COVID-19, Social Distancing, and an Ethic of Care: Rethinking Later-Life Care in the U.S.

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Abstract

In 2020, the novel coronavirus (COVID-19) disrupted life around the globe. In the United States, governors issued state of emergency orders and mandated shelter-in-place and social distancing measures. While these measures are important, they ignore the nuances of risk for vulnerable groups, such as older adults. Moreover, social distancing measures made more visible the reality that many patients in care homes often die in isolation. In this commentary, we argue that a rethinking of later-life care is necessary and to understand this need, that critical geographers should expand on how we evaluate care. Here we start from a space of radical care ethics to examine the emotional experience of place and the role it should play in how we think about later-life care. Reflecting on state-mandated social distancing, we show that the current system of geriatric care in the United States does not promote dignified living for older adults and how older adults' complex emotions are ignored in current later-life care. We conclude by recommending that the emotional experiences of place must be taken into consideration for scholars examining place-based later-life care of older adults.

Keywords

Social distancing, isolation, emotions, care ethics, U.S. eldercare

Introduction

At the time of writing, COVID-19 is causing serious illness and death across the world. Many forms of social interaction changed dramatically as society scrambled to move to virtual platforms in order to maintain education and work environments, and daily routines such as grocery shopping and meal preparation moved to online ordering and curbside to-go. The coronavirus pandemic has shaken society at its very foundation and fundamentally disrupted lifestyles and daily routines. Social distancing measures, such as six-foot spatial distancing, limiting the number of people at gatherings, and restricting access to some institutions, highly impacts our daily lives. People have lost their jobs and businesses, and many have lost their lives due to the virus. While everyone is impacted, the degree of impact is disproportionate, with some groups being exposed to significant suffering as a result of both the pandemic and the measures taken to address it. Here, we focus on the impact on older adults, particularly those in care homes by reading social distancing measures through an ethic of care. Prior to the pandemic, many receiving later-life care had reported experiencing isolation and depression (Adams et al., 2004; Huang et al., 2014; Payne et al., 2002). Now, in the midst of the pandemic, their emotional suffering is exacerbated by mandated social distancing (Abbasi,2020).[1] Many receiving care are living undignified lives and are dying alone (Goveas and Shear, 2020). The emotions and experiences of those receiving care, moreover, are not well recognized by the healthcare system or government policies. The way COVID-19 was handled shows that the discourses on the condition of later life care, which are often portrayed as an individual choice or to some degree in control of the individual or their family, are faulty. This is a fundamental point we wish to draw attention to in this commentary, because even as COVID-19 responses demonstrate that new discourses are needed, reconsidering care must be a component of this rethinking. In this commentary, we argue that to address the failures of the later-life care system we must give attention to them and re-evaluate later-life care through a critical examination of place-based emotions. To do so, we draw on the call of Wood et al. (2020) to consider a radical ethic of care within and outside the academy.

The novel coronavirus, COVID-19 is a strain of SARS-CoV-2, which emerged in 2019. Coronaviruses result in Severe Acute Respiratory Syndrome (SARS), which has proven to be extremely damaging and, in many cases, fatal. The mortality rate of COVID-19 varies widely based on the characteristics of the population (Rothan and Byrareddy, 2020; Seladi-Schulman, 2020). In places such as China and Italy, cases became concentrated in the older adult population and led to early policymaking around social distancing to reduce possibilities of transmission (Dowd et al., 2020). In the United States, Luterman (2020) notes, the rapid rate of infection in nursing homes is not a new phenomenon, because nursing homes are an ideal place for opportunistic infections (e.g. Clostridium difficile) but are usually neglected despite that status. As a result, eighty-two percent of nursing homes received complaints for failure to prevent rapid spread of infections, and additional allegations have arisen that point to systematic improper medical care (ibid: n.p.).

