

# The “Elderly” in Medicine: Ethical Issues Surrounding This Outdated and Discriminatory Term

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## Abstract

The objective of this study was to investigate and describe how the use of the term “elderly” contributes to bias and problems within the medical system. A systematic review of the relevant literature and history was conducted. The term “elderly” does not define age accurately and carries bias and prejudice that lead to harm through discriminatory practices, institutional prejudices, and “ageist” policies in society and medicine. Doctors and healthcare providers seldom intentionally try to harm any patient, but might do so through unconscious anti-elderly bias. Studies indicate that medical students already demonstrate anti-elderly bias; researchers may lump patients aged 65 and over together, confounding specific information needed for individualized treatments; and out of unwarranted concern, medical and surgical treatments may be denied, despite minimal increased risk of mortality. When the cost of healthcare rises, it is the elderly against whom rationing is suggested. The term “elderly” has no place in medicine. Anti-elderly health care rationing is as unethical as rationing targeted against any group. It is reverse paternalism to make rules that limit others’ medical care, happiness, and life span without their consent. Medicine is the science and art of individual communication, evaluation and treatment. Once we deny care to any one group, we open the door to denial to others.

## Keywords

elderly, bias, first impression, health care, opinion, prejudice, attitudes, paternalism, aging, standard of care

### What do we already know about this topic?

Bias against the elderly exists, in medical settings as well as larger social environments.

### How does your research contribute to the field?

Although the existence of bias has been academically documented, this article hopes to direct much-needed wider attention to this bias, the effect of first impression, and unfair healthcare rationing against the elderly.

### What are your research’s implications toward theory, practice, or policy?

Discouragement of unfair healthcare rationing against the so-called “elderly,” avoidance of the term “elderly” in medical discourse, and general thoughtfulness in doctor-patient relationships.

## Introduction

At times in a medical conference, one hears a patient introduced as “this elderly man” or “elderly woman,” and so forth. I find that the term *elderly* is disturbing and conjures certain associations in my mind that I do not believe apply to me, or to many of the so-called “elderly” patients I have treated. This is not because the term applies to my own age. I have always found it equally disturbing when a patient was introduced as “This nice lady,” “this professor,” “this pleasant white man,” “this black gentleman,” etc, because I find such terms are irrelevant to the symptoms which can apply to almost anyone.

I know such adjectives are often used innocently, but they can be brought up when they become relevant. What I am concerned about is that the term *elderly* is vague, outdated,

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and in medicine does not convey a specific age or specific needs for individualized treatment based on the standard of medicine. Medicine is essentially based on science with specific terminology that should be internationally applicable; bias associated with this term, which is so prevalent in society, can enter into medicine and potentially influence first impressions, which in turn affect diagnoses, communication, and treatment. In addition, this bias can create harm by promoting unfair social policies.

## Methods

We will now use historical facts and a review of the literature combined with personal observations to determine precisely how the use of the word “elderly” contributes to bias within the healthcare system and society at large.

## Discussion

Bias is conscious or unconscious attitudes or beliefs held without proof or justification in favor of, or more often against, another person. *Ageism*, a term coined by psychiatrist Robert Butler,<sup>1</sup> denotes specific forms of bias against older persons. In this article, I do not intend to prove the presence of bias against the “elderly” in society and in the healthcare system; this has already been abundantly documented.<sup>2-4</sup> Rather, I would like to indicate how the term *elderly* has outlived its use in medicine, and why denial of health care based on age alone through rationing is based on bias, is unethical, and is wrong. This is like treating individuals based solely on race, gender, or ethnicity.

First impressions are crucial in bias formation. Bruner and Potter<sup>5</sup> studied the effects of first impressions in bias by displaying blurred pictures of everyday items and asking subjects to identify them. They found that subjects’ recognition was delayed when they first viewed the pictures out of focus, and the greater the initial blur, the slower the eventual recognition. They also found that subjects stuck by their initial interpretations even when they were doubtful of their correctness.

