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The Haunting of Long-Term Care, Part Two.

"All Families Banned from the Building": Making Sense of Death and Dying in an Isolated House

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Abstract

This paper is the second 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 telling 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 second paper, tension builds as the long-term care home shutters its windows and closes its doors to the outside world in an effort to keep the COVID-19 virus at bay, isolating those who live and work within its walls. I explore the idea of isolation and consider how this influenced healthcare aides' position within the house and, in turn, their experiences of death and dying. I then describe how healthcare aides understood residents as

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dying in isolated ways in the absence of family members, revealing tensions in the common narrative that healthcare aides and residents are *family*. I then offer a philosophical discussion of how long-term care is perhaps not home for residents, despite them living there, but instead is a place of conditional hospitality and even hostility. Finally, I explore the consequences of this conditional hospitality or hostility for residents' well-being.

Keywords

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

When I think of the word *pandemic,* I immediately think of the word *isolation,* the two almost being synonymous in my mind, and never far apart. However, there is an etymological tension between these two words: While the word pandemic, having derived from the Greek word *pandemus,* may mean "pertaining to all people; public, common" (Online Etymology Dictionary, n.d.), the word isolation means "to set or place apart, to detach so as to make alone" (Online Etymology Dictionary, n.d.). While the COVID-19 pandemic may have given all of us common ground from which to make sense of our experiences, it was also good at setting us apart, detaching us from one another, and making us feel alone. Due to most of the death and dying occurring in long-term care during the first two waves of the pandemic (CIHI, 2021), long-term care homes were set apart and detached from society, and even from the family members and loved ones of the residents inside.[1]

To save lives, long-term care homes shut their doors to the outside world, with no one other than essential staff, like healthcare aides, able to go in or out. With its doors locked and windows shuttered, I imagined a thick fog enveloping the house, settling in near the windows, obstructing any view of the inside, leaving an unsettling and disorienting feeling about the place. Despite its impenetrable structure and unyielding nature, the house seemed to collapse in on itself, refusing to let go of those inside or that which had become hidden. Isolated in its confrontation with the kind of death and dying brought by the COVID-19 pandemic, the house stood in solitude, and the residents and healthcare aides living and working inside were left to face the haunting of long-term care alone.

> No live organism can continue for long to exist sanely under conditions of absolute reality; even larks and katydids are supposed, by some, to dream. Hill House, not sane, stood by itself against its hills, holding darkness within; it had stood so for eighty years and might stand for eighty more. Within, walls continued upright, bricks met neatly, floors were firm, and doors were sensibly shut; silence lay steadily against the wood and stone of Hill House, and whatever walked there, walked alone. (*The Haunting of Hill House*, Jackson, 1959/2016, p. 1)

If all living things must dream to endure reality, those who walk the halls of a haunted house must walk alone, no longer able to dream in a place so forthcoming in its terrors of what is real, or even

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[1] Although I use the words "family members" to describe those who were unable to visit long-term care residents during visitor restrictions, I consider this to also include loved ones.

what is not. I think this is what Shirley Jackson meant, with her opening passage in the novel *The Haunting of Hill House*: that when confronted with the kind of darkness so overwhelming it makes one question their sanity or experiences, we do so in isolation, as no one else is able to walk the halls for us or help us confront our fears. Perhaps this is why the haunted house always stands alone, perched on top of secluded and gloomy hills, or tucked away in thick forests; the physical isolation of the house itself a warning about the kind of isolation one experiences inside. Not unlike haunted houses, 19th and 20th century insane asylums and poor houses also stood in a kind of "rustic isolation," often located away from town to not frighten or burden general society with the kind of death taking place inside (Hunter et al., 1986, p. 1036; Wagner, 2005). The descendant of such places, the modern-day long-term care home, may no longer be physically isolated from broader social society, but those living, and dying, inside continue to experience a kind of isolation and hiddenness that is reminiscent of a dark and secretive past, which is that the institution of long-term care *is* a place of death and dying. Therefore, while death and dying may have a long history of being denied in long-term care, the unprecedented isolation of long-term care and dying residents during the pandemic meant, that, death and dying was both that of a familiar and unfamiliar ghost for the healthcare aides who provided care.

Understanding healthcare aides experiences with death and dying in long-term care during the COVID-19 pandemic was therefore to understand their experiences as taking place in an isolated kind of house, a haunted house, that had closed itself off to the outside world during times of visitor restrictions. In the first section of this paper, I began by exploring how long-term care, being that of an isolated place, had influenced healthcare aides' position within the house, and therefore their experiences with death and dying in the context of isolation. I then describe how healthcare aides understood residents as dying in isolated ways during the pandemic, and how healthcare aides had to not only step in for missing family members to care for residents but attempt to facilitate communication between them at the end of life. I then explore how this stepping in of healthcare aides revealed a tension within the house: while there may be a common narrative in long-term care that healthcare aides and residents are like that of *family,* the pandemic was a time when actual family members were not allowed in, and healthcare aides were limited by the institution in how they could care for dying residents. In the second section of this paper, I offer a philosophical discussion of how long-term care is perhaps not *home* for residents, despite them living there, but instead is a place of conditional hospitality and even hostility. I then conclude the second section of this paper by exploring the consequences of this conditional hospitality or hostility on resident's well-being.

