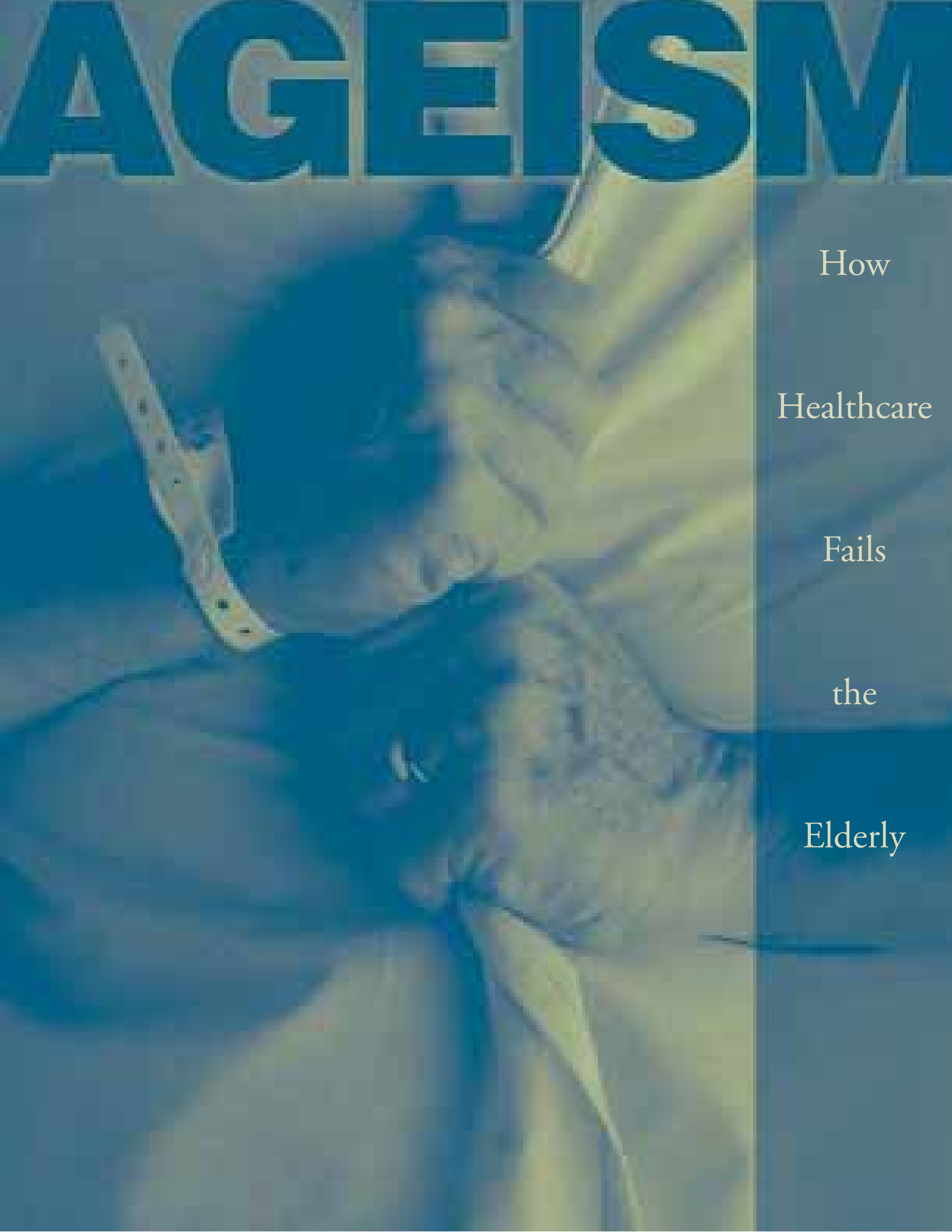


AGEISM



How

Healthcare

Fails

the

Elderly

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EXECUTIVE SUMMARY

In 1965, Congress and the President created Medicare to provide healthcare insurance for all Americans over the age of 65 and younger people with significant disabilities. While assuring access to needed health services for vulnerable populations, Medicare does not in practice guarantee that older Americans always will receive the quality of care and treatment they need. In recent years evidence has been mounting to suggest that, at all levels in the delivery of healthcare, there is a prevailing bias - ageism - that is at odds with the best interests of older people. This prejudice against the old in American healthcare is evidenced by scores of recent clinical studies, surveys and medical commentaries, many of which are referenced here. In this report, we outline five key dimensions of the ageist bias in which U.S. healthcare fails older Americans:

- **Healthcare professionals do not receive enough training in geriatrics to properly care for many older patients.**
- **Older patients are less likely than younger people to receive preventive care.**
- **Older patients are less likely to be tested or screened for diseases and other health problems.**
- **Proven medical interventions for older patients are often ignored, leading to inappropriate or incomplete treatment.**
- **Older people are consistently excluded from clinical trials, even though they are the largest users of approved drugs.**

There is currently very little agreement of what constitutes normal lab results in older people. Older patients too often do not receive preventive treatment such as vaccines and screening tests that could potentially prevent diseases from becoming life threatening. Due to a lack of standards of care for geriatric patients, born of inattention to this age group, it is much more likely that older patients will face inappropriately invasive procedures, while some others are denied what might be a life-saving surgery out of the mistaken concern that their age alone decides what treatment is appropriate. This lack of geriatrically-informed standards of care also leads to older patients being more likely to be

harmed or their lives cut short by over-medication, under-medication, or the misuse of approved drugs.

