

PRIMARY CARE PHYSICIANS' ATTITUDE TOWARD OLDER PEOPLE IN VIETNAM AND ASSOCIATED FACTORS

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A cross-sectional study included 108 physicians from the community health care centers in four provinces in the northern and center of Vietnam (Hanoi, Hue, Ninh Binh and Dien Bien) was conducted to describe ageism among Vietnamese primary care physicians. Data collection was done through interviews using a self-administered questionnaire. The questionnaire consisted of questions about socio-demographic characteristics of participants, and questions from Ageism Attitude Scale. The means total score of AAS were 67.81 ± 6.94 . The mean scores of 'Restriction elderly life', 'Positive ageism' and 'Negative ageism' sub-dimensions were 22.53 ± 4.02 , 28.42 ± 5.67 , and 16.87 ± 3.39 , respectively. Physicians who are female, aged over 40, and had over-10-year experience were significantly associated with positive attitude toward the elderly. In general, primary care physicians exhibited a neutral attitude towards the elderly. To strengthen the positive attitudes of physicians, it is recommended to increase the frequency of contacting with healthy older people.

Keywords: ageism, attitude toward elderly, primary care physicians

I. INTRODUCTION

In the "World Values Survey" analyzed by WHO in 2016, fully 60 percent of respondents reported that the elderly are not respected.¹ A study showed that the most common reason of discriminations against older people was age (28%).² Ageism originally mentioned by Robert Butler in 1969 was defined as prejudice or discrimination against a particular age group and especially the elderly. Age discrimination had a negative effect on health of older people. Everyone can be a victim of ageism if they live long enough.

Studies showed that negative discrimination

against elderly worsened their health problems, such as hearing, cardiovascular function and memory.³ Older individuals with more positive self-perceptions of aging lived 7.5 years longer than those with a less positive attitude.⁴ Ageism in healthcare is related to clinical decision-making of cardiologist or physical activities recommended to arthritis patients.⁵ Clinical drug trials seem to unintentionally exclude people over 65, so that there is a lack of useful information for proper prescription. Many older people received less treatment than younger people when they had common ailments, which were attributed to be a part of aging.

Vietnamese people had an ancient tradition of reverence to the ancestors and respect for the elders. But there was no study in Vietnam estimating the attitudes of people (including healthcare workers) to older adults.

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Vietnam healthcare system comprises of four administrative levels of health establishments: central level, provincial level, district level and commune level. Commune health centers provided a range of basic services, such as mother and child health care, treatment of common diseases, immunization, monitoring epidemic, conducting national target health program and treatment of common ailments. According to the statistics, only 25% people over 60 went for medical examination and health treatment. Over half of the time, health services were at local facilities, which included district-level health facilities and commune health centers.⁶ In fact, over 2 million older adults had periodic examination and over 1.7 million of those had their own health records. Given the changing age structure, demographers predict that people at 60 years old and older will comprise 20.1% of the Vietnam population in 2038.⁷ In light of rapidly ageing population in Vietnam, healthcare professionals must be prepared with adequate knowledge, skills, and attitudes to ensure qualitative and safe care for older people.

This paper objective is to describe ageism among the Vietnamese physicians at primary care settings and related factors.

II. SUBJECTS AND METHODS

1. Study subjects and settings

From Sep 2018 to May 2019, physicians from 81 community health stations and 4 medical centers from four provinces in Vietnam were invited to participate in the interviews. Among four provinces, Hanoi and Hue are two biggest provinces in Vietnam, Ninh Binh and Dien Bien are among typical provinces in the northern Vietnam. A community health station in the northern Vietnam often has from 3 to 8 health staffs to serve a population of

about 4,000 to 14,000 inhabitants. A district medical centers works as a preventive health center and a general hospital is responsible for its local residents' healthcare.

2. Study design

This is a cross-sectional study involving administered interviews with invited physicians.

3. Sampling and sample size

Formula for estimating sample size in determining a population means:

$$N = Z_{(1-\alpha/2)}^2 \delta^2 / d^2$$

(δ : standard deviation, d : confident limit around the point estimate)

In our study, the α was 0.05, δ was determined at 9.34 based on the study of Polat⁸ and the margin error (d) was 2. The result of calculation was 84. Our actual sample size was 108.

