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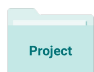

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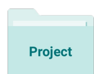

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ORIGINAL INVESTIGATION

Ageism among physicians, nurses, and social workers: findings from a qualitative study

Aya Ben-Harush[1,2] · Sharon Shiovitz-Ezra[3] · Israel Doron[4] · Sara Alon[5] · Arthur Leibovitz[6] · Hava Golander[7] · Yafa Haron[8] · Liat Ayalon[9]

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Abstract This study investigated ageism among healthcare professionals in various therapeutic settings in Israel. Using a qualitative approach, the current study aimed to examine similarities and differences across healthcare disciplines. Three focus groups were conducted with physicians, nurses, and social workers. Data from each focus group were analyzed separately, and then commonalities and differences across the groups were evaluated. Three main themes relating to older adults emerged from the data. The first theme pertains to perceived difficulties that healthcare professionals experience in working with older adults and their family members; the second focuses on invisibility and discriminatory communication patterns; and the third theme relates to provision of inappropriate care to older adults. Similarities and differences across the three disciplines were found. The differences related mainly to the examples provided for manifestations of ageism in the healthcare system. Provision of inadequate treatment to older adults due to their age appeared to be the most complex theme, and is discussed at length in the Discussion. Briefly, the complexity stems from the fact that although some behaviors can be clearly described as inappropriate and undesirable, other behaviors such as avoidance of invasive medical procedures for older patients raise ethical dilemmas. Potentially, avoidance of invasive medical treatment can be perceived as compassionate care rather than as undertreatment due to ageist perceptions. A related dilemma, i.e., longevity versus quality-of-life, is

Responsible editor: Clemens Tesch-Römer (guest editor) and Howard Litwin.

✉ Sharon Shiovitz-Ezra
sharon.shiovitz@mail.huji.ac.il

Aya Ben-Harush
ayale@mscc.huji.ac.il

Israel Doron
idoron@univ.haifa.ac.il

Sara Alon
saraa@jdc.org.il

Arthur Leibovitz
larthur@bezeqint.net

Hava Golander
goland@post.tau.ac.il

Yafa Haron
Yafa.haron@moh.health.gov.il

Liat Ayalon
ayalonl@mail.biu.ac.il

[1] The Department of Social Work, Ruppin Academic Center, Emek Hefer, Israel

[2] The Early Childhood Education Program, The David Yellin Academic College of Education, Jerusalem, Israel

[3] Paul Baerwald School of Social Work and Social Welfare, The Hebrew University of Jerusalem, Mount Scopus, 91905 Jerusalem, Israel

[4] Department of Gerontology, University of Haifa, 31905 Haifa, Israel

[5] ESHEL-Joint, Joint Hill, POB 3489, Jerusalem, Israel

[6] Internal Medicine-Geriatrics, Epidemiology and Prevention, Tel Aviv University, Ramat-Aviv, 69978 Tel Aviv, Israel

[7] The Department of Nursing, The Stanley Steyer School of Health Professions, Sackler Faculty of Medicine, Tel Aviv University, Ramat-Aviv, 69978 Tel Aviv, Israel

[8] Nursing Division, Ministry of Health, Capital Towers, 39 Jermiyau St, Jerusalem, Israel

[9] Gabi and Louis Weisfeld School of Social Work, Faculty of Social Sciences, Bar-Ilan University, 52900 Ramat Gan, Israel

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also discussed in light of the finding that the balance of these two aspects changes as patients grow old.

Keywords Ageism · Physicians · Nurses · Social workers · Qualitative research · Focus groups

Introduction

Ageism refers to stereotypes, prejudice, and discriminatory behaviors against older adults. Death anxiety is of particular relevance to the population examined in the current study, namely, healthcare professionals. People associate old age with death. Therefore, being physically close to older adults or even thinking about them tends to evoke death anxiety. Greenberg's terror management theory (TMT) attributes ageism to the human desire to dissociate from any reminder of our inevitable personal death (Greenberg et al. 2004). Ageism serves as a defense mechanism against death anxiety and any reminder of future deterioration (Martens et al. 2005).

