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AGEISM: PATERNALISM AND PREJUDICE

Linda S. Whitton*

Betty Anderson is a seventy-year-old widow whose husband died two years ago leaving her financially well set with a three-hundred-thousand-dollar house and over one million dollars in investments. Several months ago Mrs. Anderson's children admitted her to Sunnyvale Retirement Center, and now she wants to return home. You have been contacted by Mrs. Anderson for legal advice.

You discover upon meeting Betty Anderson that she is a well-dressed, articulate woman. After initial pleasantries, she describes to you in narrative fashion her life of the past two years. Mrs. Anderson states that following her husband's death she was quite depressed, became prescription drug dependent, and often had a few too many cocktails in the afternoon. Her children, claiming they were having her house repainted, took her to Sunnyvale to live "temporarily." Now, she observes, they rarely visit, and when questioned about the status of her house, they respond with ever-changing excuses for why she cannot return home.

At the conclusion of your interview with Mrs. Anderson, you speak with Mr. Cory, the Social Services Director of Sunnyvale. Mr. Cory explains that Mrs. Anderson was admitted to Sunnyvale four months ago under authority granted to her son in a durable power of attorney. Attached to the power of attorney was a physician's letter certifying that, in the physician's opinion, Mrs. Anderson was incapacitated and unable to act in her own best interests. Mr. Cory also informs you that Mrs. Anderson's son has filed a petition for guardianship over Mrs. Anderson. When asked whether he believes Mrs. Anderson would be capable of living independently in her own home, Mr. Cory replies that she has made remarkable progress at Sunnyvale. He attributes her state of well-being to proper diet and the cessation of her former substance abuse. He expresses concern that if Mrs. Anderson returns home she may get lonely and depressed again and fall back into her old pattern of living. Mr. Cory admits, though, that currently there is no apparent

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reason why Mrs. Anderson could not live on her own. Upon further investigation, you discover that Mrs. Anderson’s son has already sold her home and all of her furnishings, and that the guardianship hearing is only two weeks away.

The foregoing scenario was presented to law students in an Elder Law class as the basis for a comprehensive semester project. The fact pattern, based on a real life situation, is surprisingly not unique. The students were instructed to identify the legal issues raised by Mrs. Anderson’s circumstances and to research and develop a strategy for her legal representation. They were also asked to consider the consequences, both legal and nonlegal, of planning for Mrs. Anderson’s future in an environment of eroding family trust. Included in their responsibilities as Mrs. Anderson’s lawyer would be the particularly difficult task of informing her of the sale of her house and identifying options for her future living arrangements.

The students were required to make an oral presentation of their conclusions and recommendations at the end of the semester. As the professor anticipated, the class discussed issues related to the validity and scope of the durable power of attorney and defense strategies for the guardianship proceeding. Unanticipated, however, were the students’ recommendations concerning how an attorney should advise Mrs. Anderson about her options for the future.

A majority of the students did not even consider the purchase of another house to be a viable option for Mrs. Anderson. The most common suggestions focused on finding a “nice apartment” in a retirement community where Mrs. Anderson would be less likely to be-

1. The author, who was the professor of this Elder Law class, became aware of “Mrs. Anderson’s” situation while serving as a volunteer board member of a nonprofit community nursing home.

2. See, e.g., Barbara G. Anderson, Love and Sex After Sixty, in AGING 175 (Aliza Kolker & Paul I. Ahmed eds., 1982) (recounting the background of “Angie,” who had been “devastated by the death of her husband and had been brought to the [nursing] home in a state of deep despondency after 2 years of living alone in a large suburban home. Her only daughter had, in the meantime, managed to sell her mother’s home, so that now she found herself without a place to go.”); see also Buffler v. Buffler, 577 So. 2d 904, 905-06 (Ala. 1991) (reversing a lower court judgment which imposed a limited conservatorship where the only evidence substantiating the judgment was that the appellant had mild depression and her siblings were concerned that she might waste her money); Cummings v. Stanford, 388 S.E.2d 729, 729-30 (Ga. Ct. App. 1989) (affirming a grant of a daughter’s petition for guardianship over her mother’s property despite a psychologist’s testimony that he did not consider the mother incompetent and where the grounds in support of the guardianship consisted merely of the fact that the mother had spent considerable sums of money since her husband’s death, including buying another house and paying for a five-week vacation to Florida with her sons); In re Estate of Wagner, 367 N.W.2d 736, 739-40 (Neb. 1985) (affirming an order vacating appointment of a conservator where the evidence did not support the ostensible grounds for the conservatorship, which were the ward’s advanced age, grief over the husband’s death, and subtle undue influence).
come "lonely and depressed" again. Some even suggested that it might be best not to object to the guardianship proceeding, but to negotiate instead for limited guardianship so that a supervisory mechanism would be in place should Mrs. Anderson "fall off the wagon."

Surprised by these responses after a semester of consciousness raising about ageism and stereotyping, the Elder Law professor then asked the students to reconsider the initial fact situation with one alteration in the facts: If Mrs. Anderson were thirty-five years old instead of seventy, would your advice change? Changing this one fact, the age of the client, was a catalyst for exploring previously unexamined attitudes. The class noted that if Mrs. Anderson had been thirty-five, rather than seventy, years old, concerned family members probably would have encouraged her to enroll in a rehabilitation program or to seek psychological counseling, rather than admitting her to a nursing home. In this changed context, a recommendation that Mrs. Anderson permanently give up her home because of grief-related depression would seem unreasonable if made by family members and outrageous if encouraged by her lawyer. Nonetheless, those same actions and recommendations were previously viewed as at least palatable for a woman of seventy.

The purpose of this article is to examine what factors shape our individual and collective attitudes about age and to explore the impact of those attitudes on the ways that lawyers practice law, legislators formulate public policy, and judges make decisions. With society aging at an unprecedented rate, the integrity of the legal profession as well as other service-oriented professions will depend on the constituent attitudes, beliefs, and motivations of those individuals who, through their interactions, have the power to formulate public policy.

3. The most significant demographic trend of this century is the exponential increase in the number of elderly persons as a percentage of the total U.S. population. See Senate Special Comm. on Aging, 101st Cong., 2d Sess., Aging America: Trends and Projections (Annotated) (Comm. Print 1990). The population segment comprised of persons age sixty-five and older more than doubled as a proportion of total population between 1900 and 1987 and is expected to nearly double again between 1985 and 2030. Id. at 1-4. If these trends continue as anticipated, by the turn of the century persons age sixty-five and over will comprise 13% of the population, and by 2030 the percentage will rise to 21.8%. Id. at 3. Furthermore, this demographic trend is almost a worldwide phenomenon. See The Economics of Aging, Economist, Jan. 27, 1996, at 3 (noting that 18% of the people in OECD (Organization for Economic Cooperation and Development) countries were over the age of sixty in 1990 and that this percentage is anticipated to rise to over 30% by 2030; only Africa is expected to be exempt from this trend). As Robert N. Butler explains, "[t]he demographic revolution is not a result of extending the inherent human life span, but reflects reductions in maternal, infant, and child mortality and advances in treating and preventing cardiovascular and other diseases common in later life." Robert N. Butler, The Triumph of Age: Science, Gerontology, and Ageism, 58 Bull. N.Y. Acad. Med. 347, 349 (1982) [hereinafter Butler, The Triumph of Age].
and the privilege of delivering necessary services. Uncovering and understanding previously unrecognized or unconscious forms of ageism is thus an essential step toward promoting such professional integrity.

As a foundation for the exploration of ageism in the legal profession, Part I of the article looks at patterns of societal behavior, beliefs, and attitudes about age, including age segregation, obsession with youth, and fear of the elderly and aging. Current research about the mental and physical effects of aging will also be reviewed, and common aging myths and stereotypes reexamined. Because ageism has been discussed most extensively in the context of the health care profession, Part II will summarize the impact of attitudes about aging on the formulation of health care public policy and the delivery of medical services. The impact of ageism in the health care profession is then used as a basis for analogy in Part III, where the legal profession will be evaluated for signs of previously unrecognized ageism in methods of practice, legislation, and judicial decision making.

I. FROM AGE SEGREGATION AND YOUTH OBSESSION TO GERONTOPHOBIA—THE COMING OF AGE OF AGEISM

The term "ageism," coined in 1968 by Dr. Robert N. Butler, the first director of the National Institute on Aging, was originally defined as:

[A] systematic stereotyping of and discrimination against people because they are old, just as racism and sexism accomplish this with skin color and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills .... Ageism allows the younger generation to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings.

