ABSTRACT

This study was undertaken in response to the audit requirements for the National Service Framework for Older People Standard 1 ‘Rooting Out Ageism’. The aim of this study was to identify and describe the nature of any age-discriminatory practice in the clinical setting through the perceptions and experiences of staff working with older people.

The study adopted a qualitative approach using focus group design. Six focus groups were conducted with 57 members of staff. An aim of the study method was to isolate consensus areas of ageist practice that would facilitate targeted intervention. To assist this, statements relating to common practice experiences were developed following the first two focus groups. This was used as a discussion tool for the subsequent groups.

Perceived ageist practice could be grouped under the following themes:

- access to services
- communication and attitudes
- treatment and care
- the role of relatives
- resources.

On the basis of the findings, greater choice and control for older people need to be key features of the recommendations, through the development of a co-ordinated development programme involving all stakeholders.

INTRODUCTION

The National Service Framework (NSF) for Older People has meant that, for the first time, the government have provided an approach to the identification and potential elimination of age discrimination, in relation to how older people access and use health and social care services (DoH, 2001). Standard 1 of the NSF seeks to root out age discrimination and
develop a programme of action to address the issues related to unfair or insensitive treatment due to age.

In order to tackle age discrimination effectively, there is a need to identify the incidence at a local level. An interim report by the Department of Health (DoH, 2002) provides the results of audits collated across the NHS. In summary, it reports that the audits have shown that only a very small number of policies are explicitly age discriminatory and that there is considerable variation across the country resulting in lack of consistency.

In addition, the report states that these audits have raised a number of important issues in relation to age discrimination. It emphasises that there are complex issues when relating it to practice, especially as there is a lack of common definition or wider understanding of what it actually means and when it is evident. This is supported within the wider literature, where debates about what constitutes ageism offer no concrete solutions or guidance (Rivlin, 1995; Bowling, 1996; Williams, 1997). As a result, it is difficult to identify ageist practice and therefore hard to take action to root out discrimination effectively at a local level.

Consequent to the findings of the Department of Health’s interim report (DoH, 2002), a programme has been set out to take the NSF standard forward. This incorporates undertaking further investigation to identify staff perceptions of ageism in clinical practice, in an effort to reveal and describe the existence of any discrete and less visible aspects of discrimination, with the aim of developing recommendations. The need for such action is also supported in other published works (Bowling, 1999; Ellis, 2002). It is this action area that is the subject of this paper. The project reported here was undertaken in East Kent in July 2003.

**OVERVIEW OF THE LITERATURE**

A literature review was conducted to inform the development of the project and a brief overview is provided here. In terms of gaining perceptions of ageist practice from staff, previous research in this area was not found other than minimal anecdotal reports that implicate resources as a factor in the inability to provide adequate care (Buswell, 2001). Other publications appear to be largely discussion papers highlighting the potential for ageism in the health and social care arena, a subject that appears to have provoked considerable debate amongst academics and clinicians. This includes broad discussions on the cases for and against rationing by age (Williams, 1997; Grimley Evans, 1997), and the pros and cons of the outlawing of age discrimination (Scott, 2000).

Some publications have focused on a number of specific clinical areas and include empirical research suggesting ageism in access to specialist services, and some treatments, such as breast screening (Sutton, 1997), surgery and cardiology (Bowling, 1999). The subject of resuscitation and ageism also appears to be controversial, in relation to determining its existence and developing policy (Rosenfeld et al, 1997; Durrant et al, 2002). Another study has demonstrated the exclusion of older people from clinical trials, having serious implications for the efficacy of some treatments on this population group (Bayer, 2000). In another area, Ellis (2002) links age discrimination to quality of care of older people suggesting that there are less evident elements at play with respect to ageist practice, such as how older people are communicated with, attitudes of staff and general care, which are much more difficult to bring to the surface. As the interim report implies (DoH, 2002), it is these areas that are crucial to identify through staff perceptions in order to begin the process of ‘rooting out discrimination’ at a local level.

Overall, the literature confirms the importance of this area as a subject for continued investigation and, given the dearth of published work surrounding staff perceptions, adds weight to the need for this study. It is evident that there is a need to be clear about the range of factors that constitute discrimination in practice.

