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Featured Article

# "With your age, what do you expect?": Ageism and healthcare of older adults in Spain

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ABSTRACT

*Introduction:* Ageism could influence the relationship between older patients' meeting needs and healthcare professionals' answers.
*Aims:* To highlight the experience of older adults with healthcare systems, how they perceive ageism from their healthcare providers, and to explore the relationship between perceived ageism and self-perception of aging (SPA).
*Methods:* We conducted an exploratory qualitative study. The participants were 14 women over 65 who lived alone in their homes.
*Results:* Professional responses ignored the expression of preferences of the older patients and excluded them from decision-making processes. These answers influenced older patients' use of health services. Moreover, the negative aspects predominated in a SPA influenced by the internalization of stereotypes and a relationship weighed down by ageist behaviors on the part of health professionals.
*Conclusion:* Explicit situations of ageism influence an imbalance in power relations between older patients and healthcare professionals, a misuse of health services, and a negative SPA.
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## Introduction

### *Aging: a challenge for healthcare systems*

The World Health Organization (WHO), in the World report on aging and health, claims that the population is aging faster than in previous years. The percentage of individuals over 60 is expected to double worldwide between 2015 and 2050, from 11% to 22%.[1] Considering these data, the population over 60 would reach 2 billion people worldwide, representing an increase of approximately 900 million compared to 2015.[1–4] These data indicate those older adults as a population segment of increasing dimensions. For this, health services have tried for years to adapt to changes in the progressively aging population's meeting needs, and healthcare professionals have also attempted to adapt to the greater use of the healthcare system made by older people.[1,4–7] However, there are times when healthcare professionals are insensitive to the specific needs of older adults.[8] Healthcare professionals can show, in those cases, negative attitudes toward older patients, influencing the care they provide and giving hostile responses.[9–12] These attitudes are also described, even among health sciences students.[9,13,14]

### *Ageism as a form of discrimination*

According to Butler,[15,16] ageism is defined as a type of social and interpersonal discrimination impregnated with stereotypes based on advanced age. This could be identified in a society or a group through specific characteristics such as prejudicial attitudes against the aged, old age, and the aging process, including attitudes held by the older people themselves; discriminatory practices against them, and the

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existence of institutional practices and policies which reproduce stereotypic beliefs about the older adults, deteriorate their quality of life and limit their dignity. Ageism has become a socially accepted discrimination that creeps into the health care of the older adult population, generally harming them.[11,17,18] Additionally, the organization of healthcare favors this discrimination. For example, one of the first data we look at to describe a patient is age, interpreting longevity as synonymous with frailty or comorbidity.[19] Although current estimations envision many cases worldwide, it is a huge challenge to know precisely the prevalence of ageism in our society, despite studies that strive to offer ageism measurement tools.[20–22] On the other hand, the systematic review by Chang et al.[23] has shown the effects that ageism causes on health and its prevalence, highlighting mainly the less educated older persons, who were likely to experience adverse health effects of ageism. These consequences cover a wide range of planes in the older person, from a negative structural impact in terms of a denial of access to health services or medical treatment, going through exclusion in the participation of experimental scientific studies, to the extent of prejudicial effects on individual health in biopsychosocial and relational spheres.[23,24]

### *Aging as a subjective process*

Otherwise, although the WHO gives a biological perspective in defining aging, these changes are not linear or uniform and are accompanied by other essential modifications in each subject's roles and social position.[1,25] Considering the above, we can say that aging has the characteristic of universality; that this vital stage could be described as a complex and dynamic process in which all kinds of components intervene, physiological, psychological, and sociological; and consequently, there are objective and subjective components in aging.[26,27] From an objective aspect, it can be understood that aging begins from birth and is associated with advanced-age people. From a subjective element, all the individual's thoughts and feelings regarding aging must be considered because each person will live and experience this process differently. For this reason, the self-perception of aging is meaningful.[25,28–30]

### *The importance of self-perception of the aging process (SPA)*

SPA refers to how individuals perceive their own aging process, not the aging process in general. This concept is very subjective and varies from person to person. This self-perception will be determined by a series of expectations acquired, on the one hand, throughout the life that precedes old age, on the other hand, throughout the encounters that occur in everyday life during old age.[31] This SPA can be positive or negative, which in turn can cause positive or negative consequences for the health of older people.[32] For instance, older people with more positive self-perceptions of aging at baseline maintained better functional health throughout a longitudinal study and lived longer than those with more negative self-perceptions of aging.[31] At the same time, it has been shown that a SPA based on age stereotypes predicted a worsening in the health of older people.[33] Beyond this, in industrialized countries, it has come to be imposed that aging is equivalent to disease or deficit.[1,34,35] Regarding this social imaginary, the Stereotype Embodiment Theory (SET)[32] illustrates how people can internalize age discrimination, thus affecting SPA by unconsciously acquiring stereotypes through continuous and silent exposure to ageist messages that society sends through the institutions, social media, or education. These messages affect various physiological, psychological, and behavioral outcomes, thus influencing the way older people use health services.

Finally, and as is made clear in the Global Report on Ageism,[36] investigating and addressing age discrimination is vital to creating a world in which the dignity and rights of all human beings are respected. In the healthcare world, it has become even more relevant. In line with the WHO's report for the decade of healthy aging 2021–30,[37] this study aims to join efforts posing the following objectives: to highlight the experience of older adults with healthcare systems, how they perceive ageism from their healthcare providers, and to explore the relationship between perceived ageism and SPA.