In the early days of the pandemic, it became well-documented that older adults were more vulnerable to the virus and that many who contracted COVID-19 would not recover (Bonanad et al., 2020). News outlets and social media seized on this fact with an outpouring of opinion on the effect of social distancing, hospital triage, and impacts on the economy. We began to hear calls for 'letting grandma die' in order to save the United States from entering an economic recession (Sullivan, 2020). Alongside such macabre suggestions, an outpouring of sentiments to the effect of 'stay home and protect

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[1] We fully recognize that caregivers both paid and unpaid also suffer from emotional distress in their daily work and especially during the pandemic. We do not dismiss their important role and note that a focus on caregivers is an important site for additional research and/or commentary.

our elders' emerged (Beachum, 2020). At the same time, some news outlets began to publish "heartwarming" stories about older coronavirus patients giving up their ventilators for young people, extolling their self-sacrifice (Brown, 2020). Other such stories provide a glimpse of the isolation of those interned in institutionalized elder care, as families could not gain access to care facilities to provide care or companionship to a loved one (Schladebeck, 2020). Perhaps most shocking, news surfaced about cover-ups of coronavirus deaths in care facilities, massive shortages of caregivers, and the abhorrent conditions and deficiencies of care and care facilities in the U.S. (NYT, 2020). The pandemic revealed how relational the conditions of later life care are. Many receiving care are not self-sufficient or in charge of the conditions in which they live their lives. Instead, their day-to-day living situations are controlled or dependent on multiple forms of care (from people, medical devices and so on). In many cases this care is alienated, inattentive to emotion and presents a dynamic inadequate to dignified living.

Here we focus not on the quantity of life, but quality. Patients in eldercare facilities in many cases have little control over the circumstances of their later-life care. This situation is dehumanizing and demands that we take a critical, radical approach to how we think about care. While many health workers, from doctors to volunteers, serve tirelessly to relieve the pandemic crisis, an examination of the geriatric care system impacted by social distancing mandates during COVID-19 exposes a hard truth: those who contracted the coronavirus were unintentionally handed a death sentence (Paulin, 2020). By taking this perspective, this paper uses an ethic of care as a lens to examine how social distancing mandates ignore the experiences of older adults who reside in eldercare facilities. Mandated social distancing due to COVID-19 provokes numerous emotions resulting from activity constraints and isolated living environments (ibid). However, even before the pandemic, older adults who may not be able to advocate for themselves experienced similar emotions in their daily lives, as aging may cause changes in physical and cognitive functions.

Prior to the pandemic, many receiving later-life care reported experiencing isolation and depression (Adams et al., 2004; Huang et al., 2014; Payne et al., 2002). This already existing condition was exacerbated by state orders on social distancing and lockdowns/shelter-in-place orders (Rodney et al., 2021), which limited proximity, gatherings in public and private spaces, as well as, travel and quarantine periods. Social distancing is described by the U.S. Center for Disease Control (CDC) as maintaining six feet of physical distance between people not of the same household (CDC, 2020a). Such mandates made visitation of older adults receiving later life care impossible—and many care centers remained closed to visitors while we drafted this paper. The CDC (2020b) further put together a guide for eldercare centers to distribute to potential visitors, encouraging them to use technology to send messages, to provide outdoor visuals such as ribbons and banners, to send messages and care packages by mail, or participate in 'parade of cars' visits among other strategies for staying connected. However, the emotional experience of place is not well-recognized in the structures of the elder health care system in the context of COVID-19 and more broadly, and in this paper, we argue that to address the failures of the health care system for older adults, we must give attention to them and rethink later-life care through a critical examination of place-based emotions. Our contribution to this discussion is intended to draw attention to such emotions and the desire for dignified living, as part of an ethic of care, to create new avenues for thinking about how to reform these systems by reflecting on state mandated social distancing.

