Given that deaths lag cases, resident deaths are likely to continue to increase, but the rate at which they will increase is unclear, as improvements in treatment may have lowered case-fatality rates.[7]

CONCLUSION

Despite gains in knowledge about best practices in nursing homes, little has changed to mitigate the risk of COVID-19 to nursing home staff and residents in virus hotspots. Sporadic policy efforts to address resources gaps have been insufficient and/or ineffective to change the trajectory.

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ACKNOWLEDGMENTS

Financial Disclosure: Rebecca Gorges was supported by the National Institute on Aging under Grant Award Number T32 AG000243.

Conflict of Interest: The authors have no conflicts.

Author Contributions: All authors contributed to develop the study concept and design. Rebecca Gorges performed the data analysis. All authors contributed to the interpretation of the data and preparation of the manuscript.

Sponsor's Role: Not applicable.

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COMMENTS

Say What?! Ableist Logic Used in Misguided Attempt to Combat Ageism During COVID-19

To the Editor: In an editorial titled "COVID-19 Pandemic and Ageism: A Call for Humanitarian Care," an esteemed group of editors of America's "leading journals in geriatrics and gerontology" set out to tackle ageism amidst COVID-19.[1] In their editorial, Colenda et al call for humanitarian care for older adults and their call seems timely if we understand humanitarian care in terms such as the promotion of human welfare and the provision of necessities of life for people of all ages. But the call takes a disturbing turn as Colenda et al advance their argument by pointing to the value of the "wisdom and personal resilience" that older adults demonstrate. In arguing thus, Colenda et al succumb to neoliberal ideas that humanitarian care is something to be earned. This logic invites conclusions that older adults who cannot share wisdom, or who are not demonstrating "resilience," are less worthy. Indeed, by touting "resilience" of older adults, Colenda et al reinforce ageism by implying that the most worthy older adults—that is, older adults deemed resilient—are the ones who can behave in ways that counteract displays of age-associated decline.

We are writing as one emerging scholar (BCR student) and one established scholar (associate professor)—both of whom are devoted to researching/working with older adults, including older adults with advanced dementia and/or mental health issues. We are calling for recognition of the intrinsic worth of all human beings and we are calling out the ableist logic demonstrated by Colenda et al. We urge these editors to recast humanitarian care as care given to all people not because they are wise and resilient, but because they are people. Colenda et al describe themselves as advocates for older patients; we hope these advocates will provide apologies and clarifications about their argument.

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ACKNOWLEDGMENTS

Conflict of Interest: The authors have no conflicts.

Author Contributions: The authors contributed equally to the development of this letter.

Sponsor's Role: The authors acknowledge their funding from Social Science and Humanities Research Council (SSHRC) for their study of expressions and enactments of autonomy by people with late-stage dementia (Grant No. 435-2019-0941).

See the Reply by Colenda et al.

DOI: 10.1111/jgs.16932

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1. Colenda CC, Reynolds CF, Applegate WB, et al. COVID-19 pandemic and ageism: a call for humanitarian care. J Am Geriatr Soc. 2020;68(8): 1627-1628.

Reply to: Say What?! Ableist Logic Used in Misguided Attempt to Combat Ageism During COVID-19

To the Editor: Cruise and Lashewicz present an interesting perspective to our editorial, "COVID-19 Pandemic and ageism: a call for comment humanitarian care."[1] They point out how our editorial used "ableism" logic, e.g., discrimination and prejudicial reasoning and language towards individuals that have or are perceived to have disabilities, when we used characteristics of resilience and wisdom of older adults as justification to receive care. And in so doing we "succumbed to the neoliberal ideas that humanitarian care is something to be earned" as opposed to being universally afforded to all people regardless of their ability.[2] The authors critique was unexpected, and suggests that best intentions may reveal implicit biases. We do not feel the need to apologize, but offer appreciation for their insightful comments.

We have spent our professional careers advancing the understanding of the biopsychosocial and cultural determinants of aging, the diagnosis and management of diseases and disabilities of late life, and pushing healthcare systems to broaden care management practices for older adults. We never made the assumption that older persons with cognitive or physical impairments would or could not have wisdom or resilience. To the contrary, we are reminded of these personal characteristics every day.

The timeframe of when the editorial was written is important—in mid-March and early April, 2020. This was early in the pandemic when rapid community spread of COVID-19 was plaguing major cities in the United States; much was unknown about the illness; treatment protocols for the severely ill were not well worked out, and healthcare resources were being over whelmed with critically ill patients. In this crisis the implicit bias of "ageism" was on the rise as allocation of limited resources and triage decisions were being made for who got what treatments, when and where. We were keenly focused on mitigating the implicit bias of ageism, and to provide a voice for those at risk of losing personal agency to make decisions and rationing healthcare based on age alone. We appreciate the authors point about humanistic ideals and challenging any form of healthcare rationing based on wellness or ability.

We chose to highlight resilience and wisdom as a means to help humanize older patients and to remind clinicians, healthcare administrators and policy makers that age, in and of itself, should not be the sole determinant of who gets treated during this ongoing pandemic. It is interesting that our attempts to combat "ageism" by promoting humanistic considerations was perceived to de-humanize through the act of trying to humanize. We think that Cruise and Lashewicz have spotted a general problem with all -isms.

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ACKNOWLEDGMENTS

Conflict Of Interest: The authors report no conflicts of interest.

Author Contributions: All authors participated in drafting and critical revision of the manuscript.

Sponsor's Role: Not applicable.

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This letter comments on the letter by Bonnie Lashewicz.

[Correction added on November 20, 2020 after first online publication: Joseph G. Ouslander's affiliation has been corrected.]

DOI: 10.1111/jgs.16934