Shaping Long-term Care for Older Adults: Exploring the Role of Geriatricians in Italy and the United States

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Abstract

Aging and the need to reconfigure the provision of long-term care for aging adults has become a pressing policy issue for many high and middle-level income countries across the world. Traditionally, research on long-term care and its organization has centered on the analysis of the triangle of state/market/family to understand its operation and distribution across social actors. To this day, however, little to no attention has been paid to the role that doctors play in these processes, notwithstanding the fact that they are a key node at the intersection of the above-mentioned institutions. This paper begins to fill this gap by exploring the role that geriatric doctors play in supporting, maintaining, reproducing, and sometimes challenging how aging and its processes are understood by society at large and how they are addressed at macro and micro-levels. The paper is based on qualitative interviews with geriatric doctors in the United States and Italy operating both in the private and public sector, on participant observations at Italian geriatric conferences, and on the analysis of email threads of the American Geriatrics Society. The analysis of the data shows that limited geriatricians' presence in both countries affects both how society at large, from individuals to institutions, understand aging and its processes and the increased need for long-term care Addressing these issues from a policy perspective has the potential to greatly improve, both from an economic and social perspective, how long-term care for aging adults is understood, organized, and delivered.

Keywords: aging Italy, aging U.S., geriatric doctors, long-term care, qualitative research

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Dar forma al cuidado a largo plazo para adultos mayores: Explorar el papel de los geriatras en Italia y los Estados Unidos

Resumen

El envejecimiento y la necesidad de reconfigurar la provisión de atención a largo plazo para los adultos mayores se ha convertido en un problema de política apremiante para muchos países de ingresos medios y altos en todo el mundo. Tradicionalmente, la investigación sobre los cuidados de larga duración y su organización se ha centrado en el análisis del triángulo estado/mercado/familia para comprender su funcionamiento y distribución entre los actores sociales. Sin embargo, hasta el día de hoy, se ha prestado poca o ninguna atención al papel que juegan los médicos en estos procesos, a pesar de que son un nodo clave en la intersección de las instituciones mencionadas. Este documento comienza a llenar este vacío al explorar el papel que desempeñan los médicos geriátricos en el apoyo, el mantenimiento, la reproducción y, en ocasiones, el desafío de cómo la sociedad en general entiende el envejecimiento y sus procesos y cómo se abordan a nivel macro y micro. El documento se basa en entrevistas cualitativas con médicos geriatras en los Estados Unidos e Italia que operan tanto en el sector público como en el privado, en observaciones de participantes en conferencias geriátricas italianas y en el análisis de hilos de correo electrónico de la Sociedad Estadounidense de Geriatría. El análisis de los datos muestra que la presencia limitada de geriatras en ambos países afecta tanto la forma en que la sociedad en general, desde los individuos hasta las instituciones, entiende el envejecimiento y sus procesos y la mayor necesidad de atención a largo plazo. Abordar estos problemas desde una perspectiva política tiene el potencial mejorar en gran medida, tanto desde una perspectiva económica como social, cómo se entiende, organiza y brinda la atención a largo plazo para adultos mayores.

Palabras clave: envejecimiento de Italia, envejecimiento de EE. UU., médicos geriátricos, atención a largo plazo, investigación cualitativa

为老年人制定长期护理：探究老年病学家在意大利和美国的作用

摘要

老龄化和老年人长期护理服务的重新配置需求已成为世界上许多中高收入国家所面临的紧迫政策问题。传统上，关于长期护理及其组织的研究聚焦于分析国家/市场/家庭的三角关系，以理解其在社会行动者之间的运作和分配。不过，直到今天，医生在这些过程中所发挥的作用几乎没有受到关注，尽管事实上他们是上述机构交叉点的关键节点。本文试图填补该空白，探究了老年病学医生在支持、维持、再生产以及有时挑战“社会对老龄化及其过程的理解以及如何在宏观和微观层面应对这些过程”一事中发挥的作用。本文基于对美国和意大利私营和公共部门的老年病学医生的定性访谈、意大利老年病学会议参与者的观察、以及对美国老年医学会（American Geriatrics Society）电子邮件讨论的分析。数据分析表明，这两个国家的有限老年病学家人数会影响整个社会（从个人到机构）对老龄化及其过程的理解，并影响长期护理需求的增加。从政策角度解决这些问题有可能在经济和社会方面极大地改善对老年人长期护理的理解、组织和提供方式。

关键词：意大利老龄化，美国老龄化，老年病学医生，长期护理，定性研究

Recent developments connected to the COVID 19 pandemic have directed the spotlight on a growing concern for many wealthy, post-industrial societies, namely how to provide sustainable long-term care for growing numbers of aging adults. This issue, which has been on the table for quite some time but had never reached mainstream, is now front and center of many national debates. Who should provide long-term care, how and where care is offered, in what forms it is received, and who should fund it and how are central questions that require an in-depth investigation of the issue at macro-, meso-, and micro-levels to include the perspectives of the many social actors involved in these processes and provide applicable answers. Traditionally research on the organization of long-term care has focused on the triangle involving state, families, and market to highlight different configurations among different societies (among others Ambrosini, 2016; DaRoit, 2017; Lutz, 2016; Ogawa et al., 2018; Rugolotto, 2017; Scrinzi, 2017).