Healthcare Aides' Positionality in the Haunted House: A Kind of Governess or "Screen"

In my interviews with healthcare aides, they spoke to a kind of hiddenness of death and dying in long-term care during the pandemic, where despite the expectedness of death, it seemed to be concealed from the residents who were both living and dying in long-term care homes, and the family members forced to remain outside the house. Although healthcare aides could see death, as they so vividly described during their interviews, they were somehow also standing in front of it, shielding it from view and tucking it away, as if to protect the reputation of the long-term care home. In this way, healthcare aides reminded me of the governess archetype common in the classic haunted house novel, the often-female character who arrives at a home to care for children, unaware of its secret hauntings inside. With time however, the governess becomes aware of the ghosts who roam the halls, but attempts to either downplay, ignore, or deny their existence to those they care for. As was powerfully stated by one healthcare aide in the first paper in this serialization, "*you might lose your job"* if too many ghosts were allowed to enter the house. As such, healthcare aides were known to hold a precarious position during the pandemic, having been "systematically socially and economically devalued," and unable to question their working conditions, unfair institutional policies, or even their experiences from an equal footing of power (Lightman et al., 2021, p. 4). When considered within the context of healthcare aides' position within the institution of long-term care, or as a kind of governess entrusted with protecting the secrets of a haunted house, their experiences, as I argued in the first paper in this serialization, can still be considered that of an institutionally mediated testimony.

What differs about the positionality of healthcare aides in this paper, however, is how healthcare aides were not only denying deaths presence but concealing it from family members. As was the case in *The Turn of the Screw* (1898/2021), a gothic literature novel, the new governess finds herself face to face with ghosts, but in her duties to protect the children of Bly Manor, attempts to conceal their presence from them. While there are obvious ways the governess character is unlike that of the healthcare aide, I found myself drawn to the following passage, as it echoed the way healthcare aides described stepping in for missing family members, being the only ones able to offer them any comfort in their final moments of life:

> We were cut off, really, together; we were united in our danger. They had nothing but me, and I—well, I had *them*. It was in short a magnificent chance. This chance presented itself to me in an image richly material. I was a screen—I was to stand before them. The more I saw, the less they would. (*The Turning of the Screw*, James, 1898/2021, p. 50, emphasis in original)

Echoing the above passage, one healthcare aide described providing additional support and care to dying residents in the face of being cut off, together, in their danger:

> *It was quite a unique experience, because it involved a lot of emotion, like, there was a lot of emotions going on but at the same time we had to be like, the family for the person. Because their family was not there to care for them, but we were there, and we had to provide emotional support, as well as nursing care.*

While healthcare aides may have stepped in for missing family members in their care of dying residents, as described above, the tension of them not *actually* being the residents' family also presented itself: As the interview transcripts in the remainder of this paper will suggest, it would seem the more healthcare aides saw of death, the less residents' family members would, having become a *screen* between them. Where the word "screen" in the passage from the *Turning of The Screw* suggests the governess attempted to shield the children from the ghosts that haunted the house, my seeing healthcare aides as also a kind of screen, having stood between residents and family members, or between residents and death, was not about protecting residents, but more about concealing something about residents' dying or deaths. Often placed within the frame of a window or door, a screen allows one to peer into or out of the house, while also protecting from the outside world, blocking the rays of autumn's midday sun, or the arrival of insects that comes with warm weather. Unlike that of a clear window, however, a screen also "conceal[s], from view" and distorts that which is visible, allowing some things to pass through its fine netting, but not all things (Online Etymology Dictionary, n.d.).

Death and Dying as Occurring in an Isolated House

Under the glare of morning's light, a long-term care home stood alone. Surrounded by empty parking lots blanketed in a fresh spring snow, its windows are shuttered, and its doors locked, a kind of muffled quiet laying heavy around its perimeter. The sun beating down on its face, the windows of the house appear as if crying, icicles dripping the freezing rain from the night before. Making her way across the lawn, a woman crosses the threshold, the crunching of snow under her feet breaking the silence. Arriving at the side of the building, she reaches into her bag and pulls out a pad of white paper and a black pen. Taking off her wool gloves, she begins to write in big and bold letters, the melting ice above threatening to make the letters unintelligible, as drops of water fall on the paper. Once finished, she looks up, and wiping her forehead, knocks on the frosty window.

*

"All Families Banned from the Building"

In my interviews with healthcare aides, it became clear their experiences of caring for residents during the pandemic were understood within the context of residents' isolation, as they spoke often about the ways family members had been "*banned from the building"*:

> *Suddenly… it is lockdown. Some are crying because they are looking for their families and the family cannot go in.*

Due to the significant number of deaths occurring in long-term care homes, public health orders across Canada meant that family were banned during the worst of the pandemic and times of outbreak, or visitation was severely limited, to limit the spread of the virus and save lives (Thirsk et al., 2021). It was common to see images in the media of family members camped in front of long-term care homes, or standing outside of windows, holding up signs or trying to communicate with those inside (for an example, see the photograph in Muschi, 2020).

