Journal of Applied Hermeneutics
ISSN: 1927-4416
February 1, 2026

DOI: https://doi.org/10.55016/pe8p5z56

The Haunting of Long-Term Care, Part One.

A Suspicion of Healthcare Aides Experiences with Death and Dying as a Kind of Institutionally Mediated Testimony

Katherine Stelfox & Lorraine Venturato

Abstract

This paper is the first installment in *The Haunting of Long-Term Care: Understanding Healthcare Aides' Experiences with Death and Dying During the COVID-19 Pandemic*, a serialization of my doctoral research published in the *Journal of Applied Hermeneutics*. What follows is not only an academic inquiry, but the opening of a story – one shaped by suspicion, hiddenness and the ghosts that refuse to remain in the shadows of the house. Guided by a philosophical hermeneutic approach, I interviewed eight healthcare aides working in long-term care to understand how they made sense of death and dying during the COVID-19 pandemic. As an institution meant to care for older adults nearing the end of life, the long-term care home is, unavoidably, a place of death and dying. Yet death and dying are often kept in the shadows of long-term care, tucked into dark corners where the experiences of those who receive and deliver care remain largely unacknowledged, unexamined, and unquestioned. When the COVID-19 virus entered these homes, it did so like a kind of ghost – claiming the lives of older adults in ways that were unfamiliar, sudden, and deeply frightening. Healthcare aides were the first to encounter these ghosts, and the strange yet eerily familiar forms of death and dying they brought with them. As such, I came to understand my research as a kind of story, a frightening one, and healthcare aides' experiences as a haunting of long-term care. In this first paper, the story begins with suspicion. I describe how I first encountered it, and how I came to regard healthcare aides' testimony as institutionally mediated, shaped by institutional forces and the hiddenness of death and dying in long-term care. I then offer a philosophical discussion of suspicion, and how I made sense of it through both Gadamer and Ricoeur. Finally, I discuss the long-term care home as an uncanny house with a dark history, how I came to understand it as haunted, and the COVID-19 pandemic as a haunting by both familiar and unfamiliar ghosts.

Corresponding Author:
Katherine Stelfox, RN, PhD
Faculty of Nursing, University of Calgary
Email: Katherine.stelfox@ucalgary.ca

Keywords

Hermeneutics, long-term care, healthcare aides, death and dying, palliative care, COVID-19, hermeneutic research, gothic storytelling

I am seated at a large round coffee table, although there are only two of us, myself and the first healthcare aide I am interviewing for my doctoral research. After nearly an hour of conversation about her experiences with death and dying in long-term care homes during the COVID-19 pandemic, I notice the time on the wall and move to stop the audio recorder. The recorder now turned off, my research participant's shoulders relax, taking a sip of her coffee as she leans back into her chair. Gathering my things into my book bag, she asks me to tell her more about my research, and why it is that I want to better understand healthcare aides' experiences – her experiences. I tell her I think her profession is understudied, the work they do of undeniable importance yet poorly understood. I tell her I think her work is hard and undervalued, the unprecedented wreckage of COVID-19 in long-term care simply having revealed the quality-of-care issues that long-predated the pandemic. She pressed her eyes closed, rolling her head up and down rhythmically, letting out a hum of agreement. What followed was a testimony different than what had been captured by the audio recorder just minutes before. It would seem there were three of us at the table, including the recorder's blinking red eye ever watchful of our conversation. In the coming weeks, I would interview more healthcare aides, and this phenomenon continued to repeat itself.[1]

Even from the safety of their own home, reassured their name or place of work would not be revealed, healthcare aides not only sometimes shared something different when the audio-recorder was turned off, but their testimonies while being recorded often presented moments of contradiction, where what was said felt imbalanced with the kind of practice that was described. The more I interviewed healthcare aides about their experiences with death and dying in long-term care, the more it became clear there was something else going on, something disorienting, and catching me off guard. By sharing their experiences, healthcare aides had invited me into the long-term care home, that on first sighting felt inviting and familiar, but once inside, felt eerie and watchful, giving me a sense of something lurking in the shadows. Instead of openness and trust upon my arrival, I was confronted with a kind of tension that cautioned me to tread lightly as I walked about the house: a house with two stories. I found myself more and more curious about the second story, the hidden story, that only appeared when the recorder was switched off and I peered into the shadows that were hinted at. Faced with this tension, it seemed that understanding healthcare aides' experiences meant approaching my research with suspicion, for the ways in which the long-term care home, a suddenly suspicious kind of house, had shaped their testimonies and understanding of death and dying during the COVID-19 pandemic.

[1] For the purposes of conducting ethical research, what was said by healthcare aides after the audio recorder was turned off will not be described. Quotes provided by healthcare aides in this paper were all captured during the formal interview when the audio recorder was turned on.

In exploring this tension further, I begin this paper with two institutionally mediated truths that became evident during my interviews: 1) understanding healthcare aides' experiences meant first understanding their positionality within the institutional context as being one of relatively little power and 2) understanding healthcare aides experiences meant understanding how death and dying is hidden within institutional spaces that may want to distance themselves from such realities. Faced with this tension of two different stories inside the house, and my understanding of healthcare aides' experiences as being a kind of institutionally mediated testimony, I then offer a philosophical discussion of suspicion, exploring how suspicion helped me to make sense of the tension points I encountered, and the kind of disposition I began to develop towards my research. Finally, I explore how my suspicion led me to regard the long-term care home differently, as one that groans and creaks in the middle of the night, the history of death and dying in the house seeping through the walls and whispering its hidden secrets.

First Tension in the House: Healthcare Aides Positionality as Institutionally Mediated Testimony

Of the importance of interpretation within the context of institutions, Caputo (2018) wrote:

> Events do not take place in mid-air; they happen in institutional settings. There is almost nothing outside institutional contexts. So, everything depends upon how institutions interpret themselves and how institutions themselves interpret. (p. 220)

If, as Caputo wrote, everything depends upon "how institutions interpret themselves and how institutions themselves interpret," I cannot help but wonder: How often do institutions, such as long-term care homes, meaningfully interpret themselves in ways above their bottom lines? Trying to interpret an institution feels like trying to interpret the testimony of a faceless other; a tangible figure may appear at times, perhaps the face of a person in a position of power or the amalgamation of institutional ethos and culture, but when looked at more closely, disappears. I think of my openness towards interpreting death and dying within the institution of long-term care as being met with a kind of opposition propped up by a structural complexity as impenetrable as the steel and concrete scaffolding of a long-term care building itself, its closed doors and shuttered windows keeping me on the outside. Although healthcare aides opened the door and invited me in, I had the sense that their testimony of what went on during the pandemic was an abridged version, censored for my ears, or the watchful eye of the recorder during our interviews.

