



Centre on AGING

Newsletter, Vol 24, No. 3 ▲ University of Manitoba ▲ ISSN 0826-4694 ▲ SUMMER 2006

Ageism in Medical Care



Norma Drosdowech

The Centre on Aging held its 23rd annual Spring Research Symposium on Monday, May 1st, 2006. Three hundred and forty individuals attended the Symposium, 21 community agencies and organizations set up displays, and 20 research posters were presented. The following is an excerpt from the opening plenary, which included Ms. Drosdowech's presentation on Ageism in Medical Care. The full text is available on the Centre's web site.

You will recognize as I speak today that you are hearing many voices through mine. And I am glad that my voice can be heard for it is so vitally important that people within the healthcare system take time to listen and to hear the senior's voice and to see the world from a senior's perspective.

Ageism is a topic of many dimensions and today we can only touch on a few. A recent article by Peter Muggeridge on the CARP web site reinforces the perspective that our medical system has a deep-rooted bias vs. the elderly.

For some time, there's been a feeling that older people are simply gobbling up most of our precious healthcare dollars. Actually, the numbers don't bear this out. Studies show that only about 20 percent of seniors are heavy users of formal health services; over 90 percent of seniors continue to live on their own and not in long-term care or nursing homes.

Yet there are a number of ways in which an ageist bias seems evident in our healthcare system. The provision of mammograms is an issue that has caught the attention of many women who remain very concerned about breast cancer and want to do everything they can to prevent it. So, women are understandably upset when they receive a birthday salutation that states "because you are turning 70, you are no longer eligible for mammograms at the Breast Cancer Clinic (1995)" followed by the cautionary statement: "You should ensure that you have regular mammograms done elsewhere

because the incidence of breast cancer increases after the age of 70".

Someone suggested I should also note the language in the Cancer Care web site for the ageist tone in which it offers reasons for the age limit but also reasons why older women might choose not to have mammograms: some older women, it says, have many health problems which may outweigh the chance of ever getting breast cancer... Some women may find it hard to get to medical appointments and going for mammograms and occasionally extra tests could become an added burden, an added worry . . . And some women cannot physically manage a mammogram. Well, said one of my friends - they're really telling us it's all down hill after 70!

...continued, p.2





Still, I prefer to have a choice what I will die from - and breast cancer isn't high on my list. I agreed with her.

Many women have pointed out that they had become accustomed to regular reminders of our appointments in this caring and comfortable environment (with those roomy Tan Jay coverups!). They do not want to change and in fact some have found it impossible to do so. What action does the letter from the breast cancer clinic suggest for women? Contact your family doctor. . . of course. And if you don't have one? That presents difficulties.

I've learned that women can self-refer to some clinics...if they happen upon this information. And if their doctor refuses to make the referral, as did happen, they too might respond by referring the issue to the Human Rights Commission.

I do realize that the decision on the age category was made as a result of initial research not including people over 70... but one has to wonder, given the knowledge that the incidence increases after that age, why further research would not be done to determine the efficacy of mammograms after 70.

Certainly, not everyone would agree with this policy. The American Medical Association and the National Cancer Institute say there should be NO upper age cut-off. And the American Cancer

Society recommends women be given information about the potential benefits and risks of the procedure but that as long as a woman is in reasonably good health and would be a candidate for treatment, she should continue to be screened with mammograms.

Little wonder many seniors feel concern about their access to the healthcare system. Far too many are without a general physician, especially in rural areas where the turnover of GP's is alarming. I know that seniors will be pleased to see that the government is taking steps to alleviate the rural doctor shortage, but one might suggest that if, like Denmark, the government assumed the full responsibility of ensuring that each person has a family physician, seniors might not need to worry.

The healthcare system itself often fails to respond to what older adults need. It focuses on acute care rather than chronic care. It provides insufficient information on aging issues in training materials for most healthcare workers. It requires only limited geriatric training for medical students, even though older adults will comprise a significant proportion of their patients.

