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The Haunting of Long-Term Care, Part Three.

COVID "Wanted to Snatch Life Out": How Healthcare Aides Feared an Unfamiliar Ghost and Understood Residents' Fear of Death and Dying in the Context of Palliative Care

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Abstract

This paper is the third 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 third paper, the story reaches a kind of reckoning, as healthcare aides become fully subsumed within the haunting of long-term care and fear takes hold. Where death had long been a familiar presence in long-term care, quietly roaming hallways or lingering in the shadows, healthcare aides were now faced with a kind of poltergeist**,** which, while unseen, raged loudly in its disturbance of the house and any previous understanding of death. I begin with this ghost: a strange and unknowable Other that claimed residents' lives in unfamiliar, yet familiar,

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ways, and consider how this shaped healthcare aides' position within the house. I then explore fear, and how its presence in experiences of death and dying influenced healthcare aides' understandings of palliative care. From here, I consider how healthcare aides' fear may be better understood as a kind of anxiety, with their experiences speaking to the uncanny. Finally, I explore healthcare aides' accounts of residents' fear and palliative care through a lens of suspicion, suggesting that the institution, or haunted house itself, may have mediated their testimony.

Keywords

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

> At that moment the door swung wide and then crashed shut, and in the silence outside they could hear slow rushing movements as though a very steady, very strong wind were blowing the length of the hall. …The pounding came up the stairs, crashing on each step. …Then there came, suddenly, quiet, and the secret creeping silence they all remembered; holding their breaths, they looked at one another. (*The Haunting of Hill House*, Jackson, 1959/2016, p. 187-188)

> *When [the resident's death] happened, it happened within five minutes. ...It happened so instantly. I wasn't accepting it, in a way, until [the nurse] declared her death. Because when I was explaining to her that [the resident] is not responding. ...We lay her in bed, and we keep checking her pulse, and then she told me there is no pulse. ...I was still checking... and then we just, we just stood and looked at each other.*

I remember the news coverage of long-term care homes during the COVID-19 pandemic with absolute clarity. Glued to the screen of the television, I watched, in horror, as resident after resident had been escorted through the doors of the house; not one person in the scene was fully visible, those pushing stretchers up to the backs of ambulances or long black cars had their eyes hidden behind goggles, their mouths behind masks, and many of the residents, who lay on top of the stretchers, were not visible at all, their bodies zipped inside black bags. There was a swiftness to which the COVID-19 virus was claiming lives in long-term care that was difficult to comprehend, a kind of precision of the virus that felt calculated in its targeting of older adults. Where death may have long been a familiar ghost in long-term care, quietly roaming the halls or lurking in the shadows, the ghosts now seemed to come in hordes. They swarmed outside of the home, crawling in through the windows and seeping through the cracks, or easily entered in plain sight, familiar old death having greeted them with doors wide open. What had been familiar about death was now unfamiliar, and, in the shadow of no vaccines or defense and limited preparedness, it seemed there was no chance of exorcism.

In this paper, I begin with the ghost that had suddenly entered the house: a strange and unknowable Other, claiming the lives of residents in ways that were unfamiliar, yet familiar. I then describe healthcare aides' positionality in the long-term care home, or haunted house, as being like a governess who is supposed to care for those who have been entrusted to them, but find themselves

unable to do so, having been subsumed under the haunting themselves, and fearful of the kind of death and dying spreading about the house. I then explore how it was also residents' fear of this ghost, which suddenly appeared and isolated them from others, that meant healthcare aides considered them as not palliative, but as dying from COVID-19. Finally, I offer two discussions that build on the understanding of how healthcare aides had feared death and dying themselves during the pandemic, and how, because of this, residents had not received palliative care. First, I explore how healthcare aides' fear could be better understood as a kind of anxiety, their experiences having spoken to that of the uncanny, and then second, I explore healthcare aides' understanding of residents' fear and palliative care as being suspicious, suggesting the institution, or haunted house, may have mediated their testimony.

