Journal of Aging Studies 51 (2019) 100796

Contents lists available at ScienceDirect

Journal of Aging Studies

journal homepage: www.elsevier.com/locate/jaging

Geriatrics and humanism: Dementia and fallacies of care

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ARTICLE INFO

Keywords:
Fallacies
Care
Brazil
Geriatrics
Citizenship
Humanism

ABSTRACT

Based on fieldwork in a specialized geriatric outpatient clinic in Brazil, this article shows how a humanistic discourse that 'means well' can do good, but can also produce a regime of care that ultimately results in care that is contrary to stated values. These values – such as holistic care, multidisciplinarity, and empathy - that have been at the heart of geriatrics since its more official founding in the 1940s and 1950s, cannot be conceived as only local. The Brazilian data mirrors international geriatric values and norms, which, however, are being applied here in a specific context, in a country perceived as 'young' and with limited resources for elder care. Fallacies of care in this context result preliminary from a translation of more structural factors as individualized (self-)care and from the abstraction and generalization of aging individuals as 'older people'.

Introduction

Choosing a career as a medical doctor generally provides prestige and, in most cases, a high income; this choice is ideally also linked to a desire to do good (DelVecchio Good, 1998). The idea of doing good is especially relevant in geriatrics, a rather peculiar discipline. Geriatrics is one of the most complex fields in medicine, because health professionals need to take into consideration that many of their clients, older people, suffer from multiple pathologies, and deal with possible interactions from several medications that, additionally, were often tested on younger adults, while at the same time acknowledging the intricate social circumstances of their patients' lives. A recent New York Times article (Hafner, 2016) pointed out that geriatrics is the worst paid specialty in US medicine, rarely chosen by money-motivated MDs, although the need for geriatricians is immense and growing. This may be a generalization, but it does seem that geriatricians often come predisposed to having a caring attitude, adopting a humanistic discourse that defines geriatric practices as opposed to other medical disciplines, the latter perceived as focused more on cure than care. This tendency is certainly linked to the central condition of geriatrics – old age – that in itself cannot be cured, but also, as I will argue, to the subjects under care: geriatricians deal with human beings who, all discourses of empowerment and active aging aside, remain only partial (and frail) citizens and as such, need to be cared for.

When conceived as such, care is a practice establishing hierarchies, although the general (humanistic) discourse aims at equality. One example, among many: Claire Veselinova (2014) writes in her article on "understanding equality … in dementia care" that "…in the context of individuals with dementia, (…) care workers can ensure that rather than being marginalised, these service users are actively included in all aspects of their lives" (p. 406). Miriam Ticktin (2011, 218-19) criticizes such a position in her ethnography about French immigration politics: "Regimes of care are grounded in a politics of universality (…) [However,] [i]mmigrants are stripped of their legal personas when identified solely as suffering bodies, (…) they are not liberated into full citizenship. (…) Since the people entering France through humanitarian clauses generally come from already marginalized backgrounds, (…) this process reinforces racial hierarchies while casting France as benevolent."

Humanism can mean a number of things (e.g., see Halliwell & Mousley, 2003). For this article, I will focus more on humanism in health care that is defined in the Free Dictionary as an "approach to medicine that emphasizes the relationship between caregiver and patient. Characterized by collaboration, dignity, empathy, and trust." Even if there are scholars in the health sciences who adopt a more complex or more critical approach to humanism, there is a general tendency of defining humanism as based on interpersonal relationships of giving and receiving and on predominantly emotional and abstracting care work. This point is also made by Halliwell and Mousley (2003: 9) – in fact, a point that can be found throughout this article. The authors write about what they call "abstract humanism" that this kind of thinking "identifies human attributes outside their particular embodiment in one or another specific cultural and linguistic context." And they continue: "On this view, the categories 'man' and" woman' are mere abstractions, removed from living human beings, and insufficiently attentive to actual human diversity." When adding to 'man'

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https://doi.org/10.1016/j.jaging.2019.100796
Received 29 June 2019; Accepted 1 July 2019
Available online 16 July 2019

and 'woman' also 'older people', it becomes clear that care can become problematic and ultimately lead to fallacies of care (see below), because the cared-for person is not only often perceived in a normative way; care can also become an unquestioned higher value. These limitations, as applied in the following to geriatric care, risk a kind of blindness - although articulated through strong notions of goodness (empathy, compassion…) - that can make older people less than human, resulting in attitudes I want to denominate 'meaning well'.

