Six Propositions Against Ageism in the COVID-19 Pandemic

Hans-Joerg Ehni, PhD1*

&

Hans-Werner Wahl, PhD2

1Prof. Dr. Hans-Joerg Ehni, Institute for Ethics and the History of Medicine, University of Tuebingen, Germany, +49-7071-2978033, hans-joerg.ehni@uni-tuebingen.de

2Prof. Dr. Hans-Werner Wahl, Network of Aging Research, Heidelberg University, Heidelberg, Germany, Phone: +49-6221-548127, wahl@nar.uni-heidelberg.de

*Corresponding Author: Hans-Joerg Ehni, Institute for Ethics and the History of Medicine, University of Tuebingen, Germany, Gartenstrasse 47, 72074 Tuebingen, Germany, hans-joerg.ehni@uni-tuebingen.de

Conflict of Interest: There are no conflicts of interest to report.
Six Propositions Against Ageism in the COVID-19 Pandemic

Abstract
The risk of developing severe illness from COVID-19 and of dying from it increases with age. This statistical association has led to numerous highly problematic policy suggestions and comments revealing underlying ageist attitudes and promoting age discrimination. Such attitudes are based on negative stereotypes on the health and functioning of older adults. As a result, the lives of older people are disvalued, including in possible triage situations and in the potential limitation of some measures against the spread of the pandemic to older adults. These outcomes are unjustified and unethical. We develop six propositions against the ageism underlying these suggestions to spur a more adequate response to the current pandemic in which the needs and dignity of older people are respected.

Key Words: COVID-19, ageism, ethics of aging, triage, social distancing, digitalization

Key Points:

- Some measures suggested as reactions to the COVID-19 pandemic demonstrate underlying ageist attitudes.
- We develop six propositions against this ageism to illustrate what more adequate responses to the pandemic would look like.
- We outline what lessons can be learned to improve the situation of older adults after the pandemic.
The risk of developing severe illness from COVID-19 and of dying from it increases with age (Graselli et al., 2020; Richardson et al., 2020). This statistical association has led to numerous highly problematic policy suggestions and comments revealing underlying ageist attitudes and promoting age discrimination. Such attitudes are based on negative stereotypes on the health and functioning of older adults. As a result, the lives of older people are disvalued. Doubts are raised if the costs of isolation measures are worthwhile just to protect older people who are allegedly at the fringe of death anyway. Age limits are proposed to restrict access to intensive care. It is suggested that older people should isolate themselves instead of requiring widely implemented social distancing measures (see also Brooke & Jackson, 2020).

Due to constant repetition and consistency with ongoing negative age stereotyping (Ng et al., 2015; Ayalon et al., 2020), ageist suggestions have become prominent, taken-for-granted, and rarely questioned statements in the pandemic communication. The needs of older people remain largely unaddressed, for instance how to reduce the burden of social isolation on them. Against this backdrop we offer six propositions on the basis of gerontological knowledge and an ethics of aging against the ageism which is present in the current reactions to the COVID-19 pandemic.

**Proposition 1: Older Adults Are Highly Heterogeneous – Also Their Health and Functioning Is Better Than Negative Stereotypes Suggest**

Older people aged 65 years and older remain the most heterogeneous group in society as reflected in thousands of studies documenting inter-individual variability in psychological performance, social needs, and personality characteristics, as well as key health and medical indicators such as somatic functioning, chronic conditions, self-perceived health, cognitive health and impairment in activities of daily living functioning (Lindenberger & Reischies, 1999; Lowsky et al., 2014; Steinhagen & Thiessen, 1993. Even amongst the very old, over 80 years of age, the significant biological processes of change do not lead to a levelling of this
heterogeneity, both overall and in specific areas such as gait function (Callisaya et al., 2010; Minitzky et al., 2017; Nelson & Dannefer, 1992). In other words, chronological age is an “empty variable” and an extremely poor guide for accurately predicting behavior, needs, performance, loss of function, illness, and comorbidity (Birren & Schroots, 1996; Lowsky et al. 2014; Settersten & Mayer, 1997; Steinhagen & Thiessen, 1993). Therefore, chronological age alone is also in no way suitable for allocating medical and care resources, in the current pandemic most prominently by introducing age limits for intensive care in triage decisions, which has been suggested in Italy (Vergano et al. 2020) and in Switzerland (Scheidgger et al. 2020), as we will discuss in more detail in the next section.

