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Social death of the older adult population reinforced in pandemic times

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Abstract

In a context in which the neglect toward the older adult population grows, the COVID-19 pandemic has made evident the lack of inclusion and care that these people face, creating a phenomenon of non-belonging and exclusion that can be described by the term "social death." This study aims to analyze the social death of the older adult population from an integrative literature review that includes studies related to social death, older adults and the pandemic. Of the 1,291 studies found in the databases, 15 articles were selected, in which it was observed that aging is not understood as a physiological process, but as a disease, so that older adults are removed from society and treated exhaustively until they die in isolation. It can be concluded that a specific gaze toward this population is necessary to ensure their (re)integration and active participation in society.

Keywords: Aging. COVID-19. Comprehensive health assistance. Mental health.

Resumo

Morte social da população idosa salientada em tempos de pandemia

Num contexto em que a população idosa é cada vez mais negligenciada, a pandemia de covid-19 tornou evidente a falta de inclusão e cuidado que essas pessoas enfrentam, configurando um fenômeno de não pertencimento e exclusão que pode descrito pelo termo "morte social". Esta pesquisa objetiva analisar a morte social da população idosa por meio de revisão integrativa da literatura que inclui estudos relacionados a morte social, idosos e pandemia. Dos 1.291 estudos encontrados nas bases de dados, foram selecionados 15 trabalhos, nos quais se observou que o envelhecimento não é entendido como processo fisiológico, mas como doença, de maneira que idosos são retirados da sociedade e tratados exaustivamente até morrerem isolados. Pode-se concluir que um olhar específico para essa população se faz necessário para garantir sua (re)integração e participação ativa na sociedade.

Palavras-chave: Envelhecimento. Covid-19. Assistência integral à saúde. Saúde mental.

Resumen

Muerte social de la población anciana destacada en tiempos de pandemia

En un contexto en que la población anciana está cada vez más desatendida, la pandemia del covid-19 puso de manifiesto la falta de inclusión y de atención a que hace frente esta población, configurando un fenómeno de no pertenencia y exclusión que puede describirse con el término "muerte social". Esta investigación pretende analizar la muerte social de la población anciana mediante una revisión integradora de la literatura en estudios relacionados con la muerte social, los ancianos y la pandemia. De los 1.291 trabajos encontrados en las bases de datos, se seleccionaron 15, en los cuales se observó que el envejecimiento no se considera como un proceso fisiológico, sino como una enfermedad, por lo que se apartan a los ancianos de la sociedad y los cuidan exhaustivamente hasta que mueren aislados. Es necesario destinar una mirada específica a esta población que le garantice una (re)integración y participación activa en la sociedad.

Palabras clave: Envejecimiento. Covid-19. Atención Integral de Salud. Salud mental.

Research

The authors declare no conflict of interest.

Although aging is a natural and inevitable biological phenomenon, negative value is currently associated to this process; consequently, even subtle signs of aging—such as the first strands of white hair—are regarded with contempt and revealing one's age is almost always embarrassing. Moreover, it is disseminated that population aging implies losses to governments, with expenses on pensions, showing that, from the perspective of society, aging is synonymous with expenditure and antipathy [1].

Young people rarely have a perception of their own aging, as the society of the "now" does not instill reflection on aging and shows interest simply in avoiding this process [1]. In women, this seems to be more intense, especially in the aesthetic aspect, since procedures and drugs that promise "rejuvenation" lead sales rankings worldwide, with anti-aging advertising [2]. Thus, due to people's inability to see themselves older, it is difficult to socially include the older adult population [1].

It is important to emphasize that the older adult population is not the only population made invisible, as a similar problem is faced by any vulnerable group, including homeless people and people with disabilities. The term "social death" was coined precisely to refer to the phenomenon of neglecting certain populations, which has disastrous consequences for society and health care [3].

Older adults face lacks in autonomy that predispose them to a greater risk of falling, difficulty swallowing and urinary incontinence, and as a result they require care from health care teams [1]. This need for care, in addition to social exclusion and invisibility, contributes to the increased rates of depression and suicide in this population.

