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## AGE DISCRIMINATION IN THE DELIVERY OF HEALTH CARE SERVICES TO OUR ELDERS

Phoebe Weaver Williams\*

### INTRODUCTION: AGE DISCRIMINATION AS A HEALTH CARE ISSUE

You are contacted by a colleague, an active, engaged academic who researches, publishes, and lectures. He has just learned he has cancer. Despite his requests, physicians have refused to treat his condition. Citing his advanced age—he is in his mid-nineties—physicians have only offered him hospice care.<sup>1</sup> He seeks your help. Since what he desires most is treatment, not litigation, you attempt to locate a physician who will evaluate his condition for treatment. After a number of phone calls, you find an oncologist who agrees to assess his case. However, your colleague's circumstances lead you to explore his rights to treatment—does he enjoy legal protections from age discrimination by health care providers; did their refusals to treat him violate his legal rights. These questions along with others raised by age discrimination in health care are the focus

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\* Associate Professor of Law, Marquette University Law School. In honor of the late Walter O. Weyrauch, University of Florida Professor of Law, whose ideas were the catalyst for this article.

1. Dennis W. Jahnigen & Robert H. Binstock, *Economic and Clinical Realities: Health Care for Elderly People*, in *TOO OLD FOR HEALTH CARE?: CONTROVERSIES IN MEDICINE, LAW, ECONOMICS, AND ETHICS* 23 (Robert H. Binstock & Stephen G. Post, eds., 1991) (explaining that Western medicine has traditionally had three clinical objectives: "to cure where possible, to comfort when appropriate, and to care always;" where cure is not possible, rehabilitation may be considered or treatment offered to prevent further development of illness; in cases of hopelessly ill and dying patients, palliative medications and therapies are offered with hospice programs serving as the institutional programs that provide palliative care for dying patients).

of this article.

Part I of this article reviews examples of such age discrimination in the United States and abroad. Part II clarifies the concept of ageism, a term frequently used in the scientific and social science research that discusses age discrimination by health care providers. Medical ageism has been used to describe a broad array of discriminatory practices in health care—from demeaning age based references used for elderly patients to stereotyping elderly patients, to inappropriate use of chronological age when treating them. In order to effectively apply precise legal theories used to demonstrate unlawful age discrimination, the concept of ageism must be broken down and its practices categorized in a manner amenable to the application of legal theories that address discrimination. Part II describes selected behaviors designated as ageism and categorizes them in a manner consistent with the theories that demonstrate unlawful discrimination in litigation addressing employment and other civil rights discrimination.

Part III examines the federal law, the Age Discrimination Act of 1975 (Age Act) which arguably prohibits age discrimination in a health care context. A review of the cases brought under the Age Act's provisions reveals that so far it has not been very useful for addressing the type of medical ageism described in Part II. Despite complaints occurring over decades of health care providers using age demeaning terms, age stereotyping of elderly patients, and numerous studies documenting age based health care disparities, it appears that neither advocates nor regulators have used the Age Act's provisions to address these problems. Part IV applies selected theories for demonstrating unlawful discrimination in employment discrimination to various practices identified as ageism. Part V concludes with suggestions and recommendations. The goal of this discussion is to raise awareness of the problem and use the insights from employment law to encourage the development of initiatives that would lead to developing a theory of hostile environment for the health care

context.

### ADVANCED AGE AND THE DENIAL OF HEALTH CARE

Advanced Age and Denial of Care studies indicate significant incidence of lesser and different care for elderly patients.

#### THE UNITED STATES

The use of advanced chronological age as the determinative factor by physicians to deny or limit medical treatment is controversial.<sup>2</sup> While individual physicians will vary, during the last three decades, studies have suggested that physicians do consider a patient's advanced age when deciding on the type and level of health care services.<sup>3</sup> However, the use of a patient's advanced chronological age is not always considered medically appropriate.<sup>4</sup>

In a report that examined the impact of certain patient characteristics on the treatment received by individuals with

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2. Editorial, *Obama's Health Future*, WALL ST. J., June 26, 2009, at A14 (commenting on a recent TV health care forum where a questioner presented the following scenario to President Barack Obama for response: her 105-year-old mother was told by an arrhythmia specialist that at age 100 she was too old for a pacemaker; fortunately her mother obtained a second opinion which her daughter credited as saving her life); see Jake Tapper & Karen Travers, *Exclusive: President Obama Defends Right to Choose Best Care: In ABC News Health Care Forum, President Answers Questions About Reform*, ABC NEWS, June 24, 2009, <http://abcnews.go.com/Politics/HealthCare/Story?id=7919991&page=1> (last visited June 26, 2009) (reporting that the questioner asked if physicians should take account of a patient's "spirit" when making treatment decisions; President Obama declined to support the use of a subjective consideration such as a patient's "spirit" but called for reforms that ensure treatment for all patients and suggested that patients and physicians work together to plan for end of life treatment); see generally Anemona Hartocollis, *At the End, Offering Not a Cure but Comfort*, N.Y. TIMES, Aug. 20, 2009, at A1 (describing various medical, political, and social controversies associated with hospice and palliative care).

3. Jahnigen & Binstock, *supra* note 1, at 24; A.B. Shaw, *In Defense of Ageism*, 20 J. MED. ETHICS 188, 188-89 (1994) (discussing the ethics of rationing medical care for the elderly in Britain and noting that "[a]ge in years is a factor in treatment response. Asystolic cardiac arrest over the age of 70 is death, not an occasion for resuscitation") (citation omitted).

4. See, e.g., David C. Hodgson et al., *Review: Impact of Patient and Provider Characteristics on the Treatment and Outcomes of Colorectal Cancer*, 93 J. NAT'L CANCER INST. 501 (2001).

stage III colorectal cancer, medical researchers reviewed two decades of published studies.<sup>5</sup> They observed that some physicians might be “inappropriately” using the age of older patients to “limit adjuvant therapy.”<sup>6</sup> Analyzing data available on the National Cancer Data Base, these researchers noted that “the use of surgery plus chemotherapy declined with age: 40% of those under age 50 years received both of these treatments, in contrast to 20% of those aged 70-79 years.”<sup>7</sup> The researchers acknowledged the possibility that physicians may have been influenced by some studies that suggest that “older patients are more likely to experience chemotherapy-related toxicity.”<sup>8</sup> However, after consideration of the traditional non-age-related explanations for the differences in treatment, the researchers concluded that physicians were still using age inappropriately when treating elderly patients with colorectal cancer.<sup>9</sup>

#### *THE UNITED KINGDOM*

Concerns that physicians may be using age inappropriately to limit the treatment offered to older patients have surfaced in countries other than the U.S.<sup>10</sup> A report of a study of general practitioners and cardiologists in England concludes that “[d]octors in Britain regularly discriminate against older patients by denying them tests and treatments they offer to younger

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5. Hodgson et al., *supra* note 4, at 501.

6. *Id.* at 507.

7. *Id.*

8. *Id.*

9. *Id.*

10. Simona Giordano, *Respect for Equality and the Treatment of the Elderly: Declarations of Human Rights and Age-Based Rationing*, 14 CAMBRIDGE Q. HEALTHCARE ETHICS 83, 83 (2005) (noting that “International organizations, such as the European Union (EU), the World Health Organization (WHO), and the United Nations (UN), have condemned any form of ‘ageism,’ including ageism in healthcare provision”); SUZANNE WAIT, PROMOTING AGE EQUALITY IN HEALTH CARE 4 (2005), available at [http://www.eldis.org/UserFiles/File/GHF/Age\\_Equality.doc](http://www.eldis.org/UserFiles/File/GHF/Age_Equality.doc) (discussing age discrimination in health care but noting “there is currently no explicit legislation outlawing age discrimination in health care in Europe.”)

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 5

people.”<sup>11</sup> The British study analyzed the decisions of eighty-five physicians who “examined” seventy-two fictional patients with possible angina between the ages of forty-five and ninety-two.<sup>12</sup> Researchers found the physicians studied were less likely to refer to a cardiologist or give an angiogram or heart stress test when treating patients over sixty-five.<sup>13</sup> Studies of British physicians suggest age discrimination has been an ongoing problem.<sup>14</sup> Commenting on hospital practices, British physician, Dr. A.B. Shaw, concludes, “[a]geism already flourishes in British hospitals.”<sup>15</sup> Describing the coronary care practices at his hospital, Dr. Shaw explained that, “[p]atients under the age of 65 with suspected myocardial infarction are routinely admitted [to a useful limited coronary care facility]. Those over this age go to other wards and are transferred only if a clinical indication

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11. Celia Hall, *Shock as Doctors Admit to Ageism*, TELEGRAPH, Feb. 14, 2007, <http://www.telegraph.co.uk/news/uknews/1542630/Shock-as-doctors-admit-to-ageism.html> (reporting on the results of a study led by Prof. Ann Bowling and published in *QUALITY AND SAFETY IN HEALTH CARE*, a specialist publication of the *BRITISH MEDICAL JOURNAL*).

12. *Id.*

13. *Id.*

14. A.T. Elder, *Which Benchmarks for Age Discrimination in Acute Coronary Syndromes?*, 34 *AGE & AGEING* 4, 4 (2005) (discussing a UK study that concluded that “although older patients with ACS were at a higher risk of subsequent adverse events than their younger counterparts, they were much less likely to be given evidence-based drug treatments, to undergo coronary angiography or to be offered coronary revascularization”); P.C. Hannaford, C.R. Kay & S. Ferry, *Ageism as Explanation for Sexism in Provision of Thrombolysis*, 309 *BRIT. MED. J.* 573 (1994) (analyzing the results of information supplied by 776 British general practitioners and concluding that while all of the patients subjected to analysis had a confirmed myocardial infarction and no recognized contraindication to thrombolysis, nearly 40% did not receive it; explaining as among the reasons a “number” of patients were probably denied treatment due to their age; citing to results of an earlier questionnaire of December 1990 where two-fifths of the consultants in charge of coronary care units in Britain reported using age-related policies for thrombolysis). For a report on a more recent study, see Jenny Hope, *The NHS Really IS Ageist, Say Half of Doctors*, MAIL ONLINE, Jan. 27, 2009, <http://www.dailymail.co.uk/news/article-1128682/The-NHS-really-IS-ageist-say-half-doctors.html> (reporting on survey of 201 doctors in the British Geriatrics Society, commissioned by Help the Aged, that found that 47% thought the National Health Service was ageist; 55% worried how the NHS would treat them in old age; and two-thirds agreed that older persons were less likely to have their symptoms fully investigated).

15. Shaw, *supra* note 3, at 188 (“It has long been operated openly and secretly by doctors, and administrators”) (citations omitted).

arises.”<sup>16</sup> Dr. Shaw explains that doctors have accepted this practice for years as an “effective method of using a limited resource.”<sup>17</sup>

#### CANADA

During a health care forum in Canada, advocates for the elderly characterized as ageism some disturbing examples of poor health care.<sup>18</sup> One speaker offered an account of health care providers neglecting to properly set the broken arm of a seventy-nine-year-old Alzheimer's patient.<sup>19</sup> A social worker spoke of institutions not feeding elderly patients, not treating their bedsores, and withholding appropriate tests, characterizing these practices as “passive euthanasia through omission.”<sup>20</sup> Reports of the Canadian Medical Association's proceedings suggest such concerns have been brought to the attention of physicians and have been identified as an ongoing problem.<sup>21</sup>

#### RESPONSES TO AGE-BASED HEALTH CARE DISCRIMINATION

In Britain, complaints of age discrimination have led to initiatives to enact laws that forbid age discrimination in the provision of goods and services.<sup>22</sup> Accounts of an elderly

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16. *Id.* at 189 (noting that doctors have accepted this practice for many years as an effective method of rationing a limited resource; however the public has never been consulted about this practice).

17. *Id.* (arguing in favor of age rationing, Dr. Shaw opposes mandatory age limitations, explaining that age limits should be advisory and advanced age a factor in some clinical decisions.) *Id.* at 191.