**AIM OF THE STUDY**

The aim of this study was to:
• identify and describe the nature of any age-discriminatory practice in the clinical
setting through the perceptions and experiences of staff working with older people
• provide recommendations based on the findings.

OPERATIONAL DEFINITIONS

For the purposes of this study, the description of ‘age discrimination’ as used in the National Service Framework for Older People document will be used:

‘Age discrimination happens when someone makes or sees a distinction because of another person’s age and uses this as a basis for prejudice against, or unfair treatment of that person.’ (DoH, 2001:72)

‘Ageist practice’ refers to the carrying out of unfair or insensitive treatment because of age (Tinker, 1996).

METHOD

Study design

The study adopted a qualitative approach using focus group design, as this was seen to be a more suitable medium to explore the complexities of the study topic. In addition to exploring and expanding ideas in the subject area, focus group design is also useful for gaining consensus views of experiences in order to pinpoint specific areas of common agreement for action (Fern, 2001). This facet of focus group design was particularly useful to this project in order to identify tangible practice issues that could be developed into local policy recommendations.

Sample

A total of six focus groups lasting one hour were conducted, with a total of 57 participants. Numbers of participants per group ranged from four to 11. Staff were purposefully recruited by attendance at team meetings or through management in health, social and voluntary settings. Criteria for selection were that staff needed to be currently working with older people and to have been working with them for longer than three months; some period of exposure to the practice situation was required, in order to inform about the study topic.

Although most people taking part were working in acute or community NHS settings, a range of other qualified, unqualified, junior and senior workers from social services, the voluntary sector, health promotion and education also took part. Table 1 (page 36) provides a breakdown of participation by staff groups.

Instrumentation

The instrumentation for this study consisted of a semi-structured interview schedule. This was constructed using six topic areas derived from previously discussed literature and policy, namely access to services, communication, attitude, privacy and dignity, personal care and treatment. In addition, a sheet of loosely grouped statements that constituted a consensus view of ageist practice from the first two focus groups was developed. This was used in the remaining four focus groups to prompt discussion and test the consensus view further.

Data collection

Two facilitators were used for the focus groups. One led the discussions and wrote key phrases and expressions on a flip chart, in full view of the group, as discussion progressed. This served to provoke lively debate and helped participants to follow the flow of conversation, contribute and see where consensus could be reached. The other facilitator took more detailed notes of points raised and quotes, to ensure that as much data was gathered as possible. Although taped recordings are the preferred method of full data capture, (Pope & May, 2000) the credibility and accuracy of note taking can be enhanced in the following ways. First, at the end of each session the recordings were checked with participants and added to, or
Staff perceptions of ageist practice in the clinical setting: Practice development project

changed, to reflect their true opinions (Flick, 1998); second, the notes taken by the second facilitator served as a further check to accuracy and depth of data collection. This method does, however, result in limited verbatim quotes.

Participants were asked to provide examples of age discrimination against older people that were first-hand experiences, either seen or heard in the care setting, read in medical notes or heard via an older user or their carer within the past three years. This time span was based on the desire to capture recent experiences, and on recall ability (Pope & May, 2000).

An important feature of this work was to discuss any competing or ‘rival’ explanations for the practice that was described. This was in order to anchor the perceptions to ageist practice as much as possible, to establish credibility of the examples and to gain a degree of consensus among participants about what constituted insensitive or unfair treatment of older people.

Data analysis

The qualitative data collected from the discussion of the questionnaire was analysed using a content analysis approach as suggested by Ryan and Bernard (2003), which entailed applying a pre-defined thematic template to the data. Recorded information was sorted into three predominant themes (access to services, communication and attitudes and treatment and care), taking care to remain faithful to the original recorded discussions. As Flick (1998) notes, this is a useful way of reducing data into meaningful themes, but can be constraining and can artificially represent the data. It is important therefore, that categories brought to the data should be repeatedly assessed against them for their relevance, to avoid missing important themes and misrepresentation.

Ethical issues

This study was conducted within the model of a National Service Framework audit and service development. Given the sensitive nature of the topic under study, ethical principles were strictly adhered to. This included providing information and obtaining consent, ensuring confidentiality and establishing ground rules.

