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ARTICLE

'I've never given it a thought': older men's experiences with and perceptions of ageism during interactions with physicians

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Abstract

The subjective experience of ageism among older men has received little research attention. This study examines older Canadian men's experiences with and perceptions of ageism during interactions with physicians. In-depth, face-to-face interviews were conducted with 21 men aged 55 years and over. The findings indicate a seeming lack of awareness of ageism among many, and many did not believe ageism was likely to occur during patient–physician interaction. Negative stereotyping of older patients was common. A large majority of the participants reported that they had not personally experienced ageism during a medical encounter, nor were they concerned about it. Numerous rationales were proffered as explanations of why a particular participant had not experienced ageism and who was more likely to be a target.

Keywords: older men; ageism; patient–physician relationship

Introduction

Ageism has received considerable attention in the academic literature since Butler (1969) first introduced the term 50 years ago. However, ageism as a form of oppression has not garnered as much attention as racism and sexism, and there is still much to be learned about ageism, and how it is experienced and understood (Nelson, 2016). Defined as 'prejudice or discrimination against or in favor of an age group' (Palmore, 1990: 4), ageism is the most prevalent type of discrimination (Ayalon, 2013). Although older people can sometimes be seen in a positive light (Helton and Pathman, 2008), perceptions of and attitudes towards older adults[1] are predominantly negative (Bai, 2014). Older persons are stereotyped as sickly, lonely, dependent, depressed, incompetent, intellectually rigid, asexual and likely to be cognitively impaired (Kite and Wagner, 2002; Bennett and Gaines, 2010). Occurring at both the individual and institutional level (Bytheway, 1995; Angus and Reeve, 2006), ageism is pervasive (Cuddy *et al.*, 2005) and so much a

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taken-for-granted part of culture that it often goes unnoticed and unchallenged (Palmore, 2015; Nelson, 2016). Indeed, research indicates that ageism exists even among older adults who stereotype and attempt to distance themselves from those they have deemed to be 'old' (Minichiello *et al.*, 2000; Hurd Clarke *et al.*, 2014; Hurd Clarke and Korotchenko, 2016).

At the societal level, older adults are frequently depicted as unproductive and a burden (Nelson, 2016). Ageism in the media (Bai, 2014; Edstrom, 2018) and the workplace have been well documented (Abrams *et al.*, 2016; Stypinska and Turek, 2017). Ageist language is so commonplace it is hardly noticed (Gendron *et al.*, 2018). Negative ageist discourse can even be found among gerontology scholars, government officials and professionals who provide services to and advocate for older adults (Gendron *et al.*, 2018). There is ample evidence that ageism is prevalent within the health-care system (Kagan, 2008; Liu *et al.*, 2012; Meisner, 2012; Ouchida and Lachs, 2015; Chrisler *et al.*, 2016; Ben-Harush *et al.*, 2017; Schroyen *et al.*, 2018). A good number of studies have shown that health-care professionals, physicians in particular, often hold negative attitudes towards older patients (Protiere *et al.*, 2010; Davis *et al.*, 2011; Liu *et al.*, 2012; Meisner, 2012) and prefer to treat younger rather than older adults (Helton and Pathman, 2008; Higashi *et al.*, 2012; Ben-Harush *et al.*, 2017). Ageism exists in both acute and long-term and residential care settings (Kane and Kane, 2005; Dobbs *et al.*, 2008).

Ageism has been shown to be manifested during medical encounters in numerous ways. Physicians can be condescending and use patronising language or 'elder speak' (Schroyen *et al.*, 2018). Complaints of older patients may not be taken as seriously as those of younger patients (Greene and Adelman, 2003; Makris *et al.*, 2015). The symptoms older patients present may be inappropriately attributed to 'old age' rather than properly investigated as possible signs of illness or injury (Davis *et al.*, 2011; Stewart *et al.*, 2012). Older adults are provided fewer proven medical therapies or different treatment options than what is offered to younger patients (Sifer-Riviere *et al.*, 2010; Cherubini *et al.*, 2012). Physicians, for example, are less likely to promote preventive care to older patients (Walter *et al.*, 2010), and are less likely to recognise and treat depression in older adults (Koenig, 2007), some holding the belief 'that nothing [can] be done for this group of patients' (Burroughs *et al.*, 2006: 369). Older adults are less likely than younger adults to be screened for sexually transmitted infections (Durvasula, 2014). More likely to be diagnosed with breast cancer, older women are less likely than younger women to be screened for breast cancer and receive the same level of care (Silliman, 2009). Although older adults are 'the largest users of approved drugs', they have been 'consistently excluded from clinical trials' (Palmore, 2005: 167). They have also generally been excluded from trials used to form the basis of clinical practice guidelines (Cox *et al.*, 2011).

That older women are likely to be targets of ageism has been widely acknowledged (Cruickshank, 2003; Calasanti *et al.*, 2006; Hurd Clarke and Griffin, 2008). The extent to which older men experience ageism, however, has received little attention. Based on their study of older Canadian men, Hurd Clarke and Korotchenko (2016) argue that older men may be protected from ageism due to their privileged social position. Immunity to ageism, however, may be contingent upon being in good health and the ability to conform to the ideals of hegemonic masculinity

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(Pietila and Ojala, 2011; Hurd Clarke and Korotchenko, 2016). A study of middle-aged and older men by Ojala *et al.* (2016) found that participants were aware that ageism exists in society, however, they claimed not to have experienced it. A key finding was that the experiences and interpretations of ageism were context-specific, the men were more likely to recognise ageism at the structural or institutional level than at the informal level of interaction with family and friends.