Like other forms of prejudice and discrimination, ageism grows out of our culture and is part of all of us. This report does not intend to unjustly criticize doctors, hospitals or other parts of the healthcare system, because ageism is endemic in the population. However, as it affects and interferes with good healthcare decision-making ageism needs to be recognized and opposed for the benefit of all. Ageism is unconsciously a part of the psychology of older patients themselves, and their families, and can adversely affect medical outcomes by underestimating the physical and mental capacities of older people.

Experts say that medical care shaped by ageist assumptions hurts everyone, because it leads to premature loss of independence, increased mortality and disability, and depression in adults who might otherwise continue to lead productive, satisfying and healthier lives. Left unaddressed, ageism in American healthcare will loom even larger in the future as a national problem. Beginning in 2011, the out-sized Baby Boom generation will begin to reach the age of 65, the age of eligibility for old age health benefits under Medicare. Although people over the age of 65 only make up about 13% of the U.S. population today, it is projected that over 20% of the American population will be age 65 or older by 2030. By then, the total population of Americans over the age of 65 will have doubled to more than 70 million people.

Unless ageist attitudes are recognized and rooted out of healthcare in the U.S., the next generation under Medicare will likely discover that their quality of care is decreasing as they age.

The not-for-profit Alliance for Aging Research has prepared this report to encourage debate and action on the issues related to ageism in our healthcare system. We have put forth not only a description of the problem and its impact, but also a set of recommendations that are intended to address the problem. Those recommendations detailed elsewhere in this report include:

Recommendations

1: More training and education for healthcare professionals in the field of geriatrics.

2: Greater inclusion of older Americans in clinical trials.

3: Utilization of appropriate screening and preventive measures for older Americans.

4: Empowerment and education of older patients.

HOW HEALTHCARE

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Ten years ago journalists for a leading national news magazine disclosed that older Americans are routinely mistreated by U.S. healthcare, citing a widespread medical bias against older people. It was a shocking revelation - especially since all Americans over age 65 are covered by federal health insurance under Medicare. However, the authors made a strong case, hammering home their point with study after study showing systematic failure to prevent, detect or treat health problems of the elderly as aggressively or as well as for younger patients.¹

This journalistic blockbuster drew considerable attention when it was first published, suggesting change was imminent. But so little improvement occurred that it was possible for the same magazine to republish large portions of its original report again in March 2001. Indeed, a full decade after the initial disclosures, experts say little has changed. “A larger proportion of healthcare professionals are aware of the special needs of older people,” says Richard W. Besdine, M.D., Dean of Brown University School of Medicine and a highly regarded expert in geriatrics, “but there is still enormous room for improvement. Unfortunately, greater perception doesn’t necessarily translate into better treatment for older patients.”

Very recently, the April 2003 issue of the Journal of the American Medical Association (JAMA), published a study that makes the point anew. According to the JAMA study, 25 to 40% of Americans over 65 have some hearing impairment, enough to impact the ability of some to work, drive, enjoy music and other entertainment or hear a grandchild squeal and giggle. But despite that number, most older Americans are not assessed or treated by physicians for hearing loss, according to the study, even though hearing aids and other treatments such as antibiotics to treat ear infections could improve hearing for many.²

At the root of shoddy healthcare for America’s seniors, is the very common tendency of healthcare providers and patients alike to view many serious medical conditions in older people as simply a natural part of getting older.³ That attitude results in U.S. healthcare providers missing out on millions of opportunities every year to prevent, treat and enhance the lives of many people over age 65, and some younger. This particular bias has a name: ageism.

Ageism - the endemic prejudice that infects healthcare and surfaces elsewhere in American life - is a term first coined in the 1960s by Dr. Robert N. Butler, who later became the founding director of the National Institute on Aging. In his Pulitzer-prize winning book on being old in America, Dr. Butler defined ageism as “a deep and profound prejudice against the elderly which is found to some degree in all of us...ageism allows the younger generations to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings.”

Ageist bias that leads to ignoring the medical concerns of older Americans comes at a cost to everyone in society. Experts say the poor medical attention received by too many older Americans often results in premature dependence on family or the government, increased earlier mortality and disability, as well as depression, despair and isolation among many older adults who might otherwise continue working, perfect a golf game, smell the roses they have planted, take up new hobbies or volunteer in their communities, or do virtually all of the things that younger Americans take fully for granted.

And failing to prevent and treat medical conditions in the elderly who need care now does not just impact current patient care, it affects future generation of elders as well, says Kenneth Brummel-Smith, M.D., professor and chairman of the department of geriatrics at the Florida

FAILS THE ELDERLY

State University College of Medicine. “When you say nothing can be done, nothing happens [on the research front either] but when you say let’s look at [this condition] that’s when research begins. That’s what happened with Alzheimer’s disease and other conditions.”

Left un-addressed, ageism in U.S. healthcare can only get worse. In 2011, the Baby Boom generation will begin to turn 65. While people over 65 made up only 13% of the population in 2000, it’s projected that by 2030 one in five people, or 20% of the population, will be age 65 or older. And the total population over 65 is expected to double in 2030 from 2000, growing to 70 million people. But unless attitudes quickly change, the coming generation of older Americans is likely to find their care compromised as they get older.

Geriatricians say there are still few definitions of what normal lab test results are in older people; many people over 65 do not get preventive treatment such as vaccines or screening tests; older people may be getting far too many medications which can interact with each other, or they may not be receiving the right medications at all; and, often because standards generally don’t exist, some older patients may get too many invasive procedures such as multiple heart surgeries while others are denied what might be a life-saving surgery out of the mistaken concern that their age alone rules them out for certain procedures.

