

Brief Communication

Sri Lankan medical officers' attitudes towards the elderly: a pilot study

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Abstract

Ageism among doctors influences treatment options and care of the elderly. Attitudes of Sri Lankan doctors towards the elderly have not been studied previously. This descriptive cross-sectional study using Fraboni's scale of ageism explored doctors' attitudes towards older people in three selected hospitals in Sri Lanka and the relationship of such attitudes with demographic, employment, education and training-related factors. No association between the attitude of doctors toward the elderly and the factors studied in this pilot study were found.

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Introduction

According to the World Health Organization, the "elderly" are people above the chronological age of 60 years [1]. Ageism has been defined as stereotyping, prejudice and discrimination against people on the basis of their age. Ageism is being increasingly recognised among doctors [2]. A Singaporean study, looking at the attitudes of doctors to the elderly had reported that a majority of the participants agreed that they would be less inclined to treat patients if they were older [3]. Samra *et al.* highlight that the demographic and background of the medical students and doctors play a role in their attitudes towards older people [4]. They also report that negative emotional attitudes of doctors to the elderly are related to inadequacies in their training as well as system issues, such as the organisational context of care.

It is projected that 28% of the Sri Lankan population will be 60 years or older by the year 2041 [5]. Sri Lankan doctors will not only need theoretical skills to meet this challenge but also need to have suitable attitudes towards this group of patients if they are to provide the best possible care.

Fraboni's Scale of Ageism (FSA) is a 29-item, self-administered questionnaire developed to assess ageism [6]. The response to each item is recorded on a four-point Likert scale. FSA can be used to evaluate multiple dimensions of ageism, particularly its affective component [7]. FSA has been used to assess ageism among different groups, including health care professionals [8,9]. Ageism among medical professionals working in the hospital setting has been assessed using the FSA in several studies worldwide [3,4,10]. To our knowledge, there is a scarcity of published studies in this area in the Sri Lankan context. Therefore, this study was designed to assess ageism among medical officers working in Sri Lankan hospitals. The objectives of the study were to determine ageism among medical officers, using the FSA, and to identify the relationship between the level of ageism and several demographic, education, training and job related factors.

Methods

A descriptive, cross-sectional study was carried out using a convenient sampling method among consenting doctors of all grades attached to the National Hospital of Sri Lanka, Colombo, Colombo North Teaching Hospital, Ragama and the National Institute of Mental Health, Angoda. Ethics approval for the study was obtained from the Ethics Review Committee, Faculty of Medicine, University of Kelaniya.

Data was collected using a semi-structured questionnaire filled by the participant and the FSA [6]. FSA was chosen for our pilot study due to it being compatible with the theoretical framework of ageism. Even though the FSA has not been validated in Sri Lanka, it has been used in studies in several other countries with different cultural backgrounds [3,4,8,9,11].

The study was carried out over two months (Feb-April 2020). Data were analysed using SPSS version 21 and the Independent sample t-test and One-way ANOVA tests were used for the calculation of significance. Each of the 29 items of the FSA was scored from 1 to 4 to get a total score ranging from 29 to 116. Item numbers 8, 14, 21, 22, 23 and 24 were reverse scored as they are positive statements. The score was interpreted as higher the score, the greater the ageism [6,11].

Results

Of the 100 questionnaires distributed, only 74 medical officers responded and returned the questionnaires. The majority of them were in the age group of 30-40 years with almost equal gender distribution (Table 1). The FAS score ranged from 29 to 98 with a mean of 58.31.

Table 1 summarizes the association between the mean FAS score and several demographic, education, training and job related factors. There was no statistically significant difference between the mean FAS score and participants' age category or gender. Also, no statistically significant difference was found between the mean FAS score and factors such as the medical school from which the doctor graduated, seniority in the Ministry or involvement in postgraduate studies. Furthermore, medical officers who had working experience with the elderly were not found to have a significant difference in the

mean FAS scores when compared with those who did not have such experience. Medical officers who are considering or currently specializing in aged care did not have significantly less ageism (mean FAS score 59.2, SD=9.5) compared to medical officers who do not consider specializing in aged care (mean FAS score 58.6, SD=8.8).