## Material and methods

### *Design*

We employed a qualitative phenomenological study with a critical perspective. The objectives of our study made us opt for a phenomenological approach since it allowed us to obtain a deeper understanding of the life experiences of older patients within their reality, thus achieving a deep insight into the health meeting needs of older adults and responses received from the system, as well as the SPA.[38] We used the Consolidated Criteria for Reporting Qualitative Studies (COREQ), a checklist of 32 items developed to facilitate detailed and comprehensive research reporting.[39] The checklist is divided into three domains: research team and reflexivity, study design, and analyses and findings (Table 1).

### *Setting*

The study was performed in a community care setting in the Córdoba-Guadalquivir Health Area, specifically in two centers. The province of Cordoba is in the north center of the Autonomous Region of Andalusia (Southern Spain). According to data corresponding to the year 2021 extracted from the Institute of Statistics and Cartography of Andalusia, the province's total population is 322,071 (167,454 females and 154,617 males), whose rate of over 65-years-old population is 19,6%. Within the community care setting, there are thirteen primary care centers and nine consulting rooms in rural areas. One of the two health centers was responsible for primary healthcare services of the sixth poorest suburban district in the whole country, according to the Urban Indicators in its 2022 edition provided by the Spanish National Institute of Statistics.[40]

### *Study participants*

The sampling performed was purposive. The following selection criteria were established:

A People over 65 years of age.
B These people must live alone in their homes.
C The people had made at least one health consultation in the last thirty days.

Furthermore, the exclusion criteria were:

A Suffering from cognitive impairment.

We arranged a meeting with nurse case managers from the two health centers. We informed them about the selection criteria of our study. After consulting the active patient databases of each center and sharing their specific knowledge about possible key informants, the nurse care managers suggested to the team the potential participants, showing the characteristics of each and contextualizing the criteria of inclusion to be met. All the participants suggested by the nurse care managers were considered for inclusion in the study. After that, the reference nurses of each patient were informed by the nurse care managers about the consideration and proceeded to have first contact with the potential participants to tell them about the existence of the research project and thus verify their possible interest in

**Table 1**
Report using the COREQ checklist for reporting qualitative research.

| Domain 1: Research team and reflexivity | Description |
|---|---|
| Personal Characteristics | |
| 1. Interviewer/facilitator<br>Which author/s conducted the interview or focus group? | PMA and MMM conducted all the interviews. |
| 2. Credentials<br>What were the researcher's credentials? | PMA was a Ph.D. student and MSc in Health sciences research. MMM was a RN. MRR, PVP, VCH, and SLQ were Ph.D. |
| 3. Occupation<br>What was their occupation at the time of the study? | PMA was working as a Research Fellow at the University of Córdoba (UCO). MMM worked as a nurse at the Hospital Universitario Reina Sofía (HURS), Córdoba. MRR and SLQ were working as full professors at UCO. PVP and VCH were working as assistant professors at UCO. |
| 4. Gender<br>Was the researcher male or female | PMA, MRR, PVP, and SLQ are male. MMM and VCH are female. |
| 5. Experience and training<br>What experience or training did the researcher have? | PMA had experience in qualitative research from previous works. He received a Master's degree in Health sciences research from the University of Jaén (UJA), Spain. In addition, he underwent formal Ph.D. education in qualitative research and gave teaching lectures during his fellowship. |
| Relationship with participants | |
| 6. Relationship established<br>Was a relationship established prior to study commencement? | There was no previous relationship with any interviewee since the interviewers of the research team knew them at the time of data collection. PMA had a prior relationship with the rest of the group. MRR and SLQ were their doctoral thesis supervisors. MMM, PVP, and VCH were colleagues from the department. |
| 7. Participant knowledge of the interviewer<br>What did the participants know about the researcher? e.g. personal goals, reasons for doing the research | PMA and MMM informed the participants that the research project belonged to a thesis project of PMA. The two researchers told the older patients that their purpose was to find out their use of the health services and what answers they received from healthcare professionals, in addition to knowing how they perceived themselves based on their moment in life. When the participants asked questions about the project, they were answered by both researchers. |
| 8. Interviewer characteristics<br>What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic | The principal interest of PMA in the topic was based on his desire to focus its thesis project and future research on situations of social injustice, imbalance of power, and possible discrimination in care contexts on the health and disease processes of vulnerable social groups. |

