Covid-19: philosophical and gerontological reflections from adaptability and quality of life

Covid-19: reflexiones filosóficas y gerontológicas desde la adaptabilidad y calidad de vida

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Abstract

The aim of the article is to show how a modified version of Sgreccia's method, with the categories of adaptability and quality of life, is useful for formulating and thinking about the problems of the elderly in the emergency of Covid-19. To achieve this, the steps of the bioethical method are taken again: biomedical fact, anthropological values involved, and response to the problem with the categories of quality of life and adaptability. Empirical data related to old age and Covid-19 are analyzed, showing the vulnerability of this group to the pandemic. Subsequently, the ethical duties generated around the elderly, established by reflection and by means of the categories, are derived. In conclusion, it is sought in a way that the indicated categories lead us to recognize solidarity and sociability as the axis of the balance between responsibility and duty before the elderly.

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1. Introduction

Bioethics and gerontology are interdisciplinary and share a common question that guides their reflections. Bioethics seeks to answer the question of what is licit to do (ethically) in the face of certain states of human life, including those related to health and disease.[1] However, the answer implies asking the same question from other disciplines, such as law, medical sciences, social work, and others.

In the case of gerontology, something similar happens. The question is: how and in what sense to increase the quality of life of the elderly? This question also applies to medicine, sociology, engineering, social work, law, public administration and a long list of other disciplines that can participate in answering this question.

Both bioethics and gerontology have several common elements that unite them. Among these concepts are «quality of life» and «care». Gerontology thus seeks to increase the quality of life in old age through appropriate care. This increase in the quality of life is seen as an individual and social duty. Bioethics has also used this term to refer to the conditions of life with patients whose health is compromised by various ailments, cases in which intervention must be made to increase or avoid a decrease in quality of life. Such interventions imply the idea of care.

This article reflects heuristically on the concepts of adaptability and quality of life in relation to the vulnerable situation of the elderly in the current context of the Covid 19 pandemic in order to think of ethical guidelines of duty towards them and their duties towards others.

This is a philosophical reflection, although it is intended to turn it into concrete operational criteria, and to be able to generate as

proposed by Elio Sgreccia a more complete interventions from the perspective of bioethics/gerontology, following the methodology.

2. Quality of life, adaptability and bioethical method

The notion of «quality of life» [QL] (1) can refer to both objective and subjective components, such as income, access to specific health units, the presence of chronic diseases, and how one feels about the balance of one's life achievements and one's perception of the future.

> ...Quality of life (QL) is defined as a state of general well-being comprising objective descriptors and subjective assessments of physical, material, social and emotional well-being, along with personal development and activities, all mediated by personal values (1, p. 64).

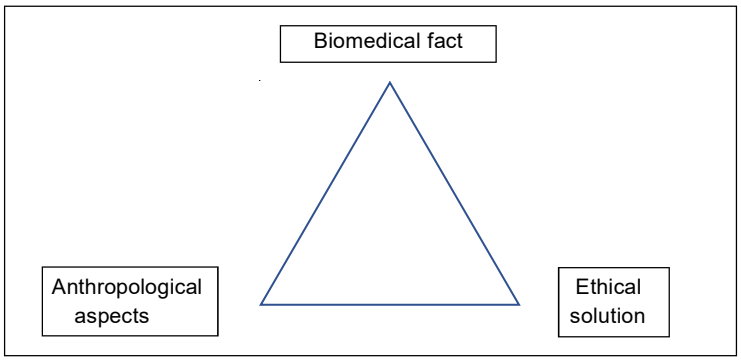
What differentiates Covid from the current pandemic situation? Well, a crucial element is the *adaptability* to the environment. The pandemic has broken down that more or less stable environment among those who are free from danger of being affected in their health and occupations, and can make themselves available for care. It has upset the balance of the environment, to the extent that everyone is vulnerable and everyone has a certain deterioration in the quality of life, as we have defined it. People are being affected in subjective components of well-being, which taken to the extreme means the loss of mental health. This vulnerability implies the need for community and individual adaptation. Due to the functional limitations of old age; adaptability is more limited than in other social groups. It could be argued, however, that the decrease in adaptability is an advantage, since the measures applied to decrease mobility or confinement may be easier for people who are used to «being at home» because of their relatively lower mobility.