After reading their article several decades ago, I did my own unofficial experiment with my students to see whether this might also apply to medicine. I would put an x-ray of skull up in the examining window and present a patient’s symptoms that were entirely unrelated. Sure enough, many students began discussing diagnoses related to the brain, although the presentation was about other anatomical locations, such as the spine or peripheral nerves. Such first impression bias can also be seen even in experts at medical conferences, with some physicians holding on to their first impressions despite certain contrary evidence.

As we age, our physical strength and certain mental functions diminish, and we become more prone to illnesses. For example, about 50% of the population will have diminished hearing after the age of 75,<sup>6</sup> and partial memory loss occurs

in about 40% of those 65 or older.<sup>7</sup> With accumulating comorbidities, outcomes of a new illness become less favorable. But not all biological functions change equally across the spectrum, for aging is a progressive and variable process, not a disease.

Older patients are often underestimated during medical interviews. Because they may mishear a word, they can lose its implication in a sentence and ask for repeats; then they appear confused or give an erroneous impression of having cognitive deficiency. An older person may have forgotten a word, but, like a second-language speaker, may still retain the concept of the word itself. Or, they may have forgotten a person’s name, but may remember a lot about the person. Sometimes the family or those accompanying the patient may take over to give information about the patient’s complaints and illness and thus unwittingly convey that the patient has diminished mental capacity. To avoid such underestimation, it is essential to face the patient directly, to ask questions and explain directly, and to discourage others’ interruption unless needed.

Some physicians may take the prerogative to talk to older patients differently. While the intention is to be “nice,” except for close colleagues or family members, with whom one has already been on a first name basis, there is no need to address patients by their first name. There is no need for unwarranted shouting, false compliments, or artificial attempts to refute older age by awkward comments such as *hello young man/young lady; you look younger than your age; or how young are you?* Older patients, like minorities, easily pick up on such false compliments and may find them offensive.

Bias and prejudice are not inborn, but learned. Events such as wars, personal conflicts, and aggressive competitive behaviors create bias and prejudice that often remain in our mind, even long after the events end. We transfer our bias from groups to individuals, and vice versa. In the words of social psychologist Gordon Allport<sup>8</sup>: Man “has a propensity to prejudice. . . . This propensity lies in his normal and natural tendency to form generalizations, concepts, categories, whose content represents an oversimplification of his world of experience.”

People develop positive or negative biases toward individuals or groups, based on real or perceived monetary gain. Or they may assign value to the degree to which they receive pleasure in exchange. In 1958, George Homans<sup>9</sup> described “social exchange theory.” Basically, in an exchange, the value is considered satisfactory or positive when the reward is equal or more than what one gives (the cost). When the ratio of the reward over the cost is or is perceived to be negative, the respect for the relationship diminishes. The exchange theory also applies to the societal perception of what is considered “elderly.” Despite all previous accomplishments, the real or perceived diminished societal contributions which come with age are perceived as lower rewards over the cost, which in turn translates to less respect for the elderly. Respect

was higher during less industrialized times, when older individuals owned the land, but this gradually diminished as societies modernized and the young became financially independent.<sup>10</sup>

Anti-elderly bias has also found its way into medicine: Reuben and coworkers<sup>11</sup> found in their five campus-wide study that medical students had “already formed some unfavorable attitudes about older persons.” In their words, students were “much less likely to admit an acutely ill 85-year-old woman to an intensive care unit, intubate her, and treat her aggressively than they were to treat an acutely ill 10-year-old girl with underlying chronic leukemia.” We feel comfortable, as we should be, to start treatments in younger patients with malignant diseases, despite median survivals of less than 1 or 2 years, yet it is surprising that we are hesitant to treat an older patient with benign diseases who might have a much longer life expectancy. Furthermore, without ill intentions, some investigators arbitrarily lump those over 65 years of age into one group,<sup>12,13</sup> as though treatment should be the same for everyone in that group, rather than for each patient as an individual.

