Ageism and moral distress in medical nurses and nurses in training: an integrative socio-psychological approach

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Abstract: Ageism, the socio-psychological negative construction of old age at both the individual and societal level, has been amply documented as a negative contributor to medical discriminatory practices, respectively differential treatment and practices regarding the distribution of limited resources (e.g. Suhonen et al., 2010). In Romania, the socio-demographic situation mirrors the one in Europe regarding the expansion of the elderly population segment, yet with quality of healthcare, welfare, public services and budget funds allotted for the elderly lagging behind the standards set forth by other European countries. Gerontological research here is sparse, conducted on small samples and overlooked by policy makers (Bodogai & Cutler, 2014; Căciulă et al., 2010). With nurses being in the front lines of healthcare, the institutionalized ageist practices in healthcare have been documented to lead to high rates of moral distress, which, in turn, leads to physical and emotional illness, burnout, staff turnover, lower quality of care and workplace satisfaction. Ageism is potentially the main source of ethical concerns for geriatric nurses, as it most likely underlies most of the morally laden matters with which they are confronted (for a review, see Rees, King, & Schmitz, 2009). Concerning nursing practices in Romania, we are faced with a paradoxical state of affairs: the more a medical professional is active in this field of work, the less sensitive they are to the ethical aspects involved in caring for the elderly (Căciulă et al., 2010). Combined with the results of the other international systematic literature reviews on this topic and with the socio-demographic shifts in age-distribution, the aforementioned data underlines the need to address the existent gaps in the scientific literature on the ethical challenges faced by the nursing personnel working with the elderly. To address these issues, we propose investigating ageism in healthcare within the framework of Social Representations Theory (SRT) and bridging the research conducted in moral psychology (i.e. Ellemers et al., 2019) with the traditions of research in ethical nursing by including predictors from the most well-known and well-tested theoretical models of moral judgement – Moral Foundations Theory (Graham et al., 2011) and Model of Moral Motives (Janoff-Bulman & Carnes, 2016). This way, we may better understand both the social and the individual contributors to ageism in healthcare, as well as their collective influence on ethical decision-making in geriatric nurses, so that we may design adequate health interventions for both practicing nurses and students to optimize the healthcare of the elderly. Since we expect that institutionalized ageism is internalized by nurses with the accumulation of professional experience (and implicitly, with exposure to ageist work climates), our findings should also shed light on designing strategies to lower the rates of moral distress in nurses.

Keywords: ageism, geriatrics and gerontology, nurses, moral distress, social representations.

Ageism, defined henceforth as the socio-psychological negative construction of old age at both the individual and societal level (Ayalon & Tesch-Römer, 2019), has become an increasingly relevant topic of research in the past few decades due to a series of socio-demographic shifts as well as to the consequences of medical advancements on prolonging the individual lifespan. The phenomenon comprises cognitive, behavioural and affective practices, often manifested in the form of policies, which involve stereotyping, showing prejudice and/or exhibiting discriminatory behaviour toward certain age groups – mainly – the elderly (Iversen, Larsen, & Solem, 2009). Among other forms of discrimination, it was shown to have the highest prevalence in Europe, and to boost the deleterious effects of the other two most often encountered types of prejudice – sexism and racism (Ayalon, 2014). Ageism is also ubiquitous in nature, since it is highly likely to be experienced by everyone who reaches an older age (Palmore, 2003). The chances of reaching an old age nowadays have increased dramatically, as revealed by the results of the Demographic Outlook for the European Union from 2019, which show a substantial increase in life expectancy coupled with a dramatic drop in fertility rates, both leading to the expansion of the elderly population segment, predicted to double in size by 2050 (Eatock, 2019). Hence, focusing on the study of the psycho-social issues specific to this population is and will continue to be of particular interest for the scientific community at large.

Past research has shown that ageism is a significant issue in Romania. Comparative demographic data collected across Europe concerning the perceived duration of middle age (i.e. the difference score between mean estimated age at which youth ends and, respectively, the mean estimated age at which old age begins) places Romania last, in the sense that the aforementioned duration is considered to be 15.1 years – the shortest duration amongst the 28 countries surveyed (Swift et al., 2018). Moreover, the perception of Romanians concerning the debut of old age reveals a mean estimated age of 61.9 years, thus ranking in the lower third of the 28 countries surveyed. A more recent study found the perceived onset of old age to be 60.5, potentially showing a decreasing trend in Romania in this regard (Rychtaříková, 2019). The necessity of studying ageism in this geo-cultural context has been signaled by laypeople as well: 41% of the respondents have experienced unfair treatment based on their age, with Romania ranking third in discriminatory practices such as being insulted and abused and fourth in lack of respect (i.e. being ignored and patronized). Also, people over 70 were most likely to be perceived as unfriendly in Romania than elsewhere, a finding supported by qualitative analyses as well (Carmen, 2012). In addition to this, Romania was in the top three countries where more than a half of the respondents believe ageism to be a significant issue in their respective countries (Swift et al., 2018). Taken together, these results underscore the importance of studying the antecedents of ageism in this geo-cultural context.