Sampling: In the Hanoi area, we built a list of commune health stations in a central district then conducted the interview of those who meet the standard of the study. In Hue, we interviewed the attendees of a conference specializing in family medicine. In Ninh Binh and Dien Bien, we interviewed the attendees of a class for primary physicians.

4. Main variables and survey tool

All information's collected using a self - administered questionnaire consisted of questions on socio-demographic characteristics and questions related to the attitudes of physicians about the elderly and related activities. Socio-demographic information consisted of age, gender, city, years of experience, history of living with older people, frequency of contact with healthy elderly and frequency of working with older patients.

Ageism Attitude Scale (Vefikulucay Yilmaz and Terzioglu, 2011) was used to assess atti-

tudes about aged people. This scale includes 17 items belong to three sub-dimensions: restricting the life of the elderly (items A1-A9), positive ageism (items B1-B8), negative ageism (items C1-C6). The answer for each item can be scored from 1 (totally disagree), 2 (disagree), 3 (neutral); 4 (agree) and 5 (totally agree). For negative items in C subscale the scored were inverted. AAS total scores ranged between 23-115 points. The higher AAS scores and sub-dimension scores indicate that the attitude towards ageism is positive.⁹ The questionnaire was translated into Vietnamese then reverse-translated to compare with the origin. The process was conducted several times to find out the final version which was the most appropriated one with Vietnamese culture . In this study, Cronbach’s alpha internal consistency coefficient was 0.63.

5. Data collection process

The interviews were conducted in a classroom about family medicine principles; the participants were the attendees of a conference for primary care physicians and physicians at the community health stations. The researchers were well trained with the research criteria. At the beginning of the interviews, the researchers explained the purpose of the study,

the confidentiality of respondents’ personal information and respondents’ right to withdraw at any time of the study. All respondents signed the consent form. The interview took about 20 minutes to 30 minutes. There was no discussion among the respondents during the interview.

6. Statistical Analysis

Data were managed and analysed using SPSS version 22.0. Distributrion of AAS and sub-dimension scores were examined and normally distributed. As the Kolmogorow–Smirnov test performed on the ageism, result revealed that the data fit a normal distribution. Frequencies, percentages, mean value, standard deviation, highest and lowest values were estimated as the descriptive statistics. Parametric tests were used are follows: Independent t-test test for categorical variables with two groups; one-way A nova test for categorical variables with more than two groups. Values of $p < 0.05$ were considered statistically significant.

7. Ethical clearance

Ethical issues were reviewed and approved by the Hanoi Medical University Scientific Committee following the Decision number 3466/QD-DHYHN dated in July 2018.

III. RESULTS

Table 1. Respondent characteristics

Variables		n	%
Gender	Male	55	50.9
	Female	53	49.1
City	Hanoi	24	22.2
	Hue	16	14.8
	Dien Bien	27	25.0
	Ninh Binh	41	38.0

Variables		n	%
Living with older people	Present	45	41.7
	Never	4	3.7
	Used to	59	54.6
Contact with healthy elderly	Daily	62	57.4
	Weekly	23	21.3
	Monthly	13	12.0
	Less than monthly	10	9.3
Working with older patients	Daily	59	54.6
	Weekly	21	19.4
	Monthly	8	7.4
	Less than monthly	20	18.5
Years of practice (M = 15.8, SD = 9.4)	0 - 10	43	39.8
	11 - 20	18	16.7
	21 - 30	45	41.7
	> 30	2	1.9
Age group (M = 41.4, SD = 8.9)	20 - 29	10	9.3
	30 - 39	40	37.0
	40 - 49	36	33.3
	50 - 59	22	20.4

Half of the respondents were males (50.9%), 22.2% were from Hanoi and 41.7% were presently living with an elderly. Over a half of the respondents had daily contacts with healthy elderly (57.4%) and worked with older patients (54.6%). Mean age of the sample was 41.4 years old, ranged from 24 to 56 years. Number of years of practice ranged from 6 months to 33 years.