According to data from the Ministry of Health pointed out by Fumegali [4], about 20% of the world population aged over 60 years lives with depression and anxiety disorders and, in Brazil, the suicide rate in older adults aged over 70 years is higher than the national average: 8.9 and 5.5 per 100,000 deaths, respectively, between 2013 and 2019.

Regarding the health care of older adults, studies that analyze medical education and the taboo of aging emphasize that, in addition to lack of care as to the health-disease process of the elderly, there is also an aversion of physicians to the end of life [5,6]. These studies demonstrate that social and psychological factors involved in the illness in older adults are often not taken into account during treatment. In addition, unnecessary therapies and procedures are applied to older adults at the end of life as a heroic measure to keep these patients alive, as death is associated with medical failure.

Accordingly, it is contradictory that health care—which has been increasingly enhanced for the treatment of several diseases in recent years—neglects the inevitability of aging, vulnerability and death, since this neglect can trigger more suffering [5,6]. Thus, it is inferred that—ironically—if in general the elderly no longer belong to society, in the medical setting, in turn, they are obliged to remain in it [1,5].

The marginalization of this population became even more problematic during the COVID-19 pandemic, as there was a higher mortality in the elderly population, since people with comorbidities such as diabetes, hypertension and obstructive pulmonary diseases had a higher risk of becoming ill. The importance of social isolation as a preventive measure was also emphasized and older adults were strongly advised not to leave the house. Thus, despite its importance for protection from a biological point of view, social isolation intensified anxiety, insecurity, fear and depression in older adults, because, in addition to the fear of becoming ill, the feeling of abandonment—already present before the pandemic—grew significantly [5].

The objective of this research was to synthesize information about the social death of the elderly population, including the pandemic period. The subject is relevant mainly for health care professionals, since the abandonment of the older population is paradoxical, because, as the demands of these people are marginalized, disregarding their historical, social, and cognitive context, several comorbidities affect them, such as depression, coronary heart disease, and STIs. These affections derive precisely from the lack of a critical and humanized consideration of the older adult population [4,7,8,10].

Method

This is an integrative, exploratory and descriptive literature review, based on relevant

studies on the subject. The PVO strategy was used to describe the population—older adults; variables—neglect of older adults, COVID-19, and health care; and outcomes—social death of the older adult population and other psychosocial sufferings. The research adopted the following guiding question: are worse clinical outcomes, as well as the increased incidence of several diseases in the elderly population, consequences of the neglect of society and physicians as to aging?

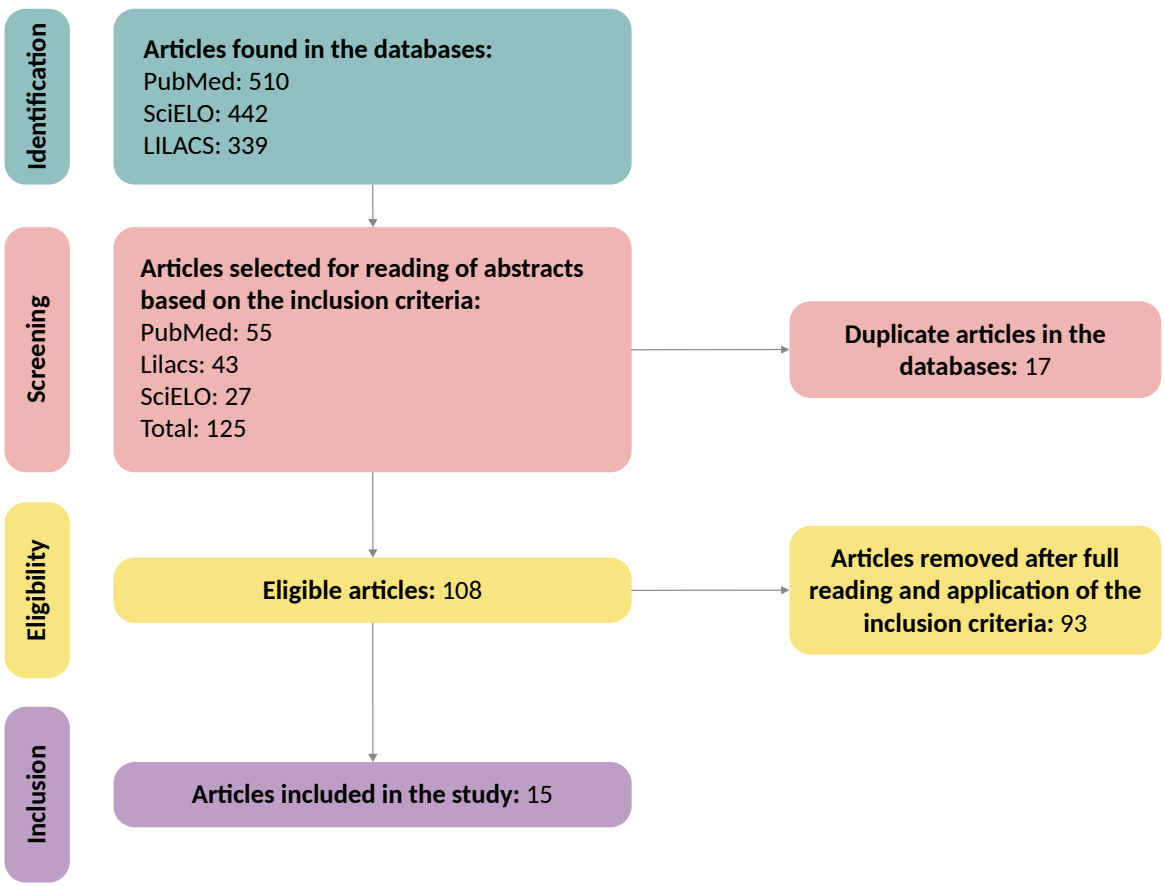
The bibliographic survey was conducted in January 2022, in the SciELO, LILACS and PubMed databases and used the following descriptors in health sciences (DeCS), in Portuguese and English: "social death," "aging," "elderly," "mental health," "COVID-19," and "health care professionals." The Boolean operators "*or*" and "*and*" were used to improve the searches.