Reflecting on what I knew of death and dying in long-term care, and the ways in which healthcare aides occupy a precarious position in long-term care, unable to question policies, protocols, or even their own experiences from an equal footing of power (Estabrooks et al., 2020; Lightman et al., 2021), I suspected the institution itself was likely responsible for molding and shaping their recorded testimonies, and them sharing something different when the formal interview ended. It was because of this kind of institutionally mediated testimony that I found myself attuned to the moments where healthcare aides spoke to their position within long-term care as being one that is caught up in power imbalances and issues of hierarchy:

> *I remember when [management] marched us into the office and they said, you have to wear this and they handed us yellow gowns. It was like, okay. Then they handed us the shields. Then they handed us the masks. Then they said, you have to wear this. And we were like, all day? All the time? And they were like, yeah, this is what you have to do now. So, we put them all on and were staring at each other, like, okay – I guess this what we do now.*

> *I have seen so many things as a healthcare aide. …and not having the power to talk, not having the power to say anything. …As a healthcare aide, I cannot do what is right. I just need to follow orders. I just have to listen to my supervisor, or my manager, whoever is higher up than me. I don't have the power to do or say something that I am not supposed to. Even though I know it is not right.*

As "*ambassadors*" of long-term care, as one healthcare aide put it, healthcare aides may feel they are not in a position to share what they actually think or feel about the long-term care home or their experiences within it, and instead, must speak on behalf of the facility, much like a diplomat speaks on behalf of the interests or needs of their government in crisis situations:

> *And we are ambassadors, to the facility. To the order of the business. Someone is paying you, is paying your bills. And what you have to give, you give your best. Your customer care. The [healthcare aide], the first thing we are, we are the customer care. We are between the owner of the business and the user of the service. So, if a resident is saying negative things about me, then I should be sacked.*

During the crisis of the COVID-19 pandemic however, healthcare aides described a consistent state of inconsistency and limited guidance or information from persons in authority positions:

> *It was a very difficult time. …every day we had a different direction. Direction from nurses, team leaders, from the managers. …So, at the beginning, no one was happy. Everyone was like, why is this going on this way? Because nobody told us anything.*

This was consistent with findings in the literature, where not only did healthcare aides experience changes to their roles and responsibilities during the pandemic amidst changing policies and protocols (Blanco-Donoso et al., 2022; Jones et al., 2022; Laher et al., 2022; Schulze et al., 2022; Snyder et al., 2021), but often did not see or speak to managers at that time, having felt their expertise and intimate knowledge of residents was not taken into consideration during care planning (Bergqvist et al., 2023; Titley et al., 2023):

> *They make rules, rules for this, rules for that. …We are the ones who don't know anything, and then when we see change, we don't know what is going on here.*

Healthcare aides were not only known to frequently experience inadequate support from managers, supervisors, and even registered nurses during the pandemic (Bergqvist et al., 2023; Laher et al., 2022; Titley et al., 2023), but the breakdown of communication meant they were often the last to be made aware of changing policies or care processes (Titley et al., 2023):

> *Our questions – it felt like they weren't always being answered. And sometimes when we kept asking too much, [the nurses] would be like, are you questioning us? That is insubordination. And I would be like, I'm just trying to understand.*

Their testimonies echoed a common narrative in long-term care, which is that the people who provide most of the care to residents, those who likely know them best, are *just healthcare aides*, and as such, find themselves excluded from decision making about care (Lightman et al., 2021):

> *Some think that we are just a healthcare aide. I am not saying everybody, but some people. Like, some people put us aside because we are just a healthcare aide.*

Even when it came to the care of dying residents, healthcare aides spoke of a lack of communication and support from persons in authority positions, such as nurses, themselves having been unable to question their experiences due to their position within the institutional setting as "*just a healthcare aide*":

> *Interviewer: What was the communication like between you and nurses regarding dying residents?*
> *Healthcare Aide: Nothing.*
> *Interviewer: Nothing? Like no communication?*
> *Healthcare Aide: I don't know if it was because I was new and I didn't know how to ask the right question? I don't think I knew enough to say, is this right?*

For how healthcare aides described themselves as being a kind of "*ambassador"* for the facility, yet holding very little power within the institution setting, I was reminded of when the whole world had been watching long-term care during the peak of the pandemic, and how healthcare aides had to navigate caring for dying residents under a shroud of controversy and outrage. Where healthcare workers in hospitals were painted in the media as heroic and brave, long-term care workers were often vilified, the easy scapegoats for long-standing institutional and structural inadequacies, their practice occurring against a backdrop of negative headlines, such as, "Canadian Military Details Horrific Conditions in Nursing Homes Battling Covid-19" (Forrest, 2020) and "Canada's Nursing Homes Have Worst Record for COVID-19 Deaths Among Wealthy Nations" (Ireton, 2021). Healthcare aides even seemed to vilify one another or other long-term care homes, either not understanding how some healthcare aides could abandon their posts during residents' time of need, or how some facilities were experiencing such significant death and dying in ways their own facility was not:

> *Remember how the media, they went into these long-term care facilities that were practically abandoned? Like how can you do that to people? I don't understand. I didn't understand the people not coming to work. I understood they were scared or whatever. But there were still people there, we still needed to care for these people. …But when I saw that people were actually abandoning some of these places…and they were not being taken care of in the first place. …that broke my heart.*

In an interview with Folio magazine for the University of Alberta, Dr. Carole Estabrooks, an elder care expert and well-known researcher of Canadian long-term care homes, argued that it

should not be healthcare aides who are the target of such criticism for having abandoned long-term care during the worst of the pandemic, but instead the institution for having created an extreme and desperate situation: "Imagine their work conditions and the anguish they must have gone through" (Brown, 2020, When Failsafes Fail section, para. 7). Despite the clear culpability of the long-term care homes in the devastating outcomes of the pandemic, I suspected healthcare aides still felt themselves in a position to protect the integrity of the institution, the above healthcare aide having shifted the blame for any structural inadequacies from that of the long-term care home onto the shoulders of their profession. However, other healthcare spoke of feeling they had done everything they could to help residents, despite the hopelessness of the situation:

> *Well, at the time there were two different voices. There were the voices saying, "yay for healthcare people, yay for healthcare people. Yay for front line people!" But then there were other voices, saying, they are not doing enough. I was like, we are doing the best we can. On one hand, I was like yay, I get free coffee. On the other hand, I felt knocked down because I'm not doing enough. But I didn't know what else I could do to help them.*

> *The facility was also accused…the news was announcing the dying people and announcing that – this facility, these numbers – and we find some family members coming around the facility and trying to yell, and trying to protect their – you know, fight sometimes, but we can't do anything. …In the news, you see it. Like, [the long-term care staff] are not doing anything, they are not making an effort, they are just leaving our family members to die.*

In the wake of the COVID-19 pandemic then, it seemed healthcare aides had been pulled into a kind of public court, society having perceived them to be accomplices to crimes committed by the faceless institution of long-term care, and the last ones holding the smoking gun when residents were dying. In this way, I was further convinced of my interviewing of healthcare aides as being a kind of institutionally mediated testimony. Not only had healthcare aides remained ambassadors for the long-term care home during the tumult of the pandemic, but their public perception, and even financial stability, was attached to the reputation of the institution, and the narrative that residents had been *left to die*. With the increasing privatization of long-term care homes in Canada (CIHI, 2021a), it cannot be overlooked that facilities are competing with each other for the business of older adults and their families, and how the unprecedented death and dying in long-term care was incompatible with corporate interests and profit making:

> *Healthcare Aide: Everybody in the facility who are working with them, we are doing everything so they will not die.*
> *Interviewer: You're doing everything to make sure they don't die?*
> *Healthcare Aide: So that they will not die. We don't want them to die, because, if residents are dying, the facility is going down. And you who are working there, you might lose your job.*

It seemed clear that healthcare aides felt they may lose their job in long-term care if residents were dying during the pandemic, as it would have meant the facility had a poor reputation and family members might have come and taken residents home. What seemed less clear, however,

was how long-term care was, in fact, already a place of significant death and dying, and how healthcare aides' testimony, which I have argued was mediated by the context of the institution, also meant to deny the presence of death, in a place where death had always been.