Table 2. AAS sub-dimensions and total scores

	Mean± SD	Min	Max	Normal range
Restriction of elderly life	22.53 ± 4.02	10	32	9 – 45
Positive ageism	28.42 ± 5.67	12	39	8 – 40
Negative ageism	16.87 ± 3.39	8	26	6 – 30
AAS total	67.81 ± 6.94	48	82	23 - 115

Table 2 demonstrates the means of AAS sub-dimensions and total scores. To be specific, given that the normal range of AAS total score was from 23 to 115 points, our study's range of the total score was 48 - 82 with the mean of 67.81 ± 6.94. The means of three sub-dimensions 'Restriction

elderly life', 'Positive ageism' and 'Negative ageism' were 22.53 ± 4.02 , 28.42 ± 5.67 and 16.87 ± 3.39 , respectively.

Table 3. The mean of sub-dimensions and total AAS scores by physicians' socio-demographic characteristics

	N	Restriction of elderly life	Positive ageism	Negative ageism	AAS
Gender					
Male	55	23.5 ± 4.2	27.7 ± 5.9	16.4 ± 3.5	67.5 ± 7.2
Female	53	21.6 ± 3.6	29.2 ± 5.3	17.4 ± 3.3	68.1 ± 6.7
p		0.014	0.166	0.128	0.643
Age group (mean age = 41.4 ± 8.9 years)					
20 - 40 years	50	21.6 ± 3.5	27.5 ± 5.5	16.7 ± 3.4	65.8 ± 6.6
> 40 years	58	23.4 ± 4.3	29.2 ± 5.7	17.0 ± 3.4	69.6 ± 6.8
p		0.020	0.104	0.712	0.004
Years of practice (mean = 15.8 ± 9.4 years)					
≤ 10 years	43	21.3 ± 3.6	27.2 ± 5.9	16.4 ± 3.4	64.9 ± 6.6
> 10 years	65	23.3 ± 4.1	29.2 ± 5.4	17.2 ± 3.4	69.7 ± 6.5
p		0.011	0.072	0.216	< 0.001
Present living with older people					
No	63	22.2 ± 4.0	28.3 ± 6.2	17.1 ± 3.4	67.6 ± 6.9
Yes	45	23.0 ± 3.9	28.6 ± 5.3	16.6 ± 3.4	68.1 ± 7.2
p		0.335	0.812	0.423	0.723
Contact with healthy elderly					
Daily	62	22.4 ± 4.2	28.5 ± 5.8	16.5 ± 3.6	67.4 ± 6.8
Less than daily	46	22.7 ± 3.6	28.3 ± 5.7	17.4 ± 3.0	68.4 ± 7.3
p		0.620	0.833	0.206	0.472
Working with older patients					
Daily	59	22.5 ± 4.0	28.6 ± 5.8	16.6 ± 3.5	67.7 ± 6.6
Less than daily	49	22.5 ± 4.0	28.1 ± 5.8	17.2 ± 3.3	67.9 ± 7.5
p		0.984	0.702	0.381	0.923

Table 3 illustrates the differences in physicians' AAS sub-dimensions and total scores by socio-demographic characteristics. As shown in Table 3, female physicians reported a higher score of "Restriction of elderly life" which showed that they had a more positive attitude toward older people than male physicians. As the age of participants was grouped with 4 groups, AAS scores of over 40

years increased significantly, so the study group was divided into 2 groups as age to express this significance. It was found that the sub-dimension “*Restriction of elderly life*” and AAS total score were higher among people who are over 40 years old. Similarly, we found that physicians who practiced over 10 years reported significant higher score of the sub-dimension “*Restriction of elderly life*” and AAS total score than those worked 10 years or less ($p < 0.01$).

On the other hand, no significant association was found between presently living with older people, contact with healthy elderly as well as working with older patients and AAS sub-dimensions or total scores ($p > 0.05$).

