Ageism, covidical syndemic and Intervention Bioethics: an interdisciplinary concreteness

Ageísmo, sindemia covídica e Bioética de Intervenção: uma concretude interdisciplinar

Ricardo Henrique Vieira de Melo[1], Karla Patrícia Cardoso Amorim[1]

DOI: 10.1590/0103-1104202213319I

ABSTRACT This is a critical-reflexive theoretical study with the aim of reflecting on issues of an interdisciplinary nature: ageism in the complexity of the COVID-19 pandemic in the light of the fundamentals of Intervention Bioethics. The assumption is that complex problems require complex solutions, which a fragmented, disciplinary view is not capable of addressing. For this purpose, the essay is organized in three acts: ageism as an old and persistent phenomenon; the COVID-19 pandemic and the expansion of ageism; and the bioethical approach as an episteme and interventional tool. It is hoped that this theoretical exercise can transcend into personal, relational, and institutional daily life, where understanding the dimensions and determinants of ageism can incite creative ethical thoughts, feelings, and attitudes to mitigate age-related derogatory aspects.

KEYWORDS Ageism. COVID-19. Bioethics. Aging.

RESUMO *Trata-se de um estudo teórico crítico-reflexivo com o objetivo de refletir sobre questões de natureza interdisciplinar: o ageísmo na complexidade da pandemia da Covid-19 à luz dos fundamentos da Bioética de Intervenção. Parte-se do pressuposto de que problemas complexos requerem soluções complexas, os quais uma visão fragmentada e disciplinar não é capaz de enfrentar. Para isso, o ensaio está organizado em três atos: o ageísmo como fenômeno antigo e persistente; a sindemia covídica e a ampliação do ageísmo; e o enfoque bioético enquanto episteme e ferramenta interventiva. Espera-se que este exercício teórico possa transcender para o cotidiano pessoal, relacional e institucional, onde a compreensão sobre as dimensões e os determinantes do etarismo possa incitar pensamentos, sentimentos e atitudes éticas criativas para mitigar aspectos depreciativos relacionados à idade.*

PALAVRAS-CHAVE *Ageísmo. Covid-19. Bioética. Envelhecimento.*

[1] Universidade Federal do Rio Grande do Norte (UFRN) – Natal (RN), Brasil.
ricardohvm@gmail.com

This article is published in Open Access under the Creative Commons Attribution license, which allows use, distribution, and reproduction in any medium, without restrictions, as long as the original work is correctly cited.

Introduction

Ageism is a complex phenomenon, with multiple dimensions and determinants, characterized by stereotyping, prejudice, and discrimination directed at people in relation to age. Its occurrence in the organizational sphere refers to the laws, rules and social norms, policies, and practices of institutions that restrict opportunities because of age. In addition, it can appear in the interpersonal sphere when it emerges in social interactions between two or more people. Finally, it is also possible to occur in a self-directed way from the internalization of ageism by the subject, against oneself[1-3].

Understanding the human aging process can contribute to reducing prejudices. The greater the demonstration of negative attitudes towards aging, the greater the ageism, because the attitudes of a person or a group of people towards something can be favorable or unfavorable and are influenced by past experiences, feelings, cognition and affection, which, in turn, modulate behavior. In this sense, perceptions and (discriminatory or evaluative) attitudes towards the elderly (and/or young people) are influenced by personal and relational social constructs[4,5].

The COVID-19 pandemic, which is currently one of the largest public health issues on the planet, despite affecting people of different ages and in different ways, has included older people in a vulnerable group, because they are considered at greatest risk to develop the severe form of the disease and present higher mortality rates. Consequently, there is an outbreak of ageism, which causes intergenerational divergences, blaming the elderly for the burden of the health system, distributing resources for the care of young people and the most productive population[6].

In this perspective, bioethics deals with knowledge at the crossroads of several disciplines, suggesting an interdisciplinary or even transdisciplinary conception. The simple statement of bioethics convinces, however, that no discipline can account for the plurality of necessary clarifications, because the notion of life, its central point, is an excellent proof of this. Intervention Bioethics (BI), a theoretical model that originated in Latin America, contributes, with its inter/transdisciplinary epistemology, to everyday thinking, feeling, and acting, to understand and face the persistent dilemmas about social, health, and environmental issues, establishing a dialog with the various fields of knowledge from a transformative perspective[7].

The terms interdisciplinarity, multidisciplinarity or polidisciplinarity and transdisciplinarity are polysemic and fluid[8]. Morin[8] argues that when interdisciplinarity means exchange and cooperation between disciplines, it becomes something organic. With regard to transdisciplinarity, this "is usually characterized by cognitive schemes that cross the disciplines, sometimes with virulence that puts them in a trance"[8(34)], because "science would never have been science if it had not been transdisciplinary"[8(34)]. The philosopher completes this reasoning by stating that not only the ideas of inter- and transdiciplinarity are important, but also everything that is contextual related to it; that is, one must 'ecologize' the disciplines.

Based on these perspectives, this essay, which is part of a doctoral thesis of the Graduate Program in Family Health in the Northeast – of the Northeast Network of Family Health Training (Renasf), at the Federal University of Rio Grande do Norte (UFRN) – aims to reflect on ageism in the complexity of the COVID-19 pandemic in the light of the assumptions of IB, themes of an interdisciplinary nature.

Therefore, the text is organized into three acts, by articulating: ageism as an old and persistent phenomenon, covidical syndemia, and the expansion of ageism, and the bioethical approach as an episteme and

interventional tool. The assumption is that complex problems require complex solutions, which a fragmented, disciplinary view is not capable of addressing.

It is hoped that this theoretical exercise can transcend into personal, relational, and institutional daily life, where understanding the dimensions and determinants of ageism can incite creative ethical thoughts, feelings, and attitudes to mitigate age-related derogatory aspects.