“Healthcare professionals often make assumptions about their older patients based on age, rather than on functional status,” says Dr. Tom Perls of the New England Centenarian Study, based at the Boston University School of Medicine. “But, assumptions people have [about the elderly] often interfere with an older person’s care,” says Dr. Perls.

Poor health is not an inevitable consequence of aging and many interventions currently exist that could reduce much of the premature death, disability and illness of older adults. “So much more could be done in terms of preventing problems in older patients well before they happen,” says Dr. Perls.

But many doctors have only limited training, if that, in the care and management of geriatric patients. Only about 10% of U.S. medical schools require course work or rotations in geriatric medicine. While many more offer geriatric courses as elective courses, the annual survey by American Association of Medical Colleges shows fewer than 3% of medical school graduates choose to take these courses.

According to a recent study in JAMA, in 1991 the Institute of Medicine recommended that medical school geriatrics programs be comprised of at least nine full-time faculty members. Nearly 12 years later, 71% of geriatrics programs surveyed had fewer than nine faculty, while 51% of reporting schools had less than six. More than 60% of the program directors cited a lack of sufficient research, faculty and trainees, poor reimbursement for clinical care, and a lack of institutional financial support as significant obstacles to geriatrics program development.⁴

There is also a deficiency of training among pharmacists, nurses, physician assistants, and others who are involved in the care of the elderly. Studies show that of the nation’s 200,000 pharmacists, a mere 720 have geriatric certifications, though most prescription and over-the-counter (OTC) drug consumers are over the age of 65.⁵

The US lags behind other developed countries that have been successful at better incorporating geriatric training into their healthcare system. This is reflected by the greater presence of geriatric departments throughout Europe, and Japan. For example, a special course in medical

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gerontology is mandatory in all medical schools in France. In Germany, Italy and Spain, and in many Eastern European countries, geriatrics is often integrated with other medical courses. Post-graduate studies are very well developed in the UK, and in Switzerland, “problem-based” geriatric training is required of all undergraduate medical students.

Without proper training, physicians and other healthcare providers are not able to address the many factors that impact health outcomes in older adults, including multiple simultaneous illnesses that can confound or exacerbate symptoms, multiple drug regimens, patient beliefs, values and preferences, the impact of isolation, lack of independence or adapting to older age, and financial issues.

Often, according to the AARP, healthcare providers are totally unaware of an older patient’s needs. Many health professionals expect older people to be frail, confused, depressed, overly talkative, needy, or quarrelsome and so often begin a medical exam defensively. The problem can be compounded if the doctor speaks only to a caregiver or adult child, making the older person feel invisible and less responsive.⁶

The relationship between physicians and their older patients is only made worse by the decreasing reimbursement physicians receive from Medicare for treating patients over the age of 65. In March of 2003, the American Medical Association (AMA) predicted that more physicians will simply stop caring for older people if reimbursement cuts from Medicare continue. Reimbursement rates were cut in 2002 and additional cuts are expected in 2004. A recent survey conducted by the AMA found that 61% of primary care physicians and 44% of specialists plan to impose new or additional limits on the Medicare patients they treat, while 71% of the physicians intend to make changes in their practices that could adversely affect patient access, such as discontinuing certain services and referring complex cases.⁷

TOO LITTLE PREVENTIVE CARE FOR THE ELDERLY

While Medicare pays for some medical screenings for older Americans (including bone mass screenings, colorectal cancer screening, glaucoma screenings, mammograms, pap tests and pelvic examinations, prostate screenings as well as annual flu shots, pneumococcal shots, and hepatitis B vaccine for qualified beneficiaries) one in three older adults do not receive flu shots and even fewer get the pneumococcal vaccine which can prevent a serious bloodstream infection, or undergo cancer screenings, resulting in tens of thousands of avoidable deaths and illnesses. In fact, according to a Rand Corporation study, flu vaccination reduces hospitalizations among older patients by 27 to 57% and reduces deaths by 27 to 30%.⁸

Although lack of awareness and education on the part of both physicians and patients plays a large role in the disparity of preventive screening measures administered to older patients, findings show that doctors are less aggressive when recommending preventive measures to the elderly. In fact, 9 of every 10 adults over the age of 65 go without the appropriate screenings, according to the 2003 CDC report, “Healthy Aging for Older Adults.”⁹

Those numbers are startling, considering that 80% of all fatal heart attacks and 60% of all cancer deaths afflict men and women age 65 and older,¹⁰ indicating that there is a great need for aggressive screening measures within this age group.

Though heart disease is the number one killer among people over the age of 65, a 2003 study revealed that of those Americans age 50 and older that have had high blood pressure readings, nearly half do not realize that they have hypertension. In a 2003 study of hospitalizations and mortality among Medicare beneficiaries with chronic heart failure, it was discovered that of

the 122,630 patients involved that required hospitalization, 50% of all cases were preventable.¹¹

While clinicians can effectively screen patients of all ages for colon cancer, and despite the fact that colorectal cancer falls second behind lung cancer in all cancer-related deaths, only one in four adults over the age of 50 have received colorectal screening tests. Even more revealing, as recent as 2001, less than 30% of older adults were aware that colon cancer can be detected early, and another 30% were not aware that there are even screening tests available, according to the American Cancer Society Chief Medical Officer.¹² Only 44% of people over age 50 have had the fecal blood test for colon cancer or more invasive, and specific, screening tests for the cancer.¹³ Interestingly, a third of all deaths resulting from colorectal cancer could be avoided with regular screenings, according to the CDC.¹⁴

Although 44% of those individuals diagnosed with melanoma are men over 50, this group comprises only one-fourth of all screenings prescribed.¹⁵

A study of 200,000 women age 50 and older conducted by the National Osteoporosis Foundation showed that 40% of the women had brittle bones, 7% had full-blown osteoporosis, and 11% had suffered from fractures since the age of 45, and in all cases, were completely unaware of their condition because their doctors never made it known. Only 12% of all women age 65 and older receive the recommended bone density mass test, and only half of all post-menopausal women are aware of needing the test.¹⁶

The numbers for other diseases like diabetes, influenza and arthritis are just as bleak, painting a troubling picture of the preventive care that many older patients are receiving.

