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Challenges of Overcoming Ageism towards Elderly People in Healthcare Context

ABSTRACT

RESEARCH OBJECTIVE: The purpose of the paper is to analyse the impact ageism may have on providing healthcare to elderly people.

THE RESEARCH PROBLEM AND METHODS: The article investigates the consequences of ageism in medical settings, where the elderly are particularly vulnerable to discrimination, distinguishing ageism from appropriate practice variation as well as giving suggestions to improve the situation. The paper analyses research published worldwide on selected issues connected with ageism with special attention to medical professionals' attitudes and ageist behaviours of the elderly's environment in a situation of their disability or illness.

THE PROCESS OF ARGUMENTATION: Firstly, the relation of ageism to other forms of stereotyping is outlined. Then, the threats of positive ageism are elaborated. The next section is devoted to self-stereotyping of the elderly and its impact on their functioning. Then, the paper discusses medical professionals' attitudes and ways to measure them, as well as educational interventions that may alter them. Finally, the article refers effective ways of adjusting health promotion messages to the needs of older adults.

RESEARCH RESULTS: Ageism bases on mechanisms similar to sexism and racism, but there are some remarkable differences. Positive ageism may be compassionate, however, might be harmful when intruding into an elderly person's decisions. Self-stereotyping may be described with a model of a vicious cycle. Contact with the elderly is found to be useful in changing medical staff's attitudes. Family-centred messages are most effective when it comes to health promotion among older adults.

CONCLUSIONS, INNOVATIONS AND RECOMMENDATIONS: Studies on ageism prove that negative convictions about the elderly are harmful and affect their functioning. Inclusion of the elderly should be applied in social contexts as well as in science, as the elderly are often missed out in research samples.

→ **KEYWORDS: AGEISM, GERONTOLOGY, HEALTHCARE, HEALTH PROMOTION**

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Introduction

The world is facing a challenge of the population's increasing longevity. The progress in medicine directly influences this phenomenon. However, although people in general want to have longer life expectancy, some of them reinforce age stereotypes, not only these of vulnerability and special needs of the elderly, but also the negative ones, which may harm instantly.

The definition of the term 'ageism' was first given by Robert N. Butler (1969). According to him, ageism is a form of prejudice expressed by one age group about other age groups. Though the concept was formed in the middle of the 20th century, ageism was existent much before that (Achenbaum, 2015). After Butler coined the term, some researchers tried to transform or adjust his definition (e.g. Bytheway, 2005; McGowan, 1996; Tornstam, 2006 and more). An alternative, joined definition of ageism was proposed by Iversen, Larsen and Solem (2009). Ageism, according to them, might be defined as either negative or positive stereotyping (cognitive aspect), prejudice (affective aspect) and/or discrimination against (behavioural aspect) elderly people because of either their actual chronological age or perceiving them as old or elderly. Ageism may be displayed on an individual (micro), social networks (meso) or institutional (macro) levels and might be implicit or explicit.

Typical myths about the elderly comprise such as: being old equals being old-fashioned, depressed and often sick; the elderly cannot learn new things and are slow thinkers; benefits from healthy behaviour cannot be obtained by people of old age; genetic factors are totally responsible for (un)successful aging; the elderly can be neither attractive nor sexually active; they are not able to have any productive societal roles and are inflexible and incompetent (Nolan, 2011; Ory, Hoffman, Hawkins et al., 2003).

It has been reported that even the researchers exclude the elderly, seeing them as a population inconvenient to recruit and study. That affects the number of research done on the older adults (Ory, Hoffman, Hawkins et al., 2003). Ageism itself is examined taking into consideration its causes, consequences and ways to limit it (Iversen, Larsen, & Solem, 2009). The fact that ageism plays significant role in social participation of the elderly, as well as in healthcare settings (Raposo & Carstensen, 2015) highlights the need to give attention to it in social and medical sciences.

Medical settings are particularly connected with ageism, since as mentioned above, mainly medicine is responsible for the lengthening of life expectancy. However, the elderly are also commonly indicated beneficiaries

of medical care. Therefore, it is important to understand the challenges and threats of ageism for the professionals providing care to the elderly. The following paper aims at elaborating on the notion of ageism, with special focus on medical settings. Firstly, the place of ageism among other forms of stereotyping is outlined. Then, the problems of positive ageism and self-stereotyping are detailed. The next sections concentrate on medical professionals: their attitudes and suggested forms of influencing and positive altering of them. The last section provides guidelines for suitable tailoring of health promotion messages to the needs of older adults.

