Ageism in Post-Acute and Long-Term Care: Is That Possible?

I have worked in nursing homes since I was 17 years old, and despite many years of loving my work with older adults, I recently began to wonder whether I could be ageist. It is hard to share that thought publicly — not just because I value dignity, respect, and inclusivity, but because I am a social worker. Is it possible that I could be harboring ageist attitudes and beliefs without even knowing it? With my curiosity piqued, I delved into exploring what it means to be ageist and the ways that I could be unknowingly contributing to this problem.

In 1969, geriatrician Robert Butler coined the term “ageism,” which he defined as “a combination of prejudicial attitudes toward older people, old age, and aging itself; discriminatory practices against older; and institutional practices and policies that perpetuate stereotypes about them” (quoted in Ashton Applewhite, This Chair Rocks: A Manifesto Against Ageism, Networked Books, 2016). Researchers at Yale University estimated that ageism is responsible for “17.04 million cases of the eight most expensive health conditions” per year in the United States, amounting to $63 billion annually (Yale News, Nov. 13, 2018, https://bit.ly/3KcBPde).

Ageism affects people of all ages, including children. Nobody is born ageist, but it starts young. According to Jill Vitale-Aussem in her book, Disrupting the Status Quo of Senior Living: A Mindshift (Health Professions Press, 2019), “research suggests that children develop negative stereotypes about old age in early childhood, around the same time that attitudes about race and gender begin to form.” From these early years, we learn to stereotype those who aren’t our peers — from “old people” to “people our parents’ age” — and we even learn early on to stereotype those younger than us, such as calling kids who cry or appear scared “babies.” We hear and see these stereotypes repeated in TV shows, on birthday cards, and through the jokes we tell. Such everyday stereotypes take root in our society and begin to affect the way we unconsciously think about those of other ages.

As Ms. Vitale-Aussem acknowledges in her book, “Once you learn about ageism and pay attention to it, you realize it is absolutely everywhere. Now I can’t stop seeing it!” I identify with that statement, and I’m growing in my capacity to notice ageist attitudes, statements, policies, and rules in the world around me.

For those of us working in post-acute and long-term care settings, unconscious ageism is something that can slip by us unnoticed — after all, many of us love working with older adults, and the last thing we want is that we are ageist. To help unpack my own ageism, I found the following three concepts helpful.

Age as a Social Experience
The first concept is that while aging is a biological process, age is a social experience. In her book This Chair Rocks, Ms. Applewhite says, We have “a conception of old age as a biomedical problem to which there might be a scientific solution. What was lost was a sense of the life span, with each stage having value and meaning.” What this comes with, she says, is a sense of shame about growing older as though it’s something to hide, cover up, fix, or medicate. As a society, we assign social roles to older adults that don’t necessarily reflect their internal identities, which may feel ageless. Simply because people biologically age, we are acculturated to silence their voices and question their opinions, which in turn may diminish what might otherwise be a rewarding social experience.

In terms of our work in PALTTC, I think we need to consider our beliefs, or perhaps assumptions, about purpose and whether we believe that just because someone lives in a nursing home they no longer desire to have purpose, or purposeful work, or meaningful things to do, that they instead merely need to fill their time.

Generational Speak
The second concept is that ageism is baked into our interactions with anyone in a different age group — from our language to our expectations about how each “generation” should behave. Take, for instance, the stereotypes we have around “millenials,” or “Gen Z,” or “boomers,” many of which are regularly debated in the media. Although there are historical changes that do affect generations, sociologists recognize that generational frameworks are more likely to reinforce social stereotypes than provide useful descriptions of social groups. As Louis Menand writes in a 2021 piece in the New Yorker, “there is no empirical basis for claiming that differences within a generation are smaller than differences between generations” (Oct. 11, 2021, https://bit.ly/3jbAKH9).

It’s only when we become aware of this socialization that we can make conscious choices to reframe our thinking and language. This includes how we speak with people who live in nursing homes. Ms. Applewhite writes, “Condescension alone actually shortens lives. What professionals call ‘elderspeak’ — the belittling ‘sweeties’ and ‘dearies’ that people use to address older people — does more than rankle. It reinforces stereotypes of incapacity and incompetence, which leads to poor health, including shorter life spans ... Nursing home residents with severe Alzheimer’s have been shown to react aggressively to infantilizing language.”