Only recently have scholars begun to focus on the many intermediaries that participate in shaping, maintaining, reproducing and, sometimes, challenging the existing organizations of long-term care. These intermediaries include, among others, nurse managers (Dever, 2018), care convoys (Kemp et al., 2018) cultural mediators and local NGOs (Degiuli, 2016; Yang, 2018), and social cooperatives (DeMarchi & Sarti, 2010). At this point, however, little to no attention has been paid to the role of doctors in these processes. This paper begins to fill this gap by exploring the role that geriatric doctors play (or fail to play) in shaping long-term care at the individual, interpersonal, and structural level. Through in-depth qualitative interviews with geriatricians in Italy and the United States, participant observations at Italian geriatric conferences, and a monitoring of web-based threads of the American Geriatric Association, the paper discusses how these social actors make sense of their limited presence in the medical communities and/or healthcare settings of their respective countries and elaborates on the societal, political, and medical effects of their limited imprint. Finally, in light of these conversations, the paper lays out some policy suggestions aimed at improving the current status quo.

Background

The world of today is aging at a great speed and is still doing so almost three years into the COVID-19 pandemic. According to the United Nations, in 2020 there were an estimated 727 million people aged 65 and over worldwide—a number that is projected to more than double in the next few decades, reaching over 1.5 billion people in 2050 (UN DESA, 2020). Preliminary research suggests that while the pandemic has and will potentially affect life expectancy for years to come, it has not slowed down the graying of populations (Harper, 2021). In Italy, a country with one of the oldest populations of the world and one deeply affected by COVID 19, the population of 65 and older has grown from 22.8 in 2018 to 23.5 percent of the population in 2020, while the percentage of 80 and over, the one most affected by the pandemic, has grown from 6.9 in 2018 to 7.6 in 2020 (ISTAT 2021, 2022). In the United States, a country experiencing one of the largest losses of life expectancy connected to the pandemic (Aburto et al., 2022), population projections show that by 2050 the total number of adults 65 and older is expected to grow from 54 million to 85.7 million, while the population of 85 and older is projected to more than double, going from 6.6 million in 2019 to 14.4 million in 2040 (AoA, 2020).

Although people living longer represent one of the greatest achievements of the last century, often an extension of life expectancy does not correspond to an extension of healthy lives. Aging populations, particularly those with a high percentage of the oldest old, are often affected by chronic conditions that render them vulnerable and frequently require extended long-term care. The COVID-19 pandemic, particularly in its early stages, has made

this vulnerability visible to all. Data provided by European Regional Office of the World Health Organization highlight that 95% of the deaths attributed to COVID 19 occurred in adults older than 60 and that more than 50% of all deaths were people aged 80 and over. Many of these deaths were among individuals with at least one co-morbidity, in particular cardiovascular disease/hypertension and diabetes, but also a range of other chronic underlying conditions (WHO, 2020). In addition, the pandemic and its effects have also highlighted the inefficiency and the fragility of the current organization for long-term care. Early international evidence estimates that up to 60% of total of mortality associated with COVID-19 can be traced to residents of care homes (Comas-Herrera et al., 2020), a pattern repeated in the United States where, during the pandemic, nursing homes and long-term care facilities became the epicenter of infection and death (Barnett & Grabosky, 2020; Kahana, 2020, p.3).

The crisis also revealed important weaknesses in other areas of U.S. and European long-term care systems. As national borders closed, thousands of migrant care workers could not go back to their homes or were unable to return to their employers (Burtscher, 2020). Those who stayed encountered difficult conditions as many were laid off and were, at least early on, excluded by governmental programs aimed at supporting those who lost their jobs. Others, engaged in informal labor relationships received no support at all (Pasquinelli & Pozzoli, 2021). Another, albeit more invisible, group of caregivers affected by Covid-19 were family caregivers, mostly women, whose daily amount of carework skyrocketed during the lockdown, making it almost impossible to juggle the many demands placed on them from work, daily management of their families, and the care required by their elderly and disabled relatives (Ranji et al., 2021; Scarpetta et al., 2020).

Observers have pointed out the need for reform of welfare states' provisions on long-term care long before the spread of COVID-19. Demographic change, the transformation of family structures, and cuts in public spending were just some of the developments exercising pressure on long-term care systems, but the current situation has made the conversation urgent.

Historically, studies on long-term care and its organization have focused on three main social actors: the State, the market, and the family to explore the potential configurations of care provision (among others DaRoit, 2010; Ogawa et al., 2018; Osterman, 2017; Schulz, 2010; Williams, 2011). Only in recent years have scholars shifted their focus on the many intermediaries operating either as public and private actors, and sometimes as a mix of both, in long-term care. These are, among others, brokering and employment agencies (Liang, 2018), convoys of care (Kemp, 2018), cultural mediators and NGOs (Degiuli, 2016; Kemp et al., 2017), nurse managers (Dever, 2018), and social cooperatives (DeMarchi & Sarti, 2010). To this point, however, little to no attention has been paid to the

role of geriatricians in these processes. I believe this gap needs to be filled because doctors, aside from playing a key role in the adaptation, maintenance, and performance of existing healthcare systems (Denis & Van Gestel, 2016, May & Finch, 2009, Waring, 2009), also have the ability to shape societal and cultural understandings of biological processes and the "best way" to address them (among others Fasih, 2020; Foucault, 1978/2009; Greco, 2020; Waitzkin, 1991).

Geriatrics is the branch of medicine that focuses on the stage of life in which biological aging, which does not necessarily reflect chronological age, becomes more advanced and progressively dominates the relationship between body and disease (Incalzi et al., 2019). Geriatric medicine also specializes in the management of multiple concurrent chronic conditions, complex health histories, fragility, and cognitive degeneration, as it aims to maintain quality of life and prevent disabilities as long as possible (Kotsani et al., 2021). In addition, geriatricians advocate for a holistic approach that goes beyond the medical, cognitive, and functional assessment of patients to include an examination of living conditions and the extent and availability of a network of care to ensure, more than life prolongation, good physical function, autonomy, well-being, social engagement, and a dignified end of life (Kotsani et al., 2021; Mishra et al., 2020; Pilotto & Polidori, 2018). As such, they appear to be, at least on paper, the ultimate authority on aging, not only from a medical perspective but also, potentially, from a social welfare one. In addition, thanks to their specific location at the intersection of state, market, and family, geriatricians have, ideally, the potential to shape aging and long-term care at different levels. They could do so as:

- **Experts** – Geriatricians have, potentially, the ability to shape societal understandings of aging and its problematics, legitimize "best practices" of long-term care, treat patients and design long-term care plans, and define/create new subjects in a clinical perspective e.g., *the frail elder* (Among others Factora & Saxena, 2021; Geddes et al., 2020; Ruggiero et al., 2007; Woo, 2018).