Ageism among other *-isms*: racism and sexism

The first comparison of ageism to other persistent and widely known *-isms*: racism and sexism was made by Palmore and Manton (1973). Then, in 1975, Butler, the inventor of the term, broadened the definition, claiming that it may be seen as a process of stereotyping against people due to the fact that they are old in a way similar to racism and sexism doing that for colour and gender. Though research on the last two is done frequently, ageism is a bit left behind. Iversen, Larsen and Solem (2009) illustrate it by mentioning thousands of articles on racism and sexism, whereas only, in the scale of this body of research, hundreds of papers on ageism.

Similarly to negative racism and sexism, negative ageism connects with social exclusion, expressed arrogance, disregard and fear (Kagan, 2008), as well as devaluation, indignity and insults. It plays on exaggerations and overgeneralizations (Raposo & Carstensen, 2015) and manifests in the media, as well as in jokes and products such as birthday cards or similar (Ory, Hoffman, Hawkins et al., 2003), which at face value make no harm and are funny, but in fact build up convictions about some social groups and might encourage discrimination. Negative ageism's role is especially significant in participation in social life and the labour market, as well as cognitive performance and self-esteem of an individual (Raposo & Carstensen, 2015). On the latter level, ageism, alike other *-isms*, might lead to internalization of negative anticipations about oneself and self-prejudicing (North, 2015), which will be elaborated on in one of the next sections of the paper. What is worth mentioning is the phenomenon of discriminations' overlap (Kydd & Fleming, 2015), when an elderly person withstands exclusion due to their age and, in addition to that, gender, ethnicity, race or another potentially stereotyping feature or features. Moreover, worth recognizing is the double jeopardy of ageing with disability, both from the perspective of cumulative effects of such

state and looking at the danger of potentially double-discriminatory social consequences. When it comes to any kind of prejudice overlap, it is particularly hard to assess which kind of negative societal convictions are in the foreground. That is the reason to enforce and encourage equal treatment, which should be an obviousness and unfortunately still is not.

What makes ageism different from other *-isms* are that it has no clear boundaries and the social sanctions are generally of lower strength than that referring to racism or sexism (Iversen, Larsen,, & Solem, 2009). What is more, little can be said about the ways ageism evinces in daily life of individual elderly persons (Raposo & Carstensen, 2015). However, the crucial characteristic of the background of this phenomenon is the fact that aging is universal (North, 2015) – in a way that gender and race are not, since everyone is to grow older by nature. Furthermore, some of the ageist stereotypes' content derives from actual constraints of functioning and higher risk of suffering from diseases, which are not true about people of various genders or races (Raposo & Carstensen, 2015). In a medical context, it is said that age itself may be a predictor of being in need of receiving healthcare services (Kydd & Fleming, 2015).

Nevertheless, the fact that some people of older age may suffer from, for instance, cognitive decline does not mean that every person should be treated as having such a condition. That is an example of an overgeneralization mentioned above, which is particularly harmful when a person internalizes a self-image of an intellectually deteriorating one. Raposo and Carstensen (2015) report that brain disease is observed only in the minority of the elderly, so claiming that cognitive decline is inevitable is a gross exaggeration. Nonetheless, the elderly respond to a stereotype threat, performing worse in given cognitive activities. Evidence for that is provided in empirical studies, among which are these of Kang and Chasteen (2009), where older adults had poorer outcomes in a reading task which was said to be indicative of memory abilities than a comparable group of older adults who were told that the task is related to reading comprehension. These outcomes prove that being under threat of self-stereotyping affects the result of a given task related to the stereotype content. A similar issue has been found among women who performed worse in a math problem solution under conditions of sexist stereotype threat (Spencer, Steele, & Quinn, 1999), which is another evidence of similarity of ageism mechanisms to sexist stereotypes' occurrence. On the other hand, the elderly exposed to ageist behaviours of their family and acquaintances might become more aware of the problem and after experiencing that they may become more sensitive to the discrimination (Huang, Liang, & Shyu, 2014).