18. Judy Gerstel, *Ageism in Health Care is Really Hidden Rationing*, TORONTO STAR, Sept. 26, 2003 at C05.

19. *Id.*

20. *Id.*

21. Patrick Sullivan, *Doctors Guilty of 'Ageism and Indifference', MD tells General Council*, 141 CANADIAN MED. ASS'N J. 729, 729 (1989); see Nancy N. Baxter, *Equal for Whom?: Addressing Disparities in the Canadian Medical System Must Become a National Priority*, 177 CANADIAN MED. ASS'N J. 1522 (2007) (discussing studies that document health care disparities and observing that “important sex- and age-related differences in the provision and outcome of care in Canada are not new. Numerous studies in Canadian populations indicate that disparities exist.”) *Id.*

22. Gaby Hinsliff, *Landmark Move to Outlaw Ageism: Harman Targets*

## 2009] DISCRIMINATION IN HEALTH CARE DELIVERY 7

woman who was later diagnosed with cancer of the spine after being initially told by her general practitioner that back pain was to be expected at her age<sup>23</sup> and a seventy-six-year-old heart patient who was told she had lived a “long life” and asked if she really wanted to stay on the waiting list for a bypass were cited as examples of the type of age discrimination that should be addressed by legislation.<sup>24</sup> A 2005 report by the Irish National Council on Ageing and Older People noted many older individuals felt service providers “fobbed [them] off because of their age.”<sup>25</sup> The study collected numerous accounts from older persons who believed that their “doctors were not taking their health needs and concerns seriously.”<sup>26</sup>

Since the late sixties, in the US, age discrimination by health care providers has been considered an issue that carries “disturbing implications.”<sup>27</sup> Age discrimination against the elderly concerns each of us since “we are either old or hoping to get there.”<sup>28</sup> After Robert N. Butler, M.D. published an influential work during the early seventies in which he exposed the problem of health care providers negatively stereotyping older patients, that subject became a health care issue.<sup>29</sup> Dr. Butler developed the concept of “ageism” to help define and explain the nature of the discriminatory conduct directed

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*Discrimination Against Elderly by Doctors As Well As Insurance and Mortgage Firms*, THE OBSERVER, Jun. 22, 2008, <http://www.guardian.co.uk/society/2008/jun/22/equality.nhs>.

23. *Id.*

24. *Id.*

25. NAT'L COUNCIL ON AGEING & OLDER PEOPLE, PERCEPTIONS OF AGEISM IN HEALTH AND SOCIAL SERVICES IN IRELAND 11 (2005) (“Discrimination . . . was evidenced by a lack of understanding of older people’s needs, as well as by an element of fatalism and low expectations about what services and interventions can achieve for older people.”) *Id.* at 14.

26. *Id.* at 95.

27. Richard Currey, *Ageism In Healthcare: Time for a Change*, 1 AGING WELL 16 (2008).

28. FREDERICK SCHAUER, PROFILES, PROBABILITIES AND STEREOTYPES 129-30 (Belknap Press of Harvard Univ. Press 2003).

29. ROBERT N. BUTLER, THE LONGEVITY REVOLUTION: THE BENEFITS AND CHALLENGES OF LIVING A LONG LIFE 40-41 (Public Affairs 2008) (explaining that ageism takes the form of stereotypes, myths, disdain and dislike, sarcasm, scorn, subtle avoidance, and discriminatory practices).



towards older patients.<sup>30</sup> For Butler, ageism was analogous to racism and sexism since it represented a “form of systematic stereotyping and discrimination against people simply because they are old.”<sup>31</sup>

Since Dr. Butler’s path breaking work, “ageism” in health care has been a focus of scholarly attention.<sup>32</sup> There has been considerable discussion in the medical and social science literature about the inappropriate consideration of advanced age by health care providers.<sup>33</sup> However, age discrimination in health care has received considerably less attention in the legal literature.<sup>34</sup>

The discourse surrounding ageism in the delivery of health care has taken some interesting directions as scholars have responded to proposals that the government should ration health care resources based on age. Proposals to ration and limit public expenditures for health care for the elderly have elicited considerable discussion as advocates and opponents have debated the issues surrounding health care rationing.<sup>35</sup>

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30. *Id.*

31. *Id.* at 40.

32. Linda S. Whitton, *Ageism: Paternalism and Prejudice*, 46 DEPAUL L. REV. 453, 456 n.5 (1997) (explaining that “Dr. Butler’s Pulitzer prize-winning work in the mid-seventies was both the baseline and catalyst for subsequent scholarly interest in ageism.”)

33. Ann Adams et al., *The Influence of Patient’s Age on Clinical Decision-Making About Coronary Heart Disease in the USA and the UK*, 26 AGING & SOC’Y 303, 304 (2006) (citing a number of studies that document ageist attitudes and assumptions by health care providers that influence their clinical decisions).

34. See generally Jessica Dunsay Silver, *From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the ‘Hidden’ Rationing of Medical Care*, 37 CATH. U. L. REV. 993 (1988); Howard Eglit, *Health Care Allocation for the Elderly: Age Discrimination by Another Name?*, 26 HOUS. L. REV. 813 (1989); Whitton, *supra* note 32; Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195 (2003); Monique M. Williams, *Invisible, Unequal, and Forgotten: Health Disparities in the Elderly*, 21 NOTRE DAME J.L. ETHICS & PUB. POL’Y 441 (2007).

35. See generally Silver, *supra* note 34; Jahnigen & Binstock, *supra* note 1; THE GENERATIONAL EQUITY DEBATE (John B. Williamson, Diane M. Watts-Roy, Eric R. Kingson, eds., Columbia Univ. Press 1999); Dorothy C. Rasinski-Gregory & Miriam Piven Cotler, *The Elderly and Health Care Reform: Needs, Concerns, Responsibilities and Obligations*, 21 W. ST. U. L. REV. 65, 82 (1993) (concluding that “[h]ealth care reform involves rationing—the planned allocation of ‘limited’ resources.”)

## 2009] DISCRIMINATION IN HEALTH CARE DELIVERY 9

Ethicists,<sup>36</sup> economists,<sup>37</sup> and social scientists<sup>38</sup> have entered into a vigorous debate about the ethical, moral, economic, and social issues associated with proposals to ration health care based on advanced age.<sup>39</sup> The rationing debate has tended to dominate the discussions of scholars interested in issues concerning age discrimination in the health care context.

Legal scholars have joined the rationing debate.<sup>40</sup> Their

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36. See, e.g., Daniel Callahan, *Age-Based Rationing of Medical Care*, in THE GENERATIONAL EQUITY DEBATE 101, 103 (John B. Williamson, Diane M. Watts-Roy, Eric R. Kingson, eds., Columbia Univ. Press 1999) (proposing universal health care to avoid premature death and the strengthening of long-term and home care support, but advocating the use of age as a categorical standard to cut off paying for life-extending technologies under Medicare).

37. See, e.g., Jagadeesh Gokhale & Laurence J. Kotlikoff, *Generational Justice and Generational Accounting*, in THE GENERATIONAL EQUITY DEBATE 75, 84 (John B. Williamson, Diane M. Watts-Roy, Eric R. Kingson, eds., Columbia Univ. Press 1999) (proposing use of a "generational accounting" to track the amount that each generation pays towards public programs over the life span; concluding that U.S. "fiscal policy is inequitable and unsustainable" because it leads to "placing enormous fiscal burdens on today's and tomorrow's children.")

38. See, e.g., John B. Williamson & Diane M. Watts-Roy, *Framing the Generational Equity Debate*, in THE GENERATIONAL EQUITY DEBATE 3, 19-30 (John B. Williamson, Diane M. Watts-Roy, Eric R. Kingson, eds. Columbia Univ. Press 1999) (identifying two frames of the debate: (1) the generational equity frame that argues that too much money has been spent on the retired elderly at the expense of the rest of the population and the problem will worsen with the retirement of the baby boom generation; and (2) a generational independence frame that emphasizes what different generations have to offer and challenges claims of an impending crisis).

39. Marshall B. Kapp, *De Facto Health-Care Rationing by Age: The Law Has No Remedy*, 19 J. LEGAL MED. 323, 323 (1998) (describing the different proposals for explicit age-based rationing as: (1) limiting public entitlement program payments for acute medical treatments that would extend the lifespan for persons who already have lived a normal life span—eighty years—offering instead to those persons comfort and palliative treatments; (2) banning or outlawing the provision of specified medical services to identified age groups regardless of who pays for the treatments; and noting that philosopher Daniel Callahan has proposed the former type of age rationing of medical care, while Robert Veatch has proposed an egalitarian justice over lifetime theory that prioritizes medical care in inverse proportion to chronological age).

40. *Id.* at 329 (asserting that the implicit, covert, soft rationing that takes place among patients of different ages represents a form of "de facto discrimination"); Clifton Perry, *When Medical Need Exceeds Medical Resource and When Medical Want Exceeds Medical Need*, 21 W. ST. U. L. REV. 39 (1993); Edward B. Hirshfeld, *Commentary, Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1845-46 (1992) (concluding that "the patient-interest oriented standard of care applicable in medical malpractice litigation should not be changed to accommodate new models of rationing.")

discussions have revealed that our current legal protections would not prevent the creation and implementation of governmental policies that would use advanced age as a basis for allocating scarce health care resources.<sup>41</sup> During 1988, Jessica Silver identified an age fifty-five cut off imposed by Medicare on heart transplant recipients as a form of age-based health care rationing.<sup>42</sup> Noting the difficulty posed by determining the effects of chronological age on the success of heart transplant surgeries, she concluded it was unclear whether statutory prohibitions against age discrimination would preclude the use of upper age limits for candidates for heart transplants.<sup>43</sup> When considering proposals that would limit or allocate access to expensive treatments or facilities or foreclose life-extending care based on age criteria, during 1989, Howard Eglit, concluded there was “no clearly drawn statute, nor any constitutional provision or court decision, [that would] outlaw such discrimination in the health context.”<sup>44</sup> There is agreement among the scholars who have considered this subject that our current regime of legal protections would not prevent the implementation of governmental age-based rationing of health care.<sup>45</sup>

Despite the concerns raised by health care rationing for elders, this article does not focus on rationing issues. There is already considerable commentary on this subject in the legal literature.<sup>46</sup> Rather, this discussion will focus on identifying the situations where the use of patients’ advanced chronological age arguably violates our current legal protections. Unlawful age-

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41. *See id.*

42. Silver, *supra* note 34, at 1054, 1064, 1070 (noting the age fifty-five exclusion of individuals for heart transplants represented an “absolute exclusion” and a form of rationing medical care).

43. *Id.* at 1071-72.

44. Eglit, *supra* note 34, at 881-82 (reasoning that the Age Discrimination Act of 1975’s statutory and regulatory exceptions that permit age discrimination “profoundly” compromise its “ostensible rejection of age-based allocations of resources.”) *Id.* at 878.

45. *See id.* at 881-82; Silver, *supra* note 34, at 1071-72.

46. *See id.*

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 11

biased decisions may result from stereotypes about the recuperative abilities of elderly patients, or value judgments about the quality or worth of elderly lives, or misconceptions about the desires of elderly patients for certain forms of treatments.<sup>47</sup> Age discrimination may occur because health care providers dislike, or are uncomfortable treating, elderly patients. These feelings may lead to displays of hostile behaviors such as demeaning age-based references, avoidance, or negative stereotyping resulting in inferior treatment. Generally legal scholars have not addressed the issues associated with these practices.

***LEGAL DISCUSSION IN THE U.S.***

The few instances where age related discriminatory practices by health care providers have been discussed suggest problems exist in health care that are not being addressed by the laws currently in place or the regulators who should be enforcing them.<sup>48</sup> During 1997, Linda Whitton described the origins and historical evolution of ageism in the health care and legal professions.<sup>49</sup> Subsequently, Alison Barnes explored the relatively limited use and usefulness of the American with Disabilities Act and the Age Discrimination in Employment Act as vehicles for addressing employment discrimination against elderly disabled individuals.<sup>50</sup> Neither statute effectively addresses discrimination against elderly individuals with long-term disabilities. During 2003, Mary Crossley explored various legal approaches that could be pursued to address physician

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47. Giordano, *supra* note 10, at 88-89 (discussing various assumptions about healthcare for older people that are inaccurate but nevertheless form a basis that some argue supports rationing policies: the elderly do not make valuable contributions to society; age affects the effectiveness of medical procedures; the good that may be done for the elderly sometimes does not offset the costs of healthcare delivery).

48. See, e.g., Alison Barnes, *Envisioning a Future for Age and Disability Discrimination Claims*, 35 U. MICH. J.L. REFORM 263 (2001).