“So much more could be done in the U.S. in terms of preventing medical problems in the elderly long before they happen,” says Dr. Perls.

And, indeed many disease prevention techniques that are routine for children and many adults are just not a regular part of practice when it comes to older patients, such as postcard reminders for dentist appointments or mammograms. It’s rare for older patients to be reminded that it’s time for a screening test or vaccination; even though a systematic review of published studies have shown that such reminders greatly increase the rate of preventive care in older patients, according to the CDC.¹⁷

AIDS AND SUBSTANCE ABUSE

Prevention of medical problems in the elderly is also an issue when it comes to less obvious but still common lifestyle-related illnesses such as AIDS and substance abuse addiction. Despite the myths and stereotypes prevalent in the general public, including healthcare professionals, many seniors are sexually active and some are illicit drug users, both of which put them at risk for HIV infection. But because healthcare providers rarely assess this risk, they often neglect to, or are hesitant, to discuss safe sex with their patients. “AIDS and HIV in older patients is a consciousness that just hasn’t happened,” says Dr. Mervyn Silverman, a member of the board of the American Foundation for AIDS Research. “Even if patients go to a physician with classic HIV symptoms, the diagnosis is often left out, because it just doesn’t occur to the doctor, and often doesn’t occur to the patient, either.”

The result is that HIV is often diagnosed in older people at a very late stage, and they therefore become ill with AIDS-related complications and often die sooner than younger HIV patients because otherwise effective treatment is often delayed through misdiagnosis and because the immune system becomes weaker as people age.

Experts say that HIV/AIDS educational programs are not targeted to older people and many

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Over 70% of the over 430,000 smoking-related deaths each year are in people over age 65, according to the Center for Social Gerontology. In addition, all the major causes of death among the elderly are associated with smoking or secondhand smoke — cancer, heart disease, and stroke.

may not use condoms because they are not familiar with HIV and other sexually transmitted methods of prevention. Most seniors are unlikely to be using condoms routinely during heterosexual intercourse if they are unaware of the need for STD protection because they are no longer concerned about birth control. There is a noted lack and a definite need for specific programs to be targeted to older adults to inform them about the prevention and transmission of HIV.¹⁸

Misuse of prescription drugs and alcohol is the most common substance abuse encountered by health care and social service providers who currently care for Americans age 60 and older. Because of insufficient knowledge, limited research data, and hurried office visits, health care providers often overlook substance abuse and misuse in their older patients. Ageism contributes to the problem in that doctors feel the abuse is not worth treating, it does not inspire the same urgency for care among older adults as for their younger patients, and that treatment for the older population is a waste of health care resources.¹⁹

A common example of how substance abuse can occur can be found with medication commonly prescribed after a significant surgical procedure, such as cardiac surgery. Because of the lack of follow up with patients about their antidepressant and pain medication use, older patients often stay on either one or both medication categories for years, which leaves them dependent on these drugs, can exacerbate other medical problems, interact with other medications and cause side effects such as drowsiness that can impact mobility and independence.

SMOKING CESSATION

“**S**moking is also a critical health problem in the elderly, but often largely ignored by physicians. Doctors typically fail to bring up an older patient’s smoking at a routine checkup, often because both the patient and doctor believe that these smokers would not be able to stop smoking after so many years of the habit and because it’s assumed that many past years of smoking have produced irreversible damage,” says James A. Bergmann, who heads up the National Center for Tobacco-Free Older Persons, at the Center for Social Gerontology in Ann Arbor, Michigan. In fact, twenty-four hours after a last cigarette, the chance of having a heart attack decreases, within three months of stopping smoking, circulation improves and lung function increases up to 30% and in 1 to 9 months, coughing, sinus congestion, shortness of breath and fatigue all decrease.²⁰

The numbers of older smokers underscore the seriousness of the issue. Over 70% of the over 430,000 smoking-related deaths each year are in people over age 65, according to the Center for Social Gerontology. In addition, all the major causes of death among the elderly are associated with smoking or secondhand smoke — cancer, heart disease, and stroke. Smoking is also the number one cause of fires that kill older persons.²¹

Smoking cessation efforts targeted at the elderly remain low despite a 1990 study published in the Journal of the National Cancer Institute that found that older smokers who attempted to quit were more likely to be successful at quitting than younger smokers.²² Currently, smoking cessation treatment is not covered by Medicare but a demonstration project being conducted by the Centers for Medicare & Medicaid Services in seven states through 2004 could result in Congress adding the benefit to Medicare if the pilot, which includes counseling and coverage for prescription products, is successful at getting older smokers to quit.²³

EXERCISE

Exercise is another prevention intervention frequently overlooked in the elderly. Yet, research from the Centers for Disease Control and Prevention has found that physical activity can have an impact in just about every area of an older person's life. Regular physical activity substantially delays the onset of functional limitations and loss of independence. It has been reported that inactive, nonsmoking women at age 65 have 12.7 years of active life expectancy, compared with 18.4 years for highly active, nonsmoking women.²⁴