The inclusion criteria were: complete scientific articles or literature reviews with public access, national and international; in Portuguese, English or Spanish; published between 2010 and 2021. In order to have their inclusion confirmed, the articles should also address at least one of the following topics: social death of the older adult population; social death of the older adult population reinforced in pandemic times; and/or health care neglect in the elderly population. The exclusion criteria were: articles that were not consistent with the proposed theme and abstracts without access to the full text.

The search with DeCS found 1,291 articles, of which 510 in PubMed, 442 in SciELO, and 339 in LILACS. In the second stage, based on the first inclusion criteria, the quantity was reduced to 125 articles, of which 17 were duplicates and 108 were eligible for the study. After reading and examination, 15 studies were selected.

Figure 1 shows the article selection process.

Figure 1. Article selection process



Results

In total, 15 articles were included in the review: seven (46.7%) from Brazil, three (20%) from the United States, one (6.6%) from South Korea, one (6.6%) from Italy, one (6.6%) from Germany, and two (13.33%) from Canada (Chart 1). Most were published in 2021, totaling six articles (40%), and eight (53.33%) are cross-sectional observational studies. Chart 1 presents the information of the included studies.

Chart 1. Articles analyzed with indication of authors, year, country, type of study, and main findings

Authors; year	Article	Country	Study type	Findings
Mazzela and collaborators; 2010 [7]	"Social support and long-term mortality in the elderly: role of comorbidity"	Italy	Cross-sectional, observational	Low socioeconomic class, loneliness and associated comorbidities are among the major determinants of readmissions and mortality among older adults. Low social interaction is an important factor that predicts mortality.
Gronewold and collaborators; 2020 [8]	"Association of social relationships with incident cardiovascular events and all-cause mortality"	Germany	Cross-sectional, observational	Feeling alone or living isolated from society is associated with high cardiovascular risk and morbidity and mortality independent of other risk factors in older adults.
Hernandez and collaborators; 2021 [9]	"Suicide among older adults: interactions among key risk factors"	United States	Retrospective	Lack of hope, followed by depression and a negative view of one's own health were the main risk factors for suicide in the older adult population. Physical diseases had little impact on the suicide rate.
Andrade and collaborators; 2017 [10]	"Vulnerabilidade de idosos a infecções sexualmente transmissíveis"	Brazil	Cross-sectional, observational	Health care professionals tend to think that older adults are "asexual" or even that they have a single sexual partner. This leads to the lack of communication on the subject with these people, being among the causes of the high rates of sexually transmitted infection in this population.
Ribeiro and collaborators; 2017 [11]	"Coping strategies used by the elderly regarding aging and death: an integrative review"	Brazil	Literature review	The different strategies to cope with aging and death depend significantly on how society sees this stage of life: denying the inevitable or adapting the difficulties of this time to each individual without judgment. In the study, it is emphasized that the West confers a negative character to aging, which makes this process a negative and lonely experience for those who experience it.
Souza, Giacomin; 2020 [12]	"Care for frail older adults in the community: an integrative review"	Brazil	Literature review	It is necessary to recognize, study and care for frail older adults; however, it is of paramount importance for the prognosis of these patients that their autonomy is encouraged.

