Ageism in Medicine

1994—"Older people have enjoyed more life and have less life left to enjoy. Age is an ethical, objective and cost-effective criterion for rationing health care. Ageism flourishes in secret.[1] Open discussion would make its application more just."

Author: A B Shaw's, Consultant Physician to Bradford Hospitals, West Yorkshire, from concluding paragraph in an article he published in the BMJ

Not just an isolated perception...

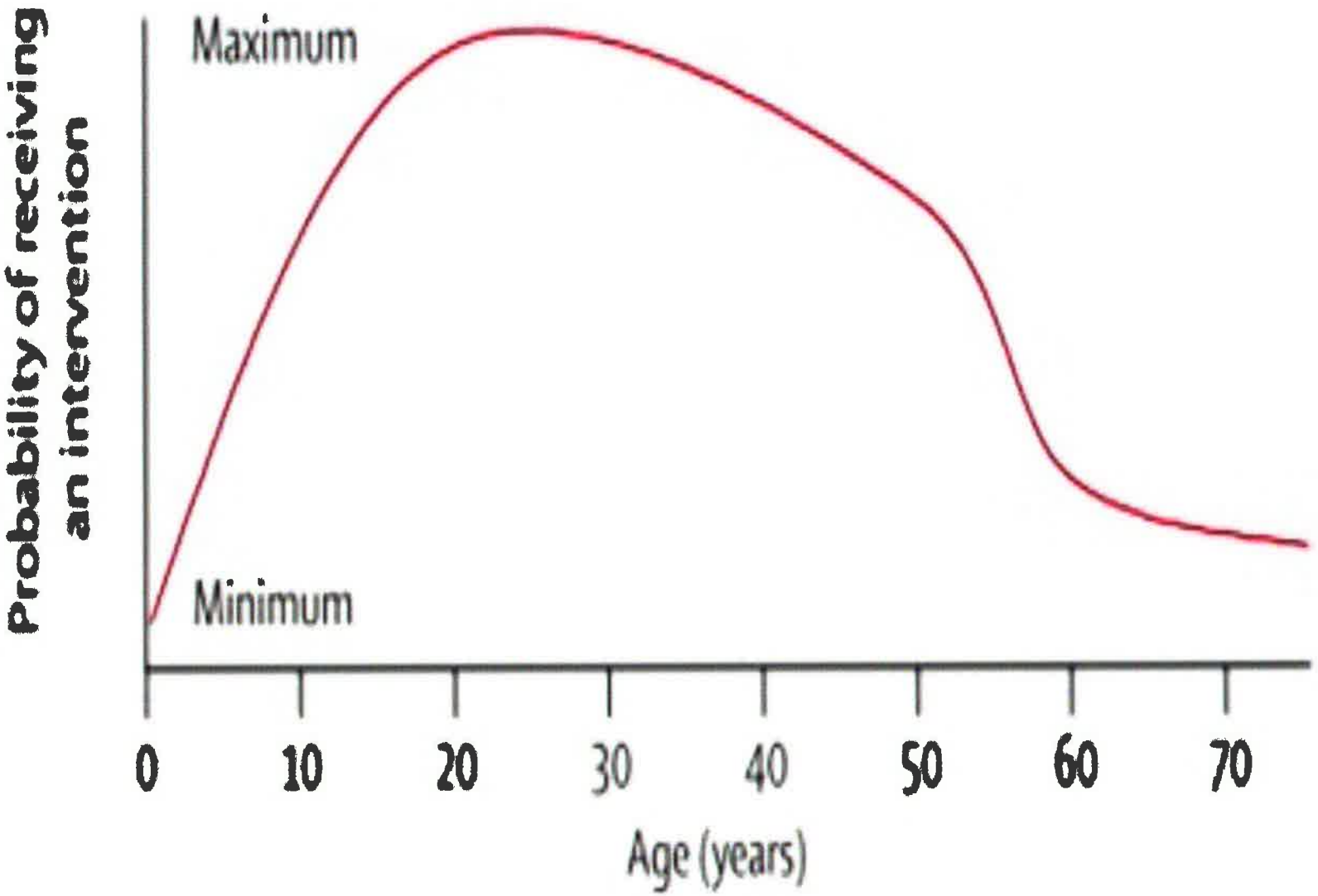
Medline search this morning using keyword Ageism yielded 127 articles addressing this issue. Virtually all of them documenting the existence of age discrimination in medical practice not only in the United States but also in many countries which spend much less on ICU care and cancer care than do we in the US.

The articles document:

--90% of older Americans never receive routine screening tests for bone density, colon or prostate cancer, or glaucoma—all conditions that increase with age.[2]
--Sixty percent of older adults don't receive routine preventive health services, including screening for high blood pressure or cholesterol.[1]
--And 35% of doctors continue to believe, despite ample evidence to the contrary, that elevated blood pressure is a

"normal" part of aging. [2]
--A survey conducted at Johns Hopkins University School of Medicine revealed that 80% of medical students would aggressively treat pneumonia in a girl aged 10, while only 56% would do the same for a woman aged 85.[3]

It's not just young medical students who would discriminate against the old; some of the brightest minds in American medicine and Bioethics believe this to be a reasonable approach.


