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Subtle aspects of age discrimination

Sylvia Wassertheil-Smoller*

Department of Epidemiology and Population Health, Albert Einstein College of Medicine, Bronx, NY, USA

That age discrimination exists in employment is well recognized and has led to laws against it. Age discrimination in health care is more complex, but also exists. What is not readily acknowledged is the ageism that underlies such discrimination. Ageism is defined by the Collins English dictionary as "unacceptable behavior that occurs as a result of the belief that older people are of less value than younger people". The term "ageism" was first used by Robert Neil Butler in 1969. Dr. Butler was the founding Director of the National Institute on Aging, NIA, of the NIH and later founded the first department of geriatrics in a U.S. medical school at Mt. Sinai Medical Center in New York. This article attempts to describe some of the forms ageism takes and suggest one way in which it can be combatted.

Age discrimination in employment is against the law. Applicants for jobs and workers are protected by the 1967 Age Discrimination in Employment Act, enforced by the Equal Employment Opportunity Commission (EEOC). This Act prohibits discrimination in hiring and firing, compensation, and promotion. And it covers people starting at age 40! However, it is difficult to counter the implicit bias that exists and that underlies overt discrimination [1].

Age discrimination in health care is sometimes cloaked in cost-benefit type of analyses. For example, the U.S. Preventive Services Task Force (USPSTF) Guidelines, which are widely adopted by health care providers and insurance companies, do not recommend mammograms for women over 75, on the grounds that there is insufficient evidence of benefit and that women over that age are likely to die of other causes anyway [2]. That there is insufficient evidence is not surprising since most trials don't include participants over age 75. These guidelines do not consider the general health and functioning of the women many of whom could live another 20 years if their breast cancers were identified at an early stage. USPSTF guidelines for prostate cancer screening state not to use the prostate-specific antigen (PSA) test for men over age 70 with a similar rationale, that the men are likely to die of some other cause [3], because prostate cancer usually progresses slowly. This does not take into account that there is wide variability in life expectancy of men depending on their health status and co-existing chronic morbidities. Nor does it consider a research that showed that treatment prolonged survival compared to watchful waiting [4] and thus detecting and treating prostate cancer might show real benefit over doing nothing. In a later statement, the USPSTF guidelines recommends against PSA test screening at any age [5].

Such tangible discrimination is made possible by the general societal view of aging. The aged are often invisible. In many instances older people are assumed not to understand technology, not to have relevant opinions or information to contribute. They may be condescended to or marginalized in subtle and sometimes not so subtle ways. These stereotypes are based on pre-conceived notions and reliance on averages. What such attitudes don't take into account is the wide variability in physical and cognitive functioning among older people.

It is true that physical function declines with age. For example, hand grip strength, one measure of physical functioning, declines linearly and rather steeply with age. The Women's Health Initiative (WHI) is an ongoing multi-ethnic study of the health of 160,000 postmenopausal women across the United States who were 50 to 79 years old when the study began in 1993 [6] and are now between 75 and 104 years old. In an ancillary study to the WHI, the Long Life Study, we found for instance in a sample of 13,095 women that the average grip strength of women 80-84 years old was 41% lower than in those 60-69 years old. Cognitive functioning also declines with age. But these findings are on average. They do not account for variability within age groups. We are taught in "Statistics 101" that giving a mean value without also providing a standard deviation or a standard error as a measure of variability is useless in describing a population sample. There are some 80-year olds whose cognitive functioning in certain domains, but maybe not others, may outperform some 50-year old.

Undoubtedly, some older people contribute to this stereotype by not being open to learning new things, by being afraid of technology, by living in the past. And yet in the WHI when women were queried about their use of computers, iPads and cell phones, we found that 84% own a cell phone, 74% use a computer, 71% use it for email, 70% use it for internet.

When the women were queried about how often they go to a cultural event such as a movie, concert, play, or lecture, 70% responded they do so at least once a month, and 40% said at least several times a month (unpublished data). The respondents were between 65 and 99 years old when the questions were asked during follow-up, lived in various parts of the country, and were of diverse economic levels and multiple race/ethnicities. While the WHI cohort is somewhat self-selected, since ill and incapacitated women would not have been participants in the study, nevertheless, this large diverse cohort shows a picture of vibrant, active older women.

What can be done about the underlying ageism that drives actual discrimination? Awareness is a first requirement. One small step is to stop using birthdate as an identifier. When you call a bank for instance, or an insurance company or a receptionist at a health care facility, or any number of businesses, you are asked your name and often you are asked your date of birth so that they can identify you in their computer

Correspondence to: Sylvia Wassertheil-Smoller, Department of Epidemiology and Population Health, Albert Einstein College of Medicine, Bronx, NY, USA, E-mail: Sylvia.Smoller@einstein.yu.edu

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system. There are many other ways they can identify you and it is not necessary to do so by age. It should be no more legal to do that than it is to ask your race or sexual preference as an identifier. When I am asked this, I say I belong to a movement whose aim is to de-legalize using birth date as an identifier, and almost always they find another means of corroborating who I am.

The main point of the above discussion is that people should be treated as individuals: they should be evaluated for jobs based on their actual qualifications and abilities, not on stereotypical pre-judgments of capability; they should be screened for diseases and treated based on their individual health profiles and not on averages; they should be accorded social recognition and respect based on their personal characteristics, not on perceived notions of what old people are like. This is such an obvious idea, though not always actualized, when it comes to gender and race, but rarely is it applied to age.

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