| Domain 2: study design | |
|---|---|
| Theoretical framework | |
| 9. Methodological orientation and Theory<br>What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis | The research paradigm for this study was a phenomenology with a critical perspective. Using phenomenology, researchers could dive into the reality of other individuals. Using a critical perspective, the researchers had a reflective approach to social injustice and discrimination situations to locate care failures and highlight areas for improvement in the care from health services. In this study, we aimed to highlight the experience of older adults with healthcare systems, how they perceive ageism from their healthcare providers, and explore the relationship between perceived ageism and SPA. Following Ricoeur's hermeneutical considerations, content analysis was used to understand older people's interpretations of their life experiences. |
| Participant selection | |
| 10. Sampling<br>How were participants selected?<br>e.g. purposive, convenience, consecutive, snowball | The article explained the sampling method, and all approached older patients agreed to participate. |
| 11. Method of approach<br>How were participants approached?<br>e.g. face-to-face, telephone, mail, email | The method of approach is explained in the article. |
| 12. Sample size<br>How many participants were in the study | In total, 14 interviews were conducted. The interviewees were older women who lived alone in their homes. |
| 13. Non-participation<br>How many people refused to participate or dropped out? Reasons? | None of the participants who were asked to participate refused to be part of the study or withdrew from it at any time. |
| Setting | |
| 14. Setting of data collection<br>Where was the data collected? e.g. home, clinic, workplace | The interviews took place at the participant's preferred location. This location was their home. |
| 15. Presence of non-participants<br>Was anyone else present besides the participants and researchers? | Caregivers were also present at the interviews with participants 8, 10, and 11. During the other interviews, only the participant and the researcher were present. |
| 16. Description of sample<br>What are the important characteristics of the sample?<br>e.g. demographic data, date | All participants´characteristics are described in Table 2. |
| Data collection | |
| 17. Interview guide<br>Were questions, prompts, guides provided by the authors? Was it pilot tested? | The authors provided the interview guide as supplementary material to this article. Considering the semi-structured and dynamic nature of the interview, the interview guide topics were used as a reference for the interviews. Still, they were open to more than the content of the interviews. The list of topics was adjusted to each participant's uniqueness throughout the research interview phase. |
| 18. Repeat interviews<br>Were repeat interviews carried out?<br>If yes, how many | Repeated interviews with the participants were not conducted. As for the patients, this was due to their multimorbidity and because many reported their state of fatigue concerning the realization of interviews. |
| 19. Audio/visual recording<br>Did the research use audio or visual recording to collect the data? | All interviews were audio recorded with the participant's verbal and written consent. The recordings were stored on PMA and MMM computers because they were responsible for data analysis. Only they had access to this data. |

(*continued*)

**Table 1** (*Continued*)

| Domain 2: study design | |
|---|---|
| 20. Field notes<br>Were field notes made during and/or after the interview or focus group? | The audio recording was accompanied by a field diary which included observations and impressions that were not recorded, such as the non-verbal communication of the participant. Field notes were used in the analysis of the results afterward. |
| 21. Duration<br>What was the duration of the interviews or focus group? | The duration of each interview was between 60–80 minutes. |
| 22. Data saturation<br>Was data saturation discussed? | Data saturation was discussed with the research team. |
| 23. Transcripts returned<br>Were transcripts returned to participants for comment and/or correction? | Due to various reasons (such as the limitations in the reading of most of the patients due to medical or literacy issues; a state of exhaustion after the completion of the interviews), the transcripts were not returned to the participants for comments or feedback. |
| **Domain 3: analysis and findings** | |
| Data analysis | |
| 24. Number of data coders<br>How many data coders coded the data? | PMA and MMM performed the data coding and the whole process of analysis simultaneously. Further information is reflected in the article. |
| 25. Description of the coding tree<br>Did authors provide a description of the coding tree? | No coding tree was used. The themes were derived from the data, following Ricoeur's considerations for hermeneutical content analysis in the data analysis phase. The authors provided narrative and visual development of this process in the article. |
| 26. Derivation of themes<br>Were themes identified in advance or derived from the data | The themes were derived from the data and were discussed and agreed on by all the authors. |
| 27. Software<br>What software, if applicable, was used to manage the data? | QSR NVIVO and SimpleMind Pro were the software tools for managing the data. |
| 28. Participant checking<br>Did participants provide feedback on the findings? | Due to several reasons, as explained at number 23, there was no feedback from the participants on our findings. During the interviews, the interviewers performed member checking by repeating and summarizing the answer of the older participant to ask for clarifications and confirmation of the researcher's interpretation of the answers. At the end of the interview, the researcher gave a summary of the content to ensure the researcher understood the main content correctly. At the end of the interview, the researchers also asked the older participants a final question about possible comments they wished to make regarding what had been said and potential topics that were not raised through the conversation but that they wanted to make explicit. |
| Reporting | |
| 29. Quotations presented<br>A Were participant quotations presented to illustrate the themes/findings? Was each quotation identified?<br>e.g. participant number | The results section is illustrated with quotes from the participants. Each quote is identified with a participant number. To safeguard the anonymity of older participants, the quote numbers do not correspond to the numbers in Table 2. |
| 30. Data and findings consistent<br>Was there consistency between the data presented and the findings? | According to our assumption, the data presented in the study and the results that emerge from them are consistent. |
| 31. Clarity of major themes<br>Were major themes clearly presented in the findings? | The main themes are present in the results section of our article. Each theme is assigned a different heading. |
| 32. Clarity of minor themes<br>Is there a description of diverse cases or discussion of minor themes? | The minor subthemes are described, along with the main themes and specific quotes for each one. |

participating. All the older people wanted to receive more information about the research project from the researchers. Each reference nurse arranged a face-to-face meeting between them, the potential participant, and one interviewer from the research team at an older adult's home. The place for the meeting and the time slot was decided and agreed upon with the potential participants. After that meeting, in which all the information related to the project was explained to potential participants, they were asked if they would be willing to participate. All the older adults agreed to participate, signing the informed consent sheet properly and arranging a second visit to conduct the interviews. The saturation of the discourse was determinant for reaching the final sample size.[41]

### Interview guide

The general interview guide topics were the SPA of the participants; their meeting needs for healthcare, the healthcare professionals' responses received, and the possible moments of suffering ageism (Supplemental file 1).

