

Are we stereotyping our elderly patients?

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Introduction

Although nurses may think they do not practice ageism – discrimination on the basis of age – this article presents four case studies which demonstrate that they may be doing just this, albeit unintentionally. Each case concerns a person with diabetes who had been allocated by the DSN to group insulin education because of the urgency of starting insulin therapy. In each case the DSN's assumptions about the individual's ability to assimilate information in a group setting proved wrong. The case studies suggest that the ability to learn new skills is not necessarily influenced by age or intelligence. The DSN acknowledges that she was guilty of ageism and has resolved to address it in future.

Ageism has been defined as 'discrimination against someone on the grounds of age' (Blytheway, 1995; Watson, 2001). Do we in the nursing profession practice this?

We are all aware that ageism exists, especially in relation to employment, advertising and in everyday life (Carrigan and Szmigin, 2000), but would like to think that we not to practice it ourselves. However, I think we do, albeit not intentionally.

Background

Approximately 8 million people (16% of the population) in the UK are aged over 65 years, with 7% over the age of 70 (Croxson, 2002). Ten per cent of these elderly people have diabetes (Croxson, 2002). Interestingly, in 1901, life expectancy was 45 years for males and 48.7 years for females but the predicted life expectancy for 2010 is 77.3 years for males and 81.4 years for females. (Government Actuary's Department, 2001). However, whilst in the modern world many people are now living into their eighties and nineties, the birth rate is actually falling (Watson, 2001).

Tinker (1996) could not identify a reason for the increase in life expectancy but Watson (2001) felt it could be due to advances in medicine and surgery, antibiotics, improved sanitation and better nutrition. On the other hand, old age and

diabetes together bring their own problems, with an increased risk of vascular dementia and, more recently, a link between type 2 diabetes and the risk of developing Alzheimer's disease (Kerr, 2004).

Determinants of learning

Poon and Siegler (1991), state that older people use crystallised intelligence in problem solving and also learn to adapt alternative strategies as they get older. Watson (2001) discusses the ageing brain in more detail and states that personality is mainly genetically determined, but memory is complex and follows a three-stage process of sensory memory, short-term memory and long-term memory. He goes on to say: 'In normal ageing, there is little change in sensory and long-term memory and only a minimal, but detectable, decline in short-term memory.' He further defines intelligence as having two components – fluid and crystallised – which are similar to wisdom and the ability to solve problems. This appears to clarify the findings of Poon and Siegler (1991). The International Labour Organisation (1992) also felt that the elderly are capable of learning, which is something that may be overlooked when health professionals educate older people.

Educating on starting insulin

At the diabetes centre where I work, we hold group insulin education sessions for

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- 1 This article proposes that nurses may be stereotyping older people, albeit unintentionally.
- 2 Four case studies of people with diabetes receiving insulin start education in group sessions because of the urgency of treatment are presented as evidence.
- 3 These studies suggest that an individual's ability to learn new skills is not necessarily influenced by age or intelligence.
- 4 The DSN's initial assumptions that the two older patients would not be able to assimilate information in the group setting, and that the two 'professional' patients would find it easy, proved wrong.
- 5 The DSN recognised that she had been guilty of ageism towards older people, and resolved to address the issue in future.

KEY WORDS

- Starting insulin
- Older people
- Education
- Ageism

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- 1 In the diabetes clinic where the author works, insulin start education is offered in either group sessions or on an individual basis.
- 2 Ideally, the DSN sees patients in the clinic to assess which form of education is best for the individual patient.
- 3 Long waits for a clinic appointment and the need to start insulin urgently mean that patients are sometimes assigned to group sessions when individual tuition might have been the better option.
- 4 However, which form of education will work best with individual patients may not be evident until the day they attend for tuition.
- 5 These cases show that the elderly are capable of learning new skills, and that nurses should not assume that elderly people will necessarily need one-to-one education.

people about to commence insulin therapy, but also see patients on an individual basis. If possible, patients are seen in clinic to assess their suitability for group education or whether they need to be seen on an individual basis. However, because of the long wait for clinic appointments, this is not always possible; also, the decision can only be made on the information provided by the referring doctor, which is usually very limited and invariably never identifies the patient's educational status.

The decision to allocate patients to receive education in a group session or individually is based on the following factors (in no particular order):

- Age
- Assumption of how the individual would be able to assimilate information in a group setting
- How urgently the individual needs to commence insulin therapy.

Sometimes patients are inappropriately placed in a group session when they should really have been seen on an individual basis, but this may not be evident until the day they attend.

Case studies

In the following case studies, the allocation of group session was based on the urgency of the change in treatment. These case

Case study 1

Stuart was diagnosed with type 2 diabetes in 1991 and had been referred for insulin therapy by the hospital consultant. He was retired and had been a widower since 1992, but had a very supportive family. Between 1992 and 1997 he lost five members of his family, including his son who committed suicide.

He attended a group insulin start session with three other patients and their relatives, where he was taught the practicalities of insulin administration including self-adjustment of his insulin doses.

Within two weeks, Stuart was self-caring with telephone support from the DSN, and was eventually discharged to the care of his practice nurse.

Case study 2

Peter was diagnosed with type 2 diabetes in 1993 and had been referred for insulin by his GP. He was a 66-year-old company director and lived with a partner but no children.

He also attended an insulin start session, without his partner but with another patient, where he was taught the practicalities of insulin administration including self-adjustment of his insulin doses.

