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EDITORIAL

Ageism revisited

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European Geriatric Medicine includes in this issue a "Carta of Florence against ageism" [1], a declaration prepared by geriatricians experts in this matter. As a starting point, we may consider, according to this document that we live in an ageist society that rejects and marginalizes older people. Ageism—bias based on age—undermines the bioethical principles of equity and beneficence. It plays an essential role in the way we understand and practice medicine. It often influences health decisions that can be detrimental to patients and should be avoided. Ageism presents older people as worthless, unproductive, frail and incapable. According to it, advanced age is seen as a period of inevitable decline, and older people are perceived as a retired group, not only in the labor force but also in a vital sense.

This "Carta" represents an excellent opportunity to address an age-old problem, very present in the daily life of our society since Robert Butler brought it to light in 1969 [2]. The official definition of ageism includes not only discrimination (how we act) but also other two components that are often associated with discrimination but less recognized: prejudices (how we feel) and stereotypes (how we think). Stereotypes and prejudices often represent hidden behaviours, while discriminations are explicit actions easily observable [3, 4]. The definition may also encompass paternalism, a well-meaning but imposing attitude. Interest in ageism as a problem (age discrimination and its derivates) has persisted over the years, with multiple international calls for attention. The United Nations (UN) declared 2016 as the year against age discrimination, and similar objectives are behind various official declarations from the World Health Organization (WHO) [5]. The social awareness of this significant problem has increased in a high proportion in recent years, not only among the victims but also among health professionals, and even among society as large. In 2021, a WHO report stated that one-third of the older European population considered themselves as victims of ageism, with up to 50% of European adults practicing ageism.

Any of the components of ageism can be observed explicitly or implicitly in individuals and populations. Ageist behaviours vent one´s fury on lower social strata with fewer socioeconomic and cultural defensive recourses [6]. In any case, there is no clear social response to the problem. While there are numerous scholarly papers on doctrinal or descriptive studies on this topic, there are few effective actions. A recent comprehensive review from HelpAge International could be a valuable source of information [7].

With these comments, I aim to emphasize several points. First, to underscore the extensive scope of the problem in social terms and, more importantly, in the field of health [8–12]. Ageism has a detrimental impact on health systems and healthcare. I want to highlight the contradiction between the perception of the problem by both patients and health professionals and the lack of effective responses in everyday medical practice. I will also mention some factors that may underlie these behaviours. Finally, I will discuss potential ways to fight against this plague. My final remarks will be dedicated to the origins of this document.

Ageism is widespread, universal, and omnipresent. It affects most aspects of our lives. In social and health fields, citizens are acutely aware of ageism when directly questioned about it. A recent study in US with a sample of 2,035 individuals, between 50 and 80 years of age, revealed that 93.4% of them experienced ageism firsthand [13]. This perception also extends to professionals working with older people (doctors, nurses, therapists, social workers, psychologists). A survey among members of the Spanish Society of Geriatrics and Gerontology, who had been working for over 17 years with older people, indicate that nearly, 90% believe ageism is present in different common social and medical practices [14, 15].

Ageism permeates medicine and affects all health-related questions. It manifests in the patient–doctor relationship [16], as well as in preventive medicine [17]. There are reports of ageism in most medical specialities. For example,

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in cardiology, with reduced and inconsistent application of accepted clinical diagnostic and therapeutic protocols [18–20], as well as in oncology [21–23], nephrology [24], and virtually every other surgical or medical speciality. It has been suggested that ageism is an independent risk factor for developing chronic medical conditions [12].

Exclusion of older populations from all sort of clinical trials is the rule [25–28]. They are also frequently excluded from research programs [29, 30]. Perhaps, the most glaring and recent example of social and medical ageism was seen in the personal and institutional attitudes during the COVID-19 pandemic [31–34].

Multiple factors may contribute to the presence of ageism in medicine, but none can justify it. One such factor is the individual vulnerabilities of older patients, due to different disabilities common in this population, including physical, mental, social, or cultural losses experienced throughout their lives. These vulnerabilities place older individuals in a precarious position in a competitive and sometimes hostile world. However, we must be cautious about emphasizing vulnerability, as some argue that dwelling on this topic may be counterproductive from a practical standpoint [35].