Receiving elder care is often accompanied by dynamic emotions based on decision-making processes to determine where to receive later-life care. Older adults have limited options to choose from when considering their later-life care in the U.S., often choosing between maintaining or downsizing their current residence or moving to a care facility. Each of these options raises complex financial considerations because the level of assistance required demonstrates the nuance of housing choices; for example, hiring in-home care, or choosing to receive around the clock care in an assisted living facility. By starting from a space of radical care, which opens up care, making it multiple (cf. Naylor, 2021;

Naylor et al., 2020), we draw attention here specifically to older adults' emotions which they may experience in the process of the where and why of movement, living, and perception of place. Examining the emotions of older adults can expand how we think about care and change how we think about reforming the structures that undergird later-life care. It has the potential to interweave the way we think about place with an ethic of care that is multiple (e.g.: medical care, emotional support, dignity of life).

While progress has been made in geography, gerontology, and psychology, especially regarding interrelationships between external environments and mental health for older adults (Andrews et al., 2007; van Melik and Pijpers, 2017; Warnes, 1990), few focus on the interplay between certain health policies (e.g. social distancing mandates) and the social atmosphere, which in some cases marks older adults as an abandoned group within eldercare systems (Giesbrecht et al., 2018; Stienstra and Chochinov, 2012). In this context, understanding why people make certain decisions and their decision-making processes can assist with explaining unspoken and unconscious emotions, which reflect on the spaces and structures of later life care (MacKian, 2004). For example, emotional ties to place, such as a family home or even aspects of such places, may drive decision-making, which fundamentally changes the character of an individual's later life care.

Understanding emotions in place, such as interactions with public healthcare structures, for example, Medicaid, or elder care facilities provides a powerful bridge between an individual's inner worlds (thoughts, feelings) and external worlds. We suggest that a new critical research approach would analyze daily emotions of older adults who need eldercare across place, including private homes, communities, and other places where daily activities occur. Findings from this new work may contribute to creating different and more supportive social environments for older adults and lead to dignified living later in life. We first ground the paper in a discussion of aging in place, geographies of social distancing, and an ethic of care to provide a basis for a subsequent discussion of why emotions should be centered in research on later-life care and decision-making around all forms of care for older adults.

Aging in Place, Social Distancing, and an Ethic of Care

As the population continues to age, and as this demographic grows in size, research on older adult's emotions is essential for creating dignified 'later-life-care' places, where older adults live, rather than considering 'end-of-life care,' which suggests a choice of where to die. Although care occurs in various settings from professional spaces such as hospitals, hospice, and clinics to individual homes and long-term care facilities (Giesbrecht et al., 2018), the later-life-care described in this paper refers to all caring provisions in which older adults feel free of isolation and imbued with dignity, whether they are ill or not. The spaces we experience are a crucial component of our emotional responses, so a closer look at decision-making that older adults have in later-life care, whether in their home or a care facility and the emotions that undergird these decisions, is imperative.

To better understand the experience of older adults, environmental gerontologists and geographers have made a number of contributions to how older people's behavior relates to their environment, especially where they live. Environmental gerontologists developed a scientific 'ecological model of aging' emphasizing significance of place attachment (Smith, 2009). Such models include Lawton and Nahemow's (1973) competence-press model and Lawton's (1982) modified equation. These earlier models analyzed a relationship between the person (P) and the environments (E) and how well suited they are based on the person's behaviors or responses (Lawton and Nahemow, 1973; Lawton, 1982). However, Lawton (1982) further developed the concept of '*competence*' by commenting that the earlier competence-press model did not cover all competencies of the intra-interrelationships of the person, and suggested a five-measure hierarchy of competence that included: biological health, sensory-perceptual capacity, motor skills, cognitive capacity, and ego strength (Lawton, 1982:37). However, Smith (2009) notes that relying too highly on the arranged model with discrete elements causes

