Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Acute care of older people column




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Ageism, older people, and hospitalization: Walking a path through the past, looking to lead in the future

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Our struggle with ageism across society and within healthcare is more fraught than ever. The experience of the COVID-19 pandemic renders afresh awareness of ageism across America and around the world.[1,2] While nurses practicing in long-term care arguably grapple with some of the most poignant effects of ageism, inpatient nurses witness the impact, too. Indeed, this pandemic shown a bright light on the profound effects of discrimination toward acutely and critically ill older people. Ageism quickly appeared as the default response to COVID-19 morbidity and mortality, in the absence of specific evidence about causal factors. In the face of responses to COVID-19, many of us committed to dismantling ageism and replacing it with age aware and age friendly understandings, found ourselves forced to return to basics.

Basics begin with calling out timeworn, inappropriate associations between chronological age and health outcomes. No, chronological age is not causal in COVID-19 outcomes nor in the outcome of any condition; the relationship is only a correlation. No, older people are not destined to die from infection with SARS-CoV-2, just as any other group of similarly aged individuals are far from certain to experience a specific outcome of any condition. Chronological age – a ubiquitous but fairly useless element is every healthcare record – is frequently and repeatedly the basis for ageism in healthcare.

Fundamentally, chronological age creates no direct effect on health status; age is, at best, a proxy variable in healthcare. Age may be proxy for biological likelihood. For example, we are more likely to be frail, the older we become. Frailty, however, is not limited to old age. Younger people may become prematurely frail as a result of treatment for conditions like childhood cancer.[3] Yet, debates over what care and resources are due older people continue to play out. Our national conversations about aging are so skewed toward ageism that elected officials and other public figures easily express discriminatory opinions with relatively little censure. Such debates are often elevated in academic circles – witness a recent pro-con piece about medical decision making in COVID-19[4] – and garner a great deal of attention with few voices dissenting against the ageist logic of questioning treatment apportioned solely on the basis of chronological age.

Our struggles with ageism might feel very contemporary. In fact, the fight against this often insidious form of discrimination stretches back decades. Ageism, as first conceptualized by Butler in the 1960′s, entered the consciousness of Americans and American nurses about twelve years before *Geriatric Nursing (GN)* arrived in libraries and mailboxes in 1980.[5] Dating back to its earliest issues, *GN* editors, authors, and readers - who sent many remarkable letters to the editor in GN's early years – fought against it, as they still do today.

A cursory glance at titles in *GN's* early volumes belies how deeply the *GN* community understood ageism and how skillfully they strove to take it down. Upon a quick glance and any reader might miss what these nurses and their colleagues from other disciplines, along with activists and older Americans themselves, thought about aging and discrimination 35 and 40 years ago. Search with the term 'ageism', as I did, and thousands of titles are returned. None, from what I surveyed, actually used ageism as a title word and few employed the term in their text.

A more leisurely virtual stroll through *GN's* early archives tells a surprisingly different story about GN's collective recognition and activism around ageism. I meandered through the first five years of this journal, looking for clues to what our predecessors thought. Some titles, especially letters and news items, simply offered nostalgic moments of joy. Journals today provide no space for a report of a collective centenarian birthday celebration held in a long-term care facility,[6] the metrics of academic publication prohibiting such an article no matter how much gerontology nurses like me might love

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reading it. I encountered insightful personal reflections on aging from legends like Virginia Burgraff.[7] Burgraff reflected on what she learned from her own grandparents to create the Wheel of Aging model, thought provoking in its holistic and comprehensive perspective, even today. Other articles served as reminders of how dramatically the healthcare landscape transformed in less than four decades. Who among us remembers when the acronyms PPS (prospective payment system) and DRG (diagnosis related groups) were new?[8] Other articles reinforced the value in discarding practices lacking evidence – once considered cutting edge but no longer useful in today's evidence-based practice. An article detailing reality orientation caught my eye[9] reminding me of just how far advanced our science often is today when compared with that of the 1980′s.

