Health Care Provision for Older Persons: The Interplay Between Ageism and Elder Neglect

Tova Band-Winterstein

Abstract
The aim of this study was to explore the link between neglect and ageism in health care provision for older persons. Semistructured in-depth interviews were conducted with 30 registered nurses with at least 2 years’ experience in 10 long-term care facilities in Israel. Interviews were digitally recorded and transcribed verbatim. Data analysis was performed according to the qualitative method. Three main themes emerged: ageism and neglect as the everyday routine (neglect is built into institution life on the platform of ageism); how the institutional system promotes neglect—between institutional and personal ageism (the ways institutions promote neglect in the shadow of ageism); from vision to reality—how neglect can be prevented in an ageist reality. The attempt to demonstrate the link between ageism and neglect and suggesting how to include them as interrelated phenomena in health care provision programs could promote older persons’ quality of life.

Keywords
quality of life, elder neglect, nursing homes, nursing

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1University of Haifa, Mount Carmel, Haifa, Israel

Corresponding Author:
Tova Band-Winterstein, Department of Gerontology and the Center for the Study of Aging in the Faculty of Social Welfare and Health Sciences, University of Haifa, Mount Carmel, Haifa 31905, Israel
Email: twinters@research.haifa.ac.il
Literature Review

Ageism in Health Care

Ageism relates to the systematic discrimination of older persons, viewing them as senile, a burden, useless, and invisible (Butler, 1975; Palmore, 1999). Ageism can be expressed on three levels: the individual (micro) level, the institutional (mezzo) level, and the societal (macro) level (Iversen, Larsen, & Solem, 2009). Ageism appears to be a widespread phenomenon in many domains of life and is known to be prevalent in health care (Kane & Kane, 2005; Palmore, 1999).

Ageism in health care is expressed in various ways: First, by the overwhelming preference of professional workers to work with younger populations (Grant, 1996). Working with the older population is considered less attractive and prestigious, and hence, the shortage of high-quality human capital with adequate knowledge of the field (Rosowsky, 2005). Second, ageism is manifest in paternalistic behavior of health professionals by helping older persons when they are actually capable of helping themselves (Grant, 1996). The third way in which ageism is manifest is in viewing older people not as human beings, which leads to the failure to refer them for expert opinions such as psychiatric evaluation (Kane & Kane, 2005). The fourth type of manifestation is in the perception of older patients as senile, which undermines their abilities and might lead them to live up to the disabilities expected of them (Grant, 1996). Such outcomes are considered “implicit ageism,” meaning that older persons internalize ageist attitudes and enact them against themselves (Levy, 2001).

Literature on ageism in health care facilities has related mainly to older people who are still at least partially functional (Grant, 1996). Nursing staff prefer to care for these patients over others who are bedridden (Simkins, 2007). When nursing staff believe their older patients to be incompetent, they might perform tasks on their behalf that they are capable of performing themselves. Although grounded in good intentions, this manifests a form of ageism (Palmore, 1999; Wells, Foreman, Gething, & Petralia, 2004), and older patients are led to believe that they are less competent than they really are (Grant, 1996). Ageist perceptions toward older persons and the existence of such an atmosphere in health care settings give rise to questions relating to elder neglect.

Elder Neglect

Elder neglect is a subcategory of elder mistreatment (Fulmer, Faan, Guadagno, Dyer, & Connoll, 2004; Lachs & Pillemer, 2004). It is defined as omission, meaning unintentional or passive acts (Pillemer & Finkelhor, 1988), and as commission, meaning intentional or active deprivation of basic needs and services...
Different types of neglect are found in the literature: physical neglect, which focuses on failure to provide physical needs (Fulmer & Ashley, 1989), and psychological neglect relating to emotional needs (American Medical Association, 1992; Aravanis et al., 1993). Medical neglect is another form (Anetzberger, 2005) and refers to postponing medical needs and services by failure to give medicines on time and to provide regular medical follow-up (Collins, 2006).

The consequences of neglect are physical and emotional. The physical could lead to morbidity and mortality and the emotional to depression, fear, anxiety, submission, anger, irritation, ambivalence, and even suicidal thoughts. However, due to the natural ageing process, it is not always easy to detect the signs (Anetzberger, 1990; Baker & Heitkemper, 2005; Cohen, 2008). In addition, social marginalization of the older population makes them vulnerable to becoming “silent victims” of neglect (Fulmer et al., 2005). Nursing staff might avoid procedures that can prevent further neglect (Rodriguez, Wallace, Woolf, & Mangione, 2006). They might be unaware of their obligation to report neglect (Muehlbauer & Crane, 2006), and the system does not penalize the lack of reporting (Luu & Liang, 2005).