There is a generalized tenderness in geriatric texts concerning the older patient that can also be found in pediatrics[1]: "It is not widely recognized enough that the care of frail older adults is a special challenge, requiring particular expertise. When it is done well, geriatric medicine is a thing of beauty, deeply rewarding to patient and practitioner," write Fillit, Rockwood and Young (2017: 2) in the introduction to the 8th edition of the *Brocklehurst's Textbook of Geriatric Medicine and Gerontology* in which, as they explain, all chapters in this latest edition had to address the specific condition of frailty that the authors perceive as at the heart of geriatrics. The notion of the patient and a more general notion of the older person – both conceived as frail - are merging and, different from younger adults (at least those who are not hierarchized by other means such as race, mental health issues, among others) can hardly ever be perceived as full citizens.

In fact, most texts about old age – in the wider fields of geriatrics and gerontology and their popular representations in the media - can be described as producing either images of frail old people or of portraying seniors optimistically as active, consuming individuals. Both orientations imprison and homogenize older people in specific kinds of partial citizenship. But especially the idea of the older person in need of protection raises a paradoxical issue in that, on the one hand, many seniors in many societies fall through gaps in social safety nets and are, in fact, in need of more protection, while on the other hand other seniors are overprotected, when they become reduced to frailty or just to "older people". Bell and Salmon (2012) recently made a similar argument when they described how illicit drug users as research subjects become overprotected by ethics committees. They described the good intentions of such committees, based on generalizations and not individually assessed capacities as "dangerous assumptions". But what could be bad or dangerous in simply protecting and caring for sick older people, especially those suffering from a dementia?

Fallacies of care

I wish to examine this question by using data from an ethnography that was undertaken in a specialized geriatric outpatient clinic in a major city in Brazil (with additional data stemming from other aging-related institutions in the country).[2] My argument here is that the question of geriatric care as potentially "dangerous" can be addressed by looking carefully at the field of geriatrics and especially its implicit and explicit values and moral orders. More specifically, in order to frame my arguments and contribute to the ever-expanding field of an anthropology of care, this article is guided by the concept of "fallacies of care" – when care motivated by good intentions can inadvertently do harm (e.g., Leibing, 2010, 2017, 2018, 2019a, Stevenson 2014, Ticktin, 2011). The way I define fallacies of care resembles and might be embedded in 'structural violence' (e.g., Farmer, Nizeye, Stulac, & Keshavjee, 2006) - structural factors (lack of access to health care and education, for instance) negatively affecting someone's well-being. At first sight it might also look like 'iatrogenesis' that Ivan Illich (1974: 12) defined some time ago as harm "done to patients by ineffective, unsafe, and erroneous treatments". However, although both structural violence and iatrogenesis do damage to patients and are most often invisible - just like 'fallacies of care' - the concept of 'fallacies of care' is more specific, in that it provides an analytical approach problematizing care that 'means well': Fallacies of care happen in a blind spot that develops from the general (and generalized) notion - tightly linked to a humanistic discourse - that in the case of geriatrics (and true as well for other medical disciplines and all sorts of social interventions), geriatricians are unquestionably doing good: the explicitly emotional connotations of care – such as love, compassion and empathy – implicitly carry a strong moral message. Fallacies of care can be related to what philosopher Michael Ridge (2015) calls "impassioned belief": a very simplified description of Ridge's central thesis would be that normative judgements are able to motivate people's action through affect; they turn action into a "desire-like" and "belief-like" state, often expressed through "'ought' and 'good'" and lacking context-sensitivity (p. 9).

Thinking about care and humanism further bears a lot of similarity to arguments made by Fritz Breithaupt (2017) who argues in his book about the "dark sides of empathy" that "the ability to empathize with others is also a prerequisite for deliberate acts of humiliation and cruelty".[3] Breithaupt observes that empathy is a dilemma – it is positive in that it makes us human and can lead to doing good, but also negative in that it is rarely acknowledged how empathy polarizes by mostly taking part in only one side (the victim's) and in this way loses nuance to one-sidedness. He further suggests that empathy is more often about the empathic helper herself, conceived as a hero, than about the recipient of empathy (and care) (see also Leibing, 2018, 2019a, 2019b).

Ben Golder (2015), in his reflections on Michel Foucault 's (anti-) humanism, argues that "Foucault's recalling of humanism in the late work on human rights is thus a calculated turning of humanism against itself in the name of its exclusions and remainders…" (p. 82) and this predominantly through a normativity and assumed universality that forgets to ground the human (and non-human) in local contexts. Didier Fassin (2012) makes a similar point when he states that international humanitarianism – based on the humanist idea of equality and inclusion - creates "hierarchies of humanity" (p. 242) and an "inequality between benefactors and victims" (idem): "the inequality of lives, often invisible, is one of their [humanitarianism's] foundations" (idem).