On the other hand, it can be insisted that this is illusory. Unfortunately, even if the elderly person has, for example, a pension,

they may not be able to go out as much. However, if they have chronic illnesses, the need for medical attention implies going out to places of greater risk, such as the clinic. In addition, even if the elderly with restricted mobility remain in their homes, they require «minimal» support for cooking and cleaning the home, which forces them to receive people from outside their homes, with the implicit risk of contagion.

It is suggested to use, as mentioned above, the Sgreccia model. Of course, other taxonomies are found that emphasize other fundamental values (2). However, I have chosen Sgreccia's personalism insofar as it shares the assumptions that there is a possibility to achieve moral good as something objective and universal (2). In addition, the triangle decision model can be adapted to the purposes of the exposition made here. Sgreccia mentions or outlines the bioethical method as follows:

The triangle must be understood in two dimensions. On the one hand, a static dimension represented by its vertices, which show the components of any bioethical analysis. These components must be present simultaneously, in an analogous way to how the triangle only takes shape when the three vertices are simultaneously present. The reality being analyzed is seen in an interdisciplinary prism, where moral reality converges or is configured thanks to the



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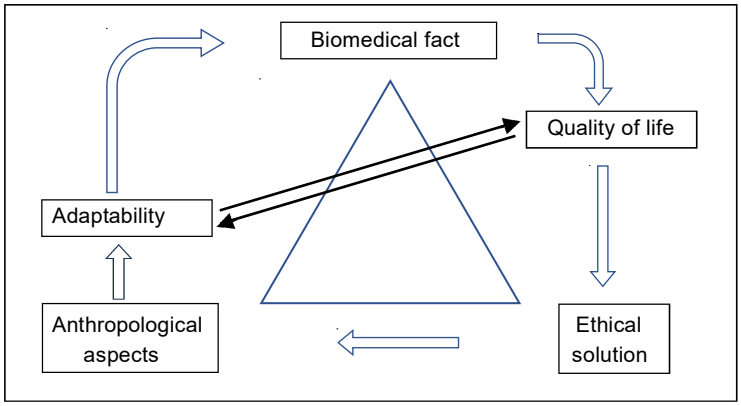
joint perspective of law and empirical data, such as the cases of medicine (or clinical bioethics), social and individual realities, etc. On the other hand, the triangle suggests a dynamic vision of ethical judgment, in which, from an anthropology, some principles are obtained that serve to interpret the facts that give us the clue of the correct action to be taken in the concrete case. Nevertheless, at the same time, we have to start from the concrete case, submit it to the anthropological sieve to discover the values at stake, and again contrast it with the empirical reality of the respective sciences.

Thus, the ethical argument is not purely deductive. The interdisciplinary relationship represents or prepares a practical judgment to determine the concrete choice, which is more in keeping with the goods to be protected in the case. «This judgment of conscience is... the expression of the concrete and, in line with the principle, non-arbitrary evaluation with which the goods to be protected are ordered hierarchically... [to] increase or respect the human condition» (3, p. 71).

The image of the triangle can also be interpreted as a true connection on all levels of decision or reflection. In other words, as truths that are similarly presented among all disciplines, allowing one to ask what would be good to do or not to do. The truth becomes present as a configuration of the duty to be: there are truths in the empirical and normative fields that give rise to the practical judgment of reason.

I propose, therefore, that the image of the triangle be interwoven with the two notions mentioned above which, in the case of the elderly, must be present throughout the analysis: quality and adaptability. In this way, the graph would be:

Some other concepts could be added to the ones proposed above. However, for the purposes of this analysis I suggest keeping these concepts in view. The arrows insist on the dynamic acceptance of the triangle. Thus, the biomedical fact (4) (although it could be extended to the facts of limit intervention on human life) must be interpreted in conjunction with anthropology. What we study are



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two elements that lead us to the practical judgment of reason, to the ethical judgment where we measure (through prudence) the adequacy here and now of those anthropological values and duties discovered. At the same time, the concepts of adaptability and quality intersect. Translated into operational terms, one could say: we ask ourselves questions about these concepts at every moment of the ethical analysis. A virtuous rather than vicious circle is produced with the anthropological character. It is virtuous because it is a spiral vision where one returns to the fact, already with a judgment made to corroborate its correct relevance (6). I suggest interpreting these elements of analysis with the two categories that we must always keep in mind. Later on, a chart will be shown on how to apply the above to the case at hand.