Twenty years later, Dr. Butler noted that the current manifestations of ageism go beyond stereotyping and alienation and include both envy

4. Or, as social constructionists would argue, the "constitutive elements, the underpinnings of what we label ageism, are part and parcel of social organization because the meaning of people, places, and things is socially created through interaction." Jon Hendricks, The Social Construction of Ageism, in Promoting Successful and Productive Aging 51, 65 (Lynne A. Bond et al. eds., 1995); see also As Time Goes By: Deep-Seated Ageism Occurs All Around Us in Many Subtle Ways, Seattle Times, Feb. 7, 1993, at L4, available in 1993 WL 5978742 (noting that there may be laws to combat age discrimination in employment, "but no legislation to cover deep-seated attitudes embedded in public policy and private opinion").

and resentment of the elderly—envy of affluent elderly for their economic successes and resentment of poor elderly for their ostensible burden on public benefits and tax expenditures. Dr. Butler concluded that there is universal fear of the increasing older population based on notions that such a population "will become unaffordable, lead to stagnation of the society’s productive and economic growth, and generate intergenerational conflict."

In the almost three decades since the term originated, ageism has received extensive attention from gerontologists, sociologists, and psychologists. Despite social scientists’ attempts to design and refine tests to measure ageism, the only conclusion which appears reasonably certain is that ageism exists but is an elusive and complex phenomenon. This section of the article will not, therefore, attempt to

7. Id. at 142.
9. See generally ERDMAN B. PALMORE, THE FACTS ON AGING QUIZ (Bernard D. Starr series ed., Springer Series on Adulthood & Aging No. 21, 1988) [hereinafter PALMORE, THE FACTS ON AGING QUIZ] (summarizing the purposes and methodology of The Facts on Aging Quizzes (FAQs) as well as the results of over ninety studies using the FAQs); Maryann Fraboni et al., The Fraboni Scale of Ageism (FSA): An Attempt at a More Precise Measure of Ageism, 9 CAN. J. AGING 56 (1990) (summarizing prior scales of measurement for cognitive perceptions of and attitudes toward the elderly and introducing the Fraboni Scale of Ageism (FSA) as an instrument designed to measure the affective component of attitude).
10. See PALMORE, THE FACTS ON AGING QUIZ, supra note 9, at 64-65 (noting controversy over the functions of the first FAQ, in particular, whether the FAQ1 is a more accurate measure of knowledge or attitudes); Fraboni et al., supra note 9, at 64 (noting the need for cross-validation studies of the FSA); see also Valerie Braithwaite et al., An Empirical Study of Ageism: From Polemics to Scientific Utility, AUSTL. PSYCHOLOGIST, Mar. 1993, at 9 (noting the divergence and complexity of study responses regarding aging and the elderly). Braithwaite and her colleagues attempted to clarify "the ambiguity that surrounds ageism" and examine "its legitimacy as a scientific concept." Id. at 10. While the data from their study did find an interrelationship between negative attitudes about aging and the elderly and negative stereotypes, as well as a relationship between fear of aging and such negative attitudes and stereotypes, the majority of responses to aging and the aged were mixed. Id. at 12.
produce finite definitions or measurements of ageism but, rather, will present an overview of the historical and theoretical explanations for the development of ageism. Notwithstanding the failure of social scientists to measure ageism with certainty, the present body of ageism-related scholarship, when taken as a whole, reveals patterns which mark ageism’s evolution. These patterns include the rise of age consciousness and age segregation, an obsession with youth, and the increasingly observed fear and resentment of the aged, sometimes labeled “gerontophobia.”

A. Age Consciousness and Age Segregation

Although people have aged since time immemorial, chronological age has not always been the important means of social categorization and organization that it is today. Written accounts of life prior to the mid-nineteenth century are practically devoid of the mention of age as an organizing principle. One explanation for the relative unimportance of chronological age in that era was the economic interdependence of multigeneration families. Prior to 1850, most families operated as self-reliant economic units in which individual family members of all ages, from small children to the elderly, contributed to the productivity of the collective. Likewise, participation in education and community activities also tended to be age integrated. So

11. See infra notes 15-53 and accompanying text.
12. See infra notes 54-89 and accompanying text.
13. See infra notes 90-101 and accompanying text.
14. The term gerontophobia is derived from two Greek words, geras (old) and phobos (fear).
15. Howard P. Chudacoff, How Old Are You?: Age Consciousness in American Culture 20-27 (1989). But see Bytheway, supra note 8, at 17-18 (noting that ancient Persians observed birthdays and Greek philosophers recorded chronological ages, but that in computing age “there was also a degree of latitude which permitted rounding, estimating, inconsistencies and forgetting”).
17. Chudacoff, supra note 15, at 15 (observing that before age-graded schools in the mid-nineteenth century, education followed “diverse and unsystematic paths . . . . There was no uniform age of entry into, or departure from, these schools, and it was not uncommon to see
unimportant was chronological age to daily existence that most people did not even keep an awareness of their exact age.18

The ambivalence toward chronological age prior to the mid-nineteenth century should not be confused, however, with an ambivalence toward the process of aging. Before chronological age gained acceptance as the standard measurement of life, the aging process was conceptualized as a series of stages.19 The number and significance of life stages varied over time and according to culture and tradition, but the archetype of life as a staged journey remained constant in art and literature from the time of antiquity.20 For example, Aristotle viewed life in three stages, delineated by growth, stasis, and decline.21 In the sixteenth century, the symbol of a two-sided staircase depicted life as a rise and fall;22 in nineteenth-century France, there were at least sixteen different versions of what was known as the “steps of the ages,” ranging from three to eleven stages.23 Stages-of-life theories were based on categories such as youth, middle, and old age,24 and on the influence of the planets25 or seasons,26 but not distinct chronological demarcations.27

Several convergent trends in the mid-to-late nineteenth century marked the emergence of chronological age as a new basis for categorizing individuals and the aging process. Although industrialization is usually cited as the most influential of these trends,28 advancements in science and medicine were at least concomitant, if not integrally re-


19. See BYTHEWAY, supra note 8, at 19; CHUDACOFF, supra note 15, at 9; COLE, THE JOURNEY OF LIFE, supra note 18, at 5.

20. For an in-depth discussion of the stage metaphor for life and aging, see COLE, THE JOURNEY OF LIFE, supra note 18, at 5-31.

21. Id. at 5-6.

22. Id. at 19-20 (describing a 1540 woodcut by Jorg Breu titled The Ten Ages of Man which depicted this symbolic staircase); see also BYTHEWAY, supra note 8, at 21 (commenting that all stage models since the sixteenth century have involved an element of rise and fall).


24. Id.


26. Id. at 14-15.

27. See CHUDACOFF, supra note 15, at 14-20 (describing the “organizations and institutions” of preindustrial America as a blending and mingling of age groups).

28. See YOUNG & SCHULLER, supra note 16, at 3 (noting that “[it] was the factory that put an end to the all-age family as the unit of production and brought into existence age-classes where there had been none before”).
lated, factors in the transition from an age-integrated to an age-conscious and age-graded society.\textsuperscript{29} The production efficiencies of factories permitted families to live above the subsistence level and diminished the need for the labor of children and the elderly.\textsuperscript{30} Not only was the labor of older workers considered less essential to family survival, writers in the early twentieth century argued that older workers were not as efficient as younger workers and should therefore retire.\textsuperscript{31} During this same time period, science and medicine began using age to organize the study of physical and psychological development,\textsuperscript{32} as well as pathology.\textsuperscript{33} In medical circles, old age became synonymous with disease and degeneration,\textsuperscript{34} leading to the conclusion that the illnesses of the elderly were a result of natural deterioration, and thus untreatable.\textsuperscript{35} Old age also became more closely associated with death as improved health care lowered mortality rates and more individuals survived to an older age.\textsuperscript{36}

By the turn of the century, the concept of age segregation had invaded education, industry, and family life.\textsuperscript{37} The emphasis on rationality and efficiency produced a new system of education where students became segregated by peer groups, rather than abilities, and were advanced in lock-step fashion by age.\textsuperscript{38} In the workplace, the

\textsuperscript{29} CHUDACOFF, \textit{supra} note 15, at 5-6.
\textsuperscript{30} YOUNG \& SCHULLER, \textit{supra} note 16, at 3-4.
\textsuperscript{32} See, e.g., CHUDACOFF, \textit{supra} note 15, at 55. According to Howard P. Chudacoff:

The earliest and most important developments in this separation [of old people from the rest of society] occurred in medicine; indeed, just as the evolution of pediatrics reflected new conceptions of the distinctiveness of childhood, a parallel movement did the same for old age and paved the way for the establishment of a new medical specialty for the treatment of old people.