My argument in this article is that geriatrics is a clinical field that has incorporated a strong humanistic discourse and, although I personally would very much like to be cared for in old age by the geriatricians who were my interviewees – most of them were adorable, sensitive individuals - the concept of fallacies of care might be useful in throwing some light on limitations and pitfalls rarely seen in geriatric textbooks.[4] In the following sections I will first provide some information about geriatrics and its core values, followed by interviews with Brazilian geriatricians and how those values are part of their discourse about care. The next section is about observations and interviews with the same interviewees that illustrate the difficulty of translating geriatric ideals into practice, though meaning well. A final discussion frames the gap between ideal and practice as a fallacy of care.

[1] In fact, as Hirshbein (2000) shows, pediatrics was an important inspiration for early foundational texts in US geriatrics and already part of Ignaz Nascher's reflections. Lopes (2000) shows the same for early Brazilian geriatric texts.

[2] A more detailed methodology was described in Leibing (2019b).

[3] Blurb of the forthcoming English translation (*The Dark Sides of Empathy,* Cornell U Press, 2019).

[4] An anecdote from my earlier work in psychogeriatrics (dementia and mental health care in psychiatry) in Rio de Janeiro illustrates Breithaupt's point of taking sides: An older man with a diagnosed dementia arrived initially almost every day alone at the psychogeriatric unit by taking buses from the relatively far away northern zone of the city - a dangerous journey for someone losing his sense of orientation. He was affectionately welcomed by the team every day, although he had no appointment, based on a general wave of indignation directed toward his family who seemed to have abandoned that poor man. Only several weeks later psychologist Virginia Mafioletti who worked with the old man's daughter revealed that he had abused his children, causing a shock among the multidisciplinary team, destroying the absolute positive image they had of the old man.

Geriatric core values

Geriatrics is today roughly defined as the medical discipline of aging individuals, while gerontology covers the psycho-social, non-medical part of the field.[5] A related discipline is old age psychiatry or psychogeriatrics that focuses on psychiatric conditions in aging individuals (in Brazil including the dementias), often closely associated with neurology. The history of geriatrics shows that the discipline had from the beginning a marginal status in medicine and was for a long time restricted to long-term care in institutions (Evans, 1997). The birth of the discipline is linked to US physician Ignace Nascher who first used the term 'geriatrics' in 1909, but the field only became more organized with the founding of the American Geriatrics Society in 1942. Geriatrics, however, was afterwards more strongly developed in the UK than in the US, initiated by surgeon Marjory Warren, often called the "mother of geriatrics". Without going into too much detail (see Evans, 1997, Moreley, 2004 for early events and important early spokespersons), there are some key concepts that are recurrent. As Barton and Mulley (2003): 229) summarize the field, "[g]eriatric medicine is essentially about optimising the care and wellbeing of older people. A key component of this is teamwork." Teamwork and multidisciplinarity, but also holistic care are some of the keywords that are important since the formation of the field in the 1940s and 1950s and which persist until today.[6] Laura Hirshbein (2000) argues that a more holistic approach to aging individuals was adopted in part because the health conditions that traditionally are more prominent among older people – such as cancer and cardiovascular diseases – were taken over by other specialities, while equally the field needed to be distinguished from other medical disciplines: "While geriatricians had promoted health care in the elderly to a wide audience, they eventually lost control over the particular diseases of old age that constituted the bulk of care provided to older people" (p. 346).

When in 1974 Robert Butler became the director of the newly founded US-American NIA (National Institute on Aging) a central concern for him was ageism, a term he had coined in 1968. Until today ageism and the combating of negative stereotypes regarding older people can be considered at the core of all aging-related disciplines (with the exception of most basic research). Thomas Cole (1992: 233) critically observes that "[t]he fashionable positive stereotype of old age showed no more tolerance or respect for the intractable vicissitudes of aging than the old negative stereotype" (see also Katz, 1996, 2000). So from the beginning geriatrics worked in a highly morally charged domain of care based on a humanistic discourse as its *raison d'être*.[7]

A similar history can be told about Brazil, a country that is greying in an extremely rapid way (Camarano, 2018; Neumann & Alberts, 2018). The Brazilian Society for Geriatrics (SBG), founded in 1961, started to include gerontologists in 1969; in the name of multidisciplinarity the society is now called SBGG – Society for Geriatrics and Gerontology. A strong third age movement (*terceira idade*) - at least in the major urban centers, and starting in the late 1980s, – reproduced the same stereotypes and dichotomies found in other societies, with the underlying intention of combating negative images of old age (e.g. Debert, 1999; Leibing, 2005).