Adaptability is not proposed here as a kind of evolutionary concept, as a mere «survival of the fittest». The concept has been applied in areas such as labor, in which it is presented as the capacity to adapt to circumstances, in a way analogous to the sociobiological model, because adaptation to new working conditions is indispensable for survival. Despite this, some definitions point to other meanings of the term. For example: «adaptability implies a modification of behavior according to changing circumstances, in

order to achieve an 'adjustment' –the correspondence between desired and actual circumstances–, as well as the adjustment between the internal and external environments of the organization» (7, p. 15).

Understood in this way, adaptability alludes to an aspect of the practical reasoning of prudence: it must see the universal or the norm of duty as general, but at the same time, it must see the particular. There must be a knowledge of both in order to make the adjustment from one to the other. Adaptability, then, implies having at the same time the ideal that reason marks and knowing the concrete situation of adjustment. Adaptability, understood in this way, has a communitarian trait: we all make the adjustment in solidarity so that we level off or have access to the basic goods that we all deserve for being people. In this last sense, the concept of adaptability moves away from the mere survival «of the best» mentioned above; it ceases to be an individual adjustment to defend oneself from threats from the outside, including other people. Solidarity-based adaptability, then, possesses the trait of universal/particular adjustment, where we see not only human goods, but also the others involved in the genesis, distribution, and enjoyment of those goods.

This leads us to the question: are adaptability and prudence the same thing? It seems to me that they are not. Prudence encompasses more, since in the ordinary situations of life, where there is no radical modification of the environment, we can only apply prudence to see the reason for the good of the action in each concrete case of the search for the good. Prudence speaks of execution in ordinary situations. I believe that adaptability alludes to a greater degree of rupture between the expectation of events and what happens, but it is directed by prudence: we must always adjust it in light of the good that is produced in me and in others.

Adaptability as a prudential component cannot make an infinite calculation of the singulars: it simply would not finish the calculation of all the possibilities but it is carried out, so to speak, a net-

work of similarities, in which we see similarities that give us patterns close to the individual (6).

Adaptability, in the community sense already indicated, refers rather to the supportive and subsidiary adjustment in the relationship between people, who all owe each other respect and a certain love of benevolence. We seek our own good, not just the wellbeing, and the authentic good of others. Thus, adaptability is the creation of the conditions of encounter, which reaffirm that we are personal beings manifesting our humanity. In turn, adaptability can be analyzed by separating its purposes: adaptability in family and friendship relationships; adaptability in consumption patterns; adaptability in support networks and a whole range of other situations. In order to make an appropriate ethical judgment, once these reflections from anthropology have been made, let us now review some empirical data in relation to the Covid and the elderly.

3. The pandemic and its impact on the elderly: the evidence and the law

As mentioned above, the notion of «quality of life» can be divided into objective and subjective aspects. The number of deaths, of course, is the field of radical loss of quality of life. There is a discrepancy with respect to this affectation. In Europe, as is known, many countries have clearly had deaths of older people, such as Spain and Italy. In Germany, however, there has been less of an effect on this age group (8). This is not surprising, given that Europe has aging populations. Likewise, if we compare the above with China:

> ...of the total number of cases that died in the country up to February 11, 2020, 14.8% of the people infected with Covid-19 were 80 years old and over. In Italy, in an analysis up to March 4, 2020, the National Health Institute detected that the average age of the 105 people who died from the virus was 81 (9, p. 8).

However, what happens in Mexico? According to data from the daily report of those affected, as of September 2 (10), the total number of accumulated deaths in Mexico was 65,816 people. The unfortunate fact is that a high proportion of people over 60 have died from the disease, even though the percentage of older adults in Mexico does not compare to that of Spain, which is 20% (8), while in Mexico it is 12.3% of the total population (10). The INEGI itself points out some characteristics that show the problem faced by the elderly in Mexico:

> ...15.4 million people of 60 years or more reside in the country, of which 1.7 million live alone. Four out of every ten people aged 60 or over who live alone (41.4%) are economically active. Seven out of ten (69.4%) older people living alone have some kind of disability or limitation (11, p. 1).