Ageism as an ancient and persistent phenomenon

Aging "is surrounded by social determinants that make conceptions about old age vary among individuals, from culture to culture, from time to time"[9(12)]. Therefore, it is impossible to think about this process, in its motor, functional and psycho-social aspects, without understanding each context in which it is inserted.

Considering that the aging process occurs in contexts of marked social, economic, cultural, and environmental transformations, in the face of technological advances, changes in marital arrangements, and in the composition of families, among others, Beauvoir[10] points out that the logic of productivist socio-cultural structuring, inspired by profitable utilitarianism, oppresses old age, mitigating the reach of longevity.

In this context, Debert[11] considers that the so-called old age is an invention resulting from a growing process of managing old age, transforming it from a private/family situation into a public condition. As a consequence, the aging process is homogenized, inducing a homogenization of the aging process for state interventions and for openness to market and to the consumption of products and services, reducing the uniqueness of older subjects and, by derivation, intergenerational solidarity.

Considering, on the one hand, that aging can be valued by the wisdom and social values of the elderly, on the other hand, it can be perceived as social devaluation, unproductivity and financial burden (social security, for instance), when considering the elderly as an unnecessary expense for the family or the State. Therefore, the quality of life during old age permeates the individual and family acceptance of this elderly, as well as the fact that acceptance and appreciation also come from society itself, which makes its choices, favoring some over others[12].

More cohesive and productive societies are known to have less violence and social dysfunctions. In developed countries, people get richer first and then get older, unlike what happens in developing countries, due to the persistence of inequality contexts, accentuating crises that compromise the quality of longevity. However, the elderly can also be seen with economic importance, contrary to the neoliberal hegemonic thought that they are unproductive[13].

Butler[14] presented the English term 'ageism' to configure antipathies and contact escapes based on myths, capable of producing prejudices and discrimination against older people, repressing social interactions and consequently hindering the understanding of the aging process. In Portuguese, the words '*idadismo*' and/or '*etarismo*' are usually used as synonyms of ageism (both for the youngest and for the oldest), and the use (exclusive to the oldest) of the words '*idosismo*' or '*velhismo*' is unusual.

Currently, the term 'ageism', although recent, represents an old phenomenon that is not only related to older or elderly people, but to any age, including younger people. Among its determinants are: age; gender; education; anxiety; fear of dying; personality types; contact with older (intergenerational) age groups; how to deal with the aging process; proportion of older adults in the region; life expectancy; mental and physical health, among others. Therefore, it is a common problem, albeit shady, that

can affect people, institutions, and the way of thinking about social policies[1-3].

Considering that most people, especially the elderly, report experiences of depreciation related to age in social contexts (jokes, indifference, insults, paternalism, infantilism, association with limitations or disabilities, etc.), the occurrence of ageism can be considered a form of violence. In this sense, the use of instruments for identification and/or measurement is important to diagnose situations and plan interventions capable of preventing or minimizing ageism, stimulating equal opportunities at all ages[4].

In the Brazilian reality, Schumacher et al.[15] affirm the need to carry out investigations on this object to assimilate the divergences and similarities of the results in different contexts, since the measurement and discussion of prejudiced conceptions and attitudes could contribute to the construction of a more harmonious and evaluative environment of intergenerational diversity.

In the context of human relations, including in the work environment, Sato et al.[16] emphasize the importance of studies focused on this theme to know the demands of workers and give greater visibility to the interactions between the aging process and work. In addition, there is a lack of investigations and actions on ageism, especially research on prejudiced attitudes against older workers, including instruments that can identify it in institutions and actions aimed at reducing it.

Regarding age stratification, the term 'elderly' was created in France in the 1960s, replacing derogatory expressions such as 'old' or 'old person', historically linked to negative aspects, such as: inactivity or disease. Another adjective, called 'young elderly', refers to the concept of the elderly for the age group between 60 and 80 years old, while 'old elderly', from 80 years old on, is traditionally associated with the image of decay or mental and physical incapacity. In addition, there are several age-related classifications (*table 1*), mainly due to lifestyle habits, consumption patterns, skills with new technologies or work profile[17].

Table 1. Cohorts of generations and times according to global and Brazilian reality. 2021

Generation	Birth	Current age in years
Veterans/Belle Époque/Traditional	1920 to 1940	81 to 101
Fourth Age	1941 and earlier	80 and more
Vargas Era	1930 to 1945	76-91
Baby Boomer/Woodstock	1940 to 1960	61 to 81
Elderly	1956/1961 to 1940	60/65 to 79
Post-War	1946 to 1964	57 to 75
Optimism	1955 to 1967	54 to 66
Iron Age	1968 to 1979	42 to 53
Middle age	1981 to 1962	40 to 59
Perennials/Ageless	1965 onwards	56 and under
Ephemerals/Ageless	1965 onwards	56 and under
Generation X	1960 to 1980	41 to 61
Forties	1976 to 1986	35 to 45

Table 1. (cont.)

Generation	Birth	Current age in years
Lost Decade	1980 to 1991	30 to 41
Be yourself	1992 onwards	29 and under
Generation Y/Millennials	1980 to 1995	26 to 41 years
Old Millennials	1980 to 1990	31 to 41
Young Millennials/Generation W	1990 to 1995	26 to 31
Generation Z/GenZ/Centennial	1995 to 2010	11 to 26
Generation Alpha/Generation M (Mobile)	2010 onwards	11 and under

Source: adapted from Motta et al.[18]; Zomer et al.[19]; Anaya-Sanchez et al.[20].

An example that ageism permeates the various age strata can be observed between generations Y and Z. The latter is stereotyped as the 'zombie generation' by the first. They are called 'zombies' because they walk in groups, have an insatiable hunger (consumption) (which is irreversible and unsustainable), contaminate themselves with each other, etc. The latter, on the other hand, refers to the first as 'cringe', which means 'embarrassed', for maintaining habits considered, by some, as obsolete – such as: paying bills using bank slips, consuming coffee; and painting/using French tip nails, among others[18-20].