49. Whitton, *supra* note 32, at 472-82.

50. Barnes, *supra* note 48, at 271, 273-74.

bias emanating from the race, sex, age or disability of patients.<sup>51</sup> Crossley considered whether common law theories—such as medical malpractice, informed consent, and breach of fiduciary duty—or civil rights laws could be used to effectively address biased decisions by physicians.<sup>52</sup> However, after identifying and discussing the considerable barriers plaintiffs would encounter when trying to prove their cases,<sup>53</sup> Crossley concluded that “patients’ prospects of obtaining a legal remedy through either a civil rights action or an action alleging breach of some professional duty are fairly bleak.”<sup>54</sup> In a 2007 law review article, Monique Williams, M.D. described research in the medical literature documenting instances of ageist attitudes and behaviors towards elderly patients.<sup>55</sup> Dr. Williams revealed the potential breadth of the problem of age-based discrimination in health care.<sup>56</sup> She described research documenting age-related health care disparities and ageist behaviors across a broad range of contexts in health care: medical education, clinical and drug testing trials, and patient treatment in a variety of clinical settings.<sup>57</sup> Her research along with numerous articles in the medical and social science literature suggest that age discrimination by health care providers deserves greater attention from legal scholars.<sup>58</sup>

#### AGEISM IN HEALTH CARE

The concept of ageism, the negative perception of individuals due to their advanced ages, is well established but has limited legal usefulness.

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51. See Crossley, *supra* note 34.

52. Crossley, *supra* note 34, at 244-64 (exploring common law theories), 264-96 (discussing the civil rights statutes).

53. *Id.* at 258.

54. *Id.* at 296.

55. Williams, *supra* note 34, at 441.

56. *Id.* at 444-53.

57. *Id.*

58. See *id.*

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 13

*AGEISM: TOO BROAD OF A CONCEPT FOR CRAFTING LEGAL SOLUTIONS*

Much of the literature that discusses research about the inappropriate use of age in health care employs concepts of either “ageism”<sup>59</sup> or “medical ageism”<sup>60</sup> to describe a variety of behaviors that may represent age discrimination against the elderly. However, while the research and discussions draw attention to the global problem, they are not particularly useful for demonstrating age discrimination as unlawful conduct. The discussion below describes and categorizes various manifestations of ageism in health care in a manner that may be more amenable for legal analysis.

*AGEISM AS BIGOTRY LEADING TO AGE HARASSMENT AND THE CREATION OF A HOSTILE ENVIRONMENT IN HEALTH CARE*

When Dr. Butler created the term ageism he considered ageism as simply another form of bigotry “identical to any other prejudice in its consequences.”<sup>61</sup> He became conscious of prejudices in the medical profession towards the elderly while he was in medical school.<sup>62</sup> For the first time he heard insulting epithets such as “crocks” applied to middle-aged women.<sup>63</sup> Dr. Butler reported also observing instances of discriminatory

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59. See, e.g., Alice Dembner, *Ageism Said to Erode Care Given to Elders*, BOSTON GLOBE, Mar. 7, 2005, at A1.

60. Kristen Gerencher, *A Pervasive Fatalism: Many Ill Seniors Succumb to Medical ‘Ageism,’* MARKET WATCH, June 19, 2003, <http://www.marketwatch.com/story/elderly-suffer-treatment-bias-due-to-medical-ageism> (noting the different kinds of “medical ageism,” including the assumption that elderly patients are not diverse; the failure to provide preventive care; and the failure to include seniors in trials that test medications).

61. Butler, *supra* note 29, at 41.

62. *Id.* at 49.

63. *Id.* (explaining he first became conscious of the medical profession’s ageism while in medical school, where the insulting epithet ‘crock’ was used to describe middle-age women, ‘hypochondriacal’ was used to describe patients who had no apparent organic basis for their complaints and many symptoms, and GOMER was used as short-hand for ‘Get Out of My Emergency Room’); see Marilyn Larkin, *Robert Butler: Championing a Healthy View of Ageing*, 357 THE LANCET 48, 48 (2001).

treatment towards elderly patients.<sup>64</sup> During his internship, older individuals considered as “problematic” were “sent from the university to the city hospital ‘as quickly as they could get rid of them.’”<sup>65</sup>

Four decades have passed since Dr. Butler first identified the problem of health care providers using demeaning terms when referring to elderly patients,<sup>66</sup> but it appears the practice continues.<sup>67</sup> In more recent discussions about ageism, Whitton (1997),<sup>68</sup> Williams (2007),<sup>69</sup> and Currey (2008)<sup>70</sup> note that demeaning references for elderly patients are still a problem in health care settings. Richard Currey has written that he became “aware of [] age-based discrimination directed toward older patients” while practicing as an emergency room physician’s assistant.<sup>71</sup> Currey explained that elderly patients presented medically complex situations that required additional time to resolve which led practitioners to refer to their cases as “train wrecks.”<sup>72</sup> While Currey expressed the belief that the emergency room personnel provided the same quality care for elderly as that provided for younger patients, he nevertheless intimated that the derogatory terms used for elderly patients represented

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64. Larkin, *supra* note 63, at 48.

65. *Id.*

66. *See id.*

67. Adams et al., *supra* note 33, at 305 (noting, “[h]istorically, negative stereotypes of older people have been noted consistently in studies of practicing US doctors, medical students and other health-care workers”) (citations omitted).

68. Whitton, *supra* note 32, at 472-73 (discussing evidence of bias harbored by mental health professionals who express a preference for treating younger patients that is so “strong that it has been given a name—the ‘YAVIS syndrome,’” (Young, Attractive, Verbal, Intelligent, and Successful Patients); discussing also discriminatory references used for elderly patients).

69. Williams, *supra* note 34, at 441 (discussing age bias in the delivery of health care and noting that “pejorative terms for older patients exist in the lexicon.”)

70. Currey, *supra* note 27, at 16 (noting that older patients in the emergency room department were referred to as “[d]isaster waiting to happen,” “[n]ightmare on a stretcher,” “[d]otty old guy in bed three,” “[g]ramps down the hall,” and “[s]weet old lady.”)

71. *Id.* (explaining that at age fifty-eight he was more sensitive to age discrimination than his younger colleagues).

72. *Id.* (reporting emergency department personnel routinely used demeaning phrases to refer to older patients: “[n]ightmare on a stretcher,” “[d]otty old guy in bed three,” “[g]ramps down the hall.”)

“ageism.”<sup>73</sup> In contrast to Currey’s observation that the ageist expressions did not affect the quality of care,<sup>74</sup> other researchers have found that individuals subjected to expressions of ageist attitudes and behaviors in hospital settings may actually suffer physical ill effects from these behaviors.<sup>75</sup>

A 2006 report, *Ageism in America*, prepared by the Anti-Ageism Taskforce at the International Longevity Center, contains a list of age-biased terms considered unique to the medical profession.<sup>76</sup> Apparently, their use has been sufficiently consistent and pervasive, so the report identifies them as ageist terms even though the comments themselves may not include express age-related references.<sup>77</sup>

Even a facial examination of the terms on that list suggests the seriousness their use may pose for elderly patients. The terms suggest the persons who use them resent treating and devalue the humanity of elderly patients: (*e.g.*, GOMER—Get Out of My Emergency Room, SPOS—Semi-human Piece of Shit). They suggest that the persons who use them harbor animus towards a patient simply because she or he is old (*e.g.*, “fossil.”)<sup>78</sup> They also convey a sense of futility about the health outcomes for elderly patients and frustration with having to meet the needs of elderly patients who may present complex medical

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73. *Id.* (explaining that that emergency rooms are hectic and those who work in them are quick to mentally pigeonhole patients who are treated there; even though he was sensitive to age discrimination, he could be guilty by complicity).

74. *See id.*

75. Butler, *supra* note 29, at 41-42 (“Yale psychologist Becca R. Levy reports that constant bombardment of negative stereotypes increase blood pressure. *Ageism can make an older person sick.*”)

76. ANTI-AGEISM TASKFORCE AT THE INTERNATIONAL LONGEVITY CENTER, *AGEISM IN AMERICA* 22 (2006) [hereinafter ANTI-AGEISM TASKFORCE].

77. *Id.* (listing the following as ageist terms used in the medical profession: “Bed blocker,” “Crock,” “Fossil,” “Gerry,” “Gogy,” “GOMER (Get Out of My Emergency Room),” “GORK (God Only Really Knows),” “SPOS (Semi-human [or subhuman] Piece of Shit.”))

78. *See id.* *But cf.* Currey, *supra* note 27, at 16 (explaining that the ageist expressions he discusses, most of which are different than those mentioned by the Anti-Ageism Taskforce, are not necessarily “voiced with overt hostility;” “[s]ome are spoken gently or intended to be humorous;” nevertheless concluding that the discriminatory labels demean and devalue patients).



histories (e.g., GORK—God Only Really Knows) or who may prove challenging to the health care system (bed blocker, a term used for “extremely disabled, hospitalized patients with long-term care needs who await transfer to nursing homes.”)<sup>79</sup>

As will be explored in later sections of this article, this type of behavior should be considered as a form of age harassment. While information would need to be gathered on the frequency and pervasiveness of their use along with their impact on elderly patients before reaching a conclusion a health care provider has permitted the creation of an unlawful hostile environment, the terms are consistent with the type of insulting, degrading, and humiliating language courts have agreed contributes to the creation of unlawful hostile environments in employment settings.<sup>80</sup>

#### *AGEISM AS AGE STEREOTYPING THAT LEADS TO DIFFERENTIAL TREATMENT*

As noted previously, ageism may refer to behaviors by health care providers that imply elders are less desirable as patients.<sup>81</sup> However, the age stereotyping that occurs in health care settings may also include assumptions by health care providers that elderly individuals will not benefit from certain health care procedures or that elderly individuals do not want

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79. ANTI-AGEISM TASKFORCE, *supra* note 76, at 23; *see* Currey, *supra* note 27, at 16 (explaining that “[o]lder patients are typically medically complex absorbers of time and resources that can lead [emergency room] practitioners to refer to their cases as ‘train wrecks’”); NAT’L COUNCIL ON AGEING & OLDER PEOPLE, *supra* note 25, at 95 (“The tendency towards characterization of older patients in acute settings as ‘bed blockers’ is a further manifestation of prejudice towards older people . . . Discussions with staff pointed to a tendency to discharge older patients before treatment is received, or recovery complete, to prevent occupancy of a hospital bed on the basis that, because the patient is of advancing years, their stay will be prolonged.”)

80. *See, e.g.,* Rogers v. EEOC, 454 F.2d 234 (5th Cir. 1971); Harris v. Forklift Sys., Inc., 510 U.S. 17 (1993).

81. *See* Whitton, *supra* note 32, at 456; *see also* Butler, *supra* note 29, at 50 (“Some doctors question why they should even bother treating certain problems of the aged; after all, the patients are old. Is it worth treating them? Their problems are irreversible, unexciting, and unprofitable. Their lives are over.”)

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 17

certain treatments.<sup>82</sup> Elderly patients may be stereotyped based on empirically-verified information, or they may be stereotyped based on spurious information emanating from misconceptions and ignorance.<sup>83</sup>

An example of stereotyping that may have an empirical basis is the tendency of physicians to use mortality table comparisons of outcomes when making decisions about the appropriateness of various medical procedures between age groups.<sup>84</sup> Critiquing this practice, medical researcher Andrew T. Elder proposes that physicians consult studies that compare the results of different treatments within similar age groups.<sup>85</sup> Elder reasons, “[a]n older person does not want or need to know whether they [sic] will do worse, or better, than a younger person when they have an angioplasty, but simply whether they will do better or worse with an angioplasty than drug treatment alone.”<sup>86</sup>

When discussing ageism in cardiology in Britain, health sciences researcher Ann Bowling attributes the ageism in medicine partly to the “lack of awareness of the evidence based literature on the treatment of older people.”<sup>87</sup> Thus, even the well-intentioned (in contrast to the age-biased) physician may use “chronologic age” as an “imperfect surrogate for physiologic age.”<sup>88</sup> This form of stereotyping may occur even when clinical guidelines do not include chronological age as a treatment

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82. Elder, *supra* note 14, at 4.