Thus, although there is a lack of data that we can cross to know if the people who died were living alone or had a disability, the INEGI data provide evidence about the risks of frailty in older people, probably increased by the pandemic. This shows the exposure and harm that older people receive. Even in cases of people not dead, but recovered at home, the need for care may be compromised. It should also be remembered that older adults in Mexico live in widowhood (11). This implies, on the one hand, that greater adaptability is required of the elderly due to their isolated circumstances and, on the other hand –because their margins of action are probably weakened– that they require support from social networks in order to remain healthy and functional. In the face of the Covid phenomenon, even in Mexico, where there was relative voluntary confinement, the elderly were easily left doubly unprotected. First, their relatives, who had to stay «far away» to protect them from the epidemic itself, could not attend them; second, they could not rely on networks of their own age, due to the same situation of isolation and functional limitations. However, another important fact is that people over 60 years old, mostly live in regions of high vulne-

rability. As a contrast: «the minimum record of the percentage of the population over 60 was 2.5% in the municipality of García, Nuevo León, and the maximum was 42% in Cosoltepec, Oaxaca; the average for all municipalities was 13% (12, p. 9).

With the information available, it can be stated that the empirical data show that not only can we conceptually imagine a frail or exposed old man, but that the very social conditions mentioned above make his existence difficult; at least, some of them live with a higher risk than a younger adult.

The above refers to the facts, but we must also consider that apart from the ethical duties towards the most vulnerable people, there is the legal consideration, which recognizes fundamental rights that can be demanded from everyone. For example, the Constitution of Mexico City states in Article 11, paragraph F:

> The elderly have the rights recognized in this Constitution, which include, among others, the right to identity, to an accessible and safe city, to specialized health services and to palliative care, as well as to a non-contributory economic pension from the age determined by law (13, p. 43).

This Constitution provides for rights or actions that should be promoted following the principle of synderesis. But it also points out aspects of what should not happen to them, preventing «...abuse, abandonment, isolation, negligence, mistreatment, violence and any situation that involves cruel, inhuman or degrading treatment or punishment, or that threatens their safety and integrity» (13, p. 43).

The above, taken to the field of care for elderly Covid-19 patients, implies that organized groups, both public and private, must guarantee these conditions in the current situation of the pandemic. The legal aspect is linked to the ethical aspect.

The current legislation allows us to have criteria to measure the vulnerability of the elderly with respect to the Covid. This vulnerability consists of all the circumstances where they are deprived of essential human goods, or are not provided with them in a way that generates isolation, deprivation or inhuman treatment. Vulne-

rability deprives or eliminates the adaptive capacity of the elderly and, ultimately, of the society as a whole. In short, the notion of vulnerability with respect to the Covid is:

> The level of vulnerability of the inhabitants to the potential effect of Covid-19 derives from the characteristics of the persons or groups in terms of morbidity, as well as from the social, cultural and economic conditions that influence their capacity to *anticipate, face, resist and recover* from the adverse effects of the coronavirus (10, p. 4).

I have highlighted the three characteristics that refer us to the concept of philosophical interpretation called adaptability, already outlined in section I. These three components can be taken with what we have pointed out from the hermeneutic circle of the Sgreccia triangle and converted into operational principles.

4. Adaptability and vulnerability: reflections on the elderly

Elders are probably exposed to a lower capacity of anticipation, so the «others» must cover that variable of vulnerability. The idea behind vulnerability is the presence of others to cover the needs of the elderly in their economic and social environments. Non-elderly people must cover, in the appropriate and sufficient proportion, only what is necessary for the elders to recover their decision-making strategies in the face of the pandemic.

The love of benevolence towards the elderly, and any other person, implies recognizing the good as a correspondence: the good that is protected and to which one responds to the same love, in freedom and responsibility. Because we men are capable of interpreting the lives of others as beings who seek their authentic good, and that I can recognize it as mine –in our example from Covid-19, health– that is what allows the activation of resources for others, and us in true solidarity.

The love of kindness is not an instinctive good of the herd animal type, in which, by imitation and preservation of the species, I take care of others and myself. In fact, the rebelliousness of individuals to use coveralls is indirect proof that caring for oneself is not merely instinctive to survive, but that I may well reject that good for myself at the expense of some other good, in this case freedom, since I consider it superior to that of my own health. Thus, «...the human being can know and want the good as such, the good itself and, therefore, the good of the other as such. And not only to perceive it and want it, but to seek it... to build it, to give it life» (15, p. 24). Animals are not strictly altruistic, but they see or perceive others as benefit or harm to their environment. Humans perceive the attraction of good at any cost.

«Coping» with the pandemic means «we face it» in the plural: efforts are synergistically joined to create the conditions for harm reduction. In the case of the elderly, due to certain limitations in their environment and social support networks, they are forced to substitute part of the means because it is their good, but, at the same time, this good can only be consented to and adapted to each case. This is true subsidiarity (16). We face it when we equalize the conditions of all to solve the health problem. Subsidiarity is not welfare in health. When handing out a mask, I must ask myself the question (ethics): what material, mental, social and spiritual requirements does this particular person require in order to be in the same social condition of not getting sick and preserving his health? This question should guide the criterion of «resistance».