Andréa Lopes (2000) who wrote a history of the SBGG, describes early geriatrics in Brazil as extremely marginal – its members were even accused of charlatanism - because of its association with old age institutions for the poor as *non-lieux* on one hand, and doubtful rejuvenation therapies on the other. After later developing an association with universities, the discipline gained more respect and approval, but always stayed relatively marginal compared with other disciplines, showing, as several interviewees mentioned, a strong aversion against aging individuals in Brazil. And although geriatrics is today well represented in the big, urban centers, though mainly in private practices, many places in Brazil have no specialized options for older people. At the same time, since the 1980s the number of professionals taking care of seniors has been steadily growing – in a "big country with big opportunities" for geriatric care, as Garcez-Leme, Leme, and Espino (2005)) observed. Brazilian researchers and health care professionals were also active at the international level, both influencing and integrating internationally circulating standardized practices and theories about old age. A relatively strong movement, led by old age psychiatrists, gerontologists and geriatricians, resulted in important, wide ranging and progressive social policies protecting older people, however lacking in more general implementation and application (Carrijo, 2019; Mendonça, 2016).

Geriatricians somehow got stuck ideologically between, on one hand, old age psychiatrists and neurologists who often belittled geriatricians with their holistic thinking,[8] and on the other hand gerontologists who had a more psycho-social approach. Geriatricians affirmed themselves by showing authority (over gerontologists) as MDs, through relying on dominant science discourses, for instance evidence-based publications, but equally by adopting a psycho-social and deeply humanistic discourse that they shared with gerontologists. The inclusion of gerontological values demonstrate and maintain boundaries with respect to other medical fields, defining geriatrics' specificity as a more caring discipline than others. I can't count how many times I listened to people in the course of my fieldwork in Brazil (health care professionals and family members alike) explain to me that for a dementia it is initially good to get assessment from an old age psychiatrist or a neurologist and, once the patient has received his or her diagnosis and medication regime, then to switch to a geriatrician who is more caring.

[5] Andrew Achenbaum (1995:86-89), in his excellent history of gerontology, describes how at the beginning of the 1940s geriatrics was seen as one part of gerontology. Edward Stieglitz, one of the early spokesmen of geriatrics, divided gerontology into three sub-fields, one of them being geriatric medicine, the other two the biology of senescence and the sociology of aging populations.

[6] Holism in geriatrics is often defined as a synonym of complexity, because of the many co-occurring conditions in many older individuals, as in Galinsky et al. (2008: 1) who write that "factors that make the assessment of the older patient more complex [are] especially the nonspecific presentation of disease and the frequent presence of multiple pathology in advanced age; (…) the impact of social and economic factors on the health status of the elderly; and, in particular, (…) the functional and clinical manifestations resulting from the combination of these phenomena." Important is also that the definition of holistic care in many cases explicitly puts holism (caring for more than the immediate clinical symptoms) as a marker for geriatrics' specificity: "The 'holistic' approach (…) is characterized by treating every client as a whole, recognizing that every individual may be different, *stretching beyond* the physical manifestations of disease to consider personal circumstances." (McGaha, 2019; emphasis added) Holism is even more accentuated in gerontology and some currents of nursing, and here often also including spiritual elements.

[7] When recently the journal *European Geriatric Medicine* included a section with short articles from the humanities, the section editor wrote that "Despite broader currents of ageism within and without medicine, geriatricians are

(*footnote continued*)
fortunate to be working with people at the richest stage of life, (…). However, our professional discourse does not always reflect the wonders of later life, and how our patients and their families manage and find vitality, warmth, humour and creativity despite multiple challenges.(…) A hallmark of later life is complexity and inter-individual variability, and great artists of all types are masters at portraying complexity through cinema, literature, music, poetry and other arts. Later life is no exception, and mature artists have even greater powers at transmitting these complicated but eventually positive messages about ageing (…) We would welcome contributions (…) that would add to the richness of experience of the practice of specialist healthcare with older people, and illuminate the extraordinary possibilities of later life to a wider audience." (Desmond O'Neill via NANAS [North American Network in Aging Studies]).

[8] This observation stems from many years of fieldwork in psychogeriatrics in Brazil that happened prior to my fieldwork in geriatrics.