Threats and advantages of positive ageism in medical context

Even though *-isms* are mainly considered in negative contexts, such as holding insulting and false beliefs about various social groups, it is in fact a Janus-face problem, as it consists of another dimension, which is called "positive." Palmore (1999) refers to ageism as prejudice both against and in favour of any age group. Positive stereotyping concerning the elderly includes compassion and often pity, it underlines the dependency of the elderly as well as the need for support (Iversen, Larsen, & Solem, 2009). It also often consists of a belief that they are 'warm' as people, while being rated as less competent (Fiske, Cuddy, Glick, & Xu, 2002). The stereotypes often reveal in excessive or exaggerated care or in patronizing attitude toward older people (Iversen, Larsen, & Solem, 2009).

However, in medical settings, some researchers regard access to some particular benefits, such as in the United States of America, where the elderly are the only privileged group who are eligible for federal insurance named Medicare, and where they are under programs of cancer prevention, some of which give them priority to participate in clinical trials (Kagan, 2008) or prioritising treatment of the elderly as forms of positive ageism. It is indeed advantageous for the elderly, but unfavourable for the younger population. A study conducted on German population has indicated that there is little preference towards prioritising medical services due to age criterion, either if it comes to children or the elderly (Diederich, Winkelhage, & Wirsik, 2011). Weighed against this is the fact that some chronic diseases have an onset in late adulthood (Kane & Kane, 2005), so access to primary healthcare with a possibility to visit a general practitioner on a regular basis seems to be a vital part of caring for the elderly and therefore should not be condemned or considered ageist. Furthermore, the notion of rationing services taking into consideration the age of the patient and their life expectancy, undoubtedly shorter, seems to be particularly disturbing and unethical.

Other forms of beneficent ageism, less controversial from the perspective of younger generations is discriminating the elderly out of positive intentions. It connects with compassion (Kagan, 2008). However, this attitude might be as helpful as harmful. A study conducted by Huang, Liang and Shyu (2014) has provided some interesting insight into the elderly people's perceptions of ageism. They did a semi-structured qualitative research in Taiwan on elderly patients who suffered hip fracture to find out how they see the change in the environment's attitude towards them after gaining a temporary disability following an operation. The participants

reported that almost immediately after discharge from the hospital they became more dependable on their family and caregivers, but they were also asserted to rest and prevented from participation in social events or even daily activities such as shopping. Gradually, they were losing contact with their friends, who excluded them from the meetings. The main given reason for the exclusion was the physical dysfunctions of the patient caused by the operation. Some of the family members had false assumptions that the elderly person needs constant contact and assistance, however, one of the patients reported that his son did not fulfil his request to take him to a hairdresser and buy him a new shirt before a party they were to attend together, as the son claimed that nobody will notice his father's looks as his form of disability enables him only to sit down at the table. What is very disturbing in this situation is the fact that a family member uses such a harming form of discrimination that, although is a little incident, touches the dignity of the elderly, who cannot fulfil their needs independently and who still have, despite their disability and/or age, the same preferences and feelings. That is a striking example how overprotection from one side might lead to emotional consequences on the other – and how 'positive' stereotyping eventually turn out to be harming.

Huang, Liang and Shyu (2014) have distinguished two forms of reactions to this overprotective treating. The first one was passivity and feeling of power deprivation, that occurred mainly right after discharge. The second one was determination to work harder at the physical rehabilitation sessions in order to reverse the consequences and to regain the feeling of responsibility and strength. Given that the sample in the referred study was relatively small (11 participants), it cannot be generalized to all elderly persons that they respond to loss of power by active coping and investing energy into recovery. Therefore, it is important to give care with responsibility, so as not to deepen the level of disability from the one side and not to make the elderly person suffer from emotional consequences of life control loss from the other.

Self-stereotyping among the elderly in health-related issues

As well as aging stereotypes persist in the society in general, it might also be observed among the elderly themselves. Research suggests that the origins and functioning of aging self-stereotypes have following, identifiable features: they stem from aging stereotypes acquired even as soon as during childhood and then might get stronger in later life; people acting on them might be unaware of their existence; during elderly

lifetime, general stereotypes of aging transmute into self-stereotypes (Levy, 2003). Unfortunately, such form of stereotyping is difficult to get rid of and seldom corrected as they conform to the image persistent in the society (Kagan, 2008).