Thus, ageism is as old as conflicts and negotiations of interests between young people, adults and the elderly are because of symbolic and/or material power relations and prestige. Therefore, since time immemorial, in all latitudes and longitudes, in face of situations in which crises occur, with or without deprivation or imminent danger of death, adults do not hesitate to initially prioritize children and young people and then consider the elderly later[12].

The internalization of ageism by the elderly is not uncommon, as they end up thinking that the acceptance of derogatory and paternalistic treatments they receive from people, institutions, (public and private) services, and social networks is normal. This naturalization is silent and dangerous because it amplifies stereotypes, making them expected attributes in relation to the elderly, including the elderly themselves. Thus, older people receive unequal treatment and access with regard to social rights and opportunities, based on ageist criteria and the fallacy of the homogenization of aging, which considers the elderly a fragile, dependent, unproductive and helpless person[13].

Ageism can also be understood from the perspective of productivity ideology in the face of neoliberal capitalist demands that minimize the life stories of the elderly, reducing their networks of solidarity and support, intensifying social inequalities, financial and educational difficulties, often reflected in barriers of gender, color/race and skin texture of the elderly, sometimes dried out by social roughness, by remembering finitude or identity invisibility that oppresses and excludes[13].

In the logic of market laws, the social security system considers the elderly as permanent expenditures for good citizens, who contribute to the progress of the capitalist nation. With this, instruments are elaborated to let live and to make die, in the gap between being and feeling productive or expensive to the system, therefore, producing conditions for physical and/or social survival or death[21].

The covidical syndemic and the expansion of ageism

The ageist discourse became, literally, more 'viral' in social networks also in the Brazilian society during the emergence of COVID-19, initially considered as a disease of the elderly, being strongly recommended to keep, and often 'arrest' or 'lock' the elderly at home. The positive representativeness of the elderly was replaced by derogatory stereotyping, disseminated along with measures to contain the new coronavirus, such as physical and vertical distancing, which also sometimes promotes neglect, loneliness, social isolation, depression, anxiety, and physical and psychosocial abuses[22].

Considering that, before the arrival of the new coronavirus, the seniors already dealt with feelings of loneliness, physical distancing, which in the imagination of the common sense is called 'social isolation', has collaborated to reduce social relations and support networks, enhanced by the feeling of mourning for the loss of family members and loved ones, minimizing the feeling of belonging to their homes and places, intensifying suffering. The challenge is to find new arrangements for intergenerational sociability and solidarity[22,23].

It is a consensus that the COVID-19 pandemic, which arrived in the country and collapsed the health systems of several cities, explained several facets of persistent ageism in Brazil. This issue should be discussed more frequently, in the

> illusory sovereignty of the living who will one day be the next dead, capitalizing social prestige to the office of the providers of life, but also of the caregivers of death[24 (550)].

In turn, social media have advanced considerably in the dissemination of information, as a means of communication, boosting the need to monitor the content of fake news in view of its rapid dissemination in several channels. Thus, in parallel to the official news published in traditional and reputable vehicles, the circulation of audios and fake videos with mistaken recommendations, often intentionally, simulated supposedly true content, distorting their sources as if they were from public prestigious institutions[25].

In addition, the Social Determinants of Health (SDH) emerged in partnership with the pandemic, enabling the Coronavirus to find a fertile territory in inequalities and social injustices so that it could operate its desolate itinerary more efficiently. Blame cannot be outsourced by attributing to the virus the social discrimination that humans make, for example, intertwined in nationalism, racism, xenophobia and capitalism, so that the advance of COVID-19 increasingly combines the characteristics of a class, gender and race pandemic[26].

The topic 'pandemic' has spread in the news and in the conversation circles between friends, neighbors, family, co-workers and in the speeches of politicians and managers. In this sense, there is much to be done beyond the financial sphere. Human investment is needed to broaden the understanding of this complex reality, especially in relation to those who advocate the reduction of social policies and who reveal difficulties in recognizing solidarity with the most economically vulnerable communities[6].

The synergistic character between diseases and social problems makes up a complex network of links and determinations, called 'syndemic' (combining the terms 'epidemic' and 'synergy'), indicating that epidemics can overlap each other under social, environmental and cultural factors conducive to the development of certain diseases. In this sense, a syndemic occurs based on the interaction of two or more diseases in a social context harmful to public health, due to the synchrony between

biological elements and social disparities, which amplify the effects, especially in more vulnerable groups[27].

Therefore, it is a synergy between individual and collective determinants and health conditions, influenced by pathogenesis, transmissibility, prevention, therapy, and prognosis of emerging and/or persistent health problems; sociocultural aspects (habits, beliefs, values, education); population structural elements (demographic, age, economic, migratory); and environmental conditions, such as pollution, depletion of natural resources, and climate change[28].

Designating the COVID-19 pandemic as a syndemic is not fad, as it amplifies the understanding of the problem towards a more comprehensive and effective confrontation, reorienting the traditional approaches of collective health, including ageism, assuming its complex, polysemic, and polymorphic character, as an articulated manifestation of phenomena, which are at the same time synergistic and antagonistic, multidimensional, multifactorial, and interdisciplinary[29].

In Brazil, currently, Veiga-Neto[29] identifies five types of synergistic crises: covidical, economic, political, ethical, and regarding stupidity. This combination becomes even more complex due to a world increasingly connected, permeable and open to the free circulation of information of all kinds, both good and bad, as well as false news, lies, orientations and disorientations, often rude or well elaborated, broad, critical or uncritical, but equally issued, disseminated and going viral.