continues...

Chart 1. Continuation

Authors; year	Article	Country	Study type	Findings
Fagundes and collaborators; 2017 [13]	"Instituições de longa permanência como alternativa no acolhimento das pessoas idosas"	Brazil	Description	Neglect in the treatment of the older adult population is institutionalized. Long-stay institutions are often seen as a negative experience for older adults. These institutions lack health inspections, as well as effective care for older adults.
Kotwal and collaborators; 2021 [14]	"The epidemiology of social isolation and loneliness among older adults during the last years of life"	United States	Cross-sectional, observational	One of the main factors responsible for the high rates of older people in social isolation is the lack of dialogue about aging and end of life, as well as the lack of methods and initiatives capable of recognizing the signs of distancing and loneliness in older adults.
Kim, Jung; 2021 [15]	"Social isolation and psychological distress during the covid-19 pandemic: a cross-national analysis"	South Korea	Cross-sectional, observational	Social isolation caused by COVID-19 was directly associated with psychological distress in older adults.
Goveas, Shear; 2021 [16]	"Grief and the covid-19 pandemic in older adults"	United States	Cross-sectional, observational	The increase in cases of prolonged grief disorder (PGD) is a sequela of the current pandemic time. And this situation is responsible for higher morbidity and mortality in older adults.
Fraser and collaborators; 2020 [6]	"Ageism and covid-19: what does our society's response say about us?"	Canada	Reflective	The way society coped with the death of older adults during the pandemic underlines the extent to which this population is underestimated. There were no critical analyses of the high number of older victims of COVID-19.
Gonzaga and collaborators; 2018 [17]	"Profissionais de saúde: um ponto de vista sobre a morte e a distanásia"	Brazil	Cross-sectional, observational	Knowledge and understanding about death and dying are among the least discussed subjects during the academic training of health care professionals. Thus, the understanding that death is synonymous with medical error is disseminated in the medical setting, which results in the acceptance and performance of dysthanasia practices.
Pereira, Rangel, Giffoni; 2019 [18]	"Identificação do nível de conhecimento em cuidados paliativos na formação médica em uma escola de medicina de Goiás"	Brazil	Cross-sectional, observational	Medical schools are deficient in addressing the inevitability of death and bioethical issues in the curriculum, hence students are not trained to have end-of-life conversations with older adult patients.
Carter and collaborators; 2021 [19]	"A rapid scoping review of end-of-life conversations with frail older adults in Canada"	Canada	Literature review	A clear and concise dialogue on the diagnosis of the older adult patient is crucial to achieve better clinical outcomes. Encouraging autonomy in conjunction with continuous dialogue determines greater survival for these patients.

In a cross-sectional study conducted in 1992 with 2,000 Italian older adults to evaluate factors that would interfere with survival, Mazzela and collaborators [7] found that the end of life in the older adult population is multifactorial and several situations can limit their survival. Conditions such as low socioeconomic class, loneliness and comorbidities are among the major determinants of readmissions and mortality among older adults. They concluded that loneliness would be correlated with worse clinical outcomes and unfavorable prognoses in this population.

Gronewold and collaborators [8] described that feeling alone or living isolated from society is associated with high cardiovascular risk and morbidity and mortality regardless of other risk factors. Conducted in Germany, this research followed more than 4,000 participants of both sexes aged between 45 and 75 years, most without a history of vascular disease, in three times: 1) between 2000 and 2003, 2) after five years and 3) after ten years. They evaluated the level of support and social integration, associated with factors such as age, sex, blood pressure measurements, lifestyle, presence of psychiatric disorder, among others.