### Table 1: Participants per staff group (n=57)

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Number (n=57)</th>
<th>Further information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community (n=29, 50.9%)</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reg. general nurse</td>
<td>10</td>
<td>This community grouping included district nurses, team leaders, specialist nurses,</td>
</tr>
<tr>
<td>- GP practice staff</td>
<td>6</td>
<td>health care assistants, primary care visitors, practice nurses, practice managers</td>
</tr>
<tr>
<td>- GP</td>
<td>5</td>
<td>and administrative staff.</td>
</tr>
<tr>
<td>- Mental health nurse</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>- GART and RR</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Acute Hospital (n=21, 35.8%)</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reg. general nurse</td>
<td>15</td>
<td>This group included staff working on rehabilitation wards, coronary care, accident</td>
</tr>
<tr>
<td>- Mental health nurse</td>
<td>2</td>
<td>and emergency and stroke units. Staff grades included health care assistants, staff</td>
</tr>
<tr>
<td>- Therapist</td>
<td>2</td>
<td>nurses, sisters, team leaders, senior practitioners, matrons and senior management.</td>
</tr>
<tr>
<td>- Social Services</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Other groups (n=7, 13.3%)</strong>:</td>
<td>7</td>
<td>This group included the voluntary sector (Age Concern and Red Cross), education,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>administration and health promotion representatives.</td>
</tr>
</tbody>
</table>
**FINDINGS**

The findings will be described in relation to the identified themes. A table of consensus statements reached will be provided, followed by an overview of the discussions that took place. Some phrases were recorded verbatim and used in the sections, presented in italics. For auditability purposes, they are referenced using the focus group number and note page.

It is important to note that, while some concerns about ageist practice would appear to exist and have been expressed, the majority of participants agreed that in some local areas great strides in the health care of older people had been made in combating unfair or insensitive treatment.

### Statement 1:

**Not being referred to specialist services locally or outside the area, when this is needed.**

### Statement 2:

**Not having surgery despite being fit enough.**

### Statement 3:

**Not being referred for investigations such as blood tests, x-rays or scans.**

### Statement 4:

**Being excluded from respite care because you are over 65, even if you had it before.**

### Statement 5:

**Having difficulties getting some services to see a person who is over 65.**

### Statement 6:

**Having problems getting a recuperative care bed if you are over 65.**

### Statement 7:

**Relatives urging for an older person to go to a nursing home when it is not appropriate.**

### Statement 8:

**Older people having a low priority with respect to medical attention, referrals, surgery or investigations.**

### Statement 9:

**Not having cardiac investigations or treatments such as pacemakers because of age.**

### Statement 10:

**Not being offered the chance to take part in research, such as entering a clinical trial.**

### Statement 11:

**Having difficulties getting onto a GP list.**

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Access to services

Among these statements there were some specific areas of concern among all groups, centring on the perceived limitation of access to specialist services. It was noted that access to the intensive care unit and coronary care unit could sometimes be restricted for older people, especially if an older person was competing with a younger person for a remaining bed. It was felt that decisions about who the most appropriate recipient would be were based on age, quality of life and life expectancy, alongside clinical need.

Conversely however, it was noted that some services are recommended for people over a certain age, such as echo-cardiograms for people over 80. They often seem to be refused however and such tests were thought to provoke unnecessary anxiety.

Other participants had experienced difficulty transferring older people to specialist units outside the area because of an age restriction in the unit’s policy.

Neurological units were cited as an example. It was felt that age boundaries imposed on access to services can sometimes be misunderstood as policy, or even be a result of what individuals believe about a policy which becomes common practice.

Participants from the acute setting also expressed particular concerns about priority of care, especially those working on older people’s wards. There was the perception that services such as phlebotomy often visited the wards last, with the result that many tests were not done due to time constraints, ultimately delaying treatment or discharge. Also, there were several examples of how older patients waiting for surgery (mostly hip replacements) were delayed to make way for paediatric or gynaecological cases, which caused distress. It was, however, acknowledged that medical emergencies should take precedence over a more stable patient but that it is often difficult to strike a balance without appearing to be discriminatory. In some acute areas, efforts were being made to rectify this, such as trauma list management to manage the issue of prioritising.