> *Some family members… they talk to them through the window. They can talk to their family member from the outside. They open the window and wear some kind of shield, if they insist they want to see their family members.*

Not only were no family allowed in during times of visitor restrictions and lockdown, but residents were often not allowed out of the long-term care home, or even their rooms (Simard & Volicer, 2020). Where previously residents would have been able to leave the building to go to appointments, activities, or simply visit with their families, they were now confined within the walls of the facility:

> *We get phone calls and they would be asking for them. They would be saying, I want to go out and see my daughter. And we would say, you can't go out you are sick. You're contagious, we can't let you out.*

While I had known that long-term care had closed its doors to the outside world during the worst of the pandemic, or during times of outbreak, I was taken aback by the kind of isolation healthcare aides described even dying residents experiencing. It seemed that all family members could do for their loved one who lay dying was to stand outside the house, peer in through the windows, and wait for their dead body:

> *Healthcare Aide: [The dying resident] did not have any visits, because they were not allowed into the facility. So, the family stayed outside. They came, you know, crying –*
> *Interviewer: To the window?*
> *Healthcare Aide: Yes, and they were outside, but they couldn't get into the facility. Until they got the corpse out. ...For the last three days, they would come, and they would just stand outside and cry. Because that's all they can do...And when they got the corpse out, they were outside –*
> *Interviewer: They only saw her, physically they only saw her, once she was already dead.*
> *Healthcare Aide: Yes. Exactly. Exactly.*

Although the words *corpse* is an accurate term for a dead body, I found myself surprised when the above healthcare aide described the recently deceased resident in this way, as if the resident who died from COVID-19 no longer had a place in the house, having disappeared into the shadows. Somewhat paradoxically, considering how healthcare aides had described the concealment of dying residents, the word corpse comes from the proto-indo-European word *kwrep*, meaning "to appear" (Online Etymology Dictionary, n.d.). While some residents may have appeared to family members only once they were a corpse, some healthcare aides described how residents' bodies remained concealed or hidden, even in death:

> *Healthcare Aide: We found out that the family cannot come around, even when they are dead. Even when they are dying, they can still infect someone. They can infect someone, even when they're dead.*
> *Interviewer: So, the family couldn't come in after they died?*
> *Healthcare Aide: No, they're not coming around. We just clean them up, we put the – they can meet them in the funeral home. And sometimes when there are many, we put them in the bag and all that. When there's too many. We don't want to make them to remain at the facility, right? So, especially when there are very many, we make sure to put them, you know, aside.*
>
> *It's kind of dehumanizing because human beings are not a package. ...But we had to follow the rules, right?*

As I listened to healthcare aides describe residents as being put into bags when the dead bodies became "*too many*," "*put aside,"* or delivered to families as a "*packaged"* "*corpse*," it seemed that death and dying and isolation were ghosts who walked the halls of the house together, hand in hand – residents having died in ways that were hidden from the outside world, and families only able to recover their bodies from the house after they had already died. It was also clear in my interviews with healthcare aides that they struggled with the public health policies that resulted in the banning of family members, but from their position of relatively little power in long-term care, had felt unable to question such practices, and instead "*had to follow the rules*" while residents died alone:

> *Some folks would start crying. Because, you know – who wants to die alone?*
>
> *And the families kept saying, you're going to make my mother die alone? And sometimes yes, they did.*

Isolation as Causing Death

Although residents had been isolated in long-term care away from their families during the pandemic in effort to save their lives, healthcare aides also felt that, for some residents, it was the isolation that ultimately led to their death:

> *We leave three or four glasses of juice or water there on the table, but they are so sick, how are they going to be able to drink? How are they going to be able to eat if they are weak? They don't have the strength to feed themselves. ...So that was a critical time, because they are really sick, and they are really weak. They needed somebody there, to help them. ...But there was nobody and we were not allowed to tell anything to the family. We were not allowed to let them come in, either. ...We were not supposed to give them information about how their family member or loved one is doing behind –*

The leaving of residents alone with food and drink despite them being unable to pick up a spoon or bring a glass to their lips confirms the findings produced by an investigative report of a long-term care home in Quebec, which found that residents died during the pandemic not just from the COVID-19 virus, but from thirst and malnourishment (Ha, 2021). Traces of healthcare aides' institutionally mediated testimony are therefore clearly present in the transcript above, as they described questioning their practice, but ultimately concealing the reality of how residents were being cared for, in ways that served to protect the institution rather than the residents or residents' family members:

> *I believe that the residents that were positive with COVID, they were not receiving the care enough. And they were not receiving the attention in the moment that they needed. And it was because of that, the residents were getting worse. It was very devastating for me. I was giving care to a resident for like, ten days…and I was talking to them from outside the door. I said, good morning. ...But that day, no answer. No answer. But I keep on talking and I said, maybe she is sleeping. ...So, when I opened the door and I get in the room, I see that she is not breathing. She is not breathing. I didn't even know what time she passed.*

When I asked why residents infected with COVID-19, even dying residents, were the last to receive care, healthcare aides indicated they had been instructed by management or nurses to do so – to limit the spread of the virus – even if they themselves had disagreed with the protocol. Healthcare aides also described being emotionally encumbered by a lack of time and resources, as well as physically encumbered by the wearing of personal protective equipment, as to why they were unable to provide adequate care to the dying:

> *Because we were only allowed to do them at the end. We did the non-infectious people at the beginning, and then at the end we did them, so, we wouldn't spread it to the non-infections people. ...Even when they were dying. ...It's not that we didn't want to go there or answer their calls. We would say, I'll be there as soon as I can. But we couldn't, we couldn't spread it.*

Even prior to the pandemic, long-term care has been plagued by systemic and persistent short staffing and inadequate palliative care strategies, dying residents often seeming out of place in a house that so desperately wants to ignore the reality of death within its walls. Despite the person who is dying requiring additional care at the end of life, staffing levels often remain unchanged when a resident is considered palliative, and palliative care approaches in long-term care are not only inadequate, but sometimes non-existent (Cable-Williams & Wilson, 2016; Hill et al., 2019). If staffing levels remain unchanged to accommodate a dying resident, it is not surprising these residents would receive care only "*at the end*," the residents who are still able to request care or ring their call bell being the ones to receive attention first:

> *[The dying resident] has less right, because they are on isolation. ...We had to wear the full [personal protective equipment] and then it was very uncomfortable for us. ...It was very tiring for everyone. So, some of the people would say, no, we will just leave this resident for the last minute. We got together so many times, saying this person has priority, why don't we start with them and then go to the people who don't have COVID last. But nobody would agree. But it was because of that, most of the residents got worse and worse. Because they need something to drink, they need something to eat, they need care, you know? ...Since they are sick most of them have [a bowel movement], they might puke, they might – all the things we need to change to maintain their health, or maintain hygiene. ...Because we were short staffed, we were really short, we were really tired. ...We are doing poorly with those COVID residents, they were receiving care at the last minute. We are not giving them care. Not even like one, two or three times because they are sick or need something. No, we only give them care once, and then that was it.*

The isolation of residents dying from COVID-19, or them having "*less right*" to receive care from healthcare aides, is also perhaps not surprising, their deaths having occurred in a place that has long been unprepared to care for dying people, however anticipated death might be. Prior to the COVID-19 pandemic, family members were allowed to enter the facility and be with residents during their dying time, allowing for at least some transparency of the dying resident's condition. During the pandemic, however, it seemed healthcare aides felt they had to be quiet, unable to really say what was going on behind closed doors, which was that sick residents were not only dying from the virus, but from neglect.

Screening Death's Call: Healthcare Aides use of Virtual Screens at the End of Life

In their position as a kind of governess in a haunted house, healthcare aides were not only that of a screen, standing before the dying residents, shielding death from family members' view, but also had to use virtual screens, such as FaceTime, to facilitate communication at the end of life:

> *When I was making a phone call for the seniors, I just… just breathe, and just say yes, no, yes, no. Because I couldn't talk. But I can't lie. I can't lie. …Making a phone call for a person who is dying, to a daughter or son, or the whole family, it doesn't matter, but I was the one who was making the call…and this person was dying. And I had to wake her up, trying to convince her, at least to say hi. But actually, that person was not there anymore.*

While the archetype of the governess found in gothic literature may attempt to protect children from the hauntings of the house, calming the children's fears by denying the presence of ghosts, it seemed healthcare aides were not protecting residents or their family members from death and dying, but were instead somehow protecting that of the institution: "*Because I couldn't talk. But I can't lie."* Even now, after the event, healthcare aides often did not explicitly name the institution of long-term care as influencing what they felt they could say, or not say, to family members, as if even whispering such truths would be too risky:

> *You have to make the time, and push a video call, even if they are not communicating with each other. Just connect the tablet, make them to see each other, and then just leave it. Then come back when it is the time, and then you just have to shut the tablet off. And then that's it.*

There was an eeriness in the way healthcare aides described the using of virtual screens for residents they considered to be *"not there anymore,"* a kind of artificiality to a deeply human experience that could be manipulated and concealed. Family members were therefore at the mercy of healthcare aides who were not only too busy to facilitate the communication but felt compelled to conceal the reality of a residents' dying state. Whether looking through windows of the long-term care home or the screen of their phone or tablet, the way in which family members saw their loves one's familiar faces was therefore distorted, with a kind of strangeness and unfamiliarity.

The Isolation of Healthcare Aides

For the limited ways healthcare aides were able to step in for missing family members, and how residents seemed to die alone after receiving inadequate care, it became clear that healthcare aides were unable to care for residents like family would, and in ways that were traumatizing for them:

> *Every time I was coming out of the room, I was just putting some cold water on my face and then keep going, keep going, keep going. All day long like that. Because we have a specific time for family to call. And it is only – maybe the resident is practically asleep, or maybe they are already dead. And you know, I had to make the call, because, they are breathing yes, they are still alive, but they are practically – you see this body, this person is not responding. For me, they are already dead. But it is my duty to go there, to turn on the tablet and make the phone call. It was really traumatizing.*

As I listened to the healthcare aide above describe how they facilitated virtual communication between family members and a resident they considered to be "*already dead*," I was struck by how strange that experience would have felt, and certainly how traumatizing. My own experience of facilitating a conversation for a dying resident at the end of life over the phone continues to haunt me, knowing I was the last person to bear witness to their connection, and how I was an imposter in an intimate, yet artificial, moment, unable to fully translate their meaning to one another.

Although the healthcare aides I spoke with did not always describe their experiences with these artificial or strange moments as traumatizing, it is well known that healthcare aides certainly experienced symptoms of post-traumatic stress because of the isolating nature of the pandemic (Brady et al., 2021; Jones et al., 2022), as well as other mental health conditions:

> *The pandemic time was a really difficult time for everyone, I believe. But in my case, it was more difficult seeing so many people passing away and being locked in a unit. Not being able to get out until it was my time to go home. It was really traumatizing. I was really exhausted, physically, but more mentally.*

Furthermore, while long-term care residents were clearly isolated inside the long-term care home, unable to leave or have their family enter, healthcare aides also experienced a kind of physical isolation, not only isolating themselves from their loved ones and families to not infect them with the virus, but also feeling isolated within the institution itself. When I asked one healthcare aide how they would describe their experience of working in long-term care during the COVID-19 pandemic, the first thing they shared was a sense of feeling locked inside the house:

> *They kind of locked us in there –*
>
> *What comes to my mind is maybe being locked, underground. ...At first, we were working on the floor right, but then the COVID started escalating and the number started getting more and more. People contracting it. So, our facility decided that they were going to have a locked unit where they were going to isolate people who tested for COVID. ...I was the first to go there –*

Not only were healthcare aides isolated within the house during the pandemic, being that of a screen between the institution and the outside world, but were also isolated from other healthcare aides, and in ways that affected their well-being.