First coined by Butler in 1969, ageism refers to the stereotyping and discrimination based on age. Ageism is manifest in the cognitive realm (beliefs and stereotypes), the affective domain

(prejudice towards the elderly), while also having a behavioral component (explicit and implicit discriminatory practices). The socio-economic rationale for studying ageism lies in its adverse consequences on employability, with older people being automatically perceived as less productive and costlier by employers, while also being at higher risk for termination, forced early retirement and being passed over for hiring, promotions and salary increases (e.g. Connen, Henkens, & Schippers, 2012). These issues are problematic for both the targeted individuals as well as for the organizations due to the fact that these decisions are not based on the competence of the employees, but rather on pre-conceived ageist notions. Moreover, ageism has been amply documented as a negative contributor to medical discriminatory practices, respectively differential treatment and practices regarding the distribution of limited resources: deciding against medical screening for diverse afflictions, setting age limits for transplants, denying access to novel and/or costly courses of treatment, communicating less to older patients in the process of decision-making, abusing them both physically and psychologically by caregivers and medical personnel. These discriminatory practices impact older people's health behaviours, in the sense that they increase the rate of detrimental behaviours and, respectively, decrease the rate of preventive practices (Hooker et al., 2019). Ageist attitudes and practices may become manifest at both the individual level (e.g. peers or doctors who harbor ageist outlooks) and the institutional level, where the allocation of resources is often prioritized according to the patient's age. In healthcare, ageism is maintained through a wide array of channels, varying from stereotyping, which supports a low level of relevant knowledge concerning the characteristics of the elderly, to policies that sustain neglect. In the current context of the COVID-19 pandemic, we were able to witness how ageism leads to the dehumanization of the elderly patients and to their being treated as expendable, which was conducive of an over-inflation of their perceived reduced life expectancy as compared to young patients. The pervasiveness of this phenomenon in healthcare (at the macro and micro level) has had dire consequences, with more polarized social groups implicitly and explicitly argued for the necessity of sacrificing the elderly for the benefit of the younger population and/or economic gain (Fraser et al., 2020).

In Romania, the socio-demographic situation mirrors the one in Europe, with older adults expected to account for 30% of the population by 2050 (Bodogai & Cutler, 2014). Despite this, the quality of healthcare, welfare and public services, as well as the budget funds allotted for the elderly lag behind the standards set forth by other European countries. In addition to this, gerontological research in this geo-cultural context is sparse, conducted on small samples (usually employing a qualitative methodology) and overlooked by policy makers (Bodogai & Cutler, 2014; Căciulă et al., 2010). To illustrate, previous research has shown the negative influence of ageism on employment practices (e.g. Sofică, 2012), healthcare quality (van den Heuvel & van Santvoort, 2011) and stereotyping (Dafinoiu & Crumpei, 2013; Duduciuc, 2016; Gherman, 2014; Teodorescu & Chiribucă,

2018). Concerning nursing practices, a study from 2010 conducted by Căciulă et al. found that abuse of the elderly is more unlikely to be identified by medical personnel as compared to home care workers, which suggests we are faced with a paradoxical state of affairs: the more a medical professional is active in this field of work, the less sensitive they are to the ethical aspects involved in caring for the elderly. Combined with the results of the other international systematic literature reviews on this topic and with the socio-demographic shifts in age-distribution, the aforementioned data underlines the need to address the existent gaps in the scientific literature on the ethical challenges faced by the nursing personnel working with the elderly.

Given the fact that old people are the age category most susceptible to illness and to using healthcare services, the lower quality of the latter and their reduced access to it make nurse ageism a highly relevant area for empirical research and intervention. Kagan and Melendez-Torres (2015) see it as a fundamental threat to both health and society, with harmful implications for both patients and nurses. Often manifested as an openly offensive type of bigotry, ageism (also known as "granny-bashing") is frequently coupled with psychological and physical abuse (Kagan et al., 2015). As compared to other forms of discrimination, negative ageism poses a universal threat to the self and to identities – seeing others age confronts one with their own mortality, engendering feelings of worry and fear, which may manifest as hostility or disparagement. Minority groups are especially vulnerable to its effects, as ageism is exacerbated by racism and sexism and may lead, under these conditions to societal assault (Hopkins & Pain, 2007). Another facet is positive ageism (also known as compassionate ageism), which may have its own deleterious effects on the elderly, because it often manifests as parental, condescending attitudes toward them and unnecessary compensatory actions, passing discrimination as humorous stereotyping through jokes targeting diminished capacities and myths regarding the inability of older people to take care of themselves (Palmore, 2005).