One area where most participants perceived there to be examples of unfair or insensitive treatment due to age was through encounters with relatives. Statement seven provoked considerable discussion in all groups with
participants giving examples of how relatives would request for their relative to stay in hospital longer, or urge their older relative to give up their own home for a nursing home place, despite the patient wanting to return home and being assessed as capable. From a community perspective, relatives were noted for sometimes expressing concern that an older person could not cope in their own home when, in fact, they could with some additional help. It was observed that often ‘battles’ took place with relatives seeming to withdraw the right for their relative to choose, effectively creating a loss of independence. Another example given was of a relative questioning an older person’s need for a pacemaker, stating ‘Is it worth it? Can’t you let him be?’ (2:2). There was a general view that sometimes relatives have a low expectation of an older person’s recovery and see rehabilitation programmes as too intensive and rushed.

Communication and attitude

Again, discussions in the groups were revealing. Some groups argued that problems with communication and attitude could occur across all age groups, but the consensus view was that they were more likely to happen with older people.

With reference to names, there was the opinion that staff assumed an older person would not mind the use of nicknames and most groups agreed that this was a particular problem among agency staff who, perhaps, were not sufficiently briefed. One group suggested that the tone of the address was often more important than getting the actual name wrong and that often getting someone’s title right (eg. Mrs or Miss) was more of an issue to older people. It was agreed that the importance of assessment to gain the older person’s preference was paramount.

The issue of exclusion during communication in the absence of any cognitive problems was seen as a particular problem in the hospital setting with medical and, again, agency staff seen as less sensitive in this area. An example was given of a consultant talking into a dictaphone at a patient’s bedside about his condition and of an agency nurse pointing to an older person saying ‘We’ll do this one next’ (2:3). The issue of exclusion was also seen to be evident in nursing and residential homes with staff speaking on behalf of older people about a matter without making sure of their opinion. Again, groups perceived there to be issues with relatives and an example was given of relatives seeming to blank their elderly relative at the bedside when seeking information from staff.

The discussions about information giving were wide ranging, demonstrating the difficulties in achieving the right approach. There was a view from some groups that staff assume the older person would not understand or couldn’t be bothered. While some participants felt that full information was essential others suggested that, in their experience, too much information and the way it is presented could be frightening. An example of information giving in cardiac rehabilitation was given, where older clients

<table>
<thead>
<tr>
<th>Table 3: Communication and attitude statements</th>
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<tbody>
<tr>
<td>Statement</td>
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<tr>
<td>1. Staff speaking to friends or relatives about the older person in his or her presence, but excluding them from the conversation.</td>
</tr>
<tr>
<td>2. Shouting at an older person even if they are not deaf.</td>
</tr>
<tr>
<td>3. Not fully informing an older person about their condition, treatment and/or care, assuming they wouldn’t understand or don’t want to be bothered about it.</td>
</tr>
<tr>
<td>4. Calling an older person ‘lovey’ or ‘duckie’ instead of their preferred name.</td>
</tr>
<tr>
<td>5. Discussing sensitive issues within earshot of the older person but not with them.</td>
</tr>
<tr>
<td>6. Speaking ‘on behalf’ of an older person about a matter without making sure of their opinions.</td>
</tr>
<tr>
<td>7. Discussing personal and sensitive issues with an older person loudly within hearing of other people.</td>
</tr>
<tr>
<td>8. Not giving enough or appropriate information about medicines – ‘just take them’.</td>
</tr>
<tr>
<td>9. Labelling older people as ‘daft’ or ‘demented’ if they have a problem understanding.</td>
</tr>
<tr>
<td>10. Talking to, or about, older people in a patronising way – treating them like children.</td>
</tr>
</tbody>
</table>
had expressed concerns about the terminology used and had experienced difficulties in interpreting information. Conversely, other participants noted that older people were becoming much more informed with better access to information through the media: ‘you have to think about all those “silver surfers” out there… they want every bit of information you have’ (5:4).

Labelling people as ‘daft’ or ‘demented’ was seen by most groups as happening infrequently and the perception was that education was improving the situation. However, it was noted in one group that the use of inappropriate labelling by some clinicians, such as ‘mildly demented’ (3:3) was still in use. There were concerns that this would have serious implications in accessing some services, such as community assessment and rehabilitation teams, who are unable to accept a client if there are mental health problems indicated.