Addressing the Tension of Healthcare Aides and Residents Being like That of Family

Visitor restrictions in long-term care meant that healthcare aides had to navigate caring for dying residents amidst immense isolation; residents were not only isolated from their family members, but isolated in their confrontation with COVID-19, having been confined to their rooms and receiving care last, even when actively dying from the virus. The ways healthcare aides described the kind of death that took place in this isolation, and how they had concealed it from those on the outside, a significant tension was revealed regarding the relationship between healthcare aides and long-term care residents, and therefore raises this question: When resident's family members were unable to enter the house, only able to peer in through windows or look through the screen of a phone or tablet, were healthcare aides really like that of family?

It is well understood in the literature that healthcare aides seem to consider their relationship with long-term care residents as being one of family, or that they love residents like they would family members (Giesbrecht et al., 2021; Hanson & Henderson, 2000; Marcella & Kelley, 2015; McClement et al., 2009; Moss et al., 2003; Touhy et al., 2005; Trotta et al., 2018; van Riesenbeck et al., 2015). When I asked healthcare aides about this, most passionately confirmed this understanding about their relationship:

> *Oh, yes. Definitely, definitely. You can feel – there is a special relationship with you and them, because you are more closer to them.*
>
> *I think we are family with the residents that we have. They all consider us family.*
>
> *I always tell them, I am your Alberta daughter (laughs). Most of us, we always say we are your daughter, we are your son.*

Surprisingly, one healthcare aide even described their relationship with residents as being no different than the relationship they have with their *actual* family:

> *There is no difference, actually, with how I perform my care within the facility and with my family. It is like a normal life for me, it is the same thing at home. When I go to work, I tell my husband and kiss my husband, and say "see you later." Same thing with our family in long-term care. It is nearing the end of our shift, so we tell them also, "okay, goodbye, I'll see you tomorrow."…And we tell them, "we are just going to our second job, our other family!" We assure them that we still love them. …We treat them like our real family. What I do inside my house I do also with them.*

If, as the transcript above suggests, healthcare aides consider residents to be like *real* family, the implied assumption would be that they also *love* them like real family, an assumption of which one healthcare aide powerfully confirmed:

> *Interviewer: Do you feel like you love your residents, is that what you are saying?*
> *Healthcare Aide: That is exactly what I am saying. Because I want to put smiles on them. I want them to smile.*
> *Interviewer: Is it a different kind of love, than the love you have for, say, your daughter and your family?*
> *Healthcare Aide: When you love, love – I can love you the way you are. What is love? Love is accepting who you are. Accepting you, and doing the right thing for you. Okay, I love my daughter, yeah. But what am I doing that is special to her? I know she is my daughter, I know I hold her. But, it is the attention that I do to her, to prove that I am her mother and I really love her.*
> *Interviewer: So, it's the actions.*

> *Healthcare Aide: It's the action. When you love someone, you put the action in. Let them know that you love them. When they are in trouble, when they are in need, you can meet it. It's beyond, I'm just doing my job.*

During the interviews, testimonies like the ones above always seemed to knock me backwards, making me lean back into my seat as if I needed to regain a sense of orientation in the conversation. Working in long-term care myself as a registered nurse, I find this narrative strange, since there are obvious ways that healthcare aides could not love or care for residents in the same way they do their *real* families, in their own homes. Furthermore, healthcare aides often described how they were unable to do the "*actions,*" or engage in the kind of practice, that would "*prove*" the kind of love they have for residents, having also described isolating dying residents to their rooms and avoiding contact with them, such as touching, whenever possible.

> *Everybody was scared of COVID, everyone was scared to get contaminated, so we avoided too much contact. …When a resident was in isolation, it was like, oh my God, this resident is on my list. I'm scared to go to that room –*

Of the kind of understanding that would only be granted when healthcare aides have physical contact with their residents through that of touch, Kearney (2015) argued that we mediate the otherness of who it is that we touch, "crossing back and forth between self and strangeness" (p. 20), in ways that give us a sense of what it means to be human in a community with others. Healthcare aides would be granted a kind of wisdom or tact through the kind of touch that is not simply physical contact, but is instead having a way with others, putting themselves at risk and in question to understand: "when we say that someone *sensible* is someone *sensitive:* they have 'the touch.' …They are attentive, tentative, in touch with things" (Kearney, 2015, p. 16, emphasis in original). Although healthcare aides' practice is primarily made up of actions or tasks that are carried out through touch, healthcare aides were forced during the pandemic to forgo the kind of touch that would require sensitivity for the dying resident:

> *Healthcare Aide: We don't have a lot of time to sit there and hold their hands and talk to them, stuff like that. I would love to, that would be awesome, because people who are sleeping, they can still hear you. …But during COVID, we really had no time. …We gowned up, we went in there, we fixed them up, we turned them, just five minutes. If they didn't respond or something, we probably had to go off and do something else.*
> *Interviewer: Wow, only five minutes.*
> *Healthcare Aide: Yeah. We had to turn them, that took two people. And we were concentrating on doing it, so it wasn't – our attention was on doing our job but not as much on – that feels sad to say.*
> *Interviewer: So [physical tasks] come first, I'm hearing. And then everything else, like sitting with someone, holding their hand, or having a conversation, that would come after, it sounds like.*
> *Healthcare Aide: Yes. That sounds horrible.*

It seemed healthcare aides had their practice reduced to a tactless use of touch that was not responsive to the needs of the other, in the way they were unable to physically touch dying residents as often or perform tasks in the ways they had previously: “So there is touch and touch. And tact knows the difference” (Kearney, 2021, p. 11).