83. SCHAUER, *supra* note 28, at 112-13 (discussing the actuarial foundations of age discrimination and distinguishing age policies based on “pure empirically unsupported prejudice” from generalizations based on age that are scientifically sound).

84. Elder, *supra* note 14, at 4 (concluding that “[c]omparisons of outcome between age groups based on mortality alone are of course implicitly prejudicial and disadvantageous.”)

85. *Id.*

86. *Id.*

87. Ann Bowling, *Ageism in Cardiology*, 319 *BRIT. MED. J.* 1353, 1353-54 (1999) (explaining that medical professionals may select low risk interventions since older persons have been largely excluded from major clinical trials).

88. Deborah Schrag et al., *Age and Adjuvant Chemotherapy Use After Surgery for Stage III Colon Cancer*, 93 *J. NAT'L. CANCER INST.* 850, 855 (2001).

criterion.<sup>89</sup>

Another stereotype that may influence age-biased decisions is the belief that older patients do not want certain medical interventions.<sup>90</sup> Although some studies do indicate that older persons may decline certain forms of treatment even when offered to them by physicians, there are other studies that suggest many older patients would accept certain treatments if physicians recommended the treatments to them.<sup>91</sup> A discussion by medical researchers analyzing the decline in the use of chemotherapy with advancing-age patients with colon cancer offered the following reasons *why* older patients may decline adjuvant chemotherapy:

Elderly patients themselves may *choose* not to receive adjuvant chemotherapy. However, the consistent finding from studies of treatment preferences is that no simple sociodemographic variable, such as chronologic age, is a reliable predictor of what patients actually want and that the only way to facilitate decisions that truly reflect preferences is to elicit them at the individual level. When surveyed, older cancer patients were just as likely as their younger counterparts to want chemotherapy, although after choosing to receive treatment, they were less likely to accept major toxicity in exchange for added survival. Furthermore, older patients have indicated that the primary determinant of their decisions regarding chemotherapy is their physician's advice. Thus, even if the elderly choose not to receive therapy, these decisions may be influenced by their physicians' attitudes toward treatment.<sup>92</sup>

The above discussion illustrates the complexity of the stereotypes and assumptions that influence age based health care.<sup>93</sup> Further, it suggests the challenges posed for crafting appropriate solutions.<sup>94</sup>

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89. *Id.*

90. Elder, *supra* note 14, at 4.

91. *Id.* (referring to studies on revascularization treatments offered older patients with acute coronary syndrome); Schrag et al., *supra* note 88, at 855.

92. Schrag et al., *supra* note 88, at 855 (citations omitted).

93. *See id.*

94. *Id.*

*AGEISM AS AGE-BASED DISPARATE TREATMENT*

## AGEISM AND THE TREATMENT OF INDIVIDUAL PATIENTS

Some of the clearest cases of medical providers engaging in age discrimination result when physicians attribute patient complaints to aging rather than health related problems.<sup>95</sup> The most common situation occurs when the physician responds to a patient's complaint by stating, "What do you expect of someone 72, 82, 92?"<sup>96</sup> According to geriatrician Dr. Steven L. Phillips, "[i]t's not fair to anyone to write the problem off or define the problem as just age. There has to be something underlying it."<sup>97</sup> Nevertheless, studies conducted over the past two decades offer evidence that "health-care professionals are likely to categorize older people's health complaints as 'normal' concomitants of ageing rather than signs of illness."<sup>98</sup> As a result, problems that would be routinely addressed in younger patients are left untreated by some physicians serving older patients.<sup>99</sup>

## AGEISM AS DEMONSTRATED BY DISPARITY STUDIES IN HEALTH CARE

A significant body of the research that measures inappropriate use of patient characteristics—particularly racial or ethnic identity—focuses on health care disparities between racial majority and minority populations.<sup>100</sup> Dr. Williams

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95. See Gerencher, *supra* note 60.

96. *Id.*

97. *Id.*

98. Adams et al., *supra* note 33, at 305 (citation omitted).

99. See Dembner, *supra* note 59 (discussing a report by the Alliance for Aging Research suggesting that "too many physicians and psychologists believe that late-stage depression and suicidal statements are normal and acceptable in older patients" and a survey published in the *Journals of Gerontology* showing that "35 percent of doctors erroneously considered an increase in blood pressure a normal process of aging.")

100. See, e.g., Ctr. for Disease Control & Prevention, *Health Disparities Experienced by Black or African Americans—United States*, MORBIDITY AND MORTALITY WEEKLY REPORT, Jan. 14, 2005, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5401a1>.

explains that health care disparities “are classically defined as racial and ethnic differences in the quality of health care that are not due to factors relevant to health care access, clinical needs, patient preference, or appropriateness of therapeutic interventions.”<sup>101</sup> She identifies a number of instances where “age and gender are also significant factors in unequal care.”<sup>102</sup>

Health care disparity studies document instances where advanced age correlates with lower quality health care for the populations studied. Typically, the studies examine the decisions of numerous health care providers across periods of time, geographical locations, and treatments. Numerous studies have been assembled and analyzed that consider the impact of advanced age on the quality of health care. However, neither the studies themselves nor the commentary that assesses them satisfy legal standards for demonstrating systemic patterns or practices of unlawful discrimination, identify the specific health care providers, or isolate particular discriminatory decisions within precise timeframes. Precise application of the pattern or practice analysis to age-related disparity studies will not be attempted here. There was insufficient data and analysis in the disparity studies examined to support application of the unlawful discrimination pattern or practice method to research documenting age disparities in healthcare. When examining unlawful discriminatory patterns or practices, courts have required litigants to identify the appropriate and relevant populations,<sup>103</sup> demonstrate statistically significant disparities,<sup>104</sup>

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htm, reprinted in 293 JAMA 922 (2005).

101. Williams, *supra* note 34, at 441.

102. *Id.*

103. See generally *Hazelwood Sch. Dist. v. United States*, 433 U.S. 299, 307-09 (1977) (explaining that plaintiffs' burden in pattern or practice cases is to “establish by a preponderance of the evidence that racial discrimination was the [employer's] standard operating procedure;” that statistical evidence of long-standing gross disparities between the employer's work force and the general population “may in a proper case constitute prima facie proof of a pattern or practice of discrimination;” but rejecting comparisons between the racial composition of the employer's teaching faculty with the racial composition of the student population) (citations omitted).

104. *Payne v. Travenol Labs., Inc.*, 673 F.2d 798, 821 (5th Cir. 1982) (explaining

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 21

and provide statistical models that account for legitimate and relevant factors that may explain the statistical disparities.<sup>105</sup>

The following discussion about a study that concludes that elderly patients with colon cancer may not have been properly referred for potentially survival-enhancing chemotherapy illustrates the problems encountered with using disparity studies as evidence of unlawful age discrimination.<sup>106</sup> This study examined the Medicare claims information for over 6,000 patients compiled during the years 1991 through 1996.<sup>107</sup> This multiple institutional and health care provider approach did not isolate or identify the particular physicians or health care provider institutions associated with acting on age bias.<sup>108</sup> Researchers found there was a steep decline in the receipt of chemotherapy with an increase in the patient's age at the time of diagnosis.<sup>109</sup> "Whereas 78% of patients aged 65-69 years had adjuvant chemotherapy, only 58% of those aged 75-79 years and 11% of those aged 85-89 years did so."<sup>110</sup>

When analyzing their results, the researchers posed the question, "Why do elderly patients fail to receive potentially

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that "[s]tatisticians tend to discard chance as an explanation for a result when deviations from the expected value approach two standard deviations") (citation omitted).

105. *Smith v. Va. Commonwealth Univ.*, 84 F.3d 672, 676 (4th Cir. 1996) ("Bazemore and common sense require that any multiple regression analysis used to determine pay disparity must include all the major factors on which pay is determined. The very factors (performance, productivity, and merit) that VCU admittedly considered in determining prior pay increases were left out of the study.")

106. *See Schrag et al., supra* note 88, at 850.

107. *Id.* at 850, 851, 854 (noting that trials conducted during the 1980s that evaluated "(5FU)-based chemotherapy for patients with stage III cancer established that treatment reduces the risk of cancer recurrence and mortality by as much as 30%," noting, however, that the median age for persons in the trials ranged from sixty to sixty-two years; but citing a study from the Mayo Clinic that demonstrated "a statistically significant improvement in disease-free and overall survival for patients over age 70 years") (citations omitted).

108. *See id.*

109. *Id.* at 852.

110. *Id.* (explaining that "[f]or the 3391 patients with no major comorbidity, age was also highly associated with treatment; utilization was 80%, 64%, and 13% for patients aged 65-69 years, 75-79 years, and 85-89 years, respectively.")

curative postoperative adjuvant chemotherapy?"<sup>111</sup> They then explored a number of plausible and arguably neutral explanations: a "high burden of comorbidity [in the elderly], financial and geographic barriers to care, physician knowledge and attitudes, and patient preferences."<sup>112</sup> Acknowledging that other health conditions that might complicate or preclude adjuvant treatment increased with age (co-morbidity concerns), researchers noted there were "low rates of utilization of adjuvant chemotherapy among elderly patients who were healthy enough to withstand colon resection and were free of cardiac, hepatic, renal, vascular, and neurologic disease."<sup>113</sup> Greater treatment toxicity was "an insufficient explanation" and since Medicare insured all of the patients in the study, financial status did not explain why the elderly were less likely to receive treatment.<sup>114</sup> Their analysis effectively dismissed two major relevant, and legitimate reasons (*i.e.*, the health or financial conditions of the patients) as explanations for the age-related health care disparities.<sup>115</sup>

When exploring whether physician attitudes and knowledge explained the disparities, the researchers noted their analysis revealed "many untreated patients did not have the opportunity for an individualized assessment of the risks and benefits of treatment from a medical oncologist."<sup>116</sup> At this point, the researchers acknowledged the limitations of their data, which did not permit further analysis that would eliminate other possible legitimate reasons for the age-related disparities, such as: (1) surgeons did not facilitate referrals; (2) patients were not interested in or were unable to attend postoperative consultations; or (3) patients who saw medical oncologists were discouraged from pursuing adjuvant treatment.<sup>117</sup>

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111. *Id.* at 855.

112. *Id.*

113. *Id.*

114. *Id.*

115. *See id.*

116. Schrag et al., *supra* note 88, at 855.

117. *Id.*

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 23

In sum, age related health care disparities may be the result of inappropriate age related motivations on the part of individual physicians. However, proof of unlawful class based age discrimination requires development of research models that document significant age related statistical disparities and dispel the lawful explanations for those disparities.

Crossley's legal analysis also discusses the challenges involved with eliciting legal evidence of "physician bias."<sup>118</sup> She explains that it is difficult to determine whether "the physician's medical judgment regarding what diagnostic intervention or treatment is appropriate for the patient appears to be affected, or biased, by a personal characteristic of the patient that may be irrelevant to the patient's medical needs."<sup>119</sup> She also concludes, "it is surpassingly difficult to design a research protocol to test for the presence of physician bias in medical decisions, while controlling for all potentially confounding variables."<sup>120</sup> Crossley has identified an essential problem that should be a focus of future age related research.<sup>121</sup>

IDENTIFIED AGE-BASED DISPARITIES IN CLINICAL TRIALS MAY IN PART RESULT FROM AGE POLICIES THAT EXPRESSLY EXCLUDE ELDERLY PATIENTS

Older adults are significantly underrepresented in clinical research trials that examine the efficacy of drug and other treatments for medical conditions.<sup>122</sup> Older adults consume thirty percent of all medications, but they are often excluded from drug trials.<sup>123</sup> The problem of under representation also occurs in clinical cancer treatment trials.<sup>124</sup> Older adults

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118. Crossley, *supra* note 34, at 196.

119. *Id.*

120. *Id.* at 198.