Talking about geriatrics

Asked why they had chosen geriatrics, every geriatrician-interviewee[9] I spoke with claimed that they were fascinated by the complexity and the holism of a form of knowledge that requires a lot of study; many gave as a counter-example cardiology – a discipline that only looks at one organ. Many also claimed that they had always been close to their grandparents, implicitly suggesting that this is unusual in a society that values youth and the young body so much as is the case in Brazil (see Edmonds, 2010, 2014). The awareness of practicing a medical discipline that is more complex than others translates into a clinical practice that also includes social factors and, at least at the observed unit, a critical consciousness regarding what could be subsumed under the category of a medicalization of old age. A senior male geriatrician explains:

> The motto of geriatrics in one word is complexity. (…) And the practice of a geriatrician in one word is care, more than cure. That makes everything even more complex, because sometimes we have to convince the patient that he should not chase after a cure that may not work. And often, these treatments do more harm to the patient than good. So, a geriatrician (…) maintains or re-establishes the conditions for life (…) and the social inclusion of the individual.

Complexity also means, as already mentioned above, providing multidisciplinary care (see Achenbaum, 1995). For example, a female resident explains:

> I always wanted to do geriatrics, but when I entered [the residency], (…) I saw that it was something completely different from what I had imagined. Because I still didn't have a vision about this 'multidisciplinary thing', the importance of the evaluation by other professionals (…). That way you can see everything. It's not only about disease and health. (…) [Geriatrics] is a different kind of [medical] specialty (…) and sometimes when I am with a patient I forget that I'm a doctor [indicating the importance of the social dimension in old age care].

The multidisciplinarity of geriatrics and its complexity are made apparent when, for example, new patients go through the Friday morning session, when each patient and her family spend four hours at the unit under study, seeing a geriatrician, a social worker, an occupational therapist, a physiotherapist, a neuropsychologist, a dentist, and a pharmacist (there used also to be a psychologist). Afterwards the whole team meets and a diagnosis or a preliminary diagnosis and a treatment plan are established based on each professional's evaluation. And although the senior geriatrician responsible for the Friday sessions has the last word, I have seen some cases in which the neuropsychologist or the physiotherapist changed the diagnosis, because the initial diagnosis did not fit with results from that specific health professional's evaluation. Weaving together the multiple reports of each professional in order to arrive at a diagnosis and a treatment plan is a complex and highly uncertain process, relying ultimately on the senior geriatrician's profound knowledge. However, a diagnosis in many cases remains preliminary because in older people several conditions often overlap, because dementia itself and its sub-categories are difficult to diagnose, especially when the symptoms cannot be observed over a longer period of time and because epistemologies are constantly changing (see Leibing, 2019b).

The interviewed geriatricians talked with a lot of empathy about the difficult socio-economic situation of many of their patients and made the point that treatments needed to be carefully adapted to the needs of each family. Social care was often linked to a critical stance toward too much or too expensive medications. Several medications are available for free in Brazil or can be bought for a small fee at what are called 'popular pharmacies', dividing drugs into expensive and cheap medications that strongly structure class-based treatment plans. Brazil has also put a lot of effort into the development of generic medications – both measures going back to the leftist governments of Lula and his successor Dilma Rousseff.

> We always ask: 'Can you afford this medication? Won't it be too hard for you?' (…) Some patients, for example, do not have access to more modern medications, better antidepressants (…) The cholinesterase inhibitor medications [for Alzheimer's] are even given [for free by the popular pharmacies], but there are strong restrictions (…). (female resident)

Finally, at least at this unit, not only the problem of over-medication, but also the specific dementia medications – there are at the moment three cholinesterase inhibitors and one NMDA receptor antagonist on the market - are viewed critically by the interviewees (see Ballenger, Whitehouse, Lyketsos, Rabins, & Karlawish, 2009), demonstrating a critical consciousness regarding pharma marketing. It was stated by all interviewees that the best treatment for dementia is non-pharmacologic, and that medications should be kept at a minimum. "Before prescribing medications," one resident explained, "people have to understand what is at stake, understand the disease, so education is important. And giving strength to the family is important. Many families see no effect from the medications, some patients even get worse." And quoting one senior geriatrician: "So, often it doesn't make sense to prescribe a pill for this kind of disease [AD], instead you have to understand the suffering of that individual, (…) you have to care." The critical stance toward (too many) medications for older people is further shown by the fact that for some years now, pharma reps no longer have access to the unit, when previously they were a strong presence, distributing samples, which were then passed on to those who could not afford treatment.

The careful weighing of the interaction of observed symptoms by a well-trained team, by including results from different assessment tools, the older person's family's social circumstances and norms based on classification systems and health policies made the professionals observed at the geriatric unit an outstanding and deeply caring group, incorporating all ideals and core values of geriatrics and gerontology: multidisciplinarity, the acknowledgment of complexity, holism (care beyond the immediate clinical symptom), and a critical stance toward pharmaceuticals.

Meaning well

In the previous section, the geriatrician's preoccupation with their older patients was at stake - a view of the older person that is 'tender', combined with a consciousness regarding social factors and circumstances. However, a number of contradictions emerge when relating discourse to practice.