As medicine became scientific during the last century, life expectancy increased everywhere. In the United States, for example, this rose from 47.3 years at birth in 1900 to 78.7 years in 2010 (for both sexes and all races).<sup>14</sup> That together with the development of diagnostic tools and better treatments for numerous untreatable diseases raised healthcare costs from 5% of the GDP in 1960 to 17.4% in 2013<sup>15</sup>; it is now nearing 20%. Consequently, however, people live longer and enjoy better healthcare. Of the 18.2 million individuals who incur the highest healthcare costs in the United States, only 11% are in their last year of life<sup>16</sup>; end-of-life cost is often exaggerated and unwarrantedly linked to the elderly, while in fact it applies to every age. Furthermore, in recent years the importance of healthy eating and exercise, as well as smoking and drinking cessation, have created more longevity across the globe; many institutions no longer have mandatory retirement ages.

Another contributing factor to healthcare costs is the advancement in cardiopulmonary resuscitation (CPR) that began in the 1960s, resulting in 10% survival with reasonable outcome. However, many patients remain in coma or suffer brain damage, generating more costs as well as profound ethical, legal, and political dilemmas. Some assign these issues specifically to the “elderly,” although the costs are in fact borne by everyone. Furthermore, studies<sup>17</sup> indicate that a large part of healthcare cost is caused by litigation, unnecessary tests, and treatments done to avoid lawsuits, as well as waste of medications and fraud, all of which require their own remedy; the cost of most of which should be included with other social problems, not with medical illnesses.

To curb costs, some philosophers like Daniel Callahan<sup>18</sup> recommended rationing healthcare against the elderly. In his

1987 book *Setting Limits*, Callahan justified rationing against the high cost of technology. He also defined a “natural life span” as “something that would ordinarily [end] in the early 70s but could extend through the late 70s to early 80s.” Public figures like former Colorado Governor Lamm<sup>19</sup> became equally concerned and suggested rationing. They of course meant well, but healthcare for older ages does not entail inappropriate or senseless treatments. Medicine is founded on scientific and medical standards and should be applied to each individual based on measures that can treat or control diseases, offer patients health benefits, and to a degree that each patient can endure and accept. It is unfair and wrong to deny care to the so-called “elderly” based solely on their age. Benefits and risks can be reasonably assessed for any age: as Del Guercio and Cohn<sup>20</sup> found, a detailed preoperative evaluation can be extremely useful in assisting doctors to determine for which patients a treatment is worth the involved risk.

Paternalism in medicine occurs when we attempt to make healthcare decisions for others without their desire or consent. Unfortunately, the notion of rationing healthcare against older ages comes to us when we are young, healthy, or have not yet experienced pain and suffering, either personally or in the family. Again, while we may mean well, the notion is still biased against our own future and is based on denial. Many disabling illnesses, such as osteoarthritis and fractures, that cause lasting pain and suffering occur later in life. Aside from the pain and suffering, the cost for treating these conditions is likely less than the cost for the long-term care of associated disabilities without treating such illnesses.

The increased costs of technology have extended life for everyone by preventing diseases and diminishing pain and suffering. We must have more, not less, of it. We must not ignore the universal goals of better health and longer life; nor should we ignore the power of science that can make them possible. The cost is worth it, and potential harm can be curbed by judicious and appropriate use of technology, medical resources, and avoidance of waste. In the end, it is up to future generations’ wisdom to design a healthcare system that is commensurate with their values.

## Conclusion

Aging is a gradual process, not a disease. The term *elderly* evokes stereotypes and biases that are improper in the profession of medicine. Like *imbecile* and *idiot*, it has lost its original meaning and has become derogatory, demeaning, and offensive. Its use must be avoided; simply mentioning a patient’s age is more informative.

Risk assessment based on potential outcome and comorbidities is an essential part of medicine for older ages, as it is for any age. Living longer is naturally associated with more cost. It is for future generations to determine their own policies and priorities. We must not restrict the progress of

science in medicine for any age. Rationing healthcare against older ages is unethical, as it is against any age or group. Each patient has the right to be treated individually, based on the standard of care in medicine.

### Author's Note

I have written about these ideas in a much shorter article which was published in BMJ Opinion on March 1, 2019, but the longer version submitted here contains a lot of material not touched upon in the shorter piece, so I believe there is value to having this longer version published.

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