This implies an extra effort: it is not enough that the one who has the means to maintain a quarantine protects himself in isolation, but he must cooperate to generate the conditions, if not equal, then equivalent for the others. This is not only a government activity or duty; it is a duty or a good that we perceive as something due from the social point of view. Thus, the rupture of selfishness is not a cheap sentimentalism, but the recognition of the being of others and the good attached to it. It is our duty to give an old

man, who needs to work outside his home to survive, the conditions so that he does not expose himself, such as receiving him or giving him the inputs to exercise his freedom and activities at home. I insist, it is not only a question of an income or a monetary subsidy from the government, but of providing all the means in all channels and social levels. For example, in the spiritual realm, it is the duty of others to provide him with the means of access to religious rites and to support him with technology that the elder may not be able to handle.

It does not mean imposing on others our vision of good, but respecting the good of others, not destroying or absorbing their capacity for decision. One might ask: is not this impossible. Do we fall into welfare by intervening in the life of the elderly?

The answer is not a simple yes or no. Again, it is a decision of prudence: a certain calculation is required to see if the help provided is not guided by interest or substitution of the other.

A certain risk must be taken before the freedom of the other person: that of the refusal of help. In this case, the only way left is persuasion, as a means to diminish the risk of losing everything in the face of everyone's weaknesses in providing conditions of resistance.

However, this measure is delicate: it can become a welfare; that is to say, to consider the needy as a minor who without you (we) *cannot* do it. This welfare clashes with a real assistance, in which I only intervene strictly what is necessary for the person to recover his capacity to react and to face and recover.

Coping, resisting and recovering, pointed out in the previous appointment, is a breakdown of adaptability. Coping is not «I put myself in your place», but an «I accompany you in the process». Thus, for example, the correct thing to do is not: «old man, don't go out to meet your needs», and I do it in your place because of your weakness, but «I go out with you», without replacing the will and autonomy of the old man. Of course, the above does not mean abdicating from taking health care measures, but that the elderly assume the risks that they consider pertinent, in a way similar

to that of any adult, elderly person avoiding childishness and the *ageism* of «subduing» them for «their own good».

For example, in Colombia, people over 70 years old were restricted from leaving their homes, but the Administrative Court of Cundinamarca, with a decision in response to a group of complainants, older adults, «...lifted the restrictions imposed on them by the National Government because of the Covid-19 pandemic. This means that, from now on, this population will be able to go outdoors as much as people between 18 and 69 years old» (17, s. p.). What reasons did the Court give?

As criteria for the removal of restrictions, it invoked independence and self-determination, and to avoid the act of discrimination with respect to other groups of adults. It should be emphasized that this is not only a matter of autonomy, but also of recognition of the freedom and equality of the rights of the elderly. The Court's criterion was therefore to oppose the treatment of the elderly as minors. To remedy this, subsidiarity and solidarity serve to discern our duties and rights with the elderly. It is a judgment proportionate to prudence, which gives weight to every element of everyone's life. That is why it is so complicated, or rather, so complex, to deal with the situations of the pandemic, due to the impossibility of a single solution. For example, from the government, the question «what to do with the elderly» –an unfortunate expression, by the way– implies the instrumentalization of its people.

Nevertheless, not only health conditions and aging endanger the elderly. Taking up again the seen elements of loneliness and isolation, which have been proven empirically (18, 19, 20), it is true that the feeling of loneliness and isolation as a structural generator are correlated, but, at least conceptually, one is not the cause of the other. It is perfectly conceivable to feel solitude inside a home or being accompanied. However, in the case of the elderly there is usually at least some correlation. It is crucial to combat it in order to facilitate adaptability and recover the quality of life. Isolation cannot be replaced only by electronic means such as video calls,

since their effectiveness seems limited (19). This must include an integral whole, where the general aspects of having visitors, receiving medication, going out to public areas, among other measures taken by prudence, must be adjusted to the concrete reality, so that the conditions of access to the goods are recovered or equalized. Thus, for example, for one-person one outing a week will be enough; another will require daily outings; others do not require assistance in medication, but others need it continuously (such as oxygen), and a long etcetera.