Healthcare professionals have a biased experience with older adults because they tend to see and treat only the most frail, sick, and senile older people (Palmore 1999; Kearney et al. 2000). The relevance of TMT to explaining ageism has been supported most recently by the finding that self-aging anxiety is related to biased attitudes among nurses (Liu et al. 2015). Ageism among healthcare professionals affects the quality of treatment and the services that older adults receive (Courtney et al. 2000; Robb et al. 2002). Evidence has also shown that ageism crosses professional borders; it exists among different healthcare providers in general, and among physicians, nurses, and social workers in particular.

Ageism among physicians

There is ample evidence for ageism among physicians in diagnostic procedures, treatment of older patients, and interactions with older patients. For example, a study carried out in England found age differences in the treatment of lung cancer patients, and revealed that the chances of being referred for surgery were slimmer for older people despite many reports that postoperative recovery is not dependent on age. There was also a clear age bias in diagnostic procedures, which was attributed to the physicians' reluctance to carry out intrusive diagnoses among older patients (Peake et al. 2003).

Ageism in diagnostic procedures has also been revealed in a study conducted among women with breast cancer in England. Even though most of the breast cancer cases were found among older women, only 7 % of the physicians participating in that study conducted breast examinations for those women on a routine basis. This was attributed mainly to a lack of awareness, and to the belief that the older women would respond negatively to aggressive treatments (Haigney et al. 1997).

Research has also revealed that physicians are less interested in treating older adults with suicidal tendencies than in treating younger people with identical problems. In the physicians' view, the existence of suicidal tendencies among older adults is logical and normal. Therefore, they are less willing to use therapeutic strategies to help older suicidal patients (Barnow et al. 2004; Uncapher and Arean 2000).

Finally, physicians are less likely to involve older patients in medical decisions compared with younger patients. They also tend to be less patient, respectful, involved, and optimistic with older patients (Greene et al. 1996).

Ageism among nurses

Compared with other healthcare providers, nurses have less accurate knowledge about the aging process. They have also expressed higher levels of anxiety about aging, and have shown a tendency to assign a lower status to geriatric nursing (Wells et al. 2004). A study conducted in the Netherlands found a correlation between nurses' attitudes toward older patients and the quality of communication and care provided to them (Caris-Verhallen et al. 1999). The more negative the nurses' attitudes, the shorter, more superficial, and more task-oriented their conversations with older patients were. The nurses tended to speak to older patients in a patronizing tone, and did not involve them in consultations or decisions. McLafferty and Morrison (2004) reached similar conclusions in a study conducted in Scotland. The nurses' negative attitudes towards older patients were reflected in their low expectations for rehabilitation as well as in their detached treatment of the patients. The nurses used shallow language and shouted, without any humor and without even addressing the patients by name. In an updated systematic review of research conducted since 2000 in various countries (Eastern and Western countries such as Singapore, the US, Canada, and Australia), a steady decline from positive to more neutral attitudes towards older people over time was found among student nurses (Liu et al. 2012).

Risk factors for ageist attitudes among nursing students and registered nurses in Sweden include young age (<25) and male gender (Soderhamn et al. 2001). Similar results have been found in Greece, where young age and male gender were positively associated with ageism as reflected in narrow knowledge about aging and negative attitudes towards older adults (Lambrinou et al. 2009). However, a

recent systematic review of 25 studies carried out in different countries (such as Australia, UK, the US, and Taiwan) suggests that age and gender are not consistent predictors of nurses' attitudes toward older patients, whereas preference for work with older patients and knowledge about old age are more consistent predictors of positive attitudes (Liu et al. 2013).

Ageism among social workers

In a similar vein, studies have found that ageism is common among social workers in healthcare settings. For example, one study found that social workers spend less time in meetings with older oncology patients than they do with younger patients (Rohan et al. 1994).