The Suddenness of Death by COVID-19: A Strange and Unknowable Other

When I sat down with healthcare aides to ask them about their experiences with death and dying during the pandemic, many of them began by speaking about how suddenly the COVID-19 virus had entered the home and claimed the lives of residents, as if encountering an infestation of ghosts:

> *Then a week later we had another resident pass away. And then maybe three days later we had another resident pass away. Every single floor is at least two or three, they are going so fast.*
>
> *COVID is like, a robber, that came in, and wanted to snatch life out –*

Meaning to "lay hold of suddenly, seize or take eagerly," healthcare aides described COVID as *snatching* life out of the home (Online Etymology Dictionary, n.d.), sneaking in through the windows and claiming the lives of residents who lay alone in their beds and confined to their rooms. Then, leaving just as suddenly as it had entered, the ghosts were gone, along with the residents' life, all before healthcare aides even had a chance to understand it, or even see it:

> *I wasn't understanding how fast this was working. Like, are we not seeing it? Like it hit me, I couldn't understand it. It wasn't a cold, it wasn't the flu, it wasn't – people just seemed to go down and then they stayed down.*
>
> *We could not do anything. Because we can't see it.*

According to Gadamer (2016), "death has a necessary unintelligibility" (p. 69), for thinking about our own death is to think beyond ourselves in ways that cannot produce an answer to death when posed as a question; we cannot think the experience of death, and instead merely grasp "a *trace* of death" (Gadamer, 2016, p. 69), or that which was "left by the passage of something" (Online Etymology Dictionary, n.d.). In other words, our own death never reveals itself directly to us, as something we can fully see, but instead is perceived indirectly, as something always there, our understanding of death always limited by our own finitude, or "in the certainty of one's own life" (Gadamer, 2016, p. 69). While Gadamer was discussing the unintelligibility of knowing that we, ourselves, will one day die, it also seemed that the healthcare aides I spoke with experienced a kind of unintelligibility of residents' deaths, unable to understand how they were dying in ways

they considered to be unfamiliar, and how in their being unable to "*see it*," they could only find traces of death:

> *When I got there, I didn't really know what is going on, I just know that COVID-19 was killing. …The impression that was given was like…you can find COVID everywhere. Where you walk, the hallway, the lifts, everywhere.*

For how healthcare aides described COVID as a kind of intruder that "*wanted to snatch life out*," I was reminded of a passage from the gothic novel, the *Turning of the Screw*, where the governess of Bly Manor becomes aware of a new and unseen ghost haunting the house: "We had been, collectively, subject to an intrusion; some unscrupulous traveller, curious in old houses, had made his way in unobserved, enjoyed the prospect from the best point of view, and then stolen out as he came" (James, 1898/2021, p. 35). If death was like an intruder – a "*robber"* leaving only traces of its presence in its being unobserved – it was also an unknowable or unintelligible Other to healthcare aides, different from the familiar old ghost of death that healthcare aides were used to. Where healthcare aides had felt there was a patience to death before the pandemic, this strange new death was no longer an insidious kind of ghost, claiming the lives of its victims over time. Instead, they were faced with a kind of poltergeist, which, while unseen, raged loudly in its disturbance of the house and any previous understanding of death:

> *You don't even know if they are going to die or not. You just see that, before our eyes, this person is gone. I said, "oh they're dead. Oh, this person is dead." …It's not palliative where you have to wait and wait and you want them to die, no. We just found out oh, the way he is going, he is definitely going. It was so rapid. It was so fast.*
>
> *Healthcare Aide: Before you know it, some of them were even shouting. Help me! Help me! Help me! But after a few hours, it's just suddenly they're gone. That's it.*
> *Interviewer: So, they would be shouting from the rooms –*
> *Healthcare Aide: Sometimes yeah, help me! Some of them would talk…but before you know it. We had a case of a guy, he's amputated, the legs... He was shouting, like, help me! Because if you had to take care of him, it was like five [people], because he was a very big guy. Before you knew it, dead. Like, how did this happen? Because I was in another room taking care of someone, so my colleague went in alone with them. And he's dead.*

