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Edward F. Ansello

Virginia Commonwealth University, eansello@vcu.edu

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Ageism in the Age of COVID-19

By

Edward F. Ansello, PhD

If ageism includes the less preferential or more harmful treatment of individuals because of their older age, the COVID-19 pandemic has brought it into sharper focus. If one cares to look.

At present, about three quarters of the deaths attributable to COVID-19 are among older adults, according to the CDC. Their greater vulnerability because of intrinsic causes such as the presence of existing illnesses, co-morbidities, and frailty are major causes. But so, too, are other extrinsic causes, conditions outside of the disease's victims. These include social determinants of health like where one lives, access to transportation and health care, economic stability, educational opportunities, and racial segregation. (See Healthy People 2020 for a fuller exploration: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources>)

Other extrinsic contributors include a too-common cultural underlayment of bias against growing older and, in effect, against older adults. The COVID-19 pandemic has released, for some people, the politically correct restraints customarily imposed on overt ageism. The worst of social media contains references to this deadly virus as a Boomer Remover.

The Decline Narrative of aging refers broadly to the assumption that individuals grow less important, contribute less to societal functioning, and deteriorate to decay with advancing age, say 65 or 70 years old. The Narrative is older than Shakespeare's Seven Ages of Man soliloquy that ends with "Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion, sans teeth, sans eyes, sans taste, sans everything."

Practical implications of this biased assumption during this pandemic translate to triaging our focus, resources, and treatments to make older adults last in priority. It's no coincidence that older adults, especially residents of long-term care facilities, account for such a huge percent of deaths related to COVID-19.

The *New York Times* reported on May 11, 2020 (lifetimes ago in COVID-19 calculus) that, while only 10 percent of the country's cases have occurred in long-term care facilities, deaths related to COVID-19 in these facilities account for more than a third of the country's pandemic fatalities. "In 10 states, the number of residents and workers who have died accounts for half or more than half of all deaths from the virus." Long-term care facilities were often at the back of the line in receiving Personal Protective Equipment (PPEs) from government sources. Very scarce resources were prioritized for acute care. Inadequate numbers of PPEs, close confinement, and concentrations of already vulnerable residents made for a deadly mix. Tragically, the Decline Narrative can affect not only older adults but those of us who care for them.

Louise Aronson, geriatrician at UCSF, asks us in a thoughtful essay in *The Atlantic* (March 28, 2020) to imagine how much different the political and medical responses to COVID-19 would be

if the pandemic were killing mostly young people, for instance, middle schoolers, rather than older adults.

Ageism is baked into our health care system, she notes.

American medicine lumps elders in with adults, despite plentiful evidence that drugs and diseases behave differently in older bodies. “Atypical presentations” of illnesses and of responses to medicine are common in older adults, wherein the traditional core features of an illness are missing, for example, having a fever without having a high temperature, or having adverse drug reactions to a medicine or greater sensitivity to its intended effects that are not seen when the person taking the medicine is younger.

Aronson anticipated the more deadly impact of COVID-19 on older adults, and ascribes contributing factors. “Medical schools devote months to teaching students about child physiology and disease, and years to adults, but just weeks to elders; geriatrics doesn’t even appear on the menu of required training. The National Institutes of Health mandated the inclusion of women and people of color in medical research in 1986, but it didn’t issue a similar mandate for elders until 33 years later, in 2019.”

I spent six years traveling with Remington Award winning professor of pharmacy Dr. Peter Lamy in our rural geropharmacy training projects; I heard him lament repeatedly that older adults were rarely, if ever, included in the clinical trials of would-be prescription drugs, even though older adults account for the greatest use of so many of them. Instead, assumed effectiveness and dosage efficacy were “extrapolated” statistically from data on younger adults. Companies opted not to spend time or money securing older adults for these tests.

People age 65 and older are at higher risk for COVID-19, declares a June 29, 2020 report from AARP. As are people with chronic medical conditions like heart and kidney diseases, diabetes, and respiratory illness. As AARP notes, “Both groups are heavily represented among the nation’s 1.3 million nursing home residents. That concentration is a key reason why 2 in 5 U.S. deaths from COVID-19 have occurred in nursing homes and other long-term care facilities, according to tracking by the Kaiser Family Foundation, but it’s not the only one.” Other conditions at nursing homes can worsen the spread of the disease, like shortages of coronavirus tests, shortages of or lack of access to personal protective equipment (PPE) such as masks and gowns, understaffing, and employees who work in multiple facilities, often because of low wages for aging-related care, thereby increasing chances for exposure.

COVID-19 has empowered those who exploit or mistreat older adults, as well.

AARP has reported a significant increase so far this year in frauds and scams perpetrated against older adults, preying on their isolation and health concerns. These include fake vaccines and COVID-19 tests, and stimulus check scams that ask for call backs to verify personal information.

Recently, in the *Journal of Applied Gerontology* (May 8, 2020), Alyssa Elman and 15 co-authors have contributed “Effects of the COVID-19 Outbreak on Elder Mistreatment.” They note that COVID-19’s social distancing requirements have increased social isolation for many older adults, and closures of group venues like senior centers and communities of faith have, among other things, taken away traditional safety checks that participation in these activities might

normally provide older adults. Those receiving care at home from visiting home health aides have found visits cut or eliminated, at the choice of the aide or the aide's agency or the older adult's family, in order to decrease risk of exposure to the COVID-19 virus. In any event, the informal caregivers end up shouldering greater responsibility, perhaps perceived as burden, for chronic care and there a fewer outside parties to witness or mitigate stressful encounters. As a result, potentially neglectful or abusive scenarios are neither prevented nor detected.

Stay-at-home orders have correlated with significant increases in reported cases of domestic violence and calls to hotlines in countries that have experienced the pandemic earlier, such as France and Spain, according to a recent *New York Times* report by Amanda Taub (April 14, 2020).

Elman and colleagues report on challenges and responses to preventing and treating elder mistreatment in New York City. There, such hospital- and emergency department-based elder abuse intervention programs as the Vulnerable Elder Protection Team at New York Presbyterian/Weill Cornell Medical Center have had to reduce the services they provide and reassign health care providers who work within the program in order to provide care for COVID-19 patients

In NYC, APS workers shifted to virtual visits but these can be compromised if a victim of elder mistreatment is on a tele-visit while the perpetrator is in the same room, or even more basically, if the older adult simply lacks the technological equipment to have the tele-visit.

Ombudsman programs are not allowed to enter facilities during the crisis because the Center for Medicare and Medicaid Services (CMS) has banned these visits. They must, instead, rely on phone calls or teleconferencing to connect with residents. And, if the residents don't know how to call the Ombudsman for help, they are left vulnerable.

Elman et al. do share some promising initiatives: an emergency food program to ensure that basic needs are met during COVID-19, with taxis delivering food to older adults, free of charge; senior centers calling their participants regularly to make sure that they are receiving meals; public benefits, such as food stamps, now being accessible online and by phone, with agency staff providing assistance to those needing help managing their case or applying by phone.

The authors encourage regular, interdisciplinary meetings among those seeking to prevent or respond to elder mistreatment and vigilance by Adult Protective Services through virtual and in-person visits with at-risk older adults. Of course, this vision can be hampered when Adult Protective Services receive just pennies for each dollar allocated Child Protective Services, which is the norm across the country.

Greater awareness of biases in health care and protective services are needed. The pandemic is worsening across the United States. Ageism is not going away but at least COVID-19 has unveiled some of its manifestations. If we care to look.