Among social workers, expressions of ageism have been found as early as at the stage of training (Kane 2007). In a study conducted among social work students, Kane (2004) revealed that participants' perceptions of bio-psychosocial assessments and interventions related to illness, aging, and death were affected by the patient's age. The students believed that it is more acceptable for older people to willingly end their life. They also believed that the prospects for recovery from an illness are much lower for older adults than for younger people with the same illness, irrespective of the quality of treatment. Similarly, social work students perceived older adults as a vulnerable and marginalized group. Older adults were also perceived as only moderately resilient in overcoming mental disorders (Kane et al. 2009). In another study, undergraduate social work students also expressed ageist perceptions (Kane 2007).

The literature provides evidence for ageism in different healthcare fields. However, although there is evidence of ageism that unquestionably impairs the quality of care provided to older patients (e.g., Greene et al. 1996), there is also evidence that raises the dilemma of what is considered adequate versus inadequate care for older patients in the healthcare system (Haigney et al. 1997; Peake et al. 2003).

The present study

Most studies to date have been conducted among samples of professionals within the same discipline. The few comparative studies that exist have focused mainly on medical staff (Liu et al. 2012). On the whole, there is less empirical knowledge on ageism in the mental health domain (Robb et al. 2002). Therefore, the current study sought to compare ageism among medical and mental health professionals who work in a variety of therapeutic settings in the Israeli healthcare system. Three main professions were examined: physicians, nurses, and social workers. Using a qualitative approach, the study aimed to comprehensively examine similarities and differences across the different health disciplines. The expansion of comparative research on this topic contributes to broadening the knowledge base in the field, and points to important future areas for intervention and training. Although there are ample quantitative empirical studies on ageism in the healthcare system, most of them are limited, in that they use scales such as Kogan's People Scale (KOP; Kogan 1961), which explore general attitudes about aging and older people without considering the healthcare background. Hence there is relatively little knowledge about expressions and manifestations of ageism in this unique professional environment. In addition, age-biased attitudes are the most prevalent component of ageism that has been investigated, whereas discriminatory behaviors have received much less attention. The use of qualitative inquiry provides a basis for gaining broad, in-depth insights about ageism, its etiology, and its manifestations in the health domain (Hanson 2014).

Methods

Sample

The research was conducted as the first phase of a larger quantitative study on ageism among healthcare professionals in Israel. The study was approved by the IRB of the School of Social Work and Social Welfare at the Hebrew University. The qualitative study was based on three focus groups of healthcare professionals. Focus groups allow for observation of interactions among informants, which provide insights into their attitudes and experiences relating to the research topics. They also provide a basis for enriching discussions through group dynamics, in which participants are encouraged to share, clarify, and question each other's responses (Freeman 2006; Morgan and Spanish 1984). This effective technique is widely used in the healthcare field (Kitzinger 1995). All three focus groups included professionals employed in various clinical settings: hospitals (general and geriatric units), primary care clinics, and long-term care facilities.

The group of physicians was conducted as part of a one-day seminar, and the other two groups of professionals were recruited through their participation in advanced training courses. The focus group for physicians included 20 participants, most of whom were women (16); nine of the physicians worked in long-term care facilities, eight worked in primary care clinics, and three worked in hospitals. Nine of the physicians were more active than the

others in the group discussions. One of the factors that contributed to this group dynamic was the gender effect: four male physicians were dominant in the discussion, which sometimes left the other participants in a position where they listened for the most part. In response to that dynamic, the interviewer encouraged the other informants to participate in the discussion. The group of nurses comprised five women: two worked in primary care clinics, and three worked in hospitals (one of them in a geriatric unit). The focus group for social workers included four women: three of them worked in different units at three hospitals, and one was in charge of the social services of a long-term care facility.