- **Mediators between patients and formal/informal caregivers** – Geriatricians have the opportunity to counsel patients and families in the decision process concerning long-term care and therapies, supervise the increasing delegation of medical tasks to formal and informal caregivers, and in some cases, help train informal caregivers (among others Van Eijken et al., 2008).

- **Enforcers and gatekeepers of public services/funding/programs and of private policies and requirements** – Geriatricians assess patients, categorize them, and provide and/or deny access to services, welfare programs, specialists. In the process, they implement decisions taken by healthcare administrators at different levels and policymakers (Denis & Van Gestel 2016; Sorrentino et al., 2005).

- **Challengers** – In the everyday practice of their job, in their direct relationship with patients, or in relating with institutions, geriatricians have the ability to transform, interpret, stretch, and, in some cases, even openly challenge health care policies' requirements and restrictions (Broom et al., 2014).

Understanding how geriatricians make sense of these different roles and their work, describe aging and its related issues, define best practices of care and why, and connect the macro-level demands of care management in the practice of daily care provision will provide insights into how long-term care for older adults is understood, managed, and provided in contemporary post-industrial societies and, potentially, how to improve it. In addition, a comparison of how these actors operate in two national systems with different care regimes[1] and different medical education systems will offer the opportunity to analyze and compare different healthcare models and consequentially potentially varying outcomes, as well as to assess increasing convergences linked to technology, neoliberal understandings of healthcare provision, and hierarchies of knowledge production (Beckfield et al., 2013; Cortez, 2009; Peters, 2011).

This paper focuses, specifically, on one of the latter, namely the scarcity of geriatricians in both countries. The limited presence of geriatricians is not a new phenomenon. It is an issue that has been well documented, particularly by geriatricians themselves for quite some time (see for example AGS, 2018; Fletcher, 2007; Golden et al., 2015; Incalzi, 2019; Lee & Sumaya, 2013). Some of the studies have also attempted to provide suggestions on how to improve the current situations in terms of improving recruitment and retention (among other Lester et al., 2020), while others have focused in proving the value of geriatricians in treating patients with very specific illnesses (among others Greene et al., 2022), after specific interventions (Coary et al., 2019; Friedman et al., 2008; Luo et al., 2022), in collaborations with other medical specialists (Callahan et al., 2006; Dham et al., 2017), in varying healthcare structures (among others D'Arcy et al., 2013; Forbes et al., 2018; Marsden et al., 2022) or in long-term care facilities (Achterberg et al., 2019; Crotty et al., 2004; Steves et al., 2009). Other studies have instead focused on geriatricians' contribution in treating frail patients (among others De Vincentis et al., 2021; Totten et al., 2012), developing comprehensive geriatric assessment (among others Ellis, 2011; Soobiah et al., 2017) or implementing interdisciplinary or integrated forms of medicine (among others Famadas et al., 2008; Puelle et al., 2018; Zhang et al., 2022). In addition, the majority of these studies have focused primarily on the medical and economic benefits that a greater presence of geriatricians could bring in improving outcomes, reducing mortality, reducing lengths of stays in expensive healthcare facilities, reducing hospitalizations or reducing overall costs (all the studies mentioned above). Up to this point, however, little to no attention has been paid to the social, cul-

tural, and, potentially, political impact that a limited presence of geriatricians has on society at large and on many social dynamics connected to ageing and its progression. This paper aims to fill this gap by exploring how geriatricians themselves make sense of their relative absence among the Italian and American medical community and discuss the effects of this absence on societal understandings of aging and its processes, of long-term care provisions, of best practices of medical and social care for aging adults.

Methods

The project, designed according to the tenets of qualitative epistemology and grounded theory (Glaser & Strauss, 1967/1999) follows an inductive approach, is and is currently on-going. This paper is based on 30 semi-structured interviews with geriatric doctors both in Italy and the United States recruited through snowball sampling in the public and private sector collected between 2019 and 2022. The interview schedules were designed as semi-structured and included open-ended questions designed to cover all the following areas of inquiry:

- *Patients:* demographics, changes, relationships
- *Caregivers:* family/nonfamily; formal/informal, demographics, relationships
- *Structures and Organizations:* transformations, current organization, difficulties, tensions
- *Problematics inherent to long-term care*: funding, availability, future
- *Personal insights/beliefs on aging, long-term care, and its management*

In addition to the interviews, the project included a smaller component of participant observation at regional and national conferences of geriatric doctors in Italy and monitored the message boards, chats, and announcements of the American Geriatrics Society.[2] As of this writing, I have interviewed 18 geriatricians in Italy, of whom ten operate in Piemonte, one in Liguria, three in Lazio, one in the Marche, one in Puglia, one in Calabria, and one in Campania. Six of them work in large hospitals, two work in post-acute structures, two visit patients privately, five work in public ambulatory settings, and two work in nursing homes. One additional interviewee, instead, works for a regional branch of the national healthcare system (ASL) tasked to assess geriatric patients who formally request economic support from the region. Finally, I attended two geriatric conferences, a regional one in Turin and a national one in Rome, and attended three workshops on long-term care organized by the Observatory on Long-term Care organized by the Bocconi University. In the United States I have interviewed 12 geriatricians: six in New York city, four in New Jersey, one in Georgia, and one in Pennsylvania. Six of them work in major research hospitals, two work in nursing homes, three provide ambulatory care, and one worked two part-time jobs: one at an independent living facility and the other for a company providing geriatric

house calls. In addition, to compensate for pandemic restrictions which made participant observation impossible, I monitored the weekly emails issued to members by the American Geriatrics Society and the web-based discussion threads of its members during 2019-2020 and 2022.[3]