According to Kearney (2003), that which is Other surfaces in "the guise of strangers, gods and monsters," and "because they threaten the known with the unknown, they are often set apart in fear and trembling" (p. 3):

> Most strangers, gods and monsters – along with various ghosts, phantoms and doubles who bear a family resemblance – are, deep down, tokens of fracture within the human psyche. They speak to us of how we are split between conscious and unconscious, familiar and unfamiliar, same and other. (Kearney, 2003, p. 4)

Regarding how death during the COVID-19 pandemic had become a monstrous kind of stranger, like a poltergeist throwing objects about the room and slamming doors, it also had a presence of that which was both "familiar and unfamiliar," or "same and other"; the unfamiliarity of death

during the pandemic only understood within the context of how it was also familiar to healthcare aides. After all, death has a long history of haunting the long-term care home, despite it being often denied or hidden, as was explored in the previous papers in this serialization. In its unfamiliarity and familiarity, and in the absence of understanding this strange experience with death as a kind of Other, I suggest healthcare aides' experiences with death during the pandemic produced feelings of the uncanny, or that which was frightening: "And in the process of this estrangement, the Other passed from the horizon of reflective understanding into the invisible, unspeakable, unthinkable dark" (Kearney, 2003, p. 7). Whether a strange Other or an unfamiliar ghost suddenly entering the house, I explore in the following section how healthcare aides described their estrangement with what had previously been a more familiar kind of death as being an experience full of fear, in the way they not only failed to understand residents' deaths during the pandemic, but were also afraid for their own lives.

> There is no doubt that [the uncanny] belongs to the realm of the frightening, of what evokes fear and dread. (Freud, 1919/2003, p. 123)

Healthcare Aides' Positionality in the Haunted House: A New Fear

> His face was close to the glass . . . He remained but a few seconds – long enough to convince he also saw and recognised; but it was as if I had been looking at him for years and had known him always. Something, however, happened this time that had not happened before . . . On the spot there came to me the added shock of a certitude that it was not for me he had come there. He had come for someone else. (*The Turning of the Screw,* James, 1898/2021, p. 38)

Where familiar old death may have been patiently watching older adults, peering in through the windows and quietly hiding in the corners of rooms, new death was now suddenly making its presence known, becoming an undeniable and unavoidable ghost that healthcare aides now had to reckon with. In part two of this serialization, I considered healthcare aides to be like that of a governess in the haunted house, attempting to protect those they have been entrusted with from the ghosts that lurk about the home. As is common with the telling of a haunted house tale in gothic literature, the coming of new arrivals or the happening of events eventually subsumes the governess under the haunting, and they become no longer able to ignore the ghosts they have walked side by side with or hide them from others they consider to be vulnerable. Although the COVID-19 pandemic had seemed to mostly come for their residents, healthcare aides experienced a kind of fear in having to care for residents infected with the virus, often using the words "*fear*," "*afraid,*" "*frightened,*" or "*scared*" in the telling of their encounters with death and dying.

In my interviews with healthcare aides, it became clear it was the suddenness of the COVID-19 pandemic, how swiftly the virus was claiming the lives of residents, that their fear was attached to, an etymological relationship existing between the words "fear" and "suddenness;" the word "fear" or "*fær"* in Old English meaning "sudden danger, peril, sudden attack" (Online Etymology Dictionary, n.d.). As this new and unfamiliar ghost became overwhelming in its "sudden attack," healthcare aides no longer described themselves as protecting residents from death, but instead as fearing the residents who encountered death. Namely, their fear seeming to have occurred in two

central ways: fear of the possibility of their own death when caring for the dying resident infected with COVID-19, and fear of the resident's dead body.