researchers to miss other potentially insightful elements. Moreover, scholars argued those models could not explain the differences in the relations between the ageing environment and everyday problems related to Instrumental Activities of Daily Living (Scheidt and Windley, 2006). Additionally, Fried (2000) warned that overemphasizing attachment to place could be counterproductive to creating opportunities for older adults to consider the potential for change in their situation. Smith and Freund (2002) showed that adults in the age range of 70-103 years old voluntarily considered environmental and personal changes upon recognition of the decline in their physical health. Finally, Klinenberg (2001) in a study with older adults in Chicago emphasized that millions of older adults in the U.S. suffer from severe isolation while ageing-in-place because the environment around them appears to be changing so rapidly. This finding demonstrated the opposite of early findings by environmental gerontologists who had advocated that older adults living in the inner-city and suffering from poor physical health would be protected by restricted spatial movement. It is not enough to consider poor environments as the only indicator of isolation as Gory et al. (1985) indicated early on that there are other considerations that should be taken into account.

In general, the places available to older adults for receiving later-life care can be divided into two categories: at home or in a professional facility. Home is an environment which receives much attention and many human geographers investigate how the home environment impacts older adults' experiences, examining accessibility, levels of independence, and awareness of place (Brickell, 2012; Dyck et al., 2005; England, 2010; Golant, 2014). Research on the experiences of older adults in the sub-discipline in the 2000s focused on a variety of lived experiences related to older adults' health and care, including in private homes, neighborhoods, retirement communities and hospitals (cf. Andrews et al., 2003; Blunt and Varley, 2004; McHugh and Larson-Keagy, 2005). Here, we note that a focus on living spaces, especially private homes, is critically important in considering emotions of older adults that are often missed. Private homes are a space of complexity compounded by, first, the material and imaginative, second, power and identity and, finally, the multi-porous character of personal/public and the political (Brickell, 2012). Put differently, older adults' emotions which arise as they choose their private home as a later-life-care place, can never be free from outside influences, especially economic and political ones. Focusing on the economic to the detriment of the political creates an atmosphere where older adults are easily cast aside when they cannot maintain their housing. The concept of ageing-in-place has been in the limelight, which, as noted earlier, allows the system to delegate the responsibility of individuals' place attachment and other complex emotional aspects of their care to the individuals themselves rather than to society as a whole. The background of this complexity should be considered carefully. However, the process of determining a later-life-care place is not simple, and the difficult emotional struggles during the process are not entirely personal.

For most people, entering the later stages of life is accompanied by a corresponding decline in physical and cognitive functions. These are normal biological processes; however, geriatric illnesses may be comorbid with these declines in some cases. To adjust to these changes in later life, many seek accommodations that allow them to carry on with the daily lives to which they were previously accustomed. According to a home and community preference survey by the American Association of Retired Persons (AARP), three out of four people over the age of fifty want to remain in their homes (Binette and Vasold, 2018), however, the health care system gives preference to other types of care institutions, such as through the provision of federal subsidies for nursing homes. From a public health policy perspective, there may be various reasons for the imbalance between the desires of older adults and the allocation of budgets, such as incapacity of home care, care institutions' lobbying against home care, and Medicaid's nursing homes entitlement (Luterman, 2020).

In the U.S, public healthcare insurance is largely administered through two federal programs Medicaid and Medicare, which older adults are entitled to after a certain age or qualifying event; they

are distinct programs that subsidize payments and have different target audiences and coverages (cf. Ng et al., 2010; Marek et al., 2012). Scholars often point to economic concerns when discussing the decision-making process behind ageing-in-place, and indeed with few exceptions, studies demonstrate that economic concerns are paramount (cf. Curryer, 2016; Löfqvist et al., 2013). However, public health insurance for elder care does not support relocation, as Medicare does not subsidize long-term care or non-skilled nursing facility care and Medicaid only applies if the beneficiary has no assets. Researchers criticize this myopic view, noting that it neglects the lived experience of older adults and points to significant socio-political structures which effectively force ageing-in-place (on vulnerable experiences, see: Means, 2007). Beyond the cost, relocation has been shown to cause distress, as institutionalized life brings about very different daily experiences. As a result of the marketization of medical care (cf. England, 2010) older adults living in the U.S. have very little flexibility, and as discussed in the next section, many emotional struggles in the decision-making process when viewed through an economic or socio-political lens. These struggles are compounded for some seeking later-life care, as vulnerability is uneven across groups, race, class, gender, and location. Considerations of experiences of place assist with opening out these narrower views. In the following section we use the case of mandated social distancing during the global pandemic as a relational geography (cf. Hall, 2019; Massey, 1994; 2004) that intersects with other experiences across space. Seeing the pandemic social distancing mandates as relational allows us to examine the current lived experience of aging and later-life care. As noted earlier, older adults are currently in a state of vulnerability in the existing health care system. Increasingly exposed to isolation as part of the ageing process, the pandemic makes this existence visible while simultaneously intensifying it.