Undoubtedly, one of the most important and frequently overlooked factors that contribute to explain ageist attitudes is ignorance. The lack of geriatric knowledge is a pervasive phenomenon, often unrecognized by many professionals, both doctors and non-doctors. Aging is frequently overlooked in medical curricula, and few physicians are experts in geriatric medicine. Physicians often lack knowledge of physiological or pathological changes derived from the aging process. However, ignorance or fear of potential negative consequences of new procedures does not justify ageist behaviours. Historically, there have been many medical decisions that could be classified as ageist, such as the exclusion of people over 65 from the initial protocols of dialysis programs [36], or the delay in the introduction of stents in older coronary patients [37]. These are aprioristic decisions that were later modified through experience. In this category, we can include also the fear—ignorance again—of the eventual risk of adverse drug reactions in older patients when they receive certain pharmaceutical groups (anticoagulants, antibiotics, oncologic drugs, etc.) or their exclusion of many technological advances. The assumption by doctors that their aged patients are unable to understand new technologies is behind many decisions.

Prejudice, stereotypes, and paternalistic attitudes follow various paths that ultimately lead to age discrimination. One of the most significant contributing factors is economic considerations, such as saving time, money, and resources. This often results in choosing the easier and more convenient option for the prescriber. While it is true that older patients may require longer visits and consume more time, communication may be challenging, and patients frequently present atypical symptoms or complex physical signs. They may also have physical, mental or social limitations and require assistance from caregivers. However, none of these reasons justifies discriminatory medical care.

What can be done to address ageism is an age-old question [38, 39], that remains relevant today [40]. It is a question with no easy answer, but the problem demands active intervention. The first recommendation is to raise awareness to detect any sort of ageism, and to fight it through charges and other available measures.

One of the primary ways to successfully combat ageism is through educational efforts. Implementing programs aimed at both citizens and professionals (doctors, nurses), politicians, journalists, and even the older population is critical. Past and recent studies have shown the effectiveness of educational initiatives [41–45].

It is essential to recognize and reinforce the focal idea that the rights of older citizens are not different from those of younger people. It must be made clear that "age is not a disease" and that we must work accepting this fundamental principle. The notion that age *"per se"* should never be considered as an exclusion criterion in social and healthcare fields should be emphasized. It is also imperative to bolster geriatric and gerontological research [29]. Furthermore, collaboration within multidisciplinary teams with diverse perspectives can yield promising results [46].

Another crucial message is to reject any form of resignation. This message is directed not only to older people, but also to ourselves, as healthcare professionals. We should encourage an active aged collective that speaks out when necessary and protests against any form of ageist behaviour. Promoting participation of older people in social, cultural and political activities may be a commendable step in this direction, as it transforms this group into an active and advocacy-driven population.

The origin of this commentary stems from the "Carta" and draws inspiration from the United Nations declaration of the "Healthy Aging Decade (2021–2030)", which identifies ageism as a "global obstacle that curtails older people' opportunities to contribute to society, realize their full potential and lead a fulfilling life". The comprehensive content of this declaration aligns with the key points I have presented. It is noteworthy to emphasize the document's emphasis on the detrimental effects of ageism in health and social care and on how ageism represents a barrier to adequate care.

The document also addresses another important topic discussed earlier, namely, "formative ageism" and its significance in the lack of geriatric knowledge regarding specific issues related to the older population. This factor can have severe consequences in daily clinical practice.

In addition, the "Carta" highlights several key questions related to the negative clinical consequences of ageism and offers strategies to overcome these challenges. Each section

of the document comprises three subsections: manifestations, consequences, and actions. A recurring message is the call for a new approach based on the person, emphasizing patient-centered decision-making, rather than solely diseased-based models. The document also advocates for the availability of treatments and preventive measures, and it underscores the role of healthcare systems and healthcare facility design in perpetuating ageism.

The absence of sufficient age-oriented research programs in geriatrics and gerontology, including the exclusion of older people from clinical trials, is another issue addressed in the document. Research serves as a positive mechanism focused on combating ageism. "Policies could be generated to promote and ensure adequate representation of older people in research". In addition, "more research is needed to develop new study designs and outcomes that enable a more inclusive participation regardless of age and comorbid conditions".

The document highlights that "ageism in healthcare technologies lies in misconceptions about older individuals' abilities to understand the use digital technologies which are typically designed for younger adults", and adds that "it is crucial to arise awareness among healthcare providers, technology developers and …. engagement of older adults in the design and implementation …. that may help to develop age-friendly tools than allow older people...".

Among the final considerations, authors reiterate the harmful impact of "negative cultural stereotypes" with "severe consequences on the life of older persons". They mention the ongoing debate surrounding "mandatory retirement", a topic closely related to ageism. Finally, the text acknowledges that "this document is not a comprehensive inventory of the many ways by which ageism hampers the health and care of older persons". In my view, it is a great document, offering insightful advice and guidance on addressing this pressing. A document that all of us should read and put into practice, as it holds the potential to improve the living conditions of a significant proportion of our aged citizens.

Declarations

Conflict of interest Author declares do not have any conflict of interest related with this paper.

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