Manitoba seniors certainly do suffer from a lack of geriatricians with a total of eleven in all: 9 in Winnipeg, and 2 serving rural Manitobans. In fact, there are 12 times as many pediatricians as there are geriatricians in all of Canada. The media has generally ignored this issue although it raised an outcry when it learned that there was no pediatrician in Brandon.

Health officials must study why geriatric specialties are among the top choices of medical students in many countries and at the bottom in Canada, and respond with effective policies and payments.

Finally, I want to refer to ALCOA's 2005 report *Overcoming Ageism in Active Living*, which sees the damage stereotyping can have in keeping seniors from becoming more physically active.

Older Canadians have learned how to "act their age" - and that is damaging their health. There is no medicine that can compete with physical activity to prevent problems of aging and promote vitality and zest for life. Yet the healthcare system has not acted to ensure that all seniors have access to fitness centres that focus on seniors' wellness. Many cannot afford to belong to Reh-Fit, to participate in the Seven Oaks Wellness Centre or the University's 55+ program.

ALCOA's report closes by saying that countering ageism will be a vital part of keeping Canada's aging population healthy in the years to come, but social policy changes are needed now to open up the possibilities for older adults to participate more equitably in society.

Healthy Aging, Active Living
- these words hold out a vision that is admirable if the healthcare system doesn't allow ageism to get in the way of progress.



Herbert C. Northcott, PhD

*Herbert Northcott is a Professor in Sociology from the University of Alberta. He visited the Centre on Aging on March 23rd and gave a presentation entitled *The Evolution of the Aging Discourse: From Apocalyptic Demography to the Deconstruction of Old Age*.*

During his PhD program at the University of Minnesota, when Herb Northcott expressed an interest in taking a seminar in the Sociology of Aging, his advisor suggested that he not take it as it was irrelevant to his program of studies. Dr. Northcott took the seminar anyway, enjoyed it and managed to publish the term paper that he wrote for the course. The paper was a content analysis of the portrayal of old age on prime time television.

In 1976, after five years at Brandon University, Dr. Northcott joined the Sociology Department at the University of Alberta. When a colleague became ill, he found himself teaching the Sociology of Aging, and has continued ever since. His research interests include the discourses of aging in the media, policy documents, and academic literature.

In his presentation, Dr. Northcott noted that although the population in Canada is aging and will continue to age due to a declining fertility rate, it wasn't until the 1980's that aging was "discovered" as a social problem. At that time, aging was looked at in apocalyptic terms. What would the consequences be? As nations faced tough decisions on caring for a growing number of older adults, aging became a global problem. "Science" would have to find a way to keep these old people healthy and productive. It was thought that 30% of the population would have to support the other 70%.



What would be the burden on the healthcare system? What social programs needed to be put in place? Aging was looked at in negative terms. This aging of the population, which was considered to be one of humanity's greatest triumphs, was also thought to be one of its greatest challenges.

In the early 1990's attitudes were beginning to change. Universal age-based programs came under attack, programs and benefits were eliminated or cut-back, and individual self-reliance and care at home were emphasized to reduce costs. A positive spin was being put on aging and the notions of active aging and successful aging, health independence and productivity emerged. Older adults were to be active contributors in an age-integrated society.

***Growing up
and growing old
are neither
positive nor negative,
they simply are.***

Emerging themes included: the re-definition of old age as 'healthy aging' and the deconstruction of the boundaries; a society of all ages; the flexible life course; and, retention of seniors in the labour force. This successful aging discourse is anti-aging, as it puts value on "not aging" and the negative effect is ageist. Do we define growing up as successful, but growing old as failure?

Growing up and growing old are neither positive nor negative, they simply are.



Global Age-Friendly Cities

The Centre on Aging has been invited to be part of a World Health Organization (WHO) project on age-friendly cities. The aim of the WHO Global Age-Friendly Cities project is to engage cities in several countries to make their communities more age-friendly.