### Data collection

A total of 14 in-person semi-structured interviews were conducted. A first script was prepared before completing the relevant interviews. A suitable environment was always sought to allow these interviews to be shown in the most comfortable way possible for the participants and, in turn, obtain sincere and profound answers. According to and following the participants' wishes, that environment was their own home. Initially, the interview was introduced through open questions so the participants could answer freely and convey their first impressions. Subsequently, the interview was structured and guided around more direct questions. All interviews were audio-recorded and accompanied by a field diary where the interviewer added information. After that, the recordings were transcribed and imported into the QSR NVivo 12 qualitative analysis software tool for subsequent analysis.[42] The duration of each interview lasted between 60–80 minutes. The caregivers of patients 8, 10, and 11 were also present during the interview.

We understood translation in qualitative research as an essential process to accurately convey participants' meanings between languages; hence we intended to ensure the trustworthiness of this qualitative research.[43] The interviews were conducted in Spanish, which was the original and native language of both the participants and the research team. Therefore, our translation process began in the dissemination phase of our work in English.[44] During this process, we translated the research, so we adopted the figure of researcher-translator, advised by a native English speaker. We identified some cultural difficulties when translating metaphors and personal

expressions to convey the exact meaning of the older patientś discourse in our experience, something that we addressed to the native English speaker and worked alongside her to reach a consensus in translation.

### Data analysis

Content analysis has been performed to interpret and synthesize the information collected through the hermeneutical considerations proposed by Ricoeur.[45] The first step after transcribing the interviews was an in-detail reading to create an explanatory framework based on the main ideas gained using the starting categories. In the first phase, each idea or statement that was complete enough to be informative was designated as a node. Based on the initial category, the found nodes were classified into a category according to the presented cognitive dimension. Second, categories and subcategories were defined by the recombination of nodes within each pattern; in this way, the nuances of each pattern were provided by the taxonomy branch, which in turn was supplied by the subcategories. Finally, a deep understanding of patients' experiences was sought in the third phase, which would close the so-called interpretation arc. In addition to the verbal discourse, the participants' non-verbal language and various manifestations when expressing their answers were considered to perform this analysis.

### Rigor and quality guarantee

For the rigor and methodological quality of this study, see Supplemental file 2, where we provided a detailed and in-depth description of the following sections proposed by Calderón.[46]

### Ethical and legal aspects of the study

The participants were informed before attending the interviews. They were previously told that the data collected would be used only for research purposes and that all identifying information would be anonymized. The participants were also informed of the research objectives, how their personal information would remain guaranteed, how the data would be disclosed, and that they could stop the interview whenever desired. At all times, the anonymity of the person was guaranteed. In addition, the study has the permission of the Ethics Committee for the province of Córdoba.

## Results

### Description of the participants

All the older people participating in this study were white Spanish women, with a mean age of 85 (Table 2). The participants' health information was obtained by consulting their medical and nursing records through the nurse care managers. The socioeconomic status was obtained by self-reported through a direct question to each participant outside the interview guide provided.

### Conceptual map for the synthesis of the results

In an illustrative manner, the results seen in Fig. 1 exemplify how the use of the health system that older women who live alone made could transform a misuse due to a poor attitude and praxis on the part of the healthcare providers. Healthcare professionals created an imbalance in power relations that made these older patients an oppressed group in the eyes of the system.[47] Older patients saw how their dignity and right to receive quality health care were resented. On the other hand, healthcare providers turned into a sometimes-oppressive group that took advantage of professional superiority, leaving older patients unsatisfied with the care they genuinely deserved.

### Narrative development of the results

The results of this study describe the meeting needs that older women have for healthcare services and discover ageist responses from healthcare professionals. These responses influence the misuse that older patients make of these services. Through the older participants' statements, we have identified that they mostly share a negative SPA, influenced by internalized stereotypes about aging and ageism by healthcare professionals.

### Use of healthcare services by older patients: an imbalance

One essential aspect of this work is the use of healthcare services. Concerning this, most participants' responses were consistent and homogeneous. Firstly, we should differentiate between a consultation requested as a follow-up —a routine consultation, a revision related to a chronic process—and a consultation for a specific reason. The older adults understood the latter as an occasional problem at a particular time that we could identify as an "acute process". This