Instead, we expect all actors to align their statements regarding older adults and COVID-19 with the recognition that older people are an extremely diverse group with great importance to our community. That they are active in voluntary work, provide a lot of instrumental help as grandparents, and are also important consumers (see findings on “productive aging”, summarized by Diehl & Wahl, 2020). Yes, they are also more at risk for severe illness from COVID-19, but by no means does this apply equally to everyone above a specific chronological age. Those with pre-existing conditions and significant multimorbidity are particularly at risk. This subgroup is probably approximately 20% of the age group over 65 years of age (Sheehan et al., 2019). And, although a highly significant group in the crisis (Béland & Marie, 2020), only a relatively small proportion of those 65 years and older live in institutions (e.g., 4% in Germany) where the effects of COVID-19 have been especially devastating (Comas-Herrara et al., 2020).

Proposition 2: Age Limits for Intensive Care and Other Forms of Medical Care Are Inappropriate and Unethical

The exponential increase of COVID-19 with severe disease progression is currently leading to dramatic shortages in intensive care in many countries. For such situations of scarcity and the tragic decisions to which they lead, there are often no binding guidelines and
regulations currently in place. The physicians, who treat patients under severe psychological strain, are forced to decide who is to receive artificial ventilation and whose lives should be saved if there are no longer enough beds available in intensive care. Based on the traditional triage in war-zone situations, expert committees around the world are currently developing recommendations.

The Italian Society for Anaesthesia, Analgesia, Resuscitation and Intensive Care Medicine (Vergano et al, 2020) recommends that age limits should be a direct criterion for access to intensive care treatment due to the current scarcity of resources. In addition, the Society recommends that resources should be used in such a way as to maximize the years of life gained, which also means giving priority to younger people. Such considerations presuppose that an alleged longer life span of a younger person can be weighed against the shorter life span of an older person. This supposition is flawed, in part, due to the diversity of older people, whose life expectancy may show significant variation even at more advanced ages. More importantly, however, dignity requires that the same value should be attributed to human lives without regard to age, gender, ethnicity or impairments.

In Germany, the German Ethics Council has emphasised this latter point in its ad hoc statement (Deutscher Ethikrat, 2020); so too have seven German medical societies together with the Academy for Ethics in Medicine in recommendations for dealing with situations of scarcity (DIVI et al., 2020). These recommendations are essentially based on the prospects of individual patient success, which is based on their state of health. In this way, as many human lives as possible can be saved while respecting the rights of individuals. Age as a criterion for intensive medical treatment is explicitly rejected. However, caution is required to ensure that chronological age is not reintroduced through the back door as a placeholder for supposed chances of success. Here, too, the diversity of older people should be emphasised. Health and functioning of each patient should be considered carefully in decisions about medical care and its limitations. Simplistic uses of chronological age to deny care should be avoided and a
societal debate on these issues is urgently needed to avoid implicit rationing on an arbitrary basis.

**Proposition 3: Mass Deficit Views of Old Age Are Dangerous to Older Citizens and Societies at Large – Intergenerational Solidarity Must Be Strengthened**

We believe that negative age stereotyping is currently taking place on a massive scale in light of COVID-19. Statements are common in which older people are uniformly categorized as “at risk” and that the reduction of this risk is also the main reason for the current measures to limit the spread of the pandemic. This view is simply inaccurate since not all older people may be at elevated risk, and not all those who are at risk are simply above a certain age. Male gender and obesity seems as well to facilitate severe cases of COVID-19. Other risk factors such as pollution, mutations of the virus and genetic dispositions are discussed and remain unclear. Therefore, highlighting advanced age may not only raise unjustified worries among older adults, but may also lead to feelings of false safety among other age groups.