Part of this stupidity stems from poorly prepared and uncritical profiles of consumers of information and contents viewed, read or heard, absorbed as if everything were, a priori, lie or truth, often presented in an apparently plausible, intentional, intuitive way to deceive or confuse. Certainly, these aspects leave part of the population at the mercy of external influences, drifting, erratic, biased to change their opinion based on manipulation and not on criticality or reflection[29].

In a recent integrative review, Silva et al.[30] pointed out some impacts of social isolation and the use of technologies and social media on intergenerational relations in the COVID-19 scenario, as well as criticized the allocation of resources and intensive care based exclusively on age criteria. Most publications indicated that ageism has always been present in society; however, it was more evident during the new coronavirus pandemic, in the form of discrimination against the elderly.

In this sense, ageist discourses negatively influence the lives of the elderly, causing social and psychological losses. The treatment given to the elderly, in the pandemic context, confirms the more common occurrence of ageism in relation to the older than related to the younger, probably by the combination of the greater biological vulnerability and the lower political power of the elderly when compared to the latter[30].

Nowadays, regardless of pandemics, most of the elderly are increasingly faced with the possibility of living alone, with fewer opportunities for social interaction, as they spend more time at home and increasingly less time in social and recreational activities, due to the difficulties of accessibility. In addition, this audience uses less instant communication applications for information, purchases, contacts and for fun. All these things increase the risk of loneliness due to social and physical distance exacerbated in the COVID-19 syndemic[31].

Considering social isolation as the absence of contact or social communication or participation in social activities, its occurrence is associated with a one-third increase of mortality, so that emotional loneliness emerges as a personal experience of producing negative feelings (lack of interest, boredom, fatigue and apathy), which amplify pain, insomnia, lack of appetite and sedentary lifestyle, increasing the possibility of evolution to depression and mental suffering[32].

Reformulating it as a syndemic allows the aforementioned aspects to be considered as non-isolated parts of a larger problem that affects the whole world, which goes beyond individual injuries and specific care with diseases to general care with human and environmental health, seeking to identify biological, social, cultural, political, economic and environmental interactions, specifically in developing countries, where educational problems, unemployment, lack of basic sanitation, waste treatment, etc., persist. In this context, this complex of problems that amplify the existing and persistent complications and difficulties can generate a kind of biopolitical catastrophe, whose difficult solution will require attitudes that are equal, in ways of seeing, being and acting biopolitically[33].

In the field of biopolitics, on the one hand, there is the articulation of astute or unprepared managers, with good intention or not, and, on the other hand, the governed ones, partly uninformed or indifferent to learning and to the need to develop stances and morally justifiable ethical conduct, according to principles structured in a historical-social way, to promote mutual, respectful and supportive mutual recognition. Therefore, sharing without being charitable, based on the capacity for listening and reflection, centered on the power of the encounter, on the 'governmentality' that connects the government of oneself with the government of others[29].

In fact, more than ever, it is essential to consider the need to think, feel and act through the proposition of biopolitical and/or bioethical measures to face both the manifestations of covidical syndemia and ageism, to mitigate its multifactorial determinants in its various dimensions. As the narrative of each government has been of confrontation, either denying or being indifferent to the pandemic, COVID-19 has amplified ageism, especially in relation to those over 60 years old, from invisibility to a widespread opening and on a global scale[28].

In this sense, the frequent representation of the elderly in the context of the covidical syndemic exposes them as a risk group, as if this public were a homogeneous stratum of the population formed only by defenseless, vulnerable people with protection needs who, in a contradictory way, will not receive adequate attention due to the prioritization of care for the younger people[28].

Ageism linked to COVID-19 can affect the mental health of older people during social distancing, as it is already expected, of course, that the elderly isolate themselves, regardless of whether or not they have any health condition. In addition, many of them feel they are a burden to society, increasing the feeling of frustration and depression, also due to the demonstration of indifference, by people and institutions, regarding the number of deaths of the elderly due to the pandemic[28].

One of the possible solutions permeates the proposition and dissemination (viralization) of initiatives to value spaces, autonomy, dignity and opinions led by older people so that they feel welcomed and perceived by society as active, independent, critical, productive and digital citizens, and not just a heavy amorphous mass.

After all, the lack of appreciation of aging by society makes this same society a tormentor of itself, disregarding its own aging process by disseminating several manifestations of ageism or infantilizing the image of the elderly. The world urgently needs longevity activists.

The bioethical approach as an episteme and inter/transdisciplinary interventional tool

An 'ethical' questioning occurs when it relates to everyday human action involving

– in whole or in part – people, collectivity, and the environment. Therefore, an ethical posture combines existential behaviors and discernments, modulating social relations to harmonize personal and collective interests associated with quality of life. In addition, bioethics – while applied ethics – is concerned with the limits and purposes of human action (intervention) on life, understanding conflicts to find plausible consensus in each situation analyzed[34].

Considering that human expertise develops criteria for ethical framing centered on the benefit and cohesion of society, ethical acts (free, voluntary and conscious) should be: performed by subjects with freedom of thought and without coercion of any kind; and based on the perception (awareness) of the existence of conflicts, with free positioning between emotion and reason (autonomy) and with emotional maturity, coherence, and social repertoire[35].

The proposal of the current of thought called 'Intervention Bioethics' is to be an instrument of reflection on persistent and/or emerging bioethical problems contextualized in scenarios of social inequalities, such as Latin America and other countries in the Southern Hemisphere. The IB contemplates in its scope a perspective of critical social justice that challenges the social, cultural, economic, scientific, and environmental neocolonialism of developed countries over developing countries[36].

Among the assumptions of the IB are: political awareness of moral dilemmas in circumstances of social exclusion, thought according to the reality of the Southern Hemisphere; dialogicity in permanent construction, sustained by solidarity committed to the daily and evaluative differences; the proposal of transformation through social mobilization in democratic spaces of encounter, reflection, contestation, and negotiation; a decolonized consequentialism concerned mainly with the persistent problems that should no longer happen in contemporary times, such as racism, sexism, and ageism[37,38].