Table 4: Treatment and care statements

<table>
<thead>
<tr>
<th>Statement</th>
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<tbody>
<tr>
<td>1. Giving an older person an incontinence pad when they don’t need one.</td>
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<tr>
<td>2. Not giving an older person enough privacy when helping them with activities such as toileting, washing or dressing.</td>
</tr>
<tr>
<td>3. Letting older people have a limited choice in things like when and what they eat, when they go to bed or have a bath.</td>
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<tr>
<td>4. Giving older people inappropriate clothing.</td>
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<tr>
<td>5. When undertaking assessments, missing out questions about sexuality.</td>
</tr>
<tr>
<td>6. Having some expensive treatments refused because of age, such as beta-interferon for MS sufferers and drugs for Alzheimer’s disease.</td>
</tr>
<tr>
<td>7. Giving older people inappropriate aids/equipment, such as beakers, or tip-back chairs.</td>
</tr>
<tr>
<td>8. Giving older people too many tablets and not reviewing them often enough.</td>
</tr>
<tr>
<td>9. Catheterising older people unnecessarily.</td>
</tr>
<tr>
<td>10. Assuming that people over 80 do not want to be resuscitated.</td>
</tr>
</tbody>
</table>

Treatment and care

In this section, by far the most prevalent experience was the lack of assessment of sexuality. It was felt that this was an issue that affected all age groups but, again, was observed to be more pronounced for older people. There appeared to be an assumption about sexual activity amongst some, as this respondent illustrates: ‘We think that older people don’t have sex … it’s a generational thing, although when I’m older I may think differently!’ (2:6). In some groups, it was felt quite strongly that older people do not always feel comfortable with questions about their sex lives and do not want to be asked. Another stated: ‘I’m not sure who is more embarrassed about asking people about sex, us or the older person’ (4:4).

However, others had had experiences of older people being relieved to be able to discuss these issues, such as a couple who were admitted to a residential home, and an older gentleman in the wake of a recent illness. Other participants had observed inpatients talking about sex between themselves, but they had problems talking to professionals about certain issues. Reasons for this were seen as generational, in the way that people had been brought up; gender, in that some professionals appear insensitive to the feelings of an older gentleman being assessed by a young female nurse; and professional inexperience and, as some suggested, maturity, in how to broach and assess the subject. It was acknowledged that this type of questioning was not suitable in an initial assessment but should be deferred to an appropriate time.

Statement five also stimulated general discussions about assessment. The way older people are jointly assessed was also a topic of concern, particularly among groups with mental health participants. The view was that joint assessments include opinions from all involved in the care except for the views of the older patient and questions arose as to how valid the ultimate decisions about care and treatment were, in the absence of these views. Some were concerned that decisions could possibly be made based on financial gain,
particularly when a status change could result in greater payment to the home for the person’s care. An example of the status of elderly mentally infirm was given.

Over-medication and the need for reviews were perceived as an important issue, and this provoked a wider discussion about drug therapy and older people. The perception that insufficient time and attention was paid to the problem because of the age of clients was expressed by most groups, although it was noted that this could happen in other age groups. There were some revealing examples in relation to older people. Some participants noted that patients discharged from hospital on a new treatment regime were sometimes readmitted still on the old treatment. Others felt that, on discharge, instructions for a new set of medication were quickly forgotten due to the lack of understandable written instructions. On some occasions community staff observed that this had led to clients taking both old and new drug regimes with serious results. This was seen to be compounded by the fact that there is a delay between discharge and information from the hospital consultant being provided to the GP. Aside from this, there was a consensus view that instructions for medication are confusing and inappropriate for older people who, for a variety of reasons, may be unable to synthesise the information.

While the giving of inappropriate aids was not often witnessed, the discussions produced several examples of this. The groups had encountered the dispensing of drinks by unqualified staff resulting in inappropriately giving beakers to patients. Giving an older person an incontinence pad when not needed was not viewed as a large problem, but the use of large pads when smaller more discreet ones would suffice was witnessed and considered inappropriate by one group.