\textit{Id.} at 55. The author also noted the development and impact of psychologist G. Stanley Hall's theories of child development. \textit{Id.} at 66-67.
\textsuperscript{33} See, e.g., Achenbaum, \textit{The Obsolescence of Old Age, supra} note 31, at 30 (describing the work of Drs. Charcot and Loomis as laying the basis for a pathology of senility); CHUDACOFF, \textit{supra} note 15, at 56 (same).
\textsuperscript{34} CHUDACOFF, \textit{supra} note 15, at 56.
\textsuperscript{35} \textit{Id.} at 58.
\textsuperscript{36} \textit{Id.} at 13-14; COLE, \textit{THE JOURNEY OF LIFE, supra} note 18, at 3-4.
\textsuperscript{37} CHUDACOFF, \textit{supra} note 15, at 27-28, 65.
\textsuperscript{38} See \textit{id.} at 35-36 for discussion of the evolution of graded common schools:

Through the standardization of grades, educators thought they had found a means of bringing order to the socially diverse and seemingly chaotic environment of American schools. To achieve their goals of efficient management, reformers explicitly copied the new factory system, in which a division of labor was used to create a product, from raw material, in successive stages of assembly, each stage building upon the previous one.

\textit{Id.} at 36.
rising prevalence of old-age pensions encouraged workers to accept age sixty-five as the appropriate end of productive life. Even the age composition of families changed as the size of the average family decreased with the shift from agrarian to industrial life. Preindustrial American families were typically composed of a large number of children spread over many years, and distinctions between generations were blurred by a broad age range among siblings. In postindustrial families with fewer children, the gap between generations became greater because the ages between children were more compressed. The combined result of these trends was a growing importance of peer associations and a decreasing significance of intergenerational relationships.

The rise of age consciousness and age segregation in the nineteenth century can be objectively verified by the aforementioned trends in industry, science, medicine, and education, but the subjective impact of these trends on attitudes about aging and the elderly is more difficult to assess. Just as modern written accounts are tainted by the inherent biases of the authors' views and objectives, the writings of past generations must also be viewed skeptically before accepted as representative of the societal values and beliefs of the day. But even accounting for such biases, a comparison of religious, popular, medical, and scientific writings of the nineteenth century reveals significant similarities in attitude shifts about aging.

Scholars may disagree about the predominant causes of these attitude shifts, but the observed pattern of attitude change itself is

40. See CHUDACOFF, supra note 15, at 93-95.
41. Id. at 93-94.
42. Id. at 95.
43. Id. at 97-98 (noting that "[t]he family, once generationally integrated in a functional and emotional sense, had become a way station for different peer groups").
44. BYTIEWAY, supra note 8, at 17 (observing that in addition to the biases contained in historical data, "historians are in business with their publishers, and they do good business paradoxically, not just by challenging what they perceive to be widely held but invalid beliefs, but also by adopting uncritically other popular assumptions and terminology"); Achenbaum, The Obsolescence of Old Age, supra note 31, at 26 (noting that most historical data are derived from works written by "white, male professionals living in an urban environment").
45. See Achenbaum, The Obsolescence of Old Age, supra note 31, at 26; see also infra notes 48-53 and accompanying text (discussing the attitude shifts about aging).
46. Compare COLE, THE JOURNEY OF LIFE, supra note 18, at 90 ("The origins of ageism... lie both in the revolt against hierarchical authority and in the rise of Victorian morality."); with Achenbaum, The Obsolescence of Old Age, supra note 31, at 26 ("A preliminary profile of changing attitudes toward old age emerges from a consideration of four factors: the aging of the population; new scientific research into the physiological and psychological aspects of senescence; a deliberate effort by big business to retire workers arbitrarily at sixty-five; and the emergence of a cult of youth."); see also PALMORE, AGEISM: NEGATIVE AND POSITIVE, supra note 8,
nearly the same: a neutral or predominantly positive view of old age prior to the mid-to-late nineteenth century, followed by an increasingly negative attitude at the turn of the century.\textsuperscript{47} Explanations for a neutral or positive view of the aged in the mid-nineteenth century include the elderly's hierarchical power to control testamentary distribution of land in an agrarian society,\textsuperscript{48} the generally pervasive romanticism and idealism of the period,\textsuperscript{49} and the important family roles of the elderly in intergenerational homes.\textsuperscript{50} Negative attitudes, on the other hand, have been attributed to early medical and scientific studies that increasingly linked old age with physical and mental pathology,\textsuperscript{51} the preoccupation with efficiency prompted by industrialization of the early part of the century,\textsuperscript{52} and the higher proportion of elderly in the population, obsolescence of older workers' skills because of new technology, and greater emphasis on individual achievement and efficiency; Brian Gratton, \textit{Factories, Attitudes, and the New Deal: The History of Old Age, in Growing Old in America: New Perspectives on Old Age} 28, 28-39 (Beth B. Hess \& Elizabeth W. Markson eds., 3d ed. 1985) (summarizing debates over the role of industrialization and modernization in the history of old age).

\textsuperscript{47} See Achenbaum, \textit{Images of Old Age}, supra note 23, at 20-21 (commenting that in the exhibit, \textit{Images of Old Age in America, 1790 to the Present}, produced by the author and an art librarian, the section dealing with 1790 to 1864 accentuated positive images, and the period from 1865 to 1934 emphasized the negative); Achenbaum, \textit{The Obsolescence of Old Age}, supra note 31, at 26; see also Palmore, \textit{Ageism: Negative and Positive}, supra note 8, at 59-63 (describing the social influences that contributed to the decline in status and prestige of the elderly from the post-Civil War era until after World War II). \textit{But see Cole, The Journey of Life}, supra note 18, at 231-32. Cole argues that the shift in attitude about the aged did not turn from positive to negative but, rather, became dualistic:

Victorians split old age into sin, decay, and dependence on the one hand, and virtue, self-reliance, and health on the other. According to the consensus constructed by revivalists, Romantic evangelicals, and popular health reformers between 1830 and 1870, anyone who lived a life of hard work, faith, and self-discipline could preserve health and independence into a ripe old age; only the shiftless, faithless, and promiscuous were doomed to premature death or a miserable old age.

\textit{Id.} at 232.

\textsuperscript{48} Gratton, supra note 46, at 31-32.

\textsuperscript{49} Cole, \textit{The Journey of Life}, supra note 18, at 136 (“Romantic ministers idealized the aged and painted them as symbols of an idyllic rural or revolutionary past.”).

\textsuperscript{50} Achenbaum, \textit{The Obsolescence of Old Age}, supra note 31, at 27 (noting that the elderly performed important duties in the home, including child-raising responsibilities and that this association between the elderly and the home “created an appealing and sentimental image of old age”).

\textsuperscript{51} See, e.g., Chudacoff, supra note 15, at 56. One of the most sensational examples of negative attitudes in the medical community was the farewell lecture delivered by Sir William Osler in 1905 on the occasion of his departure from Johns Hopkins University. William Osler, \textit{The Fixed Period} (Feb. 22, 1905), in \textit{Aequanimitas} 375, 381-82 (1906), \textit{reprinted in The “Fixed Period” Controversy: Prelude to Ageism} (Gerald J. Gruman ed., 1979). He titled his address, \textit{The Fixed Period}, after a novel by Anthony Trollope in which all persons over sixty-seven and one-half years of age were euthanized. \textit{Id.} at 382. Osler advocated in his lecture that creative work should be left to those under age forty and that all those over age sixty are useless and should retire. \textit{Id.} at 382-83. Although some critics believed that Osler intended, on one
zation, and a growing association between new technology and youth.

B. The Obsession with Youth

The association between youth, new technology, and the future formed the foundation for what historian W. Andrew Achenbaum has described as the "youth cult." The advent of this obsession with youth actually preceded the "baby boom" of the mid-twentieth century and is attributed to a cultural belief at the turn of the century that young people embodied the qualities necessary to advance society into a new progressive era. Achenbaum summarized the phenomenon as follows:

In short, popular writers created a new image of old age from the perspective of exalted youth. The young refused the old admittance into their world. Youth no longer revered age; they excluded it. The stage of life romantics once characterized as the season of rest had become one of discontent.