He was in constant telephone contact with the DSN every three to four days, needing constant reassurance. Dietary advice was repeated several times, as was the need to regularly test blood glucose. He needed constant encouragement to self-adjust and was seen again in clinic to go through the practicalities of insulin administration and self-adjustment.

Telephone contact reduced after three months and he was eventually referred back to his practice nurse 10 months after starting insulin.

Case study 3

Susan was diagnosed with type 2 diabetes in 1996 and had been referred for insulin by her GP. She was a 50-year-old teacher and happily married.

She was seen with her husband and was taught the practicalities of insulin administration, including self-adjustment of her insulin doses.

When she was seen two weeks later to commence insulin therapy, she appeared to have retained a lot of the information provided at the previous education session. She also had the support of her friend, who was a paediatric nurse.

Initially Susan was in telephone contact with the DSN almost every other day, but this eventually settled to a weekly contact. At every contact, information had to be repeated regarding diet, blood glucose monitoring and insulin administration, and she was seen again in clinic for one-to-one education.

Fourteen months later she was referred for continued care under the supervision of her practice nurse.

Case study 4

Mabel was diagnosed with type 2 diabetes in 1994 and had been referred for insulin by the hospital consultant. Mabel is 72 years old, happily married and has one daughter.

She was seen in a group with her husband and daughter and another patient who also had her husband with her. Mabel has a hearing problem and also suffers from glaucoma, but her husband is very supportive and wants to encourage her to do everything herself, using himself as 'back-up'.

All the patients and respective carers were seen the following week, and Mabel, despite being very apprehensive, administered her insulin perfectly. During the course of the morning her daughter continually berated her mother and father, saying they forget things and would not be able to manage.

At present, Mabel is receiving weekly telephone contact, having only started insulin in June 2004, and both Mabel and her husband are doing very well. Mabel's husband is supervising self-administration of insulin and is adjusting her insulin doses as required.

studies highlight the problem of ageism from both the diabetes specialist nurse (DSN) and the relatives of patients. The author personally saw each of the patients for education about transfer to insulin therapy.

Conclusion

Although these cases are just a small random sample and therefore open to criticism, they suggest that an individual's ability to learn new skills is not necessarily influenced by age or intelligence.

Indeed Peter (case 2), a 66-year-old company director, continued directly under the care of the DSN for 10 months after commencing insulin. It could be argued that he was 'too busy' to take on board the information or that he did not consider his diabetes to be as important as his work. However, from personal involvement with Peter, I feel that this was not the case – he

just could not grasp the essentials of insulin administration. A similar situation was seen with Susan, who was also a professional person – a teacher.

Interestingly, both Stuart (case 1) and Mabel (case 4) were elderly people who appeared to understand insulin administration and managed their regimen exceedingly well, despite being educated in a group session.

This may be due to the fact that they were older and realised that good health was very important at their time of life, enabling them to maintain an active lifestyle and stay independent. What was noticeable was how ageist Mabel's daughter appeared.

Because of the urgency of the insulin requirements, I assigned both Stuart and Mabel to a group session with trepidation, but my fears proved to be unfounded. I wrongly assumed that they would not be able to assimilate the information provided within a group setting. I also felt that the pace may be too fast, and this too proved to be untrue.

In relation to the 'professional' patients, I again wrongly assumed that they would easily assimilate the information and that the pace of the session would be well within the time limits allowed, but in fact we overran by 45 minutes and both patients required intense follow-up.

Was I guilty of ageism? I think so, but following the research undertaken for this project I hope I can now address this issue. ■

In the interest of confidentiality, the patients' names have been changed to protect their identity.

Blythway (1995) *Ageism – rethinking ageing*. 1st Edn. Open University Press, Buckingham
 Carrigan M, Szmigin I (2000) Advertising in an ageing society. *Ageing and Society* **20**: 217–34
 Croxson S (2002) Diabetes in the elderly: problems of care and service provision. *Diabetic Medicine* **19**(Suppl 4): 66–72
 Government Actuary's Department (2001) Figure 7.1 Expectation at birth: by sex, United Kingdom. (Available from www.statistics.gov.uk/STATBASE/Expodata/Spreadsheets/D7420.xls)
 International Labour Organisation (1992) An active future for older workers. *ILO Information* **28**(1): 4
 Kerr D (2004) Diabetes and old age: who cares? *Diabetes Digest* **3**(1): 6
 Poon LW, Siegler IC (1991) Psychological aspects of normal ageing. In: Sadavoy J, Lazarus LW, Jarvik LF (eds). *Comprehensive Review of Geriatric Psychiatry*. American Psychiatric Press, Washington: 117–45
 Tinker A (1996) *Older People in Modern Society*. 4th edn. Longman, London
 Watson R (2001) Old age: mind, body and spirit – the biological stages of ageing. *Journal of Community Nursing* **15**(4): 24–28

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1 Stuart and Mabel were elderly people who appeared to understand insulin administration and managed their regimen exceedingly well, despite being educated in a group session.

2 This may be because they were older and realised the importance of good health at their time of life, enabling them to maintain an active lifestyle and stay independent.

3 In contrast, Peter and Susan, both of whom were younger, and 'professional' people, took much longer to grasp the essentials and required DSN and telephone support for much longer.

4 These case studies provide evidence of ageist attitudes towards older people from both the DSN and a relative (Mabel's daughter).

5 They also highlight the importance of not stereotyping older people regarding their ability to learn new skills.