Although the literature usually presents elder neglect and ageism as separate bodies of knowledge, the aim of this article is to combine the two by describing and examining how ageism functions as a mechanism for promoting elder neglect in long-term care facilities.

Method

Elder abuse has been broadly addressed in the literature using quantitative methods relating to screening, prevalence, and correlations (Cohen, 2008). However, the phenomenon includes subjective perceptions of the parties involved. In addition, we know that the staff not only encounters but also creates neglect. Therefore, a holistic approach to the phenomenon enables us to describe and examine it closely regarding various forms of neglect and the ways of dealing with them (Patton, 2002).

This was a qualitative study based on the phenomenological tradition, aimed at capturing the “lived experiences” of nursing staff in various long-term health care facilities (Moustakas, 1994).

Sample and Participants

I used purposeful sampling for selecting the participants (Patton, 2002) to obtain the widest possible range of information within the nursing experience with older
persons in long-term care. The criteria for inclusion in the study were professional nurses, who had at least 2 years’ seniority in long-term care facilities for older persons. The actual sample included 30 Israeli registered nurses aged 26 to 58 years (20 women and 10 men from various ethnic origins and with seniority ranging from 2 to 30 years).

Long-term facilities in Israel include nursing homes for fully dependent older persons, as well as homes for the aged, which are homes for the frail elderly. The 15 institutions in which the study participants worked were very diverse. Some were small, with only 30 beds, and others were larger, with up to 300 beds. The professional staff in these institutions consisted of nurses, social workers, and physiotherapists alongside nonprofessional caregivers. All the institutions were registered and licensed by the Ministry of Health and the Ministry of Welfare and Social Services.

Procedure and Data Collection

In-depth semistructured interviews were conducted, each lasting 1.5 to 2.5 hr and were tape-recorded and transcribed verbatim. The interview guide included four worlds of content based on the literature review, and the author’s professional clinical experience of working with older persons. Questions were formulated for each world of content, as follows:

Research Question 1: The professional encounter with elder neglect: How do you feel, think, and act when you encounter elder neglect at your workplace?
Research Question 2: The personal encounter with the phenomenon: How does an encounter with neglect influence you personally?
Research Question 3: Attitudes of professional nurses on ageing in general and neglect in particular: How do you perceive frail and bedridden older persons you encounter at your workplace?
Research Question 4: Policy and intervention with elder neglect in long-term care facilities for older persons: How do you think elder neglect should be handled at your workplace?

It should be noted that the motivation for this study was derived from my personal experience of caring for my older parents over the past three years, including their experiences in long-term care facilities, and from my professional expertise in elder abuse and neglect. This personal experience served as a “personal pilot study,” which was a forerunner of the present study.
**Ethical Considerations**

Confidentiality was particularly significant because collecting staff members’ perceptions of elder abuse is considered a sensitive issue (Corbin & Morse, 2003; Dickson-Swift, James, Kippen, & Liamputtong, 2007; Renzetti & Lee, 1993). Each interviewee signed a letter of consent to participate after receiving a brief explanation of the study and an assurance of confidentiality that their responses and the institutions to which they belonged would remain anonymous. They were also promised that the interview content would be available to the researcher for research purposes only, with access barred to anyone else. These procedures led the ethical board of the University of Haifa to approve the study.

**Analysis**

Data analysis was performed according to the phenomenological method. First, to establish “bracketing,” I reflected on my personal experiences, biases, and prejudices regarding elder neglect and ageism (Moustakas, 1994). Second, I read each interview to become familiar with the text. In the next reading, I began the process of horizontalization by finding statements about the interviewees’ experiences with the phenomenon. In the third step, I grouped the statements into units of meaning, including quotes to describe their experiences and perceptions. In the fourth step, I identified the emerging themes by shifting from the descriptive to the interpretive levels of analysis (Creswell, 2007; Moustakas, 1994).

**Trustworthiness**

To ensure reliability and validity (trustworthiness; Lincoln & Guba, 1985), I gave the transcribed quotes chosen for each theme to a second party, who was not directly involved in the study and could serve as an outside expert in gerontological qualitative research. He provided comments and further analysis of the quotes together with me (Creswell, 2007; Lincoln & Guba, 1985) to address face validity.