Given these definitions, it might be said that self-stereotyping and acting as the society expects an elderly to behave is a form of a vicious cycle. As the society in general has some presumptions how an elderly person should function, a person may follow these rules, even unconsciously. The observed behaviour reasserts the convictions of the environment, which again influences the elderly person and so on. It is said that people who are in jeopardy of being subject to negative stereotypes might display deteriorated cognitive performance, self-effectiveness, and may present lower will to live (Ory, Hoffman, Hawkins et al., 2003), their life expectancy can be relatively shorter whilst suffering due to poorer health (Raposo & Carstensen, 2015). The consequences might be also detrimental to the person's self-image and self-confidence (Palmore, 1999). Evidence of such model of a vicious cycle are given in empirical research, such as experiments by Chasteen et al. (2005) and abovementioned study by Kang and Chasteen (2009) which focused on memory performance under perceived stereotype threat in the elderly.

Kane and Kane (2005) suggest that old people are the firmest practitioners of stereotypes about their age group. They mention an example of getting used to living in nursing homes among younger people and the elderly. The younger see their health limitations and disabilities as the main reason that averts their full participation in social life. As people get older, however, they more likely see this condition as unavoidable and try to accept the obligation to settle.

On the other hand, there is some evidence that not every elderly person has a tendency to react to the ageism presented by their environment with withdrawal and passivity. Although some of them indeed tolerate the ageist attitudes and conform to them, some disregard them and work harder to overcome the situation of dependency, as mentioned above in the case of some temporarily disabled elderly patient recovering from hip fracture (Huang, Liang, & Shyu, 2014).

Ageism in medical context – healthcare professionals' attitudes

In the medical context, the healthcare professionals are crucial actors who can also be practitioners of ageism. As nowadays the organization of

hospitals transforms from specialized institutions to large, general health service ones and the elderly patients outnumber the trained geriatricians (Ory, Hoffman, Hawkins et al., 2003), the ageist attitudes might be enforced in medical settings and among the care providers.

Iversen, Larsen and Solem (2009) report that particularly in the situations of tight schedule, doctors tend to devote less time to patients of older age. What is more, in situations like that they were inclined to attribute the complaints made by them to the age. Research done on medical staff and social workers (Pedersen & Mehlsen, 2011), who had to evaluate younger and older adults with brain injury in following areas: unsatisfied needs, assisted living, treatment, relevance of services, social activities and care burden, has shown that healthcare professionals were more likely to rate older people as having not that many unsatisfied needs for support and service than the younger persons. However, the researchers cannot undoubtedly claim that this difference can be assigned to an age bias.

The fact is that other studies indicate on similar phenomena among healthcare professionals. In an abovementioned study conducted in Taiwan on elderly patients suffering from hip fracture (Huang, Liang, & Shyu, 2014), some of the interviewed reported being told by a doctor that a person of his age cannot expect less pain in medical conditions. Such bias leads to neglect and providing less care, which is necessary for successful recovery. Doctors and nurses report that they frequently prefer younger patients to older, accounting for that by saying that the younger are more productive and have greater healthy life expectancy (Simkins, 2007). Similar results have been obtained in a study by Kaufmann and Becker (1986), where healthcare specialists rated the elderly age stroke patients' potential for recovery as being in decline. However, compensational abilities of older people should not be assessed so negatively right from the outset and without deepened analysis of an individual's actual environment and characteristics. Sohlberg and Mateer (2001) suggest that the elderly might be even better than the younger people in compensating for their health problems, taking into consideration the possible stability of life circumstances, well-established social support networks and coping strategies which are often more firmly consolidated than in the young. Not only are negative attitudes detrimental for the elderly, but also they affect the quality of communication between the professional medical specialist and the patient (Ory, Hoffman, Hawkins et al., 2003). That is a valid argument for interventions which are proved effective in combating the stereotype, not only at the students' education level, but also later on, during medical practice of a specialist.

Positive stereotyping of the elderly among healthcare practitioners again proves to be not always beneficial. During treatment planning, some specialists tend to prescribe or suggest less aggressive solutions basing solely on age of the patient (Ory, Hoffman, Hawkins et al., 2003). North (2015) describes a phenomenon of undertreating some symptoms in elderly patients, which are sometimes seen by the practitioner as a consequence and a natural part of the aging process. Ageism can also express itself in overprotection of the elderly person by the medical staff, at times even having features of intrusion into the freedom and rights of a treated person (Kane & Kane, 2005).