Despite the vast body of literature documenting its prevalence within the health-care setting, in particular during encounters with physicians, few studies have investigated older adults' subjective experience of ageism and whether ageism during medical encounters is of concern to them. Despite the fact that they are heavy users of the health-care system, little is known about how older adults experience, interpret and respond to ageism within this context. The few studies that have investigated older women's perspectives on their health-care experiences indicate that they are concerned about ageism (Tannenbaum *et al.*, 2003; Evans and Robertson, 2009), even when they may not have personally experienced it (MacRae, 2018). Research examining older men's experiences with and understandings of ageism within the health-care setting is unfortunately sorely lacking. Research investigating older adults' subjective experience of ageism during medical encounters is important as ageism can have significant negative effects, affecting quality of care provided and self-care behaviour (Levy and Banaji, 2002; Chrisler *et al.*, 2016). Addressing an important gap in health research and the sociology of ageing, this paper examines older men's experiences with and perceptions of ageism during medical encounters. The paper draws upon data collected as part of a larger study of older men's views on health and perceptions of their health-care experiences.

Theoretical framework and methodology

Focusing on older men's subjective experience, the study was guided by a symbolic interactionist theoretical framework. Symbolic interaction emphasises the significance of meaning and social interaction in the study of human behaviour (Mead, 1934). The subjective standpoint of individual actors is of central concern, based on the premise that 'human beings act toward things based on the meanings that the things have for them' (Blumer, 1969: 2). Human agency is emphasised, humans conceptualised as having the capacity to construct and modify meaning and make choices among alternative lines of action (Mead, 1934). Meaning making is, however, a collective endeavour; meanings are socially created and negotiated through the process of social interaction (Hewitt, 1991). Inasmuch as ageism involves categorising and assigning meanings and labels (Hendricks, 1995; Bytheway, 2005), symbolic interaction is a useful conceptual framework with which to investigate older men's experience of age-based stereotyping and discrimination.

Usually conceptualised as a structural element and macro-process, an interactionist approach to power is concerned with 'how people actually engage one another in power relations, and the ways in which power is accomplished and resisted as people interact with one another in everyday life (Prus, 1999: xv). Sociologically, the patient–physician relationship is conceptualised as inherently asymmetrical; possessing specialised technical knowledge, the physician has power and occupies a position of dominance (Freidson, 1989). Lacking this

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specialised knowledge, the patient occupies a position of relative dependency and subordination. This does not mean, however, that patients are without influence in the medical encounter. Well-informed, highly educated patients, for example, are apt to challenge physicians and insist on taking an active role in their own care (Freidson, 1989). Social change, especially the medical consumerism and patient rights' movements, has altered the patient–physician relationship, with the result that patients are less likely to accept unquestioningly physicians' right to dominance (Rodwin, 1994). There has been a shift away from a 'paternalistic doctor-centered model of the clinical encounter' to a more democratic patient-centred encounter where patients are less likely to be passive recipients of care and more likely to expect to be negotiators of their own care (May *et al*., 2006: 1024). Although research suggests older patients may be more likely than younger patients to prefer a more traditional model of care (Adams *et al*., 2012), this does not mean that all older adults will approach the medical encounter in the same way. Younger, older adults of the baby-boom generation, in particular, may be more assertive patients who are less inclined to defer to physician authority, and more likely to insist on a patient–physician relationship in which they have more say (MacRae, 2016).

Adopting a theoretical framework emphasising subjective meaning, this study focuses on older men's perceptions of their medical encounters and the meanings they have given to their health-care experiences. The primary aim being to develop an understanding of men's experiences with and perceptions of ageism during a medical encounter, the in-depth, face-to-face interview was the research instrument of choice. Audio-recorded interviews were conducted with 21 men ranging in age from 55 to 96 years (*see* Table 1). All participants were white and of European descent. Twelve had university degrees, three with Masters and another a PhD. Five had graduated from high school, the remaining four had less than high school education. All participants lived independently in the community in the province of Nova Scotia, Canada; 14 resided in urban locations and seven lived in rural areas. Thirteen were married, three were divorced or separated, two were widowed, one was single and another two were in a common-law relationship. Thirteen participants were in the younger age range of 55–74 years and eight were 75 years and over.

An interview guide was used to focus the interview (Rubin and Rubin, 1995) and ensure certain topics were consistently covered; however, most questions were open-ended so participants could describe their experience in their own words. The men were also given ample opportunity to talk about aspects of their experience deemed significant to them. The interview guide covered the following areas: awareness and understanding of ageism; personal experience of ageism; and concern about ageism. All interviews were conducted by the author; 15 took place in participants' homes, two in my home and the remaining four at the university. The sample was recruited primarily through a notice placed in the provincial newspaper. Three participants were recruited through the snowball technique where men who had been interviewed suggested others who might be willing to participate. All participants signed consent forms, giving consent to be interviewed and to have the interview audio-recorded. Ethics approval was obtained from the University Research Ethics Board.

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Table 1. Demographic information and descriptive statistics

	N
Age:	
55–64	5
65–74	8
75–84	5
85 and over	3
Marital status:	
Married/common law	15
Divorced/separated	3
Widowed	2
Never married	1
Education:	
Less than high school	4
High school	5
University degree	8
Postgraduate degree	4
Employment status:	
Employed full-time	4
Employed part-time/semi-retired	1
Retired	16
Place of residence:	
Urban	14
Rural	7
Location of interview:	
Participant's home	15
Researcher's office or university	4
Researcher's home	2

Note: N = 21.

