The term “ageism” was coined in 1969 by Robert Butler, who likened it to other forms of bigotry such as racism and sexism, defining it as a process of systematic stereotyping and discrimination against people because they are at or beyond a certain age. Ageist attitudes are perpetuated in many ways. Institutions perpetuate ageism and reinforce ageist stereotypes by not hiring or promoting older workers and through mandatory retirement. Ultimately, stereotypes are dehumanizing and promote one-dimensional thinking about others. Elders are not seen as human beings but as depersonalized objects who, therefore, can be more easily denied opportunities and rights, leading to cruel and inhumane treatment. Ageism, as manifested by mandatory retirement, is based on fallacious thinking and untenable policies. Chronological age is a poor predictor of the competence of the older adult. Furthermore there is far more variation of productivity, ability and intelligence within than across age groups.

The Ontario Government’s Bill 211, which is now in effect, should force London Health Science Centre’s (LHSC) and St. Joseph’s Health Centre’s (SJHC) to amend their by-laws that gave an absolute cut-off for hospital-based, OHIP or LHSC/SJHC-funded remunerative work to individuals over 70 years of age. However, the plan not to reinstate those recently terminated before December 2007/January 2008 will unjustly curtail the careers of several capable, internationally renowned academic clinicians. Thus, this arbitrary decision perpetuates the injustice that existed here before Bill 211.

Why should we persist in discriminating against individuals who are otherwise well qualified? If we cut off physicians’ livelihood, i.e., the ability to be remunerated for clinical work, they cannot viably continue their academic pursuits, even if the university position remains. Mandatory, age-dependent retirement has been abolished in most Canadian universities and hospitals. The policy is, above all, inhumane: “The deprivation of the opportunity to work has been the most widespread disadvantage imposed on people because of old age.” At a time of physician shortages, we are losing good people who could still make valuable contributions in research, teaching and patient care. Within the academic medical centre the academic milieu is damaged. There are aspects of collegiality, best demonstrated in academic rounds and collaborative research projects, that would be compromised if these individuals were forced to retire.

We need not look far for examples of the damaging effects of mandatory retirement. We have lost a number of internationally famous individuals, who have moved to other institutions, e.g., Mayo Clinic, when they could no longer work at LHSC and SJHC. In the past two years several prominent, active, productive faculty members have lost even their outpatient privileges and their ability to carry on their needed activities in established units at the LHSC and SJHC, because of ageist bylaws of convenience. This makes no sense if they want to work and if they are needed.

Why must this persist, when LHSC and SJHC are otherwise so progressive and prominent in research, teaching and patient care? Within medical and surgical departments, mandatory retirement was a convenient means for department heads to be freed from the responsibility of passing judgment on the
competence of senior departmental members, some of whom were the mentors or professors of current department heads or service chiefs. It also allows the system to eventually free itself of incompetent and non-productive members. Mandatory retirement is one of the few methods by which positions are created to hire new departmental members. However, if the senior member is still active and capable (often such individuals are in their prime at age 65, 70 years or beyond), this cannot be justified. Why should they be sacrificed? From an ethical perspective it is wrong: the ends do not justify the means.\(^5\)

Also, at a time of physician shortages in almost all branches of medicine, forcing out our most productive, competent and prestigious colleagues is both wasteful and unwise.

Reform is the best approach to counteracting ageism within institutions. The object is to have quality members in the department, regardless of age.\(^6\) To do this we need a better model. Although it will be a challenge to design and implement a workable, fair system, it is the right thing to do. Departments have Appointments and Promotion Committees that have the duty of assessing the performance of departmental members and recommending their continuation, promotion, demotion or discontinuation. Surely these committees should function as they were intended and allow for yearly, fair, merit-based assessments of each Departmental member. The committee should be empowered to make decisions about appointments, promotion as well as the dismissal of individuals based upon agreed-upon qualifications and record of research, teaching and service in the “stream” appropriate for each member. This would take the onus off the divisional chairs to make such decisions in isolation. Other models for the operation of hospital and university departments can be formulated that allow continuation of the best and hiring of the brightest: the Faculty could derive another system for physician assessment with appropriate oversight, principles of function, accountability and authority with checks and balances. Individuals should be maintained on our staff while they continue to make meaningful contributions to the missions of the university, hospital and departments. Mandatory retirement from LHSC/SJHC, with respect to admitting, consultation and billing privileges should be abolished. It is shameful at a time when we need capable and knowledgeable academic clinicians for them to be effectively dismissed.

This would be a very good time for LHSC and SJHC to abolish mandatory retirement as well as the “no re-entry” policy for the unjustly retired. We need to develop other models for dealing with competence and productivity, so that the incompetent and non-productive can be jettisoned from and the good retained in academic medical centres.

References