In Brazil the public health system has a very negative image and is reported in the media regularly as being a last resort and only for people in desperate need, with long waiting lines, and neglected patients. However, universal access to medical institutions was a major achievement in Brazil; treatments are free for all, and although the public system is far from being perfect, the general idea that private care is better care is not always true. There are very well-functioning units in the public system - even areas of excellence (like the unit I observed) - and health in general has significantly improved in the country since 1988, when, as part of the new constitution, the SUS, or Unified Health System, – now threatened by the current ultra-right

[9] The interviewees mentioned in this article are three senior geriatricians who are responsible for the unit, two geriatricians with a permanent position, and a group of 10 first and second year residents. Other professionals - pharmacists and her students, neuropsychologist, social worker, occupational therapist, physiotherapist, and dentist, of which only the social worker had a full position – are not mentioned here. Some of these professionals, as well as the senior geriatricians, only spend some time at the unit.

government (Lourenço, 2018) - was implemented (Fiocruz, 2011; Khazan, 2014). The fact that the private system is based on profit also sometimes negatively effects health care outcomes (cf. Bahia & Scheffer, 2018).

Despite the negative image of the public system, it is ironic that one of the core concerns in geriatric care – multidisciplinarity - is only possible in a public setting, while in the private sector, where many geriatricians work, and as one interviewee told me, so many health professionals under one roof would mean "financial suicide". Yet the observed unit – part of a university hospital – should also be seen as an exception within the public system, because specialized units with such a high number of resources (number of employees, level of training, a well-kept site) are extremely rare. The implantation of satellite units in other regions, coordinated by geriatricians trained at the unit, help older people have access to care closer to their homes, but resources for those smaller units are much more limited, and real multidisciplinarity is not possible to achieve.

The second point, complexity as defining geriatrics, includes multidisciplinarity – different gazes on a patient often with many co-existing conditions – but also a more general notion of the patient herself as not necessarily easy to care for, and including the complexity of the social conditions in which many families live and perform care. While well-articulated in the interviews and relatively well implemented into the structure of the observed unit – for instance by longer time slots allocated to each patient when compared to other clinical specialities - the translation of efforts to address complexity into people's real lives barely occurs: complexity often stays within the unit and, once back in the community gets conflated into disease management based on the prescription of a great number of medications: specific dementia drugs, psychiatric drugs such as antipsychotics and antidepressants, as well as those for other health issues.

Asked about the contradiction between the critical stance of many interviewees regarding over-prescription and actual prescription practices, but also the limited efficacy of specific dementia medications known by specialists at least since 2005, when several critical reports were published (e.g., Birks, 2005; NICE, 2005), interviewees explained that they regularly lowered medication regimes, but at the end patients still receive too many medications; they did not have much choice.

Especially more senior geriatricians stated on various occasions that they actively tried to lower medication regimes of prescriptions stemming from previous health care practitioners their patients had been in contact with. However, the capacity of families to care for their older family member with dementia also needed to be considered. If families were overburdened, medications might be adjusted to keep the patient more docile. Further, although geriatrics is a speciality that acknowledges the social dimensions of aging and promotes a holistic approach to the person, medical training in Brazil, like in most countries, is focused on pharmaceuticals and not on non-pharmaceutical interventions (see DelVecchio Good, 1998; Webster et al., 2017), something that could be clearly observed at the unit. The reading of symptoms and its pairing with medications that was constantly adapted, we called elsewhere "fine-tuning" (see Leibing, Engel, & Carrijo, 2019).[10] A complex net of expectations and habits further influence prescription practices. The explanations of one female interviewee, a researcher specialized in pharmacology, shows the multilayered and complex logic of prescribing practices in Brazil:

> I just read Guilherme's thesis about medicalization. Medicalization happens because we set all our hopes on the medication. That's because – if I [the fictive patient] cannot resolve a problem, because I do not have the money for it (…) so the drug will resolve it for me, and people [MDs] medicate. So we [the health professionals] have to observe and try not to medicalize the patient. There is the problem of access, there is the team and I want to make sure they pay attention to drug interactions and adverse reactions and doctors often do not pay enough attention to such reactions. (…) And then old people are different. I always joke with my students, tell them: 'do you know Gianecchini [a good- and healthy-looking Brazilian actor]? Medications were made for him, who weighs 70 kg, has maybe one minor health problem, but older people, their organs are getting weaker (…) So for older people everything is 'less' – less medications and smaller doses. (…) And especially dementia treatment is less dependent on medication than any other condition, you understand? (…) But I would give it to my mother – if her brain works better, even for a limited period of time, I am sure she would like to get this chance.

