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Editorial

COVID-19 Pandemic and Ageism: A Call for Humanitarian Care

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The severe acute respiratory syndrome coronavirus 2 is a deadly threat, and although all individuals are susceptible, advanced age is one of the risk factors for its direst consequences in those who are infected. There are precious few times when individuals can come together to make clear a common cause for advocacy and health. We, the consortium of the editors of the nation's major geriatric and gerontology journals, offer this perspective as a way to raise awareness about ageism in association with the coronavirus disease 2019 (COVID-19) pandemic, and to acknowledge the extraordinary work that healthcare providers across all disciplines, including geriatrics, are doing at the frontlines of care. We also offer these thoughts as advocates for older patients, their families, their providers, and the broader community.

COVID-19 transited the world with staggering speed, which speaks to the fact that the world is borderless when it comes to a virulent 50–200 nanometer mRNA virus. Initially, our nation's response to the pandemic was slow and poorly coordinated. Political and personal interests superseded evidence-based public health practices. Fortunately, steady and consistent efforts by teams of scientists and public health officials, and the visible impact of the illness in communities, have changed the narrative and nationwide response. To be sure, significant challenges with our healthcare and public health systems remain, and include supply-chain shortages, insufficient hospital bed capacity, poor public engagement with preventive measures, and lengthy treatment and vaccine development.

We have been struck, however, by the emergence of an ageist bias towards older adults as part of the response and public discourse.[1] For example, our colleague, Dr. Louise Aronson, in a sobering commentary in *The Atlantic*[2] wrote about ageism making the pandemic worse, pointed out how differently we might be acting if COVID-19 put young people, as opposed to older people, at more risk. She pointed out ageist comments such as COVID-19 being "Boomer removers" and perceptions about older adults as being irresponsible, and contrasted these observations with the more empathic actions taken by responsible businesses such as grocery stores that offered reserved hours for older customers. Her most challenging reflection, however, was her medical center's initial lack of developing specific prevention and management protocols for older adults.

We recognize the emerging thorny ethical and moral challenges that our frontline colleagues are beginning to face. One example is the need to decide who should or should not receive ventilator support when ventilators are in short supply. If medical resources were unlimited, the decisions of where, when and to whom they should be deployed is quite simple—everyone gets what is needed. COVID-19 has revealed significant inadequacies in the nation's supply of ventilators necessary for respiratory support for patients in extreme respiratory distress. How, then, should decisions be made as to who should or should not be afforded access to them? Is the battlefield triage analogy applicable—meaning categorizing patients as healthy enough to survive without a ventilator; likely to die even with a respirator; high likely of survival if a ventilator is used? If this strategy is employed, an unavoidable question is the extent to which age of the patient should be considered in the decision. Such issues have already arisen in Italy, and all to easily age was advanced as the criterion for decision making rather than developing more nuanced approaches, as proposed by White and Lo.[3]

The need to make such decisions, should it arise, will create not only ethical conundrums, but also conditions for moral injury for providers who may already be experiencing burn-out and perhaps loss of their own family members.[4,5] Fortunately, many prognostic models in medicine demonstrate that age is but one of many factors in triage decisions such as this. Still, front line clinicians and families will face numerous care decisions that require multiple probabilistic judgments where guidelines may not be clear. These situations require the valued participation of interprofessional teams, in collaboration

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with the patient (if capable) and families, in order to bring about better decisions—tough though they may be. Experts in geriatric medicine and healthcare bring a critical informed voice to this decision-making.

Society's diminished valuation of individuals as they age is a continuing thread within ageism. Tackling ageism in this pandemic requires evidence that contravenes these preconceived notions, and we offer two examples as evidence—the value of wisdom and personal resilience. First, leaders who are older are often deemed wise. A most notable example is the scientific leadership coordinating the nation's response to COVID-19. These leaders are in their 60's and the most respected voice—coming from Dr. Anthony Fauci of the National Institutes of Allergy and Immunology, is 79 years of age.

During this national crisis the value of intergenerational wisdom should also not be discounted. For example, grandparents may have critical roles in nurturing and helping their grandchildren understand the many personal sacrifices that are being made to fight COVID-19. Conversely shared wisdom may encourage younger family members, because of their technology nativism, to assist older family members reduce social isolation through video streaming and help them interpret what they are viewing or reading. Intergenerational engagement is known to reduce ageism and bias.

Resilience, the successful adaptation to adversity and to recover from crises with a sustained sense of purpose, has been an increasing focus of successful aging. Ageism is the implicit bias that older adults are less resilient and less capable to adapt to challenging events such as COVID-19. Older adults have shown remarkable agency in this crisis as witnessed by their willingness to engage in positive public health practices such as social isolation, shelter at home and basic hand washing. Older adults have engaged in meaningful social connection through email, social media, and other forms of electronic communication. And older retired healthcare workers have demonstrated great moral purpose by volunteering their skills to help frontline healthcare providers treat those afflicted with COVID-19.

Last, we recognize that COVID-19 will require sustained efforts over an uncertain time frame. Specifically, we urge greater attention to four goals: (1) make clinical research more inclusive of all ages, such as emergent use of experimental therapies and diagnostic tools; (2) engage geriatricians and gerontologists in institutional decisions regarding care, including rationing; (3) inform policy and funding with cognizance of the needs of vulnerable populations (e.g., personal protective equipment for home care workers and better infection control in long term care facilities; and (4) emphasize the importance of personalized approaches to older adults that enact respect for autonomy, justice and beneficence.

In appreciation for the contributions that older adults make to society, we as editors of the nation's leading journals in geriatrics and gerontology believe that drawing upon the experience and resources across the life span will build resilience against despair. Our obligations are to steadfastly tackle ageism in all of its forms, and to offer hope, compassion and empathy to those for whom we are responsible.

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