Following the principles of qualitative data analysis outlined in Lofland and Lofland (1995), Charmaz (2006) and Marshall and Rossman (2011), the data were analysed inductively. The analysis was guided by the initial research questions, concepts and insights derived from the theoretical framework guiding the study, and the relevant body of literature (Marshall and Rossman, 2011). Some codes and themes are based on interactionist concepts (*e.g.* agency) which served as 'sensitizing concepts' (Van den Hoonard, 1997). Adopting the general principles of grounded theory (*e.g.* generating concepts and properties through the constant comparative method), the primary focus was on categories emerging directly

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from the data, identifying their properties and relationships among them (Glaser and Strauss, 1967; Charmaz, 2006). Interview transcripts were read and re-read as initial understandings of the data were tested, and inconsistencies and contradictions carefully examined. Many analytical memos were written as themes and conceptual categories were developed and connections among them identified (Charmaz, 2006).

In addition to careful re-reading of the interview transcripts and looking for negative cases (Lincoln and Guba, 1985), participants were offered the opportunity to review their interview transcripts. Only six expressed interest and none provided comments or clarifications, although invited to do so. A single researcher project, there was no opportunity to compare interpretations of the data with a second investigator as a means of maximising the trustworthiness and credibility of the findings. In the presentation of the findings, many verbatim quotations are included to support interpretations of the data (Charmaz, 2006).

Findings

The following analytical categories are discussed in the presentation of the findings: (a) awareness of ageism; (b) stereotypical and ageist beliefs about older patients; (c) personal experience of ageism; (d) concern about ageism; and (e) avoidance of ageism and views about who is most likely to be a target. Although awareness of ageism, personal experience of ageism and concern about ageism were areas covered in the interview guide, these concepts were not imposed on the data but brought into the research as a 'guiding empirical [interest] to study' (Charmaz, 2006: 16), prevalence of ageism in the health-care setting being well documented. Operating as 'sensitizing concepts', they were employed as 'points of departure' (Charmaz, 2006: 17) in analysing the data. Remaining open to what would be revealed by the data, they would have been dispensed with had they proven irrelevant. The two other categories emerged directly from the data. Nonetheless, these pre-identified areas of interest may have influenced the findings.

Awareness of ageism

With only one exception, there was no mention of ageism at either the institutional or interpersonal level in participants' discussion of their health-care experiences prior to the questions asked to elicit their understandings of and experiences with the phenomenon. Asked about the nature of his relationship with his physician, 96-year-old Charlie[2] complained that his doctor was always commenting on his age:

> Every time I come in, [he's] always bugging me about my age. If I said to him like … my right leg and my knee are bothering me, he just looked at me and sneered and [said] 'What do you expect?'

The belief of many that ageism was not likely to occur during patient–physician interaction, and seeming lack of awareness of it, was a notable theme in participants' replies to inquiry about its probable occurrence within the health-care

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setting. Participants were first asked two questions designed to elicit perceptions about ageism and the likelihood of its occurrence during a medical encounter. They were asked 'Do you think it makes any difference to the doctor whether his or her patient is an older or younger person?' and, following that, 'Do you think the age of the patient in any way influences how the doctor treats the patient?' Six participants did not think patient age would make any difference to a physician; six others said they did not know:

> Not to my doctor, I haven't met a doctor yet who indicated that. (Art, 96 years)

> I don't know if it does or not, ah I don't know. (Pete, 72 years)

Almost half (48%) did not believe age of a patient would influence how a physician would treat a patient:

> Well, certainly, if you have a disease or disorder which requires treatment, I don't think age is going to make any difference; they're going to treat you. (Dr Jones, 81 years)

> I'm pretty sure in my thought that it doesn't matter, you know. (Ken, 83 years)

Only a few who believed age would matter to a physician or influence how a physician treats a patient referred to ageism in their explanations. Common among these was the belief that physicians are not likely to offer older patients the same treatment as younger patients because older patients are nearing the end of their lives, or as one participant put it, 'they're past their best before date':

> Definitely, I feel the older people are not treated the same when they have health problems, sometimes I feel, 'he's at the end of the road'. (Ernie, 65 years)

> I think it does … I think as you get older, they have a tendency to, well, 'it's only a matter of time type thing' … I don't think they really, you know, give them the same [treatment], as it's, I think a different attitude completely. Older people, it's past your time, it's time to roll on. (Joe, 89 years)

Only one participant indicated that his belief was based on personal experience:

> Oh, I think some doctors feel that way … what did the doctor say to me? 'But you're 83 years old' … Well, then, I said to the doctor, you know, that I wanted some of the problems I have, well that affects me, well that thing on my bum, that, you know, should be cured some time [or something should be done about it]. 'Yes, yeah, you have to accept that.' Well, if it's impossible fine, but is it possible?

Many participants had difficulty answering these questions, their comments suggesting lack of awareness about ageism. Seventy-one-year-old Herman, for example, found it difficult to say whether patient age would make any difference to a

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physician, stating: 'I've never seen him interact with younger patients so, no … I don't get that question actually, I don't know how you can answer it.' Asked if he thought patient age could influence how a physician treats a patient, perplexed with the question (even after I attempted to clarify its meaning), he replied: 'I don't know how to answer that question.' When 89-year-old Joe was asked, later during the interview, if he had personally experienced ageism, he replied: 'How would you know?' When I offered an example, he stated: 'Well I might have, I never gave it a thought you know.' Eighty-three-year-old Ken, a diabetic, described, with amusement, what his physician said to him when he complained about problems with his feet: 'He keeps telling me, you know, you got to [accept], your legs are a thousand years old, he said, what are you worried about? They've done a lot of walking, what do you expect?' Asked whether he thought his doctor might have handled his complaint differently, he replied 'No, no, no. He, when he said it, he sort of explained, you know, it's part of life … He said this is life Ken, you know, you're doing very well, what are you worried about?' When it appeared that the meaning of ageism was not entirely clear to many of the participants, I began to clarify, offering an example of a subtler form of ageism where a physician might interpret an older adult's medical complaint as a normal part of ageing rather than investigating the problem. Offered this example, 71-year-old Angus, who insisted he had not ever experienced ageism, responded: 'Well, if I were told that, I would tend to agree. I'm not sure that is ageism. You can't expect everything to work perfectly forever.'