Second Tension in the House: The Denial of Death and Dying in Long-Term Care as Institutionally Mediated Testimony

Long-Term Care as Not a Place of Death and Dying

Before I began conducting my interviews with healthcare aides for my doctoral research, I knew I wanted to ask them the following question: *Do you consider long-term care to be a place of death and dying?* It seemed important to ask this question, as there is a hidden truth in long-term care: that while there may be a common social knowledge that long-term care is a place where people die, this remains largely unspoken and unacknowledged within these institutions, and by those who work there (Stelfox, 2022). Preparing to ask this question, I thought, surely healthcare aides would challenge this narrative now, having been confronted with unprecedented death and dying during the COVID-19 pandemic. What healthcare aides told me, however, surprised me:

> *Healthcare Aide: No, it doesn't sound right for me.*
> *Interviewer: It doesn't sound right?*
> *Healthcare Aide: Yeah. Because we believe it's their home. That is their home. And that is the way we treat them. We then let them feel – It is not a prison, yet. It is not a prison yet for them, where it is a death sentence, where they get the death. The facility is not where the residents get their deaths. It is their home, it is where they belong.*

> *I would say it's wrong, in a way. Because long-term care is for living. The people that live in long-term, it is their home, they live there. …Long-term care is like my house, it is like me living at home. So, to them, it is they're home, and I only happen to work there.*

It seemed that healthcare aides clearly considered long-term care to not be a place of death and dying on account of it being where a resident lives, or "*where they belong,"* the word "*home*" appearing in the transcripts often. However, I was also surprised how healthcare aides did not seem to question this understanding of long-term care being *home* for residents, despite the happenings of the COVID-19 pandemic, and how residents would have been prevented from leaving the facility during times of lockdown, and their family or loved ones from entering.

> *It is still normal life. It is not because it is long-term care that it is already the end of life for them, or it is some kind of waiting game for that time, no. They are still there to continue living and perform their everyday routine as normal people. We give them their freedom still, their freedom to live whatever they want.*

I found myself stuck on the words "*normal life"* used to describe the resident living in the long-term care home, and how healthcare aides had considered it to be no different than how they themselves live in their own home, despite obvious contradictions to this having come through in their interviews:

> *Of course, long-term care is not only for demented people, but it is for everybody. People who cannot move, things like that. We have some residents who are cognitive, but they literally cannot move or anything.*

Despite the above healthcare aide having said that long-term care is for "*everybody*," long-term care is also not for every *body*, as the people without cognitive impairment who have physical control of their bodies or who can complete activities of daily living independently, or with only some assistance, would not meet the criteria for admission into a long-term care home:

> *I don't believe a facility is where they go and die, no. That is not where they go. Because the nurses give them the medication at the right time. Timely, and on time. We give them their food at the right time. We give them their shower, we do their laundry, we do what they want. What their demand is. …So, I don't see why a facility should be a place where they come and die.*

Clearly long-term care residents do not, in fact, have the kind of "*freedom"* characteristic of "*normal life"* in a normal house, the healthcare aide above having described the ways in which a resident is at the mercy of having to be fed, medicated, showered, and clothed by another person in their place of living. Furthermore, these demands of the resident are often not met in timely ways due to consistent staffing shortages and a lack of resources (Estabrooks et al., 2020). One healthcare aide even described long-term care as being a more desirable place to work than assisted living, on account of residents being less cognitively aware and having less freedom to move about the facility, and therefore less demanding of their needs:

> *Assisted living is also nice, but I find it more tiring there. …Because they are still cognitive. They are very demanding, they are very bossy, they treat you like their servants, really. …In long-term care they are more calm. …They are more accepting. Because maybe they know that they are needing more help.*

For the long-term care resident who is less independent and less demanding of their needs, it can be assumed they would also be closer to death than a resident living more independently in assisted living, of which suggests the closer a resident is to death, perhaps the easier healthcare aides may find them to care for.

A Consistent Confrontation with Death

> People have to live and die *somewhere*, after all, and a house can hardly stand for eighty years without seeing some of its inhabitants die within its walls. (*The Haunting of Hill House*, Jackson, 1959/2016, p. 71, emphasis in original)

Despite healthcare aides having told me long-term care was not a place of death and dying, their eyebrows furrowing or their heads shaking at the idea, they would often go on to describe their experiences with death on a regular basis:

> *Once you enter the facility you know already that you are taking care of sick people, elderly people, and there is a tendency that they are going to be sick, that they are going to die.*
>
> *We want to think that long-term care is a happy place for them [not a place of death and dying], though we know their cases – but our priority is to still maintain their quality of life. It is still the highest priority for us, in long-term care. Because we know already that just a few more steps and they are already there –*

There was a memorable point of tension for me during an interview with a particular healthcare aide, where despite them having first described long-term care as not being a place of death and dying, they then went on to describe how they began each shift with an acknowledgement of death's very real presence in the house:

> *I usually come at seven, we start at seven thirty after our report. And that was the first thing we do, we go on rounds. We go around just to monitor how the residents are doing, to see if they are still breathing. …That is our routine. Like a check-up. We usually do that every half an hour. We do rounds, we check the residents, make sure they are breathing –*

I was not surprised to learn it was routine for healthcare aides to check if residents were breathing throughout the night, as I also worked in long-term care, and carried a small flashlight in my pocket so I could do just that. What did surprise me, however, was how the reality of death and dying in the home seemed incompatible with the needs of an institution that was focused on quality of living.