Procedure

A social worker with training in qualitative research was the interviewer in all three focus groups, which were conducted between December 2010 and February 2011. We used a funnel approach consisting of 11 questions, starting with broad questions such as "Tell me briefly about the populations you work with," and followed by more specific questions about the participants' general experience working with older patients (e.g., "How would you describe your work with older adults?"). The informants were also asked to indicate how working with older patients is unique or different from working with other populations. The last two questions explored negative and positive expressions of ageism (e.g., "To what extent have your patients experienced age-based discrimination?"). Interviews lasted from 60 to 90 min, and were conducted in an uninterrupted environment. All interviews were recorded and transcribed verbatim.

Analysis

Data categories were coded in stages: In the first stage, each interview was coded thematically for recurring thematic topics. In the second stage, commonalities and differences across focus groups were evaluated, and themes were regrouped into one of two categories: common themes to the three focus groups; and common themes to all focus groups that had a unique component characterizing the particular profession. The data analysis was an interpretative process based on an "open coding" approach, which is sensitive to the content of the focus group and is not affected by predetermined conceptions (Pidgeon and Henwood 1996; Strauss and Corbin 1998). Finally, the main categories that form the "story line" were chosen (Strauss and Corbin 1998), with emphasis on common and unique expressions of ageism among healthcare professionals.

Establishing sources of trustworthiness

The transcribed texts were read separately by two scholars (with research experience in qualitative methods and gerontology), who agreed on the categorization process. The findings were discussed in detail with experts, and their feedback was incorporated. These processes of peer debriefing and triangulation allowed us to describe research findings in a way that authentically represents the meanings described by the participants (Creswell 1998).

Findings

Three main themes relating to ageism emerged from the data: the first theme addressed perceived difficulties that the healthcare professionals experienced in their work with older adults; the second theme focused on discriminatory communication patterns; and the third addressed the provision of inappropriate care to older patients.

"It is very hard": Perceived difficulties related to working with older adults and their families

The participants discussed four major difficulties related to working with older patients: (a) patients who want to manage their own treatment; (b) patients who are demanding and complain constantly; (c) patients whose behavior is offensive; and (d) unpleasant and unaesthetic aspects of treating older adults. The participants also discussed difficulties related to working with the family members of older patients.

(a) "They do not let me help them": Older patients who want to manage their own treatment.

The three groups of professionals experienced similar difficulties in dealing with older patients who were perceived as having their own opinion about the treatment they need, and who were often unwilling to listen and follow professional advice. One physician portrayed this theme as follows:

> …the hardest patients are those who do not let me help them… I have a Russian [older] patient…who says no to every medical suggestion. I am a physician and want the best for my patients. But she doesn't let me help her, and doesn't let me prescribe suitable medicines. This is very hard for me.

Social workers reported similar feelings with older patients who refused to accept any emotional or instrumental support:

> I treat an 82-year-old Holocaust survivor who separated from her husband who beat her all her life. Two years ago, she finally had the courage to leave him.

> But now she is not willing to be helped at all. She can't live by herself… She is so preoccupied with her rebellion that she won't let anyone tell her what to do any more. She won't accept any help….

Finally, a nurse working in a long-term care facility also relates to the complexity of working with older adults:

> I have 40 tenants, each with their own personality and habits. It is far from being simple. You have to work with each one in their own way.

(b) "They want attention": Older patients as demanding patients

The physicians, social workers, and nurses emphasized the need for constant attention, which characterizes many of the older adults they treat on a daily basis. The need to contend with ongoing demands and complaints, which disrupt their daily routine and impair their ability to complete their tasks, was a common challenge raised by participants from all three disciplines. This is illustrated in the following statement by a physician:

> Some [older] patients are completely disabled, but they want attention and are demanding… It is very hard to provide what they are asking for, especially if they demand something every half an hour in order to get your attention.

The nurses described a similar pattern:

> Some [older] patients won't let you work, and will approach you every second… You know that they are not going to die right now, but they still need plenty of attention.

Even though the patients who insist on their opinions and refuse to follow professional advice as well as the patients who have constant demands can belong to any age group, the professionals from the three focus groups were more likely to associate these behaviors with the older age group when they were asked to compare different groups of patients.