The paper is based predominantly on the interviews, while participant observations and the monitoring of the announcements, discussion threads, and emails were used as background information to better understand the different national context in which the two groups of geriatricians operate. Due to the restrictions connected to COVID-19, the majority of the interviews (22 out of 30) were conducted either via Zoom or via phone, recorded (26 out of 30), and then transcribed. In four cases, the interviews were not recorded because the interviewees did not agree to it. In those cases, I asked them to go slow and repeat their points multiple times to capture full quotes and write extensive notes. All the interviews were then coded and analyzed in two cycles (Saldaña, 2012). First, the data was coded manually through a process defined as "open coding" (Charmaz, 2008), which consists of reading the interviews line by line to produce a first level of analysis. At a later stage, categories and patterns that emerged in the first coding were analyzed with the help of ATLAS.ti, a qualitative software that allowed for a more sophisticated grouping of the data according not only to words and categories, but also geographical location, which allowed for a more nuanced theoretical coding of the material.

Findings

Indirect Influence: Absence Rather than Presence

In both Italy and the United States, the first fact that becomes immediately apparent is that the number of geriatricians is quite low, and this comes in stark contrast with the demographic characteristics of the populations and potential need. In Italy, according to ISTAT, in 2017 there were 4,249 doctors with a specialization in geriatrics, of whom 2,167 work in the North, 775 in the Center, 899 in the South, and 408 in the Islands. However, according to both SIGG and SIGOT[1] Italian geriatric associations, in 2019, only 2,500 of these doctors currently worked in this capacity (SIGG 2019, personal conversation). The future does not look better. In 2017-18 there were only 164 students specializing in geriatrics (compared with 396 future pediatricians) against an estimated need of 450 a year (Incalzi, 2019). A similar pattern exists in the United States. According to the American Geriatrics Association, as of 2018 there were only 7,298 certified geriatricians practicing in the United States—a fraction of the estimated need of 20,053 (American Geriatrics Society 2019). Here too the gap will not be easily filled if we consider that of the 153 geriatric fellowship programs for the

1 SIGG stands for Società Italiana di Gerontologia e Geriatria, while SIGOT stands for Società Italiana Geriatria Ospedali e Territorio.

2022 appointment year, only 57 were filled (NRMP 2018).

The reasons behind the low numbers vary between the two countries and, while an in-depth analysis of them goes beyond the scope of this paper, three explanations recur among the interviewees independently of national context. One is that geriatricians' wages are perceived to be lower than those of other specialists, partly because older adults require more time than younger patients for their visits. Second, the amount of emotional labor required to care and support aging adults, and sometimes their families, is considered too high and too time-consuming when compared to other branches of family medicine or other specializations. Third, geriatricians see themselves as having low status both among the medical community at large and among healthcare and hospital administrators. While all elements are important and require further analysis, the third is particularly relevant for the specifics of this paper because, according to a majority of the interviewees, their low status among the medical community, and, consequently, their limited political power directly affect their ability to promote a more nuanced understanding of aging and its processes. This has negative implications for society both at the individual and at the structural level, but also directly affects geriatricians' ability to influence the organization of long-term care. Dr. R, a male geriatrician practicing in Rome, Italy, explains:

> To this day, acute care still appears to be a more valued asset than chronic care. This does not make sense at all if we consider that most people, particularly in countries with aging populations, are affected by one or more chronic conditions. Nevertheless, hospital administrators prefer to invest in flashy departments like cardiology than in post-acute structures for the elders. Therefore, in the last ten years, geriatric departments across the country have been dismantled or fused with other departments. This applies to us as well. A cardiologist or a neurologist has more value and, consequently, more political power than a geriatrician. What we do is still highly devalued and, honestly, poorly understood.

Dr. J, a female geriatrician working in New York City, echoes this sentiment:

> I tell people a sort of an anecdote. I graduated from medical school in 1983, so I've been a geriatrician for 30 years if you start with the end of my training and my first job after [my] fellowship. When I was a resident and I went [inaudible] with one of the program directors, he said, "Don't go into geriatrics. It's for losers." And that was the general gist. You went to geriatrics because you couldn't do anything else. Now it's changing, but we still spend a lot of time justifying our existence.

Both doctors highlight a very interesting contradiction in contempo-

rary post-industrial societies with aging populations: to this day acute care continues to be valued more by the medical community, health care administrators, and politicians, than the management of chronic illnesses and long-term care. This is particularly interesting when we consider that in both Europe and the United States, chronic illnesses are considered one of the biggest challenges of contemporary healthcare systems (Nolte et al., 2014; Raghupathi & Raghupathi, 2018). In addition, the quotes highlight why it is so difficult to recruit geriatricians in both contexts, given the low interest demonstrated by colleagues and health administrators in supporting geriatricians in their work together with the low value, both political and economic, that is placed in caring for older adults. Finally, both quotes illustrate how ageism and its negative dimensions, far from being limited to its direct subjects, spills over to encompass professionals involved in the care of elderly populations (Ayalon, 2020; Ball 2018; King, Roberts, & Bowers, 2013).

According to geriatricians, these practices, and the cultural and ideological discourses that support them, make it very difficult to garner the necessary strength to call societal and political attention to aging and the growing need for long term care. In addition, they hinder geriatricians' ability to promote open conversations about biological aging, the variety of patterns it may follow, the changes it can bring, and the potential ways to address them. In the next sections I will discuss three specific areas that, according to geriatricians, are particularly affected by their absence: these are education, evaluation, and treatment.