Table 4. Factors associated with AAS scores in multivariate regression model

	Restriction of elderly life		Positive ageism		Negative ageism		AAS	
	Coef.	p	Coef.	p	Coef.	p	Coef.	p
Female	-0.250	0.008	0.135	0.166	0.141	0.151	0.035	0.712
Years of practice	0.257	0.008	0.180	0.074	0.076	0.447	0.333	0.001
Present living with elderly	0.184	0.063	0.051	0.623	-0.044	0.675	0.127	0.204

Table 4 shows several factors associated with AAS scores in multivariate regression model. AAS total score had significant statistical relationship with years of practice ($p = 0.001$). Score of the sub-dimension ‘*Restriction of elderly life*’ associated significantly with gender and years of practice ($p < 0.01$). To be clear, female had 0.25 lower points of ‘*Restriction of elderly life*’ score than male. With one more year of practice, ‘*Restriction of elderly life*’ and total score increased 0.257 and 0.333, respectively.

IV. DISCUSSION

In society, attitudes towards older people were determined to be generally positive.¹⁰ In the present study, it was found that primary care physicians had positive attitudes towards elders with 67.81 ± 7.29 points of AAS total score on average. This result was compatible with many studies using AAS such as Hatice Simsek et al¹¹ in 2019 on research assistant physicians in a university hospital (mean AAS score was 86.9) and Ulku Polat et al⁸ in 2014 study on physicians in a university hospital (mean AAS score

was 83.17).

Many studies using other tools also had similar results. In the study conducted by Doherty¹² on attitudes of healthcare workers towards older people in a rural population and the study conducted by Lui and Wong¹³ on junior doctors using Kogan scale (Attitudes towards older people scale), it is reassuring that these healthcare workers hold positive attitudes towards older people. Results of a study performed by Yang et al¹⁴ using ASD (Aging Semantic Differ-

ential Scale) showed that overall, general practitioners exhibited a neutral attitude towards older people.

It was indicated that female physicians had more positive ageism towards the elderly. A statistically significant difference was revealed between the Gender and '*Restriction of elderly life*' (Table 3). Although no significant difference between gender and AAS scores was found in many studies in literature, it was found that women had more positive attitudes toward older people, since women are usually responsible for the health care of all members of the whole family including elder people. Thus, women appears to have a thorough understanding of aging and elders' health than men.¹⁵ On the contrary, no significant difference between the mean attitude scores of physicians according to sex was found in a study conducted by Simsek et al.¹¹ Similarly, no significant associations of ageism were observed with sex in the study performed by Polat et al.⁸

The study also determined that over 40-year-old physicians had more positive ageism towards the elderly. In the literature, the correlation between age and attitude towards elder adults was mixed.⁸ Also found in the present study was that physicians with over 10 years of practice had more positive attitudes than those who had a working period of 0-10 years. Moreover, a Leung's study has revealed that physicians' characteristics are associated with more positive attitudes towards the elderly included age of ≥ 30 years and postgraduate years ≥ 10 ($p < 0.001$).¹⁵ In contrast, two studies showed that no significant associations of ageism were linked with years of practice.^{8,13} There is a possibility that various scales and cultural difference were the reasons for the difference in results mentioned above.

Additionally, this study demonstrated that

there was no significant correlation between living, contacting or working with elders and attitudes toward older people. In the study performed by Unalan et al,¹⁶ participants who had previously lived with an elder family member exhibited a positive attitude toward older adults. Moreover, hospital doctors who weekly social contact with healthy older people had positive than those who less frequently contact with healthy people ($p < 0.001$).¹⁵ Similarly, a study conducted by Smith¹⁷ in 2017 showed that students who frequently contact or live with elders hold less negative attitudes toward older people. On the other hand, Lisa¹⁸ supposed that it was not frequency but quality of contact that is affecting the attitudes towards elders.

V. CONCLUSION

This study revealed that healthcare professionals, in particular primary care physicians, had positive attitudes towards the elders. Physicians, who were over 40, women, had working over 10 years hold more positive attitude than the rest.

To our knowledge, this is the first study to describe the attitude of primary care physicians toward older adults and related factors in Vietnam. This paper is also the first study using Vietnamese version of AAS. More studies are needed to determine the attitude of other medical staffs toward elderly as well as the solution to maintain and improve positive attitude.

Conflict of interest

There are no conflict of interests. This research did not receive any funding from agencies in the public, commercial, or not-for-profit sectors.

Limitation

The sample size was small and non-randomized due to limiting of time and budget.

Vietnamese version of AAS were firstly used without validation, some terms may be difficult to comprehend.

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