In addition, trustworthiness was also established by presenting the findings to nursing professionals in workshops and asking for comments and feedback to strengthen the interpretations of the data (Lincoln & Guba, 1985).

**Findings**

As a qualitative study, the purpose was not to generalize what occurs in long-term care facilities but to use these facilities as an opportunity to highlight the “twilight zone” between ageism and elder neglect.
Three main themes emerged from the data analysis: (a) ageism and neglect as the everyday routine, (b) how the institutional system promotes neglect: between institutional and personal ageism, and (c) from vision to reality: how neglect can be prevented in an ageist reality.

**Ageism and Neglect as the Everyday Routine**

The findings indicate that neglect is built into institutional life and that ageism serves as its platform. Different forms of neglect during hospitalization in long-term care are illustrated as follows:

The elder population is almost transparent, I mean, they don’t receive attention, due to lack of sufficient diagnosis and doctors’ lack of caring. For instance, they receive painkillers to deal with symptoms, but aren’t sent for overall checkups, so by the time the diagnosis is made, it’s often too late. This is because of disrespect, lack of attention and lack of concern.

The starting point is that the elder population is not seen. Being transparent is an expression of ageism, which is followed by a lack of concern and disrespect, leading to medical neglect. In this case, the lack of timely medical diagnosis and the treatment of symptoms without investigating the cause is a case in point. The question remains as to whether the source of ageism is a personal or institutional policy.

The everyday routine in long-term health care is characterized by lying in bed for hours due to illness or fatigue. The following quote illustrates the attitude toward an older person in these conditions who has the addition of a mental disability:

The attitude toward people who are bedridden and have intellectual disabilities is as if they are an object. . . . Failing to provide their physical needs, ignoring people’s requests, failing to perform essential medical treatments, such as changing positions. . . . Everything is done automatically and lacks a gentle touch.

Here, too, the initial assumption is that bedridden and cognitively impaired older persons are considered to be no more than objects. This process of objectification has ageist roots, which leads to both emotional and physical neglect. Emotional neglect is illustrated by the lack of communication with the older person and physical neglect by the failure to perform essential tasks, such as changing the person’s position in bed.
Objectification of older persons is apparent in various other routine institutional situations, as illustrated below:

A patient returned from an invasive medical procedure at the changing of shifts, and the nurse didn’t even uncover the sheet to check the situation. After a while, the older patient was found severely bleeding in bed. Not adhering to medical protocols is a type of neglect . . . as is not giving medicine on time or “forgetting” to give.

The older bedridden patient was completely dependent on the nursing staff. He was returned to the ward like an object at an inconvenient time and was forgotten. The “object” was remembered only when heavy bleeding occurred and could no longer be ignored, which in turn called for drastic medical intervention. Being forgotten is an expression of invisibility, which is a part of ageism, combined with neglect of medical care.

The next quote illustrates another link between ageism and neglect:

What shocked me most was shower time; 8-10 older men and women are placed together in a row, then each in turn is passed to the nurse for a shower, and then is passed back to be dressed, one after the other, all in wheel chairs, like on a conveyer belt. It is all done very quickly, to wash as many people as possible in a short space of time and with no personal touch. The older person is treated like a commodity, transferred from place to place, like in a factory.

The metaphors used for describing the shower time picture—“conveyer belt” and “factory”—relate to the way the older residents are treated. The treatment of the older persons is automatic, with no consideration for their specific needs. The parameters for a successful “mission” are the number of people washed and the length of time taken to accomplish the task.

Another scene is linked to the financial considerations of institutional housekeeping:

To save money . . . less absorbent towels are used to dry the older patients after their shower. This is because they weigh less than absorbent towels and therefore cost less at the laundry. As a result, we find fungus and rashes on the older patients’ skin.

The ageist assumption that is apparently behind this practice is that money is not worth spending on the older persons. This leads to the twisted conclusion of
using towels with poor absorption to save on expenses. The consequence is poor hygiene and physical injury, which constitutes elder neglect.

**How the Institutional System Promotes Neglect: Between Institutional and Personal Ageism**

Whereas the previous theme exposed the relationship between ageism and neglect on a daily basis, the following theme focuses on the ways institutions promote neglect in the shadow of ageism. This is examined through several aspects such as institutional climate, attitudes of staff members, and formal policy.

Of course I reported it: At that very moment, I called the nurse in charge, but the caregiver wasn’t fired; just got a letter of warning. It’s really frustrating because they want you to report, you try to have concern for the patient, but no one actually cares. They don’t do anything with the information, so you don’t report.