Related to this kind of thinking is the principally positive prohibition of pharma reps at the unit – showing a critical attitude toward drug marketing – that resulted in reps meeting doctors outside of the unit. And many doctors now –especially residents who do not yet have a private clinic – carry medication samples for longer periods in their cars and pass them to patients outside of the unit, which is not a good stocking space for meds, in a warm country like Brazil.

For the specific dementia medications that almost all interviewees described as by far less important than psychosocial interventions (such as social inclusion and counseling families), the interviewees argued that although the effect was small, there was nevertheless a notable positive effect (as mentioned by the expert in pharmacology above). The effect was described as either cognitively, or as a general better connectedness with people and everyday life such as a return to previous activities. Some spoke of an effect in 30% of patients; others thought it was about 50% of those who received the dementia-specific drugs. The most important argument though was that, according to the geriatricians interviewed, patients had the *right* to receive whatever does them good. An apparent contradiction between results from the literature – for instance, the already mentioned meta-analyses showing only a very small effect from the four existing dementia drugs, something that was acknowledged by the interviewees – and a discourse of patients' rights based on a notable effectiveness of the same drugs can be explained by mainly two facts. First, the literature is not at all clear about results - the interpretation of effectiveness often depends on the funding for the study. For instance, a recent "Group Recommendations in Alzheimer's Disease and Vascular Dementia of the Brazilian Academy of Neurology" (Do Vale et al., 2011), an authoritative publication summarizing the state of the field, describes studies about the four dementia medications as positive and thus diverging from independent studies in the international literature (e.g., Matthews, McKeith, Bond, Brayne, & MRC, 2007). The Brazilian group of neurologists sums up each section in a positive way: "Recommendations – The use of cholinesterase inhibitors is effective for mild-to-moderate Alzheimer's disease (Level of evidence A)" (p. 180); "Recommendations – The use of cholinesterase inhibitors is effective in severe AD (Level A)" (p. 181); "Recommendations – The use of memantine, alone or associated with AChEI, is effective in individuals with moderate to severe AD (Level A)" (p. 181) and so on. Although the immense group of co-authors "report no conflict of interest" (p. 178), many of them and their studies are sponsored by the pharmaceutical industry, a fact which was not declared in the article that appeared in Dementia & Neuropsychologia, a Brazilian journal published in English and Portuguese, and on whose editorial board many of these authors serve. It is well known that the pharmaceutical industry invests heavily in Brazil, a country with one of the largest medication and health technology markets in the world (e.g., Burton, 2018).

The first dementia medication, Tacrine, which arrived in 1993 on the international market and which is not being prescribed anymore

[10] The reading of signs, stemming from the person with dementia and transmitted to the geriatrician by family members, results in a constant alteration of medications and dosages, testing dosages in line with the progression of the disease and the effect of multiple, interacting medication—two kinds of signs that often cannot be separated from each other (see Leibing et al., 2019)

because of serious side effects, especially liver damage, was imported by the Brazilian Ministry of Health after ongoing pressure from different interest groups in the name of elder rights – and this although already at that time first doubts were reported regarding effectiveness - merging with the more general humanistic notion of aging individuals as in need of more rights, a major movement in Brazil (e.g., Mendonça, 2016) - can be found as well in the interviews.

Second, health technologies, including medications, are generally seen as positive and desirable in Brazil, and this is very different from a more general mistrust regarding technologies perceived as cold and pharmaceuticals as polluting the body by critics in many richer nations (Aisengart Menezes, 2003; Pols, 2012; Van der Geest, Whyte, & Hardon, 1996). The high regard for medications in Brazil is also visible in urban geographies: the extremely high concentration of pharmacies in every city, one of the highest numbers in the world, remained even stable in years of economic crisis (Pereira, 2017).

In other words, the geriatric patient is situated between two statistical tensions: In Brazil, according to a recent survey, there is one geriatrician for every 24.000 older individual, while the WHO recommends a ratio of 1:1000 (Ruge, 2019). At the same time there is one pharmacy for every 2100 Brazilians (all ages) in Brasília, while the WHO recommends 1:8000 (Pereira, 2017). Too few geriatricians and a great many pharmacies helps explain, at least partly, the phenomenon in Brazil of what one could call a pharmaceuticalization of old age (Collin & David, 2016; Williams, Martin, & Gabe, 2011) - the strong entanglement of elder care with an intense pharmaceutical regime.

