise on ageing *Old Age* (19), Simone de Beauvoir described two stereotypes of older people.

The purified image of themselves that society offers the aged is that of the white haired and venerable sage, rich in experience, planing high above the common state of mankind; if they vary from this then they fall below it; the counterpart of the first image is that of the old fool in his dotage, a laughing stock for his children. In any case either by their virtue or by their degradation, they stand outside humanity.

de Beauvoir, 1979

Older people have not always been undervalued. Minois (20) traced the history of old age in western culture and society. The knowledge and experience of older people, he argued, were valued by civilisations which relied on oral tradition and custom. In Ancient Greece and the Middle Ages, older people acted as collective memories during long evenings and at legal proceedings. The advancement of the written word during Roman times rendered their knowledge of custom useless. The Renaissance was a time of progress and relative acceleration of history, Minois continued, during which older people were considered antiquated and useless. Perhaps the onset of the computer age and considerable technological advances of the last 50 years have fostered a similar perception that older people are ‘behind the times’. It has also been proposed (21) that societies which value physical beauty tend to depreciate old age whereas those which aim at a spiritual ideal entertain a more abstract aesthetic ideal. The latter are less revolted by physical signs of ageing such as wrinkled faces and grey hair.

Societal attitudes to changes in demography and morbidity seem to be different in Canada and the USA compared to the UK. In 1994, in a handwritten note to the American people, Ronald Reagan openly acknowledged his diagnosis of Alzheimer’s disease, concluding “I now begin the journey that will lead me into the sunset of my life” (22). His actions were praised for their “courage” with eponymous research awards set up as a tribute (23). In contrast, when the dementing illness of former British prime minister Margaret Thatcher was made public by her daughter 8 years after symptom onset (24), one associate wrote in the national press of “an opportunistic book” that “felt not only like a terrible invasion of an old woman’s privacy, but a personal betrayal” (25). This difference in attitudes was confirmed by our group in a critical discourse analysis of obituaries in Canada and the UK (26). In the 799 obituaries studied, chronological age, suggested donations in memory of the deceased and donations to dementia charities were each included in significantly more obituaries in Canada than in the UK. Of the donations to medical charities, nearly half (n=117) were to cancer charities and one fifth (54) to heart and stroke foundations. In the UK, obituaries for those aged ≥ 70 years were more likely to recommend donations to children’s charities (n = 12) or the Royal National Lifeboat Institution (8) than dementia charities (7). Military service was explicit for significantly more men aged ≥ 80 years in Canada compared to the UK (41% versus 4%; $p < 0.05$) which we felt was an additional marker of the value placed on the contributions of older people to society.



ATTITUDES OF OLDER PEOPLE THEMSELVES

Having good health is an integral prerequisite to ageing well and is often a benchmark for successful ageing. Good health enables the older person to maintain functional independence and preserve their quality of life in their home environment. This is well recognized by members of the public. In a population survey of an Australian cohort, the major factors identified to determine if an individual was considered "aged" were that individual's attitude towards life, level of fitness and health status rather than work status or general appearance (27).

Apart from physical wellbeing, health and wellness to the older person also encompasses mental, social and spiritual aspects. Notably, the older person's inherent attitudes towards ageing have been associated with different outcomes. The benefits of adopting a positive attitude towards ageing are diverse. A positive outlook towards ageing can help curtail the age related decline in usual walking speed and swing time of a person's gait (28). In addition, older people with positive age stereotypes were 44% more likely to fully recover from severe disability than those with negative age stereotypes (29). The Ohio Longitudinal Study of Aging and Retirement also demonstrated that a positive self-perception of ageing was associated with a 7.5 years survival benefit in older people (30).

Due to the negative stereotypical view of ageing and a positive bias associated with youth in wider society, older people have been shown to feel, desire and perceive themselves to be younger than their chronological age. Paradoxically, priming older people with positive age stereotypes make them feel older. On the other hand, negative age stereotypes, as expected, lead to a more negative perception of ageing (31). A systematic review has also shown that negative age stereotypes have a three times greater negative influence on behaviour than positive age stereotypes (32). Therefore, along with promoting positive age stereotypes, it is just as imperative to eradicate negative age stereotypes in the older person.

CONCLUSION

Geriatric medicine is a low prestige specialty, facing problems with recruitment. With the ageing of the inpatient population, it is critical that all physicians and nursing staff have the knowledge and respect to care for older patients appropriately and with dignity. It is essential to consider the broader cultural milieu of medical schools, as this may have a

greater influence than the formal curriculum on physicians' personality and conduct (33). Positive forces such as governmental edicts to abolish ageist practices are undermined by what medical students hear and see on the wards. Qualitative studies of trainees have confirmed that "clinician-teachers sometimes make disparaging remarks about particular medical specialties which may act as a barrier to recruitment" (34). At a time when even the British Geriatrics Society debates changing its name since "geriatrics" has "acquired negative connotations" (35), we should be careful about the message this sends to others about the patients we care for. Through explicit consideration of the hidden curriculum, students may learn to challenge rather than accept ageist practices and behaviors.

It is particularly important to foster positive attitudes among older people themselves, as this may impact both recovery from illness and life expectancy. Larger interventional studies investigating whether older people's outcomes can be improved by targeting their own attitudes would be a worthy focus of further enquiries.

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