Therefore, there is a proximity of the scope of IB to the field of collective health, by stimulating the exercise of citizenship to achieve justice as equity, entwined in a capillarity of transdisciplinary knowledge, expanding interdisciplinary views on conflicting aspects about the complexity of life in multiversal societies. In addition, both support their constructions in the reflections of human actions on the challenges of concrete social situations demanding responsible transformative attitudes (personal, social, sanitary and ecological), through applied ethical interventions[7,39].

It is believed that the bioethical debate about the values that permeate the stigmatizing issues of ageism could help in the visibility of this problem, minimizing the vulnerabilities that mainly affect the elderly. Therefore, IB and collective health share the same militancy as episteme and tools of inspiration and application (intervention) of strategies capable of contributing to reducing social inequalities, as well as mitigating the determinants and conditions of ageism in its institutional, personal and self-inflicted dimensions, proposing pacts and resignifications, balancing its relations of power[40].

For this, IB considers the individuals of society as protagonists, with critical awareness and committed to social participation, for the equitable achievement of rights that ensure the reciprocal recognition of people and groups, honoring their diversities and their values[41,42].

Given the context of the COVID-19 syndemic, stereotyping and age-based stigmatization demanded important ethical discussions. Initially, due to the imminent risk of overload and collapse in access to health systems, the debate was about the allocation of health resources primarily for younger and adult users, feeding the fundamental ethical dilemma about the right to

life and the right of some professional(s) to decide who should live or die[30,43].

To paraphrase Singer[44], when he argues about the lack of intrinsic difference between killing and letting die, there is no intrinsic ethical meaning between discriminating and letting discriminate. Therefore, consequently and apparently, in the face of everyday situations in which thoughts, feelings or derogatory attitudes related to people's age are identified or perceived, all of them would be ageist.

Among the most evident ethical dilemmas during the COVID-19 syndemic, initially, the classification of utility screening emerged, regarding access to biomedical equipment, in three possible situations, contextualized in the face of the scarcity of resources: people likely to survive without medical care; individuals with chances of survival if they received medical assistance, and those who, even if they received care/medical assistance, would not survive. Faced with this dilemma, in many places, only the subjects classified in the second alternative described above received medical assistance. In this situation, the consensus reasoning was the utilitarian idea of balancing limited resources as effectively as possible[45].

The persistent ageism made it difficult to achieve the fullness of rights: health; access; justice; and dignified life (and death). The logic of selecting bodies (especially of the elderly) as disposable has transferred the celebration of the conquest of increased life expectancy, verified in the demographic transition, to stigmatization as a financial burden supported by social security, as well as in relation to the abandonment or absence of the government in ensuring the protection of the elderly, with the argument that their death in the pandemic would represent savings to the public administration and social security. Consequently, the COVID-19 syndemic has exacerbated, in Brazil, the psychological, economic, cultural, and physical abuses already existing and, now, more than ever, persistent[45,46].

Returning to the issue of occupancy of scarce beds in Intensive Care Units (ICUs) and access to airway devices, the depreciation related to the elderly contributed to model social practices when it predominantly associated lifetime as a social evaluative criterion for each one, so that protocol decisions may contain implicit biases disregarding the diversity and pluralism of aging. In this sense, protocols that incorporate, in a reductionist or simplistic way, decisions contrary to older people, without taking into account the complexity of the other aspects, can act as instruments in the service of an ageist necropolitics[47].

Lloyd-Sherlock et al.[48] point out the need to recognize the singularity of old people, which should be considered in the preparation of local, national, and international plans to face the new coronavirus, since the risk of death from COVID-19 increases with age, to avoid the application of discriminatory criteria, due to the impossibility of meeting all of them. In this context, bioethics is indispensable to stimulate pertinent reflections seeking coherent alternatives.

Some situations should be considered in the context of developing countries, because of the risk of increasing inequality of access and marginalization of the elderly: the family dynamics in which parents work far from their homes, leaving their children with their grandparents while they are at work, a fact that hinders physical distance; the significant number of elderly people residing in long-term care homes (senior homes), which require health inspection so that they do not become infection incubators; the ability of health systems to deal with increases in demand, especially in situations that require respiratory support, particularly in relation to older people, in the face of equipment and capacity restrictions, and the number of health workers with adequate expertise to face, in a timely manner, the challenges of the syndemic[48].

Therefore, the allocation of resources and opportunities for access to health based

only on age are characterized as ageism, because even in situations considered critical, other parameters should be required, such as clinical limitations, vulnerabilities, functionalities/capacities, and comorbidities. Everyone has the right to live, and quick decisions should be made by the team, together with the user and their family. Appropriate communication between all those involved is becoming increasingly important to improve the understanding of the heterogeneity of aging, renouncing stereotypes related to old age[30].

Intergenerational tension, characterized as a conflict between people of different generations, was usually manifested in the form of anger, hatred or cancellation on social networks, for example, due to the resistance of some regarding the use of masks or the lack of adherence to distancing measures. In addition, the way health professionals consider aging and the elderly can determine and influence the care and treatment that old people receive[49].

In addition, in the covidical syndemic, in some territories, the premise that the elders have already lived their lives sufficiently was established, so it was now time to renounce their autonomy, independence and their social needs. These facts indicated a marked difference in life prospects, as well as an increase in animosity between generations, when based in a simplistic way only related to age, as a kind of risk and lethality marker[43].