Probability of receiving an intervention
Maximum
Minimum
0
10
20
30
40
50
60
70
Age (years)

This already plays out in hospitals nationwide. In a presentation to the American Thoracic Society in 2003, Dr Wes Ely noted that people 65 or older account for more than half of all intensive care unit (ICU) days nationwide, and people 75 or older account for seven times more ICU days than those under 65. Despite this, "Older patients actually receive less aggressive care than do younger patients," noting specifically that the use of mechanical ventilation in the ICU sharply decreases in patients 70 or older.

It is all too easy for doctors to project their own values on others. Dr Ezekiel Emanuel in an essay entitled "Why I hope to die at 75"[5] is a poster child for this reality. "Once I have lived to 75, my approach to my health care will completely change," he wrote. "I will stop getting any regular preventive tests, screenings, or interventions. I will accept only palliative—not curative—treatments if I am suffering pain or other disability."

A thoughtful geriatrician reacted to this statement a bit more ~~thoughtfully~~, ""He's confusing chronological age with functional age," the New York geriatrician said. "Many people at age 75 are functionally much like many middle-aged patients. Meanwhile, a person in their 40s can have debilitating chronic diseases and not function well."[6]

It is not just the Ezekiel Emanuel, a Nebraska qualitative study[7] by one of my colleagues in family medicine showed the biases of many young doctors...

--Elderly patients present "various obstacles to getting the whole story, getting the truth out," one physician reported. "They don't remember, and sometimes they just don't think it's important, and sometimes they're just in denial of what's really wrong."

--Another physician said she had to cut back her practice because elderly patients are "so complex and they take so much time," she said. "It's just not physically, humanly possible. It just isn't. You would need to have a smaller patient population to do a good job."
--One doctor said cognitively impaired patients left him cold. "I don't find any particular satisfaction in taking care of them," he said. "The essence of their humanity is long since gone and I'm tending to a body which has no hope of recovery, and it's hard for me to get real excited and enthusiastic in that setting."
--Another doctor complained that he couldn't make elderly patients better. "There are some patients that they're always going to have the same problems year after year after year," he said. "They're not going to be fixed. You know, it's their back pain from their osteoporosis and scoliosis and you can't do anything about it."

I find these same biases emerging even at my own institution. 13 months ago, a 98 year old patient of mine who I have know for years was admitted from the ED for lower abdominal pain and inability to void. A catheter was placed and the problem was blamed on constipation. No investigation or imaging beyond basic labs and a plain x-ray was done and he was discharged. Two weeks later he was back in the ED with abdominal pain and about to be discharged again. I was notified, came to the ED and examined my patient, and encouraged the ED doctor to pursue a CT prior to discharge. The CT showed my patient's bladder was herniated into his known inguinal hernia that had never been repaired (even though it had been symptomatic at times). The surgery consult was reluctant to operate saying to me, "You know we can fix his hernia, but we may not make him better."
I encouraged my colleague saying I knew this patient and he doesn't generally complain unless something is really wrong. The operation was done, his problems completely resolved,

and he left the hospital in a couple days. In 11 days he will celebrate his 100th birthday with about 4-500 other people."

I wish this were an isolated case—my lived experience and the literature confirm this problem. It has been a part of congressional testimony by republican and democratic senators alike include our own Senator Ron Wyden in the early 2000s. This should be an issue that transcends political parties. Discriminating medical care on the basis of age is wrong.

Finally, in the interest of full disclosure, while I believe in and legally care about the aged, I should note that I am now 66 and continue to age. As such, I suppose I have an inherent conflict of interest in supporting this legislation.

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[1] Shaw AB. In defence of Ageism. 1994 BMJ

[2] International Longevity Center (ILC), 2006 Report on Aging in America

[3] Currey R. Ageism In Healthcare: Time for a Change
Aging Well, Winter 2008, Vol. 1 No. 1 P. 16

[4] Persad G, WertheimerA, Emanuel EJ. Principles for allocation of scarce medical interventions. Lancet 2009; 373: 423–31.

[5] Emanuel EJ. Why I hope to die at 75: an argument that society and families—and you—will be better off if nature takes its course swiftly and promptly. The Atlantic. October 2014. http://www.theatlantic.com/features/archive/2014/09/why-i-hope-to-die-at-75/379329/ Accessed December 22, 2014.

[6] Are Doctors Neglecting Their Older Patients? Leigh Page. Medscape;February 19, 2015. **http://www.medscape.com/viewarticle/837430_2**

[7] Adams WL, McIlvain HE, Lacy NL, et al. Primary care for elderly people: why do doctors find it so hard? Gerontologist. 2002;42:835-842. http://gerontologist.oxfordjournals.org/content/42/6/835.full.pdf Accessed December 22, 2014.