Of course, the strength in numbers of the baby boom generation intensified the cult of youth, as is reflected by the focus of present-level, for his comments to be humorous and self-deprecating given that he was over the age of fifty-five when he delivered the lecture, they also noted the underlying seriousness of his message. See Gerald J. Gruman, Introduction to The "Fixed Period" Controversy: Prelude to Ageism (Gerald J. Gruman ed., 1979); James Crichton-Browne, The Prevention of Senility (July 20, 1905), in The Prevention of Senility and a Sanitary Outlook 3, 13-14 (1905), reprinted in The "Fixed Period" Controversy: Prelude to Ageism (Gerald J. Gruman ed., 1979).

52. See Achenbaum, The Obsolescence of Old Age, supra note 31, at 31 for a quote from F. Spencer Baldwin, professor of economics at Boston University:

In the first place there is the direct loss involved in the payment of full wages to workers who are no longer reasonably efficient, and in the second place, there is the direct loss entailed by the slow pace set for the working force by the presence of worn-out veterans . . . .

Id. at 31. Another classic example of this sentiment is the work of Dr. George M. Beard, who argued that the most productive potential in a man's life is between the ages of thirty and forty-five and that young men are better at original work because it requires enthusiasm, whereas older men are better at routine work which relies more heavily on experience. George M. Beard, Legal Responsibility in Old Age: Based on Researches into the Relation of Age to Work 7-8 (1874), reprinted in The "Fixed Period" Controversy: Prelude to Ageism (Gerald J. Gruman ed., 1979).

53. See, e.g., Palmore, Ageism: Negative and Positive, supra note 8, at 59 (noting that both rapidly changing technology and child-centered education tended to make obsolete the knowledge and job skills of elders); Achenbaum, The Obsolescence of Old Age, supra note 31, at 32 (recounting evidence from popular writings at the turn of the century which reflected the view that "America's economic system thrived on youth, not age").

54. Achenbaum, The Obsolescence of Old Age, supra note 31, at 32.

55. Id.

56. Id. at 33.

day popular media and marketing campaigns. Studies of prime-time television dramas, commercials, magazines, and advertisements reveal very few images of older people. When older Americans are featured, it is usually in the context of programs dealing with the "plight" of the elderly. A recent study of ageism in the advertising industry concluded that multiple factors influence the youth-driven culture of the media. These include that: (a) the majority of advertising agency professionals are young adults and are more comfortable advertising to young consumers like themselves; (b) most advertising is aimed at a narrow group of consumers who are in their twenties and thirties; (c) advertising professionals resist the notion that baby boomers will mature and that there is a need to become educated about older consumers; and (d) there is little, if any, pressure to change core-industry paradigms in order to accommodate the rapidly aging market. Furthermore, while the advertising professionals who participated in this study believed themselves to have a high level of knowledge about older markets, eighty percent overestimated the actual number of consumers over age fifty; seventy-five percent underestimated the discretionary spending power of the older market; and eighty-five percent underestimated the mature market's personal net worth. The study concluded that these misperceptions, taken as a whole, reflect an erroneous consensus among advertising professionals that mature consumers represent "[a] lot of poor people with little consumer potential."

Beyond the obvious impact on advertising content, erroneous notions held by advertising professionals have an even more pervasive


59. Friedan, supra note 58, at 39-41 (observing that a concomitant trend to the "pervasive media blackout of images of older people . . . in everyday American life" was increased "media attention to the 'plight' of the elderly, to age as a 'problem'" and citing programs on nursing homes, Alzheimer's disease, and the burdens of Social Security and Medicare as examples).


61. Id. at 12-17; see also Adele Scheele, Coping with Ageism, Working Woman, Feb. 1994, at 44 (describing the difficulties of a successful forty-eight-year-old advertising executive who found herself being ignored and shut out of opportunities by her thirty-one-year-old boss and co-workers who were in their twenties).

62. Lee, supra note 60, at 27.

63. Id. at 28.

64. Id. at 29.

65. Id.

66. Id.
effect on the content of media programming. Advertisers, relying on the advice of their advertising firms, generally believe that youth-oriented programs best attract the consuming public.67 This orientation has produced a kind of "youth nepotism" in the film and television industry similar to that in the advertising industry. Young executives tend to be selected to produce youth-oriented programs, and these young executives tend to surround themselves with young writers, directors, and actors.68 In fact, so widespread is the problem that the Caucus for Producers, Writers and Directors produced a documentary, titled Power and Fear: The Hollywood Graylist, highlighting discrimination against older television and film professionals.69

As the "young is better" campaign has gained momentum, the negative stereotypes of old age that began with the biomedicalization of age in the early twentieth century70 have become more entrenched. The typical negative stereotypes reported and studied by sociologists, psychologists, and gerontologists include beliefs that the old are impaired, incompetent, unproductive, depressed, disengaged, inflexible, senile, and lack sexual desire.71 These stereotypes are based on the premise that physical and mental failure in old age is inevitable.72

The "decline and failure" model of aging was supported by early gerontological cross-sectional studies.73 More recent studies of cogni-

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68. See, e.g., Easton, supra note 67, at 7 (noting that "young producers tend to staff shows with their peers—who are equally young"); Horowitz, supra note 67, at *2 ("Three-fifths of all TV writers are between ages 30 and 45.").


70. See supra notes 32-35 and accompanying text.

71. See Butler, Why Survive, supra note 5, at 6-10; Levin & Levin, supra note 8, at 95; Palmore, Ageism: Negative and Positive, supra note 8, at 18-25; Shura Saul, Aging: An Album of People Growing Old 20-27 (1974); Mary Lee Hummert et al., Judgments About Stereotypes of the Elderly: Attitudes, Age Associations, and Typicality Ratings of Young, Middle-Aged, and Elderly Adults, 17 RESEARCH ON AGING 168, 175 (table summarizing stereotype trait sets). But see Palmore, Ageism: Negative and Positive, supra note 8, at 29 (noting that ageism has also produced positive, but less common, stereotypes of old age, including the characteristics of "kindness, wisdom, dependability, affluence, political power, freedom, eternal youth, and happiness").

72. See supra notes 34-35 and accompanying text; see also Butler, Why Survive, supra note 5, at 7 (describing among the common myths and stereotypes of old age the belief that an older person is "a study in decline, the picture of mental and physical failure").

tive aging have revealed the deficiencies of the cross-sectional research design (which compares individuals of different ages at the same point in time) for measuring cognitive change. The weaknesses of the cross-sectional methodology include: (a) the difficulty of obtaining equally representative samples of persons within each age group; (b) the inability to differentiate cohort effects (generational differences in education, nutrition, social customs, exposure to media, etcetera) from the effects of age; and (c) the inability to measure intrapersonal change. Contrary to the results of cross-sectional studies, longitudinal studies (which are performed with the same group of individuals over a longer period of time) have found that "[s]ubstantial intellectual changes within individuals occur only late in life and tend to occur for abilities that were less central to the individuals' life experiences." Furthermore, there is increasing support for the theory that cognitive decline is not integrally related to aging.

[Psychological study of the aged is heavily infested with biomedical conceptions of aging as a disease or a result of some deteriorative process. For instance, cognitive processes at older age are often described in terms of failure, loss, insufficiency, inadequacy, impoverishment, decrement, inefficiency, or impaired performance. These biomedical conceptions reflect the dominant metaphor that aging is a biological or medical problem, and that the elderly make up a problem group in society.]

74. See Meredith Minkler, Aging and Disability: Beyond and Beyond the Stereotypes, 4 J. AGING STUD. 246 (1990), reprinted in PERSPECTIVES IN SOCIAL GERONTOLOGY 11, 12 (Robert B. Enright, Jr., ed., 1994) ("[L]ongitudinal studies . . . have demonstrated that, contrary to myth, no significant decline in intellectual functioning occurs with aging for the majority of older people . . . ."); K. Warner Schaie, Intellectual Development in Adulthood, in HANDBOOK OF THE PSYCHOLOGY OF AGING 266, 268 (James E. Birren & K. Warner Schaie eds., 4th ed. 1996) (noting that "cross-sectional data are not directly relevant to the question of how intelligence changes with age within individuals, nor will such data help discover the antecedents of individual differences in the course of adult development"); Baltes & Schaie, supra note 73, at 35.