A report from the CDC shows few older Americans reach the minimum recommended 30 or more minutes of physical activity on five or more days a week. About 28 to 34% of adults aged 65-74 and 35 to 44% of adults age 75 are inactive, according to the report.²⁵

The U.S. Preventive Services Task Force recommends regular physical activity, especially balance exercises, for the prevention of falls. One study reported a 58% reduction in falls among older women who began an exercise program.²⁶ The American Academy of Rheumatologists recommends physical activity in the management of arthritis. One study reported that regular walking reduced pain and improved function among people with osteoarthritis in their knees.²⁷ Physical activity often reduces the symptoms of depression according to a study that found strength training was as effective as medication in reducing depressive symptoms among older adults.²⁸

MENTAL HEALTH

Mental health is another area where the health needs of older Americans remain grossly unmet. Chronic depression affects 15 out of every 100 adults in the US. The disorder affects a much higher percentage of those older people found in hospitals and nursing homes. Untreated depression can lead to disability, worsened symptoms of other illnesses and lead to premature death.

Older Americans commit suicide at a rate that is four times the national average, yet too many physicians and psychologists believe that late-age depression and suicidal statements are normal and acceptable in older patients. Seventy five percent of older adults that commit suicide do so within four weeks of seeing their primary care physician, and 39% do so within the same week, clearly demonstrating a discrepancy between the mental healthcare that is needed and what is actually initiated by primary care providers.²⁹

A study funded by a grant from the Center for Mental Health Services found that 18 to 25% of older Americans are in need of medical care for depression, psychosomatic disorders, adjustment to aging, schizophrenia and anxiety. But less than 3% of Medicare reimbursement is spent on psychiatric care of the elderly.³⁰

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A recent study showed that aggressiveness of ICU therapies such as mechanical ventilation, pulmonary artery catheters and hemodialysis decreased progressively by age. However, multiple studies have suggested that age should not be the deciding factor for treatment decisions in the ICU.

PROVEN BENEFITS OF TREATMENT FOR OLDER PATIENTS OFTEN IGNORED, LEADING TO INAPPROPRIATE TREATMENT

Inappropriate treatment of older Americans appears to be common in just about every medical discipline. “When we see disease,” says Brown University’s Dr. Besdine, “the goal must be to identify the cause of the function lost and to apply the best treatment for that individual patient.” Evidence abounds that show less than aggressive tendencies of doctors to utilize treatments when compared to tactics used in similar cases with younger patients.

Many surgeons decline to operate on older patients who could greatly benefit from that surgery even though studies point to a benefit. One study from the Mayo Foundation found that people 100 and older who do not have life threatening diseases can undergo surgery without increasing their immediate risk of death.³¹

Coronary heart disease is the leading cause of morbidity, peaking in prevalence and incidence at age 65 and older, yet patients of this age are less likely to receive medications to reduce heart attacks, such as beta-blockers, aspirin, and clot-dissolving drugs.³²

A study at the University of Wisconsin revealed that patients over the age of 75 were one-third less likely to receive aggressive radiation or chemotherapy than younger patients. A study in the Archives of Surgery points out that women with Stage III colon cancer were less likely to receive chemotherapy. Of the reasons cited for not prescribing the treatment, in 34% of the cases the physician simply did not offer it, while in 20% of the cases it was because the physician thought the patients were too old.³³ This indicates a clear ageist bias on the part of medical providers.

In a study of 146 patients with ovarian cancer at the Memorial Sloan-Kettering Cancer Center in New York, only 29% of all patients over the age of 65 received aggressive treatment, while 63% of the younger patients were given such treatment. While some of the patients who did not receive the treatment were too frail, 25% were capable of undergoing the procedure but were never considered by the physician, regardless of the evidence that supports a better response to treatment in older patients with some cancers because of less aggressive tumors.

Doctors take more radical measures with older patients with breast cancer and are less likely to strive to preserve breast construction. Surgeons recommend a radical mastectomy in almost 40% of patients age 59 and older, but only 11% of the time for cases of women under the age of 31. Doctors offer breast reconstruction to 96% of younger patients but to only 70% of those patients over the age of 59.³⁴ Less than one-fourth of patients over 65 receive chemotherapy in conjunction with surgical treatment, and even more striking, in cases where chemotherapy was clearly appropriate, only 25% of older patients were prescribed the treatment.³⁵

Older patients also receive less aggressive care than younger patients while they are in the intensive care unit (ICU) in the hospital. Age-bias against use of life-saving therapy, such as thrombolytics for heart attack, appears to be an ongoing component of medical decision-making that is often not supported by research.³⁶ A recent study showed that aggressiveness of ICU therapies such as mechanical ventilation, pulmonary artery catheters and hemodialysis decreased progressively by age. However, multiple studies have suggested that age should not be the deciding factor for treatment decisions in the ICU.^{37 38 39}

Treatment gaps for older Americans may be best highlighted by a recent study in the American Journal of Public Health, which found that

many older Americans frequently seek care in hospital emergency rooms, often for serious medical problems that could have been prevented or handled during a routine office visit.⁴⁰

In too many instances, American healthcare is clearly not meeting the needs of elderly patients. Older patients are often either virtually ignored by physicians or must suffer inappropriately aggressive treatment. Both extremes represent a significant dearth in understanding of how to manage and treat the complex health needs of our rapidly expanding population of older patients.

OLDER PATIENTS ARE TOO OFTEN LEFT OUT OF CLINICAL TRIALS FOR NEW TREATMENTS

It is estimated that one in every four people taking prescription and OTC drugs is over the age of 65, yet participation by older adults in clinical trials of all types is alarmingly low. A recent report from the International Longevity Center-USA states, “40% of clinical trials between 1991 and 2000 explicitly excluded people over 75 from participating.”