Social distancing mandates fundamentally changed the character of care giving and support and how people were able to access and occupy space. Geographers have a long-standing interest in understanding and framing social spaces (Simandan, 2016), which allows for a re-framing pertinent to the social distancing mandates. Social distance, more generally, can be understood to reflect an inherent spatial dimension and is used across cultures (Wiseman, 2014). The concept of social distancing, however, complicates how people experience place because spaces are imbued with social processes beyond physical distance (Malpas, 2015; Pierce et al., 2011; Wilson, 2017). Simandan's (2016) early work focused on theorizations of individual subjectivity 'from a distance' within 'construal-level theory' of psychology, attempting to reconstruct and amplify the concept of distance. In this context, social distance is a concept based on physical space, as distinguished from social relations, and an intentional limit through social distancing measures ultimately entails the manipulation of people's spatial experiences and has numerous positive or negative consequences. For example, before social distancing mandates were put in place, groups of people—whether in close kinship or other relations— could gather together at their leisure and physical distancing or proximity may have been used to express social relationships and the make-up of such spaces. Drawing on two archaeological case studies, Wiseman notes, "people who feel '*close*' to others socially will try to get physically close to them. Conversely, people will try to put distance between themselves and those who are socially '*distant*'" and that, ultimately, proximity among groups leads to the cultivation of care based on affection and emotion (2016:1027; authors' emphasis). Through experimental research, Wiseman argues that social distance is a 'metaphor' with complexity encompassing human cognition, behavior, and spatial arrangement. Wiseman's earlier theorizing supports an argument that 'social distancing' mandates, by only focusing on spatial proximity fail to account for how people perceive, behave, and change in response to (or not) public health policy. As a result, taking three characteristics of social distance including the magnitude of distance, the emotional experience of distance, and care as it relates to distance, we focus specifically on how officially mandated distancing through social distance orders disrupts how we typically characterize distance in space and the social impact of these measures for older adults, especially those living in eldercare facilities in the U.S. While an important measure for limiting the spread of the

coronavirus, it appears that very little consideration about the "social" aspect of social distancing was undertaken, leading to a variety of negative outcomes.

In this context, an ethic of care as a lens focuses on a more holistic way of understanding the impact of social distancing measures. As Wood et al. argue, "…care ethics emphasize the centrality of emotions to human relations" (2020:428). A geographic perspective is important to how we consider an ethic of care because emotions may form how society reacts to injustice or problematic conditions (Askins, 2017; Wood et al., 2020). The alienated interdependence discussed earlier, that comports later-life care at present requires that we center and amplify the multiple relations of care ongoing. For example, infanthood and older age are among the times we are most vulnerable in our lives. Looking to an example of infants receiving care in a medical setting, Naylor et al., 2020 found that in the neonatal intensive care unit, critically ill and premature infants received care in many forms. Infants receiving treatment are often isolated (the cribs they are treated in are even called isolettes), yet studies have found that kangaroo care, which is the practice of holding skin-to-skin between an infant in diaper only and a caregiver who has removed their upper garments, is incredibly effective in maintaining a healthy heartrate, as well as, improving cognitive development, emotional regulation and sleep patterns (cf. Ludington-Hoe et al., 2004; Ludington-Hoe, 2011; Naylor et al., 2020). A greater number of NICUs are adopting this care practice. This example suggests that when thinking about care as multiple, different outcomes may be possible.