(c) "Thankless job": Older patients perceived as behaving offensively

The professionals portrayed the most problematic, albeit less prevalent aspect of working with older adults as the need to deal with offensive behavior. Professionals from each group revealed that some patients tend to yell, curse, and in extreme cases even spit on them and hit them. They mentioned one main coping strategy, which was trying to be tolerant and not take the offensive behavior personally. This is illustrated by the following statement by one of the nurses:

> It's a very hard and sometimes thankless job, because we are talking about disabled patients who are in serious condition, both physically and cognitively. We are dealing with people who have behavior problems. They curse and hit. We try not to react, to remember that nothing is personal and therefore we shouldn't be offended.

(d) "Old age is not pretty": Unpleasant and unaesthetic aspects of treating older adults

The professionals claimed that it is more pleasant and aesthetic to treat a younger patient than an older one:

> … Sometimes you have to do unpleasant things such as bathing an older person with deformations, changing the person's diaper. It's not pleasant… (nurse)

Social workers discussed the unpleasant physical appearance of neglect as another unaesthetic aspect of working with older patients:

> They [older adults] neglect themselves. Working with those who neglect themselves is the hardest part.

One nurse conceptualized this theme well:

> It is more pleasant to take care of a younger person. It is more aesthetic. That's it. Old age is not pretty….

It is important to note that the difficulties mentioned by the informants, specifically those in the physicians' group, were intensified by different clinical settings. This point was clearly reflected in the experience of one physician who holds two positions in the health system: at a primary clinic, and in a long-term care facility. She indicated that even though she sometimes gets energy from her work in the clinic, she feels that working in long-term care is depressing, drains her energy, and sometimes "takes her joy of life away".

Nonetheless, the informants also acknowledged the importance of working with and caring for older patients. Some of them even claimed that they prefer working with older adults and serving as their advocates. One social worker emphasized the importance of being the older patients' voice:

> Young patients have enough strength to take care of themselves and to be assertive and self-assured with their physicians…this is not the case for older patients…I will represent them and make sure that they get the best possible treatment…

Perceptions of older patients as being helpless and as having an unheard voice made the professionals from the different disciplines feel obligated to speak for these patients and to make sure their rights are not ignored.

Perceived difficulties associated with working with family members of older patients

The professionals also discussed the difficulties entailed in working with family members of older patients.

Participants in all three groups mentioned that family members often refuse to share the responsibility for the older patient with the professional, and that family members tend to complain about the treatment provided to the older patient. The professionals shared the same challenge related to working with the older person's family, although the participants in each discipline coped with specific aspects relating to their skills and expertise. For example, the physicians coped mainly with the family members' clear expectations of them to prescribe medications every time the patient complains:

> If you don't prescribe anything, even once, then both the older adult and the family feel that you are not a good physician. The older adult and his family think that the patient must receive medication for every little thing.

Social workers and nurses faced broader challenges due to the holistic nature of their profession. A social worker addressed the burden of expectations from family members to take full responsibility for the patient's care:

> Some families expect you to solve each and every problem, and they don't take responsibility themselves…

Nurses experienced difficulties in the attempt to collaborate with families and find the best solution for disabled older patients:

> We try to find the optimal arrangement together with the family…Often families are unhappy because they live in a certain area and the older adult lives in another. There are problems.

It is important to emphasize that there were some gender differences (among the physicians), primarily in terms of the way they expressed themselves. The men were more judgmental, harsh, and critical towards older patients and their families.

From "not a single question" to "elderly talk": Invisibility and the discriminatory communication patterns towards older patients

Invisibility and exclusion of older patients from their own medical care was one of the main themes discussed in all groups. The participants indicated that the older patients were not involved in their care. The patients were neither asked questions about their medical history, nor were they told about medical plan or their prognosis. Professionals from all groups either "bypassed" the older patient by approaching younger family members, or simply made a decision without any meaningful conversation:

> In the primary care clinic where I work, when a gastro specialist talks to a patient, the conversation is actually with the person who accompanies the patient. Then the specialist sends a letter claiming that the patient is not interested in the examination. Did you even ask the patient? You did not… (physician)

A nurse mentioned the same pattern of behavior among nurses:

> Nurses can come and take out the catheter without even looking at or talking to the patient.