Table 1: Participant characteristics and the corresponding mean FAS score (n=74)

Characteristic		Number (%)	Mean FAS score (SD)	p-value*
Age category	25-30 years	9 (12.2%)	59.4 (11.8)	0.703
	31-40 years	53 (71.6%)	57.6 (8.6)	
	41-50 years	11 (14.9%)	59.9 (14.0)	
	51-60 years	1 (1.4%)	67.0 (.)	
Gender	Male	38 (51.4%)	59.2 (9.9)	0.451
	Female	36 (48.6%)	57.4 (9.9)	
Years since graduation of doctors with no postgraduate training (n=30)	< 5 years	7 (23.3%)	56.7 (11.8)	0.485
	5-10 years	11 (36.7%)	57.4 (11.7)	
	> 10 years	12 (40.0%)	61.8 (7.6)	
Specialty of doctors with postgraduate training (n=44)	MD Pathology	1 (2.2%)	38.0 (.)	0.108
	MD Community Medicine	1 (2.2%)	67.0 (.)	
	MD Emergency Medicine	3 (6.7%)	59.3 (6.0)	
	MD Medicine	7 (15.6%)	56.1 (9.1)	
	MD Obstetrics & Gynaecology	2 (4.4%)	70.5 (10.6)	
	MD Paediatrics	4 (8.9%)	59.8 (13.0)	
	MD Psychiatry	23 (53.3%)	56.9 (8.4)	
	MD Surgery	2 (4.4%)	68.5 (9.2)	
	MD Venereology	1 (2.2%)	49.0 (.)	
Postgraduate years since graduation (n=14)	< 5 years	13 (92.9%)	55.6 (8.3)	0.251
	≥ 5 years	1 (7.1%)	66.0 (.)	
Predominately work with geriatric patients	Yes	13 (17.6%)	57.5 (10.7)	0.774
	No	61 (82.4%)	58.5 (9.8)	
Interest in Geriatrics (n=66)	Considering or currently specializing in aged care	10 (15.2%)	59.2 (9.5)	0.853
	Not considering specializing in aged care	56 (84.8%)	58.6 (8.8)	
Frequency of contact with elderly patients	More than weekly	40 (61.5%)	58.7 (9.1)	0.860
	Less than weekly but more than monthly	11 (16.9%)	60.0 (7.3)	
	Less than monthly	14 (21.5%)	59.8 (8.1)	

FAS = Fabroni's scale of ageism

* p-value ≤ 0.05 was considered as significant

Discussion

In this pilot study, we failed to find any significance between demographic factors or characteristics such as years since graduation, working in geriatrics, etc. with the mean

FAS score. However, studies carried out elsewhere report different findings. For example, a study among junior doctors in Singapore found that doctors who reported treating older adults to be unrewarding had a more negative attitude [3].

A review by Jacobson reported that negative attitude bias among physicians led to the non-prescription of statins to elderly patients who required it [12]. Peak *et al* state that negative attitudes towards older adults were considered as a cause for the large age-related differences in management and survival in patients with lung cancer [13].

Lueng *et al*, highlight the importance of exposing medical officers to healthy older people from an early stage in order for them to develop positive attitudes as opposed to them being exposed to only very ill and frail elderly patients [10]. Even though our findings are encouraging, medical teachers should continue to develop future doctors' attitudes towards the elderly. Further research including doctors from all sectors including consultants will help to provide more information regarding this important area.

Limitations

The negative findings in our study cohort may be due to the opportunistic methodology and convenience sampling of doctors. The study also had more doctors working in psychiatry than other disciplines. The other limitation may be that the FAS has not been validated in the Sri Lankan population. We also did not look into correlates such as the organizational context and the healthcare system which may have an effect on the doctors' attitude towards the elderly.

Conclusions

This pilot study with limited sample size and methodology sheds some light on the attitudes of a cohort of Sri Lankan doctors towards the elderly. Further research should be conducted to look into the generalizability of these findings as attitudes among healthcare professionals are vitally important in the optimal provision of health care services to the rapidly increasing ageing population in Sri Lanka and the ultimate goal of providing a better quality of care for our ageing population.

Statement of contributions

Conceptualisation, AH, KALAK, RF; Methodology, AH, KALAK, RF, GR; Data collection, RF, GR, NL, MF, IP; Data analysis, AH, RF, GR; Manuscript preparation, RF, GRAH, KALAK; Supervision, AH, KALAK

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