Healthcare Aides as Fearing Their Own Death When Caring for the Dying Resident with COVID-19

> *Because it's an infection that kills. The death, like, am I going to survive this? The anxiety. The fear. Because nobody is treating anyone. You can't go to the hospital.*

> *One of the staff, I went to the first floor when we came back from the locked unit, and she just ran away. She was like, "what are you doing here? You are not supposed to be here!"*

There may have been a general fear and anxiety among people about the possibility of dying from COVID-19, especially during the early months of the pandemic, however, healthcare aides seemed to have more reason to fear for their lives than the general population. According to the Union Network International (UNI) Global Union (2021), the outcomes of the COVID-19 pandemic have made long-term care one of the most hazardous, and deadliest, places to work in the world. Not only did the majority of COVID-19 deaths occur among the older adult population in the first two waves of the pandemic (Statistics Canada, 2021), and among those living in long-term care homes (CIHI, 2021), long-term care staff were also more likely to be infected, and even die, from the COVID-19 virus than the general population (UNI Global Union, 2021). From the beginning of the pandemic until February 2021, 22,089 long-term care workers in Canada were reported to have contracted the virus, with 25 having died, a ratio of 1 death to every 884 cases (UNI Global Union, 2021). In the United States, the number of long-term care worker deaths per COVID-19 cases was alarmingly higher, with one death occurring out of every 354 cases. Of importance to note, in both Canada and the United States, these statistics are thought to be conservative due to a lack of robust reporting systems in both countries (UNI Global Union, 2021).

Paving the way for these deaths, the working situation in Canadian long-term care homes during the pandemic was thought to be precarious at best, "characterized by income loss, reduced hours of work, and unpaid leave," which "was associated with stress and poor general health among immigrant and non-immigrant workers in the sector," and poorer mental health (Antonipillai et al., 2024). Therefore, it is not surprising that working in long-term care during the pandemic was considered to be one of the deadliest jobs in the world, being more dangerous than commercial fishing or logging (UNI Global Union, 2021), nor is it surprising that the healthcare aides I interviewed had very real fear and anxiety about the possibility of their own mortality at any moment:

> *It's not easy. We are also afraid of our lives, too.*

The way healthcare aides spoke about their fear of a resident infected with COVID-19 also seemed to confirm the kind of isolation described in part two of this serialization, and how residents had been isolated to their rooms and were purposely avoided, only to receive care infrequently or at the end of healthcare aides' shift:

> *It was like, oh my God, this resident is on my list. I'm scared to go to that room, you know?*

As if they could be snatched the moment they disappeared behind the door, healthcare aides' fear of entering a resident's room, and not understanding why death was occurring so suddenly, also spoke to a general unknown about the virulence or transmission of COVID-19 at the time. After all, recommendations from public health experts and infectious disease specialists were constantly changing as they learned more about how the virus was working.

In being afraid of the virus and the possibility of their own deaths, healthcare aides described being unable to care for residents in the ways they would have liked to, distracted by their fear, and the wearing of personal protective equipment, as if they had to hold their breath until they were safely outside of a resident's room:

> *And you have [personal protective equipment], some people wouldn't come to work because the [personal protective equipment] is suffocating for them, like they can't breathe. And then, the fact that they are in an area where it is contaminated now, they are just – they are just nervous, right? They just want to get in there, and get out, get it off of their body faster so they can breathe. …You cannot predict how a person is going to react when they are in fear. Especially, sometimes if a resident touches you by mistake and you reacted in a way that you shouldn't…maybe you don't mean it, it's just an impulse reaction or response, and then later on you realize, I shouldn't have done that.*

Not only would the wearing of personal protective equipment have impeded a healthcare aides' ability to connect with residents or offer them comfort, their faces hidden behind masks and or shields, but the wearing of personal protective equipment may have been frightening to residents as well, especially residents with dementia who may not have understood its purpose. Consequently, healthcare aides themselves may have become a strange Other to residents, or that of an unknown caregiver who could not offer them comfort, or even care for them at times, since they were also afraid:

> *Having to work while you have the fear of catching COVID, while you are there. Like, you are present in the action, but yet, in the back of your mind you are scared. It is different, than you doing your normal job, before COVID. …So, I would say, neglect it is one of the things that might happen during COVID, where you are not providing the care, the quality of the care you used to provide, pre COVID. And then you having to be in fear now, and providing lesser quality care then what you would do before. …Before, you could sit next to a resident before, and have a conversation, or when someone is emotional, like, you provide the support for them before. But now during COVID, you don't want to sit. You are speaking from a distance. Or you have to go an attend to someone else, so the time is limited, and the quality of care has declined. So, if someone is in fear, they are not going to focus. They are not going to do everything –*

While the above healthcare aides' use of the word "*focus*" in this context is obviously intended to mean "concentration" or "attention" (Merriam-Webster, n.d.), the etymological origin of the word is ironic due to the very thing that healthcare aides could not offer residents, since they were unable to focus because of their fear. In Latin, the word "focus" means "hearth, fireplace," and although figuratively with unknown origin, also means "home, family" (Online Etymology Dictionary, n.d.).

Although fear, when considered as a kind of clinical anxiety, is known to impede the ability to focus (Robinson et al., 2013), it seemed that fear also impeded the ability of healthcare aides to offer any warmth, or a sense of home and family:

> *If I'm in fear and I am doing the care, I am going to be shaking, and I might not – I might upset a family member if I ever done something wrong, or if I'm not speaking to someone and not respecting them. Because people are hesitant to do the care in a way, because in the back of their mind they have that fear.*

Where fear had fallen about the house, there seemed to be a cold air spreading from room to room, stifling breath and slowing the travel of sound, an eery quiet settling in and around the doors of residents' rooms as they froze shut. As a kind of governess of a haunted house, healthcare aides were no longer able to protect those they had been entrusted to care for or shield them from the ghosts that had come to claim residents' lives. Instead, their fear seemed to give way to neglect and isolation, and perhaps, guilt. For how fear may have driven healthcare aides to commit actions that produced feelings of guilt, it is fitting to suggest that "fear and guilt are sisters" (*The Haunting of Hill House*, Jackson, 2016/1959, p. 162).

Healthcare Aides as Fearing the Dead Body

Fear of the dead body is a widely universal experience that transcends culture and the course of history, the dead body being a physical reminder of our mortality and finitude: "The concept of death is intricately tied to the human body. It is the body that dies. The body is corruptible; the body is the recipient of disease and subject to decay" (Moore & Williamson, 2003, p. 6). Gothic literature is well-known for playing on this fear, the appearance of dead bodies in the form of ghosts, monsters, or zombies emblematic of the genre. Perhaps what is scary about the reappearance of dead bodies is the unnatural way these bodies do not stay "put to bed," so to speak, having escaped the cultural traditions and rituals that would have guaranteed their safe passing from one realm to another. According to Gadamer (2016), what separates humans from all other living beings, "is that human beings bury their dead and invest the grave with their feelings, their thoughts and their creative works" (p. 60). As such, the participation in death rituals and ceremonies, such as the entombing of bodies with meaningful earthly possessions, is important because it shows the way humans understand or mourn the departure of a loved one. The passing from one state to another is an important part of life, and death. Where family members had previously been able to surround the recently deceased body of a resident and mourn the death of their loved one, the residents who died from COVID-19 seemed to become only a "dead body," having been divested of any meaning or memories that would have been provided by family, or even healthcare aides:

> *Interviewer: So, if you were dying during COVID, you maybe had a very different experience with dying than someone –*
> *Healthcare Aide: Terrible.*
> *Interviewer: Could you tell me about that?*
> *Healthcare Aide: Yeah. Because after death… if you are dying from COVID I think they will just go directly – …The residents will go directly to the morgue. I don't know if the*