Understanding Aging and Its Processes

When asked to discuss the potential downside of having small numbers of geriatricians in the context of growing numbers of ageing adults, respondents in both countries pointed to a lack of attention and a failure to acknowledge the reality of ageing and its needs at the structural level, coupled with a lack of accurate information and understanding of the process itself. Dr. C., a U.S. geriatrician operating in New York City, explains:

> The medical community has failed to communicate to society the reality of aging and what that entails. It has failed to communicate how important it is to prepare for it in terms of economic resources certainly but also in terms of thinking about what one would want for him/herself. We have started to do that for advanced care directives, but we do not have that for long-term care, we haven't really told people to prepare for it. So, these problems tend to sneak up on families.

A similar preoccupation, albeit presented in different terms, emerges in the words of Dr. P., an Italian geriatrician practicing in Rome. He states:

> The fact that there are so few of us means that only a few aging

> adults have the chance to meet us early on … For the most part, until there is bigger problem, they keep going to their GPs. This is great, but it does not help them to understand that at 75, while you may still feel healthy and young, you are entering a different stage of the life cycle, one that may require a different approach and, in time, some changes, not only from a medical perspective … In other words, it allows for a collective denial of what is going to come.

Independent of national context, geriatricians discuss how to this day institutions fail to fully acknowledge ageing and the overall graying of the population as a central aspect of contemporary society. Denying these realities does not permit the medical community to shift its attention to where is needed, namely in the management of chronic disease, potential physical and cognitive deterioration, and the varying care needs that these developments may generate. In addition, these doctors point out some of the consequences that this approach generates both at individual and the structural level. At the individual level these processes fail to promote a full acknowledgement of the reality of aging in all its complexity and variation, including the potential physical and cognitive deterioration that accompany it. This failure, in turn, neglects to produce an individual reflection on how to address these declines not only in terms of wish and desires, as pointed out by Dr. C., but also in terms of care needs, potential care burden, and economic preparedness. On the contrary, coupled with the culturally and economically enforced requirement to remain *young* typical of wealthy, post-industrial society, these same processes promote a collective desire to deny this stage of the life cycle or avoid it as long as possible. Dr. M., a geriatrician working in the Italian region of Campania, elucidates:

> In the current moment, our society sees aging as a loss of value, as negative. It is a stage of human life that needs to be postponed or hidden. We have heard it every day, read it every day during the pandemic: "It is only old people who die" as if their life had less value than that of others. This is wrong because it is more than ageist, it openly suggests that older people are second class citizens who have less value. In this context who would want to see or define themselves as old? Who would want to acknowledge this reality?

The fear of being understood or seen as *old* became even more prominent during the COVID-19 pandemic when being labelled as *old* not only meant a loss of value and respect, but also, potentially, the difference between life and death. As witnessed during the COVID-19 pandemic, aging adults, and particularly the oldest old among them,[4] were approached predominantly through the lens of chronological age and not, as geriatricians would argue, through a multi-level assessment of comorbidities and functional abilities

(Cesari & Proietti, 2020). This means that often the oldest old end up being considered expendable in terms of resources, funding, and efforts, even when their physical and mental conditions are better than those of much younger patients. Dr. L., a geriatrician practicing in New Jersey, explains:

> I took care of a guy who into his early 90s his love was hiking in the Swiss Alps, and every summer he spent a month hiking in the Alps … Here was a person who was traveling, was physically robust, and for that kind of person I'm much more willing to be aggressive, because their functional status, and their disease burden is so low my gut is telling me that they have – with exception of dying of a stroke or a heart attack […] still have more years left to live that are probably good. As opposed to somebody with the six diseases and 12 medicines. So, it's not age alone, no. It's really – it's their level of frailty/co-morbidity.

This misunderstanding of aging and its dynamics became so dangerous that the American Geriatric Society felt compelled in 2020 to produce a position statement aimed at "stakeholders including hospitals, health systems, and policymakers about ethical considerations to consider when developing strategies for allocating scarce resources during an emergency involving older adults" (Farrell et al., 2020, p. 1137). The goal was to replace arbitrary notions on advanced age with a scientific review of existing literature conducted in collaboration with interprofessional experts in the fields of ethics, laws, medicine, and nursing.

A limited understanding of the aging process also affects how individuals, and their families respond to the increased need for care often associated with longer life expectancy. Dr. T, a female geriatrician working in Turin, Italy, elucidates:

> The lack of understanding of how aging progresses is a problem, a problem that is reflected also in the ways in which families manage care provision. The common misconceptions I deal with are … I would say, three: one, that the process of body/mind deterioration [determined by aging] is a progressive development that does not end or resolves itself quickly; two, that it may take only one small medical event to transform a perfectly functioning older adult into a fully dependent person; three, that caring for an aging adult is not like caring for a child. The families I work with often hire a homecare assistant in the same way in which they hire a baby-sitter. They hire somebody only to get over a small hurdle, something that will get better in time, but it is not like that. It can be for some time, but at any moment things can escalate or they can degenerate in patterns that are not necessarily linear.