75. See Kathryn A. Bayles & Alfred W. Kasznik, Communication and Cognition in Normal Aging and Dementia 222 (1987); see also Clark Tibbits, Can We Invalidate Negative Stereotypes of Aging?, 19 GERONTOLOGIST 10, 11 (1979) (quoting B.M. Steffl for the proposition that many early studies focused on elderly who were "congregated in poor farms, nursing homes, and state mental hospitals").

76. See Bayles & Kasznik, supra note 75, at 222 (stating that because "cohort effects are inextricably confounded with chronologic age in cross-sectional studies, it is not possible to differentiate ontogenetic . . . from cohort contributions to obtained research results"); Schaie, supra note 74, at 273-74 (explaining the significance of cohort effects).

77. See Schaie, supra note 74, at 268.

78. Id. at 270. Schaie also raises the interesting question of whether intellectual decline is normative or simply due to disuse and discusses the reversibility of intellectual deficit through cognitive training. Id. at 279-80.
processes but, instead, is a function of close proximity to death.\textsuperscript{79} For the majority of persons, it is now believed that age-related change in cognitive abilities is a very slow process, with only minimal declines of insignificant functional consequence.\textsuperscript{80}

A complete review of modern gerontological research on physiological and cognitive aging is beyond the scope of this article,\textsuperscript{81} but several conclusions, about which there is growing consensus, are worth mentioning:

1. The degree and rate of aging varies among individuals without regard to chronological age;

2. physiological and cognitive changes tend to occur at different rates within the same individual; and

3. the elderly, when defined as a group chronologically, are more heterogeneous than homogeneous.\textsuperscript{82}

\textsuperscript{79} For a discussion of the “terminal decline or drop” theory, see Stig Berg, \textit{Aging, Behavior, and Terminal Decline}, in \textit{HANDBOOK OF THE PSYCHOLOGY OF AGING} 323 (James E. Birren & K. Warner Schaie eds., 4th ed. 1996). \textit{See also} Baltes & Schaie, \textit{supra} note 73, at 36-37 (discussing the results of an intelligence study conducted by psychologists Klaus and Ruth Riegel which “pointed to a sudden deterioration during the five or fewer years immediately prior to death”); Minkler, \textit{supra} note 74, at 11-12 (noting “terminal drop” as the exception to the belief that “no significant decline in intellectual functioning occurs with aging for the majority of older people”).

\textsuperscript{80} See Minkler, \textit{supra} note 74, at 11-12; Schaie, \textit{supra} note 74, at 270-71; \textit{see also} Schaie, \textit{supra} note 8, at 181-82 (discussing the importance of distinguishing between cognitive changes that are only statistically significant and those that are significant in terms of magnitude).

\textsuperscript{81} As K. Warner Schaie observed in 1988, there has been “an explosion of knowledge in gerontology in general and in the psychology of aging in particular. The publication rate of research relevant to the psychology of adult development and aging has grown to more than 1000 articles and chapters per year . . . .” Schaie, \textit{supra} note 8, at 179.

\textsuperscript{82} See Birren & Schroots, \textit{supra} note 73, at 10 (summarizing conclusions drawn from longitudinal studies that “aging is at least in part an individualized process that differs among individuals and among functions”); \textit{id.} at 17 (“Chronological age is an initially appealing false lover who tells you everything and nothing.”); Fred L. Bookstein & W. Andrew Achenbaum, \textit{Aging as Explanation: How Scientific Measurement Can Advance Critical Gerontology}, in \textit{VoICES AND VISIONS OF AGING: TOWARD A CRITICAL GERONTOLOGY} 20, 28-38 (Thomas R. Cole et al. eds., 1993) (noting that “processes of aging do not proceed evenly with respect to the calendar” and arguing for a new measure of “gerontological age” that would incorporate the “differential rates in the dynamic processes of aging”); \textit{see also} BUTLER, \textit{WHY SURVIVE}, \textit{supra} note 5, at 7. Butler debunks the myth of chronological aging:

\textit{[T]here are great differences in the rates of physiological, chronological, psychological and social aging within the person and from person to person. In fact, physiological indicators show a greater range from the mean in old age than in any other age group, and this is true of personality as well. Older people actually become more diverse rather than more similar with advancing years.\textit{Id.} at 7; Minkler, \textit{supra} note 74, at 12 (noting the “substantive heterogeneity” of the aging population, Minkler observed: “While ‘downwardly’ sloping lines may accurately be drawn for aggregate population groups on such dimensions as vital capacity, there is in fact considerably \textit{less} clustering around the mean for older people than there is for their younger counterparts”).}
In sum, most current literature rejects the decline and failure paradigm of normal aging, concluding that both cognitive and physiological changes occur in varying degrees and at individuated rates.\(^8\)

But despite all of the evidence to the contrary, artificial "homogenization" of the elderly persists. When Dr. Butler first coined the term "ageism," the primary danger of negative stereotypes was thought to be the promotion of discrimination against and avoidance of the elderly.\(^8\) However, in 1979, Richard Kalish observed that negative stereotypes were not only being used by "ageists," but also by many advocates for the elderly.\(^8\) He labeled this phenomenon "New Ageism" and summarized its message as follows:

"[W]e" understand how badly you are being treated . . . [and] "we" have the tools to improve your treatment, and . . . if you adhere to our program, "we" will make your life considerably better. You are poor, lonely, weak, incompetent, ineffectual, and no longer terribly bright. You are sick, in need of better housing and transportation and nutrition, and we . . . are finally going to turn our attention to you, the deserving elderly, and relieve your suffering from ageism.\(^6\)

Kalish described New Ageism as operating on "failure models," one of which uses the premise of the elderly as incompetent to attract funding from governmental and private agencies.\(^7\) Kalish observed: "The obvious difficulty with this model is that as soon as the failures become successes, the incompetents become competent and in need of fewer services, . . . the advocates will lose their jobs and, more than that, lose their status as serving the 'Incompetent Failure of the Year.'"\(^8\) He concluded that the "Incompetent Failure Model" could potentially be as damaging to the elderly as overt ageism by under-

\(^{83}\) Minkler, *supra* note 74, at 12.
\(^{84}\) See *supra* note 5 and accompanying text.
\(^{85}\) Kalish, *supra* note 8, at 398.
\(^{86}\) *Id.*
\(^{87}\) *Id.* at 399.
\(^{88}\) *Id*; see also *John McKnight, The Careless Society: Community and Its Counterfeits* 32 (1995) (arguing that society's need for more service income has encouraged the "commodification of age"). He describes the phenomenon as follows:

The economic use of classifying "oldhood" as a problem serves two purposes. The first is that it produces more service jobs by classifying old people as problems. Second, by the very act of classification it also defines old people as less productive or non-productive and diminishes their capacity to compete for jobs. Thus, we create more jobs for one class by diminishing the job capacity of another. Indeed, one might say that what has happened in the United States since World War II is that those people of middle years have needed "problems" called old and young in order to create more "needs" while diminishing the number of people eligible to meet the needs.

*Id.* at 31.
mining opportunities for self-determination and damaging self-esteem.\(^8\)

C. **Gerontophobia—Fear and Blame**

The evolution of ageism has not culminated in the obsession with youth and professional paternalism. As Dr. Butler observed in his reassessment of ageism, there are new manifestations which include envy, resentment, and fear of the elderly.\(^9\) Although gerontologists may disagree over the use of the term “gerontophobia” to describe this trend,\(^1\) the term will be used here, not in its narrow connotation (i.e., a *neurotic* fear of or hostility toward the elderly), but in a broader sense to represent the general fear of aging, the fear ascribed to sharing scarce resources among generations, and the growing tendency to blame the elderly for society’s problems.

In the 1980s, the growing “gerontophobic” sentiment in public debate was widely observed. If what Kalish described in 1979 was “New Ageism,” then what social analyst Harold Sheppard predicted in 1987 was an even newer New Ageism.\(^9\) Sheppard, who was the Presidential Counselor on Aging during the Carter Administration, used the term “New Ageism” to warn of a growing antagonism toward the elderly “generated in part by envy about rich elders and in part by resentment over the presumed burden on the non-elderly caused by an ‘aging population.’”\(^9\) Sheppard noted in 1990 that the latest element to be added to the definition of this newer New Ageism is the belief that the elderly are greedy.\(^9\) Stated another way, the public mood had shifted from mere envy and resentment to blame.