It was found that older adult women are, on average, more independent than men in the same age group for daily activities, but consume more antidepressants and are more sedentary. In addition, participants who reported receiving less emotional support had a higher rate of depression, less social interaction, and higher tobacco use [8].

In the 13.4-year follow-up period, there were 339 cardiovascular events (8.47%; $p<0.001$), of which 122 strokes, 183 coronary events, and 34 deaths related to diseases of the circulatory system. The authors point out that participants with these outcomes had less financial and emotional support, less social interaction and more severe depression [8].

Through interviews with family members and data collection in medical records, Hernandez and collaborators [9] analyzed the history of 32 older adults who had died from suicide and 45 who had died from natural causes ($p<0.001$). They concluded that lack of hope, depression and a negative view of one's own health were the main risk factors for suicide in this population.

Interestingly, the sum of physical diseases had minimal impact on the suicidal population and older adults with comorbidities who committed suicide had a more negative view of their diseases compared to those with the same diseases who died from natural causes. Moreover, social isolation can be both a consequence and a cause of weak mental health. This makes evident that health care professionals and society need to have greater attention to the mental health of older adults, in order to trace signs of depression and suicidal ideation and deal with them [9].

Other diseases related to the social death of these people are sexually transmitted infections (STIs). According to Andrade and collaborators [10], there is a distortion of conceptions in society, as people tend to consider the older adult population as "asexual" or even think that they have sexual relations with only one partner. This is compounded by the trivialization and indiscriminate use of erectile dysfunction medications, which can provide a feeling of confidence that makes the person forget about the use of preservatives.

Although these factors are relevant, the most important reason for the increased number of cases of these diseases in this age group is the lack of dialogue on the subject with health care professionals. The research also found that information on STIs is scarce in basic health care units and the elderly consider STI contagion a taboo, restricted to young people [10].

Ribeiro and collaborators [11] point out that aging in today's society is a continuous process of lacks in autonomy, weakness and, above all, suffering. Losses are part of aging, but the way they are coped with throughout life defines whether this process will be lighter or with suffering.

Many people no longer find sense in staying alive over time, after losing autonomy due to physical limitations, loved ones or social roles, isolating themselves more and more and subjecting themselves to waiting for death. However, in societies that accept aging, older adults have spiritual comfort and receive significant social support [11].

The different strategies to cope with aging and death depend significantly on how society sees this stage of life: denying the inevitable

or adapting the difficulties of this time to each individual without judgment. According to the authors, Western society is not attentive to aging and consequently there are no discussions about death and the inevitable frailties of aging. Thus, older adults associate their condition with something shameful and, also considering the growing abandonment, develop depression and several comorbidities [11].

According to Souza, Giacomin and Firmo [12], the necessary care for older adults, specifically those in frailty conditions—with reduced cognitive and physical functionality—is multifactorial and essentially requires sensitivity and patience. The researchers note that, as a significantly growing group in the demographic pyramid, its specific needs require consideration in the health care system.

Thus, it is essential for the biopsychic and mental health of frail older adults that they are provided care while being equally respected in relation to others, preserving their autonomy and observing their limits. Despite the frailty of the elderly, assuming that they are unable to perform tasks can be harmful. Therefore, observing them and offering them help only when necessary stimulates their autonomy and confidence, improving their prognoses [12].

According to Fagundes and collaborators [13], neglect in the treatment of the older adult population is even institutionalized. The term "institutionalization of the elderly" refers to long-stay institutions (LSIs), which in theory should provide care, but often provide a negative experience to older adults, abandoned in these places to await death—already consummated for society—in a negligent and veiled manner.

LSIs are popularly known as "nursing homes" and originated in the middle ages, with the rise of the first caregiving services for needy people, who required basic care, but should not be exposed in society. The authors note the need to reform these institutions in order to ensure better living and health conditions for inmates, who are sidelined in society [13].