A social worker provided another example of older patients being ignored:

> …when a physician wants to check a disabled patient, instead of saying 'I am taking you to the physician', a staff member comes, takes the wheelchair and walks the patient….

Even though the participants in all three focus groups shared the same experience, the social workers were unique in that they tried to explain why it was so common to ignore older patients:

> …Sometimes we make the mistake of choosing the way that is easiest and most comfortable for us… it is easier for personnel to speak to a younger family member, who might understand faster and have no hearing problems….

The social workers provided additional explanations [for ignoring older patients]:

> …We don't do it with an awareness or intent to make these patients lose the ability to express their opinion or will. We do it out of lack of awareness.
>
> …We do it mainly because we want to protect, to defend, to do well….

However, this social worker's colleague took the motivation for such behavior one step further, and pointed to a patronizing attitude as the cause:

> It's the same patronizing behavior that I talked about. It's taking too much on yourself and making too little use of the patient's ability, not putting the patient in the center, not relating to the patient.

As can be seen, the healthcare professionals tended to treat older patients like they are absent–present. Yet another central pattern of discriminatory and insulting communication toward older patients relates to condescending and infantilizing language used with older patients. One of the social workers elaborated on this pattern:

It's sad to say, but sometimes the patient is treated like … a child… Honey, no, honey. All kinds of things that are inappropriate… This person could be a doctor….

"They put the older person in a diaper so fast": Providing inappropriate care to older patients

The healthcare professionals also discussed several ways in which older adults receive inappropriate or lower quality care. When it comes to older adults, there are certain behaviors that reflect age-biased discriminatory practices.

The nurses provided examples of older patients who receive inappropriate care that can potentially cost their lives:

…When you have a forty-year-old male in cardiac arrest, you will work on him for hours. With an old person, you might do intubation, and you might not. In geriatrics, the treatment is more routine and focuses on maintenance, the usual.

The social workers gave many practical examples of inappropriate care. One meaningful example was how quickly the dignity of older adults can be taken away by carrying out age-biased immediate actions as soon as they enter the healthcare system:

When an older person enters the hospital, there is a certain approach towards them that makes them more dependent. The patient can be a very independent person… and somehow the attitude of the personnel towards them makes them change…they immediately put a diaper on people who did not need a diaper before… Something about entering a hospital promotes a regression for every person, and for older adults the regression is even harsher. They put a diaper on so fast because they don't want to deal with it. Someone has to help these patients stand and walk them to the bathroom… there is no time…

Although the above-mentioned findings point to an ageist rationale for inappropriate care of older persons that is not based on medical considerations, other content discussed by the participants reveals a much more complex picture that raises a question as to whether inappropriate care could be perceived as adequate under certain medical circumstances.

For instance, in certain cases physicians have justified the differential care offered to older patients as an attempt to avoid using invasive treatments:

I think that some examinations are irrelevant at a certain age. After the age of eighty… if I suspect an oncological or terminal disease, I will not start performing invasive examinations… It is not as if I am not giving the patient treatment. It is simply a different consideration.

A social worker shared the same perception:

There are many cases of cancer patients who are very old, and you don't want them to suffer… It is forbidden not to save a life, and they (physicians) often take into account the family's request that the person suffer no longer. Oftentimes they don't operate on tumors… because they think the patient will not be able to deal with it.

The last two statements raise more than one dilemma. First, it is unclear whether the considerations guiding healthcare professionals in their work with elderly patients could actually be described as inappropriate treatment or simply as a way of providing adequate care that is based on empathy and compassion, and is appropriately tailored to the patient's age. Second, the participants discussed the notion of preventing suffering, which is related to the dilemma of quality-of-life versus longevity, and will be discussed further.

