

Social Isolation of Older Adults in Long Term Care as a Result of COVID-19 Mitigation Measures During the COVID-19 Pandemic: Protecting the Individual or a Means to an End?

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ABSTRACT

In response to the threat of COVID-19, CMS issued unprecedented restrictions severely limiting the liberty of older adults residing in long-term care. Older adults are identified as at a high risk of becoming infected through exposure to SARS-Cov-2 and of suffering the most severe morbidity and mortality. While protecting the individual from disease, the restrictions also had a determinantal effect. The restrictions exacerbated social isolation and loneliness, two pervasive public health concerns within the older adult population. Legally, the restrictions pass constitutional muster. The ethical analysis presents more questions and debates. Initially, the restrictions to protect the older adult were grounded in public health ethics and bioethics principles. However, the ethical lines become blurred as the risk of harm secondary to isolation increased over the time that the restrictions remained in effect. The ethical point of view becomes more divergent considering the restrictions also preserved medical resources for the greater good of society, arguably diverting them to serve younger people. We have a moral obligation to reduce social isolation and recognize the older adult as a valuable member of society with equal worth and dignity.

Keywords: Pandemic, Long-term Care, Public Health, Resources, Social Isolation, Loneliness

INTRODUCTION

In response to the threat of COVID-19, CMS issued unprecedented restrictions severely limiting the liberty of older adults residing in long-term care. Older adults are identified as at a high risk of becoming infected from exposure to SARS-Cov-2 and from suffering the most severe morbidity and mortality. While protecting the individual from disease, the restrictions also had a determinantal effect. The restrictions exacerbated social isolation and loneliness, two pervasive public health concerns within the older adult population. Legally, the restrictions pass Constitutional muster. The ethical analysis presents more questions and debates. Initially, the restrictions to protect the older adult were grounded in public health ethics and bioethics principles. However, the ethical lines become blurred as the risk of harm secondary to isolation increased over the time that the restrictions remained in effect. The devastation of COVID-19 within the older adult population extends beyond the immediate risk and harm of infection.

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At the beginning of the COVID-19 pandemic, experts determined that older adults, especially those living in long-term care, were at a greater risk of becoming infected and depleting scarce medical resources. Two days after WHO declared the pandemic, the Centers for Medicare & Medicaid Services (CMS) followed the Centers for Disease Control (CDC) recommendations and announced mitigation measures that required long-term care facilities to (1) restrict volunteers and nonessential personnel from entering the facility; (2) cancel all group activities and communal dining; (3) screen residents and health care personnel for fever and respiratory symptoms; and (4) encourage residents to stay in their rooms. The social isolation resulting from the mitigation measures posed a credible threat to five core domains of healthy aging: (1) promoting health; preventing injury and managing chronic conditions; (2) cognitive health; (3) physical health; (4) mental health; and (5) facilitating social engagement.¹

I. Social Isolation and Loneliness

COVID-19 highlighted two pervasive public health concerns confronting older adults—social isolation and loneliness. Social isolation is an objective deficit in the number of relationships and the frequency of contact with family, friends, and the community.² Social Isolation is a risk factor for loneliness. Loneliness is the subjective perception of a lack of meaningful relationships.³ Loneliness has three dimensions: (1) absence of a significant person to provide emotional support and affirm one’s value as a person; (2) absence of a small group of people seen regularly, such as a card group; and (3) absence of a larger network group of people who provide support by being together as a group, for example, church services or rotary meetings.⁴ COVID-19 restrictions affected all three dimensions.