As with access to services, the issue of resources was keenly expressed in this section. Lack of choice in when older people go to bed or have a bath was seen to be the result of insufficient staff in both acute and community settings, and recruiting staff to work twilight hours. This was not necessarily only affecting older people, but this age group were seen to be the biggest users of the service. Choice of meal times was also thought to be restricted by the organisation of hospital and community services rather than unfair treatment due to age. One group remarked that schemes such as Meals on Wheels were not able to offer client choice due to the large distribution difficulties.

While most people had not encountered unfair treatment regarding resuscitation, the need to have conversations with older people about this was universally seen as difficult. In addition, whether or not older people desired such a conversation was largely unknown and was seen as hard to establish. The new resuscitation policy was felt to have engendered a culture of unnecessary resuscitation by one group, whereas in another group participants had witnessed anger from a crash team at being called to resuscitate an 85-year-old man.

The role that relatives play in treatment decisions was also discussed. There was the view that younger relatives could be quite insistent about treatments, difficult to handle, and were listened to above the wishes of the patient. Comments such as ‘shouting the loudest’ (6:3) and ‘weekend relatives syndrome’ (6:3) were made by respondents, where concerned relatives tended to strongly urge for services or treatments at weekends when they were able to visit. The perception was that, as relatives were not able to gain a full picture of care, judgements about the right treatment became confused with feelings of guilt and this was seen to affect the older person adversely.

Some general issues about care were highlighted in the group discussions. Much debate about care and the potential for ageist practice, again centred on assumptions, this time about what certain standards should be and that these were not necessarily based on the client view. For example, showering every day may be a standard of hygiene subscribed to by professionals, but not by older people. The issues of dentures was raised, and some participants noted that soft diets are ordered in a hospital setting because of the assumption that people cannot manage normal food. These were perceived as small, but significant, examples of insidious ageist practice.

All participants were aware of the very difficult problems in making clinical judgements that were in the best interests of the client. Seeming not to permit access to services, treatment or care could appear discriminatory, but there was a view that it is
difficult to separate age discrimination from frailty, and that making clinical decisions with clients with complex social and multi-pathological conditions can never be straightforward. In addition, many practice issues are challenging to undertake, such as assessments of sexuality, information giving and involving people in discussions about resuscitation. Avoiding these issues was felt to appear insensitive and ageist, but could be due to the lack of knowledge about the right approach to use.

**Discussion**

This study has provided a range of perceptions around insensitive treatment because of age, and has appeared to reveal a complex and multi-faceted picture of the more discrete and less visible aspects of discrimination through the experiences of the participants. The discussions have shown that ageist practice is far from straightforward, and there are a number of issues that are worth briefly elaborating on here. There are clear links between ageist practice and quality of care. From a practice perspective, the debates that centred on insensitive treatment and the right approach to a feature of care seemed to indicate that predominant problems lay with the following main areas. These were a lack of client-centred care, especially assessment, unfair decision-making around clinical priorities, and the absence of agreed clinical standards, with communication problems ranging across all areas. In addition, the role of relatives emerged as an added variable. These issues will now be discussed further.

**Client-centred care**

A factor that could be instrumental in contributing towards discrimination in this area could be the difficulties inherent in engaging older people in their care. Explanations for this vary, but a fact remains that patients who do not participate in decision making about their care are more frequently older people, despite the fact that they do have a desire to take part (Hamalainen et al., 2002). Different care choices are not always discussed with older patients, and even those who are highly educated are not always heard (Tinker, 1995). As a result, older people may, over time, become resigned to acceding to doctors’ decisions, and be modest and inactive in the consultation (Hamalainen et al., 2002).

The resulting detachment could result in professionals taking over and older people becoming reliant on workers to do their decision making for them. This, in turn, results in a less than client-centred outcome. For example, one study demonstrated that most older people did not agree with a nursing assessment of their abilities (Harkness et al., 2002). Clues that workers in this study were making decisions on behalf of older people were evident in the perception that ‘assumptions’ were being made about care and treatment needs. While this can be confused with the caring role, there were many instances where judgements based on an assumption of what was right, were in fact inappropriate and insensitive. This occurred, for example, when addressing older people, giving them beakers to drink from, deciding what information to give them, or assuming they are deaf, or will not understand.