“People aged 65 and older are woefully under-represented or even excluded from clinical trials, which evaluate the safety and efficacy of drugs and treatments,” Dr. Butler, president and CEO of the ILC-USA states in their recent report. “This can result in adverse drug reactions, inappropriate dosages or treatments and the misperception that older people cannot tolerate or benefit from new drugs and procedures.”

Despite the fact that heart disease is the number-one killer of older patients, a 2002 Duke Medical Center study revealed that, of a database of 15,000 patients that compares the effectiveness of aspirin versus new drug treatments to dissolve blood clots, only 11.3% were age 75 or older. Duke researchers also found that only 2%

of all clinical trials of procedures to unclog blocked arteries included patients over the age of 75. In other instances of heart disease treatment trials, there was not a single person age 65 or older involved.⁴¹

Age is the most consistent and strongest risk factor for cancer. Yet a study published in the New England Journal of Medicine found that while 63% of all cancer patients are age 65 and older, only 25% of patients included in clinical trials fall within that same age bracket. Most cases of colorectal cancer occur among older people, which is incongruous with the fact that little more than a third of the patients involved in treatment research are above the age of 65. Over half of the cases of breast cancer are older women, yet only 9% of the patients involved with clinical trials to treat the disease.⁴²

In a review of 19 clinical trials conducted between 1990 and 1999 for statin drugs to treat high cholesterol, a common problem in older adults, none of the trials enrolled patients who were over 75 years old. Since statin drugs, while effective, can also have rare but serious adverse events including risk of serious liver damage, researchers say it is important to have clinical trials on which to base treatment strategies.⁴³

The NEJM study found that reasons for low enrollment rates in clinical trials among the elderly include patient and provider misconceptions about the benefits of such treatments for older patients. A study published in the Journal of Clinical Oncology found that 50% of oncologists surveyed determine a patient to be ineligible for clinical trials on the basis of age alone. Additional reasons for leaving older patients out of trials can include coexisting medical problems which can conflict with trial eligibility or make trial participation cumbersome for older patients and logistical barriers such as problems with transportation including distance and cost, and difficulties with physical access to a testing site.

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“The basic problem is that if one wants to learn about the effects of a new treatment in older patients, it is necessary to study a sufficient number of older patients to be able to draw valid conclusions,” says Dr. Richard Schlisky, vice chairman of the Coalition of Cancer Cooperative Groups. “Ideally, a trial would enroll patients of all ages to be able to compare the groups...[but] the accrual of older patients is almost always far below expectations...the only solution we have found for this is to design trials that enroll only older patients...but comparisons with younger patients cannot be made [for treatment decisions] and must instead be inferred from comparison with other studies...”

Without an understanding of how a drug will behave in the human body, the likelihood of administering an improper dosage or producing adverse drug reactions, spike to unacceptable levels. It refutes logic that the largest group of prescription drug users should be one of the groups that is most discriminated against in medical studies.

Aside from the ethical implications it presents, the exclusion of the elderly in clinical studies brings on great economic cost to a medical system already taxed and unprepared for the demand that the nation’s aging population imposes. Without a more comprehensive outlook on drug development, the healthcare system will continue to spend the \$177 billion a year in medical costs, a figure that will only continue to rise as the nation’s aging population grows.

Our nation’s aging population grows larger with every passing year and the problem will only worsen as time progresses. Participation of the elderly in clinical drug tests is absolutely necessary to enhance our healthcare system and ensure the quality and safety of the care given to elderly patients.

COST-EFFECTIVENESS OF UNDERUTILIZED INTERVENTIONS IN THE MEDICARE POPULATION

The U.S. Public Health Service Panel on Cost-Effectiveness in Health and Medicine recommended that reference case analyses use “cost-utility analysis,” in which cost-effectiveness ratios are presented in terms of costs per quality-adjusted, life-years (QALYs) gained. In the following chart provided by Peter Neumann Sc.D., of the Harvard School of Public Health, the cost effectiveness of certain interventions are estimated.

The estimates in this table are intended to provide a rough guide to cost-effectiveness and percent implementation. However, study methodology for estimated cost-effectiveness often varies across analyses. Moreover, cost-effectiveness may depend on factors such as the age and gender of the population, and the particularly screening and technologies used.

Note that some interventions in the table may save money – i.e., the intervention in question such as antidepressant medications itself costs money but there are offsetting costs such as hospitalizations avoided downstream that may be greater than the intervention costs. Other strategies might be considered cost-effective in the sense that they are more costly and more effective, but society is willing to pay for the quality-adjusted years of life gained or other health outcomes produced. While there is no accepted U.S. standard for what constitutes “good value for money,” cost-effectiveness ratios under \$50,000 per QALY are said to offer good value for money. All the interventions in the table above would be cost-effective by this standard.

Health intervention	Cost-Effectiveness (\$/QALY)	% Implementation in Medicare population
Mammogram	\$10K to \$20K/QALY	75% (depending on age)
Colon cancer screening	\$10K to \$20K/QALY	20-40% (depending on age)
Annual eye exam	Cost saving	50-60%
Osteoporosis screening	\$10K to \$20K/QALY	35%
Influenza vaccine	Cost saving to \$10K/QALY	40-70%
Pneumococcal vaccine	Under \$10K/QALY	55-60%
Hypertension control	\$10K to \$50K/QALY	35%
Beta blocker treatment after myocardial infarction	\$3K to \$10K/QALY	85%
Antidepressant medication management	Cost saving to \$25,000K/QALY	40-55%

Data compiled by Peter Neumann ScD, Harvard School of Public Health

RECOMMENDATIONS

Now is the moment for the U.S. to take an active, more realistic role in confronting and preparing for the issues that the aging of the U.S. population raises. It is imperative that sensitivity and awareness to ageist bias be recognized and combated among healthcare providers and educators, in all segments of the healthcare system from insurance to care management organizations, among the public, in Congress and all regulatory and financing agencies of government, to better prepare for what lies ahead.