The reporter of the neglect is confronted with a double-bind message. On the declared level, the requirement is to report each incident. However, in practice, the institutional response is discouraging because, instead of carrying out its own policy, either compromises are made by letters of warning rather than job dismissal or the incident is ignored altogether. All this is easier to carry out in institutions for older persons that nurture an ageist climate.

Another aspect relates to formal policy. Such institutions are officially under state supervision, which in practice is inadequate.

What state supervision cares about is that everything is written down according to protocol; they are not really interested in what is happening to the older patient. In the past, the unplanned supervision visits took an interest in the hygiene of patients and facilities. For example, they used to examine between the toes and in the groin of older patients. These days, they examine paper work and numbers and don’t even look at the residents.

Supervision systems also convey a double-bind message. They view supervision as important but from a bureaucratic perspective, whereas the encounter with the patients becomes irrelevant. This change in policy implementation strengthens the notion of patient transparency, implying that ageism might promote neglect.

The next quote illustrates personal attitudes and perceptions of staff members:
When you have a neglected older patient, no one gets alarmed because they say it’s very difficult to take care of an older person. But in practice, the only thing you have to do is provide basic needs and all the rest doesn’t matter. The body has passed the sell-by date, it has lived its life, and that is how it is.

This quote reflects an attitude of living in peace with neglect that is justified by the difficulty in taking care of older persons. It relates to old age from a pathological perspective, which is understandable under the circumstances of approaching death. This approach, however, leaves no room for any sort of positive attitude or the ability to perceive the older patient as a human being with a past. The “past the sell-by date” metaphor ironically expresses the medical staff’s perception of the older person as medicine that has passed its expiration date and is therefore no longer relevant. This leaves little opening for a different viewpoint.

**From Vision to Reality: How Neglect Can Be Prevented in an Ageist Reality**

The question is whether neglect is inevitable in an ageist reality. Nursing staff suggest how elder neglect could be prevented or at least reduced.

The first way to reduce and prevent neglect in an ageist reality is related to working in multidisciplinary teams:

There should be a constructed process of working in such a team in order to prevent neglect. In addition to nurses, the multidisciplinary team should include social workers, physiotherapists, doctors, occupational therapists, as well as caregiving, logistics, and housekeeping staff.

Neglect can be prevented by working together for the benefit of the older patients. Cooperation can be achieved by systemic team collaboration within the institution, which leads to commitment to the mission. Such commitment creates a sense of togetherness toward a common goal, which reduces the voices of negative attitudes.

Another way is through self-reflection regarding one’s care of older persons:

Caring for older persons isn’t an easy job. It is often repulsive, but there’s nothing you can do; you have to cope with it and continue to work without forgetting that every old person was young once and that this could happen to anyone.
Self-reflection and perceiving the older person from a life-course perspective enables the staff to see the older person in the context of a life history, which includes a past, a present, and a future. This serves as a reminder that our time is temporary and passing, and that we, in turn, can become the victims of neglect.

Yet another way to avoid neglect is by professional discourse, education, and training:

It’s important to have conversations and staff meetings and give examples of ageism and neglect. Staff members do not always understand and things can be explained so that in the future, they’ll know why repositioning is important, why it’s important to make sure the meal was eaten . . . and there is lack of training, especially on this topic. It is not enough just to bring someone to take care of older people and expect him to do a good job.

Ongoing open conversations on topics related to neglect and to ageist attitudes through experiential learning can help to encourage respectful caregiving in a nonjudgmental way and can help to overcome burnout in the workplace. In addition, providing knowledge empowers employees to function better.

The last issue relates to professional status:

There’s no fair recompense for our caregiving. It’s just like working in the operating room. You receive no praise, no money, no promoting advertisement. It’s not a popular issue, and is therefore passed over without a blink.

The professional status is contaminated by ageism, “an unpopular issue.” Therefore, promoting the professional image, encouraging and internalizing humanistic values, and cultivating a sense of mission by providing adequate resources could improve the treatment given to older persons and reduce neglect.

**Discussion**

This article addressed the topic of elder neglect within ageist realities in health care systems. Three themes emerged from data analysis: (a) ageism and neglect as the everyday routine, (b) how the institutional system promotes neglect: between institutional and personal ageism, and (c) from vision to reality: how neglect can be prevented in an ageist reality.