With the emergence of moral conflicts related to the value of the life of the elderly, some observations based on ethics and knowledge about healthy aging to combat ageism during the COVID-19 syndrome stand out: the elderly are part of a heterogeneous stratum, with health and functionality much better than what negative stereotypes suggest; age limits/barriers for access to health services, as well as to intensive care and other forms of medical assistance, are inappropriate and unethical; the derogatory view of old age is dangerous for the elderly and for society itself, which also ages; solidarity between generations must be strengthened; one must resist to paternalistic or childish attitudes related to the elderly, and the COVID-19 crisis requires the use of modern information and communication technologies among the elderly[50].

Primary Health Care (PHC) is important as a scenario to identify, prevent and cope with manifestations of ageism, in the sense of improving health surveillance actions, by linking communities more closely, such as the Family Health Strategy (FHS) teams, especially by Community Health Agents (CHAs), who work daily in the territories. Therefore, PHC needs to be considered from a more comprehensive approach, generating information and knowledge about the unique aspects of life in all its stages and ages[51].

The perennial capillarity among workers, users, and managers, in PHC and SUS, helps us to think about joint coping strategies, establishing lines of care in the local and intermunicipal health network, based on interprofessional work, with articulated intersectoral partnerships, in more emphatic actions that are not only at the level of discourses and that have, in fact, an interventional and transformative component inspired by the references of IB[36,38,52].

The current global and local crisis is syndemic, sanitary, political, economic and social, and requires innovation in the modes of operation and radicalization of the logic of community intervention in the exercise of new forms of sociability and solidarity. The PHC has in its favor the proximity of knowledge of the territory, access and the link between users and their health teams, in the integrality of care, in the monitoring of vulnerable people and families and in the monitoring of suspected and mild cases, fundamental to contain the pandemic and to avoid the worsening of people with the

disease. This capillarity can be decisive in raising awareness and respecting the mitigation strategies of ageism[6,51,52].

Final considerations

This article articulated aspects of ageism related to the COVID-19 syndemic, considering the references of IB as an epistemological current and an interventional tool approaching knowledge to the scope of collective health. The theoretical exercise of addressing complex problems from the perspective of interdisciplinary dialogues is discussed: the covidical syndemic for bioethical confrontation and understanding of ageist determinants and conditions.

The confrontation of ageism must occur from the implementation of perennial public policies aimed at intergenerational well-being, in addition to an education that rescues human respect, the appreciation of the elderly, while equally preparing the younger people to age in a healthy way, with intergenerational solidarity and respect for rights and life.

The critical-reflexive nature sustained by important theoretical assumptions that allow analyzing several critical sociocultural and comprehensive points in public health is emphasized, bringing to light this topic that is still little discussed in relation to the COVID-19 syndemic in Brazil and worldwide. It is necessary to increase efforts to reduce ageism, as well as the responsible dissemination of information about this harmful practice.

From a practical point of view, it is hoped that the article can encourage discussion on the topic in society and stimulate the implementation of practices to mitigate ageism, in order to stimulate ethical acts of reconnection that are responsible and capable of expanding knowledge, skills, and competencies to develop and apply plausible intergenerational interventions based on the ethics of life.

Acknowledgments

Pro-Rectory of Graduate Studies of the Federal University of Rio Grande do Norte (UFRN); Northeast Network of Family Health Training (RenasF); and Coordination for the Improvement of Higher Education Personnel (CAPES) – Brazil.

Collaborators

Melo RHV (000-0003-0595-6020)* and Amorim KPC (0000-0003-4047-6073)* have equally contributed to the preparation of the manuscript. ■

*Orcid (Open Researcher and Contributor ID).

References

1. Officer A, Thiyagarajan JA, Schneiders ML, et al. Ageism, healthy life expectancy and population ageing: how are they related? Int. J. Environ. Res. Public Health. 2021 [acesso em 2020 out 25]; 17(9):3159. Disponível em: https://pubmed.ncbi.nlm.nih.gov/32370093/.

2. World Health Organization. Decade of healthy ageing: baseline report. Geneva: World Health Organization; 2020.

3. World Health Organization. Global report on ageism. Geneva: World Health Organization; 2021.

4. França LHFP, Siqueira-Brito AR, Valentini F, et al. Ageism in the organizational context – the perception of Brazilian workers. Rev. bras. geriatr. gerontol. 2017 [acesso em 2021 out 25]; 20(6):762-772. Disponível em: https://doi.org/10.1590/1981-22562017020.170052.

5. Ridgway V, Mason-Whitehead E, McIntosh-Scott A. Visual perceptions of ageing; A longitudinal mixed methods study of UK undergraduate student nurses' attitudes and perceptions towards older people. Nurse Educ. Pract. 2018 [acesso em 2021 out 25]; 33(s.n.):63-69. Disponível em: https://pubmed.ncbi.nlm.nih.gov/30245188/.

6. Sousa AJ, Torres AA, Araújo MM, et al. Atenção primária à saúde e covid-19: uma revisão integrativa. Cadernos ESP. 2020 [acesso em 2021 out 25]; 4(1):45-52. Disponível em: https://cadernos.esp.ce.gov.br/index.php/cadernos/article/view/313.

7. Silva LES, Drummond A, Garrafa V. Bioética de intervenção: uma prática politizada na responsabilidade social. Universitas: Ciências da Saúde. 2011 [acesso em 2021 out 25]; 9(2):112-119. Disponível em: https://doi.org/10.5102/ucs.v9i2.1510.

8. Morin E. Complexidade e transdisciplinaridade: a reforma da universidade e do ensino fundamental. Natal: EDUFRN; 2000.

9. Secco CLTR. As rugas do tempo na ficção. Cadernos IPUB-UERJ. 1999; (10):9-33.

10. Beauvoir S. A velhice. 2. ed. Rio de Janeiro: Nova Fronteira; 2018.

11. Debert GG. A reinvenção da velhice: socialização e processos de reprivatização do envelhecimento. São Paulo: Editora da USP/FAPESP; 2004.