The result is that often individuals and their families face the growing need for long-term care as a short-term crisis instead of an enduring event often requiring increasing levels of intervention. This means that families tend to respond to the growing need for long-term care in a private, individual manner, as quickly as possible, and, often, particularly in Italy where market options are limited, through cost containing options found predominantly in the informal labor market (Degiuli, 2016). This is, once again, problematic at different levels. At the individual level, urgency defeats quality, and care plans, instead of being assessed professionally with the well-being of the aging adult in mind, end up being devised predominantly based on family needs and capabilities. At the structural level, urgency and need fail to produce a collective reflection on ageing that would generate societal demands and require or, at least, encourage politicians, healthcare administrators, and policymakers to address long-term care and its provision in a more systematic manner. Dr. M., an Italian geriatrician operating in a hospital in the vicinity of Turin, explains:

> There is a sort of blindness from the part of the administrators and politicians insofar they do not see how important it is for contemporary societies to keep the aging population healthy and able. They think it is a waste of time to spend money and resources on the oldest adult because they will end up dying. They do not understand that supporting them allows to support the entire network involved in the care of that adult. It is a valuable expense because it relieves the load on families, on personal and homecare aids, and this is a serious problem. To this day spending money on things that shine and look good like a reanimation unit, an expensive cancer medication, is still considered a priority.

This "blindness" is perilous because it prevents a full understanding of the impact that long-term care management and provision has, not only on the social actors directly involved, but also on large swaths of the population directly and indirectly related to them. Care and its provision are, in fact, social and collective processes that affect and shape relationships at multiple levels and areas of social life: at the micro-, meso-, and macro-level, and across institutions, from family to work, from immigration to global/national politics. And while these ideas have gained some traction at the policy level in terms of childcare, little to no conversation on this has been generated for aging and long-term care.

Assessing Patients, Managing Care, and Defining Goals

The limited availability of geriatricians also means that the American and Italian health care systems lack specialists capable of accurately assessing the needs of a complex population, or the ability to respond to it in a nuanced and effective manner. To

this day aging adults, and particularly the oldest old among them,[5] continue to be understood and addressed predominantly through the lens of chronological age, an approach that geriatricians consider simplistic and dangerous at the same time. Dr. F, a geriatrician operating at a nursing home in New Jersey, explains:

> Labelling the population only in terms of chronological age is inaccurate because it lumps together older adults who display enormous variation in terms of cognitive and physical abilities. If we look at the numbers this way, the problem of aging becomes daunting, and no one wants to deal with it. The reality is much different.

In place of using chronological age, geriatricians argue for a multi-dimensional and multidisciplinary assessment of aging designed to evaluate functional ability, physical health, cognition, and mental health as well as socioenvironmental circumstances. Dr. Z., a male geriatrician practicing in Turin, Italy, explains:

> Geriatricians are trained to see their patients in their globality. We assess physical function, the composition of the family in which the patient lives, the relationships that go on between the patient and his wife, the patient and his daughter…we need to use psychology to fully understand the patient.[…] Sometimes they hide.[…] One needs to spend some time with them to fully understand what is happening in their lives—the stressors[…]Everything matters from a medical point of view.[…] If he comes with a swollen knee, I can't just look at his knee.[…] I need to assess his diet—if he eats or not. I need to assess if he is still able to move if his living conditions allow him to go out or not. I need to make sure that there is no underlying depression. Older adults are complicated because they are often subject to multiple pathologies at the same time, and it is crucial to understand what is causing what.

This approach, which differs from that of general practitioners and other specialists, is crucial according to the interiewees because it allows them to obtain a full picture of the current conditions of the patient—physical, mental, but also social—as well as an assessment of all possible interactions capable of increasing patients' fragility[6] in the future. This, in turn, allows them to provide patients and their care networks with an overview of their current care needs together with a tentative prediction for future ones. Finally, this comprehensive and dynamic view of a patient overall status in the present and the future also allow geriatricians to help patients and their networks evaluate the pros and cons of different care options. Dr. L, a New York geriatrician operating predominantly in an outpatient clinic elaborates:

> I think one of our roles as a geriatrician is a capacity assessment.

> Do [patients] have the insight, the capability to decide what care would be most safe for themselves? For the most part, they don't for a variety of reasons. This is part of – I think as a geriatrician, this is what we do all the time, making a mental status evaluations or gait problems, looking at complex evaluations and finding clues.

In addition, geriatricians' multi-dimensional evaluations help to fully highlight, for individuals but also for stakeholders and policymakers, how important it is to bridge medical and social needs. Dr. E, a female geriatrician working in Atlanta, Georgia, explains:

> Taking care of aging adults in a sensible manner requires thinking not only about medical issues, but also social issues … but also about very practical things like transportation or company. As they say here, to take care of them properly 'requires a village.' We should think about the problem from different angles and come up with multidisciplinary, multilevel solutions.

Conducting evaluations on a wide scale, and using a standardized format across states and/or regions would also help to address the issue at the structural level. Dr. G., a geriatrician operating in Rome and head of an important Italian NGO concerned with the well-being of the aging population, explains:

> If we could generate a standardized multi-dimensional evaluation widely adopted not only by geriatricians, but by all medical structures and professionals who treat aging adults, we would be able to collect data useful for many, for healthcare administrators and professionals, politicians, and policymakers who would gain a full view of the existing needs of the population, needs that are both medical and social and that are often hidden and addressed at a great cost, both economically and emotionally, by individual families.

According to the majority of geriatricians interviewed for this project, bringing to light the full extent of the existing need for long-term care would be beneficial at all levels: at the individual level, it would help individuals and their families feel less isolated, allow for a freer exchange of information among different members of the care network, and generate collective conversations about aging that could possibly produce collective demands. At the policy level, it would provide stakeholders with statistical evidence of the complexity, extent, and magnitude of the issue which possibly would prompt action, while at the same time offering a roadmap of where to intervene first, in what ways, and with what tools.