Kotwal and collaborators [14] carried out an epidemiological analysis of older adults at the end of life in the state of California, in the United States. The study included more than 3,000 older adults, of whom 19% were socially isolated, 17.8% felt lonely and 5% were in both situations. The high rate of social isolation can be explained by the fear of the impending death, as well as the shameful character conferred by aging, resulting in difficulties for older adults to seek emotional, financial and psychological help.

Kim and Jung [15] collected data through a questionnaire on behavior and perception about the COVID-19 pandemic and found that social isolation had important direct effects on the mental health of older adults. The results show that quarantine was directly associated with psychological suffering in older adults, corroborating the understanding that the lack of social integration would lead to deleterious consequences for mental health.

The authors noted that, although social isolation measures were important and helped to protect public health, they had unintended negative consequences on the mental health of older adults. They already suffered with the loss of interpersonal bonds before the pandemic and the intensified isolation worsened their psychological burden [15].

Goveas and Shear [16] report an increased number of cases of prolonged grief disorder (PGD) as a sequela to the pandemic. In fact, circumstances, contexts and consequences of deaths caused by COVID-19 are risk factors that increase the rate of PGD. Associated with that, restrictions on the movement of people, especially older adults, changed the experience of death; thus, the risk of PGD seemed to be higher in older adults and/or those with a psychiatric history.

Fraser and collaborators [6] note that the pandemic intensified exclusion and caused even more harm to older adults, because the crisis of the health care system led to a disturbing discourse on aging, which questions the value of the lives of people who contributed so much to society. Initially, it was said that the pandemic was dangerous only for the older adults and the situation was treated with insignificance, as if this fact brought relief to the young population.

Often, the death of older adults was only computed as statistics, without social and psychological analyses. The authors also say that

it is necessary to understand that the point is not only preventing the loss of lives or reducing the demand on the health care system, but also to make it clear that older adults are invaluable members of our society. Several comorbidities and unfavorable outcomes of this population may be a consequence of this negligence [5,6].

Paradoxically, the factors affecting the survival and health of older adults originate in the community that should care the most for this population and study it to understand its limitations, capacities and finitudes: physicians. According to Ferreira, Nascimento and Sá [17], knowledge and understanding about death and dying are among the least addressed subjects during the academic training of health care professionals. In a research carried out in a teaching hospital based in Campinas/SP, they observed that the culture of denying death prevails even among those that are the most knowledgeable on the subject.

The research brings to light the physicians' discomfort when witnessing the patients' end of life, with their distancing being common, which is opposite to the expected conduct of these professionals, since it is their function to promote the maturation of the family and the patient in the face of the impending death. This feeling of denial of dying ends up being replaced by the "naturalization" of suffering, in an attempt at emotional protection of the physician that can culminate in dysthanasia, that is, artificial prolongation of the death process. The damage triggered by failures in health education makes the end of life of older adults painful and slow [17].

Furthermore, according to Pereira, Rangel and Giffoni [18], inadequate medical practices in the face of the end of life have their origin in medical education. The authors evaluated the knowledge about the end of life of students of a Brazilian medical program and most did not know how to define the concept of dysthanasia and considered that training on palliative care and death in undergraduate programs was scarce.

The medical schools' deficiency in addressing end-of-life bioethical issues implies that students are not prepared to talk about the subject with patients and, indirectly, corroborate the understanding that patient death is a failure of medicine. Lacking knowledge on concepts so valuable for bioethics, such as dysthanasia, may be one of the factors responsible for this practice, since physicians who have not studied the subject tend to believe that the forced extension of life is natural and necessary [18].

Carter and collaborators [19] emphasize that discussions on end of life should be conducted with critically ill patients since diagnosis, in order to better prepare them and provide them with understanding as to choices during the development of the disease. Thus, these patients can be referred to palliative care instead of following a treatment that leads only to physical and emotional exhaustion.

They note that not providing older adults choices about their treatment is a problem, as clinical prognoses and outcomes are worse when the life course is not decided by patients—and, therefore, their autonomy is not encouraged. In order to correct such flaws, it is necessary to have transparency in relation to the prognosis—only identifying it being insufficient—and to discuss the development of the disease, in order to align patient expectations. When older adults are encouraged to learn more about their condition, the end of life becomes more comfortable, and there may even be clinical improvements [19].

