

Strategies to Combat Ageism in Emergency Medicine

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INTRODUCTION

Ageism refers to the stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) towards others and/or oneself on the basis of age.¹ Ageism can affect people of all age groups. Within medicine, biases against older adults, commonly defined as individuals that are age 65 and older, can negatively impact experiences of health care and health outcomes. While many older adults develop illnesses, frailty, and limitations in functional status as they age, others remain mentally healthy and physically well into their 90s. Emergency clinicians are disproportionately exposed to the former in medical practice and may equate aging with dependence and conflate advancing age with disability and frailty.² Such perspectives may be subconsciously expressed in the ways we interact with our patients. Some examples include preferentially communicating with a family member rather than directly with an older patient, making assumptions about their medical history, or referring to an older patient as “dear,” as further detailed below. Patients who perceive differential or disrespectful treatment on the basis of age may have decreased trust in their care team and a lower likelihood of following recommendations or returning to care. There are multiple practical steps that we as clinicians can take to combat ageism in emergency medicine.

COMMON PRACTICES AND LANGUAGE THAT MARGINALIZE OLDER ADULTS

Reflect on common language and practices that marginalize older adults. Advance inclusive language about aging, as outlined by best practice communication guidelines such as that developed by the Reframing Aging Initiative.³

- Avoid language that marginalizes. An example of a blatantly offensive but common statement is comparing an older adult’s emergency department (ED) workup to ‘veterinary medicine.’ A more appropriate way to describe clinical uncertainty could be to state that one’s differential diagnosis must remain broad. Such language avoids provoking negative stereotypes associated with aging.³
- Avoid using the term “atypical.” A more subtle example of implicitly biased language includes conceptualizing older adults’ symptoms of various conditions—such as angina or COVID-19—as ‘atypical,’ which presumes a younger patient as the standard. Instead, we can talk about the ‘usual’ presentation of a condition among older adults.
- Consider how commonly used phrases can bias us into incorrect clinical conclusions. As one example, ‘mechanical fall’ is often used in a way that reassures clinicians against a syncopal cause of fall—even though many non-syncopal causes of fall can be dangerous (e.g., polypharmacy, substance use, clutter, or impaired proprioception or vision).

- Avoid making assumptions about the types of activities older adults do or do not engage in. For example, omitting to take a sexual history of an older adult with dysuria may lead us to miss a diagnosis.

COMMUNICATING WITH OLDER ADULTS

Avoid “elderspeak,” a form of communication that uses inappropriately juvenile and overaccommodating lexical choices. See **Table 1** for examples. While clinicians may intend to demonstrate care through elderspeak, negative impacts include patients feeling patronized, discounted on the basis of age, and perceiving worse comprehension of clinical information.⁴

- Do not address older patients with inappropriate terms of endearment, such as ‘honey,’ ‘dear,’ ‘young lady.’ Consider asking your patient how they would like to be addressed at the beginning of your encounter. Some clinicians communicate with older adults in the context of their own cultural experience, rather than that of the patient. Prioritize the patient’s expected cultural/linguistic convention, such as addressing them by last name (e.g., “Mrs. Jones”) or including a title or suffix that conveys respect (e.g., “*Doña* [First Name]” as might be used in Spanish, “Mr. [Name]-*ji*” as might be used in Hindi).
- Reflect on how older adults may perceive a high-pitched, over-nurturing voice as infantilizing.
- Think about non-verbal cues that can convey disrespect: avoid preferentially speaking to and making eye contact with an older patient’s family member at the bedside rather than the patient themselves.

Appropriate communication is not only a means for demonstrating respect to older adult patients but is also a critical aspect of patients’ hospital care experiences that factors into Hospital Compare scores by the Centers for Medicare & Medicaid Services.⁵

INSTITUTION AND SYSTEM-LEVEL ADVOCACY

Ageism can manifest at multiple levels. Beyond interpersonal examples described above, consider how institutional policies and omissions can negatively impact older patients. Advocate to make your institutional policies as inclusive as possible.

- Pediatrics is a core competency in emergency medicine (EM,) but geriatrics is not, despite older adults representing about one-fifth of emergency department (ED) patients. Advocate for geriatric EM education in your medical school and residency programs, using expert-developed core competencies.⁶
- In the COVID-19 pandemic era, hospital visitor restriction policies can disproportionately affect older adults who rely on care partners to engage with their medical teams.⁶ Advocate to allow masked, asymptomatic care partners to be present at bedside.
- Consider how the ED environment can be deliriogenic and difficult to navigate both cognitively and physically for older adults, particularly during times of boarding, crowding, and hallway care. Develop protocols that promote hydration and diet, mobility, and accommodation of those with hearing and vision impairments whenever possible.

Table 1: Examples of Elderspeak in Medicine		
Aspect of Communication	Example of Elderspeak	Respectful Communication Strategies
Speech Content	<ul style="list-style-type: none"> Inappropriate terms of endearment – “honey,” “dear,” “young lady” Collective pronoun substitute – “Do we need to use the restroom?” “Can we take our medicine now?” 	<ul style="list-style-type: none"> Ask patient how they would like to be addressed. Address patient directly whenever possible, rather than speaking for them or about them to others
Speech Delivery	<ul style="list-style-type: none"> High-pitched vocal adjustments Over-nurturing voice Exaggerated intonations, smiles, nods Short, slow sentences 	<ul style="list-style-type: none"> Initiate your interaction speaking as you would to another patient. Adjust delivery of speech to meet specific needs of the patient (e.g., patient with hearing impairment, summarization/ teach back regarding care transition.)
Non-Verbal Features	<ul style="list-style-type: none"> Standing over patient Yelling into patient’s ear Patting patient on the head 	<ul style="list-style-type: none"> Approach patient at eye level whenever possible. Ask patients with hearing impairment where to position oneself to be best heard. Ask permission to examine or touch the patient.

KEYWORDS

Ageism, elderspeak, health equity, implicit bias, advocacy

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REFERENCES

- World Health Organization. Ageing: Ageism. Published March 18, 2021. Accessed March 2, 2022. <https://www.who.int/news-room/questions-and-answers/item/ageing-ageism>
- Wyman MF, Shiovitz-Ezra S, Bengel J. Ageism in the health care system: Providers, patients, and systems. In: Ayalon L, Tesch-Römer C, eds. *Contemporary Perspectives on Ageism*. Vol 19. International Perspectives on Aging. Springer International Publishing; 2018:193-212. doi:10.1007/978-3-319-73820-8

3. Reframing Aging Initiative. Communication Best Practices: Reframing Aging Initiative Guide to Telling a More Complete Story of Aging. Published 2022. Accessed April 18, 2022. <https://www.reframingaging.org/>
4. Shaw CA, Gordon JK. Understanding Elderspeak: An Evolutionary Concept Analysis. *Innov Aging*. 2021;5(3):igab023. doi:10.1093/geroni/igab023
5. Centers for Medicare & Medicaid Services. HCAHPS: Patients' Perspectives of Care Survey | CMS. Published December 1, 2021. Accessed April 18, 2022. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS>
6. Hogan TM, Losman ED, Carpenter CR, et al. Development of Geriatric Competencies for Emergency Medicine Residents Using an Expert Consensus Process. *Acad Emerg Med*. 2010;17(3):316-324. doi:10.1111/j.1553-2712.2010.00684.x
7. Lo AX, Wedel LK, Liu SW, et al. COVID-19-19 hospital and emergency department visitor policies in the United States: Impact on persons with cognitive or physical impairment or receiving end-of-life care. *J Am Coll Emerg Physicians Open*. 2022;3(1):e12622. doi:10.1002/emp2.12622