Thinking about care relationally assists with revealing the myriad emotions associated with later life care. As Lawson notes, "caring relations of dependency, frailty, grief and love all shape the ways we reason and act in the world" (2009:210). Using this foundation, many scholars have looked inward to what a radical care ethics in geography might do (cf. Askins and Blazek, 2016; Carreta and Faria, 2019; Dombroski et al., 2018; Hall 2021; Middleton and Samanani, 2021; Williams, 2017; Wood et al., 2020). Drawing on Tronto's (1993) original work on an ethic of care, which emphasized the interdependence of human-environment relations, Williams argues that an ethic of care that is situated in the "here and now," that is place-based, can be reparative (2016:825). As Lawson (2009) pointed out, the individualizing character of neoliberal relations have created inequitable and 'care-less' spaces. Reading later-life care through a radical ethic of care means taking a people-centered approach.

The elder care system in the U.S. is a strong example of how society has largely divested from older adults. By arguing for an ethic of care in conducting research on later-life care, we build on work in geography that recognizes the changing landscape of care from the intimate to the global and that care is multiple (cf. England, 2010; Milligan, 2012; Milligan and Wiles, 2010; Naylor et al., 2020). Our approach here is two-fold: first, to read care as multiple, and in the case of later-life care, encompassing more than medical care; and second, to show that in producing scholarship about later-life care, an ethic of care approach that is attentive to emotions and the interdependence of care is essential going forward. What this means in practice is, we see later-life care as medical, emotional, self-based, familiar, a money relation and so on, while also urging scholars investigating later-life care to consider the emotional experience of place. As a result, we suggest that a critical care ethics approach allows for a more nuanced analysis of daily emotions of older adults who need elder care across place, including private homes, communities, eldercare facilities and other places where daily care activities occur. To suggest reforms for the current public later-life care structure, examining the role of emotions at work is key to understanding what social structures push older adults to make choices, which may result in isolation and undignified death.

Emotions, Isolation, and Later-life Care

Measures put in place at the start of the outbreak of COVID-19 were deliberate disruptions of everyday life and tested the question of whether public health could be protected through individual

behavior change. Yet these policies largely failed due to competing political and social attitudes across the U.S. Many discussions focused on the impact of these measures on economic and political benefits and losses. Greenstone and Nigam (2020) examined the overall economic benefits, which may arise from these measures, noting that social distancing had the potential to save 1.7 million lives, translating to a savings of $8 trillion dollars overall and $60,000 per household on average in the U.S. This study in monetizing life suggests that it is not only valuable to protect life, but to reduce burdens on the healthcare system overall. Indeed, Dowd et al. (2020) emphasized the differences in demographics to show the areas of highest risk of mortality and suggested social distancing as a measure to reduce mortality, "flatten the curve," and reduce the burden on the healthcare systems charged with caring for those infected. They simultaneously demonstrated that there was a great need to take care of vulnerable populations using protective countermeasures. However, we argue that social distancing policies cannot serve as a replicable public health policy in response to the pandemic, despite economic advantages: first, we see inequities in the level and duration of their implementation by states, and second, we note that they overlook specific groups' distinct characteristics, such as vulnerabilities present in care facilities. As a result, social distancing measures raise ethical issues in their impact on older adults. Here, using an ethic of care as a lens, we focus on elements that cannot be monetized, such as dignity and emotions in later life. This perspective offers a chance to consider what is undervalued in the economic modeling of value of life.