Older people face increasing challenges due to the sensory and other changes that aging brings. In an age-friendly community, policies, services, and structures related to the physical and social environment are designed to support and enable older people to "age actively" - that is, to live in security, enjoy good health and continue to participate fully in society. Public and commercial settings and services are made accessible to accommodate varying levels of ability. Age-friendly service providers, public officials, community leaders, faith leaders, and business people recognize the great diversity of older persons; promote their inclusion and contribution in all areas of community life; respect their decisions and life-style choices; and, anticipate and respond flexibly to age-related needs and preferences. (WHO Brochure: Global Age-Friendly Cities)

The project will initially focus on what seniors experience as age-friendly in their daily lives. Seniors will be consulted and involved as partners in all phases of the study. **Portage la Prairie, Manitoba**, is one of 13 communities world wide to be included in this initiative. **Verena Menec**, Director, Centre on Aging, will conduct local focus groups with seniors, caregivers, seniors' organizations, business, and community leaders. Information from all participating cities will be compiled into practical, *Age-Friendly City Guidelines*.

Studying Lung Cancer Stigma

Michelle Lobchuk is an Assistant Professor in the Faculty of Nursing and a Research Affiliate with the Centre on Aging.



Michelle Lobchuk, RN, PhD

When an individual is diagnosed with lung cancer the first question in most people's minds is "does s/he smoke?" Smokers who develop lung cancer often get little sympathy from the media and those around them. After all, isn't it their own fault that they have cancer?

Blame, anger and resentment are all feelings that individuals with lung cancer and their family members often face. These are rarely associated with individuals diagnosed with other types of cancer.

According to Dr. Lobchuk, in palliative care and chronic illness, healthcare professionals are caring not only for the patient, but the whole family. When family members who are informal caregivers have these feelings of blame, anger, and resentment towards the patient, it can have a direct impact on the care that they are able to provide and their perception of their family member's symptoms such as pain. Since care providers often depend on family members' experiences to determine not just the level of pain in patients but other symptoms as well, providing appropriate care can often be difficult.

Using Weiner's Theory of Social Conduct (1995), Dr. Lobchuk is currently examining "the effects of patient and caregiver illness attributions on caregiver perspective-taking and perceptual accuracy on patient symptoms; and, the existence of discrepancies in patient and caregiver perceptions of illness attributions and caregiver perspective-taking,

and whether these discrepancies pose a hazard for caregivers to accurately perceive patient symptoms of pain, shortness of breath, and fatigue".

With funding from the National Cancer Institute of Canada and the Manitoba Health Research Council, she plans to develop a profile of caregivers at risk for faulty assessments of lung cancer symptom experiences; and to develop interventions that target high risk caregivers to improve their empathetic communication with patients to enhance understanding and optimal symptom management by informal caregivers.

While prevention may be the best plan of attack, it does nothing for those who are dying of lung cancer.

Alzheimer Society of Manitoba Fellowships

The Centre on Aging adjudicates two fellowships for the Alzheimer Society of Manitoba each year.

Face recognition and aging

Cassandra Adduri is a Master of Arts student in Psychology. Her Advisor is Jonathan Marotta.

One of the most debilitating aspects of Alzheimer Disease (AD) to everyday life is an increasing disconnection with the perceptual world. As the disease progresses, patients have increasing difficulties

recognizing family members and friends. This inability can be devastating to caregivers when they are no longer recognized. According to Ms. Adduri, research on perceptual deficits in AD is scarce, yet the possibility of facilitating face recognition is one that deserves investigation.

Examining the sensitivity of face recognition in people with Alzheimer disease may reveal the underlying neurology associated with AD. Localizing the underlying neurology associated with AD will provide insight into how a patient's visual world gradually becomes distorted as dementia increases.