After I would say goodbye to each of my research participants and thank them for their valuable time, I found myself always asking the following question on the drive home: How could long-term care not be a place of death and dying? My memories of caring for dying long-term care residents would wash over me, recalling the times I had held someone's hand as they passed away, or stumbled upon their death in the middle of the night. I therefore understood healthcare aides' testimony as having occurred within the context of the institution being a place that wants to convince people that long-term care is, in fact, a place older adults want to be, and not die. Although most healthcare aides felt that long-term care was not a place for dying, but a place for living, there were some healthcare aides who *did* acknowledge the ever-present nature of death in homes where older adults live as being why long-term care could be considered a house of death and dying:

> *It's true. It's true. Because you can see a resident today, give them a shower, do everything, and the next day you come to work, and they're gone. It happens. Happens all the time.*
>
> *The seniors already are sick, and then going to the hospital that will make them more sick. So, some of them prefer to stay in their home. Because of that, it makes long-term care more the place for people dying, instead of the hospital.*

In Canada, almost 80% of resident deaths take place within the long-term care home (CIHI, 2021b), and on average, within two years of admission (Hoben et al., 2019). Despite most resident deaths happening in long-term care, and within a relatively short time period, most of the healthcare aides I interviewed were inclined to deny death's presence, even after the pandemic, their testimony seeming to echo within the silent and hollow space this narrative had already filled inside the house (Stelfox, 2022).

So far in this paper, I have suggested that I was suspicious of healthcare aides' testimony, for how they had shared something different about their experiences when the audio recorder was turned off, described themselves as ambassadors for the facility while on an unequal footing of power, and denied the presence of death in long-term care despite its centredness in their experiences. Due to these tension points, I considered their words to be a kind of institutionally mediated testimony that disclosed something about their marginalized position within long-term care, and the service delivery of death and dying care. Reading through all the transcripts carefully then, my sense of suspicion began to thread itself through all my understandings of healthcare aides' experiences with death and dying, and I knew I needed to consider my suspicion from a philosophical perspective to be true to the kind of disposition I began to develop toward my research, or, how to make sense of the tensions inside the house.

*

I had just left the home of a healthcare aide whom I had interviewed, when I received a phone call from work: "Can you please work tonight? We are desperate." In between my interviews with healthcare aides, I sometimes took a break from my research by picking up shifts in long-term care where I worked as a registered nurse. I preferred the evening shifts, liking the way the stress of the day was over, and all that was left to do was settle everyone into bed for what would hopefully be a restful sleep. Finished the last of the medication and done my physical assessments for the night, I finally sat down at the nurse's station to take in the quiet for the last half hour of my shift. "*It is still normal life."* The words felt stuck behind my eyes, as if I was trying to see the long-term care home through the letters but could not. "*They are just leaving our family members to die."*

A slight drizzle of rain fell outside the window, as I mulled over in my head what the healthcare aides had told me. I absent mindedly dragged my finger along the wall next to me, feeling the ridges of puckering wallpaper and old paint, bumps in an otherwise smooth finish. *Buzz.* The alarm on my phone brought me back from my thoughts. Looking down at the time, I was relieved to see it was eleven at night. Time to go home. After giving report to the oncoming nurse, I put on my jacket, bracing for the rain outside and winter's denial of spring. As I walked down the hallway towards the elevator, my mind wandered again to my interviews with healthcare aides, and what I knew about this place from my own experience. Something felt strange to me, suspicious, and through the quiet murmur of oxygen machines and televisions playing old game shows on repeat, I almost thought I heard the house whisper something to me.

A Philosophical Discussion of Suspicion: A Way of Confronting the Tension of Institutionally Mediated Testimony

Grappling with this tension between what I found in healthcare aides' institutionally mediated testimony and what I knew of long-term care, I was reminded of *aletheia*: "the happening of truth and untruth" or "the event of concealment and unconcealment" (Caputo, 1987, p. 115), and how death and dying in long-term care seemed to be submerged in Lethe's murky waters. As the mythical river of Hades, Lethe's currents are responsible for that which is forgotten, hidden, or denied (Online Etymology Dictionary, n.d.). For how we must pull what has been concealed out of the water, Moules (2015) said, "In hermeneutic understanding, we know that things must be awakened, recalled, remembered, and suffered. It is why we embrace with 'trembling and fear'"… (p. 4). For how I had come to understand healthcare aides' testimonies as concealing something true about death and dying in long-term care during the pandemic, it was my suspicion that made me search for hidden truths, however fearful I was of what I might find.

In its etymological origin, the word suspicion means to look "under, behind" something, the person who is suspicious being "open to doubt" and "inclined to suspect or believe ill" (Online Etymology Dictionary, n.d.). To suspect is to "look at distrustfully," while the person who *is* a suspect, is to be doubted, mistrusted, and held "to be uncertain" (Online Etymology Dictionary, n.d.). Although it was healthcare aides' testimony that gave me a sense of suspicion, I did not regard them as suspects to be doubted or mistrusted, but instead thought of them as pointing me towards the shadows in the corners of the house – shadows that seemed to hide the complex social institutions that held a firm grip on their testimonies, as if the house would not easily let go of its secrets. To reveal something true of healthcare aides' experiences with death and dying, my disposition of suspicion felt necessary for me interpret their experiences as having taken place within complex social institutions.

Trusting Testimony Versus Distrusting Testimony: Drawing on Both Gadamer and Ricoeur to Make Sense of Suspicion

Gadamer's hermeneutics can be thought of as an unveiling, while Ricoeur's hermeneutics is that of an unmasking (Felski, 2011); while both speak to *aletheia*, what speaks to me about this unmasking is to not reinforce biases or assumptions of institutional contexts, and as such, the need to be suspicious of the testimony of the other, and attuned to questions of power and influence. Ricoeur's hermeneutics of suspicion is therefore "the practice of reading texts against the grain to expose their repressed or hidden meanings" (Felski, 2011, p. 215). In other words, it is an "interpretive strategy that distrusts immediate meaning, tracing it back to an unconscious will to power" (Grondin, 1991/1994, p. 15). Although my research is about death and dying, and not that of power imbalances, I found myself unable to make sense of healthcare aides' experiences with death and dying without also making sense of how their testimony had been influenced by issues of power and hierarchy within the social context of the institution. In other words, making sense of healthcare aides' experiences also meant making sense of how I, at times, distrusted their immediate meaning as being influenced by the institution of long-term care. Reading healthcare aides' transcripts with suspicion then, I found myself looking for "darker, more unpalatable truths" that the text would not easily give up (Felski, 2011, p. 216).

Of a kind of tracing of texts to questions of power, hierarchy, class, and unconscious desires, or that which may be an unpalatable truth, Ricoeur (1970) argued that we should be suspicious of the traditions (or institutions) that are handed down to us. Having been greatly influenced by

three prominent thinkers of the nineteenth century, Friedrich Nietzsche, Karl Marx, and Sigmund Freud, the three of whom he considered to make up a "school of suspicion" (Ricoeur, 1970, p. 32), Ricoeur suggested that a hermeneutics of suspicion differs from that of a hermeneutics of trust, for how we may distrust immediate meaning:

> If the hermeneutics of trust accepts meaning as it presents itself, the hermeneutics of suspicion calls into question this evidence of meaning, for it can abuse consciousness and induce a 'false consciousness,' for which Nietzsche, Marx, and Freud offer a hermeneutics of depths. (Grondin, 2014, p. 51)

However, Ricoeur considered this suspicion of our false consciousness, or questions of will to power, economics, and unconscious drives (Nietzsche, Marx, and Freud) to be an understanding that still finds itself subject to the hermeneutic experience (Grondin, 2014). In other words, suspicion is *still* interpretation. Inspired by a thinking of false consciousness or what remains hidden from us, Ricoeur's ideas surrounding suspicion as an interpretive strategy lends itself well into my topic, as it raises questions of institutional influences on healthcare aides' testimony.