1. Increase Training and Education of Healthcare Providers and Research into Aging

If access to physicians and healthcare personnel with formal training in geriatrics were more

widely available, older people would benefit from improved health status, enhanced personal independence and a substantially lower rate of institutionalization. The result would be a healthier population of older Americans, lower medical, social service and long-term care costs and, a more vital, financially secure population of older Americans in the 21st Century.

The current geriatrics training curricula and faculty capacity in most health professions schools is far from adequate. The training infrastructure needs to be enhanced so that every physician, nurse, pharmacist, and allied health professional receive appropriate exposure to geriatrics as part of their training or residency experience. Certainly not every older patient needs to receive his or her primary care from a geriatric specialist. But it is important that every healthcare provider

Without a more comprehensive outlook on drug development, the healthcare system will continue to spend the \$177 billion a year in medical costs, a figure that will only continue to rise as the nation's aging population grows.

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who treats elderly patients should have some specialized training.

These improvements must be extended to all levels of healthcare, including psychologists, physical and occupational therapists, social workers, nurses, and other healthcare professionals. Geriatrics competency and knowledge should be part of licensing and credentialing examinations wherever appropriate. Federal dollars should leverage other sources of support for strengthening academic training programs and faculty in geriatrics, in a multidisciplinary setting where older patients can receive optimal care and research can be conducted. Medical schools should institute rotations to ensure that all medical students see not only the frail and sick that need treatment, but also the results and benefits of maintaining health and independence in older people to help dispel ageist myths that undervalue the care and rehabilitation of older patients.

Pursuing a career in geriatrics should be made more attractive to young healthcare professionals. The U.S. should adopt strategies that target financial incentives, such as education loan repayment programs to encourage students to enter into the field of geriatrics. Just as important will be continuing education and other programs to imbue geriatric training in practicing health professionals. By reducing the income disparity between geriatricians and other specialties, a career in geriatrics would appear to be a more viable and lucrative career path for prospective young professionals. This goal could be partly achieved by enhancing reimbursement for the extra time a geriatrician spends in assessing geriatric cases and in managing a multidisciplinary geriatric healthcare team. Appropriately enhancing the value of geriatric interventions in Medicare would likely affect the quality of care in all health programs, including privately insured care.

It is especially important that the U.S. must devote sufficient resources to fund geriatric research and centers to develop a critical mass of academic faculty grounded in geriatric diagnosis, practice and rehabilitation techniques.

Just as important, the nation should commit greater attention and resources to the scientific research required to delay or eliminate some of the diseases of aging. Understanding the biology of aging and how to delay chronic illnesses will help find solutions to extend the independence of older patients and to offset the rapidly increasing medical costs that challenge current budgets and the financing of healthcare in the future.

Extended research efforts will help generate the interest of universities and other learning institutions further increasing awareness of issues in aging among the academic and medical communities. New discoveries in the science of aging from public institutions, and private “gero-technology” and biotechnology ventures, have great potential to improve the older person’s quality of life, provide the means to reduce disability and dependence in old age, while decreasing the burdens on a healthcare system strained at its limits.

2. Inclusion of older patients in clinical trials

Older Americans should be made aware of the availability of experimental new drug trials and Medicare should facilitate their participation. Recruiting older people as participants in clinical trials can be a complex and difficult task. Nonetheless, the FDA should encourage that additional Phase IIIB studies be conducted by pharmaceutical companies to identify actual and potential medication-related problems and limitations of medications that will be used frequently by older persons, particularly the oldest old and persons residing in long-term care facilities. Clinical trials should include identification of

outcomes that can be particularly relevant to the elderly population, such as effects on cognition, mood, or gait stability. It is important to include frail and vulnerable older persons as well as women and ethnic and racial minorities so that mediations to be used by these groups will have been tested on people like themselves. To produce the necessary incentives, a range of inducements from special allowances for labeling to extensions of patent life for the medications being studied, similar to what has been done to encourage pediatric drug research, should be considered by policymakers.

Healthcare providers should be educated on the benefits and success rates of treatments among elderly patients to further their inclusion in medical studies. The medical research in clinical trials should be translated aggressively into practice in order to make available more appropriate treatment options for older patients.

3. Utilization of appropriate screening and treatment methods

Despite some preventive measures now covered by Medicare, older Americans still face hurdles to optimal health promotion due to endemic ageist biases, especially in the form of prevention and screening methods. Prevention is the first step in the treatment of any ailment and is, perhaps, the most easily accomplished.

Education is critical, for both patients and physicians, to heighten public awareness of the availability and consequence of screening procedures. Patients must be better informed on the necessary screenings and treatments and on the availability of financial assistance from Medicare and private insurance. Family members and caregivers must also be educated on the availability and importance of screening to understand that many health problems common to older people can be prevented or greatly delayed if the proper measures are taken. The empowerment of

patients and caregivers will also ensure that older patients receive these screenings.

Advocates for better healthcare for older persons should also work alongside the U.S. Preventive Services Task Force to establish outreach programs to better educate the public on screening recommendations and to help demonstrate to healthcare providers how best to administer preventive screening.