**Table 2**
Characteristics of the participating older patients.

| Participant No. | Age | Health condition | Social support (type) | Economic difficulties (with help) |
|---|---|---|---|---|
| 1 | 68 | Hypertension, osteoarthritis, overweight, type II Diabetes Mellitus. | No | Yes (no) |
| 2 | 81 | COPD, intolerance to physical activity, urinary incontinence. | No | Yes (no) |
| 3 | 81 | Asthma, hearing loss, stroke. | No | Yes (no) |
| 4 | 95 | Bladder cancer (operated), intolerance to physical activity, cataracts, urinary incontinence. | Yes (family) | No (no) |
| 5 | 86 | Heart failure, osteoarthritis, type II Diabetes Mellitus. | No | Yes (no) |
| 6 | 88 | Constipation, hip replacement, hypertension, Ménière's disease, osteoarthritis. | No | No (no) |
| 7 | 78 | COPD, intolerance to physical activity, smoking. | Yes (friends) | No (no) |
| 8 | 84 | Intolerance to physical activity, obesity, type II Diabetes Mellitus. | Yes (formal caregiver) | Yes (yes) |
| 9 | 97 | Duodenitis, gastritis, hypertension, mild renal failure, mitral regurgitation, urinary incontinence. | Yes (family) | No (no) |
| 10 | 86 | Atrial fibrillation, epicondylitis, hearing loss, hypercholesterolemia, hypertension, intolerance to physical activity. | Yes (informal caregiver) | No (no) |
| 11 | 90 | Colonic diverticulitis, coxarthrosis, discarthrosis, dizziness, glaucoma, gonarthrosis, hypertension, ischemic heart disease, osteoporosis, type II Diabetes Mellitus, urinary incontinence. | Yes (formal caregiver) | No (no) |
| 12 | 84 | Atrial fibrillation, breast cancer, colon adenocarcinoma, knee osteoarthritis, obesity, urinary incontinence. | Yes (family) | No (no) |
| 13 | 83 | Osteoporosis, urinary incontinence. | Yes (family) | Yes (no) |
| 14 | 90 | Dizziness, gonarthrosis, hearing loss, heart failure, hypercholesterolemia, hypertension, intolerance to physical activity, spondylarthrosis, tinnitus. | No | Yes (no) |

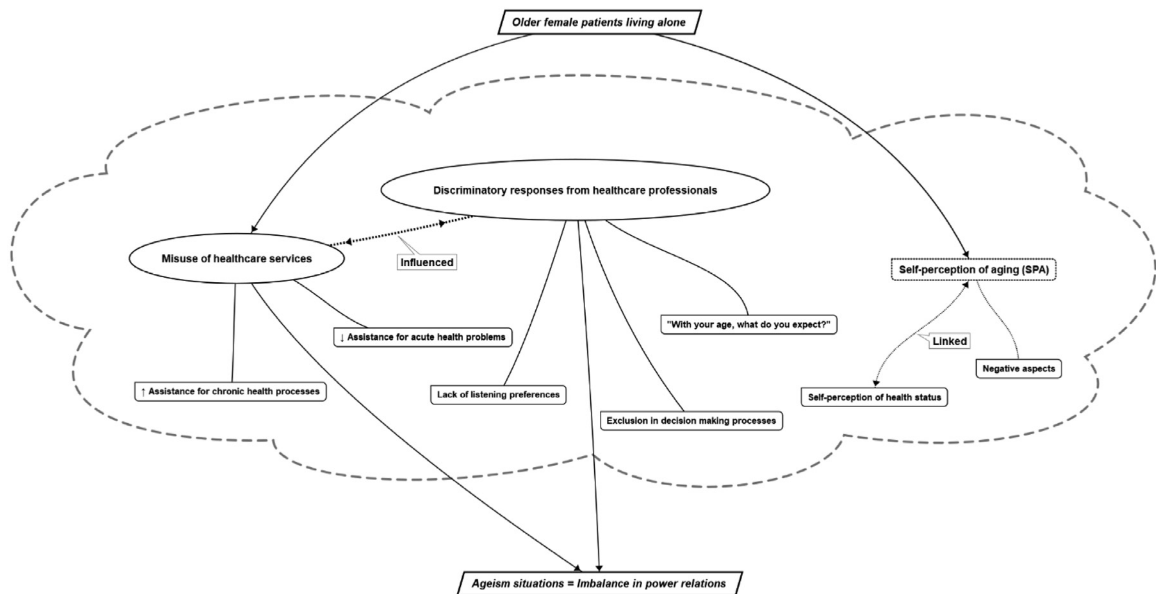


**Fig. 1.** Ageism, power relations and their elements between older patients and healthcare professionals.

distinction existed because different answers were obtained regarding both situations during the interviews. So, concerning the frequency with which they used health services when referring to consultations related to periodic revisions, checkups, or control of some chronic process, most participants answered that they attended these visits. In contrast, a low level of consultation was generally observed for acute problems:

"I go scarcely." (Participant 1).
"I go from time to time." (Participant 5).
"I only go to my checkups." (Participant 14).

This was justified by the perception of need that each of the participants had, or lack of joint planning between healthcare professionals and older women, like participant 4 conveyed when the nurses made appointments for her without any previous consideration:

"I go when I need to." (Participant 14).

"When I have an appointment or something, if they tell me... maybe they'll call me very early. It's harder for me to get up. I mean oh please, can't I have that later?" (Participant 4).

Most participants reported not consulting a healthcare professional when a health problem occurs. In the case of doing so, they perceived that problem as challenging when it had not been remitted after self-medicating. In this sense, we found that self-management of their health was frequent. Older patients opted to self-medicate when they had any ailment or physical distress; therefore, on many occasions, they did not see the need to seek professional help:

"I just go when it's something serious." (Participant 2).
"[I go] when there's something that is not going away, but I'm good with some painkillers for so long." (Participant 3).
"I think I don't need anyone right now, you know?" (Participant 4).

In addition, there were specific cases in which the previously stated reason must be added to the existing physical limitations that discouraged them from consulting: "No, I just can't walk well... I don't go out." (Participant 13).