Moreover, public debates in which the lives of older people are disvalued and considered expendable could have hugely detrimental effects on the physical and mental health of older adults (see also Levy et al., 2020). Stereotype research on ageing has clearly shown that negative age stereotypes can be quickly triggered in older people (Diehl et al., 2020; Wurm et al., 2017); that they are three times more powerful in their unpleasant effects than positive stereotypes (e.g. all older people are wise) in their positive effects (Meisner, 2012). Many findings suggest that negative age stereotypes can be expressed in somatic illnesses and functional health, and not only on the psychological level (Wurm et al., 2017; Westerhof et al., 2014). We also know that negative age self-stereotyping is indicated in inflammatory processes, for example, by C reactive protein, and leads to reinforced and raised cortisol secretions (Levy et al., 2000, 2016; Stephan et al., 2015). These are all physiological
pathways that are closely related to cardio-vascular disease and severe loss of cognitive performance, among other conditions.

It may be that the consequences of negative age attributions could even increase the susceptibility to COVID-19, say, through its effects on enhanced inflammatory responses, though, of course, nobody knows. At the very least we must investigate. We hope for a hypothesis that is partially recognized and supported by existing findings and arguments to render it plausible. And that it is this plausibility that, in turn, mitigates the use of such ageist arguments going forward.

In light of negative age stereotyping, older people could also feel pressured to refuse medical care in connection with a potential scarcity of medical resources. Or, the internalized disvalue of their own lives could lead to corresponding advance directives that prematurely close off avenues to potentially beneficial interventions. It is important that nobody receives unwanted burdensome end-of-life care, and this must be addressed as well in the current situation. Yet it is still more important that older people are not pressured into writing statements in which they “voluntarily” renounce appropriate treatment.

Negative stereotypes and expressions of disvalue may have huge and unforeseeable negative effects on older people and the health system at large (Levy et al., 2020). Negative stereotypes of old age undermine intergenerational solidarity as part of the general camaraderie, cooperation and social cohesion now needed as a common reaction to prevent unnecessary harm in the current pandemic. Thus, it is crucial to raise public awareness among experts, policy makers, and the media to avoid such stereotypes in the communication about the disease and the reactions to it.

**Proposition 4: Resisting the Assumption of a Paternalistic Attitude Towards Older Adults in the Crisis is Important**

We must avoid treating older people with a paternalistic attitude and telling them what they can and cannot do (Ayalon et al., 2020; Fingerman & Trevino, 2020; Morrow-Howell et
al., 2020). They are the group in our community with the greatest amount of life experience. For the most part, they act reasonably and in accordance with the needs of the situation without being told by others to do so. So, extending “social distancing” only above chronological age limits is unnecessary as well as discriminatory. Current older adults are historically seen the generation highest in physical capacity, cognitive functioning and educational level ever (Carstensen, 2011; Diehl & Wahl, 2020). This capability is the best prerequisite for cooperative communication; there is no need to target them separately from other age groups.

By contrast, we could listen and learn from our older adults, who could act as advisors during this crisis. As mentioned before, they have by far the most life experience and they know about privations from previous situations and experiences. But nobody seems to want to give them a voice. Why not?

Proposition 5: The COVID-19 Crisis Demands Fostering the Use of Modern Information and Communication Technologies Among Older Adults

At the present moment, information and communication media holds a crucial place in our society. Please do not say that they, the elderly, are not capable. For example, around 77% of over 65-year-olds in Germany today have a conventional personal computer and 52% have a notebook (Doh, 2019). Tablet computers are (also) becoming increasingly popular among older people, and already account for 28%. Smartphones are being used by older people at around 46%, meaning that almost half of the people over the age of 65 can potentially use all the functions that smartphones offer today. The number of internet users over the age of 65 now amounts to 75%. In other countries (e.g., Denmark), emerging trends are even more promising. Thus, older people are far from starting from scratch where the use of information and communication technologies are concerned.

The digitalization of learning and schooling is currently promoted and accelerated during the COVID-19 crisis through the provision of the necessary technological equipment
and infrastructure. In the same way, we propose to provide free tablet computers and support to the thousands of older people in need, for instance in nursing homes, which we know are suffering from social withdrawal symptoms (Berg-Weger & Morley, 2020; Marston et al., 2020). In addition, we would suggest the organization of nationwide conversations and exchange networks to maintain social participation of older adults (see also Czaja, 2017; Czaja et al., 2018). Physical and mental fitness training can also be offered efficiently in this way. Even if the evidence on mental fitness training (“Brain Games”) is not fully convincing (Simon et al., 2016): the same principle applies as with physical fitness training: use it or lose it. We know that forms of engagement and new stimuli is generally beneficial to older people. And because of the current restrictions, older people have a higher risk of worsening relatively quickly through “disuse” in basic functional-motor-cognitive skills. This deterioration is completely unnecessary if we act now to prevent long-term negative effects.