The spread of gerontophobia was also predicted by Carroll Estes and Robert Binstock. Already in 1983, Carroll Estes wrote:

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89. *See* Kalish, *supra* note 8, at 398 (observing that New Ageism “encourages the development of services without adequate concern as to whether the outcome of these services contributes to reduction of freedom for the participants to make decisions controlling their own lives”); *id.* at 399 (noting the potential damaging effects of older people internalizing New Ageist rhetoric and believing it of themselves as individuals).
90. *See supra* notes 6-7 and accompanying text.
91. *See supra* note 14; see also *Letter from Erdman Palmore, Professor of Medical Sociology, Duke University Medical Center, to Jerome Kaplan, contributor (July 5, 1972),* reprinted in 12 *GERONTOLOGIST* 213 (1972).
93. *Id.*
94. *Id.* (citing as examples the title of a *New York Times* op ed article titled, *Elderly, Affluent—and Selfish*, and a George Will column in *Newsweek* describing the means of the elderly for perpetuating their alleged selfish well-being as “codger power”).
When the economy is expanding, optimism abounds and resources for dealing with societal problems tend to increase, as they did for the elderly in the 1960s and early 1970s. Conversely, periods of scarcity tend to produce limited and inadequate (and often punitive) social programs, as in the 1980s. In the 1980s, the definition of the problems of the elderly has shifted. More and more, the elderly are blamed for the inadequate situations in which they find themselves by those economic and political interests that have the most to gain from public policies that reduce domestic social spending and that seek to shift public responsibilities to the individual or to other levels of government than the federal level.95

And a year earlier, at the 35th Annual Scientific Meeting of The Gerontological Society of America, Robert Binstock delivered the Donald P. Kent Memorial Lecture titled The Aged as Scapegoat.96 He noted the following axioms which place blame upon the elderly: (1) “The Aged Are Well Off; They Have Been Lifted Out of Poverty”; (2) “The Aged Are a Potent, Self-Interested Political Force”; and (3) “Demographic Changes Mean That the Aged Will Pose an Unsustainable Burden on the American Economy.”97 He observed that the “New Ageism” identified by Richard Kalish, which Binstock refers to as “compassionate ageism,” actually “set the stage for tabloid thinking about older persons by obscuring the individual and subgroup differences among them.”98 Binstock further concluded that the major age-based benefit programs and subsidies fostered by “compassionate ageism” in effect positioned the elderly as the scapegoat for the subsequent era of economic instability.99 It was during the beginning of this era of economic instability—the 1980’s—that AGE (Americans for Generational Equity) was formed, and the generational equity debate began.100 As we draw near the close of the twentieth century, heated political debate over the federal budget deficit, distribution of public

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97. Id. at 137-39.
98. Id. at 140.
99. Id.
100. See Meredith Minkler, Generational Equity or Interdependence?, in DIVERSITY: NEW APPROACHES TO ETHNIC MINORITY AGING 65 (E. Percil Stanford & Fernando M. Torres-Gil eds., Baywood Publishing Co. 1992) (critiquing generational equity and arguing for a shift in focus from generational equity to generational interdependence); see also Binstock, supra note 8, at 432-38 (debunking the stereotypes that fuel the intergenerational equity debate and arguing that preoccupation with superficial issues of intergenerational equity diverts serious consideration from the substantial health and welfare reforms needed to deal with inequities within age groups).
benefits in general, and the merits of such programs as Social Security and Medicare in particular, continues.\textsuperscript{101}

In the last century and a half, our collective consciousness of age has undergone radical transformation. From relative age indifference in the mid-nineteenth century to acute age awareness by the mid-twentieth century, the concept of age has changed not only in character, but also function. Whereas age was once primarily a means of description, it has now become a paradigm of explanation and prediction. The exaltation of youth and concomitant disparagement of old age has promoted unreflective aggregation of both young and old according to artificial and stereotypic similarities—a phenomenon known as ageism.\textsuperscript{102}

Perhaps because the law is viewed by some as a weapon against ageism, or at least age discrimination,\textsuperscript{103} we have not felt the need to self-reflect in any formal way upon unconscious ageist attitudes and behaviors in the legal profession. The health care profession, however, birth mother of the “decline and failure” model of aging,\textsuperscript{104} has engaged in sporadic self-examination concerning ageism over the past twenty-five years.\textsuperscript{105} Although the literature dealing with ageism in the health care profession is a mixture of anecdotal evidence, informal surveys, and limited studies, an overview of what the health care profession has learned about “professional” ageism may provide some initial parameters for navigating the uncharted territory of ageism in the legal profession.


\textsuperscript{102} See Christopher L. Bodily, \textit{"I Have No Opinions. I'm 73 Years Old!": Rethinking Ageism}, 5 J. AGING STUD. 245, 259-61 (1991) (arguing that the concept of ageism applies to any situation where age is used unreflectively for explanatory, rather than descriptive, purposes).

\textsuperscript{103} See, e.g., Howard Eglit, \textit{Agism in the Work Place: An Elusive Quarry}, \textit{Generations: J. Gerontological Soc’y}, Spring 1989, at 31 (questioning the effectiveness of the Age Discrimination in Employment Act (ADEA) to deal with ageism in the workplace due to the ambiguous milieu in which it must operate and be enforced).

\textsuperscript{104} See \textit{supra} notes 32-35, 73 and accompanying text.

\textsuperscript{105} See, e.g., \textit{Butler, Why Survive}, \textit{supra} note 5, at 229-34 (discussing the prejudices against and disinterest in the old by the mental health profession). Butler’s book, published in 1975, was a ground-breaking effort to expose and discuss, in a comprehensive fashion, aging and ageism.
II. AGEISM AND THE HEALTH CARE PROFESSION

Given that it was the medical community that generated the "decline and failure" model of aging, the presence of ageist attitudes and practices in the health care profession is not surprising. Professional ageism in health care parallels, to a certain degree, the general evolution of ageism in society, exhibiting characteristics of prejudice, paternalism, preference for youth, and gerontophobic concerns with generational equity. For example, ageist prejudice is apparent in the negative-treatment bias which some physicians have labeled "therapeutic nihilism"—the belief that medical interventions for the elderly are futile.106 Paternalism, or "compassionate ageism," is detectable in the indifference of many health care professionals to participation by elderly patients in their own treatment decisions. Dr. Alvin Levenson has observed:

[It] is not uncommon to witness the physician and other health care professionals omnisciently and omnipotently determining the quality of life someone 65 years or older deserves, the decision being based mostly on the patient's age. Frequently, such decisions are rendered regardless of the patient's desires, or without the patient's participation.107

A preference for youth is also evident in the health care profession based on the shortage of health care professionals who are willing to specialize in geriatrics and long-term care.108 In mental health services, the treatment bias toward younger patients is so strong that it has been given a name—the "YAVIS syndrome," representing the tendency of mental health professionals to treat primarily "Young, Attractive, Verbal, Intelligent and Successful" patients.109 Finally, controversial proposals for age-based, health care rationing indicate that gerontophobia and the generational equity debate have also invaded the health care profession.110

106. See id. at 231; Levenson, supra note 8, at 56.
107. Levenson, supra note 8, at 56-57.
108. See Palmore, Ageism: Negative and Positive, supra note 8, at 134. Palmore notes that it is not uncommon for medical school geriatric fellowships to go unfilled. Id. at 133.
109. See Butler, Why Survive, supra note 5, at 233 (attributing to William Schofield the origination of the acronym "YAVIS" and discussing supporting statistics for the "syndrome").
110. Compare Daniel Callahan, Setting Limits: Medical Goals in an Aging Society (1987) (suggesting that health care priorities be reordered to guarantee a "minimal and common baseline of accessible health care up through a normal life span" for everyone; and arguing that although such a system would necessitate denying Medicare support for life-extending treatments beyond a certain age, the resources could be shifted to improve preventative health care and long term care), with Too Old for Health Care?: Controversies in Medicine, Law, Economics, and Ethics (Robert H. Binstock & Stephen G. Post eds., 1991) (explaining that rationing health care should not be based on age alone).
Anecdotal instances of professional paternalism and prejudice toward elderly patients are legion.\textsuperscript{111} Derogatory labels for elderly patients include: "gomers" (an acronym for "Get Out of My Emergency Room"),\textsuperscript{112} "crock," and "dirt balls."\textsuperscript{113} Patronizing language which infantilizes older patients is also common.\textsuperscript{114} As one nursing home resident observed:

Why do you think the staff insists on talking baby talk when speaking to me? I understand English. I have a degree in music and am a certified teacher. Now I hear a lot of words that end in "y." Is this how my kids felt? My hearing aid works fine. There is little need for anyone to position their face directly in front of mine and raise their voice with those "y" words.\textsuperscript{115}

Other forms of compassionate ageism are manifested in treatment protocols which encourage dependency and decrease autonomy. Classic examples are daily routines in long-term care facilities that provide few choices for residents regarding their schedules and activities,\textsuperscript{116} or worse, the overuse of restraints.\textsuperscript{117}

There may be only a fine line between compassionate ageism, which strips a patient of self-respect and autonomy, and "therapeutic nihilism," which results in undertreatment or nontreatment of the elderly. It has been estimated that between ten and thirty percent of treatable mental disorders are misdiagnosed as irreversible in elderly patients.\textsuperscript{118} Two biases in particular are hypothesized to result in undertreatment of elderly patients who have mental disorders. One stems from the "decline and failure" view that senility in old age is both


\textsuperscript{112} See Butler, \textit{The Triumph of Age}, supra note 3, at 348; Levenson, \textit{supra} note 8, at 55; Peppin, \textit{supra} note 111, at 16.