Social isolation can be as dangerous as smoking fifteen cigarettes per day, earning its designation as a public health priority.⁵ Isolation increases the risk of cardiovascular disease, obesity, anxiety, and depression. Loneliness can lead to depression, alcoholism, and suicidal thoughts.⁶ Some studies found that loneliness is also a factor in cognitive decline. For example, caregivers reported that 63 percent of older adults with cognitive impairment experienced cognitive decline during the COVID-19 pandemic.⁷

In 2017, the American Association of Retired Persons (AARP) reported that social isolation accounted for \$6.7 billion in additional Medicare spending although only 14 percent of older adults in the US reported being socially isolated.⁸ Approximately 24 percent of community-dwelling older adults in the US are socially isolated. Forty-three percent of adults aged 60 and older report feeling lonely. Those living in long-term care report loneliness at a rate of at least double of community-dwelling older adults.⁹

WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹⁰ A broad definition of health highlights the detriment of social isolation in older adults. There is a moral obligation to mitigate the effect of isolation.¹¹ The additional Medicare spending costs attributable to the effects of social isolation secondary to COVID-19 will be extraordinary. Providing social support will directly benefit older adults and indirectly benefit society by reducing Medicare spending associated with the effects of social isolation. Combating the pervasiveness of social isolation requires immediate collaborative community action.

Many long-term care residents who depend on visits from family and friends to socialize increasingly felt lonely, abandoned, and despondent,¹² increasing the risk of feeling grief and loss, including individual and collective trauma reactions.¹³ Also, normally social opportunities, medical, and legal appointments defaulted to telephone or virtual appointments. The cessation of in-person medical appointments interfered with optimal management of chronic conditions and preventive care. Some older adults lack access to the technology, are unfamiliar with technology, or cannot use technology for other reasons. At

least one study supports the potential for older adults to benefit from technology and suggests that training could promote long-term benefits in older adults aged 80 years and over.¹⁴ Focusing on technological advances specific to older adults with input from older adults should be a priority.

When communal dining abruptly stopped, residents had to eat all their meals alone in their rooms. Older adults often mention the difficulty of eating meals alone, especially if recently divorced, widowed, or otherwise separated from a spouse or partner. Closure of the exercise facilities limited the ability of an older adult to stay physically active. Reduced physical activity creates long-term adverse health effects.¹⁵

II. Measures to Mitigate Isolation

To facilitate some contact, long-term care facilities devised window visits. The resident remained safely inside the locked facility, standing or seated in front of a window. Visitors stood outside in the grass or parking lot. Any conversation took place over the telephone. To simulate physical contact, residents and visitors pressed their palms together, separated by the glass barrier. The window visits recall the prison visits depicted in movies and television.

In late June 2020, CMS relaxed the restrictions and advised that long-term care facilities could resume some communal activities and permit outdoor visits. Although CMS eased the restrictions, interpersonal contact remained minimal. Outdoor visits required scheduling an appointment during limited hours of availability. The facilities limited the visits per week and the duration of each visit to thirty minutes. In addition, the staff enforced wearing personal protective equipment and maintaining physical distancing.

Several impracticalities diminished the optimism of the relaxed restrictions. Residents could leave their rooms for meals but remained physically separated at a distance that prevented any meaningful interaction. Similarly, the limitations on the in-person visits presented problems. Non-resident spouses with mobility challenges found the outdoor access difficult, if not impossible. Residents or spouses with hearing and vision losses experienced challenges in communicating while sitting outside, six feet apart, and wearing masks.¹⁶

III. Legal Precedent for Emergency Measures

The primary legal issue stems from the conflict between individual liberty and the public good or health. *Jacobson v. Massachusetts* provides a framework for balancing individual liberty rights and the public good during a pandemic.¹⁷ *Jacobson* clarified an essential point of law - the rights and liberties secured by the US Constitution are not absolute.¹⁸ Faced with a pandemic, a community has the right to protect members of the community.¹⁹ *Jacobson* outlines four standards for imposing public health mandates during a pandemic. First, the State overreaches when it uses public health powers unnecessarily.²⁰ Second, the state must use the least restrictive means to prevent harm.²¹ Third, the state must use reasonable means expected to prevent or ameliorate a health threat.²² Finally, the intervention must not pose an undue risk.²³

The guidelines in *Jacobson*, established during the smallpox pandemic, apply to COVID-19. In response to the threat of COVID-19, public health authorities enacted mandates to protect the public, especially older adults, against the highly contagious and virulent virus. The CMS restrictions specifically addressed older adults living in long-term care facilities. While the CMS directives obstructed residents' liberties, they also contradicted the Assisted Living Facility social model, which places autonomy and independence at the forefront.