12. Veras RP, Oliveira M. Envelhecer no Brasil: a construção de um modelo de cuidado. Ciênc. Saúde Colet. 2018 [acesso em 2021 out 25]; 23(6):1929-1936. Disponível em: https://doi.org/10.1590/1413-81232018236.04722018.

13. Moura LBA. A Pessoa Idosa na Área Metropolitana de Brasília: oportunidades e desafios. In: Vasconcelos AMN, Moura LBA, Jatobá SUS, et al., organizadores. Território e sociedade: as múltiplas faces da Brasília metropolitana. Brasília, DF: Editora UnB; 2019.

14. Butler RN. Ageism: a foreword. J. Soc. Issues. 1980 [acesso em 2021 out 25]; 36(2):8-11. Disponível em: https://doi.org/10.1111/j.1540-4560.1980.tb02018.x.

15. Schumacher AA, Puttini RF, Nojimoto T. Vulnerabilidade, reconhecimento e saúde da pessoa idosa: autonomia intersubjetiva e justiça social. Saúde debate. 2013 [acesso em 2021 out 25]; 37(97):281-293. Disponível em: https://www.scielo.br/j/sdeb/a/PpD98dYQWT4hMv8HTFxCknx/abstract/?lang=pt#.

16. Sato AT, Barros JO, Jardim TA, et al. Processo de envelhecimento e trabalho: estudo de caso no setor de engenharia de manutenção de um hospital público do Município de São Paulo, Brasil. Cad. Saúde Pública. 2017 [acesso em 2021 out 25]; 33(10):e00104717. Disponível em: http://dx.doi.org/10.1590/0102-311X00140316.

17. Marques AM. Velho/Idoso: Construindo o sujeito da terceira idade. Rev. Esboços. 2004 [acesso em 2021

out 25]; 11(11):65-71. Disponível em: https://periodicos.ufsc.br/index.php/esbocos/article/view/336.

18. Motta AB. A atualidade do conceito de gerações na pesquisa sobre o envelhecimento. Soc. estado. 2010 [acesso em 2021 out 25]; 25(2):225-250. Disponível em: https://doi.org/10.1590/S0102-69922010000200005.

19. Zomer LB, Santos AR, Costa KCO. O perfil de alunos do curso de administração: um estudo com base nas gerações X, Y E Z. Revista GUAL. 2018 [acesso em 2021 out 25]; 11(2):198-221. Disponível em: https://doi.org/10.5007/1983-4535.2018v11n2p198.

20. Anaya-Sánchez R, Castro-Bonaño JM, González-Badía E. Preferencias del consumidor millennial respecto al diseño de webs de social commerce. Rev. bras. gest. neg. 2020 [acesso em 2021 out 25]; 22(1):123-139. Disponível em: https://doi.org/10.7819/rbgn.v22i1.4038.

21. Krenak A. O amanhã não está à venda. São Paulo: Companhia das Letras; 2020.

22. Bezerra PA, Soares SA, Franco SB, et al. Perfil sociodemográfico e narrativas de pessoas idosas que já viviam a solidão antes da sindemia do Covid-19. REALIS. 2020 [acesso em 2021 out 25]; 10(02):185-196. Disponível em: https://doi.org/10.51359/2179-7501.2020.248751.

23. Moratelli V. O idadismo no contexto da pandemia da Covid-19: como o preconceito etário se tornou evidente no Brasil. RDS. 2021 [acesso em 2021 out 25]; 27(1):9-29. Disponível em: https://doi.org/10.46551/issn2179-6807v27n1p9-29.

24. Maciel WC. Pandemia, necropolítica e purificação simbólica dos cuidadores da morte. In: Grossi MP, Toniol R, organizadores. Cientistas sociais e o coronavírus. Florianópolis: Tribo da Ilha; 2020.

25. Lana RM, Coelho FC, Gomes MFC, et al. Emergência do novo coronavírus (SARS-CoV-2) e o papel de uma vigilância nacional em saúde oportuna e efetiva. Cad. Saúde Pública. 2020 [acesso em 2021 out 25]; 36(3):e00019620. Disponível em: https://doi.org/10.1590/0102-311X00019620.

26. Butler J. El capitalismo tiene sus límites. In: Amadeo P, organizador. Sopa de Wuhan: Pensamiento contemporáneo en tiempos de crisis. Buenos Aires: ASPO (Aislamiento Social Preventivo y Obligatorio); 2020. p. 59-66.

27. Singer M, Bulled N, Ostrach B, et al. Syndemics and the biosocial conception of health. The Lancet. 2017 [acesso em 2021 out 25]; 389(10072):941-950. Disponível em: https://pubmed.ncbi.nlm.nih.gov/28271845/.

28. Horton R. Offline: COVID-19 is not a pandemic. Lancet. 2020 [acesso em 2021 out 25]; 396(10255):874. Disponível em: https://doi.org/10.1016/S0140-6736(20)32000-6.

29. Veiga-Neto A. Mais uma Lição: sindemia covídica e educação. Educ. Real. 2020 [acesso em 2021 out 25]; 45(4):e109337. Disponível em: https://doi.org/10.1590/2175-6236109337.

30. Silva MF, Silva DSM, Bacurau AGM, et al. Ageismo contra idosos no contexto da pandemia da covid-19: uma revisão integrativa. Rev. Saúde Pública. 2021 [acesso em 2021 out 25]; (55):4. Disponível em: https://www.revistas.usp.br/rsp/article/view/184066.

31. Douglas M, Katikireddi SV, Taulbut M, et al. Mitigating the wider health effects of covid-19 pandemic response. BMJ. 2020 [acesso em 2021 out 25]; (369):m1557. Disponível em: https://doi.org/10.1136/bmj.m1557.