Neuronal excitability, amyloid plaque deposition, Alzheimer disease, & acquired epilepsy

Kathryn Collister is a Master of Science student in Pharmacology and Therapeutics. Her Advisor is Benedict Albensi.

Ms. Collister proposes that the deposition of amyloid plaques in the M146V mouse hippocampus causes changes not only in the structure of the hippocampus but also the neuronal excitability of this highly active portion of the brain. She will examine whether A β plaques correlate to the localized changes in transcription factor NF κ B and changes in calbindin expression; and do the EEG recordings of electrical activity correspond to the areas of calcium imbalance caused by plaque deposition.

Ms. Collister's experiments are highly translational to human medical treatment as they involve two main readily available noninvasive diagnostic systems. Given that there is no cure for Alzheimer disease, there is a pressing need for early detection of it. It is anticipated that the findings from this research will assist in early detection.

Centre on Aging 2006-2007 Student Awards

Family perceptions and satisfaction with end of life care in long-term care facilities

Genevieve Thompson, a PhD student in Community Health Sciences has been awarded the Centre on Aging Betty Havens Memorial Graduate Fellowship. Ms. Thompson has also received a Clinical Research Fellowship from the Canadian Institutes of Health Research (CIHR).

As an increased number of older adults make a long-term care (LTC) facility their home, these institutions will be faced with providing quality end of life care to an escalating number of dying persons. Though some people will face death alone, most individuals with a life-limiting illness will have the support of significant others around them. As such, family members will themselves be recipients of care in the form of emotional support, health education, and bereavement follow-up. The purpose of Ms. Thompson's research is to examine the quality of dying in LTC facilities using family informants. In this regard, a thorough understanding of the experience of dying in a LTC facility and the relationship between the various factors which may influence satisfaction with end of life care may be achieved. She will use mixed methods research to address three main research questions:

- What are family members' perceptions of the quality of end of life care and their satisfaction with end of life care in the long-term care setting?

- What are the associations between resident and family characteristics, systems characteristics, quality of care and family satisfaction with end of life care?
- What do family members identify as areas for improvement in the quality of end of life care provided in long-term care facilities?

In the first phase of her research, quantitative data will be collected from recently bereaved family members using a validated tool to measure the relationship between the needs, perceptions of care, family/resident and system characteristics and satisfaction with care provided at the end of life. In the second phase, qualitative focus groups will be conducted, with individuals who wish to participate, to probe significant results obtained in the first phase of the study and to explore aspects of satisfaction or dissatisfaction with end of life care in more depth.

Ms. Thompson's Advisor is **Verena Menec**, Community Health Sciences, Director, Centre on Aging.



Robert Tate (Chair, Scholarship Adjudication Committee), Genevieve Thompson, Kathryn Collister, Helen Rodgers, Cassandra Adduri, Lee Baugh, Sylvia Rothney (Alzheimer Manitoba), Joanne Keselman (Vice-President Research)

Obesity, diabetes, and aging - An important triad in altered pain sensitivity?

Helen Rodgers, a Master of Arts student in Psychology, is the recipient of the Jack MacDonell Scholarship for Research in Aging.

Her research objective is to investigate and elucidate the underlying causes of the difference in nociceptive (pain-sensing) response between aged obese, diabetic mice and lean mice. She will use the tail-flick test, which measures pain response according to the time that it takes for the mouse to move its tail away from a thermal stimulus to determine:

- Is there a change that occurs with aging that makes obese/diabetic mice less able to detect noxious thermal stimuli?
- What role does leptin play in modifying the apparent analgesia to thermal stimulation in aged obese mice?
- Does blocking mu-opioid receptors in aged obese mice decrease their tail-flick latencies in the thermal analgesia test?
- Do aged obese mice demonstrate greater analgesic response in the tail-flick test to exogenous opiates than do aged lean mice?

Understanding that differences in pain occur between different populations and the factors behind these differences are important for both preventive and medical care. Increased knowledge can lead to new pain management strategies or preventive measures for those with reduced sensitivity.

