VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: What the pandemic measures reveal about ageism

David Oliver *consultant in geriatrics and acute general medicine*

Berkshire

Older age and a range of underlying medical conditions mean a higher risk of serious illness, admission, and death from covid-19 than in younger or fitter groups. Over 70s have been advised to avoid unnecessary social contact, remain largely indoors, and to do any outdoor exercise at a safe distance from others. The reaction of some older citizens to this announcement shone a light on some wider attitudes towards ageing—not least from older people themselves.

The *Times* letters page on 17 March had several contributions from older people arguing against the advice.¹ Their arguments boiled down to some older people being far fitter and more active than other older people (or indeed than much younger people); having enough common sense to make self-protection decisions; and feeling insulted, patronised, and categorised by the generic advice.

There are some very legitimate concerns about the policy. Older people are already prone to social isolation, loneliness, and their effects on mental health. They may worry that they'll lose further fitness by staying indoors; that their contributions as good neighbours, volunteers, and workers will be lost; and that they'll still require food, drink, and maybe personal care. But there are ways to mitigate many of these.

This may not have been communicated clearly enough through mainstream media, but the policy has a clear rationale, as justified by modelling from Imperial College.² Part of that rationale is not to belittle older people or fail to recognise their diverse levels of youthfulness.

I've devoted my professional life to care of older people and have campaigned repeatedly against ageist attitudes, language, and blatant discrimination with no rationale behind it. But even the Equality Act allows for some "differentiation" based on age, as "a proportionate means of achieving a legitimate aim."³ Not having avoidably large numbers of people over 70 being admitted acutely to hospitals that are already struggling to cope, and with a far higher risk of what could be an unpleasant death from respiratory distress syndrome, seems legitimate to me.

Of course, many people in their 70s and 80s remain fit, active, independent, and socially connected, making major contributions

to society. By no means do they all live with severe frailty,⁴ dementia, or life limiting conditions. We see major differences between different groups in healthy life expectancy at 65.⁵ However, even fit older people show poorer immune responses than their younger selves in the face of infection.⁶ The speed of the covid-19 pandemic doesn't allow us to assess each person over 70 for individual risk—and the government has made a pragmatic decision.

What is undoubtedly ageist is a collective fear of ageing and death in our societal and media values, meaning that appearing old is seen as being diminished, invisible, and unvalued by society. This in turn leads to older people themselves "othering" any older people they see as being vulnerable, different from their more youthful and active selves. This can lead to "grey on grey" ageism.

We need to put ego aside here and do what's in the national interest. The policy on over 70s is not an excuse for a youthfulness contest or an excuse to take umbrage. It's a serious business, which earlier generations who went through wartime privations and restrictions would recognise.

Competing interests: See www.bmj.com/about-bmj/freelance-contributors.

Provenance and peer review: Commissioned; not externally peer reviewed.

- 1 Smyth C, Elliott F, Whipple T, Lay K. Coronavirus: Britain in lockdown. *Times* 2020 Mar 17. <https://www.thetimes.co.uk/article/coronavirus-britain-in-lockdown-t3hs9663c>. (Login needed).
- 2 Ferguson NM, Laydon D, Nedjati-Gilani G, et al. Imperial College COVID-19 Response Team. Impact of non-pharmaceutical interventions (NPIs) to reduce COVID19 mortality and healthcare demand. 16 Mar 2020. <https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf>.
- 3 Oliver D. We must end ageism and age discrimination in health and social care. *King's Fund*. 29 May 2013. <https://www.kingsfund.org.uk/blog/2013/05/we-must-end-ageism-and-age-discrimination-health-and-social-care>.
- 4 Clegg A, Bates C, Young J, et al. Development and validation of an electronic frailty index using routine primary care electronic health record data. *Age Ageing* 2016;45:353-60. 10.1093/ageing/afw039. <https://academic.oup.com/ageing/article/45/3/353/1739750>. 26944937
- 5 Age UK. Healthy ageing evidence review. 2010. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health-wellbeing/rb_april11_evidence_review_healthy_ageing.pdf.

- 6 Montecino-Rodriguez E, Berent-Maoz B, Dorshkind K. Causes, consequences, and reversal of immune system aging. *J Clin Invest* 2013;123:958-65. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3582124/>. 10.1172/JCI64096 23454758

Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to <http://group.bmj.com/group/rights-licensing/permissions>