From a policy perspective, the resultant disempowerment is further compounded by the enduring perception that ‘doctor knows best’ (Irvine, 2002). Ham and Alberti (2002) suggest that this particular perception is predominant with older people due to an implicit ‘compact’ between doctors and patients that was fostered at the inception of the NHS. This agreement stems from the government granting the medical profession a large measure of autonomy and control over its work, culminating in the power inequity between doctors and patients (Klein, 1983). Ham and Alberti argue that new policy that attempts to shift the balance of power through imposing patient involvement criteria has not accounted for the different generational expectations of how the NHS should work, and the subsequent difficulties of its implementation in this age group.

The issue of empowerment and its relationship to discriminatory practice was evident again in this study, but this time more subtly, with the lack of choice in all care settings. Both in the acute and community settings, resources and rigid organisational frameworks were squarely blamed for poor
flexibility around going to bed, having a bath or mealtimes. While it was recognised that all service recipients are vulnerable to this lack of choice, older people are the largest users (DoH, 2001). With the potential for disempowerment and the associated lack of assertiveness in this population group (Bytheway, 1995), this situation does raise questions as to whether services would be more flexible were the largest recipient to be younger and more vocal.

Clinical priorities

It was of concern that discrimination in relation to admission or access policies were clearly evident, affecting the most critical and vulnerable people. That some situations were seen to be linked to resources, highlights how the issue of discrimination can be intertwined with rationing debates (Grimley Evans, 1997). In addition, older people waiting for surgery appeared to be ‘bypassed’. This finding runs counter to client-centred care objectives, and how willing older people are to give up their place in the surgery ‘queue’. Bowling et al (2002) conducted a large national survey targeted at people over 65 on the cardiac surgery waiting list, asking if they would be prepared to give up their place for a younger person. Most did not wish to cede priority, although willingness to give up one’s place increased with age. This could be interpreted as older people valuing themselves less and being less assertive. The authors warn however that ageing ‘baby boomers’ may be even less willing to give up their place or tolerate an unequal position, and will be more outspoken about their rights to health care provision.

Clinical standards

As identified in the study, it was evident that all participants were in agreement about the very difficult problems involved in making clinical judgements that were in the best interests of the client. Key to some of these practice issues seemed to be the difficulties in developing and operationalising clear clinical standards to assist in making decisions, as evidenced by the intricate and often circular debates in the groups. Even when systems or standards are in place to ensure quality of care, resource implications seemed to impede best practice. This was seen in relation to access to Rapid Response and the use of dosset boxes for safe medication. While some standardisation in trauma management was being tested in the acute setting, it appeared to be absent with some of the more challenging areas such as assessment of sexuality, communication and resuscitation.

Guidance is confusing. Taking resuscitation as an example, the implementation of the Human Rights Act 1998 has led to updated guidelines from professional bodies. These are likely to need careful interpretation in light of local circumstances before they can become a practical tool for decision making (Stewart et al, 2003). Guidance on how to achieve ‘openness and transparency, whilst maintaining sensitivity and inclusiveness’ (BMA, 2001) is not evident. Further to this, a survey of nearly 500 members of the British Geriatric Society revealed that distress to patients and relatives, lack of time, resources and patient knowledge were all barriers to ‘Do not attempt resuscitation’ discussions with users (Durrant et al, 2002). This illustration serves to highlight the importance of seeking greater clarity in how policy can be implemented.

The role of relatives

A further dimension highlighted by the study findings relates to the role of relatives. On the face of it, ageist practice would appear to be connected to staff’s behaviour with older people (Tinker, 1996; DoH, 2001). It was of interest, therefore, that the groups implicated relatives as being instrumental in engendering the potential for discrimination to take place. Strong feelings were expressed about the conduct of relatives and the conflicts inherent in managing care decisions that were non-ageist and in the best interests of the older person. From the relative’s perspective however it could be argued that being presented with a situation which may result in having to take on caring responsibilities of any nature is highly emotionally charged and conversely not always in the best interests of the carer (Henwood, 1998). Given the economic and physical cost of caring (Carer’s
UK, 2002), such a reaction is hardly surprising. This no doubt accounts for the pressure exerted to defer this responsibility by insisting that the older person goes into institutional care, rather than back home which may seem to be a less secure option.