The beliefs about the aging process, sometimes false and embedded in stereotypes, sometimes based on the practitioner's experience, may affect the process of dealing with a disease in many ways. A study conducted in Great Britain has indicated that it was less probable for the persons older than 85 to obtain medical care in accordance with latest treatment guidelines and to be subject to secondary prevention, as well as rehabilitation (Rudd, Hoffman, Down et al., 2007). Having no important recommendation of such, the elderly do not undergo screening and are not directed to rehabilitation, being considered unable to physically withstand its rigorous principles (Kane & Kane, 2005).

The discussion above about the ageist attitudes that might occur in medical practice would not provide the full image if it was not said that not every difference in treatment of elderly people comparing to the younger is a sign of ageism. Some practices are appropriately suited to the special needs of this age group. A patient might be prescribed fewer medications due to the fact that another than currently treated disease process might be in progress or the response to the treatment may be unpredictable or too dangerous for the general health (Kane & Kane, 2005). Let for an instance serve oncological treatment. In spite of the fact that the elderly should gain the same benefits from chemotherapy as do younger patients, the consequences of this form of treatment are found to be greater in this age group (Extermann, Boler, & Reich, 2012; Hurria, Togawa, Mohile et al., 2011; Muss, Berry, Cirrincione et al., 2007). Sometimes certain types of cancer treatments bear too much risk of sooner death due to the side effects than death out of cancer itself (Cronin & Feuer, 2000; Fowler, McNaughton Collins, Albersten et al., 2000).

How to distinguish between ageism and proper variation in practice, well-suited to the age? The key is trust to the medical specialist, whose obligation is to suggest treatments which are at first not harmful more than the disease is itself. However, as a negative mutual attitude affects the quality of communication and disturbs the relation, an effective way

of providing better care for the elderly might be educating and training the future and current healthcare professionals.

Trying to overcome the stereotype in healthcare settings – educational interventions and measuring attitudes

Not only did Robert N. Butler coin the term 'ageism', but also actively sought effective ways of eradicating it. Given that he was a trained psychiatrist, one of the fields he regarded crucial to achieve this were medical settings (Achenbaum, 2015). Healthcare professionals, in his views, should be trained to treat elderly persons compassionately and with dignity. Butler himself founded and managed International Longevity Center in New York. One of the main aims of the institution was to conduct workshops to combat ageist attitudes. However, to date, geriatric training is still given less time during medical training, compared to another fields of practice (North, 2015).

Research indicates that students of social work rank geriatric area of practice low when asked about their future specialization (Chonody, 2015). Such ranking at the bottom might be correlated with lacking in contact with people of elderly age, lacking in knowledge or skills to work with such group, being anxious about aging themselves, being of younger age and male. The researchers found no association of this view with lack of interest. Chonody has made a systematic review of literature on pedagogical interventions based on scientific evidence aiming at reducing ageist attitudes among healthcare students. She found that participation in trainings about the matters of aging patients are efficient. When the intervention provided the participants with information on these issues, the knowledge rose. However, it was not enough to alter attitudes. They changed when the pedagogical intervention consisted of an experimental component, such as contact (for instance: being placed on an internship, focusing on work with an elderly person or making an interview with a person from this age group). That is consistent with intergroup contact hypothesis by Gordon Allport (1954). Nevertheless, neither providing information nor taking part in an experiment affected the interest in practice related to gerontological matters (Chonody, 2015). This was the area most inflexible and unresponsive to change.

The other matter to be discussed is the ways attitudes towards the elderly might be assessed. There is a need of using standardized measures in order to obtain valuable, comparable and reliable outcomes which could be reproduced in another research. One of such ways is using validated

questionnaires. For instance, Carolina Opinions on Care for Older Adults (COCOA) might serve as such an instrument (Hollar, Roberts, & Busby-Whitehead, 2011). The reason of designing it was the concern about physicians' attitudes towards the patients which may impact their behaviour (as discussed above) and the problem of choosing careers in geriatrics by medical students. The tool consists of 24 items and has shown good psychometric values in a validation study. The scale has six constructs named as follows: early interest in geriatrics, empathy and compassion, attitudes towards geriatrics careers, ageism, clinical and social services for older adults, social value of older adults. Another tools to measure similar theoretical constructs are Rosencranz's factor analysis of attitudes toward the aged (Rosencranz & McNevin, 1969), Geriatric Attitude Survey (GAS) (Reuben, Lee, Davis et al., 1998) and Maxwell-Sullivan Attitude Survey (MSAS) (Maxwell & Sullivan, 1980). However, the last two have been reported to exhibit some reliability problems in an examination by Stewart, Roberts, Eleazer et al. (2006) and therefore the outcomes obtained from them should be treated with caution. Such questionnaires might be useful in order to, for instance, assess the impact of educational interventions undertaken or diagnose the attitudes of medical staff in certain institutions.