Ms. Rodgers' Advisor is **Linda Wilson**, Psychology.

Student Awards (continued)

Dorsal and ventral visual abilities in an aging population

Lee Baugh, a PhD student in Psychology, is examining the two cortical visual pathways. The dorsal (action-based) stream transforms information into online information that is used to mediate the visual control of action. The ventral (perception-based) stream processes visual information that allows us to identify and attach meaning to our surroundings. While examining each stream in isolation provides valuable insight, in order to fully understand how people are able to interact with their visual world requires examining how the two streams complement each other in performing goal-directed tasks.

Mr. Baugh's proposed research will provide a starting point to investigate dorsal and ventral visual abilities in an aging population, and examine how the two systems collaborate to form our visual experience as we age. It is anticipated that such information will be used to develop treatment regimens, assess preserved abilities and skills in older adults, and to better control for visual deficits when constructing tests designed to detect pathological conditions.

Using the "viewing window task" to manipulate either action-based or perception-based requirements will result in a better understanding of how the two systems work in unison. These manipulations may also provide insight into the effects of aging on the visual system and cognitive functioning. The impact of this on the use of assistive devices by many older adults will also be investigated.

Mr. Baugh's Advisor is **Jonathan Marotta**, Psychology.

On the Occasion of His Retirement



*John B. Bond, Jr., PhD
Professor, Family Studies,
Faculty of Human Ecology*

Dr. Bond joined the University of Manitoba in 1974. During his years at the University of Manitoba, his areas of research interest and expertise included volunteerism and life satisfaction; adult children as support for their elderly parents; satisfaction in retirement; intergenerational relationships in rural areas, financial abuse and neglect of older adults; and, most recently, end of life care.

Dr. Bond is a Research Affiliate of the Centre on Aging and the Riverview Health Centre, a rehabilitative and long term care facility in Winnipeg. His research in end of life care encompasses care in personal care homes, the experiences of parents of adult children who have died from cancer, and death anxiety of adolescents. His recent publications in this area include:

Ens, C., & Bond, J. (2005). Death anxiety and personal growth in adolescents experiencing the death of a grandparent. *Death Studies, 29*, 171-178.

Goodridge, D., Bond, J. B., Cameron, C. & McKean, E. (2005). End-of-life care in a nursing home: a study of family, nurse and healthcare aide perspectives. *International Journal of Palliative Nursing, 11*, 226-232.

In addition to his teaching and research, Dr. Bond was instrumental in the development of the

Undergraduate Interfaculty Option in Aging. The Option consists of 18 credit hours of aging-related coursework including two required courses, the Social Aspects of Aging, and the Health and Physical Aspects of Aging. He also sat on the Centre on Aging ad hoc Committee on Curriculum Development at the Graduate Level. Dr. Bond has been appointed Senior Scholar and will continue to engage in scholarship and research!

In honour of his retirement, and in lieu of gifts and a retirement reception, Dr. Bond would appreciate a donation to the Centre on Aging in support of graduate student research in end of life care. Donations to this fund should be addressed to:

**Centre on Aging End of Life Care
University of Manitoba
179 Continuing Education
Complex
Winnipeg, R3T 2N2**

CENTRE ON AGING INFORMATION

The Centre on Aging, established on July 1, 1982, is a university-wide research Centre with a mandate to conduct, encourage, integrate, and disseminate research on all aspects of aging.

Director: **Verena Menec**, PhD
Canada Research Chair (CRC)
in Healthy Aging
Community Health Sciences
Faculty of Medicine

The Centre on Aging News is published 3 times a year and is available on our web site or by request. Direct comments and inquiries to:

**Centre on Aging News
338 Isbister Building
University of Manitoba
Winnipeg, MB Canada
R3T 2N2**

Tel: (204) 474-8754
Fax: (204) 474-7576

E-mail: aging@umanitoba.ca
Web: <http://www.umanitoba.ca/centres/aging>