121. *See id.*

122. Williams, *supra* note 34, at 447.

123. *Id.*

124. Mike Mitka, *Too Few Older Patients in Cancer Trials: Experts Say Disparity Affects Research Results and Care*, 290 JAMA 27 (2003).



represent sixty-three percent of U.S. cancer patients, but they are only twenty-five percent of the participants in clinical cancer treatment trials.<sup>125</sup> Researchers note that this underrepresentation of elders affects not only research results but also affects the quality of patient care.<sup>126</sup> Several reasons have been cited for the disparate results: "patient fear and misunderstanding;" "physician bias against suggesting enrollment in trials;" and "too-rigorous exclusion criteria that eliminate many potential applicants."<sup>127</sup>

When discussing the results of research trials that examined the efficacy of chemotherapy treatment for 6489 patients with breast cancer, Hyman Muss, M.D. noted the problem that older women were underrepresented.<sup>128</sup> Although "50% of new breast cancer diagnoses are made in women aged 65 years or older, only 8% of the patients in [the] trials were aged 65 years or older and only 2% were aged 70 years or older."<sup>129</sup> Dr. Muss reported that older patients appear to derive the same benefits as younger patients without undue toxicity.<sup>130</sup> He suggested "physicians remain unaware of the advantages of systemic therapies for older patients."<sup>131</sup>

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125. *Id.* (noting that a majority of the trials have criteria such as requiring participants who are "either ambulatory and able to work" or "capable of independently performing their activities of daily living" and that such criteria "greatly hinder older patient enrollment"); Hyman B. Muss, *Factors Used to Select Adjuvant Therapy of Breast Cancer in the United States: an Overview of Age, Race, and Socioeconomic Status*, J. NAT'L CANCER INST. MONOGRAPHS, Dec. 2001, 52, 52, 53 (noting "several trials have shown that older women are less likely to receive appropriate local therapy, such as postoperative local radiation, or adjuvant systemic therapy compared with younger women.")

126. Mitka, *supra* note 124, at 27; see Schrag et al., *supra* note 88, at 855 (noting problem of under representation of elderly patients in trials; documenting dramatic declines with advancing chronological age for patients offered chemotherapy treatment; noting many patients were not offered "the opportunity for an individualized assessment of the risks and benefits of treatment from a medical oncologist;" and stating "[p]hysicians' knowledge and attitudes may explain the low utilization of adjuvant chemotherapy among the elderly.")

127. Mitka, *supra* note 124, at 27.

128. *Id.* at 28.

129. *Id.*

130. *Id.*

131. *Id.*

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 25

Food and Drug Administration researcher, Lilia Talarico, M.D. noted that older patients are underrepresented in clinical trials for new cancer drugs.<sup>132</sup> Dr. Talarico explained that the under representation of older individuals resulted in “statistical ramifications” that did not “allow for the assessments of risks and benefits of many treatments for older patients.”<sup>133</sup> Talarico stated that “[h]ealth care providers should evaluate older cancer patients for enrollment in clinical trials on the basis of their health status, cognitive function, and socioeconomic support, rather than by their chronological age.”<sup>134</sup>

In an article discussing his research, Dr. Muss offered more direct comments about the possibility that age bias affected physicians’ decisions regarding which patients were appropriate candidates for the trials.<sup>135</sup> He stated:

A sobering finding from this analysis is the observation that only 8% of patients entered in the trials analyzed in this study were aged 65 years or older; about 50% of new breast cancer diagnoses occur in women in this older group. Although good clinical judgment likely played a role in limiting the offering of these trials to many older patients, it is likely that age bias remained a major factor for offering older women clinical trial participation.<sup>136</sup>

His discussion illustrates the difficulty involved with distinguishing inappropriate considerations of age from legitimate differences in professional judgment.<sup>137</sup> Dr. Muss explained that older patients in four of the trials had “a significantly higher number of positive lymph nodes than younger patients, suggesting that physicians were wary of offering these trials to lower-risk, node-positive older

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132. *Id.*

133. *Id.*

134. *Id.*

135. Hyman B. Muss et al., *Adjuvant Chemotherapy in Older and Younger Women With Lymph Node-Positive Breast Cancer*, 293 JAMA 1073, 1080 (2005).

136. *Id.*

137. *See id.*

patients."<sup>138</sup> Ultimately, he concluded that with patient consultation about the higher risk of treatment related toxicity, "[o]lder patients with high risk early breast cancer who are in otherwise good health should be offered participation in ongoing clinical trials of adjuvant chemotherapy."<sup>139</sup>

Responding to Dr. Muss' article, Drs. Gradishar and Kaklamani offered insight into the problem, noting that some of the clinical trials excluded individuals based on age.<sup>140</sup> Disagreeing with this policy they concluded, "[c]learly age should not be the sole determining factor for who should be offered chemotherapy."<sup>141</sup> For the older woman who is frail with comorbid conditions, Gradishar and Kaklamani note that tools exist that can assist physicians with risk calculations so they can make individual assessments without relying on chronological age.<sup>142</sup> Ultimately, they agreed with Dr. Muss that physicians should consult with their patients about the potential benefits and adverse effects of adjuvant therapy.<sup>143</sup>

Physician decisions to exclude older women from clinical treatment trials illustrate the complexity of the issues that are raised when age bias affects physician treatment decisions. When is it appropriate for physicians to use chronological age? Trial participation protocols may include upper age limits. Under what circumstances are these requirements lawful or unlawful? Who should ultimately decide if the benefits of treatment are worth the risks of harm? After describing the federal prohibition against age discrimination in health care, this article will draw on insights developed by courts when interpreting antidiscrimination law and offer additional suggestions for addressing questions.

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138. *Id.*

139. *Id.*

140. William J. Gradishar & Virginia G. Kaklamani, *Adjuvant Therapy of Breast Cancer in the Elderly: Does One Size Fit All?*, 293 JAMA 1118, 1119 (2005).

141. *Id.*

142. *Id.*

143. *Id.* at 1120.

**DETERMINING WHEN UNLAWFUL AGE DISCRIMINATION  
OCCURS IN HEALTH CARE**

A number of theories accepted in other types of discrimination may provide a basis for a cause of action in health care age discrimination.

***THE AGE DISCRIMINATION ACT OF 1975***

Federal legislation exists that purportedly prohibits most health care providers from engaging in age discrimination against elderly patients.<sup>144</sup> During the latter part of 1975, Congress passed the Age Discrimination Act of 1975 (Age Act).<sup>145</sup> Congress deferred the effective date of the Age Act until the Department of Health, Education, and Welfare (DHEW) promulgated regulations.<sup>146</sup> Therefore the Age Act did not become effective until 1979, after DHEW (which is now the Department of Health and Human Services (DHHS)) had issued its interpretive regulations.<sup>147</sup>

The Age Act provides that “no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.”<sup>148</sup> When setting forth the Act’s prohibition, Congress used rather broad terms.<sup>149</sup> The Age Act contains no minimum age limits that designate which individuals are protected by its provisions.<sup>150</sup> As a result, it precludes all age

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144. See 42 U.S.C.A. §§ 6101-6107 (Westlaw through 2009 Pub L. 111-62).

145. Cannon v. Univ. of Health Scis./Chicago Med. Sch., 710 F.2d 351, 354 (7th Cir. 1983).

146. *Id.*

147. *Id.*

148. 42 U.S.C.A. § 6102; see 34 C.F.R. § 110.10(a).

149. 42 U.S.C.A. § 6102.

150. Rannels v. Hargrove, 731 F. Supp. 1214, 1220-21 (E.D. Pa. 1990) (addressing a “reverse age discrimination” action brought by an individual who claimed exclusion because she was too young; noting the text contains no limitations; and explaining the legislative history contains references that the Act was intended to cover all ages).

discrimination—against the young and the old.<sup>151</sup> However, the legislative history of the Age Act demonstrates Congress was most concerned about addressing discrimination by federal grant recipients against older individuals.<sup>152</sup>

The Act covers “all of the operations” of federal funding recipients who include:

- (a) [S]tate and local governments, agencies, or instrumentalities; (b) a college, university, other post secondary institution, or a public system of higher education, or a local education agency or other school system; (c) a corporation, partnership, or other private organization or sole partnership, or part thereof depending on receipt of Federal financial assistance.<sup>153</sup>

Since virtually all health care providers perform their services in settings that serve beneficiaries of Medicare or Medicaid programs, they, along with the institutions that employ them, are potentially “federal funding recipients” subject to the Age Act’s provisions and regulations.<sup>154</sup>

Alongside the Age Act’s broad prohibition against age discrimination are a relatively broad range of exceptions.<sup>155</sup> As a result, the Age Act permits a number of instances where recipients of federal financial assistance may use age criteria.<sup>156</sup> When examining the Age Act’s prohibition relative to its

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151. *Id.*

152. *Id.* at 1221 (explaining the Age Discrimination Act of 1975 was part of the Older Americans Amendments of 1975; noting references by members of Congress to the importance of protecting the elderly).

153. *Lannak v. Biden*, 2007 U.S. Dist. LEXIS 13124, at \*4 (citing 42 U.S.C. § 6107(4)).

154. *Eglit*, *supra* note 34, at 872 (explaining that in non-Age Discrimination Act cases courts have found that Medicare and Medicaid are “federal financial assistance programs, and there is no reason to believe that a different interpretation would apply regarding the age statute” (citing *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1042 (5th Cir. 1984)); *United States v. Univ. Hosp.*, 575 F. Supp. 607, 612 (E.D. N.Y. 1983)); *but see* *Crossley*, *supra* note 34, at 265-66, 277 (discussing a federal Dept. of Health, Education and Welfare interpretation of Title VI and the Age Act of 1975 that would preclude coverage of private physicians because they accept Medicare payments; noting however, that acceptance of Medicaid payments would extend coverage to private physicians; *Crossley* argues that physicians with managed care HMO’s should also be considered as recipients of federal funding).

155. *See Eglit*, *supra* note 34, at 874-75.

156. *See id.*

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 29

exceptions or statutory caveats, Howard Eglit concludes, “these caveats are so broad that the Act turns out to prohibit very little, indeed.”<sup>157</sup>

*AGE ACT LITIGATION SUGGESTS THE STATUTE HAS NOT BEEN  
VERY USEFUL FOR ADDRESSING AGE DISCRIMINATION IN  
HEALTH CARE*

A review of litigation under the Age Act leaves one with the impression that the statute has not been a very useful tool for regulating age discrimination in health care.<sup>158</sup> During 2007, almost three decades after the Act’s effective date, Judge Barbara Crabb of the Western District Court in Wisconsin noted the Age Act had been “rarely litigated.”<sup>159</sup> The litigation that has occurred has involved claims in the health care context on rare occasions. The few cases concerning health care issues were summarily dismissed on procedural questions or because plaintiffs failed to provide convincing evidence of age discrimination. Plaintiffs were generally unsuccessful. None of the cases addressed issues concerning ageist practices like those described in the literature as medical ageism.

One of the early cases brought under the Age Act in 1983, *Cannon v. University of Health Sciences/Chicago Medical School*,<sup>160</sup> involved a plaintiff who claimed several medical schools denied her applications for admission because of her advanced age.<sup>161</sup> When dismissing this claim the court explained that her applications were filed during 1974, before the Age Act became effective in 1979;<sup>162</sup> therefore she could not rely on the Age Act.<sup>163</sup>

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157. Eglit, *supra* note 34, at 874-75. The exceptions have been explored elsewhere in the literature that discusses the Age Act and are beyond the scope of this paper.

158. *See, e.g.,* Sheskey v. Madison Metro. Sch. Dist., 2007 U.S. Dist. LEXIS 71790 at \*9.

159. *Id.*

160. *Cannon*, 710 F.2d 351 (7th Cir. 1983).

161. *Id.* at 353-54 (alleging her application “was denied pursuant to a published admissions policy that discouraged applicants over thirty years of age.”)

162. *Id.* at 353, 355.

163. *Id.* at 355.

Further, the court noted that during 1979, the DHEW had addressed any age limitations in medical school policies by issuing regulations that provided that age should not be considered when making admission decisions.<sup>164</sup>

A second case related to health care, *Lannak v. Biden*, concerned claims of a medical researcher who alleged that due to his age members of Congress refused to direct the DHHS to analyze and prove his research results.<sup>165</sup> The court found that the Age Act did not require members of Congress to assist constituents in response to their requests.<sup>166</sup> *Wheat v. Mass* involved a claim of age discrimination brought by the survivors of a patient who did not receive a liver transplant.<sup>167</sup> Initially the court noted the plaintiffs faced considerable procedural issues that would need to be resolved before they could even establish that their relative was denied a liver transplant because of her advanced age.<sup>168</sup> However, the court declined to address the procedural issues and, perhaps employing judicial expediency, simply dismissed the action stating there was no showing that the hospital denied the deceased a transplant because of her age.<sup>169</sup>

*NAACP v. Medical Center, Inc.*, is well known as one of the hospital relocation cases where plaintiffs challenged decisions to relocate hospitals from urban areas to the suburbs as racial discrimination violating Title VI of the Civil Rights Act.<sup>170</sup>

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164. *Id.* at 354 (citing 42 C.F.R. Part 90 (1979)).