It is also possible that feelings of guilt over the amount of contact relatives do have with an older relative may provoke a sense of concern in relatives when interacting with professionals, that could be interpreted as overly demanding. Reasons for this could stem from poor interaction between nurses and patients’ relatives, where relatives have difficulty initiating dialogue and receiving information (Laitinen & Isola, 1996). Also, relatives can be typically avoided or ignored by many professionals (Henwood, 1998). In addition, health and social care workers do not fully recognise the competence and knowledgeable ability that relatives have of the older person, which results in irritation (May et al., 2001). When this is coupled with the lack of health and social care resources, heavy workloads and resultant frustration felt by workers, it is not surprising that conflict can arise. Such a situation highlights the clear need for careful, appropriate and inclusive dialogue with relatives throughout the care cycle, in order for clinical decisions to be mutually understood and agreed upon and for conflict to be avoided.

Given all these forces at play therefore, it is evident that a paradox arises. If there is a fundamental lack of engagement with older people caused by power imbalance, health belief systems, poor communication and lack of appropriate clinical guidance, it could be argued that older people are unable to be sufficiently aware of what the appropriate choice is for them. As a consequence, it becomes hard for older people to engage in client-centred care, and safeguard their own interests by assisting in the, often complicated, decision making processes. Further conflict ensues when relatives and professionals assume this function, as there are still barriers to implementing best care. It can be seen that such a situation of heightened susceptibility provides a fertile ground for ageist practice to take place.

**Limitations of the study**

This was a qualitative study based on perceptions and, as such, can never be representative of the sample population. Qualitative research of this nature however does not seek ‘representativeness’ but gains credibility through the collection of diversity of experiences.

The study focused on staff and does not capture any views of users and carers, which in itself could be criticised as being discriminatory. This is however, a central feature of suggestions for further work emanating from the findings.

It is important to note that the identification and articulation of what was seen to constitute ageist practice was of a subjective nature, although consensus was reached within and between groups on a range of issues. Clinical incidents deemed as discriminatory often hinged on individual understanding of terminology. For example, groups often used the term ‘inappropriate’, which by its nature is a clinical judgement and can vary between professionals. Many of the views expressed by participants will differ from those reading the report, true consensus in this area and therefore practice guidelines may be difficult to reach because of this.

**Conclusion and Recommendations**

The day-to-day experiences of frontline staff provide an insightful perspective and represent a helpful lens through which to view patients’ experience of services. These reveal a wide diversity of issues that lead potentially to the ageist label being attached to particular circumstances.

Underlying these circumstances are complex and interrelated factors. There is no simple manifestation and therefore no straightforward intervention to address ageism in the provision or delivery of services. Additionally, running through many of the findings are hints of wider societal attitudes that will need a longer term approach than merely providing staff training or patient leaflets.
On the basis of the focus group work, the key words that need to flow through all future work in this area are choice and control. Whilst a factor influencing the environment in which services are delivered to current users of older people’s services is the level of assertiveness and knowledge of the client group itself, there are signs already of a shift in this situation.

In an effort to tackle this, a programme of initiatives needs to draw on models of good practice in the local area and national arena and could include:

• Communications programme developed with, and aimed at, users around the general standards of service that can be expected – in particular values and standards – which could include targeted material on the ‘difficult’ issues identified by focus groups.
• Training and education of staff around issues such as behaviour and communication that uses effective models of practice.
• Review of organisational systems impacting on older people’s services from the client perspective.
• Review and development of workable models that will facilitate the engagement of older people and their carers, working towards enhancing client-centred service provision.
• Review of lessons from parallel situations – such as Metropolitan Police learning from the conclusions of MacPherson (Stephen Lawrence) Inquiry.
• Assessment of resource allocation processes and provision of facilities (including assistive technology) from the client/carer perspective.
• Communications programme aimed at relatives and carers about expectations and aspirations of services for older people.
• Piloting and evaluating new developments to ensure effectiveness before wider dissemination.

The awareness and understanding of users of health services are set to increase substantially over the coming decade. It is important therefore, to be framing service provision now with the perspective of a knowledgeable and assertive clientele. This will ensure that services in the future meet the demands required of such clientele, but importantly it will shift the expectations and current users and providers of care.

References


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