**Proposition 6: The COVID-19 Crisis Not Only Demands the Best of Virology But Also the Best of Gerontology For Policy Guidance and Understanding the Consequences of the Crisis At Lareg**

Virology has been placed center-stage in Germany and other countries. Virologists have provided valuable expertise, professional recommendations and orientation in the current situation. Other scientific disciplines are also in demand. Gerontology is particularly important when it comes to giving equal and appropriate consideration to the health and well-being of all citizens in the current crisis. Gerontologists have thus been called upon to share their knowledge and expertise in contributing to the development of policies addressing the specific needs of older people. We estimate, for example, that approximately 15-25% of older people aged 80 years and older cannot easily cope with a strategy of social isolation and contact exclusion (DeJong Gierveld & van Tilburg, 2010). And by no means only in nursing homes! Here, policy makers need the immediate proactive advice and suggestions for support programs that gerontologists can provide.
The crisis is also likely to change the way many older people experience their own ageing. Many opportunities for social interaction and participation are currently not existing. New ways to create such opportunities have to be found and supported. Here, gerontology is now called upon to better understand what is happening psychologically to older people by utilizing targeted research in the field. The participation of older adults in myriads of gerontological studies proves that they have no problem when research is conducted with them, compared to when research is conducted on them. And they can always say no, as is the ethical standard. And then, of course, translation is necessary. Older adults, as human beings have the right to have the best research generated not only by virologists, but as well by gerontologists to support their quality of life and prevent permanent damage.

**Conclusion**

This crisis provides an opportunity to learn and improve upon past practice. This opportunity includes better understanding the living situations of older people and how to counteract the problems affecting them. Older adults have a lot of strengths and many are functionally well in physical and mental terms. We doubt our readers have frequently encountered such characterizations of older individuals in the recent debate linked to COVID-19, although the evidence available in contemporary gerontology clearly supports such a statement (e.g. Diehl & Wahl, 2020). Now is the moment to create a broader awareness both about negative stereotypes against older people, and their harmful impact, and the strengths of older adults, their valuable contributions to society, and their potential.

We are currently experiencing a situation in which numerous moral dilemmas and conflicts are arising. It is difficult to find the best course of action. It is tempting to fall into a crude utilitarianism that values lives differently; where we pit one group against another and give lower priority to those of whom have a lower value attributed to them. Too often, the lives of older people are weighed less than others. They should simply be isolated because they are the most vulnerable. They have lived their lives and have had their chance at living a
fulfilling life. They are, in any case, amongst those who are going to die soon. These and similar arguments can be found in everyday discussions as well as in the opinions of experts and ethicists. At the extreme, such views might contribute to breaks in civilization, as in Spain, where the residents of a nursing home were left to their own devices and ultimately died (Rada, 2020). These views contradict the basic values of our society as expressed in the idea of human rights. Importantly, this refers to equal value and respect of each human being and the right to non-discrimination on the basis of traits such as age, gender, race, or disability (Nickel, 2019; Gosepath 2011). Such arguments undermine attitudes such as being happy about the rescue of a 95-year-old patient or sacrificing oneself for the care of residents suffering from dementia in nursing homes. Especially in a crisis, it is important to preserve the basic values of our society and to protect the rights of individuals, especially the weakest. We must all be reminded of our basic human vulnerability, which requires mutual protection, care and solidarity in the midst of this pandemic.

References


Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin (DIVI), Deutsche Gesellschaft für Interdisziplinäre Notfall- und Akutmedizin (DGINA), Deutsche Gesellschaft für Anästhesiologie und Intensivmedizin (DGAI), Deutsche Gesellschaft für Internistische Intensivmedizin und Notfallmedizin (DGIIIN), Deutsche Gesellschaft für Pneumologie und Beatmungsmedizin (DGP), der Deutschen Gesellschaft für Palliativmedizin (DGP), & und der Akademie für Ethik in der Medizin (AEM).