*Responses from healthcare professionals: ageism at the root of care*

The participant's perception of the responses they obtained when making a consultation came with experiences and impressions with practically no positive aspects. One aspect that emerged frequently was a lack of time. There were experiences in which the health professionals told them that it was not possible to attend them due to insufficient time:

"The last two times I went to the nurse, I told her to look at my [blood] sugar, and she said that she couldn't and that she didn't have time. That has happened to me several times." (Participant 2).
"Once, when I went, a couple entered the doctor's office and stayed there for more than half an hour. Then the doctor came out: look, I cannot spend more than 5 minutes with you; I close the consulting room at eight. I can't dedicate myself to this, be aware of that." (Participant 3).

The participants even reported situations in which a lack of time must be added to an imposing nature on the part of the staff who attend them. Examples arose when the health professional did not listen, thus, giving immediate, reactive, and mechanical responses:

"He was going to give me some pills, and I said: Look, be careful; I'm allergic to medicines. Look at the computer. The doctor said: You have to take this because I don't have time to look at the computer." (Participant 7).
"You know? And I told the doctor not to send [the pill]it to me. That he couldn't send it to me because he was doing many blood tests on me, how it was... But nothing. Even if I begged, nothing." (Participant 10).

However, it was a matter of haste and inattention to older women's routines. Far beyond not listening, there was no consideration of the clinical condition, and there was no predisposition to listen or to

pay attention to the older patients' preferences. In other words, the patient was not considered at all. As an example of this situation, participant 2 told us that she repeatedly visited the social worker and the nurse case manager to request a home care visit service. She explained how the appointment times did not suit her situation:

> "My problem is that I live alone. And I get no solution for that. And who would think of scheduling an older woman for an appointment at 8 a.m.? I live close by, but I can't go alone because it's still dark and raining. How outrageous!" (Participant 2).

Regarding home visits, it was no different. The participants reported that they were excluded from the planning of agendas, and there were plenty of occasions when professionals used to arrive home without previously notifying the older patients of the incipient visit:

> "The nurse comes directly because she knows that I'm always here... Does not call." (Participant 9).
> "She comes, sometimes she let me know, some others not. She has her day. Depends on how things go." (Participant 6).

However, beyond a lack of time and not considering the patient when planning agendas, older patients generally perceived a lack of interest from the healthcare professionals. For instance, when asked during the interview if older adults thought that professionals were interested in their health condition in a consultation or if older adults received any interest expression from healthcare personnel, we got answers such as the following:

> "They don't usually... this doctor that we have now, he doesn't usually ask much; he sends you off right away." (Participant 5).
> "What [the nurse]she says is that she has to attend to many people." (Participant 9).

Moreover, they reported a lack of concern among healthcare professionals about older patients' problems. There were some experiences in which the professional ignored a noticeable health problem:

> "Well, once I went to the doctor because I had awful pain in my legs. He was in front of the computer and wasn't telling me anything. That is not listening to you, that is not paying attention to you, that is not having any idea of being a doctor, that is not having any idea of anything else." (Participant 5).
> "And why didn't he operate me? And every year... And here I am, when the pain wants it hurts me..." (Participant 13).

Perhaps, the most graphic example of this situation was reported by participant 8 when explaining that posing a health problem has been accompanied sometimes by the following statement from healthcare professionals:

> "Sometimes they tell me: with your age, what do you expect?" (Participant 8).

One of the participants specifically mentioned having consulted her general practitioner (GP) due to severe jaw pain not remitting for days; she requested to be referred to a specialist because the pain prevented her from eating. She mentioned that her GP told her it was because of osteoarthritis without even examining her. On the day of the interview, a month later, she was still in pain and had still not been treated:

> "He is stringing me along, the ear washing... Now he has referred me to the dentist but not the one I wanted him to refer me to; no, I requested it. I was the one who told him... That I don't usually do that, you know? Nevertheless, I saw that my ear hurt and that I couldn't open my mouth and, ouch! It still hurts... (at that moment, she opened and closed her mouth, and it heard the crack) ... That is osteoarthritis (she imitates the doctor with a tone of indifference). Well, osteoarthritis, and if you refer me to the specialist, won't I be calmer? He discarded that, and we already say: well, we already know that [pain]it doesn't come from the inside of the ear, but I have been left with the desire because he has not referred me" (Participant 5).

Sometimes, the older patients' demands were ignored and perceived as "calls for attention" to obtain the interest of healthcare staff:

> "Because I call my family doctor... and he says: well, what are you calling me for? I told him that I had called because this had happened to me. Furthermore, he says: what you want is for me to see you? And I say, well, you look at me and tell me what happens to me. The doctor replies: It's silly; if I can't prescribe you medicines because you are allergic, I can't prescribe you anything. Then, goodbye. Then why am I going to call him?" (Participant 7).

In addition, they reported situations in which care lacked respect, and even harm was sought:

> "Moreover, I have even suffered mistreatment. They are stubborn about self-injecting me, and I have been stubborn about that. I'm not going to give the injection by myself; they have to give me the injection, and they are getting paid for that. One took one day and gave me such a pinch that she left me bruised for two weeks." (Participant 3).
> "And I say, what is that? And he says, well, you could die. I say, oh my God! Don't tell me those things, man. Anyway, he was going to give me a pill, and I say, oh, please, look at you, you should be careful because I am allergic to some pills. Look at the computer. He says: I don't stop at that, you must take this, and that's all." (Participant 7).