In contrast with Ricoeur's hermeneutics of suspicion, Gadamer's philosophical hermeneutics is not one of distanciation, but one of belongingness and a fusion of horizons (Helenius, 2022), Gadamer (1984) stated, "Is not *every* form of hermeneutics a form of overcoming an awareness of suspicion?" (p. 313, emphasis in original). Although Gadamer's fusion of horizons provides some of the philosophical bedrock on which I have approached my doctoral research, how I began to interpret healthcare aides experiences with death and dying was not by overcoming suspicion, but instead by lingering in it. By doing so, I was better able to question the tradition of the institution from a standpoint that was more critical.

Regarding the way I wanted to linger in my suspicion of healthcare aides' testimony, Ricoeur (1976) suggested suspicion can complement that of understanding by way of appropriation, suspicion being a kind of mode of explanation that allows for critique and a fuller understanding of the whole (Moloney, 1992). Of the kind of appropriation Ricoeur described, I imagine understanding and suspicion as that of DNA's double helix, the two threads twisting and turning around each other, and the genetic code only made intelligible located between them as being the kind of appropriation created by this duality of interpretation. In this way, the testimony of healthcare aides provides one kind of understanding, and my suspicion of their testimony another – the two modes of understanding, or two stories, attempting to make sense of each other to reveal the hidden truths buried in that which is influenced by the institution.

Suspicion as Allowing for Critique of Institutions

Ultimately, the question of suspicion also raises the question of critique, such as how we may be critical of the traditions, or institutions, that we find to be suspicious. While Ricoeur agreed with Gadamer that we are historically effected beings who belong to tradition, such as the western institution of long-term care, "the question of tradition always opens up as the question of tensional duality between belongingness and critical distance" (Helenius, 2022, p. 276). To this point, Grimwood (2024) argued the ways in which we may be critical of institutions is itself something that has been learned within institutions, the practice of which normalized in ways

that often prioritize utility and the social order of the very institutions we serve. However, Gadamer also argued that any mode of critique of the long-term care institution itself belongs to authority and tradition, but that in this belonging, we are still able to be critical of such things:

> Rather, as he argues, interpretive experience remains critical, in that such experience unfolds precisely though the questioning of our prejudices, and judgment about what aspects of our prejudices remain valid and which have become invalid for matters of concern to us now. (George, 2020, section 6.1, para 3)

By acknowledging the centredness of suspicion's place for my understanding healthcare aides' experiences with death and dying, and therefore the place of critique, I am also bringing attention to the moral obligation of research: a "suspicious interpretation is an exercise not just in meaning-making, but in moral-making" (Felski, 2011, p. 222). Regarding the culpability of long-term care institutions influencing healthcare aides' testimony and experiences with death and dying, I have an ethical obligation to recognize healthcare aides' positionality within long-term care and their marginalization within broader society, or the "more menacing structural forces that leave a spreading stain on the social body" (Felski, 2011, p. 224). By doing so, I am better able to advocate for healthcare aides' well-being and experiences, and the quality of care dying residents receive in long-term care.

Although I may be critical of the institution of long-term care, my intention is to avoid closed-off understandings that would lead me down a path of unwavering skepticism and superiority, doubting the testimony of my research participants from the start, thinking myself the knower of what is really going on. However, Grimwood (2024) argued that critique done well is vulnerable in its positionality towards a better future, a better way of doing things, and the endless possibilities of thinking and practicing differently. Where this vulnerability of critique is, in fact, hermeneutical, is in the ways we put our ideals, values, and beliefs into question, or what has called us to be critical (or suspicious) in the first place, and how we consider the uniqueness of every event of understanding as opportunity to adjust or expand our horizon (Grimwood, 2024).

With the help of both Gadamer and Ricoeur, I suggest my use of suspicion for understanding healthcare aides' testimony as being influenced by the institution *is* an interpretation. As such, this interpretation will allow me to not only open new ways of understanding death and dying in long-term care during the COVID-19 pandemic, but to stay attuned to what may require a kind of criticalness of the long-term care home.

*

As the doors parted, I walked out of the elevator only to bump into a healthcare aide rushing back up to the floor to retrieve something she had left behind. After sharing a laugh, I began to walk towards the main entrance of the building when she called out to me. "Wait, your book!" Having dropped it on the floor of the elevator after colliding, she picked it up and handed it to me. "Looks scary," she said, looking down at it, still smiling. A dark forest enveloped the cover, the red letters of the title the only thing visible through the thick branches: *The Haunting of Hill House*. Tucking the book under my arm and thanking her, we said goodbye a second time, and I made my way towards the parking lot. Sitting under the only streetlamp, my car seemed to glow

in the night, a film of rain reflecting the bright light above. Searching my pocket for my keys, a brisk wind suddenly brushed against the back of my neck, and I looked over my shoulder to take in the building behind me. Staring at the house I was beginning to regard as suspicious, a strange thought came over me… Could it be this house is haunted?

The Haunting of Long-Term Care: An Uncanny House with A Long History of Death and Dying

> Once upon a midnight dreary, while I pondered, weak and weary,
> Over many a quaint and curious volume of forgotten lore—
> While I nodded, nearly napping, suddenly there came a tapping,
> As of some one gently rapping, rapping at my chamber door.
> "'Tis some visitor," I muttered, "tapping at my chamber door—
> Only this and nothing more." (*The Raven*, Poe, 1845, lines 1–6)

Long-Term Care: A Kind of Uncanny House

Perched in my writing chair later that evening, a cup of tea in my hand, I suddenly get the feeling I am being watched. Out of the corner of my eye, I see two eyes unblinking, a small mouth unsmiling, two cheeks red but not rosy, and a head of curls unmoving. A perfect doll, its features so lifelike it has my daughter fooled. At two years old, she carries this doll everywhere, from room to room, up into the highchair and down into the bath, and if ever apart, worriedly calls out "baby!" until she finds it. In the daylight this doll feels cheery, making my daughter smile as she pretends to feed it a bottle or change its diaper, but tonight, something about the doll feels off, unfamiliar, a kind of eerie lifelessness in that which earlier looked lifelike.

According to Sigmund Freud (1919/2003), the feeling that something familiar, an old doll for example, suddenly feels unfamiliar in a particular context, is that of the uncanny or *das unheimlich,* meaning unfamiliar, strange, eerie, or "un-homely" (p. 124). The word *unheimlich* in the German is also used to mean that which may be hidden in the home, or "everything that was intended to remain secret, hidden away, and has come into the open" (Freud, 1919/2003, p. 132). In its English origin, and within the context of a house, the house that can be described as *unheimlich,* or uncanny, is one that is haunted (Freud, 1919/2003). As its antonym, *heimlich* means "belonging to the house" and "homely" (Freud, 1919/2003, p. 126), or perhaps more fittingly, "a place that is free of ghostly influences" (Freud, 1919/2003, p. 133).