The findings of a thematic literature review concerning nurses' perceptions of ethical issues in the care of older people have concluded that ageism is potentially the main source of ethical concerns in this domain, as it most likely underlies all the morally laden matters identified by the authors – sources of ethical issues for nurses (doctors, lack of financial and personnel resources, patients' families, societal and organizational attitudes, routine-centered care, relationship with peers), differences in perceptions between nurses and patients/relatives, nurses' personal responses to ethical issues, and, respectively, patient-nurse relationships (Rees, King, & Schmitz, 2009). In 2017, Wilson at al. have conducted a review of literature reviews to explore the scientific evidence regarding how extensive and common healthcare ageism is, as well as to examine its influence on patients and medical personnel alike. They also sought to retrieve data regarding evidence-based interventions and prophylactic methods aimed at reducing ageist attitudes and practices. Their results revealed the existence of gaps in empirical research regarding contributing and causal factors that

influence ageism, adequate methods that assess ageist attitudes, a solid knowledge base concerning ageing and, respectively, appropriate techniques to study the existence and extent of ageism. One of the most common ageism topic found by Wilson at al. (2017) concerned the attitudes exhibited by different social groups towards the elderly, with medical students and physicians holding more positive attitudes as compared to practicing nurses and nursing students – a trend which only worsens in time (Chonody, 2015; Hanson, 2014). Another thematic area which received scientific attention concerns the outcomes of healthcare ageism, with harm to elderly people being the most notable consequence (e.g. Hanson, 2014; Meisner, 2012).

Concerning interventions to prevent or treat ageism, educational and informative strategies seemed to have fostered more positive attitudes toward older people (Chonody, 2015), although the results concerning the effects of acquisition of new knowledge were mixed (Meisner, 2012). In the nursing educational settings, ageism may be observed in practices of prioritizing specialties other than gerontological ones, as well as a failure to promote knowledge in positive attitudes towards caring for older people (e.g. Shen & Xiao, 2012). Other ways in which ageism is manifest in nursing include the nurse-patient relationship and nurses' comprehension of ethical issues when caring for the elderly (Rees et al., 2009). The undesirability of geriatric nursing, as perceived by students and practitioners alike, translates into a poorer care provided to the elderly (Gallo, 2019; Kagan et al., 2015). Specifically, the outcomes of ageism in nursing healthcare are: inhibiting care of the elderly, speaking down to them, providing unequal care as compared to their younger counterparts (DeBrew, 2015), talking slower or louder to older adults, stereotyping concerning the elderly's appearance, feelings of powerlessness and low self-esteem among the elderly, inadequate care provision via the attribution of physiologic complications to age rather than to disease (DeBrew, 2015), disproportionate provision of oncologic treatments (Schroyen et al., 2015).

Past research has also shown that the attitudes of nurses towards the elderly are influenced by a series of factors including culture, age, gender, socio-economic status, education, previous experience and interaction with this segment of population, the valence of the discourses employed in nursing education, the clinical environment of work, attitudes of other professionals, workload pressures, regarding gerontological nursing as uninteresting and unchallenging, a low level of knowledge and skills concerning gerontological nursing, a perceived lack of career advancement opportunity in this segment of work (for a review, see Coleman, 2015).

To address these issues, we propose investigating ageism in healthcare within the framework of Social Representations Theory (SRT) and bridging the research conducted in moral psychology (i.e. Ellemers et al., 2019) with the traditions of research in ethical nursing by including predictors from the most well-known and well-tested theoretical models of moral judgement – Moral Foundations Theory (Graham et al., 2011) and Model of Moral Motives (Janoff-Bulman & Carnes,

2016). This way, we may better understand both the social and the individual contributors to ageism in healthcare, as well as their collective influence on ethical decision-making in geriatric nurses, so that we may design adequate health interventions for both practicing nurses and students to optimize the healthcare of the elderly.