Participant 7 even reported similar experiences in the case of hospitalizations. She told about the bad experience she had when she was admitted to the hospital, and the staff bathed her with cold water every day:

> "When I was admitted, a b**** wanted to bathe me every day, and I asked her why? If I don't even have dust. I wouldn't say I liked how they treated me. And I let them, but they did not add cream or deodorant or anything, and I need cream because I am very particular about that. However, it turns out that one of them had a fixation with me because I felt very cool with my dyed hair. Also, she was taking a bucket of cold water and pouring it over me. She befuddled me. I asked the nurse what I had done to make her treat me like that when I have always treated everyone with respect. Hasn't anyone told you that you are a b****? You could have thrown the bucket on yourself. And she laughed." (Participant 7).

*SPA in older adults: a negative conception*

Despite everything described in the previous point regarding the ageism existing in healthcare professionals, older patients not only

did not consider that healthcare professionals treated them differently because they were older but also felt that they were treated even as if they were younger, something that they considered to be beneficial:

"No, because they see me young and are surprised that I am 81 years old. They see me well. Because I'm very active... They treat me better; they see me young." (Participant 2).

"No, no, the age... They have treated me as if I were young." (Participant 11).

"She receives me as if I were 20 years old." (Participant 12).

In addition, not only did the older participants' discourses link their SPA with ageism but also to their self-perception of health. In this sense, answers were obtained regarding the physical, social, and emotional health spheres. In all of them, the participants showed mainly negative aspects. Concerning physical condition, the older adults reported feeling pain, tired, and, on some occasions, physical distress:

"It is tough for me to go to the health center. It's hard for me now because I get exhausted, and I arrive there without breath..." (Participant 8).

"Osteoarthritis is not operated. Well, what I have is pain. What a pain I got..." (Participant 12).

Concerning the social sphere, the older patients highlighted the need to receive help when performing the basic activities of daily living in most interviews:

"I would need a young lady to come and help me around the house and help me go shopping." (Participant 2).

"I went to the social worker because I would need a woman once a month or every two weeks to clean the lamps, the furniture on top." (Participant 3).

"What I need is a woman to come in the afternoon, in case she can take me out because I can't go by myself." (Participant 1).

Regarding the emotional aspect, they referred to an apathetic state, even going into issues related to a lack of will to live. Participants underlined the monotony of life and how little hope they had to move on:

"I am sick of living, sick of living, because this is always the same, always the same." (Participant 7).

"Any day I will be found dead." (Participant 1).

Regarding living alone, one of the inclusion criteria when selecting participants for the study became the cornerstone of this subtheme. Older women did not just live alone. In addition, they sometimes felt lonely as they had lost their spouses, and even several of them had lost their offspring or could not count on close people.

Adopting a joint vision of the results obtained, the relationship between the older patient-healthcare professional was loaded with evaded, undervalued, and even ignored meeting needs. On the other hand, the existence of frustrating responses from healthcare professionals meant that older patients did not see their needs met and that they understood the use of the health services as a waste of time and something completely useless. Despite all this, the participants claimed to be free when expressing their opinions or preferences during consultations:

"I have no problem about saying something. Sometimes, I tell my family doctor that my evenings seem very long." (Participant 9).

"I am inquisitive, so once I asked her what the little bottle that I have in the fridge was for, the one that she puts on me when she comes, and she explains it to me, yes, yes." (Participant 6).

## Discussion

Concerning the above-described health situations, the participants in our study affirmed that they did not usually consult a healthcare professional when having an acute health problem. This statement is inconsistent with most scientific literature, classifying older adults as hyper-users of the healthcare system.[48–50] However, the literature clarifies that this hyper-attendance shows differences depending on socioeconomic status because low status is related to increased primary care visits. In contrast, those older patients with a high socioeconomic status attend more specialized care consultations.[51–54] Furthermore, to explain this over-attendance, various studies reported that meeting needs are frequently associated with chronic diseases, such as diabetes mellitus, high blood pressure, and cardiovascular diseases.[48,55] This is consistent with the present study results, where the checkups and periodic revisions in healthcare centers have been the primary references that the participants gave. In any case, it is relevant that the participants in our study stop visiting health professionals when a health problem has occurred. Perhaps, this fact is better understood if we consider previous studies reporting how most older adults have a terrible opinion of the care they receive; they even show signs of mistrust.[56–58] Furthermore, this satisfaction was even lower when the older patient's functional limitation was more significant or when a persistent feeling of loneliness prevented the patient from visiting the general practitioner.[59–61] For this reason, patients may feel frustrated, which will probably lead to the non-use of health services in case of acute problems.

The results of the present study show the ageist responses that health professionals gave to the meeting needs of older patients when they attended the consultation. These older patients, therefore, were a group affected by their condition of advanced age, compared to another group that exercised a role of power through an ageist attitude. This is consistent with Van Dijk's theory of power relations,[47] which states the power imbalance between social groups through reproducing an oppressive discourse against an oppressed group. This fact is reinforced by the principles of Social Identity Theory (SIT),[62,63] which explains the complex network of attributes that shape intragroup relationships and behaviors, in this case, of older patients and healthcare professionals. From this socio-cognitive prism, the SIT points out the existence of mechanisms of distorted differentiation between groups that cause this power imbalance. The social categorization present in the results of our study brought a conflict between groups that pivoted around age as a category that causes social stigma.[64] According to the SIT, the ageism of healthcare professionals characterized their social identity as a privileged group, which conceived and referred negatively to the outgroup of older patients.