In his exhaustive exploration of the semantic content and etymological history of the word *unheimlich,* Freud (1919/2003) brings attention to this ambivalent nature of the word, its root word *heimlich* meaning both what is kept safely within the walls of the home, but also that which is secret within the home, or that which is "incomprehensible, something that is dangerous and strange and ought to remain hidden" (Svenaeus, 1999, p. 240). As its opposite, then, *unheimlich* encompasses both a sense of what is homelike yet secret, or what is familiar yet unfamiliar (Freud, 1919/2003; Svenaeus, 1999), much in the same way healthcare aides had described long-term care as being home for older adults, yet not home:

> *It is still their normal life. It's just that we are their hands and their feet for them. We are just the ones doing it for them. We are just helping them. They still perform and continue living, even though they are not able anymore.*

When considered within its etymological history then, Freud (1919/2003) considered the haunted house, or the "uncanny house" (p. 148), to be the most potent example of that which is familiar, yet unfamiliar.

For Freud (1919/2003), the uncanny "belongs to the realm of the frightening, of what evokes fear and dread" (p. 123), meaning, that which terrifies or produces anxiety in the uncanny sense, is something already known to us, although repressed, but has now returned to haunt us. Despite the centeredness of death and dying in healthcare aides' experiences of working in long-term care, it being a familiar kind of ghost, I suggest the happenings of death and dying during the COVID-19 pandemic would return to haunt healthcare aides, death having become an unfamiliar ghost to be reckoned with. Of this kind of haunting, Freud (1919/2003) said: "To many people the acme of the uncanny is represented by anything to do with death, dead bodies, revenants, spirits and ghosts," the primitive question of our "relation to death" one that continues to confront us, no matter how repressed it becomes throughout history (p. 148).

Long-Term Care: A House with a Haunted History

> This house, which seemed somehow to have formed itself, flying together into its own powerful pattern under the hands of its builders, fitting itself into its own construction of lines and angles, reared its great head back against the sky without concession to humanity. It was a house without kindness, never meant to be lived in, not a fit place for people or for love or for hope. (*The Haunting of Hill House*, Jackson, 1959/2016, p. 30)

Our very understanding of long-term care is one in which history is operative, this understanding only made possible from within the tradition in which we already find ourselves, tradition being "that which is handed over" to us (Vessey, 2022, p. 117). As the descendent of 19th and 20th century poor houses and almshouses (charitable institutions), long-term care has a long history of filling a space in society that has not been well understood, its purpose handed over to us in ways that are socially reconstructed to fit the needs of society at the time (Estabrooks et al., 2020; Mah & Gallup, 2021; Wagner, 2005). Historically in Canada, the eldest son in each family was expected to care for his parents as they grew older, and to ensure appropriate and suitable living accommodations (Estabrooks et al., 2020; Mah & Gallup, 2021). If not afforded housing by family, older adults were subject to Elizabethan Poor Law and sent to live their final years in poor houses, where it was understood they were no longer a person of value in society. Considered lower class, and without means to pay for room and board, they were expected to work until they were too frail to do so, or until they died (Mah & Gallup, 2021).

The movement of people into cities during 19th century industrialization resulted in increased numbers of older adults requiring shelter, and the Canadian government began to problematize these older adults as "destitute, ill, and dependent," since ageing was considered an issue of poverty (Montigny, 1997, p. 29). Consequently, older adults were not only sent to live, and die, in poor houses, but also insane asylums, and even prisons, as if growing old was a crime to be

punished (Montigny, 1997; Wagner, 2005). In late 19th century Ontario, for example, the rhetoric from institutional administrators, government, and the media at the time suggested institutionalized older adults were mere "decrepid [*sic*]" and "decaying" beings, destined to die in the streets if not for the institutions forced to take them in (Montigny, 1997, p. 29). From its early origins, long-term care is the latest manifestation of an answer to the ongoing question of the worth older adults have in society, and where people should go to die.

> the concept of certain houses as unclean or forbidden—perhaps sacred—is as old as the mind of man. Certainly there are spots which inevitably attach to themselves an atmosphere of holiness and goodness; it might not then be too fanciful to say that some houses are born bad. (*The Haunting of Hill House*, Jackson, 1959/2016, p. 63)

Near the bottom in the hierarchy of healthcare, long-term care is perceived as being a place of little technology, expertise, or curative medicine, stigmatized as simply custodial care for the old and dying. A lack of both federal government regulation and a sense of public responsibility toward the care of institutionalized older adults has arguably meant limited funding and consistency of research across Canada (Canadian Healthcare Association, 2009). As "traditioned-beings who inherit various prejudices, customs, and practices" (Nielsen & Utsler, 2023, p. 64), it would seem that we have inherited a social collective knowledge that long-term care is a place of little value, yet it continues to fill an essential need in society in the absence of community supports and government-supported home care options (Sinha et al., 2019).

While the marginalization of the older adult population in society has also contributed to a gap in our understanding of death and dying in long-term care, Gadamer (1993/1996) would argue that modern society has long been inclined to deal with death by systematically repressing it. Consequently, long-term care as a place of death and dying becomes further marginalized in a society that is socially conditioned to repress death. About the increasing hiddenness of death in society, Gadamer (1993/1996) argued that "modern civilization eagerly and enthusiastically seeks to bring this tendency to repression which is rooted in life itself to institutional perfection and so to push the experience of death wholly onto the margins of public life" (p. 65). Specifically, since society has been incapable of confronting death, death has become increasingly institutionalized, away from the domestic life of family, and in this institutionalization, becomes but a shadow we are left to wrestle with alone: "We portray death as the robber of life, a phantom cloaked in black that waits in darkness to descend upon its victim. We would like nothing better than to sweep the streets clean of all suggestions of our mortality" (Smith, 2016, p. 113).

Perhaps nowhere is this sweeping of death from the streets more present than in long-term care, where despite the expectedness of death, long-term care homes have been systematically repressing and denying its presence. Hiding any traces of death, names of long-term care homes such as, Golden Years Long-Term Care (https://peoplecare.ca/long-term-care/golden-years/), and Better Living at Thompson House (https://mybetterliving.ca/long-term-care/), speak to a focus on quality of life, and very few long-term care homes make any mention of the inevitability of residents dying within their walls (Cable-Williams & Wilson, 2016; Hill et al., 2019). To be brought back from the margins of social life, it would seem long-term care homes want to shake off the cloak of death by opening the curtains and letting the sunshine in, banishing any shadows

that might have whispered the secrets of the house. While the long-term care home may be a different house than that of the 18th and 19th century insane asylums and poor houses, I suggest the ghosts of older adults who once died in such places can still be found roaming the halls, despite being a place where it seems there is a collective effort to pretend that no one dies here.