Regarding how healthcare aides were unable to complete task-based care with a sense of tact and sensitivity for the dying resident, it seemed clear their practice was at odds with the kind of love they described having for residents they considered to be family, a tension which clearly presented itself in the following testimony:

> *When their family isn’t there, it is you who they know, well you become the family. Because they always ask, “where is my daughter? I need my daughter.” But when it comes to them realizing that they are closer to dying, or they have accepted their reality, they no longer ask for their family. So, when they see you, it’s only you that they need. That’s why they cling to you. They hold onto you, and they will tell you don’t go. They don’t want me to leave. Even though, after I have taken care of them, and I tell them to lay down, or – you have to be there, more than you should. That’s why it takes longer to be there, because they are scared. You can see the fear in their face and when they talk, they don’t want you to leave. Especially like, they are in agony.*

In my reading of the transcript above, I understand the healthcare aide as describing a resident who has lost all hope; hope they might see their family before they die or hope that they might be comforted by those they love in their final moments. While the healthcare aide suggested their relationship with the dying resident was meaningful, having said, “*it’s only you that they need,”* they also described caring for dying residents as having to “*be there, more than you should*.” I could not help but feel how the healthcare aide, in that moment, was so different from that of actual family, the caring of dying residents being one obligation among many that must be completed within an eight- or twelve-hour shift. In the way healthcare aides are obligated to care for dying residents within the institutions where they work, one healthcare aide spoke of their relationship with residents like that of a business transaction:

> *It is a profit to the owner of the business. It’s not me. My own business is to deliver my compassionate attitude, my right attitude, my right mind, my love.*
>
> *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.*

It almost seemed as if the healthcare aide above was describing a kind of commoditization of their love for residents, them being a screen “*between the owner of the business and the user of the service*,” echoing a kind of institutionally mediated testimony in the way their love of residents is ultimately a “*profit to the owner of the business*.” This understanding of love as being a kind of business transaction is powerful for how it challenges the inherent virtuousness often assumed in the caring professions (Nelson & Gordon, 2006), and how the kind of love healthcare aides “*deliver”* to long-term care residents does not take place outside of the institutional context.

Not only did I find tension surrounding the well-trodden narrative that healthcare aides love long-term care residents as if they were their own family members, but I also found that healthcare aides differed in their views on whether residents *were* family or were *like* family. As such, a better understanding of this relationship may be that healthcare aides and residents are more a family of circumstance – the isolation of the pandemic leading healthcare aides to consider themselves their residents' "*people,"* when their actual family members could not be there:

> *The healthcare team were the only humans that were present, to support the person in their dying process. So, when people are leaving, it's important that human beings are around them. The TV will not do anything, you know. They needed to have people, and we were the people.*

Although healthcare aides may be residents' "*people*," getting to know them over many months, and sometimes years (Giesbrecht et al., 2021), there are clearly limits to their relationship, the isolation of the pandemic having revealed how, despite being familiar caregivers, healthcare aides were also made "*strangers*" when they had to assume the intimate care of dying residents without family present:

> *[The residents] feel when their families are there. But when [the family are] leaving like this, we are like strangers. Of course, we're the nursing staff, but were like strangers, and then we have to do everything and sometimes we had to have FaceTime for the chaplain to do the thing, you know? It was very different and very strange.*

Healthcare aides could therefore be thought of as *familiar strangers*, for the way they had to step in for missing family members during residents intimate last moments of life in ways that were not only "*strange*," but at great emotional cost:

> *I know we're there, but we're not their family. We care for them, but we don't love them like family. I mean, yes, we have special ones that we do love, or whatever. But we can't love all of them like family, that would be so hard on us emotionally if we invested ourselves that deeply into the job.*

When healthcare aides described becoming a kind of *familiar stranger* when residents were dying, it seemed to be that of an uncanny experience, their familiarity with residents having become unfamiliar when attempting to traverse otherness during intimate end-of-life moments within the context of the institution:

> When the 'stranger' in question morphs into the 'uncanny,' it takes on a weirdness that the uncanny itself suggests. … a feeling of dread or inexplicable strangeness, seeming to have a preternatural cause, as if locked into the present by some ominous and long forgotten past. (Richardson, 2011, p. 155)

As is common in gothic literature about haunted houses, the past is often what continues to haunt the inhabitants, that which has not been addressed or fully understood reappearing in ways that produce feelings of dread and strangeness: "the ghost represents that which haunts a culture" (Smith, 2007, p. 149). Not unlike those inside a haunted house, the ominous past of long-term care haunted healthcare aides in the present of the pandemic, considering how the dying of residents was happening within a long and continued history of their deaths being hidden or denied, and therefore isolated, in the institutional context (as explored in the first paper in this serialization).

In the reappearance of this troubled past, death and dying during the pandemic was both a familiar and unfamiliar ghost, and from their position in long-term care as a kind of governess or screen, healthcare aides were both familiar caregiver and unfamiliar stranger.