Discussion

The present study evaluated attitudes towards and perceptions of older adults and their care among three different professional groups. We mainly found similarities across the three disciplines. The differences we found were largely related to the examples provided for specific ageist expressions in the healthcare system. Three major themes emerged from the group interviews. In their description of perceived difficulties, the healthcare professionals identified challenges relating to work with older adults and their families. Older adults were described as wanting to manage their own treatment, making constant demands, behaving offensively, and being unpleasant and unaesthetic. Although these descriptions could have applied to any age group, they were used to describe the particular age group of older adults. Hence, the descriptions reflect ageist attitudes and perceptions.

Interestingly, the view of older adults as making too many demands and managing their own treatment plan stands in clear contrast to the general view of older adults as submissive (Kenny 1990) and incompetent (Cuddy et al. 2005). Potentially, this contradiction between older adults who actually stand up for their rights and the general perception of them as submissive, passive, and incompetent is problematic for healthcare professionals. Because behaviors such as violence and aggression are not usually attributed to older adults (Mullan and Badger 2007)

healthcare professionals might find those behaviors to be more noticeable and challenging in this age group. Alternatively, the uncharacteristic behaviors of older patients might be attributed to the invisibility of this population in the healthcare system, as reflected in the second theme. The use of such behaviors may be an optional means for older people to make themselves seen and heard. This is in line with narrative findings that shed light on the willingness of older men and women to be independent and self-reliant. It has been explained as a mechanism for coping with the experience of bodily impairment. The desire for independence was stressed when the informants disclosed anxieties about becoming frail, weak, and disabled (Aléx 2010). Another interpretation of these findings is rooted in more of a system-constrained perspective. For years, professionals in the Israeli healthcare system have contended with limited resources and a heavy workload (Rosen and Merkur 2009). In this workplace atmosphere, the need to devote any extra attention to patients might be perceived as a burden.

Previous studies have argued that the two most discriminated against age groups are young children and older adults (Berg-Weger 2012). The present study points to another similarity between these age groups: the involvement of other family members in their care. Even though family members often see themselves as treatment advocates for the older adult (Hinrichsen and Niederehe 1994), previous research has consistently shown that healthcare professionals are not trained to work effectively with family members (Ward-Griffin and McKeever, 2000). This could potentially explain some of the challenges described in the present study. It is also possible that family members feel helpless when facing the decline of their older relative (Au et al. 2013). Thus, the relatives' complaints and requests might be seen as attempts to gain control over an anxiety-provoking situation. Given these negative perceptions of older adults and their families, it is not surprising that the healthcare professionals in the present study described ageist behavior towards older adults.

The use of condescending and infantilizing language and the exclusion of older adults from their medical treatment have been documented in previous research (Lagace et al. 2012). The current study adds to existing literature by developing hypotheses about the etiology of these behaviors. Professionals admit that they adopted some of the ageist communication patterns simply for convenience. Asking questions and explaining things to older adults requires patience and willingness to speak slower or louder, and professionals perceive this as time consuming. It has been stressed that most ageist behavior patterns are unintentional, and are motivated by a genuine desire to do good. Nevertheless, as clearly indicated in the present study, showing compassion may mean depriving patients of their remaining abilities, which diminishes their sense of dignity.

The desire to protect the older adult also underlies crucial decisions regarding whether and how to treat terminal older patients. The third theme, i.e., inadequate treatment of older adults due to their age, was the most complex. The complexity inherent in this theme stems from the fact that although some behaviors can be clearly described as inappropriate and undesirable, other behaviors such as failing to refer older cancer patients for invasive treatments raise ethical dilemmas (Walter and Covinsky 2001). Potentially, avoidance of invasive medical procedures for older patients can be perceived as compassionate care rather than as undertreatment due to ageist perceptions.