\textsuperscript{113} Butler, \textit{The Triumph of Age}, supra note 3, at 348; Levenson, \textit{supra} note 8, at 55.

\textsuperscript{114} Levin et al., \textit{supra} note 8, at 50 (giving as an example—"The nurse who gives an 82-year-old woman a patronizing pat on the arm while saying, 'Good girl! You ate all your breakfast!'").

\textsuperscript{115} Anna Mae H. Seaver, \textit{My World Now}, NEWSWEEK, June 27, 1994, at 11. This column was printed from notes found in Mrs. Seaver's room at the nursing home after her death.

\textsuperscript{116} See, e.g., Barry L. Hall & Jochen G. Bocksnick, \textit{Therapeutic Recreation for the Institutionalized Elderly: Choice or Abuse}, J. ELDER ABUSE & NEGLECT, No. 4, 1995, at 49 (identifying conflicts between residents' needs for self-determination, control and autonomy in program participation and recreational therapists' goals and expectations).

\textsuperscript{117} \textit{See generally} Lois Evans & Neville E. Strumpf, \textit{Tying Down the Elderly: A Review of the Literature on Physical Restraint}, 37 J. AM. GERIATRICS SOC'Y 65, 66 (1989) (indicating that between 25% and 84.6% of the American nursing home population is subject to physical restraints).

\textsuperscript{118} Butler, \textit{Ageism}, \textit{supra} note 111, at 9.
inevitable and untreatable, and the other is based on overestimation of the prevalence of Alzheimer's disease.

In addition to undertreatment of mental disorders in the aged, the documentation of mental health agencies suggests that the elderly are underserved with respect to all types of mental health services. Summarizing a 1971 Group for the Advancement of Psychiatry report, *The Aged and Community Mental Health*, Robert Butler listed the following reasons why therapists have an aversion to treating the elderly:

[T]he old arouse therapists' apprehensiveness about their own old age; they arouse conflicts about the therapists' personal relationships with their own parents; therapists convince themselves that the old cannot change behavior; therapists believe it is a waste of valuable time and energy to treat people who may soon die; therapists are threatened by feelings of helplessness at the thought that patients may actually die while in treatment; and finally, therapists may be wary of the contempt of their colleagues if they show an interest in old age with its low social status.

As the foregoing summary illustrates, the underlying attitudes and beliefs that may comprise ageism are complex and not easily ascertainable. Nonetheless, researchers have attempted to analyze medical encounters in an effort to distill the effects of ageism. One such study was designed to measure ageism by comparing medical interviews between physicians and patients who were sixty-five years old or older ("old patients") with those of patients age forty-five or younger ("young patients"). Physician behavior on three axes—information giving, questions, and support—was scored. The results showed that physicians raised more psychosocial issues with young

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119. *See id.*
120. *See Gatz & Pearson, supra* note 8, at 186 (finding that nearly half of all respondents to the Alzheimer's Disease Knowledge test overestimated the prevalence of the disease).
121. *Id.* at 184.
123. *See supra* notes 9-10 and accompanying text.
126. Psychosocial issues were defined for purposes of the study as concerns about the health care system, activities of daily living, work and leisure activities, money and benefits, homemaker duties, the physical home and environment, family and significant other problems, bereavement, family and social networks, death, crime and victimization, worries regarding the patient's own physical condition and related matters, depression, and general anxieties. *Id.* at 117.
patients than with old patients\textsuperscript{127} and, likewise, provided better questioning, information, and support with the young patients,\textsuperscript{128} leading researchers to conclude that physicians are "less respectful, less patient, less engaged and less egalitarian with their old than with their young patients."\textsuperscript{129}

Another study reached similar conclusions with respect to interactions between social workers and oncology patients.\textsuperscript{130} Researchers collected data from three outpatient oncology centers for a period of one year in order to compare social worker interaction with adult patients under the age of sixty-five years to that with patients age sixty-five and older.\textsuperscript{131} Categories of analysis included the psychosocial problems addressed in the encounter, types of social work services provided, and the intensity of treatment.\textsuperscript{132} While there was no significant difference in the number of psychosocial problems addressed in both groups, the types of problems addressed tended to differ between the younger and older patients.\textsuperscript{133} A larger discrepancy was found in types of services provided, with younger patients receiving more individual treatment than older patients.\textsuperscript{134} The greatest disparity was discovered in the category of treatment intensity. Intensity was measured according to the average (mean) per patient time spent providing all services, the average (mean) time spent on specific services for each patient, the number of contacts between patients and social workers, and the interval between the initial and last service date.\textsuperscript{135} Comparing measurements of treatment intensity, the study concluded:

In each measure of intensity of social work treatment, significant underrepresentation of the elderly was found. Social workers spent more time overall, spent more time in individual treatment (the most frequently delivered service), had more patient-social worker contacts, and had longer durations of treatment with the younger than with the elderly patients.\textsuperscript{136}

\textsuperscript{127.} Id. at 118.
\textsuperscript{128.} Id. at 119.
\textsuperscript{129.} Id. at 121.
\textsuperscript{131.} Id. at 205-07.
\textsuperscript{132.} Id. at 207.
\textsuperscript{133.} Id. at 211, 216-17 (finding that social workers more frequently addressed problems such as illness-related adjustments, housing, insurance, and finances of younger patients while focusing on transportation problems of older patients).
\textsuperscript{134.} Id. at 212, 217 (noting, however, that the level of other direct and concrete services was the same).
\textsuperscript{135.} Id. at 213.
\textsuperscript{136.} Id. at 217.
While evidence of ageism in each of the foregoing studies was not blatant, researchers believed that covert ageism did impact the quality and extent of services provided.137

What then can the legal profession learn from the health care profession in conducting a self-study of professional ageism? The foregoing overview demonstrates that in the health care profession, evidence of ageism is both overt (e.g., derogatory and paternalistic comments, practices, and policies; treatment biases which favor youth; and age-based proposals for health care rationing) and covert (e.g., instances where ageism can only be implied as the possible cause of different treatment patterns for patient groups who are similar except for age). Also, although ageism is a phenomenon which seems to be beyond exact measure or dissection, anecdotal evidence, as well as formal studies, suggest that ageism, overt and covert, impacts both the quality of services provided and access to services. The question one might ask, in each instance of alleged ageism, is: "But for" old age, would the attitude, behavior, or policy distinction be the same? And if not, is age a legitimate basis for the distinction?

III. AGEISM AND THE LEGAL PROFESSION

The legitimacy of age-based distinctions in the law is a relatively "young" issue among the topics of legal scholarship. As Howard Eglit has noted, no separate listing for age or the aged appeared in the Index to Legal Periodicals until late 1973.138 It was the enactment of the Age Discrimination in Employment Act of 1967 (the ADEA)139 and the Age Discrimination Act of 1975 (ADA)140 that ignited the profusion of legal interest in age distinctions. In the almost thirty years since the ADEA was first enacted, a rich dialogue has ensued over the relationship of age to legal responsibilities, entitlements, and discrimination.141

137. Id. at 217-19 (concluding that the findings made it difficult to rule out ageism as the cause of disparities in treatment); see also Ageism Study, supra note 124, at 121 (noting that ageism produced a "liability in power dynamics" between the physician and patient which resulted in the old patients obtaining less physician attention for their individual concerns than young patients).