Mandated social distancing had an immediate emotional impact on society, both within and outside kinship networks (cf. Wiseman, 2016). Through administrative orders at the national/federal, state, and local executive levels related to COVID-19, society experienced just how disproportionately social distancing impacted different demographics, as young people, intent on attending social gatherings, flouted the measures, while working parents were suddenly forced to both work and care for their children simultaneously, and some older adults faced dehumanized death, severed from social connections, dying alone (Bonanad et al., 2020). Social distancing measures created isolated environments in daily life for all generations. In reporting on the work of psychologist, Jamil Zaki, De Witte quotes that social distancing "pushes against human beings' fundamental need for connection with one another," and that we should instead practice "distant socializing" (2020: n.p). Experimental studies conducted by Kwon et al. (2020) and Williams et al. (2020) demonstrate that social distancing had mental and emotional impacts on daily life. Rodney et al. (2021) argue that the lack of emotional support structures during the pandemic increased mortality among older adults in eldercare facilities. Williams et al. (2020) further emphasize that the emotion of loss was a major stress factor that is often ignored in policy implementation. Thus, social distancing policies cannot serve as a replicable public health policy response to the pandemic and they reflect how little we think about care. The unidirectional focus on social distancing reflects an approach that reduces later-life care to medical care.

Although the pandemic reveals the risk of isolating environments, which many older adults are subjected to, isolation is recognized as a serious problem in contemporary society. Isolation is a concept specific to a social situation that is more than just, for example, living alone, being reclusive, or loneliness. It is used to describe a lack of connection to social networks or having few or no social ties (Klinenberg, 2001). Historically, western society has provided few options for older adults to prevent isolation (Warnes, 1990) yet, dying alone and/or dying at home has been long-viewed as a strong indicator of social abandonment and failure (Seale, 1995). Based on these social structures and atmosphere, Klinenberg (2001) notes that, in general, older adults show willingness to live alone in the U.S. because of perceived danger of urban environments. Put differently, some older people voluntarily choose isolated environments because of various emotions (e.g. fear of crime) derived from social structures, not from their inner worlds—that is, decision-making happened via structural pressure rather than agency. However, this decision-making is problematic, as isolation is not often considered a public health or care issue, but instead is considered an individuals' choice or fault.

Moreover, in the context of the coronavirus pandemic, forced isolation by social distancing orders may create a sense of relief or hope of not falling ill for older adults; however, they faced the negative aspects of increased isolation due to changing relations of care in the pandemic (Rodney et al., 2021). Undignified conditions during incidents such as epidemics are preventable with structural interventions in and recognition of diverse emotions, which can lead to isolation. The isolation of older adults has become standard in this society, exacerbated by a system, which restricts income and provides paltry social services to support older adults, and treatment differs across groups. Yet, the present situation suggests that scholars and policy professionals must examine isolation issues and older adults' choices to live alone, or not, from new perspectives, such as through their emotions and emotional experience of place. Sustained dignity in later life should be guaranteed by society rather than derived as a result of one's choices (which in the status quo are largely made in the context of medicalized care alone).

Emotions provide a powerful bridge between individual's inner worlds (thoughts, feelings) and external worlds, as emotions (e.g. happiness, sadness) can be distinguished from one another and can differ depending on a person's environment (Pile, 2010; Bondi, 2014), showing how the spatiality of care processes are embodied, interpreted, and how they exist in individual's relationships with people and place (Askins, 2019; Wood et al., 2020). This body of work examines, for example how emotions are politicized, negated, or healed through social relations and relations to place (Bondi, 2005; Davidson and Milligan, 2004; Fannin, 2006; Hepworth, 2005; Roberts et al., 2012; Tarrant, 2010). Many studies demonstrate that there are interrelationships between the places we live, available social services, and social norms related to caregiving (Angus et al., 2005; Dyck et al., 2005; Hanlon et al., 2014; Milligan and Wiles, 2010; Wiles, 2003; Wiles et al., 2012), yet missing from these accounts are analyses of the emotions of older adults resulting from health policies or health care systems and subsequent investigations of influence of their complex emotions in later life and decisions about their place(s) of care. To influence reforming the current later-life care system, examining the role of emotions at work is key to understanding what social structures push older adults to choose to live alone and endure isolation and possibly dehumanizing death alone.