SRT is a supradisciplinary field in Social Psychology, studying everyday knowledge shared by social groups (Moscovici, 1961). The main contribution of SRT to the Health Psychology field is its ability to shed light on how lay people understand health and illness, and of how these meanings evolve in time and under the influence of certain socio-cultural and historical factors. In the study of ageing, SRT has often been employed in an attempt to construct a Social Psychology of Ageing, which bridges the current gaps between Medical Sociology, Social Gerontology, and the more mainstream approaches to the Psychology of ageing (e.g. Health Psychology). The largest proportion of the research conducted in these aforementioned fields has mainly focused on intraindividual psychological processes specific to ageing, and on interindividual characteristics of the elderly, as explained by decontextualized psychological factors. SRT addresses these limitations and allows us to locate the elderly in their social, symbolic and material contexts, where ageism plays an important role in shaping up what older adults experience both socially and psychologically (i.e. the importance of the way in which we interact with older people, as it was shown to significantly influence their cognitive performance as measured by standardized tests) (for a review see Wright-Bevans & Murray, 2018). Given that ageing is mainly associated with decline and illness - except for when it is specifically framed in a positive way in the social discourse (e.g. Gherman, 2014) – it is very important for us to investigate the role of social power asymmetries and the relevant social agents (e.g. health professionals) in the legitimization and perpetuation of the currently hegemonic negative SRs of ageing and the elderly. SRs both shape and define how people conceptualize ageing, as they represent a powerful communicative tool, embedding systems of values, ideas and practices. Through social interaction, we all create and maintain SRs, which contribute significantly to the formation and negotiation of social identities. For example, one source of moral distress in geriatric nurses were their conflicts with doctors, whom they perceived as morally disengaged from older patients, but also as more powerful social agents in the medical field (Suhonen et al., 2010). This is how SRs allow us to study knowledge from a political perspective as well, by identifying the social groups who become "othered" in the interplay between professionals, policy makers, popular figures and passive minorities. In our case, we expect that in different contexts, both nurses and elderly patients may feel as minority out-groups in relation to other social groups (e.g. doctors) or to governmental regulations perceived as ageist. Previous literature reviews have underlined that nurses both perpetuate and suffer adverse consequences of ageism in what regards geriatric healthcare; for instance, they experience *moral distress* when they feel forced by external factors to make ageist decisions, while subtly

manifesting prejudice towards the elderly themselves, by regarding their symptomatology as a natural consequence of ageing and not of a specific affliction (Morley, Bradbury-Jones, & Ives, 2019; Yildiz, 2017). Whether symbolic or instrumental, power leads to the reification and legitimization of SRs, which may normalize ageist negative or harmful practices, as well as cultures of exclusion and unequal distribution of resources in healthcare (Wright-Bevans & Murray, 2018). Concerning ageing, negative SRs may be both the cause and consequence of ageist attitudes and practices, interwoven through communication and the fabric of social and governmental institutions (e.g. the segregation of older people and residential communities or institutions).

The main research goal of our project is to explore and investigate a series of social and individual contributing factors to ageism in healthcare and their cumulative influence on the processes of ethical decision-making in practising nurses and nurses in training. To our knowledge, this would be the first study in this field to consider ageism as a mediating variable between socio-cultural and individual factors and, respectively, ethical decision-making in practicing nurses and nurses in training. Study 1 aims to detect ageism in this population and its most significant predictors by exploring their social representations of the elderly and of ageing, as well as a series of concepts revealed by previous literature reviews to be of relevance. The goal of the second study is to test the influence of the relevant predictors identified in Study 1 on ethical decision-making and moral behaviour, and the influence of ageism as a potential mediating variable.

A pilot study will be conducted first with the dual objective of appraising how problematic ageism is in the nursing profession (by exploring the content of the social representations of the elderly and ageing) and, respectively, of identifying the moral dilemmas with which the latter are often confronted in Romania through assessing their moral distress. In 2019, Morley, Bradbury-Jones and Ives have shown the relevance of studying moral distress in nurses with qualitative methods, such as interpretative phenomenological analysis, a manner in which we may identify the main sources of moral distress among this population. In the UK, the authors found moral tension, moral uncertainty, moral constraint, moral conflict and moral quandaries to cause psychological distress in critical care nurses, topics which we will explore in our interviews for this study. We aim to further their line of research by diversifying the methods they used and investigating the issues of moral distress in this population in the Romanian context. Hence, for data collection, we will employ within-method triangulation, respectively, the episodic interview, which combines answering questions with invitations to recount relevant situations in a narrative and has been previously employed in SRT studies on nurses' social constructions of health and illness (e.g. Flick, 2000). The aim of this procedure is to access episodic as well as semantic memories, based on an interview guide meant to orient the interview topically and to elicit narrative data. This will enable us to explore sources of moral distress as well as ageism, both semantically (at an abstract level) and narratively (i.e. in

episodic recollections of real-life events from personal/witnessed past experiences), thus increasing the ecological validity of our research.