Another way to find answers to the needs of older people is to ask the right questions. The following is an example of how the various factors seen throughout the reflection can become ethical questions:

Biomedical problems or facts	**Adaptability**	**Quality of life**
Isolation and depression (21).	**Cope, resist, recover.** What resources are available to isolate him and for how long? What elements of social networks can be maintained as means of contact, such as the telephone or other means with continuous accessibility, if possible? Is it feasible to have a visit with all the precautionary measures? What resources should be made available to others, without putting them at risk of contagion but reducing isolation? If there is a risk or presence of depression, are there responsible people and access to emergency services and/or people who can help in a crisis? Are there protocols?	What criteria to use to determine that the interactions result in true personal contacts, and not just informational about the status of the elderly incarcerated? If conventional means such as the telephone are used, what can be done to increase proximity?
Loss of support in social networks for food and medicines, among others.	What measures have been taken to bring medicines closer to people? What proportion belongs to the government and what part should be left to the actions of the citizens?	How to ensure that not only access, but also patients who require special nutrition due to chronic diseases, are covered without prejudice to the decisions of the elderly and their specificity?

Consequences of the disease: arrhythmias and heart attacks (22).	Ensure the availability of medical equipment to attend emergencies. The mere discharge of Covid is not enough, but monitoring to avoid the risk of death. By privileging the Covid, how do you supply, and who should supply, access to continuous-use resources such as home oxygen tank filling or physical therapy?	How and who should intervene to reduce the risk of death due to inattention?
Inflammation and acute respiratory distress syndrome (22).	Has the probability of requiring steroids, supplemental oxygen and bronchodilators been considered, allowing some recovery of the functions of the elderly? Who and how can the probable loss of activities of daily living (ADLs) be addressed without jeopardizing the older person's decision?	Self-care functions can be restored. Who should guarantee access to medicines? How to distribute them without putting those involved at risk? In the event of a shortage, who should answer for them?
Inaccessibility of government public services (23).	Is it possible, and how, to implement remote access mechanisms, according to the abilities of the elderly for essential procedures?	With the elderly person, who should replace them and until when, for example, with powers to resolve their legal issues?
Inaccessibility of health services for diseases not related to Covid.	The emergency lines have considered that the isolation prevents requesting an emergency service. What routines should non-elderly people follow to check daily the condition of elderly people? From the perspective of the Government, has part of the emergency services been reserved and is it possible to guarantee effective and efficient access to emergencies not derived from Covid? What care can and should be transferred to citizens' associations and which should remain exclusive to the state, such as, for example, the execution of Covid tests in elderly people?	How to maintain the quality of care, by having health personnel assigned to the pandemic itself?

Source: Own elaboration.

5. Conclusions

The method of Sgreccia allows in itself an integral and simultaneous vision of the elements of ethical decision-making. However, it can be complemented with other categories that enrich or allow a better focus on ethical decisions. In the particular case of older people, the concept of quality of life and adaptability, widely used in gerontology, enriches this methodology and helps us to reflect on the central ethical question. what should we do about the needs of older people that respects their freedom but, at the same time, does not leave them at a disadvantage compared to non-elderly people and maintains their quality of life? The table of ethical questions tries to give elements to improve the solutions regarding the elderly in this crisis of the pandemic.

The above discussion can be translated into subsidiarity (16). Older persons should be provided with elements that do not put them at risk, or risk them only in proportion to respect for their autonomous decisions and the assets that are safeguarded; that is, always with respect for their freedom and in correspondence with their personal and social responsibilities.

The bioethical and gerontological reflection on the pandemic implies considering a synergy in ethical principles, such as that of human solidarity and sociability typical of personalism, together with empirical evidence that supports true interventions that respect dignity, but at the same time, envisioning its feasibility of implementation.

The suggested questions serve to remind us of what Thomas Aquinas said about the nature of prudence: we have to measure, in situations such as the pandemic, how we continue to respect human dignity, which manifests itself in the capacity to decide and execute, as far as possible, one's own life decisions. Likewise, we must make a calculation that maximizes the quality of life, without violating the principle of proportionality.

Covid-19 reminds us that ordinary ethical reflection is not only not replaced, but also amplified and demanded of all, by the principle of sociability, to assume responsibilities and rights of all involved. In the case of the elderly, it generates a demand for solidarity that is not optional, but the only way to respond with human fullness.

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[1] Bioethics is not reduced to medical ethics, so it addresses issues such as environmental ethics, genetic engineering and others.

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