Finally, the geriatric patient – as mentioned above, a subject of tenderness in the interviews and more generally, in geriatric texts – is also a subject of severe, and mainly class-related blame. While previously a lack of education was the main risk factor associated with dementia, providing a reason for why poorer people had more dementia (although in earlier epidemiological texts in Brazil – and internationally - this was sometimes acknowledged but strangely did not influence mean national dementia rates; see Leibing, forthcoming, b), now the new risk factors - more widely known after the Lancet Report from 2017 (Livingston et al., 2017) – are seen to be bound up with many conditions, such as diabetes, obesity, hypertension - conditions that are generally more prevalent among poorer people.

People demand the right to health but they do not take care of themselves. It's a cultural question. So they do not do physical activity, don't stop smoking, don't stop drinking. All this (…). And then, when they need access to health care, access is difficult – the population is big and the health care system cannot take care of everybody. (female resident).

This kind of blame – here called "cultural" in the sense of inert[11] – and even linking a structural problem, access to health care, as dependent on the right personal attitude – can also be found in other interviews (for a more extensive discussion on this see Leibing forthcoming, b). As one senior geriatrician bluntly stated when being asked why people do not take their medications as prescribed:

> Because medications are distributed for free (…) [and] in the population I studied where older people have good access to certain medications, they do not control their blood pressure the way they should. (…) They don't take these medications – hypertension is so common, why take this medication? Because it makes people ordinary. (…) Hypertension is a disease of poor people. 'I want to have a disease of rich people', they say.

[11] This association reminds of the more North American debate on cultures of poverty (Jessica Robbins, personal communication; see also Cohen, 2010 for an overview).

Conclusion: Fallacies of Care

The initial question, 'What could be dangerous or simply bad in protecting and caring for sick older people, especially when suffering from a dementia?' can now be answered by stating that practices based on humanistic values cannot only invert stated values, they may also hide structural inequalities and, as a result, help to reinforce this reality by transforming questions of access to food, education, and good medical care into questions of individual attitude. That does not mean that a caring attitude – a tender gaze - should be abandoned, but rather put into perspective. Jean-Paul Sartre, in *Being and Nothingness*, speaks in this sense about a 'spirit of seriousness' – the belief that something is intrinsically good that then can lead to bad faith: "The spirit of seriousness (…) considers values as transcendent givens, independent of human subjectivity…" (quoted in Collier 2003: 85).

In geriatric care in the Brazilian context it is especially the merging of the notion of an older patient as merely a partial citizen – related to being old, sick and frail, and especially when poor - with what some call a "culture of medications" in Brazil (see Pereira, 2017, also Leibing et al., 2019) - that could be considered the main underlying mechanism of the here-described fallacy of care. In order to show this, I have tried to sketch out a discourse of ideal dementia care and at least some factors related to the gap that exists between this geriatric discourse and actual practices. But is there a solution, a way to bridge the gap? Bell and Salmon, in the above-mentioned article about ethics committees, see a valid solution for overcoming such a gap through personalized treatment of and acknowledging each individual's circumstances and, in this way avoiding "cookie cutter answers" (p. 197). Seeing each person in her specific context would avoid generalizations - in the case of geriatrics, of frail old people, and therefore avoid such a category becoming, in Sartre's words, a "transcendent given". In a similar vein, Johnsdotter (2019), in her study of immigrant families suspected of practicing female circumcision in Europe, sees a solution in the questioning of and a conscientization regarding public belief systems. She relates the gap between the intention to do good and resulting fallacies to false assumptions and prejudice.

Becoming aware of transcendent givens and commonplace notions of people in need of care might be a first step toward avoiding fallacies of care. During the recent visit of a resident from the observed unit in Brazil to a geriatric public clinic in Montreal, the young geriatrician was astonished by two facts: 1. That in Canada, as she observed, dementia patients received many fewer medications than Brazilian patients, even when suffering from similar conditions. And although living conditions and access to health care cannot be directly compared between the two countries, the resident was able to become more aware of and question her own practices. 2. The resident further observed that many patients, even with a diagnosis of a dementia, arrived alone at the clinic in Montreal, something that is not even allowed in Brazil. The reason is a question of security and veracity – a family member's observations are supposed to be more reliable than those from an older individual who might suffer from a dementia. The immediate association of someone with dementia and frailty and helplessness became challenged by her observation (although she was also convinced that many families in Brazil feel more responsible for their elders). Changing perspectives might be then one way of dealing with and becoming aware of fallacies of care.

Acknowledgments

This research was funded by Social Science and Humanities Research Council (SSHRC) grants [grant numbers 430-2015-01165 and 435-2018-0599]. I am grateful for the suggestions made by the reviewers. I further thank Jessica Robbins for discussing the topic of this article with me in beautiful Santa Fé.

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