Many also did not perceive ageism as a potential problem when they were asked a third question designed to further elicit perceptions and beliefs about its occurrence in the health-care context. This question asked: 'Do you believe doctors take older patients' symptoms and health concerns as seriously as they take the symptoms and concerns of younger patients?' Illustrating consistency in response across these questions, ten participants believed physicians would take the symptoms and concerns of older patients just as seriously as those of younger patients. One believed this to be the case even though he had heard friends complaining about their experiences with doctors: 'But you know I have a lot of friends that are my age and, you know, when you get talking to them, some of them have expressed disappointment.' Another 55-year-old did not think physicians would treat older patients' symptoms or concerns less seriously even though he noted that his older brother had complained about physicians not taking his complaints as seriously as he thought they should: 'Yeah, like … my oldest brother … he's felt that way. I know he's felt that way. I mean he certainly has felt that they are not taking him seriously, and … he's 72.' Indicating earlier he was unfamiliar with the term ageism, 72-year-old Pete replied to this question with the statement: 'I think so, I just assumed they would. I never really thought about that one.'

Six participants said they did not know whether a physician might take older patients' symptoms and concerns as seriously as they would the symptoms and concerns of a younger patient. Three were unwilling to generalise to all physicians, stating, for example, 'Well I think it's hard to generalise on that … so I'm sure, like the rest of society, some do and some don't take older people less seriously.' Another suggested age of the older patient was pertinent, with symptoms perhaps not taken as seriously 'when you get into your nineties maybe'. As discussed later, belief that older age and ageism are related was shared by other participants.

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Although 81-year-old Dr Jones believed physicians might not take older patients' symptoms and concerns as seriously as those of younger patients, his comments illustrate ambiguity concerning what is or is not ageism and how a patient may unwittingly be complicit in its accomplishment:

> No, I think there are some symptoms which they probably immediately dismiss because of age. I mean, if I've got a pain … in my knee, or pain in my hip, they [will say] take two aspirin and call me in the morning. On the other hand, if you come in with something other than normal ageing pains … I think they would take that very seriously. [When I note this is an example of what could be considered a subtler form of ageism, he went on to say] That's interesting, that's a really, a really good point. That's an excellent, really honestly, a very good point. Because I'm guilty. I know when I go to see [his doctor], if I've got a, my hip is bothering me … I just assume it's good, old-fashioned arthritic hip and so, in a sense, set her up for that.

Ageist and stereotypical beliefs about older patients

In line with other's findings (Minichiello *et al.*, 2000; Hurd Clarke *et al.*, 2014), many participants viewed ageing and older adults in terms of ageist stereotypes. Among participants believing patient age would make a difference to a physician, there was, for example, a good deal of ageist stereotyping in explanations of why age would matter. Fifty-eight-year-old Paul, for example, perceptively noted that 'treat' can mean 'different things; if we mean by treat prescribes, I think yes, if we mean by treats personal relationship, no'. However, pausing for a moment, he stated:

> actually yes even then too [because of] the likelihood of multiple chronic conditions and the complexities of fragility … the ageing person is more likely to be on multiple drugs and have multiple things wrong.

He also believed the doctor would be more likely to treat the older patient differently because 'if we are talking about a person who is so ancient that capability and competence are in question, the physician [must get the family "involved"], not just the patient'. Assuming older patients would be less healthy than younger patients, some believed patient age would matter to a physician for financial reasons:

> I think from a financial perspective he would prefer that they're younger, only because they likely have less things wrong with them, and he's gonna get paid for one appointment. (Norman, 66 years)

> Older patients can take a lot more time, that's for sure, and … most of these doctors are business people, so, you know, time is money … You don't get much more money to see an older patient who might require a lot more time. (Angus, 71 years)

Although patients with multiple and complex health problems are likely to require more of a physician's time, these comments exemplify the stereotypical tendency to equate 'old' with illness and disability.

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In reply to the question, 'Do you think the age of the patient in any way influences how the doctor treats the patient?', Norman believed physicians were likely to be 'less tolerant' because: 'The patient may have a harder time describing their issue and they might not be willing to delve deeper into what the issue is there.' Sixty-three-year-old Dean, one of the highly educated participants, offered an explanation for why he believed patient age would matter to a physician that implied that at least some ageism, or what he referred to as 'reasonable bias', was acceptable:

> I would say, in most cases, yes. I would say that there is probably some ageism built into the medical system at all levels. Older lives are probably considered worth less than younger lives, and I understand that, that is a reasonable bias. If somebody is, you know, 85 years old, they … shouldn't require or get the same kind of heroic efforts as somebody that was in their twenties or thirties that has, you know, a lot of life to live. So, I think that's reasonable.