32. Smith BJ, Lim MH. How the COVID-19 pandemic is focusing attention on loneliness and social isolation. Public Health Res Pract. 2020 [acesso em 2021 out 25]; 30(2):3022008. Disponível em: https://doi.org/10.17061/phrp3022008.

33. Santos GP, Vitório SC. A sindemia global da covid-19: uma análise sobre vulnerabilidade social e políticas públicas no Brasil. RED/UnB. 2021 [acesso em 2021

out 25]; 1(19):340-371. Disponível em: https://periodicos.unb.br/index.php/redunb/article/view/37292.

34. Fortes PAC. Refletindo sobre valores éticos da Saúde Global. Saúde soc. 2015 [acesso em 2021 out 25]; 24(supl1):152-161. Disponível em: https://doi.org/10.1590/S0104-12902015S01013.

35. Segre M, Cohen C. Bioética. 3. ed. São Paulo: EDUSP; 2002.

36. Garrafa V, Porto D. Intervention bioethics: a proposal for peripheral countries in a context of power and injustice. Bioethics. 2003 [acesso em 2021 out 25]; 17(5-6):399-416. Disponível em: https://doi.org/10.1111/1467-8519.00356.

37. Selli L, Garrafa V. Bioética, solidariedade crítica e voluntariado orgânico. Rev. Saúde Pública. 2005 [acesso em 2021 out 25]; 39(3):473-478. Disponível em: https://doi.org/10.1590/S0034-89102005000300020.

38. Nascimento WF, Garrafa V. Por uma vida não colonizada: diálogo entre bioética de intervenção e colonialidade. Saúde soc. 2011 [acesso em 2021 out 25]; 20(2):287-299. Disponível em: https://doi.org/10.1590/S0104-12902011000200003.

39. Porto D, Garrafa V. A influência da Reforma Sanitária na construção das bioéticas brasileiras. Ciênc. Saúde Colet. 2011 [acesso em 2021 out 25]; 16(supl1):719-729. Disponível em: https://doi.org/10.1590/S1413-81232011000700002.

40. Vieira ABD, Monteiro PS. Comunidade quilombola: análise do problema persistente do acesso à saúde, sob o enfoque da Bioética de Intervenção. Saúde debate. 2013 [acesso em 2021 out 25]; 37(99):610-618. Disponível em: https://www.scielo.br/j/sdeb/a/GwYSxxVb5DCDkyrXhSxW4JG/abstract/?lang=pt.

41. Lacerda TF, Monteiro PS. Bioética e diversidade: condições de saúde da população adulta em situação de rua do Distrito Federal. Saúde debate. 2012 [acesso em 2021 out 25]; 36(92):77-85. Disponível em: https://www.redalyc.org/pdf/4063/406341764010.pdf.

42. Garrafa V. Ampliação e politização do conceito internacional de bioética. Rev. bioét. 2012 [acesso em 2021 out 25]; 1(20):9-20. Disponível em: https://revistabioetica.cfm.org.br/index.php/revista_bioetica/article/view/711.

43. Ayalon L. There is nothing new under the sun: ageism and intergenerational tension in the age of the COVID-19 outbreak. Int Psychogeriatr. 2020 [acesso em 2021 out 25]; 32(10):1221-1224. Disponível em: https://doi.org/10.1017%2FS1041610220000575.

44. Singer P. Ética prática. 4. ed. São Paulo: Martins Fontes; 2018.

45. Dadico CM. Epidemias, pandemias e o ódio: caminhos para a governamentalidade da pandemia da Covid-19. Revista Publicum. 2020 [acesso em 2021 out 25]; 6(1):70-93. Disponível em: https://doi.org/10.12957/publicum.2020.57572.

46. Bispo JP, Santos DB. COVID-19 como sindemia: modelo teórico e fundamentos para a abordagem abrangente em saúde. Cad. Saúde Pública. 2021 [acesso em 2021 out 25]; 37(10):e00119021. Disponível em: https://doi.org/10.1590/0102-311X00119021.

47. Santos B. A Cruel Pedagogia do Vírus. Lisboa: Almedina; 2020.

48. Lloyd-Sherlock P, Ebrahim S, Geffen L, et al. Bearing the brunt of covid-19: older people in low and middle income countries. BMJ. 2020 [acesso em 2021 out 25]; (368):m1052. Disponível em: https://doi.org/10.1136/bmj.m1052.

49. Anderson RM, Heesterbeek H, Klinkenberg D, et al. How will country-based mitigation measures influence the course of the COVID-19 epidemic? Lancet. 2020 [acesso em 2021 out 25]; 395(10228):931-934. Disponível em: https://doi.org/10.1016/S0140-6736(20)30567-5.

50. Ehni HJ, Wahl HW. Six propositions against ageism in the COVID-19 pandemic. J Aging Soc Policy. 2020 [acesso em 2021 out 25]; 32(4-5):515-525. Disponível em: https://doi.org/10.1080/08959420.2020.1770032.

51. Teixeira MG, Medina MG, Costa MCN, et al. Reorganização da atenção primária à saúde para vigilância universal e contenção da COVID-19. Epidemiol. Serv. Saúde. 2020 [acesso em 2021 out 25]; 29(4):e2020494. Disponível em: https://doi.org/10.5123/S1679-49742020000400015.

52. Mazuchelli LP, Soares MFP, Noronha DO, et al. Discursos sobre os idosos, desigualdade social e os efeitos das medidas de distanciamento social em tempos de covid-19. Saúde soc. 2021 [acesso em 2021 out 25]; 30(3):e200885. Disponível em https://doi.org/10.1590/S0104-12902021200885.

Received on 10/27/2021
Approved on 03/16/2022
Conflict of interests: non-existent
Financial support: Coordination for the Improvement of Higher Education Personnel (Capes) – Brazil – Financing Code 001, through the Dean's Office of Graduate Studies of the Federal University of Rio Grande do Norte (UFRN)