Making Sense of How Isolation Turned Hospitality into Hostility: A Discussion

> The gates are locked. Hill House had a reputation for insistent hospitality; it seemingly dislikes letting its guests get away. (*The Haunting of Hill House*, Jackson, 1959/2016, p. 61)

A house that must insist upon its hospitality for those who would rather get away, is perhaps not a place of hospitality, but a place altogether different. While long-term care is projected to become home to over 600,000 Canadians by the year 2031 (Deloitte, 2021), most older adults consider long-term care to be a house to avoid at all costs (Feil et al., 2021). Being in a place where they must be cared for by others due to either physical or cognitive limitations, the older adult who moves into long-term care would have to confront their own vulnerability and dependence on others, no longer able to live where they had previously called home. In this exchange of their freedom and sense of authority for a kind of hospitality, older adults may feel like guests in a home they never wanted to stay at in the first place, in a place that society, in general, wants to avoid. As was brought to light by the COVID-19 pandemic, the kind of isolation that ensued revealed how the long-term care home had insisted upon its hospitality, and how older adults ended up being confined to a house that, on one hand, intended to staunchly protect them from the outside world by isolating them, and on the other hand, was an oppressive force that concealed their state of death and dying through that of healthcare aides.

Long-Term Care as Kind of Conditional Hospitality and Place of Hostility

If long-term care is not *really* home for older adults, who may feel more like guests, then the long-term care home would play host, their hospitality being within the context of how institutions are concerned with the exchange of goods and services, corporate interests, and profit making. Unlike the kind of virtuousness inherent in true hospitality, the long-term care home offers a kind of "*conditional hospitality*" (Dausner, 2018, p. 54, emphasis in original), where older adults must not only meet certain criteria that qualifies them to live in the house, but behaviors considered *poor* would make them unworthy houseguests (Kearney & Fitzpatrick, 2021). Of Dausner's (2018) account of conditional versus unconditional hospitality, Kearney and Fitzpatrick (2021) wrote, "many hosts never fully relinquish 'control' or 'power' over the situation—cautiously keeping guests at a distance, despite letting them into their house" (p. 5). The house that is haunted would also be concerned with a kind of conditional hospitality, its guests or inhabits allowed to stay so long as they fail to confront the ghosts haunting the halls, either willfully ignoring or accepting their presence.

Of hospitality, Treanor (2011) argued that "hospitality always happens in a place" (p. 50), in the way those who would be considered guests are given a kind of space by those that are considered the host. If hospitality requires a certain "primacy of place" (Treanor, 2011, p. 51), I am reminded of how Heidegger (1927/1962) considered our thrownness into the world as being a kind of situatedness of place, us always making sense of our world from *somewhere* in the world.

Heidegger (1927/1962) argued that we are therefore both at home in the world, yet not at home, and it is the space between these two experiences or understandings that produces that of the uncanny, a sense of both that which is homely and unhomely, or familiar and unfamiliar. While the familiar narrative might be that long-term care is home for older adults, or a place of hospitality, the unfamiliar and hidden narrative is, long-term care is also *not* home for older adults, and is, instead, a place of conditional hospitality, and with the happenings of the COVID-19 pandemic, a place of hostility.

The hostility of long-term care came to light when visitor restrictions meant the isolation of residents from their family members, and healthcare aides feeling compelled to hide or conceal residents' state of death and dying, being a kind of screen between residents and the outside world. I argue it was the physical place of the long-term care institution then, the house, that in its isolation, locked residents inside and shut families out, the empty and expanding space suffocating those inside. While the word hostility suggests unfriendly behavior, conflict, or even acts of warfare (Merriam-Webster), it is the etymological root of the word "hostility" that reveals something about how the conditional hospitality and isolation of long-term care made it a hostile place. As a noun, the word "hostility" originates from the Proto-Indo-European root word "ghos-ti-," meaning "stranger, guest, host," bringing attention to the historical reciprocity inherent in the word hospitality (Online Etymology Dictionary, n.d.). Although the word "ghos-ti" is not related to the English word "ghost," it does seem to suggest something haunted, or the uncanny, in that something hostile may have simultaneous characteristics of a stranger, guest, and host, or both the familiar and unfamiliar.

Through working in an isolated place, healthcare aides appeared to move between roles of stranger and host, being familiar to their guests in one moment, and caring for them, but also unfamiliar in the intimate moments as they lay dying. While the word "ghos-ti" signals the reciprocity of hospitality, in the way a person is always traversing between that of stranger, guest, and host, the long-term care resident will never reciprocate hospitality in a place that is not really their home. Instead, they will always be the recipient of conditional hospitality, and at the mercy of the needs of an institution that oppressively shapes the experiences, and testimonies, of those inside. In summary, the isolation of long-term care during the pandemic made clear the limits, or the conditions, of the kind of hospitality long-term care institutions or healthcare aides can offer residents, despite the common narrative that long-term care *is* a residents' home, and that the healthcare aides *are* their family. It is in these limits or conditions of hospitality that the house became a hostile place where residents died alone.