One could argue, of course, that there are occasions where it is reasonable that a physician takes patient age into account in prescribing appropriate medical treatment (Pasupathi and Lockenhoff, 2002). For example, one participant, explaining why he believed age could influence a physician's decision how to treat a patient *medically* in a way that should not be interpreted as ageism, offered his own experience to illustrate:

> Well I think it probably does, and it probably should. I mean … take the example of my prostate cancer. When you're at my age, watchful waiting is often the best approach … If you get it when you're 50, it can be a really serious disease that can progress very fast, I think. (Angus, 71 years)

Responding to the question concerning whether a physician would take an older patient's health concerns as seriously as those of a younger patient, 58-year-old Paul suggests the older patient may be unreasonable, expecting too much from a physician:

> I think one of the disconnects [*sic*] is between what the patient expects a physician to be able to fix, or address, *versus* what the physician can actually address. And, again, I've seen this in person, and I've heard it from other ageing people, 'My physician isn't helping me fix this.' Well, you might be describing something that is unfixable.

Suggesting the patient rather than the physician might be to blame if an older adult encounters ageism has been reported elsewhere (MacRae, 2018). Implied blame of those subjected to ageism is also evident in the final section which discusses participants' beliefs about how older adults might avoid becoming a target of ageism.

Personal experience of ageism

Participants were asked two questions designed to determine whether they believed they had personally experienced ageism. They were asked: 'Do you think *your age* in any way influences how your doctor treats you? Then later, more directly: 'Have you personally experienced ageism in your interaction with a physician?' The vast

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majority (18 participants, one was 'not sure', no data for another) did not believe their age in any way influenced how their physician treated them. Ninety-six-year-old Charlie was the only participant who believed his age was influencing how his physician was treating him. As noted earlier, Charlie complained, long before being asked questions pertinent to ageism, that his physician was 'always reminding [him] of his age'. Later asked if he thought his age in any way influenced how his physician treated him, he reminded me of this stating: 'I said, if you don't want somebody my age, then … I told him point blank, every time I see you, you're getting in digs about my age.'

Similarly, the majority (19 participants) did not believe they had personally experienced ageism. Some, like 71-year-old Ernie, were adamant they had never experienced it: 'Not in the medical, no sir, no ma'am, not at all and I've been through the radiation. I dealt with a lot of technicians and so on.' The two who indicated they had personally experienced it were both over 80 years old. Ninety-six-year-old Charlie again complained about his physician's frequent reference to his age and comments concerning his health concerns such as 'you're not any spring chicken' and 'what do you expect?' Indicating he had personally experienced ageism, Stewart was annoyed that his physician sometimes dismissed his concerns with the statement: 'But you're 83 years old.'

Concern about ageism

After participants were asked questions designed to elicit their perceptions of ageism, they were asked: 'Is ageism something you are concerned about in your interaction with a physician?' An overwhelming majority (19 participants, no data for one and 'don't know' for another) indicated that they were not concerned about ageism. Three younger participants noted that although they were not now concerned, they might be in the future:

> I'm not concerned about it now, but I know it exists. I might be at the point where I'm, you know, I may not be subject to it as much as I might be in another five or ten years. (Dean, 63 years)

> No, I'm not concerned at this point but maybe further down the road. (Ernie, 65 years)

Sixty-six-year-old Norman was not concerned about ageism because he did not see himself as an 'old' person: 'No, I don't think, my issue is that my eyes see the same way they did 20 years ago. Even when I look in the mirror, I don't see, well, who is that old guy?' Moreover, there was a great deal of ageist stereotyping of older adults in participants' replies to this question, this distancing from the stereotypical older adult seemingly reinforcing their lack of concern about ageism.

The objective being to ascertain older men's understandings and knowledge of age-based stereotyping and discrimination, the term ageism was intentionally not used in the questions designed to investigate perceptions of ageism prior to asking explicitly whether participants were concerned about it. Notable, when the word was used in this question, some participants indicated that they were unfamiliar

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with the term ('I can't say that I have [heard of it]') and that ageism was something they had given little thought to prior to the interview. Dr Jones, for example, engaged in a lengthy discussion of what might or might not constitute ageism as he pondered prior to committing to a response to the earlier more implicit questions relevant to ageism. Yet when asked if ageism during a medical encounter was something he was concerned about, he indicated he was still wrestling with the meaning of the term, and uncertain whether he should or should not be concerned about experiencing it:

> Well, if I suddenly turned up with a major disease, God forbid, and I get referred from my family doctor [he did not believe his own physician would be ageist], to a specialist, the question is going to be is that doctor going to say to me, 'well, you're beyond a certain age, you've outlived your lifeline, so, you know, forget it', or am I going to be treated and receive surgery or treatment that I should receive and a follow-up to that? … I don't know. I understand what you're saying and I don't know the answer. Am I worried about that?

Although 89-year-old Joe believed patient age might make a difference to a physician, asked if ageism during interactions with physicians was something he was concerned about, he indicated he was not only unfamiliar with the term but that, prior to the interview, he had not even thought about ageism:

> What's that? I ain't heard so much of that. No, I've never really noticed that. I haven't come across or thought of it. I don't know, I just ah, I've never given it a thought. How would you know? [I offer an example] Okay, okay, is there much of that around? But the thing is, I haven't heard that … You've caught me this time; it's a new one on me.