Walking on, down my virtual path, I found treasures of insights about ageism, still relevant in our times. Early issues of *GN* are replete with many short letters and essays, anachronistic communications in contemporary publishing. These works represent two trends – one regarding the state of being old and learning from elders and the other of challenge and reform to improve the state of being old and receiving care – that shaped *GN's* first years, trends from which we may learn today.

First, many authors writing the articles in the early years of *GN* that caught my eye are older nurses and other elders writing about the state of being old and the meaning of old age for individuals and society. Their writing reflects brightly on considerations for improving acute and critical care for older people today. Harris[10] highlights value in learning about aging and being old from those who are, themselves, old. Too often, ambivalent ageism[11] prompts us as nurses, along with other clinicians and adult children of older patients, to believe we know best and to speak for and not with older people. Still today, most of us need reminders to learn from and work with older people.

Other authors took a more activist and futurist stance. Kuhn and Sommers[12] - activists in the legendary group The Gray Panthers - and Phaneuf[13] – an esteemed nurse academic writing during Older American's Month in the first year of *GN's* publication – look to the future as they critique the then current challenges faced by older people. Kuhn and Sommers and Phaneuf all write about the state of being old and meaning from their different vantage points. Kuhn and Sommers take a wider view. They outline a radically different society with age integration including new institutions for age integration with elder training for all. They go on to describe what they term the Society for Helping Each Other (S.H.E.O.), as a means of age integration, and Last Perches, an alternative to the nursing home. They called for healthcare to be, in their words, turned on its head and derived the notion of healthy blocks as an approach to a locally organized, nationalized system of care. Sadly, in my view, nurses appeared to play little if any direct role in Kuhn and Sommer's future vision. Perhaps the way in which they overlooked our potential to lead for change should inform our role now. Our practice in every hospital holds the potential to influence the larger sociopolitical context of our aging society today. Taking such a role underscores our recognition that dismantling ageism requires our action both as professionals and as citizens.

Phaneuf, as a nurse herself, spoke directly to her colleagues working in the early 1980′s. She dissected dichotomies of old and young, well and ill, emphasizing the vicissitudes of intersecting forms of discrimination. Phaneuf presciently identified the role of what we now term the social determinants of health and intersecting forms of discrimination on the basis of age, sex, race, and health. In addition to highlighting ageism and healthism – the form of discrimination based in perceptions of ill health – Phaneuf described what we now understand as negative age-related self-stereotyping, the ageism we levy against ourselves. Serendipitously, Phaneuf arrives at conclusions similar to those reached by Kuhn and Sommers. As we might expect of a nurse, Phaneuf, too, calls for a national system of care and makes it personal as we might expect of a nurse. Phaneuf notes that the old who have endured the challenges that make them frail deserve care, but not at the expense of the young, for to privilege one – old or young – against the other is intolerable. That Archard and Kaplan addressed themselves to the young over old debate in 2020, speaks volumes about the extent to which our society heard the guidance offered by Phaneuf, Kuhn and Sommers, and others who saw the peril our aging society and, as a result, the profession of nursing now faces.

In the second trend I see, other *GN* authors boldly challenged accepted wisdom, building on activist perspectives, showing nurses new and better direction for practice. In my favorite exemplar of this trend, Wolanin and Phillips[14] asked 'who is confused here?', emphasizing the grave responsibility in making that diagnosis, in their 1980 article. They aimed to improve care by dissecting nursing approaches to confusion among older people during hospitalization. In a confrontational style rare in nursing, Wolanin and Phillips bluntly ask nurses if they are simply labeling elderly patients as confused because they find the label easier to apply than they find understanding and solving their patients' problems. The science of delirium today is radically different than in 1980, including the very term itself. No longer should anyone carry the label 'confused' in lieu of the diagnostically correct term 'delirium'. Nonetheless, appreciating their essay and their bold approach to improving nursing practice, albeit contextualized within the time in which they wrote is worthwhile.