Study 1 will investigate the social representations of aging and the elderly in three groups – nurses in training, nurses in acute-care settings and geriatric nurses through verbal association tasks, respectively *prototypical analysis* and *hierarchical evocations*. Our purpose is to appraise the existence, extent and nature of ageism in the Romanian socio-cultural healthcare context, as well as to identify its strongest predictors. To this end, we will measure a series of significant predictors revealed by previous research conducted elsewhere, respectively: age, gender, socio-economic status, level of education, whether living with an older person, previous working experience with geriatric population (self-report item, open-ended, to estimate duration), frequency of social interaction with healthy older people (self-report item, multiple choice, ranging from *more than once a week* to *once a year*), preference to work with the, knowledge of aging, self-ageing anxiety, death and self-ageism. We hypothesize that the SRs of the elderly and the SRs of ageing will best predict ageism, because they are apt at reflecting the tripartite structure of ageism (affective components – prejudice, cognitive elements – stereotypes and behaviours – discriminatory practices). Thus, the valence (positive/negative) of the SRs of ageing and the elderly should account for a larger proportion of variance as compared to self-ageism, anxiety towards ageing, previous knowledge regarding the elderly and other individual predictors, due to the institutionalized ageist practices we expect to find (Căciulă et al., 2010). We also expect to find differences between nursing students and practicing nurses with respect to the influence of SRs on ageism, because it may be the case that institutionalized ageism is internalized by nurses with the accumulation of professional experience (and implicitly, with exposure to ageist work climates), according to the findings of Suhonen et al., 2010 and Yildiz, 2017. Thus, we believe that the studied SRs will best predict ageism for geriatric nurses, followed by nurses in acute-care health institutions and, respectively, nursing students.

The purpose of Study 3 is to assess whether *ageism* is a mediating variable in the relationship between several socio-cognitive factors and, respectively, moral decision-making and behaviour in healthcare. First, we will assess the moral motives of our participants with the Model of Moral Motives Scale (Janoff-Bulman & Carnes, 2016) to understand how morality operates in the social regulation of moral behaviours. We expect that a stronger motivation to protect (rather than to provide) will be associated with higher levels of ageism, based on the results of previous research, which showed that proscriptive morality leads to higher in-group favouritism and out-group derogation (e.g. Janoff-Bulman & Carnes, 2016). Second, we will appraise the moral beliefs and concerns of our participants with the Moral Foundations Questionnaire (Graham et al., 2011) concerning five factors – Harm/care, Fairness/reciprocity, Ingroup/loyalty, Authority/respect, and Purity/sanctity. Previous studies have shown the relevance of nurses' beliefs regarding autonomy and

authority concerning their moral decision-making (e.g. Georges & Grypdonck, 2002), as well as potential connections between *purity/sanctity*, disgust and ageism (Gilleard & Higgs, 2011).Thus, we believe that interindividual differences in moral foundations will influence the ethical courses of action selected by our participants more than their knowledge of the deontological code of conduct specific to their profession.

Nurses' moral decision-making and behaviours will be assessed through their answers at a series of moral dilemmas. In constructing the dilemmas, we will use the results from our first pilot study employing episodic interviews, as well as thematic areas previously signalled as problematic by scientific literature reviews conducted on international populations (and pilot tested for relevance in a Romanian sample), and we will present participants with choices made by characters who are to be considered as typical Romanian nurses. To sum up, the independent variables in Study 2 will be the significant predictors of ageism found in Study 1, the socio-professional group to which they belong, along with the participants' moral motives and foundations.

Our project proposes for the study of the ethical issues faced by gerontological nurses and nursing students an original interdisciplinary integration between moral psychology, sociology, social psychology and, respectively, health psychology, at both a conceptual and a methodological level. Thus, by employing the framework proposed by the Structural and the Social Positioning Approaches to SRT in assessing ageism, we bring together social cognitive and the sociological perspectives in an attempt to seize the context-specific as well as the individualized characteristics of the antecedent factors to ageism in the Romanian healthcare nursing setting. Finally, assessing how nurses and nursing students cope with ethical dilemmas constructed according to the culturally-operational ethical code of conduct, past research and rigorous pretesting is a novel approach to investigating this phenomenon; also, the influence of ageism on this type of ecologically valid life-like scenarios has not been studied before, to our knowledge.

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