Avoidance of ageism and who is more likely to be a target

Of particular interest in the data analysis were the numerous rationales proffered (often without any probing) as explanations of why a particular participant had not or was not likely to experience ageism personally and who was more likely to be a target. Some clearly believed age was a relevant factor, exemplified in 58-year-old Paul's response when asked if he thought his age in any way influenced how his physician treated him: 'I'm too young, I haven't dealt with that.' Seventy-two-year-old Cecil believed 'if you're really old, then, maybe [physicians] won't give you as much attention'. Although a number of younger participants believed they were too young to experience or be concerned about ageism, some noted it might be a concern later when they were older. The belief that older, older adults were more likely to be targets of ageism was typically associated with the stereotypical belief that as one ages health inevitably deteriorates, or as 57-year-old Ryan put it, 'things are [going to] fall apart'. He believed there was reason for concern about ageism if one was older:

> Because, as you get older … things are gonna fall apart. This is gonna happen, this is gonna happen. It's just part of your natural part of ageing and that's where I think more of a, you're getting older, just live with it, move on. I think the

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> perception that because you're an older person, you should not be concerned about these things. Yeah, so, yes, I think there is ageism in certain aspects of the medical profession.

It was not just being young but being healthy that appeared to be significant. Sixty-three-year-old Dean, for example, did not believe his age influenced how his physician treated him because he was 'relatively healthy and vigorous'. The belief that older age and declining health were inextricably linked was frequently part of participants' understandings of who was more likely to be the target of ageism. Although Dean believed he was too young to be concerned about ageism, he 'expected' that 'in another five or ten years' (he would be 68 or 73 years old) he might be 'subject to it' because his health would deteriorate:

> I'm not concerned about it now, but I know it exists … I may not be subject to it as much as I might be in another five or ten years. I think when you start to show, you know, signs of deterioration, especially mental deterioration, I think, you know, you're definitely going to be treated [differently].

Although 71-year-old Ernie was adamant he had not personally experienced ageism, he suggested that people who were 'a lot older' and 'in worse shape' were more likely to be targeted:

> But at the same time, there in the waiting room, lined up for other treatments … there's a whole bunch of characters that are a whole lot older and a whole lot worse shape than I am. I can see that, so maybe they treat them badly … oh, hey, this [Ernie] is almost our age, you know, we'll treat him nicely.

Not surprisingly, the body was implicated in the experience of ageism, and looking after one's body was, for some participants, a suggested means to avoid becoming a target. Seventy-one-year-old Herman indicates this when he explains why he is not concerned about ageism:

> The only correlation that might occur to me, not that it has, but it might, is the fact that my body is just older. As you get older, it starts to shut down, little by little. So, other than that, no. No, my mind is the same as 30, 35. But, over my life, I've looked after myself. I've done everything from high-impact stuff, aerobics and jogging, and everything else.

When I noted that ageism during a medical encounter could be subtle, Herman was still adamant he had not experienced it ('Not remotely close, no'), suggesting youthful appearance may explain this: 'It may have to do with the fact that when he first met me he thought I was 15 years younger than I was.' Similarly, 55-year-old Rex was not concerned about ageism because he was responsibly taking care of his health and body:

> I'm not 'cause I feel like I do a lot of stuff for my health on my own. So, 'cause I exercise and I … eat [well] … and, so, I've taken some of that responsibility. I tend

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> to believe that if you're someone who doesn't do any of that and you just go to the doctor thinking the doctor should fix you, then, you're probably gonna be treated differently.

Fifty-seven-year-old Ryan's response when asked if he thought patient age makes any difference to a physician illustrates how physicians' comments can reinforce the tendency to equate ageing with deterioration of the body:

> I don't know. Yes, I think they look at the person and they look at it, well, whatever age you are, that's just part of the natural progression; and the doctor has said to me, 'you're getting older, things are gonna hurt more'.

Pondering at length about when and why someone might experience ageism, 81-year-old Dr Jones and his wife, present for this part of the interview, suggested that youthful appearance and being active could enable older adults to avoid ageism. Suggesting youthfulness might be a relevant factor, Dr Jones stated: 'But … don't you think that depends on … how young the older person is?' Addressing his wife, he asked: 'Yeah, and so, the question is, are we experiencing ageism? I don't know about you, have you experienced any?' In response to her husband's enquiry, she first proposes that appearance might be a factor, but upon further reflection, suggests being active was also relevant:

> I mean the white hair makes you ['old'], but I think, many people, saying, 'you don't [look your age], you're not your age', I mean, I'm 75. So, I mean … we're travelling, we're going and doing, and we're quite active, so we get that a lot.

Noting that he and his wife were assertive patients, and acknowledging that he might not recognise ageism should he be a target of it, with some amusement, Dr Jones suggested being assertive might also be a protective factor: 'Maybe it's something we'd recognise if somebody pulled some ageism crap with either one of us, maybe they're afraid to.' Although belief that remaining youthful, healthy and active can be a means of avoiding ageism does not explicitly blame those who experience it, implicit is the notion that older adults who are targets may be at least partially responsible because they did not look after themselves.

Although good physical health was deemed relevant to the probability that an older adult might experience ageism, for some, as noted in some of the quotations above, mental health was also a factor that could influence how a physician interacts with an older patient, with cognitive impairment making an older person a more likely target. Seventy-one-year-old Angus, for example, suggested that an older person's 'mental state' was likely to be influential:

> Well, it depends on, I think it depends on what mental state the older person has, for example, I mean if, you know, they are chronically showing signs of dementia and so on, I can imagine how it would change how they might interact with the patient.

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Sixty-three-year-old Dean was not concerned about ageism because he believed that being educated, well informed, articulate and a responsible patient decreased the likelihood of experiencing it:

> I'm not concerned about it now … The way I feel about it is, if you go in to see a physician and I'm articulate and I speak their language, I know some of the medical terms, and I demonstrate that I'm willing to be a partner in my health care … I think I'm treated with more respect, and I think I get better service because I'm an informed consumer … and I think I get better service because I know how to advocate. I mean my education and my knowledge are going to stand me in good stead when it comes to getting health care because I will advocate for myself, you know, I'm speaking their language [*e.g.* 'diagnostic imaging'] and they're going to respond to that.