Lastly, according to the interviewees, low numbers of geriatricians and a limited understanding of geriatric principles also affect the quality of medical care that patients receive. This too has great consequences: at the individual level, it affects the quality of life

of the individual, at the interpersonal level, it impacts the relationships with both formal and informal caregivers, and at the structural level, poor medical care has the potential to exacerbate costly problems such as repeat visits, unnecessary testing, stressful and often damaging ER visits, and/or hospitalizations. Interviewees argue that a lack of specialized care is particularly problematic because it generates two somewhat contradictory outcomes. On one hand, when older adults continue to see their regular GPs instead of switching to a geriatrician they are subjected to the same protocols and requirements applied to the general population. This means that often when a medical problem emerges, GPs assess the problem and direct patients to different specialists for each of their ailments. The result is that older patients can end up with extensive and complex medication regimens that, over time, may lead to overmedication, overtreatment, or negative interactions. As in the case of ageism, this issue had been addressed as early as 2013 by the American Geriatric Society in collaboration with the American Board of Internal Medicine through an awareness campaign[7] and through other publications (including AGS 2019), as well as by the Italian Geriatric and Gerontological Association through presentations at national and regional congresses (among others Ferrara, 2018). Nevertheless, this issue continues to be a concern. Dr. F., a geriatrician working in Pennsylvania, elucidates:

> This is something that we as geriatricians see often and try to focus on, it's called polypharmacy and it is a real issue. Many of the people we see have, over the years, had several health issues and seen several specialists, and you know, they come in with a laundry list of drugs and we take a close look at them because these drugs when not carefully managed in terms of interactions and benefit can cause more harm than good. We do have a digital system in place to catch the bigger issues, but they do not always catch all the potential side effects or risk of adverse effects specific to the older populations … like increasing dizziness and therefore the risk of falls or other things like cognitive issues … for example in the general population we worry above all about strokes or heart attack, but for seniors the risk of falling and breaking their hip and/or hitting their head and dying are very real and, somewhat, underestimated.

On the other hand, because of their age, some of the health and/or behavioral problems created by overmedication and/or negative interactions, instead of being thoroughly investigated and addressed, tend to remain unidentified and often ascribed simply to the condition of "being old." Dr. P, a female geriatrician working in a small town in the region of Piedmont, Italy, explains:

> Just to give you an example […] I have a patient who has dementia—a frontal-temporal dementia characterized by behavioral

disinhibition and apathy. He says inappropriate things; he has no self-restraint—is agitated and often confused. His wife died four months ago, and she was his caregiver […] He was a writer, a truly brilliant person, who had had a bad case of polio when was young and was in constant pain […] Chronic pain as you know is a big problem in older adults, and because of that he was followed by an anesthesiologist to control it. This specialist had given him two medications—very effective—but that, in elderly patients, can cause agitation and confusion. His GPs did not know that, or had not been paying close attention, in any case he didn't catch it. Three months ago, the patient fell in his house, and he broke his leg. He was recovered in the ER and then was brought up to our [post-acute] department. At the beginning he was considered capricious—truly unbearable—and nobody wanted to work with him. He was intolerable with his family and with the physiotherapist assigned to him. They all thought that his behavior was connected to his age. Truthfully, it was a terrible combination … frontal-temporal dementia stimulated by the medications given to reduce the pain—a perfect storm. I said, 'No, let's not give up on him.' I called my colleague and asked to revise the protocol. A week later his daughter called me saying 'What did you do? My father is more present, he wants to work, he asked for his computer, he doesn't call me every five minutes.' And I answered: 'What happened is simply that we tried to understand your father.'

As the quote indicates, a greater ability to understand older adults in all their complexity and with an eye to their individual histories, skills, and needs, coupled with expert knowledge helps to improve not only the quality of life of older adults themselves, but also that of the entire formal and informal care network surrounding them. This has an enormous positive effect for relationships, working conditions, care burden, and overall well-being of all subjects involved. Finally, doctors interviewed for this project point out that greater access to geriatricians or other personnel trained in geriatric principles would allow an approach to aging and its management less focused on discipline-specific guidelines aimed at extending life, and more on patients' goals. Dr. V., a geriatrician working in New York City, explains:

> As geriatricians we look primarily at the patient's goals. I think that one of the main things that we do is to understand how patients' goals fit into what treatments are available. So I think, sometimes, people have—there's a problem and people look for a treatment per se, but they don't really look at what the goals of the patients are. Will it really benefit someone as they're older? And

> one kind of example is that let's say you are age 40 or 50 and have diabetes. In this case the goal is really to be tighter and stricter in monitoring the sugars and make sure that distributors are low because we need to make sure that you arrive at 60s or 70s in good conditions. But [once] you are in your 80s and 90s we can become more liberal in monitoring your sugars. I think we're coming at it at a holistic approach. We're saying, "Well, okay, well, you don't treat an 80 or 90-year old with a diabetes the same as you treat a 40 or 50-year-old." We question and think about those things and do not prescribe aggressive treatment for someone when that can actually harm them.

The thinking of geriatricians aims at placing aging adults at the center of medicine and not as an afterthought. While this is crucial to increase the overall quality of their living and to help society at large to understand the different needs of biological aging, it would also help managing and reducing the cost of care in a way that would benefit individuals but also institutional actors.

Conclusions

The interviews with American and Italian geriatricians bring to the fore patterns and contradictions underlying the ways in which these two post-industrial societies, very different in their configurations of welfare and healthcare systems, approach the graying of the population and the increasing need for long-term care. The geriatricians interviewed for this project demonstrate that the actual process of ageing and its many complex and varying dimensions continue to be poorly understood by the stakeholders involved in its management. These stakeholders include hospital and healthcare administrators, the medical community, politicians, policymakers, as well as society at large. In practice, this means that to this day governments, healthcare systems, and the medical community not only have failed to fully acknowledge the extent of this new reality and to provide a systematic approach to the demands that aging generates, but, through their inaction, have supported a negative and stigmatizing understanding of it. In turn, this has promoted and continues to promote a devaluation of all the subjects involved, from aging adults to the people who care for them both formally and informally. This devaluation has also meant that despite the growing numbers of aging adults and a shift from acute medicine to chronic medicine, the attention of hospital and healthcare administrators and policy makers has not followed. To this day both Italy and the United States do not have enough specialized doctors to care for their growing ageing populations, and geriatricians' work and value for society continues to be poorly understood.