The problems in care Wolanin and Phillips describe remain. Ill older people are still judged by characteristics unlikely to hold any clinical value. Even reasons for hospital admission reflect such judgment as persistence of non-diagnostic labels 'social admission' or the medicalized British synonym 'acopia' confirm. Just how deeply social desirability, for instance, shape nursing assessment and care tragically persist is vividly illustrated by Maben and colleagues.[15] In building their argument, Wolanin and Phillips create a typology of patients who elicit challenges for nurses caring for them. The challenges presented, they posit, push nurses away from optimal practice and toward the option of mistakenly applying the label of confused. Today, their very typology must be seen as a list of stereotypes and labels. Nevertheless, Wolanin and Phillips' argument highlights how characteristics of our older patients too easily influence our perceptions of them, altering assessments, interventions, and outcomes. Maben and colleagues' findings show how behavior and social desirability alter nursing care in contemporary practice. Ageist understandings of appropriate behavior may unconsciously guide us as nurses, for example, to miss detecting hypoactive delirium or mistake agitated behavior for willful aggression instead of hyperactive delirium resulting from untreated pain. The risks of not knowing which of us is confused persist today as we practice in the context of unrecognized ageism.

Our collective experience of COVID-19 signifies grave need to redouble efforts to win rights of agency, respect, and equitable treatment across health care settings due all people, especially as they age. Acute and critical care units, no matter how advanced their technologies and robust their nursing governance, are not immune from institutionalized and structural ageism. Consider how quickly new media and nursing media alike reverted to analyses of palliative care for older people hospitalized with COVID-19. In the absence of clear understandings of which hospitals face decisions regarding distribution of critical, scarce resources, much of what was written and spoken across media held the implicit assumption that older people will and must die of COVID-19. That implicit assumption is anchored by a frequently unspoken understanding that palliative care is always end of life care. The convenient conclusion then is that our effort to improve care is best placed in developing palliative approaches for older individuals. While palliative care is absolutely necessary for these people, as it is for patients of all ages, to turn away from understanding curative and, indeed as we now know, rehabilitative needs[16] shows our collective, institutionalized ageism.

As I wrote in this column eight years ago,[17] ageism too easily sneaks into our nursing practice. New, unexpected, and dire

circumstances like COVID-19 catch us off guard, expanding the chance that unconscious, societally ingrained institutionalized ageism may slip into our care anywhere in the nursing process. Ageism's persistent social acceptability, coupled with common negative age-related self-stereotyping – when did you last hear "Oh no, I'm too old…"? - makes unwitting discrimination of the basis of age all the more likely. Dismantling ageism in healthcare, in hospitals, and specifically in acute and critical care nursing might feel insurmountable. In reality, we have many resources and allies. Why not consider these options for action in your own nursing practice and share them at your unit's next staff meeting?

- Consider participating in the Age Friendly Health Systems movement at the unit or even the hospital level. The Age Friendly Four M's – what Matters, Mobility, Mentation, and Medication – are an effective guide for reorienting assessment and intervention in ways that replace ageist practices. The Four M's work well in combination with Nurses Improving Care for Health System Elders (NICHE) and the Hospital Elder Life Program (HELP).[18]
- Using screening and assessment tools to enact Age Friendly care requires awareness of ageism. Launch your own ageism awareness campaign. A variety of educational programs and web-based resources are available to use in such a campaign.[19] Committing to a collective effort to recognize and dismantle ageism is difficult but worth the effort. Join together to help each other to recognize ageist statements and actions unwittingly made, offering suggestions for being age aware and age friendly in the moment of recognition.
- Replace comments featuring chronological age – unless you are helping a patient celebrate a birthday – with appropriate screening and assessment tools. Assessing frailty, along with assessing each of the four M's, provides data to circumvent assumptions made by clinicians on the explicit or implicit basis of perceived old age.

Dismantling ageism and embracing age aware and age friendly attitudes and actions in health care and throughout our community takes courage, strength, and vigilance. The work is hard but the risks are too great to continue in our implicit acceptance of ageism. Our future selves – all patients of nurses yet to be educated – and our current patients are depending on us.

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