4. Empowerment and education of older Americans

As patients, older Americans are often harmed by an underlying prejudice against the old, but they also carry that bias themselves to their own detriment. The evidence appears in multiple surveys as well as anecdotally: older patients are likely to neglect bringing health problems to the attention of their care providers, chalking symptoms up to old age. Passivity, stoicism, embarrassment and — most of all — incorrect assumptions about aging get in the way of patients reporting difficulties with mobility, hearing, sleeping, sexual dysfunction, incontinence and pain among other conditions. Older people may be influenced by their own recollections from years past how their elders endured the “vicissitudes of aging.” This may be an understandable point of reference for some, but is not a realistic guide for what to expect from American healthcare in the 21st Century.

A study of older people with cancer in New Mexico found that 1 in 5 patients put off going to a doctor for at least four months after noticing their symptoms. The researchers concluded that this resulted in more advanced disease upon diagnosis and deadlier outcomes. The reasons for such passivity, even in the face of a deadly disease, are still under study. However, older people, when asked, are likely to say they did not think the doctor could help, or that they did not want to bother their doctors with their complaints.

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In their highly regarded book *Successful Aging*, Drs. John W. Rowe and Robert L. Kahn cited several aphorisms in the American language that bespeak these ageist myths, and which in the context of healthcare are downright dangerous. Those attitudes include passive acceptance of health problems that could otherwise be successfully addressed (“To Be Old Is To Be Sick”), the belief that older people cannot or will not make positive healthy changes in their lives (“You Can’t Teach an Old Dog New Tricks”), and the damage done by time to body and mind is irreversible (“The Horse is Out of the Barn”). Drs. Rowe and Kahn, leaders of the McArthur Foundation Research in Successful Aging Project, exposed these and other ageist myths with research suggesting that humans possess far greater powers for health, resilience, adaptability and positive change than is often assumed by health providers and older patients alike.⁴⁴

It is also important that older Americans are aware that healthcare delivery in the U.S. is flawed by ageism and be advocates within the system for quality care. Many ailments that older patients face are not inevitable and do not naturally come with aging, nor does having to tolerate shoddy care at the hands of those who underestimate human potential. With an increased public awareness, systematic change toward improvement will more likely occur. As the nation’s aging population grows larger with every passing year, it becomes increasingly vital that patients educate themselves and that the medical community as well as policymakers seek improvements to ensure long, healthy, active and satisfying lives for our people.

THE HUMAN COST

Mrs. B is a woman in her middle 80s, and was enjoying her winter vacation in Florida with her husband when she fell and broke her hip. The hip was repaired surgically and she was discharged from the hospital within a couple of weeks. A team of three home care professionals – a home care specialist, a doctor, and a physical therapist – supervised her further rehabilitation at her winter home.

Once she and her husband returned to their home in New York in the spring, Mrs. B was recuperating well, using a walker to move around. On May 29, 2002, she walked into her kitchen and reached for a chair for balance. She missed the chair and fell, breaking her other hip.

She again underwent surgery, this time in the hospital near her home in New York. Shortly after the surgery, she was transferred to a rehabilitation facility, where she and her husband expected her recovery to proceed similarly to the earlier incident. She was treated for bed sores she contracted in the hospital, but remained bedridden for weeks.

Finally in August, concerned over the progress of his wife's recovery, Mr. B questioned why she was

still in bed. The nurses and the supervising physician gave conflicting accounts over whether the doctor had authorized Mrs. B to carry weight on her injured hip. Regardless of whether the doctor had authorized the change in treatment in July as he claimed, it was clear he had not followed up to check on her progress.

The bed sores and the muscle deterioration from her lack of motion impeded Mrs. B's further progress. Eleven months after the incident, Mrs. B was still in the rehabilitation facility and Medicare was no longer paying for her care because of the length of time she had been in treatment. The couple was paying about \$7,000 per month out of pocket.

When Mr. B asked staff at the rehabilitation facility what would happen if he could no longer pay the monthly expenses, he was told that Medicaid would take over. Once well-positioned financially, the couple enjoyed dancing and traveling together. Now they face a major lifestyle change with continued rehabilitation at home and the potential loss of their financial independence as a result of Mrs. B's prolonged recovery.

Mrs. G is an 82-year-old woman who lived alone, worked at a hospital three days a week, and drove herself wherever she wanted to go. She was at her home in Arkansas when she fell and hit her head. At the hospital after the fall, she was evaluated and her family was told that she could have Parkinson's Disease. Doctors said that the disease is difficult to diagnose, so they would give Mrs. G medication and see how she responded.

For the first two or three days, her condition seemed to be improving. However, after that point it began to deteriorate quickly. She was in a wheelchair and if she tried to stand, she would stiffen and lose her relationship to the space around her. She often felt as though she was falling.

Hospital personnel responded to the worsening of her condition by increasing her medication. She was on progressively higher doses for more than six weeks while in a rehabilitation facility. She was so heavily medicated that she was no longer lucid and often hallucinated. When her

daughter asked to speak to doctors about her treatment, her request was denied. She was told by hospital staff that Mrs. G was being treated by a team of doctors who were doing what they felt was best.

A nurse at the hospital where Mrs. G was being treated told her daughter about a geriatric specialist, affiliated with a different hospital, who was considered to be an expert. Mrs. G's family met with the doctor, who reviewed her medical records and recommended that she be removed from the facility she was in and taken off the medication. He said he did not believe she had Parkinson's Disease, and he agreed to take her on as a patient of his own.

The specialist performed numerous neurological tests and determined that the medication Mrs. G had been on had caused a series of strokes that had done irrevocable harm to her brain. She continues to suffer strokes and is not expected to fully recover.

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