The focus of this article, however, is not the role of age distinctions in the law, but the role of ageism in the legal profession, a topic heretofore unaddressed by legal scholarship. Framed as a question, the inquiry is: Are the manifestations of ageism found in society-at-large also lurking, undetected, in the legal profession? The case of "Mrs. Anderson" and the overview of ageism in the health care profession both demonstrate the difficulty of detecting ageism because of its often subtle, and always complex, nature. Rather than rely on the ambiguities of anecdotal evidence, the following analysis is based on a survey of all adult protection, guardianship, and conservatorship statutes in the United States; a random sample of guardianship, will and trust contest cases; and professional practices dealing with guardianship. Each of these areas was scrutinized for signs of characteristic manifestations of ageism—prejudicial stereotypes based on the "decline and failure" model of aging and paternalistic, age-justified professional interventions. Language or practices were considered ageist if old age was used unreflectively to explain or predict characteristics of individuals rather than merely to describe their chronological age.

The survey of adult protection legislation revealed that twelve state statutes list "age," "old age," or "advanced age" as an independent basis for considering a person to be "impaired," "incapacitated," "disabled," or "vulnerable" and in need of protection. Similarly, ten

142. See, e.g., Bernice L. Neugarten, Age Distinctions and Their Social Functions, 57 CHI-KENT L. REV. 809, 825 (1981) (suggesting that "age-based stereotypes may influence legal decisions in a variety of covert ways" but noting that such issues have not been studied).

143. See the hypothetical case of "Mrs. Anderson" in the opening introduction and accompanying discussion.

144. See supra notes 106-37 and accompanying text.

145. See supra notes 34-35, 73, 106 and accompanying text.

146. See supra notes 85-89, 116-17 and accompanying text.

guardianship and conservatorship statutes currently list "advanced age" as an independent basis for imposition of guardianship or conservatorship,\textsuperscript{148} and at least fourteen states had ageist language in their guardianship and conservatorship statutes until recently amended or repealed.\textsuperscript{149}

1995) (stating that "'[v]ulnerable adult' . . . includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging including, but not limited to . . . advanced age"); Tenn. Code Ann. § 71-6-102(2) (1995) ("'Adult' means a person . . . who because of . . . advanced age is unable to manage such person's own resources"); Va. Code Ann. § 63.1-55.2 (Michie 1995) ("'Incapacitated person' means any adult who is impaired by reason of . . . advanced age . . ."); Wis. Stat. Ann. § 55.01(3) (West 1987 & Supp. 1995) ("'Infirmities of aging' means organic brain damage caused by advanced age . . .").


The random sample of case law also contained decisions where advanced age was the only basis reported for imposition of guardianship or was one of the factors considered in determining undue influence in will and trust contest cases. However, opinions were also found indicating that mere "old age" and "forgetfulness" were insufficient bases for judicial determination of incompetence and that more than "old age" and "poor health" must be established to prove lack of capacity or undue influence.

Even more revealing in the case law sample was the age-related rhetoric of some opinions. The following examples speak for themselves:

As all of us grow older, we gradually lose our faculties, both physical and mental. The longer we live and the older we become, the more we lose. If a voluntary conservatee, not mentally incapacitated, were to be given an unbridled power to contract or deed away his property Inter vivos, the voluntary conservatorship would seldom be used, because the relatives of the elderly person, seeking to protect the loved one from his or her own actions, would of necessity, utilize the compulsory conservatorship procedure. Hence, the old folks would in most instances be required to spend their golden years branded as "incapacitated" or "incompetent."

The appellant was ninety-one years old when she moved for [guardianship] termination and had suffered several strokes. While advanced age has been removed from the statutory definition of incompetency, it can remain a consideration.

The trial judge admitted evidence of appellant's physical condition, including his heart problems, lung problems and failing eyesight into evidence over appellant's objection, saying that he wanted to get a "complete picture" of appellant. Evidence of appellant's physical condition was relevant to the issue of whether the necessity for the guardianship still existed. As a matter of common experience, a


person's physical condition directly relates to that person's mental condition, especially in cases of advanced age.\textsuperscript{156}

Unfortunately, during the last year—probably due to advancing age—she has failed to adequately cope with her daily living needs... She is, however, obviously an intelligent person who can be gracious if she chooses. Indeed, her problems are not unusual among the elderly.\textsuperscript{157}

There was testimony submitted that the decedent's condition at or near May of 1981 allowed her to watch a four-year-old child, that in 1981, like all elderly persons, the decedent had good and bad days, but mostly good days, and that her condition did not drastically deteriorate until January of 1983.\textsuperscript{158}

Quite understandably, Mrs. S. resented a guardian being appointed for her property. She particularly resented the manner in which it was accomplished in that she had no notice of it until after it had been accomplished. Mrs. S., being in remarkably good health and active, was resentful of the implication that she is unable to handle her affairs and like most people her age probably does not accept the fact that at her age she does not have the same memory that she had at an earlier age... After hearing all of the evidence, I am of the opinion that due to the infirmities of old age, particularly forgetfulness, Mrs. S. is in danger of losing or dissipating her property and it would be in the best interest of Mrs. S. that the guardianship of her property be continued but only for a limited purpose.\textsuperscript{159}

Based on the foregoing research, it would appear that the "decline and failure" model of aging has heavily influenced the formulation of legislation and case law, mirroring the ageist societal view of old age as synonymous with inevitable deterioration.\textsuperscript{160} The case excerpts poignantly illustrate how unquestioningly and openly these beliefs are held.

Reported guardianship practices by lawyers also indicate the operation of prejudicial stereotypes about old age but on a more covert level. Although legislative reform in many states permits courts to
consider limited guardianship for individuals as a less restrictive alternative to plenary guardianship, studies and anecdotal evidence indicate that limited guardianship is woefully underutilized. For example, a 1985 survey of the probate court in Cook County, Illinois (reported to be the busiest probate court in the United States) showed that limited guardianships were used in only 5 to 7 of the 1,400 guardianship petitions filed that year. The speculated reasons for aversion to the limited guardianship alternative amount to an "advocacy nihilism," not unlike "therapeutic nihilism" in the health care profession. These reasons include that lawyers and judges are reluctant to spend the extra time and effort necessary to establish parameters for a limited guardianship because they believe the elderly ward's condition will most likely deteriorate, thus requiring a rehearing and more time investment on the part of the attorney and court, as well as financial expenditure on the part of the client. The silent assumptions and stereotypes that support overuse of plenary guardianship practices illustrate why covert ageism is so difficult to identify and assess.

Just this brief investigation into the role of ageism in the work of lawyers, judges, and legislators has shown that ageism in the legal profession, like the health care profession, operates both overtly (e.g., ageist language in legislation and judicial opinions) as well as covertly (e.g., ageist assumptions underlying advocacy practices and judicial decision making) and can substantially influence the quality of legal services provided. With the present population aging at an unprecedented rate, such findings suggest an urgent need for deeper inquiry into the prevalence of ageism in the broader spectrum of advocacy, legislative, and judicial functions. For example, areas ripe for closer scrutiny include estate and long-term care planning practices which may encourage premature divestiture of an older person's assets based on stereotypic notions of inevitable physical and mental failure, as well as malpractice and personal injury practices which may ignore or undervalue the elderly client's claims based on views that death is more imminent and life less valuable for such clients.


162. Iris, supra note 161.

IV. Conclusion

During the course of the twentieth century, ageism has evolved from mere heightened age consciousness at the turn of the century to the present gerontophobic furor over the generational equity of public benefits such as Medicare and Social Security. The faces of ageism are many: prejudicial stereotypes based on outmoded notions of the "decline and failure" model of aging, as well as paternalistic interventions that encourage dependency and decrease autonomy. Studies and anecdotal evidence in the health care industry indicate the presence of ageist attitudes among health care professionals and suggest that the result for elderly patients is often undertreatment or nontreatment—"therapeutic nihilism." Despite the marked evolution of ageism in this century, the legal profession has failed to initiate self-examination about ageist biases and practices. As the foregoing survey of guardianship and adult-protective statutes reveals, an alarming number of jurisdictions still condone mere "advanced age" as an independent basis for terminating personal and legal autonomy. Furthermore, case law confirms the willingness of some judges to reinforce ageist biases. The potential of unwitting prejudice and paternalism to compromise client self-determination, zealous legal representation, and impartial adjudication is sobering. As guardian of the public trust, the legal profession, more than any other service profession, should strive to ensure that ageist stereotypes do not become rebuttable presumptions against which the elderly must defend themselves to maintain the same rights and privileges in society as the non-elderly. What better place to first meet this challenge than among our own ranks?