165. *Lannak*, 2007 U.S. Dist. LEXIS 13124, at \*1-\*2, \*4-\*5 (dismissing plaintiffs claims on the grounds that the Age Act does not cover members of Congress; refusals of members of Congress to assist a constituent are not cognizable claims); see *Maloney v. Social Security Administration*, 517 F.3d 70, 74, 76 (2nd Cir. 2008) (upholding determination that the Age Discrimination Act of 1975 does not apply to the Social Security Administration or its employees as agents of the federal government).

166. *Lannak*, 2007 U.S. Dist. LEXIS 13124, at \*4-\*5.

167. *Wheat v. Mass*, 994 F.2d 273, 275 (5th Cir. 1993).

168. *Id.* at 275-76 (court raised but declined to consider whether a private cause of action exists under the Age Act and whether such an action may be brought by a decedent's survivors).

169. *Id.* at 276-77.

170. *NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322, 1324 (3rd Cir. 1981).

## 2009] DISCRIMINATION IN HEALTH CARE DELIVERY 31

However, *Medical Center, Inc.*, also involved claims that the relocation of the main hospital disproportionately disadvantaged elderly patients and elderly visitors of patients, thus violating Age Act.<sup>171</sup> This was the other case where the courts addressed the substantive question of whether the hospital relocation represented unlawful age discrimination.<sup>172</sup> Plaintiffs applied the disparate impact theory used in employment law cases to the defendant's decision to relocate the hospital facility.<sup>173</sup> Under the disparate impact theory, plaintiffs have the burden of initially identifying a neutral practice or policy that disadvantages elderly patients.<sup>174</sup> Rejecting plaintiffs' arguments that the relocation would adversely impact elderly and minority patients and visitors who must travel greater distances for hospital care, the circuit court upheld the district court's finding that the adverse impact upon elderly patients and visitors would be "de minimis," "insignificant," and "minor."<sup>175</sup> The evidence was insufficient to meet plaintiff's burden of demonstrating adverse impact.<sup>176</sup>

Litigation under the Age Act has primarily involved claims of unlawful age discrimination in educational contexts.<sup>177</sup> For

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171. *Id.* at 1327, 1331-32.

172. *See id.*

173. *NCAAP v. Med. Ctr. Inc.*, 657 F.2d at 1326-27, 1131-32.

174. *Id.* at 1326-27 (noting the case was divided into several categories of neutral practices: access, quality of care, linguistic discrimination, and racial identifiably; concluding that the hospital's plan would bring about significant improvements in patient care).

175. *Id.* at 1327, 1332.

176. *Id.* at 1326, 1332-33, 1338 (recognizing that the case would be appealed, the district court had assumed *arguendo* that plaintiffs had met their *prima facie* case and concluded that the defendant had demonstrated the decision was *bona fide*, necessary, and could not be accomplished using less discriminatory means); *but see* Derek W. Black, *The Mysteriously Reappearing Cause of Action: The Court's Expanded Concept of Intentional Gender and Race Discrimination in Federally Funded Programs*, 67 MD. L. REV. 358, 371-72 (2008) (discussing the Supreme Court's decision in *Alexander v. Sandoval*, 532 U.S. 275, 280-81 (2001), that held that under Title VI individuals could only bring causes of action for intentional discrimination; the adverse impact theory of discrimination was still available under the regulations).

177. *Stephanidis v. Yale Univ.*, 652 F. Supp. 110, 111, 113 (D. Conn. 1986) (dismissing claims that plaintiffs' rejection by Yale's graduate school program in English violated the Age Act); *Mittelstaedt v. Bd. of Trs. of Univ. of Ark.*, 487 F. Supp. 960, 965, 973 (E.D. Ark. 1980) (dismissing claim brought by faculty member



example, *Parker v. Board of Supervisors University of Louisiana-Lafayette* involved a complaint by a thirty-one-year-old student of age discrimination because the school coach told him he was too old to try out for a university football team.<sup>178</sup> *Adams v. Lewis University* concerned a student who complained she was graded differently than younger students in a course due to her age.<sup>179</sup>

Other Age Act litigation has involved claims that challenged special programs granting the elderly benefits.<sup>180</sup> In *Rannels v. Hargrove*, the plaintiff brought an action against the Pennsylvania Secretary of Banking to compel her to exercise her supervisory powers over a bank that offered a higher rate of interest to persons over the age of fifty.<sup>181</sup> When dismissing Rannels' complaint, the court concluded that it lacked jurisdiction because Rannels had not met the statutory requirements to first exhaust administrative remedies before bringing suit in federal court;<sup>182</sup> furthermore, Rannels had not fulfilled the Age Act's notice requirements.<sup>183</sup> Likewise, the court in *Sheskey v. Madison Metropolitan School District* dismissed the plaintiff's claim that an over-fifty eligibility requirement for enrollment in a school district sponsored recreation program

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that his forced retirement violated the Age Act; finding the Age Act did not recognize a private cause of action) (questioned by *Stephanidis* which also found that a private cause of action does exist under the Age Act); see *Tyrrell v. City of Scranton*, 134 F. Supp. 2d 373, 384 (M.D. Pa. 2001) (noting the 1978 Amendments to the Age Act created a private right of action for injunctive relief only after the federal regulatory agency failed to ensure compliance with the Age Act); *Barea v. State Univ. of N.Y. at Albany*, 1:05-CV-1523 (GLS/DRH), 2006 U.S. Dist. LEXIS 46681, at \*4, \*15 (N.D. N.Y. Jul. 10, 2006) (dismissing claims brought by a thirty-five-year-old student that a reassignment of his dormitory room violated the Age Act); *Heckman v. State Univ. of N.Y. Coll. at Brockport*, 737 F. Supp. 177, 179 (finding that program was supported by private funds; dismissing research assistant's age discrimination claim).

178. 296 Fed. Appx. 414, 415, No. 08-30565, 2008 U.S. App. LEXIS 22024, at \*1-\*2 (5th Cir. Oct. 21, 2008) (upholding the dismissal of plaintiff's claims based on failure to provide required notices to the defendants).

179. No. 97 C 7636, 1999 U.S. Dist. LEXIS 3413 (N.D. Ill. Mar. 11, 1999).

180. See, e.g., *Rannels v. Hargrove*, 731 F. Supp. 1214 (E.D. Pa. 1990).

181. *Id.* at 1216.

182. *Id.* at 1221.

183. *Id.*

violated the Age Act.<sup>184</sup> Again, the court cited the plaintiff's failure to meet the Act's notice requirements.<sup>185</sup>

***AGE ACT PROCEDURAL REQUIREMENTS BURDEN COMPLAINANTS WITH TECHNICALITIES, BUT LEAVE FEDERAL ADMINISTRATIVE AGENCIES FREE TO USE INFORMAL METHODS WHEN FULFILLING THEIR PROCEDURAL RESPONSIBILITIES***

Under the Age Act, a complainant must comply with the following administrative procedures before bringing suit in federal court.<sup>186</sup> First, one must file a timely complaint<sup>187</sup> with the relevant federal funding agency.<sup>188</sup> The complaint form is available online,<sup>189</sup> but the content of form itself is relatively sparse.<sup>190</sup> It offers little guidance to assist a complainant with providing the relevant information or even knowing what potentially constitutes health related age discrimination.<sup>191</sup> DHHS does not consider a complaint to have been filed until it provides sufficient basic information for processing.<sup>192</sup> If DHHS finds that the complaint falls under its jurisdiction and does not involve one of the statutory exceptions, which as noted earlier are numerous, both parties will be required to participate in mediation.<sup>193</sup> After mediation, DHHS will initially informally investigate unresolved complaints or proceed with a formal investigation if the complaint is not resolved.<sup>194</sup> In the event the

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184. *Sheskey v. Madison Metro. Sch. Dist.*, 06-C-764-C, 2007 U.S. Dist. LEXIS 71780, at \*1, \*10-11 (W.D. Wis. Sept. 26, 2007).

185. *Id.* at \*10-11.

186. 45 C.F.R. §§ 91.42-44, 91.50 (2008).

187. 45 C.F.R. § 91.42(a) (Complaint must be filed "within 180 days from the date the complainant first had knowledge of the alleged act of discrimination.")

188. *See, e.g., Rannels*, 731 F. Supp. at 1221 (citing 42 U.S.C. § 6104(f); 45 C.F.R. § 90.50(a)).

189. OFFICE FOR CIVIL RIGHTS, DEP'T OF HEALTH & HUMAN SERVS., *DISCRIMINATION COMPLAINT* (2008), available at <http://www.hhs.gov/ocr/civilrights/complaints/complaintformpackage.pdf>.

190. *See id.*

191. *Id.*

192. 45 C.F.R. § 91.42(b).

193. 45 C.F.R. § 91.43 (mediation can not last more than sixty days).

194. 45 C.F.R. § 91.44.

complaint is not resolved within 180 days or DHHS issues a finding for the recipient, DHHS must promptly advise the complainant of her rights to bring an action in federal court for injunctive relief and reasonable attorneys' fees.<sup>195</sup> However, no later than thirty days prior to bringing an action in federal court, the complainant must provide notice by registered mail to the Secretary, the Attorney General of the United States, and the recipient.<sup>196</sup> The notice must include a statement of the alleged violation of the Age Act, the relief requested, the court where the action will be brought, and whether the complainant will demand attorneys' fees if the plaintiff prevails.<sup>197</sup>

As noted in the earlier discussion of litigation under the Age Act, the courts have dismissed actions when plaintiffs have failed to satisfy these procedural and pre-litigation notice requirements.<sup>198</sup> While federal regulations require complainants to provide sufficient written notice to federal agencies before bringing suit in federal court, they do not require that federal regulators provide complainants with written notice of their right to sue, agency decisions, or complex notice requirements.<sup>199</sup> So, the existing regulatory structure is one that allows strict enforcement of procedural technicalities against complainants while the federal agencies and their professional staffs responsible for enforcement have considerable flexibility when complying with Age Act regulations.<sup>200</sup> For example, in *Parker v. Board of Trustees of Univ. of Louisiana*, the plaintiff alleged that the Office of Civil Rights (OCR) "verbally informed him of his right [to sue] and pointed him toward 34 C.F.C. Sec. 110.39 for

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195. 45 C.F.R. § 91.50.

196. 45 C.F.R. § 91.50(b)(3)(iii).

197. 45 C.F.R. § 91.50(b)(3)(vi).

198. See, e.g., *Parker*, 296 Fed. Appx. 414, No. 08-30565, 2008 U.S. App. LEXIS 22024 (5th Cir. Oct. 21, 2008).

199. *Id.*, 296 Fed. Appx. at 418, No. 08-30565, 2008 U.S. App. LEXIS 22024, at \*6 (noting that nothing in 34 C.F.R. § 110.39 requires that notice of a claimant's right to sue be in writing; 34 C.F.R. § 110.39(b)(2) only requires that the Department of Education promptly "advise[] the complainant of his or her right to bring a civil action for injunctive relief.")

200. See *id.*

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 35

information regarding his right.”<sup>201</sup> In an unpublished opinion citing the lack of Code of Federal Regulations requirements imposing written notice requirements on the Office of Civil Rights, the Fifth Circuit agreed that OCR did not have to provide written notice to the complainant.<sup>202</sup> In *Parker*, the court held a pro se complainant to strict compliance with pre-suit registered mail and notice requirements while allowing the federal regulatory agency to informally fulfill their regulatory requirements.<sup>203</sup>

In summary, the Age Act and its interpretive regulations appear to have had little impact on the type of age discrimination that occurs in health care. Despite discussions about ageism and significant health related age disparities, neither the individuals affected nor the advocacy groups that support elders have availed themselves of the Age Act’s protections. Further research is warranted to determine the exact reasons why the Age Act has not been very relevant for addressing the problems of age discrimination in health care.

**THE POTENTIAL APPLICATION OF EMPLOYMENT  
DISCRIMINATION LEGAL CONCEPTS TO SELECTED TYPES OF  
AGE DISCRIMINATION IN HEALTH CARE**

A number of discrimination theories are appropriate for application in the health care context.