To summarize the final section of this paper, I have suggested long-term care can be considered that of a haunted house, for not only is it an uncanny kind of house where death and dying are both familiar and unfamiliar ghosts, but it is tethered to a long history of ignoring and concealing those ghosts, much in the same way a haunted house attempts to hide death and dying both within and behind its walls. As such, I suggest the metaphor of the haunted house is not only a powerful way to better understand healthcare aides' experiences with death and dying in places where death has always been, *yet hidden*, but to also understand how the institution shaped and influenced their testimony. The metaphor of the haunted house has spoken to me through my reading of gothic literature, as I often found myself struck by the similarities between the ways healthcare aides described their experiences with death and dying, and my evening reading in the gothic genre. For a more detailed discussion on metaphor and the power of gothic storytelling, please see my Invited Editorial: *The Haunting of Long-Term Care: Understanding Healthcare Aides' Experiences with Death and Dying During the COVID-19 Pandemic*, published in the *Journal of Applied Hermeneutics*. It is my hope that, when used to ground the interpretive chapters of my doctoral thesis, the metaphor of the haunted house is not only an illuminating one for better understanding death and dying in long-term care, but for understanding differently the position from which healthcare aides had to make sense of their experiences during the COVID-19 pandemic.

Closing Thoughts

In this paper, I have explored how I suspected that what healthcare aides shared in their interviews was a kind of institutionally mediated testimony, and how my suspicion was rooted in the interpretive problem that presented itself: First, when the audio recorder was turned off, participants shared something different about the long-term care institutions in which they work, a kind of testimony that cannot be quoted by the researcher or verified by the reader. I have argued this discrepancy in healthcare aides' testimony should be considered within the context of how healthcare aides are a largely hidden workforce and occupy a position of relatively little power within long-term care homes and broader social society. Second, healthcare aides seemed to deny death and dying within long-term care, the event of the COVID-19 pandemic having been publicly alarming, yet remaining concealed from those on the outside, further hinting at their experiences as being a kind of institutionally mediated testimony. Additionally, my own position of working in long-term care as a registered nurse contributed to me having a sense of suspicion, there being a tension between what was said during interviews and what I experienced in practice.

By drawing on both Gadamer and Ricoeur for a philosophical understanding of suspicion in research, I have argued that my suspicion *is* an interpretation of the topic and allows for a kind of criticism of the long-term care institution I consider to be a suspicious kind of house, having shaped and influenced the testimonies of those inside. Considering the rootedness of suspicion for understanding healthcare aides' experiences, I have interpreted their experiences as occurring

in an "uncanny house," or one that is haunted, as death and dying is both a familiar and unfamiliar ghost in a place attempting to conceal their presence. In the Spring of 2020, however, healthcare aides would have no choice but to reckon with these ghosts, and as I explore in next paper in this serialization, would have to do so in isolation from the outside world:

> The place, moreover, in the strangest way in the world, had, on the instant, and by the very fact of its appearance, become a solitude. …It was as if, while I took in – what I did take in – all the rest of the scene had been stricken with death. I can hear again, as I write, the intense hush in which the sounds of evening dropped. The rooks stopped cawing in the golden sky, and the friendly hour lost, for the minute, all its voice. But there was no other change in nature, unless indeed it were a change that I saw with a stranger sharpness. (*The Turning of the Screw*, James, 1898/2021, p. 32).

Note: Portions of this paper were published in the *Journal of Applied Hermeneutics* as "A Suspicion of Testimony and the Tradition of Institutional Contexts: An Exploration of Translative Practice for Conducting Ethically Responsible Research," and "Death, Dying, and Credibility in Long-Term Care: How Healthcare Aides Were the Voiceless Other During the COVID-19 Pandemic." Reprinted by permission.

References

Bergqvist, M., Bastholm-Rahmner, P., Gustafsson, L.L., Holmgren, K., Veg, A., Wachtler, C., & Schmidt-Mende, K. (2023). How much are we worth? Experiences of nursing assistants in Swedish nursing homes during the first wave of COVID-19. *International Journal of Older People Nursing*, *18*(1), Article e12498. https://doi.org/10.1111/opn.12498

Blanco-Donoso, L. M., Moreno-Jiménez, J., Gallego-Alberto, L., Amutio, A., Moreno-Jiménez, B., & Garrosa, E. (2022). Satisfied as professionals, but also exhausted and worried!!: The role of job demands, resources and emotional experiences of Spanish nursing home workers during the COVID-19 pandemic. *Health & Social Care in the Community*, *30*(1), e148–e160. https://doi.org/10.1111/hsc.13422

Brown, M. (2020, April 22). *How COVID-19 overwhelmed Canada's long-term care system*. University of Alberta Folio. https://www.ualberta.ca/en/folio/2020/04/how-covid-19-overwhelmed-canadas-long-term-care-system.html

Cable-Williams, B., & Wilson, D.M. (2016). Dying and death within the culture of long-term care facilities in Canada. *International Journal of Older People Nursing, 12*(1). https://doi.org/10.1111/opn.12125

Canadian Healthcare Association. (2009). *New directions for facility-based long-term care* [Policy brief]. https://www.healthcarecan.ca/wp-content/themes/camyno/assets/document/PolicyDocs/2009/External/EN/NewDirectionsLTC_EN.pdf

Canadian Institute for Health Information. (2021a, June 10). *Long-term care homes in Canada: How many and who owns them?* https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

Canadian Institute for Health Information. (2021b, September 28). *Profile of residents in residential and hospital-based continuing care, 2020–2021*. https://www.cihi.ca/en/quick-stats

Caputo, J. D. (1987). *Radical hermeneutics: Repetition, deconstruction, and the hermeneutic project*. Indiana University Press.

Caputo, J. D. (2018). *Hermeneutics: Facts and interpretation in the age of information.* Penguin Books.

Estabrooks, C. A., Straus, S., Flood, C. M., Keefe, J., Armstrong, P., Donner, G., Boscart, V., Ducharme, F., Silvius, J., & Wolfson, M. (2020). *Restoring trust: COVID-19 and the future of long-term car*e [Policy brief]. Royal Society of Canada. https://rsc-src.ca/sites/default/files/LTC%20PB%20%2B%20ES_EN_0.pdf

Felski, R. (2011). Suspicious minds. *Poetics Today*, *32*(2), 215–234. https://doi.org/10.1215/03335372-1261208

Forrest, M. (2020, May 26). *Canadian military details horrific conditions in nursing homes battling Covid-19.* Politico. https://www.politico.com/news/2020/05/26/canadian-military-details-horrific-conditions-in-nursing-homes-battling-covid-19-282605

Freud, S. (2003). *The uncanny* (D. McLintock, Trans.; H. Haughton, Intro.). Penguin Books. (Original work published 1919)

Gadamer, H.-G. (1984). The hermeneutics of suspicion. *Man and World*, *17*(3–4), 313–323. https://doi.org/10.1007/BF01250456

Gadamer, H.-G. (1996). *The enigma of health* (J. Gaiger & N. Walker, Trans.). Polity Press. (Original work published 1993)

George, T. (2023). Hermeneutics. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy* (Spring 2023 ed.). Stanford University. https://plato.stanford.edu/archives/spr2023/entries/hermeneutics/

Grimwood, T. (2024). *Against critical thinking in health, social care, and social work: Reframing philosophy for professional practice*. Routledge.