Seventy-one-year-old Angus also thought intelligence and competence were factors likely to influence whether an older adult would experience ageism: 'Not me personally, not yet at least. [You said not yet, what did you mean by that?] I think I present as a competent person you know, still half ways intelligent and so on.' Seventy-one-year-old Marshall suggested duration of the patient–physician relationship could positively influence the way a physician interacts with an older patient:

> Bear in mind, I've had the same doctor for 15 years. [Do you think that's a benefit if a doctor knows you for a longer period of time?] I think it's a benefit, yeah, or he's just flattered that I followed him from [one community to another].

Discussion and conclusion

Notable in this study of older men's perceptions of and experiences with ageism during interactions with physicians is the finding that, although ageism permeates our society (Calasanti and Slevin, 2006), many participants seemed unaware of the possibility of ageism occurring during a medical encounter. This is consistent with the results of Hurd Clarke and Korotchenko's (2016) study. Although not focusing on ageism within the context of health care, they found that

> 13 of [their] 29 participants voiced confusion with or lack of awareness of the term ageism such that requests for information about their personal experiences of age-based discrimination were initially often met with puzzled silences, shrugs of shoulders or requests for a definition of the concept. (Hurd Clarke and Korotchenko, 2016: 1763)

In an earlier study of perceptions of ageism among older Australians, Minichiello *et al.* (2000) found that the term ageism was neither understood nor used among many of their participants, although they were able to talk about the experience of ageism. They conclude: 'Only time will tell whether a similar study in the future will reveal that the word ageism is more widely recognised among older people, and that its consequences are neither acceptable nor to be accommodated' (Minichiello *et al.*, 2000: 277). It would appear that two decades later many older

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adults are still not familiar with the term ageism and may not recognise ageism when it occurs.

That most participants reported that they had not personally experienced ageism is also consistent with findings of previous research. Although a majority of participants in Hurd Clarke and Korotchenko's (2016) study believed age discrimination was prevalent in Canadian society, most did not believe they had personally experienced it. Like some of the participants in this study, they believed they were immune to ageism because of their active lifestyle and youthful attitudes. Also consistent with the results of this research, the men in Hurd Clarke and Korotchenko's (2016) study frequently negatively stereotyped other older adults but failed to recognise their own age-based prejudice. In a Finnish study of middle-aged and older men, Ojala *et al.* (2016) found that although many were aware that ageism exists, they did not believe they had experienced it themselves. Similarly, in a study of older women's subjective experience of ageism within the health-care setting, MacRae (2018) found that although most believed ageism was likely to occur during interactions with physicians, few claimed to have personally experienced it. It may be that some participants in this study had experienced ageism but did not wish to acknowledge it as acknowledging it would mean acknowledging their location 'within the old age category' and the devaluation and stigma associated with it (Calasanti *et al.*, 2006: 20).

Although few older women in MacRae's (2018) study believed they had experienced ageism, in contrast to the men participating in this study, the women appeared to be more aware of ageism and they were more concerned about it. Awareness among some of the women appeared to be related to observations of the care their elderly parents or parents-in-law had received, the women often accompanying older family members to medical appointments and present during patient–physician interaction. Only three participants in this study (one only upon probing) mentioned parents' health-care experience during discussion of ageism, each indicating they or their siblings had not been satisfied with the care their parent had received. The typical complaint was related to quality of care or the belief that the parent 'should have had more done [for him or her]', however, the term ageism was not used to describe it. Perhaps men are less aware of ageism because they are less likely than women to be a familial care-giver and to accompany an elderly parent on a medical visit where they would observe patient–physician interaction. MacRae (2018) also reported that awareness of ageism, and belief that it could occur during a medical encounter, among some of the women appeared to be based on 'stories' heard from family members, friends and others about their health-care experiences. Only two participants in this study made reference to what they had heard from others about experiences with ageism. Asked whether he believed physicians take older patients' symptoms and concerns less seriously than those of younger patients, Herman replied: 'My own experience is no, but … I have a lot of friends that are my age, and … some of them have expressed disappointment.' Rex was aware of ageism because he had heard his older brother complaining that '[physicians were] not taking him seriously'. Perhaps men are less aware of the potential for ageism during medical encounters because they are less likely to discuss health-care experiences with others.

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Hurd Clarke and Korotchenko (2016) have suggested that men's perception that they are immune to ageism may be linked to hegemonic masculinity or the culturally dominant ideal of what it means to be a man (*e.g.* strong, independent, stoic). Older men who are able to perform hegemonic masculinity successfully may be less likely to be targets of ageism, less aware when they have been targeted or unwilling to acknowledge that they have personally experienced it. Future studies exploring possible gender differences in awareness and perceptions of ageism could contribute to a more comprehensive understanding of the nature of ageism and how it is experienced.

The explanations participants proffered as reasons why they believed they had not been targets of ageism are similar to what older men in Hurd Clarke and Korotchenko's (2016) study offered as explanations of their perceived immunity to ageism and the strategies that the participants in the studies by Minichiello *et al.* (2000) and MacRae (2018) employed to manage ageism. As these older men perceive it, although chronological age is relevant, it is not age alone that places an older adult at risk of being a target of ageism: being youthful and the health and state of the body and mind are influential factors. A tendency to connect ageing and health, and 'to see good health as equivalent to not growing old' (Calasanti *et al.*, 2013: 19), is consistent with the findings of studies of middle-aged, working-class men's perceptions of health and ageing (Pietila and Ojala, 2011; Calasanti *et al.*, 2013). Pietila and Ojala's (2011) participants conceptualised ageing not so much in relation to chronological age but in terms of health and functional ability. Men were perceived as 'old' not based on chronological age but on the basis of perceived impaired functional ability and an increasing number of health problems. The belief that one can fight the ageing process (and presumably ageism) and avoid becoming 'old' by keeping oneself healthy and fit is a strategy that is not an option for everyone. Moreover, it marginalises older adults living with chronic illness or disability who cannot 'do ageing' (Pietila and Ojala, 2011) in a way that the body remains youthful, healthy and fit.