The Consequences of Isolation and Hostility for Long-Term Care Residents

For how healthcare aides seemed to conceal something true about dying and dead residents from their family members, or isolated dying residents in their rooms, I was reminded of Lethe, the river of forgetfulness that flows through the underworld of Hades. As John Milton conveyed in his *Paradise Lost* (1667/2004), the dead would be encouraged to drink from its waters to forget their earthly lives, easing their transition from one world to another:

> Far off from these, a slow and silent stream,
> Lethe, the river of oblivion, rolls

> Her watery labyrinth, whereof who drinks
> Forthwith his former state and being forgets—
> Forgets both joy and grief, pleasure and pain. (lines 582–586)

Not unlike drinking from the waters of Lethe, the concealment of death and dying in long-term care implies a kind of sinister easing of residents' transition from life to death, residents forced to forget their family members and earthly lives in their dying, both in, and of, isolation. Etymologically, the word Lethe is related to word lethal, meaning "deadly, fatal" (Online Etymology Dictionary, n.d.). This is significant, in the way healthcare aides seemed to feel that their concealing of death by way of isolating residents may have quite literally been deadly or fatal, or at least had a profound impact on the quality of care dying residents received.

In the years since the first lockdown occurred in long-term care homes, there is now a better understanding of how catastrophic this isolation was for residents, and especially for dying residents (Abbasi, 2020; Government of Canada, 2022; Grignon & Hothi, 2023; Savage et al., 2022; Simard & Volicer, 2020; Smith et al., 2023; Wister & Kadowaki, 2023; Yuen & Carter, 2022). For example, research by Savage et al. (2022) found that among long-term care residents in Ontario, those who had no personal contact with family or loved ones during the pandemic were 35% more likely to experience mortality, than those who had contact. This was thought to be due to not only the emotional and mental health consequences of loneliness and isolation, but to a lack of family and loved ones advocating for the needs of the resident. Of the devastating ramifications visitor restrictions had on resident well-being, Bergman et al. (2020) argued there was "potentially irreversible physical, cognitive, psychological and functional decline" (p. 1760). Not only would long-term care residents have experienced significant decline after being isolated, they would have also experienced profound loneliness, especially when dying (Aho, 2022).

For how long-term care residents had to exist, and die, in an isolated place, Aho (2022) argued their isolation was able to thrive in a place already primed by an atmospheric mood of loneliness that goes beyond physical space, akin to Heidegger's consideration of mood being that which is embodied, or way of *being-in-the-world*. Having shaped how residents were able to understand themselves at that time, "the mood of loneliness has nothing to do with being physically alone. Indeed, it is often most pronounced when we are surrounded by others but are unable to feel connected or 'at-home' (*heimelig*) with them" (Aho, 2022, p. 1056, emphasis in original). Although not confined to that of a physically isolated space, Aho (2022) argued that loneliness, as a kind of embodied mood for residents, was still physically limiting in the effect it had on detaching them from meaning-structures and the world: "In Heidegger's words, they are 'no longer-able-to-be' (*nich-mehr-dasein-könnens*) because the global sense of disconnection 'strips away' or 'overtakes' (*überholt*) their self-understanding" (p. 1055). Therefore, long-term care residents were not only more likely to experience a significant decline in their well-being, or die from the virus, due to their isolation, but in their loneliness, experienced a kind of estrangement from a place meant to be home, as if no longer "belonging to the world at all" (Arendt, 1962, as cited in Aho, 2022, p. 1058).

> There is a loneliness that can be rocked. Arms crossed, knees drawn up; holding, holding on, this motion, unlike a ship's, smooths and contains the rocker. It's an inside kind–wrapped tight like skin. Then there is the loneliness that roams. No rocking can hold it

> down. It is alive, on its own. A dry and spreading thing that makes the sound of one's own feet going seem to come from a far-off place. (*Beloved*, Morrison, 1987/2004, p. 323).

Concluding Thoughts

In this paper, I explored how healthcare aides had to make sense of death and dying within an isolated kind of house, the visitor restrictions and facility protocols in long-term care meaning residents either died alone or because of their isolation. Healthcare aides were therefore positioned in long-term care as that of a kind of governess or screen, having felt compelled to conceal death and dying from family members in ways that echoed a kind of institutionally mediated testimony. I also explored how the isolation of long-term care during the pandemic disclosed something about the tension of healthcare aides being like that of family for residents, despite their being unable to care for them as they would their own families outside of the institutional context. I then considered how the isolation of the house made it not a place of hospitality but a place of hostility, and the consequences this had on the well-being of long-term care residents.

From the understanding that the physicality of place is primary for understanding that which is either considered hospitality or hostility, I have argued it is the long-term care home itself, being an institutional space, that has shaped the testimonies and experiences of healthcare aides. Namely, it seemed that the house, in its isolation, was also no longer a place of hospitality, but one of hostility, healthcare aides being both that of stranger and host in their caring for dying guests. Not unlike the way a haunted house in gothic literature is often anthropomorphized to reveal it as both a place of homeliness and unhomeliness, or hospitality and hostility, the long-term care home came to life during the pandemic in its haunting of healthcare aides' experiences; the window frames like glaring eyebrows hovering above dull yellow light flickering behind opaque glass, their sallow glow staring into the night, and the door open, like a scream, before slamming shut, swallowing the happenings inside the house. Stuck inside an isolated house, healthcare aides were forced to confront the familiar and unfamiliar ghosts that were now emerging from the shadows and roaming the halls, and in this confrontation with death and dying, would come face to face with a kind of fear that was creeping over the house and consuming those inside.

> The next thing I saw was that, from outside, he had reached the window, and then I knew that, close to the glass and glaring in through it, he offered once more to the room his white face of damnation. It represents but grossly what took place within me at the sight to say that on the second my decision was made; yet I believe that no woman so overwhelmed ever in so short a time recovered her grasp of the *act*. It came to me in the very horror of the immediate presence that the act would be, seeing and facing what I saw and faced, to keep the boy himself unaware. (*The Turning of the Screw*, James, 1898/2021, p. 139).

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