Ageist Design
The third concept is that of ageist design. In their nature of being places to care for adults, long-term care facilities are often designed with ageist notions. As Ms. Vitale-Aussem notes, our “institutional culture of ageism persists” in every level of living and even in the most beautiful of buildings. “It’s a culture that purports to honor aging but continues in many situations, to operate based on processes and policies infused with paternalism, ageism, and antiquated thinking.” These spaces often assume a lack of agency for residents — the purpose is for staff to “take care of” the people who live there, not to support or enhance their independence. However, a sense of agency, dignity, and meaningful purpose is important at any age — it doesn’t go away.

As Ms. Vitale-Aussem points out, even the electronic medical record is designed with ageist assumptions and categories intended to “manage risk” instead of protecting individual agency. What could easily be labeled a “behavioral problem” from a dropdown menu may actually be an understandable reaction to an environment designed to take away a resident’s agency; in such cases, it’s the environment that needs modification, not the resident.

As I consider the psychosocial assessments that I’ve done over many years, I feel a sense of regret that I was not aware of my own internalized ageisms. I no doubt placed limitations on people — the belittling ‘sweeties’ and ‘dearies’ aren’t “real” — and language. This includes how we speak with people who live in nursing homes. Ms. Applewhite writes, “Condescension alone actually shortens lives. What professionals call ‘elderspeak’ — the belittling ‘sweeties’ and ‘dearies’ that people use to address older people — does more than rankle. It reinforces stereotypes of incapacity and incompetence, which leads to poor health, including shorter life spans ... Nursing home residents with severe Alzheimer’s have been shown to react aggressively to infantilizing language.”

• Look at your own biases and attitudes about aging by looking for ways in which you are ageist instead of looking for evidence that you aren’t” (Applewhite).

• Question your assumptions. You aren’t sure whether something is ageist or not? Consider whether it would be appropriate if used for someone your own age — would you use words like ‘spry’ or ‘cute’ to describe your own peers? (Applewhite).

• Avoid qualifiers like “for your age” or using of the word “elderly” (Applewhite).

• Avoid asking people how old they are — this often isn’t relevant information (Applewhite). Also consider whether you make any assumptions when you learn of a person’s age. Do you relate them to a particular category or group?

• Consider starting a consciousness-raising group around ageism in your facility. According to Ms. Applewhite, “consciousness-raising is a tool that uses the power of personal experiences to unpack unconscious prejudices and to call for social change” (see the resources list with this article).

• Create cultures of inclusivity that involve tackling ageism alongside sexism and racism (Vitale-Aussem).

• Consider the ways in which “managing age” unconsciously translates into denying residents their agency. Ms. Vitale-Aussem recommends eliminating words like “refused” and “noncompliant” and using words that support a human being making a choice.

• Create communities, not facilities — ask the residents and staff what community means to them (Vitale-Aussem).

• Reconsider your admission process, assessments, and questions. So much of what we ask is about the past, but why don’t we ask about the future? What would they like to learn, discuss, focus on? These questions promote what Ms. Vitale-Aussem calls an “evolving sense of self” and can help residents find new purpose and meaning in their lives.

• Consider the ways that staffing can help create age-inclusive communities. When possible, hire people who truly want to work in PALTTC and want to learn. Create a culture where the staff feel like

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\text{homeless poor in Atlanta by providing a range of services (soup kitchen, shelter, and clothing closet). While also advocating for supportive and just legislation to end homelessness. As I arrived back in Atlanta, they needed a volunteer and onsite coordinator for the weekly medical clinic, and I fit the bill. }

\text{For five years, I recruited and trained volunteers, worked with faculty and students from Emory University School of Medicine, and found my own passion for patient care through starting a foot clinic to care for the ragged and injured feet of the patients who came to the clinic for medical management and treatment. Two years into this adventure, I enrolled in nursing school and started bringing my friends along with me to the clinic each week (it was a brilliant recruitment strategy).}