A number of scholars have drawn attention to the relationship between the body, appearance and ageism, noting that ageism is an embodied form of oppression (Bytheway, 1995; Slevin and Linneman, 2010; Calasanti and King, 2018). Since 'bodies serve as [principal] markers of both age and health' (Calasanti *et al.*, 2018: 235), it is not surprising that older men might believe that having a healthy body, youthful appearance and staying fit are ways to avoid being seen as 'old' and becoming a target of ageism (Slevin and Linneman, 2010). An interactionist approach to the study of ageing and ageism aligns with the work of scholars who conceptualise age as a social construction and an accomplishment (Hendricks, 1995; Laz, 2003). For constructionists age is something people 'do' or 'accomplish'; it 'is constituted in interaction and gains its meaning in interaction and in the context of larger social forces' (Laz, 2003: 506). Belief that controlling the body can be a means by which to avoid being seen as 'old' and a target of ageism is consonant with the widespread, neoliberal cultural view that one must 'stay young' and resist 'not just old age, but ageing itself' through physical exercise, self-control and disciplining the body (Gilleard and Higgs, 2000: 59; *see also* Calasanti *et al.*, 2013).

Some participants suggested that if older patients were educated and well informed, they would be less likely to be targets of ageism. Given the relative

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'invisibility of age-based prejudice' (Hurd Clarke and Korotchenko, 2016; *see also* Nelson, 2016), and that ageism can operate 'implicitly or without awareness' (Levy, 2001: 578), educating older adults and health-care professionals about ageism is important. Older adults could be made aware of ageism generally, the potential for it to occur during interactions with health professionals and the subtle ways it may be manifest during medical encounters. Some participants in this study may have experienced ageism but simply did not recognise it. Both patients and physicians may have difficulty recognising ageism, especially its more subtle forms. The tendency for some physicians to dismiss or diminish the importance of older patients' complaints as normal ageing may not be perceived as ageist, by either physician or patient, since the tendency to associate the ageing process with disease 'permeates both the popular and medical culture' (Sharpe, 1995: 11). Although education is important, it is not enough. As Hendricks (1995) argues, while it is easy to point a finger at individuals, including physicians, who engage in ageism, age bias and age-based discrimination found within societal institutions, social policy and a 'master cultural narrative [that normalises] the devaluing of age and aging' (Gendron *et al*., 2018: 248) must also be addressed. Inasmuch as culture is a resource individuals draw upon to give meaning to age, ageing and their own ageing experience, a cultural narrative that 'shames' and 'blames' older adults (Gendron *et al*., 2018) must be acknowledged and contested if ageism is to be eradicated.

Combating ageism in the health-care setting is particularly important as 'ageism in the healthcare sphere is not just demeaning but can be dangerous, as it is often the cause for both over- and under-treatment of older adults' (Ouchida and Lachs, 2015: 46). The frequent stereotyping of older adults and ageist views expressed by participants in this and other studies (Minichiello *et al*., 2000; Hurd Clarke and Korotchenko, 2016; MacRae, 2018) is also concerning as research indicates that internalising ageist stereotypes can have important negative consequences for older adults' physical and mental health (Schafer and Shippee, 2010; Makris *et al*., 2015; Chrisler *et al*., 2016), especially if they come to accept the belief that old age and illness are inevitably linked and dismiss symptoms of illness as 'just old age' (Stewart *et al*., 2012).

There are limitations to this study that should be considered in evaluating the results. The findings are based on an ethnically homogeneous sample of men who volunteered to participate; many were well educated, and only one identified as other than heterosexual. With few exceptions, most were in relatively good health. The two who reported that they had experienced ageism were both over the age of 80 and living with chronic health problems. Research indicates that chronic illness and complex health problems can negatively affect the patient–physician relationship and patient satisfaction (Campbell and McGauley, 2005; Poot *et al*., 2014). Since physicians tend to find chronically ill patients whose medical problems are difficult to manage challenging, older adults with multiple morbidities may be at risk of being perceived as 'difficult patients' (Hahn, 2001) and possibly targets of ageism. Research also indicates that persons of all ages are more likely to negatively stereotype adults 80 years and older than younger older adults, with physical appearance an influential factor (Hummert *et al*., 1997). Age-related changes in appearance make it more difficult for adults this age to 'look young'

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and possibly avoid ageism. Only seven participants were 80 years or older. Had there been more men of this age, the findings may have been different. Many participants described themselves as assertive patients. Some research suggests physicians are inclined to view assertive patients more favourably and respond to their treatment requests (Adler *et al*., 1998), although older assertive patients may also run the risk of being perceived as demanding and complaining (Ben-Harush *et al*., 2017). Nonetheless, assertiveness may have enabled some of the men to avoid being targets of ageism (MacRae, 2018).

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Notes

1 Following American Psychological Association guidelines and recommendations of the Gerontological Society of America, the term older adult is used throughout this paper (*see* Meinz *et al*., 2006).
2 All names are pseudonyms.

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