Grondin, J. (1994). *Introduction to philosophical hermeneutics* (J. Weinsheimer, Trans.). Yale University Press. (Original work published 1991)

Grondin, J. (2014). Do Gadamer and Ricoeur have the same understanding of hermeneutics? In M. Xie (Ed.), *The agon of interpretations: Towards a critical intercultural hermeneutics* (pp. 43–64). University of Toronto Press. https://doi.org/10.3138/9781442696303-004

Helenius, T. (2022). Ricoeur and Gadamer. In T. George & G.-J. Van der Heiden (Eds.), *The Gadamerian mind* (pp. 275–287). Routledge.

Hill, C., Duggleby, W., Venturato, L., Durepos, P., Kulasegaram, P., Hunter, P., McCleary, L., Sussman, T., Thompson, G., Surtees, D., Wickson-Griffiths, A., & Kaasalainen, S. (2019). An analysis of documents guiding palliative care in five Canadian provinces. *Canadian Journal on Aging*, *38*(3), 281–295. https://doi.org/10.1017/S0714980818000594

Ireton, J. (2021, March 30). *Canada's nursing homes have worst record for COVID-19 deaths among wealthy nations: report*. CBC News. https://www.cbc.ca/news/canada/ottawa/canada-record-covid-19-deaths-wealthy-countries-cihi-1.5968749

Jackson, S. (2016). *The haunting of hill house*. Penguin Books. (Original work published 1959)

James, H. (2021). *The turning of the screw.* Arcturus Publishing Limited. (Original work published 1898)

Jones, K., Schnitzler, K., & Borgstrom, E. (2022). The implications of COVID-19 on health and social care personnel in long-term care facilities for older people: An international scoping review. *Health & Social Care in the Community*, *30*(6), e3493–e3506. https://doi.org/10.1111/hsc.13969

Laher, Z., Robertson, N., Harrad-Hyde, F., & Jones, C.R. (2022). Prevalence, predictors, and experience of moral suffering in nursing and care home staff during the COVID-19 Pandemic: A mixed-methods systematic review. *International Journal of Environmental Research and Public Health*, *19*(15), Article 9593. https://doi.org/10.3390/ijerph19159593

Lightman, N., Evehe, M.-S., & Baay, C. (2021). *More than "just a health-care aide": Immigrant women speak about the COVID-19 crisis in long-term care*. Parkland Institute. https://d3n8a8pro7vhmx.cloudfront.net/parklandinstitute/pages/1894/attachments/original/1624976097/More_than_Just_a_Health_Care_Aide_Final.pdf?1624976097

Mah, J., & Gallup, B. (2021). A short history of long-term care in Nova Scotia. *Canadian Geriatrics Journal*, *24*(1), 77–81. https://doi.org/10.5770/cgj.24.464

Moloney, R. (1992). Stages in Ricoeur's hermeneutics. *The Irish Theological Quarterly*, *58*(2), 118–128. https://doi.org/10.1177/002114009205800203

Montigny, E.-A. (1997). *Foisted upon the government?: State responsibilities, family obligations, & care of the dependent aged in late 19th-century Ontario*. McGill-Queen's University Press.

Moules, N.J. (2015). Editorial: Aletheia - - Remembering and enlivening. *Journal of Applied Hermeneutics*, 2. https://doi.org/10.11575/jah.v0i1.53255

Nielsen, C.R., & Utsler, D. (2023). Gadamer, Fricker, and Honneth: Testimonial injustice, prejudice, and social esteem. In P. Giladi & N. McMilan (Eds.), *Epistemic injustice and the philosophy of recognition* (pp. 63–86). Routledge.

Online Etymology Dictionary. (n.d.). Lethe. In *Online etymology dictionary.* Retrieved October 13, 2024, from https://www.etymonline.com/search?q=lethe

Online Etymology Dictionary. (n.d.). Suspect. In *Online etymology dictionary*. Retrieved September 3, 2024, from https://www.etymonline.com/word/suspect#etymonline_v_22434

Online Etymology Dictionary. (n.d.). Suspicion. In *Online etymology dictionary*. Retrieved September 3, 2024, from https://www.etymonline.com/search?q=suspicion

Poe, E.A. (1845). The raven. Retrieved August 20, 2024, from https://www.gutenberg.org/files/1065/1065-h/1065-h.htm

Ricoeur, P. (1970). *Freud and philosophy: An essay on interpretation* (D. Savage, Trans.). Yale University Press.

Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Texas Christian University Press.

Schulze, S., Merz, S., Thier, A., Tallarek, M., König, F., Uhlenbrock, G., Nübling, M., Lincke, H.-J., Rapp, M. A., Spallek, J., & Holmberg, C. (2022). Psychosocial burden in nurses working in nursing homes during the Covid-19 pandemic: A cross-sectional study with quantitative and qualitative data. *BMC Health Services Research*, *22*(1), 1–949. https://doi.org/10.1186/s12913-022-08333-3

Sinha, S., Dunning, J., Wong, I., Nicin, M., Nauth, S., Persaud, A., & McKee, A. (2019, September). *Enabling the future provision of long-term care in Canada*. National Institute on Ageing. https://cnpea.ca/images/futureoflong-termcare_v7_final-09-09-2019.pdf

Smith, R. (2016). Acknowledging the shadow. In K.P. Ellison & M. Weingast (Eds.), *Awake at the bedside* (pp. 111–122). Wisdom Publications.

Snyder, R.L., Anderson, L.E., White, K.A., Tavitian, S., Fike, L.V., Jones, H.N., Jacobs-Slifka, K.M., Stone, N.D., & Sinkowitz-Cochran, R.L. (2021). A qualitative assessment of factors affecting nursing home caregiving staff experiences during the COVID-19 pandemic. *PloS One*, *16*(11), e0260055. https://doi.org/10.1371/journal.pone.0260055

Stelfox, K. (2022). Death, dying, and credibility in long-term care: How healthcare aides were the voiceless other during the COVID-19 pandemic. *Journal of Applied Hermeneutics*, Article 12. https://doi.org/10.11575/jah.v2022i2022.76002

Svenaeus, F. (1999). Freud's philosophy of the uncanny. *The Scandinavian Psychoanalytic Review*, *22*(2), 239–254. https://doi.org/10.1080/01062301.1999.10592708

Titley, H.K., Young, S., Savage, A., Thorne, T., Spiers, J., & Estabrooks, C.A. (2023). Cracks in the foundation: The experience of care aides in long-term care homes during the COVID-19 pandemic. *Journal of the American Geriatrics Society*, *71*(1), 198–205. https://doi.org/10.1111/jgs.18024

Vessey, D. (2022). Gadamer on tradition. In T. George & G.-J. Van der Heiden (Eds.), *The Gadamerian mind* (pp. 117–126). Routledge.

Wagner, D. (2005). *The poorhouse: America's forgotten institution*. Rowman & Littlefield Publishers.