***DEMEANING REFERENCES FOR ELDERLY PATIENTS AS EVIDENCE OF  
AN UNLAWFUL AGE-BASED HOSTILE ENVIRONMENT***

One theory accepted by courts for demonstrating violations of the Aged Discrimination in Employment Act (ADEA) that potentially applies to the age-related insulting comments and derogatory references used by health care providers is the

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201. *Id.*

202. *Id.*

203. *Id.* (explaining that the agency verbally notified the plaintiff of its decision).

concept of the unlawful hostile environment. The age based demeaning references and insults should be considered as evidence that a health care federal funding recipient has permitted or tolerated an unlawful hostile environment that unreasonably interferes with or limits the ability of elderly patients to participate in or benefit from the services, activities, or privileges provided by a federal health care funding recipient.

Enacted during 1967, the ADEA provides that it is unlawful for any employer "to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age."<sup>204</sup> The Supreme Court has explained that the ADEA is part of an "ongoing congressional effort to eradicate discrimination in the workplace [and] reflects a societal condemnation of invidious bias in employment decisions."<sup>205</sup> The substantive antidiscrimination provisions of the ADEA were modeled after an earlier antidiscrimination law, Title VII of the Civil Rights Act of 1964, which forbids discrimination based on race, color, national origin, sex, and religion.<sup>206</sup> Although there have been exceptions,<sup>207</sup> based on the similarity between Title VII and the ADEA, courts have applied the standards, methods, and manner of proving unlawful discrimination in Title VII to ADEA cases.<sup>208</sup>

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204. 29 U.S.C.A. § 623(a)(1) (Westlaw through 2009 Pub L. 111-62).

205. *McKennon v. Nashville Banner Publ'g Co.*, 513 U.S. 352, 357 (1995) (noting that Congress also enacted Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq.*—which prohibits employment discrimination based on race, color, sex, national origin, and religion—and the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.*).

206. *Id.*

207. *See Gross v. FBL Fin. Servs., Inc.*, 129 S. Ct. 2343, 2350-52 (2009) (holding in a 5-4 decision that Congress did not intend for the "mixed motive" analysis to apply to ADEA claims; noting that the Court's approach to interpreting the ADEA in light of Title VII has not been uniform); *but see O'Connor v. Consol. Coin Caterers Corp.*, 517 U.S. 308, 311 (1996) (applying the Title VII disparate treatment analysis to an age claim even though the Court had not had the occasion to decide whether the application of the disparate treatment model was correct; explaining that since the parties had not contested that point, the Court would apply the *McDonnell Douglas* evidentiary framework).

208. *Crawford v. Medina Gen. Hosp.*, 96 F.3d 830, 834 (6th Cir. 1996) (the first circuit court case to hold that the hostile environment theory applies to claims

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 37

Under Title VII it is well established that “an employee has a cause of action when an employer maintains a hostile working environment” based on an employee’s protected status.<sup>209</sup> Although the Supreme Court has not had the occasion to decide the issue, at least one circuit court, the Sixth Circuit, has found “it a relatively uncontroversial proposition that such a theory [a hostile environment claim] is viable under the ADEA.”<sup>210</sup> Other circuit courts have considered, without necessarily deciding, whether hostile environment claims are cognizable under the ADEA.<sup>211</sup>

While no court has had the opportunity to address a hostile environment claim brought under the Age Act of 1975, similar principles regarding the interchangeability of methods of proof apply to the Age Act and other spending power legislation enacted by Congress that forbids invidious discrimination by governmental contractors or federal funding recipients.<sup>212</sup> For example, the hostile environment theory has been applied to cases brought under Title VI of the Civil Rights Act, which protects individuals from discrimination based on race, color or national origin in programs and activities that receive Federal financial assistance.<sup>213</sup>

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brought under the ADEA).

209. *Id.* at 834 (explaining that the hostile environment cause of action was first recognized in *Rogers v. EEOC*, 454 F.2d 234 (holding that an employee of Spanish origin had a cause of action against her employer who created a working environment heavily charged with ethnic discrimination); later applied to cases alleging sex discrimination, like *Harris v. Forklift Sys., Inc.*, 510 U.S. 17; and also applied to cases alleging racial and national origin discrimination).

210. *Crawford*, 96 F.3d at 834.

211. *See, e.g.*, *Halloway v. Milwaukee County*, 180 F.3d 820, 827 (7th Cir. 1999); *Hipp v. Liberty Nat’l Life Ins. Co.*, 252 F.3d 1208, 1245 n.80 (11th Cir. 2001); *Brennan v. Metro. Opera Ass’n*, 192 F.3d 310, 313 (2d Cir. 1999).

212. *Cf. Black, supra* note 176, at 359-60 (discussing the obligations of recipients to comply with various antidiscrimination statutes such as Title VI and Title IX when they accept federal funds; but noting that “due to ambiguous, conclusory, and seemingly conflicting Supreme Court decisions, determining when a defendant’s actions rise to the level of actually contravening those statutes and, hence, entitle an individual to sue, is often difficult.”)

213. *See* Notice of Investigative Guidance, Racial Incidents and Harassment Against Students at Educational Institutions; Investigative Guidance, 59 Fed. Reg. 11448 (Mar. 10, 1994); *see also* Black, *supra* note 176, at 360-61 n.7 (citing holdings where the Supreme Court has applied sexual harassment theory to actions brought

When determining if employees have been subjected to unlawful age-based hostile environments, courts have required proof that: (1) the employee belongs in the protected group; (2) the employee has been subjected to harassment based on age, either through words or actions; (3) "[t]he harassment had the effect of unreasonably interfering with the employee's work performance and creating an objectively intimidating, hostile, or offensive work environment;" and (4) "[t]here exists some basis for liability on the part of the employer."<sup>214</sup> When applying these standards courts have required a showing that the work environment was both subjectively hostile (as perceived by the employee) and objectively hostile (according to a reasonable person).<sup>215</sup> Courts have considered circumstances such as "the frequency and severity of the discriminatory conduct; whether it was physically threatening or humiliating, or a mere offensive utterance; and whether it unreasonably interfered with [the employee's] work performance."<sup>216</sup>

Of course, application of the above analysis will require considerable adaptation of the principles developed in employment law to the unique circumstances that arise in the health care context. However, courts have applied the hostile environment theory in ADEA cases where employees in health care settings have complained of being subjected to the use of demeaning terms, insults, and humiliating behaviors because of their age.<sup>217</sup>

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under Title IX, which forbids sex discrimination by federal funding recipients: *Davis v. Monroe County Bd. of Educ.*, 526 U.S. 629, 633 (1999) (recognizing a private cause of action for student-on-student harassment when the funding recipient is deliberately indifferent to the harassment); *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 277 (1998) (finding school not liable for teacher's sexual harassment of student absent proof school district official acted with deliberate indifference to the harassment)).

214. *Crawford*, 96 F.3d at 834-35.

215. *Swiech v. Gottlieb Mem'l Hosp.*, No. 98 C 5749, 2000 U.S. Dist. LEXIS 5854, at \*18 (N.D. Ill. Mar. 30, 2000) (citing *Harris v. Forklift Sys. Inc.*, 510 U.S. at 21).

216. *Id.* (citation omitted).

217. *Id.* (finding that based on the evidence that demonstrated supervisors' preferential treatment of younger workers and the fact that supervisors were the source of the discriminatory harassment, "a rational trier of fact could find that [the plaintiff's] workplace was permeated with discriminatory conduct.") Among the

Setting forth the precise parameters for an actionable hostile environment claim in a health care context is beyond the scope of this article. When determining the factors for a hostile environment claim in health care, consideration should be given to the following issues: (1) what is the nature of the duty imposed on health care providers to provide a health-care environment free of invidious discrimination;<sup>218</sup> (2) what factors should be used to determine the severity or pervasiveness of the harassment in health care settings;<sup>219</sup> (3) how should institutional health care policies that address age-based harassment influence hostile environment determinations;<sup>220</sup> and (4) what principles should be applied to determine when federal funding recipients are liable for the behaviors of health care personnel.<sup>221</sup>

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plaintiff's claims were allegations that her supervisor preferred spending time with other clerks because "they were just young" and "they had a lot of potential;" that she was required to check with the younger clerks before taking time off; that after being told she would play a major role in a work project she was subsequently reassigned and told to "take your medication, stay in the corner, don't worry about it;" that she was told she was "too old and set in her ways" and should have "more of an open mind." *Id.* at \*2-\*5; see *Tate v. Main Line Hosps., Inc.*, No. 03-6081, 2005 U.S. Dist. LEXIS 1814, at \*64, \*81 (E.D. Pa. Feb. 8, 2005) (denying defendant's motion for summary judgment on age-based hostile environment claims; noting the following allegations could be viewed by a reasonable fact finder as "ageist:" "I am sick and tired of you older senior nurses going behind my back and complaining;" "You've been here too long, and you just can't keep up with the way things are in health care;" "You older nurses can't do the job, and you complain about everything; and you're too resistant to change.")

218. *Cf.* Notice of Investigative Guidance, *supra* note 213, at 11449 (explaining that when OCR evaluates the severity of racial harassment, "the unique setting and mission of an educational institution must be taken into account.")

219. *Cf. id.* (explaining that age of the students, forms of harassment, size of the recipient, relationships of the accused harasser to the victim would be considered when assessing the severity of the racial harassment).

220. *Cf. id.* at 11450 (explaining that "if the recipient does not have a policy that prohibits the conduct of racial harassment, or does not have an accessible procedure by which victims of harassment can make their complaints known to appropriate officials, agency capacity—and thus constructive notice—is established.")

221. *Cf. id.* (placing duty on recipient to respond to notice of a racially hostile environment if the recipient "knew or should have known that the conduct was of a racial nature or had sufficient information to conclude that it may have been racially based;" consideration will be given to the recipient's response to the conduct); see *Tate*, No. 03-6081, 2005 U.S. Dist. LEXIS 1814 at \*73-\*74 (E.D. Pa. Feb. 8, 2005) (holding that a reasonable fact finder could find that the hospital was liable for supervisor's harassment of the plaintiff under the ADEA; no evidence submitted that hospital had an anti-harassment policy with a complaint procedure; or that it exercised reasonable care to prevent and promptly correct any harassing behavior;



Despite concerns expressed over the past four decades about ageist epithets and insults, the DHHS regulatory structure has not addressed this issue. By contrast, since March of 1994, the Department of Education's Office of Civil Rights has had in place and utilized an Investigative Guidance Memorandum for Racial Incidents and Harassment against Students at Educational Institutions.<sup>222</sup> This adaptation of hostile environment theory to educational contexts can be consulted for guidance when considering the appropriate factors for determining hostile environment claims in a health care context. The OCR has tailored its advice and regulatory instructions to educational institutions to reflect the unique concerns and diverse educational environments. A similar initiative should be undertaken by regulators of health care funding recipients.

***EXPLICIT AGE REFERENCES, AGE STEREOTYPING, AND CLASS-BASED AGE EXCLUSIONS AS DIRECT EVIDENCE OF AGE DISCRIMINATION IN HEALTH CARE***

As stated, some of the clearest examples of age-based discrimination occur when health care providers dismiss

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further, plaintiff's attempts to register a complaint about the age harassment were rebuffed by a human resources investigator who focused only on the particular work-related issue before her for investigation); Black, *supra* note 176, at 373-76 (discussing the Supreme Court's decision *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274 (1998); noting the Court distinguished Title IX from Title VII when determining the principles that should be applied for federal funding recipient liability; Title VII expressly embodies agency principles, while Title IX does not include agency language; therefore, the Court indicated that liability must be based on a theory other than agency principles; required proof that the harassment became the policy of the school rather than solely the act of an employee or third party; the harassment becomes a policy of the school when "an official who at a minimum has authority to address the alleged discrimination and to institute corrective measures . . . has actual knowledge of discrimination . . . and fails adequately to respond;" labeling the inadequate response as "deliberate indifference to discrimination.")