According to Soares and collaborators [20], medical practices fail not only in the lack of dialogue and guidance about end of life, but also in not seeing aging as a heterogeneous process. In addition, there is a socially widespread view of older adults as fragile, dependent and with multiple comorbidities and gradual levels of forgetfulness—a prejudice known as ageism. In this regard, the researchers point out that one of the explanations for the collapse of the health care system in many European countries at the beginning of the COVID-19 pandemic was precisely the generalization that older adults would have more severe clinical outcomes than the younger population.

It is crucial to channel health resources to care for older adults to ensure their well-being, considering the neglect they suffer. It is also necessary to ensure that this investment is based on scientific data and has no discriminatory bias, enabling empathic care. The notion that older adults cause

losses to governments due to the public spending they demand must also be overcome [20].

Discussion

The social death of the older adult population has several negative consequences for society, since aging, which should be seen as natural and physiological, is interpreted with horror or ignored [1]. As a result, this population is marginalized and institutionalized, spending the end of their lives in precarious and isolated places [1,16]. Thus, aging is treated as an infectious disease and not as an inevitable aspect of life [16].

A universal health care system should include everyone in care and cover the geriatric population in its heterogeneity, with various spectra of fragility and specific diseases [7]. Paradoxically, when there is a consideration as to providing care to this population, it focuses on the care of the disease, and not of the sick older adults, and does not cover the social and psychological determinants of the health-disease process.

Few medical care measures address the patient's view of aging, their sensations, anxieties, perceptions and, above all, their desires. Thus, how to provide care to an elderly patient if society does not put itself in their place, does not know the determinants of their diseases, and does not guarantee space for them [1]?

Neglect in the treatment provided to older adults was exposed during the COVID-19 pandemic, as the disease affected this population more severely, who already faced age-based discrimination, leading to a vicious cycle of physical and mental illness [6]. In addition, the lack of a specific and empathetic medical consideration of this population is responsible for the high rates of depression, STIs, coronary diseases, among others [9,12].

Protective measures, such as social distancing, during the COVID-19 pandemic were undeniably important; however, that does not justify the way the social isolation the elderly had been experiencing for a long time was reinforced. This situation also showed society's indifference as to losing the older population [6].

The training of health care professionals is based much more on healing than on relief of suffering, hence death triggers a feeling of impotence or is seen as an evil to be overcome. Thus, the end-of-life subject is little addressed in medical training and, consequently, there is not a comprehensive view on older adults that can comprehend their cycles and limitations [7]. This limited care not only causes greater suffering during the end-of-life period, but can also lead to several diseases that are common in this age group, such as depression and STIs, because the dialogue of health care teams is not effective [6,7].

The social death of older adults may be undergoing a "normalization" in society and, consequently, in medicine. However, it is paradoxical to swear that one will care for patients at graduation, but not to establish a concrete bond of dialogue and respect with them, nor to ensure that the end of life is cared for with quality, and not with abandonment [8].

Precisely because there is no such dialogue, physicians do not accept the inevitability of death and several hospitalized older adults are submitted to dysthanasia. That is, the foundations of the social death in the older population may be in the current culture, in addition to the lack of communication and study on the end of life among health care professionals [8].

Moreover, opportunities to improve their quality of life are lost due to the misconception that older adults have no desires, skills or even sexual partners [9]. Health care professionals should understand that aging is a natural, heterogeneous and dynamic process, and not an evil to be fought and/or forgotten. That is, healthy aging requires not only acceptance, but also understanding and respect for limitations, with constant and clear dialogue [15].

Final considerations

This review included valuable observational studies that address the social death of older adults and how current society and the health care system have dealt with the issue negligently, leading to a precarious life of this population and affecting the quality of end of life and death. Such neglect, intensified by the COVID-19

pandemic, worsened the situation of these people, who already faced isolation, depression, coronary heart disease, and STIs.

It is necessary to provide specific care to older adults, capable of understanding their needs and limitations, with support so as to integrate them into society. The medical community and people in general need to address aging, issues of this age group and end of life more openly with older adults.

Diseases, such as depression and coronary heart diseases, and clinical outcomes, such as the cases related to COVID-19 mentioned in this work, are increasingly prevalent in the geriatric population because of the lack of care and inclusion by physicians and society.

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