\text{Providing care for patients experiencing homelessness is rife with complexities. Morbidity and mortality rates among this population are appalling; some sources note a decrease of life expectancy by as much as 50%. This staggering statistic, combined with the fact that homelessness disproportionately impacts patients with other marginalized identities (people of color, veterans, low socioeconomic status, lower educational completion, etc.) illuminates the realities of intersectional oppressions combining to systematically disenfranchise this whole population. }

\text{As I knelt to care for the feet of many patients over these five years, I heard stories and built relationships that have shaped me as a clinician, teacher, and human — and as I grew to care deeply for many of these patients, I became increasingly horrified by the system of care that created barriers for their access to any sort of medical management or treatment. These challenges grow even more complex for patients experiencing homelessness when they receive a life-limiting diagnosis or have palliative or hospice care needs.}

\section{Access to Palliative and End-of-Life Care}

The combination of complex chronic care needs and barriers to care can make accessing palliative and end-of-life care nearly impossible for patients experiencing homelessness. Examples from the literature include negative experiences with health care providers leading to deep distrust and therefore an unwillingness to engage with providers; an often complete lack of available resources to manage chronic and life-limiting illness in the absence of stable housing; lack of creative models, like street outreach teams, to help stabilize and provide ongoing care to patients with high symptom burden; and the use of traditional approaches rather than harm-reduction approaches and trauma-informed care (BMC Palliat Care 2016;15:96; BMC Palliat Care 2018;17:67; Omega [Westport] 2020;8:63–91). On the organizational side, hospice and palliative care organizations struggle to identify patients experiencing homelessness because the requirement of a place to receive care often disqualifies them for admission unless the patient meets the criteria for inpatient hospice admission. As my clinical and research interest in palliative and end-of-life care have grown, I’ve always gone back to my experiences in the foot clinic. These sorts of opportunities to build trusting relationships with clinicians are exactly what is needed to reach patients experiencing homelessness who need care at the end of their lives. But there are few opportunities for this sort of relationship and trust building to happen in traditional health care settings where efficiency and profit considerations are paramount.}

\text{As Ashton Applewhite, ‘‘Who me, old?’’ (FrameWorks Institute, 2019) says well, it’s difficult to balance regulations at the federal and state levels and hundreds of policies and procedures, not to mention the impact and long-term implications of the last three years living and working in a pandemic. But regardless of these challenges, what I’ve ultimately learned in my work is this: it’s important to initiate conversations about difficult topics like ageism and really listen to what other people share. Talk to people about their frustrations, disappointments, and successes. Offer support when people get discouraged. And remember that change happens slowly — keep going!}

\section{A Successful Model}

One very successful model is the Palliative Education and Care for the Homeless (PEACH) program in Toronto, Ontario. In this model, clinicians reach patients who are experiencing homelessness or vulnerable housing by focusing on accessibility, flexibility, and a humanistic approach to human dignity. Leveraging relationships with community organizations, particularly those with harm-reduction programs, PEACH clinicians build long-term relationships with patients who are concomitantly dealing with life-limiting disease and experiencing homelessness or housing vulnerability. (For more information on their program, visit their site at Inner City Health Associates, PEACH – Palliative Education and Care for the Homeless, https://bit.ly/3qtbBgQ.) This organization is one of several that have both a street outreach team and an inpatient facility where patients can live while receiving end-of-life care.

\section{Moving Forward}

The connection between homelessness and palliative and hospice care is clear: homelessness itself is a life-limiting diagnosis, and palliative and hospice care using a harm reduction and trauma-centered approach helps address the barriers to care. As we work to reduce harm and engage with our patients, we all need to create opportunities to sit at our patients’ feet and listen to their stories, to provide care that addresses their own identified needs, and to help them find comfort in a way that honors their precious lives.}

\text{Hannah Murphy Buc is the director of the BSN program and program coordinator for Restorative Justice at University of Maryland, Baltimore School of Nursing and is a PhD candidate at The Conway School of Nursing at The Catholic University of America. In her work with students and patients, Hannah seeks opportunities to build a more just and anti-racist healthcare system where humans, rather than profits, are at the center.}

\text{Resources}

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  \item Reframing Aging Initiative, “Reframing Aging: Quick Start Guide” (FrameWorks Institute, 2019).
  \item For creating community and purpose: A Heart to Serve program, https://www.ahearttoserve.com/
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