Given the gravity of harm and the uncertainties in the early phases of the pandemic, the restrictions were arguably the least restrictive means to manage the immediate threat. The effectiveness varied from facility to facility, with many deaths throughout the US in long-term care facilities. While valuable early in the pandemic, at some point the continuation of the mitigation measures increased social isolation and its associated risks.

In *Jew Ho v. Williamson*, the Supreme Court overturned a quarantine order to contain the bubonic plague.²⁴ The officials enforced the order only against a targeted ethnic population which did not present an identified risk.²⁵ In reaching its decision, the Court determined that the quarantine order was not a reasonable regulation to prevent the spread of the bubonic plague. Rather, it was racially motivated. The Court ruled that the government cannot impose public health orders in a racially invidious manner.²⁶ There are similarities between *Jew Ho* and the CMS restrictions. Like the quarantine order in *Jew Ho*, the restrictions targeted a specific population. But with COVID-19 older adults were an identified high-risk population because of their susceptibility to infection and severe illness. During the early phases of the pandemic, the directives were reasonable to accomplish the purpose of preventing the spread in the identified high-risk population. They were not discriminatory according to the rule of law in *Jew Ho*.

The argument supporting the constitutionality of the CMS restrictions wanes as the length of the safety precautions increased.

IV. Ethical Analysis of the Lengthy Social Isolation

The CMS restrictions require the ethical analysis of harm, proportionality, reciprocity, and transparency. As well as analysis under the principles of autonomy, beneficence, non-maleficence, and justice.

a. Harm and Proportionality

As previously discussed, older adult long-term care residents were more susceptible to COVID-19 and to severe physical effects requiring hospitalization. In addition, older adults are more likely to die from COVID-19. Based on a totality of the circumstances and what we knew about the virus in the early phases of the pandemic, the restrictions were the least restrictive means to protect this high-risk population. But the question of proportionality requires ongoing assessment and re-evaluation. While the initial uncertainty and chaos justified the restrictions, as the pandemic continued and the risk of harm from the restrictions increased, the pendulum began to swing. At some point, upon proof or likelihood of safety, less restrictive alternatives should have been adopted.

b. Reciprocity

The concept of reciprocity is a core principle of public health and requires the balancing of the benefits and burdens of the social cooperation.²⁷ When individuals sacrifice their liberty for the benefit of others, they should not be penalized as a result of making the sacrifice, and thus society owes a reciprocal obligation to the individuals, such as providing individuals support and not discriminating against them.²⁸

Residents did not have any input or choice when CMS and the administrators stripped away their autonomy and liberties. While the restrictions protected the individual resident from the direct harm of infection, the restrictions also protected society from the indirect harm of the depletion of scarce medical resources. Public health officials identified long-term care residents as most likely to require significant medical resources. One talking point repeatedly broadcast was the need to prevent the depletion of hospital beds, ventilators, medications, and supplies. Most assisted-living facilities are for-profit, and residents pay for

their food, shelter, and personal needs. What does society owe these long-term care residents in return for the liberty they sacrificed for the benefit of society at large? At the very least, I suggest we owe these individuals the commitment to conduct research exploring and addressing the effects of the restrictions.

c. Transparency by Government, the Media, and the Long-Term care Facilities

The communications from government and public health officials about the pandemic and the restrictions were opaque, leaving unanswered questions, doubts, and speculation. Some facilities provided families with basic information communicated through robocall messaging, with words of encouragement, painting rosy pictures of the residents' sequestered daily lives.

Public health officials assert the common good and protecting the public's safety and health justify paternalism and compulsory powers.²⁹ One counterargument is that the compulsory interventions or restrictions push paternalism to new levels.³⁰ The COVID-19 pandemic and the mitigation interventions highlight this tension between libertarian and epidemiological models based on (1) shortages that triggered rationing and prioritization; and (2) measures that safeguarded public health but infringed on individual rights.³¹

d. Autonomy, Beneficence, and Non-Maleficence

Through a bioethical lens, we immediately see the clash between the CMS restrictions and the long-term care residents' autonomy. However, autonomy is not absolute. There was a benefit for the individual resident: the protection from a deadly virus. Thus, I argue that the initial restrictions were beneficent. Yet I also point to the deleterious secondary physical and emotional effects of the isolation and assert that the restrictions should have been safely modified as new information on viral spread and safety came about. We can accept the beneficence of protecting the high-risk resident from a deadly disease while acknowledging the associated harm. However, at some point, we must also ask if the harm experienced due to prolonged severe restrictions reached a level that exceeded the boundaries of beneficence and became maleficent.