222. Notice of Investigative Guidance, *supra* note 213, at 11452 (citing selected administrative decisions: *Trenton Junior College*, OCR Case No. 07-87-6006 (finding Title VI violation "where college failed to provide adequate security for black basketball players who were subjected to a break-in, cross-burning, and placement of raccoon skins at their campus residences"); *Wapato School District No. 207*, OCR Case No. 10-82-1039 (finding Title VI violation "where teacher repeatedly treated minority students in racially derogatory manner."))

medical conditions as simply symptoms of ageing. Accounts that some health care providers have ignored, failed to diagnose, or treat medical conditions because they are consistent with the ageing process arguably constitute direct evidence of discrimination.<sup>223</sup> Direct evidence of discrimination is “evidence, which if believed, proves [the] existence of [a] fact in issue without inference or presumption.”<sup>224</sup>

In employment discrimination law, one of the central issues is whether the defendant’s adverse decision was because of the plaintiff’s age.<sup>225</sup> Courts have not been uniform as to the type of evidence sufficient to constitute direct evidence that the age of an employee motivated an employer’s decision.<sup>226</sup> The Eleventh Circuit has set forth one of the more rigorous tests for direct evidence, holding that “only the most blatant remarks, whose intent could be nothing other than to discriminate on the basis of age’ will constitute direct evidence of discrimination.”<sup>227</sup> In a different case that court characterized a memorandum stating, “Fire Early—he is too old,” as direct evidence that plaintiff Early’s discharge was due to his age.<sup>228</sup> Courts have also limited direct evidence to cases where the biased statement came from the decision maker and explicitly referred to the allegedly discriminatory decision.<sup>229</sup> However, even in those instances where the courts apply the most exacting standards when

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223. See *Scarborough v. Mineta*, No. 3:03cv328-RS-EMT, 2006 U.S. Dist. LEXIS 18218, at \*8-\*9 (N.D. Fla. Apr. 7, 2006).

224. *Id.* (citing *Rollins v. TechSouth, Inc.*, 833 F.2d 1525, 1529 (11th Cir. 1987) (quoting *Black’s Law Dictionary* 413 (5th ed. 1979)) (citation omitted) (emphasis omitted)).

225. *Id.* at \*8 (explaining that the plaintiff may establish that his discharge was because of age discrimination in one of three ways: “(1) direct evidence of discriminatory intent; (2) statistical proof of a pattern of discrimination; or (3) satisfying the test set forth in *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973).”)

226. See, e.g., *Damon v. Fleming Supermarkets of Fla., Inc.*, 196 F.3d 1354, 1359 (11th Cir. 1999); *Early v. Champion Int’l Corp.*, 907 F.2d 1077, 1081 (11th Cir. 1990).

227. *Damon*, 196 F.3d at 1359.

228. *Early*, 907 F.2d at 1081.

229. *EEOC v. Alton Packaging Corp.*, 901 F.2d 920, 924 (11th Cir. 1990) (remarks by non-decision makers or remarks unrelated to the decision making process itself are not direct evidence of discrimination).

determining what is direct evidence of age discrimination, accounts of health care providers summarily dismissing patients' complaints of medical problems as simply ageing would likely be considered as direct evidence of age-based discrimination. Simply telling patients, "what do you expect at your age," and doing nothing more about a patient's complaint arguably represents a situation where there is direct evidence of age discrimination. The remarks demonstrate an age-based motivation, and the lack of attention to medical issues that should be addressed represents the adverse action linked to the patient's advanced age.

There are other instances of age-based stereotyping in health care that also may meet the standard of direct evidence.<sup>230</sup> In employment cases, courts will consider expressions of bigotry linked to adverse employment actions as direct evidence of disparate treatment based on age.<sup>231</sup>

Such age-based stereotyping does not have to emanate from bigotry or animus in order to implicate employment laws.<sup>232</sup> Under the Age Discrimination in Employment Act, the use of chronological age as a basis for assessing employee qualifications for employment can be unlawful, even when the assumptions about the effects of an employee's chronological age on his qualifications have a rational or empirically-justified basis.<sup>233</sup> To the extent it can be demonstrated that medical providers use age as a proxy to determine the appropriateness

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230. See, e.g., *Gorance v. Eagle Food Ctrs., Inc.*, 242 F.3d 759, 762 (7th Cir. 2001).

231. *Id.* at 762 (requiring "real link" between bigotry and an adverse employment action); *EEOC v. Alton Packaging Corp.*, 901 F.2d at 924 (remarks must be made by the decision maker and be related to the decision-making process itself to constitute direct evidence).

232. See, e.g., *Western Air Lines, Inc. v. Criswell*, 472 U.S. 400 (1985).

233. SCHAUER, *supra* note 28, at 110 n.4, 112 (discussing the Supreme Court's ADEA review of an employer's age sixty mandatory retirement for commercial airline pilots, *Western Air Lines, Inc. v. Criswell*, 472 U.S. 400: "In the case of using age as a proxy for diminished hearing, diminished vision, slowing of reaction times, and heightened risk of sudden incapacitation, however, it is clear that there is a substantial evidentiary foundation for taking age as statistically indicative of a decline in hearing acuity, of a slowing of reflexes, and of impairment of the other physical traits highly desirable in commercial airline pilots.")

2009] *DISCRIMINATION IN HEALTH CARE DELIVERY* 43

of medical interventions or the desires of patients to undertake those interventions, the fact there exists some empirical basis that may support such decisions does not make them immune from scrutiny as unlawful age discrimination.<sup>234</sup> On the contrary, policies that expressly provide for age classifications (express age limits for participating in clinical trials for example) may be considered unlawful age discrimination unless the federal funding recipients who use them can establish statutory affirmative defenses.

Applying the Age Act's statutory affirmative defense to instances where express age criteria have been used to exclude elderly patients from clinical trials illustrates the difficulties health care providers may encounter if such policies are challenged as unlawful age discrimination.

The Age Act's statutory defense was modeled after the Age Discrimination in Employment Act's (ADEA) affirmative defense, the bona fide occupational qualification (BFOQ).<sup>235</sup> The BFOQ has been used by defendants to justify using age classifications or policies that would ordinarily represent statutory violations.<sup>236</sup> The DHHS regulations basically set forth similar principles used in ADEA cases that raise the BFOQ defense.<sup>237</sup> They provide that an action reasonably takes age into account if:

- (a) Age is used as a measure or approximation of one or more other characteristics; and (b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; and (c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and (d) The other characteristic(s) are impractical to measure directly on an individual basis.<sup>238</sup>

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234. See, e.g., *Western Air Lines, Inc. v. Criswell*, 472 U.S. 400.

235. See 29 U.S.C.A. § 623(f) (Westlaw through 2009 Pub L. 111-62).

236. See *id.*

237. See 45 C.F.R. § 91.13 (2008).

238. *Id.* The Age Act and its regulations also permit recipients to take action if

It may be argued that chronological age was used as a proxy for assessing the ability of a patient to tolerate the toxic effects of chemotherapy and that this assessment was essential, thereby satisfying the first three criteria in the affirmative defense.<sup>239</sup> However, the affirmative defense is stated in the conjunctive; therefore, each of the criteria must be demonstrated by the federal funding recipient who seeks to defend the use of chronological age.<sup>240</sup> However, there exists research that recommends using individualized assessments to determine the ability of elderly patients to tolerate chemotherapy.<sup>241</sup> These studies suggest physicians can and should make individual assessments and discuss the risks of treatment with older patients.<sup>242</sup> Therefore, medical providers may not be able to establish the fourth aspect of the defense.<sup>243</sup>

What about the increased risks for older women because of the toxicity of medications used for adjuvant therapy? We return to the question, who should decide if the benefits outweigh the risks of adjuvant therapy? When confronted with

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they are "based on a factor other than age, even though that action may have a disproportionate effect on persons of different ages." 45 C.F.R. § 91.14 (2008). The factor must bear "a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective." *Id.*

239. Hodgson et al., *supra* note 4, at 507 (after reviewing a number of studies that assess the influence of age on adjuvant therapy offered elderly patients, researchers noted "[s]ome, but not all, studies suggest that older patients are more likely to experience chemotherapy-related toxicity and this observation may, in part, explain why older patients are less likely to receive adjuvant therapy;" but concluding also that "the number of elderly patients enrolled in the trials that define the standard use of adjuvant therapy is small, so that the benefit of such therapy in older patients is less certain;" referring to research on the delivery of breast cancer treatment that shows "physicians may inappropriately limit adjuvant therapy to older patients" and noting other studies indicate "a similar phenomenon may be occurring for older patients with colorectal cancer") (citations omitted); Muss, *supra* note 125, at 53-54 ("The potential benefits of adjuvant therapy in older women have been estimated recently with the use of a mathematical model; it is clear that the value of adjuvant therapy diminishes substantially as age and comorbidity increase and as non-breast cancer-related illness becomes a major competing cause for death. What is also clear is that older women in good general health tolerate standard chemotherapy regimens almost as well as younger women") (citations omitted).

240. See 45 C.F.R. § 91.13 (2008).

241. See Gradishar & Kaklamani, *supra* note 140, at 1118-20.

242. See *id.*

243. *Id.*

similar questions that implicate risks and safety issues in employment cases, courts have distinguished situations where the employment poses safety risks for *employees* from those cases where the employment of the plaintiff poses risks for *third parties* in the workplace.<sup>244</sup> The Supreme Court has explained that, in the former case, the “decision to weigh and accept the risks of employment” should be left to the individual employee.<sup>245</sup> Applying this principle in the health care context, patients should be given the opportunity to “weigh and accept the risks” of adjuvant treatment; at least they should be involved in the decision making process that determines whether they should assume the risks of adjuvant therapy.<sup>246</sup>

The selected principles discussed here do not exhaust the potential applications of employment law principles for age discrimination in health care context. They only represent some of the more obvious applications that may be used by those interested in exploring legal avenues to address problems of “medical ageism” in health care. Specific application of discrimination theories should occur after input from health care providers, legal professionals, medical researchers, governmental regulators, and elder advocates.

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244. *Int'l Union, United Auto., Aerospace & Agric. Implement Workers of Am. v. Johnson's Controls, Inc.*, 499 U.S. 187, 202-03 (1991) (explaining that where safety concerns were considered a bona fide occupational qualification the courts considered the safety of third parties).

245. *Id.* (contrasting situations where the safety risks were posed to the employee with those where they were posed to third parties; in the former case the employee could decide to weigh and accept the risks).

246. Schrag et al., *supra* note 88, at 854-56 (comparing the life table estimates of survival of elderly stage III colon cancer patients with the average survival life spans of elderly stage III colon cancer patients receiving chemotherapy; concluding the comparisons “indicate that they merit the opportunity to at least discuss the potential risks and benefits of adjuvant treatment.”) How to appropriately involve patients when making decisions about alternative treatments for medical problems is currently under study. See Laura Landro, *The Informed Patient: Weighty Choices, in Patients' Hands*, WALL ST. J., Aug. 4, 2009, at D2 (describing various decision-aid programs available to patients, along with initiatives to increase their use by patients).

**CONCLUSIONS AND RECOMMENDATIONS: BRIDGE THE GAP  
BETWEEN THE RESEARCH AND LEGAL PROTECTIONS**

There is a considerable distance between what the research, studies, and discourse describe as ageism in health care and the legal protections available to address unlawful age discrimination. Even the most blatant and overt instances of ageism have not produced claims for protections under the Age Discrimination Act's provisions. The two perspectives, medical and legal, must converge to bring about the necessary reforms to protect our elders.

What practical steps should be taken to advance this convergence? Based on the previous discussion, multiple initiatives are warranted. Included among the initiatives that should be considered are revisions of DHHS regulations. Specifically DHHS regulations should be expanded to define as unlawful age-based harassment and age-based stereotyping. Regulatory officials should provide health care consumers with information that describes in relevant detail what the Age Act prohibits rather than simply the age discrimination it permits.<sup>247</sup> Regulators and elder advocates should explore the application of traditional methods for demonstrating discrimination to problems identified as ageism in healthcare.

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<sup>247</sup>. Compare OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., FACT SHEET: YOUR RIGHTS UNDER THE AGE DISCRIMINATION ACT (2006), available at <http://www.hhs.gov/ocr/civilrights/resources/factsheets/age.pdf> (describing in detail the exceptions to the Age Act's prohibitions without offering any meaningful description about the prohibited conduct), with OFFICE FOR CIVIL RIGHTS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., FACT SHEET: YOUR RIGHTS UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 (2006) (setting forth examples of prohibited discriminatory acts).