According to geriatricians' own assessments, this approach, or the lack of a systematic approach, to the growing numbers of aging adults and their needs has created multiple problems

both at the individual and structural level. To this day aging and its development, which may vary greatly from individual to individual and does not necessarily follow chronological age, continues to be only arbitrarily understood as are the potential physical and cognitive degenerations that the process carries with it. Because of these failures and oversights very little has been done both at the institutional and individual level to prepare for it. At the structural level little has been done in terms of allocating funds to support the population in need of long-term care or in designing and providing services and support. At the individual level, a stigmatization of old age has generated a collective denial that often brings individuals and their families to acknowledge its reality only through a crisis, with little preparation in terms of both care decisions and economic planning. To address these societal, political, and economic issues, it is essential to implement changes at all levels of society and revalue how we understand the aging population and the impact that caring for them has on society at large. In addition, it is crucial to combat ageism at all levels to remove the stigma attached to this stage of the life cycle. It is essential not only to ensure more respect and dignity for the growing numbers of aging adults, but also for those who care for them in different functions: from geriatricians to caregivers, from nurses to homecare aids.

To achieve these changes, policymakers and stakeholders should implement educational campaigns, training programs, and policies aimed directly at the medical community and at society at large. First and foremost, it is essential both in Italy and the United States to address the acute shortage of geriatricians and geriatric healthcare professionals at all levels. This should be done through programs aimed at reducing the costs of education, through economic incentives for students' committing to the specialization, as well as through a valorization of the profession and its goals. Secondarily, it is crucial to develop and promote at the state/regional[8] levels geriatric training for all healthcare providers to ensure an optimization in terms of quality, costs, and caregiver burdens. Third, national Geriatric Scientific Associations in both countries should, in collaboration with other associations such as the American Board of Internal Medicine in the United States or the Ordine dei Medici Chirurghi e degli Odontoiatri in Italy, develop a geriatric multi-dimensional evaluation to be adopted by all medical institutions providing care to aging adults to gather federal/national data on existing social and medical needs of aging adults. Data gathered from the evaluations would help to understand the areas of the needs and potential investment in both medical and social areas. Fourth, geriatricians and geriatrics health professionals should be allocated funding by federal/national governments to develop an educational campaign aimed at informing society at large on aging and its processes and on the need to prepare emotionally, strategically, and economically for this specific stage of the life cycle. Fifth, states/regions should fund, de-

sign, and implement campaigns aimed at all ages to combat negative and arbitrary understandings of ageing. These programs should be implemented at all educational levels, in all workplaces, and in public spaces such as, for example, libraries. Taken together these campaigns, programs, and policies will help reframe our current understanding of aging and provide stakeholders and society at large with the understanding and support it needs to address the graying of the population in an equitable and caring manner.

Limitations

Despite the significant contribution that this study makes both in filling a gap in the existing literature and in providing policy suggestions it has some limitations. The size of the sample does not allow for empirical generalizations applicable to the entire category of doctors both in Italy and the United States. In addition, the sample does not capture the range of diversity in terms of age, gender, and race/ethnicity of the target population or correctly reflects their distribution in geographical terms. Similarly, the snowball sampling adopted for the study may have potentially attracted respondents who share a similar understanding of geriatric medicine and its application. Finally, the differences in national contexts between the United States and Italy have been sketched more than fully detailed. However, it is important to keep in mind that this study does not intend to be conclusive. On the contrary, its main goal is to provide a starting point for new research including, but not limited to, ageism in the medical community, understanding of ageing and its processes among the general population, individual and family planning for ageing and long-term care, and comparative analysis of long-term care provision and organization in different countries.

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Endnotes

1 The Italian system is characterized by universal healthcare, relatively generous public pensions, mandated familial involvement, low public investment in long-term care (1.3% of the GDP), and an underdeveloped formal market of care (European Commission 2018) while the American is characterized by an insurance-based health care system, a mixed (public/private) pension system, limited welfare provisions for long-term care, voluntary familial involvement, and a highly developed formal market of care.

2 Unfortunately, the pandemic limited my ability to attend geriatric conferences in the United States. It is for this reason that I decided to include web-based material to the data collection.

3 I chose this approach because in the past two years access to scientific conferences was difficult due to the restrictions connected to Covid 19.

4 As Kahana pointed out in the first issue of this journal and my own personal experience in Italy, aging adults were often treated as expendable in the early phases of the COVID-19 pandemic when medical resources were limited independently from their levels of frailty. For specifics see the studies of Britain (Merrick, 2020) and Italy (Cesari & Proietti, 2020), for benefits, instead, of being co-treated by geriatricians see Piers et al. 2021

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6 The literature discussing frailty and fragility in relationship to ageing is a burgeoning one. I am mentioning it here only in passing because this is how the respondents chose to discuss it. While frailty and fragility were widely discussed in the literature and the conferences I attended, the interviewees did not go into the specific of it during the data collection.

7 Since 2012, the American Geriatrics Society (AGS) has also been collaborating with the American Board of Internal Medicine (ABIM) Foundation, joining its "Choosing Wisely" campaign. The campaign aims to engage healthcare organizations and professionals, individuals, and family caregivers in discussions related to the safety and appropriateness of medical tests, medications, and procedures. Geriatricians collaborated to the campaign by generating two lists titled: Five Things Healthcare Providers and Patient Should Question. The first was published in 2013 and the second in 2014. They are available at: https://www.healthinaging.org/tools-and-tips/tip-sheet-ten-things-physicians-and-patients-should-question.

8 I use this language because in the United States some programs are federal and other are state-based, similarly in Italy some programs are nationally based, but others are regional.