Although earlier scientific environmental theories attempted to explain or predict why specific living places are better than others, they failed to consider how older adults differently perceive, manage, or perform daily tasks in their living environment (Golant, 2003). We suggest that rather than generalizing or attempting to model older adult's behavior, thus placing the totality of the responsibility on older adults, that scholars consider the emotional experience of making the choice of where to receive later-life care, considering what older adults face in making this decision. Most older adults will eventually be faced with deciding where to get care or live as they age. As noted by Golant (2003), older adults are called to decide from a number of different options: relocation to a planned retirement community, a smaller apartment unit, congregate housing, assisted living facilities, care retirement communities; or staying at existing homes to manage changes in their physical and cognitive abilities. Considerations of inner worlds, or what emotions can occur in the process of deciding on a place for later-life care based on the concept of relocation and ageing-in-place is an approach that should be undertaken in studies of later-life care. In tandem, researchers should additionally raise questions regarding how those emotions are influenced as part of the push and pull of structure versus agency— for example, how much of the way the U.S. healthcare system is structured influences how older adults feel about their ability to make decisions about later-life care. We suggest that because the system is structured around medical care and does not consider other forms of care it neglects possibilities for a people-centered focus when creating later-life care options and support.

Later-life care decision-making has ageing at its center, which potentially includes physical, cognitive, social, and economic decline. Economic changes are significant in this regard, as countermeasures can be costly. Cost comparisons for where to receive care that fall between relocation

and ageing-in-place often find that not relocating is the least expensive option. As noted earlier, the U.S. healthcare system does not support relocation. Additionally, scholars often point to economic concerns when discussing the decision-making process behind ageing-in-place, and indeed, with few exceptions, studies demonstrate that this is the case (cf. Curryer, 2016; Löfqvist et al., 2013). As a result, older adults have very little flexibility and many emotional struggles in the decision-making process when viewed through an economic or socio-political lens. Bringing a radical ethic of care to thinking about how choices are made for later-life care means shifting beyond these narrowed lenses and valuing the interdependence that care in its multiplicity requires.

For later-life care, many older adults who decide to relocate or have had their decision-making power stripped from them either by the state, their family, or severe illness, have additionally undertaken a new economic burden, adapted to an unfamiliar environment, and potentially fought existing stereotypes about care facilities. Simultaneously, those who choose to age-in-place for their later-life care may begin to suffer from isolation and physical struggles in their daily activities. Presently, both choices appear to cause a degree of suffering and undignified living, no matter what the basis of the decision (e.g. economic). Thus, an understanding that later-life care is not simply about medical care is essential.

Conclusion

The social distancing mandates put in place to "flatten the curve" were appropriate to protect public health. However, these orders did not take into account the impact on vulnerable demographics, especially older adults. Media and scholarship produced in response to COVID-19 focused on rate of infection and mortality and economic outcomes rather than the realities faced by older adults during the pandemic and prior. Thus, as we argued, a deeper look at the everyday emotions of older adults is necessary to better understand how to create improved policies and attentive options for later-life care.

In this commentary, we briefly addressed the isolation caused by COVID-19 from a geographic perspective, with a specific focus on emotional experiences of place, considering what options are available for later-life care and what impact socio-political structures have on decision-making. We argued that constructing later-life care as a choice is not an appropriate way to examine these decisions, and that relationships and everyday emotions, along with the current healthcare system in the U.S., have great influence over where older adults receive later-life care. Whichever option is chosen, there is a possibility of severe isolation, a sense of loss and fear, negative social stereotypes, or economic burdens. Complex emotions and isolation can lead to a loss of dignity. Thus, reading later-life care through an ethic of care that holistically examines the emotional experience of place broadens this approach and makes care multiple—framing later-life care not just as medical care but also, as involving social contact. COVID-19 exposed already existing issues with later-life care, however the scope of coronavirus infections deeply intensified these stark realities and exposed the older adult community to the possibility of undignified death in isolation. These factors must be taken into consideration when studying later-life care and reforming healthcare policies. A deep look at how we create sites to accommodate an aging population is paramount.

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