Ageism is found on three levels: individual, institutional, and societal. The individual level among younger persons could be explained from a psychological perspective, such as through the terror management theory (TMT; Bodner, 2009).
The main TMT thesis claims that humans have created psychological anxiety buffers consisting of a cultural worldview and self-esteem to cope with the potentially threatening unconscious awareness of their inevitable death (Bodner, 2009). Ageism serves as a means to manage the fear of dying. As younger members of society, nursing staff prefer to avoid contact with older persons and to work with younger populations (Nelson, 2005). Nursing staff working with older persons who show advanced stages of deterioration can experience fear of suffering, helplessness, and dependency (Agnus & Reeve, 2006; Rosowsky, 2005; Slevin, 1991). The need to cope with these emotions might explain their ageist behavior toward the older patients.

On the institutional level, ageism involves, among other aspects, inappropriate care in institutional settings (Palmore, 2004). The study findings provided detailed descriptions of the many layers leading to this form of neglect. Ageism becomes a platform on which neglect can flourish and become routine in long-term institutional care. This was found in the lack of accurate medical diagnoses, in objectification of older patients, and in attempts to save money at their expense. Unfortunately, the most severe and most negative type of ageism is targeted against the most incompetent older persons, who are bedridden and cognitively impaired. Perceiving them as invisible (Minichielo, Browne, & Kendig, 2000) and as no longer human (Butler, 1975) makes them easier to neglect.

The societal level relates to patronization and the use of ageist language, which was illustrated in this article in the metaphor of a body that has “passed the sell-by date.” This type of institutional climate that weakens older patients has a devastating effect on their quality of life (Bodner, 2009). This was illustrated by the participants’ descriptions of the double standard upheld in reporting neglect, the concealment of neglect, and the bureaucratic health supervision that fails to prevent it. Another example was the description of shower time. In this context, we can identify various ageist assumptions that lead to emotional and physical neglect. The first assumption is that older persons lose their sexuality, which justifies mixed communal showers. The second is that the older person is emotionally numb and this absence of feeling justifies the “passing from hand to hand” technique. The third assumption is linked to a paternalistic attitude, as the decisions about patients’ everyday functions are made solely by the staff and not by the patients. In this case, the obligation to shower is of highest priority, whereas the process seems unimportant.

On the global level, Israel is in transition between traditionalism and modernity (Lavee & Katz, 2003) and is considered a collectivistic society (Bodner & Lazar, 2008). However, studies have found that non-Western societies have become influenced by modernization tendencies of marginalizing older people, and ageism has therefore become a universal reality (Bodner, 2009).
Study Limitations and Recommendations for Further Research

This qualitative research was an attempt to highlight the lived experiences of nursing staff members in long-term care facilities by providing thick descriptions of links between ageism and neglect. Despite the advantages of such descriptions in enhancing awareness of the situation within long-term care institutions, generalization ability of the ageism and neglect phenomenon is limited.

Further quantitative research is recommended to examine the prevalence of neglect as well as the relationships between the ageism and neglect variables and the predictability of the phenomenon.

Institutions for elder care are a microcosm of society. This study focused on nursing staff, but the voices of professional workers from various disciplines and of the older persons themselves should also be heard. The differences between the various types of long-term care institutions should also be examined. Examples are wards for older persons with cognitive impairment, geriatric hospital wards, and nursing wards for older persons with disability.

This study was limited to long-term care facilities. Additional qualitative studies are recommended to provide a broader picture of ageism and neglect in long-term and short-term care as well as in other types of health care facilities.

Another limitation of this study was that the participants came from various cultural backgrounds, such as Jewish and Arab, but these were not reflected in the analysis. Future studies should examine ageist perceptions and elder neglect in different cultural settings.

Practical Implications

Ageism and neglect are considered to be two phenomena and have therefore been implicated separately in professional practices. Here, I attempted to demonstrate the link between the two and to suggest how they can be combined in educational programs for students and professionals of all levels and disciplines for promoting knowledge about ageing.

Understanding the link between the two could assist in tracking and tracing neglect and ageism and in exercising self-reflection to detect attitudes toward older persons and ageing. Such a climate will also enable the opening up of sensitive issues such as the fear of death. This might help professional workers to manage their fear based on TMT, by finding conscious cognitive and emotional management strategies that will not be at the expense of the older persons.

Another challenge is to bring about change in social policy and leadership in the health and welfare professions. Improving the prestige of gerontology as a
profession can be achieved by developing training programs for professionals and care providers at all levels.

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**Bio**

**Tova Band-Winterstein**, PhD, is a lecturer in the Department of Gerontology and Research Associate at the Center for the Study of Aging in the Faculty of Social Welfare and Health Sciences, University of Haifa, Israel.