Perceiving the long-term care resident as a passive recipient of care is paternalistic and antithetical to autonomy and a person-centered approach.³² Instead, society must recognize older adults as essential stakeholders in policymaking. The direct and active involvement of older adults allows the individual to retain agency rather than becoming a passive recipient of care.³³ Prioritization of the older adult as an autonomous active participant counters ageism and promotes autonomy.

e. Justice

Justice calls for analysis of several discrepancies. First, the special protection of long-term care residents seems justifiable due to their special vulnerability. CMS treated long-term care facilities alike. Most community-dwelling older adults could decide whether to adhere to stay-at-home restrictions and were not subject to the same level of enforcement that existed within long-term care facilities. The restrictions were far more oppressive for long-term care residents. In response to the assertion that selective lockdown discriminates against older adults, the same arguments discussed above demonstrate the morally relevant justification: older adults are more likely to require hospitalization and die from COVID-19.³⁴

One convincing argument against restrictions on older adults echoing Kant's categorical imperative argues that selectively restricting older adults for the good of other people amounts to treating older adults as a means to an end for others.³⁵ While the restrictions imposed on the individual might slow the spread of

the disease within the specific long-term care facility, which protects that individual resident, they also impose on the individual resident to serve the greater good: the preservation of scarce medical resources. The second application pushes the restrictive measures closer to violating Kant's categorical imperative by treating the older adult as a means to the end of others. That is, younger people and those living outside of long-term care would have more hospital resources available to them if long-term care residents were more severely isolated keeping them from needing hospitalization.

From a Kantian perspective, the categorical imperative demands respecting the dignity of persons—Kant's supreme (formal) principle.³⁶ When we consider the restrictions, I suggest that we must also consider the impact on dignity. It has been suggested that dignity is the "overarching principle of bioethics."³⁷ In the context of an analysis of the socially isolating COVID-19 mitigation measures on older adults in long-term care facilities, we should consider the relational aspect of dignity, recognizing the adult as having value and equal worth. The protracted imposed isolation of older adults to preserve medical resources devalues older adults. Ongoing COVID-19 restrictions should be analyzed for their unjustified harms.

A second justice concern outside the scope here is that long-term care facilities are resourced differently, and had different results due to quality of care, number of staff, infection control protocols, and previous health infraction records.

CONCLUSION

The myopic focus on mortality ignores the risks of morbidity secondary to the devastating effects of social isolation on the older adult's health and quality of life. The paternalistic prevention eclipsed the resident's autonomy. At some point, the attention and priority must shift. When formulating policies, we must figure out at what point or in which situations the negative impact of restrictions outweighs the protective benefits.

Although the restrictions may have slowed the spread of COVID-19, we must not discount the negative consequences, which may be long term. From an ethical perspective, we must acknowledge the harm that has occurred within this population and accept the responsibility to redress the harm and prevent repeating the mistakes.

The prolonged restrictions stretched legal and ethical boundaries. The mixed purpose of the restrictions (protecting the individual resident and preserving healthcare resources) makes the ethical analysis more challenging. Yet doing something for someone's own good is still paternalistic and problematic. The public health justification includes the collective.

We must confront the tough questions about the efficacy of pandemic mitigation measures and the mitigation measures' adverse consequences. Leaving the doors to long-term care facilities open during the pandemic would have exposed every resident and staff member to a contagion that presented a significant risk of morbidity and mortality. But locking the doors exacerbated social isolation and loneliness, increasing the risk of morbidity and mortality. Julian Savulescu may be correct that there was no desirable solution. We must still work to find better solutions that will reduce social isolation and recognize the older adult as a valuable member of society with equal worth and dignity.

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