If we train our specialists and find measures to assess their knowledge and attitude, is that enough to successfully assist the population in its aging? Probably, as in most situations where two sides are involved, it needs a bit of a give and take. The parallel step should be adjustment of health promotion to the target group.

Well-tailored health promotion targeted at the elderly – is it achievable?

Science has proven that regular exercise has the potential to delay the aging process, both in psychological and physical areas (Lobo, 2011). Moreover, health-promotional behaviour may be of great benefit to the functional capacity of an individual. Although it is currently indisputable in the medical fields, interventions to encourage to take up physical activity are less potent with older persons (Raposo & Carstensen, 2015).

Why is that the case? Are the elderly genuinely uninterested in physical activities? Or is that a problem with tailoring the prevention programs to the needs and preferences of this age group? Ory, Hoffman, Hawkins et al. (2003) argue that it is the latter that is responsible for the modest response of the elderly to the health promotion programs offered. They

indicate at the myths about ageing that might serve as a partial explanation of the fact that older people have not been targeted at when it comes to disease prevention programs and health promotion activities. Ory, Hoffman, Hawkins et al. propose ways to improve the *status quo* by taking into consideration the feedback given by the elderly during research on successful fitness advertising. The opinions have been gathered by in-depth individual interviews and in focus groups.

A key motivator for the elderly to decide on increasing the amount of exercise done appeared to be family. Messages that displayed images or ideas that being more fit might enable an elderly person to participate more in family life and take part in activities with family members were more effective than a perspective of being more engaged in friendships. The features of the advertisements that motivated the group to take up physical activities were as follows: the models in the advertisement ought to be possible to identify with, for instance the ones that might be considered similar to the participants or as somebody they would like to befriend with; the advert should provide specific information on the expected amount of exercise to be done and number of days in the week when the activities should be done which would be optimal for them, as well as redirection to other sources of information, such as telephone numbers or websites; the obstacles that might occur should be recognized and addressed properly.

Conversely, the identified features of health promotion advertisements that do not have an impact on the elderly people are following: exercise or fitness named as such straightforward in the advert; the age of the target being referred to; super-fit athletes as models, which the participants of the study considered an unachievable goal; the exercise looking like work.

Focus interviews solely with the elderly are not a common practice, as the group seems to be neglected in targeting valuable messages, such as these promoting health. Existence of the research discussed above shows a trend to be continued and provides interesting guideline to be followed while designing adverts or another forms of influence, serving for a good reason of encouraging healthy behaviour, which undoubtedly lengthens life, to be practiced daily by the elderly.

Conclusion

If ageism is so endemic and persistent, can it change? It has its place among other forms of stereotypes, not easy to eradicate. It preys on some actual features of old age, such as vulnerability and poorer, compared to

the younger population, health, mixed with some myths transmitted in the culture. It sometimes wears a mask of positivity, which may result in discrimination, exclusion and emotional harm. It is noticeable for the elderly, who may internalize the stereotype content and step into a vicious cycle of false convictions about themselves. It is visible among doctors, who admit some prejudice or ageism. However, what brings hope is intervening with actions to combat the stereotypes. The interventions may be focused on giving people a chance to experience contact with the elderly to establish intergenerational linkages, providing knowledge on old age and raising awareness about it.

All humans have a relational need to belong (Nolan, 2011). The elderly are not excluded from this need. Creating opportunities for them to have productive roles and adjusting the environment and messages to resonate with their needs may be a solution to accommodate the older adults in the society. Constantly widening body of research on the elderly age and advocacy movements might be supportive to social inclusion. Conversely, the tendency to devaluate the elderly, to encourage intergenerational tensions and to provide ill-tailored care will definitely be a gross obstacle that can only worsen the situation.

What is crucial to bear in mind is the fact that ageism is to affect literally everyone. Recognition of individual differences of every elderly person and the specific context of their life is a key to understand and provide well-suited care and service, not only in medical, but also in social and educational settings.

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