The longevity versus quality-of-life dilemma was also addressed in the study, and revealed a change in the balance of these two aspects as patients grow older. Our results might reflect an age bias in favor of quality-of-life, which could stem from the general perception that associates old age with death. Therefore, healthcare professionals as well as older patients and their families prefer to avoid painful and invasive treatment that could be lifesaving. Similarly, in a recent qualitative study, the quality-of-life theme was at the heart of the dilemma concerning whether or not to use advanced technologies to restore vital signs and prolong life. Older people perceive quality-of-life as the most decisive factor, which has been defined in terms of how much more "good" life an individual can expect. It appears that decisions about prolonging life involve weighing pros and cons from a cost-benefit perspective (Vandrevala et al. 2006). The bias in favor of quality-of-life as people grow older also puts healthcare professionals, and specifically physicians, in an unfamiliar arena. Health professionals, whose core expertise is to save people and prolong life, are forced to suffice with relieving pain. This can place the professionals in a more modest, less heroic position that might cause them to feel a sense of futility (Wilkinson and Ferraro 2002). The consequences of this situation are worthwhile exploring in future research.

There are several reasons for age-specific medical decisions in the field of health care. These are supported by empirical evidence concerning short- and long-term health and quality-of-life considerations. However, these decisions might also be attributed to restricted resources and ageist perceptions (e.g., "Save the young—the elderly have lived their lives"; Ivey et al. 2000). The healthcare professionals participating in this study aptly indicated that age is one factor that should be taken into consideration in decisions about provision of care. Nevertheless, when age becomes the main factor or the only factor that is taken into consideration, treatment is impaired and can be described as inadequate.

It is noteworthy that respondents either played the role of "actor," or they were "observers" of particular expressions of ageism. In the role of actor, they referred to themselves and described their own thoughts, feelings, and behaviors relating to older patients. In the role of observer, they described other people as being ageist. The decision to adopt the role of actor or observer might be based on the severity of the ageist expressions described by the respondent. Regarding the first theme, which mainly addressed the difficulties encountered in their work with older patients and their families, the nurses, physicians, and social workers felt safer sharing their own experiences and thus played the role of actor. However, with regard to the second and third themes, which reflected more problematic types of ageism, the informants tended to dissociate themselves from the situation and talked about other health professionals as actors who engage in ageist behaviors. In this vein, when describing positive expressions of ageism, professionals assumed the role of actor. However, the basis for positive ageism ("giving a voice" to older patients) was portrayed as negative ageism in the case of other professionals (who were described as ignoring older patients). In this unique situation, the actor who engages in positive behavior is the observer of negative behavior.

The present study was restricted by its reliance on a small number of focus groups and limited gender representation, which limits the generalizability of the results. The findings of study are based on self-reflection, and are therefore restricted to overt and self-aware ageism. Moreover, the informants were not asked about different contextual factors that previous studies have associated with ageism, such as seniority in the workplace, the percentage of older patients, and characterization of the workplace (Liu et al. 2013). Therefore we could not distinguish the specific contribution of each contextual factor. Nevertheless, the study sheds light on ageism in the healthcare system among professionals in three different healthcare disciplines who encounter older patients from three different perspectives: medical, nursing care, and social work/mental health. Similarities across the three disciplines might be attributed to a common background deriving from factors such as self-selection into the field of gerontology and geriatrics, as well as to ongoing socialization in the field of aging. Moreover, all of the participants referred to the difficulties they encountered in dealing with old age and the deterioration that accompanies the aging process. The hardship of coping with these issues might minimize the impact of different professional perspectives and limit the variation across different disciplines, clinical settings, and workplaces. These aspects are strongly related to the theoretical origin of ageism, which relates to death anxiety, physical deterioration, and losing one's previous social status and self-esteem. From that perspective, healthcare professionals who work with the frailest older adults on a daily basis might be similar to each other. In the same vein, one way of coping with the emotional burden reported by professionals is to adopt a pattern of dissociative communication that places the old patient in the role of "other."

Future interventions should explicitly address the challenges that healthcare professionals associate with working with older adults, specifically in light of the limited resources available in the healthcare system. This should generate a candid discussion of emotions and thoughts that develop in the presence of older patients. In the course of medical training there is a need to further explore the implicit conflict involved in providing too much treatment, too little treatment, or simply inadequate treatment to older adults (Covinsky et al. 2000).

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