On the other hand, the results of our study show that older women had a negative SPA marked by a self-ageist conception in most cases. This, in turn, agrees with the SET,[32] which explains the gradual assimilation of age-stereotyped concepts unconsciously through encounters full of mostly pejorative social signals, continually letting them know they were older. These signals come from the same institutions, which also agrees with what is shown in this study. In line with the SET and consistent with the results of this study, there are longitudinal and experimental studies that demonstrate the negative influence that ageism has on SPA in older people, to the extent of finding that ageist stereotypes harm SPA and also act as a predictor of health.[33,65,66]

Besides, some older patients reported not only that they did not feel treated differently due to being older but also that they felt treated as if they were young, which they considered beneficial. This apparent contradiction has its explanation in the Self-Categorization Theory (SCT),[67] which delves into the depth of the comparative construct of identities at the same level of abstraction and the consequences self-categorization has for the individual. Older women who said they felt active or younger were evaluated more positively than their peers who did not share this feeling, which allowed them to differentiate themselves from members of their same social group. This agrees with the SIT to the extent that being older was considered a negative social identity, so older women who said they felt young identified it as something positive. This led them to try to cross the group barriers they considered to be permeable to be seen as young people and, therefore, belong to a higher-status group. This phenomenon within the SIT corresponds to an attempt at social mobility. Furthermore, it would also be equivalent to what Luken[64] defines as reclassification because these older women identified being older as a discrediting attribute. This identification caused a desire to be reclassified in another social group of a better position. In conclusion, this was just another sign that, in the form of an acquired self-stereotyped attitude in the case of older people and in the form of an oppressive attitude in the case of healthcare professionals, ageism is a socio-cognitive web that permeates the social relations between both groups.[68]

## Conclusions

The use of healthcare services was primarily high regarding attendance for chronic issues in older patients and not for acute issues despite recognizing negative health states. However, when they decided to consult for an acute health problem, they suffered from ageism by healthcare professionals as a response because these problems were underestimated and blamed on advanced age. The care received from the healthcare professionals in those situations presented clear areas for improvement since the health problems of older patients were ignored, ineffective results of the treatments were tolerated, and even abuse situations were reported. Therefore, older patients considered consultations a waste of time. On the other hand, older patients showed a predominantly negative SPA, influenced by internalized ageist stereotypes and age discrimination from healthcare professionals. In addition, the older women related their SPA with their self-perception of health, which was also negative. In some cases, older women said they felt active or young and highlighted this as beneficial when dealing with healthcare professionals. However, this was nothing more than a reflection of an ageist conception within their SPA.

### *Study limitations and further considerations*

Regarding the characteristics of the participants, all in this study were older women, so that this fact may have influenced the results somehow. Not having older men among the available sample has possibly determined the nature of the perceptions we studied and has prevented us from applying a gender perspective segregated by sex or gender. For this reason, it would be advisable to conduct future research that ensures a sample as homogeneous as possible between men and women to discover possible peculiarities and differences between sex or gender. According to the older participants' experiences, the results of this study address a relationship between interpersonal ageism and SPA of older adults, thus considering SPA a multifaceted phenomenon. This added that many elements spin the context and interact in these situations; diving deeper into this topic becomes necessary. We decided to focus our study on older people who lived alone because it was a characteristic associated with vulnerability in advanced age. Some recent studies linked a negative SPA with loneliness, isolation, and depressive symptoms.[69,70] This evidence has influenced our results to the extent that they also point towards a negative SPA. Considering other older patients in more varied social circumstances could have provided some possible variation or deepened the differences between SPA.

### *Relevance to clinical practice*

Giving older people a voice in the context of their care is vital to understanding their state of health and the elements that shape their use of health services. Although fourteen interviews with older women cannot be considered representative of the experiences of all older patients, they could be transformed and applied to resemblant situations. Considering this, this study makes visible the older adults as a group prone to being vulnerable that sometimes suffers from the oppression of a health system in occasions paternalistic, plagued with ageist responses that reproduce through the discourse of the participants. In this age discrimination, there is an imbalance of power in relations between social groups.[47] This is crucial to provide a critical vision within the organization of the health system and our performance as health professionals. The results of this study shed light on a reality that leaves room for improvement in the professional approach to one of the axes of health care, such as the older patient, for which we suggest the reinforcement of clinical interventions that are based on respect and moral consideration in processes such as shared decision-making, the opportunity for older people to express their preferences in care and to encourage their active participation in these processes. Furthermore, we can affirm that the older participants in this study provided relevant information from a holistic healthcare perspective, allowing the reader a profound understanding of their inner reality and use of healthcare services.

## Declarations

### *Ethical approval*

The research was carried out following the Declaration of Helsinki, and personal data obtained have been treated following Regulation EU/2016/679 of April 27, 2016.

The present study obtained the approval of the Research Ethics Committee of Córdoba to be accomplished (Minutes No. 283, Reference 4118).

### *Availability of data and materials*

The authors confirm that all data generated or analyzed during this study are included in this published article.

## Declaration of Competing Interest

None.


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