> *family are allowed, but I don't think so. …I think they will go to the morgue and just directly bury you –*

One healthcare aide I spoke with even described the lack of rituals or end of life traditions as being what scared them, as if the banality of what happened to residents' bodies brought them face to face with the loss of meaning encountered in death:

> *Healthcare Aide: During COVID, some of the bodies don't get transported out. So, we had an experience where we had to bag, where we had to put her in the body bag and just – so we did. We bagged her. …That was the first time I ever seen a body bag. Because I had experienced death here in the facility when it was normal, or not during COVID, but I never experienced bagging someone or seeing the body bag.*
> *Interviewer: What was that like, seeing the body bag for the first time? And having to bag someone?*
> *Healthcare Aide: It was scary, in a way. Not in the way like I am scared of the death, but just the body bag – in the back of my mind – that's where you get put in after you die. …I didn't know. …That is when it hit me, like, okay, so, this is what is done when you have to pass away.*

It seemed there was a finality to residents' deaths in their being sent "*directly to the morgue*" or their bodies being put "*in the body bag,*" and healthcare aides describing dead residents as being hidden during the pandemic, as was explored in part two of this serialization. No longer having a place, residents became only a body that was still capable of infecting, much like a ghost is the dead still capable of haunting the living:

> *In the nursing home, they don't have separate rooms. So, they can be three, they can be four. And anyone that is not dead, take them out. Just leave them there for the funeral guys to come and take. …We cannot leave the person with the dead. Like, we cannot leave them in that room until the funeral guys come and pick them up.*

To summarize healthcare aides' positionality in the house, death, as Gadamer described it, may be unknowable, but the kind of death brought by the COVID-19 pandemic seemed to make death even more unknowable and unfamiliar to healthcare aides, in the sudden way it had entered the house and claimed the lives of residents. In this sense, death became a strange Other, being that of a frightening ghost that healthcare aides considered to be not of the home, despite it having always been of the home. Where healthcare aides were previously positioned as a kind of governess attempting to protect or shield residents from death, as was explored in part two of this serialization, they now had become fearful, and in their fear, avoided dying residents and their dead bodies. In the next part of this paper, I explore how healthcare aides considered the residents dying from COVID-19 as not palliative on account of their also being afraid, residents having expressed their fear and anxiety about their dying and death. So while healthcare aides were afraid to care for dying residents, avoiding them due to their own fear of the virus (or their having been instructed by management to do so, as was explored in part two of this serialization), it was also residents' fear of death and dying, and being left to face their ghosts alone, that would mean they were not considered palliative when death came knocking.

Fear of Death and Dying as the Reason Residents Did Not Receive Palliative Care

> As soon as I appeared in the moonlight on the terrace, [the boy] had come to me as straight as possible; on which I had taken his hand without a word and led him, through the dark spaces, up the staircase where [the ghost] had so hungrily hovered for him, along the lobby where I had listened and trembled, and so to his forsaken room. (*The Turning of the Screw*, James, 1898/2021, p. 76)

The practice of palliative care means the alleviation of suffering without the intention of curing illness, the word "palliative" meaning to "cover with a cloak, conceal" (Online Etymology Dictionary, n.d.). Where palliative care is intended to cloak the symptoms of an illness, protecting a person from some of the painful experiences associated with death and dying (Rome et al., 2011), healthcare aides described themselves as not being able to cloak residents in any sort of blanket of protection, and being unable to alleviate their suffering:

> *Because [the resident dying from COVID-19] have the symptoms. So, when they have the symptoms, they are going through the agony, the pain, the coughing, you know, the breathing, they are not breathing very well. The palliative, like someone when they are dying from a palliative, they just lay there in bed, you are just taking care of them, repositioning and stuff, and you have to stop their fluid, like nothing goes by mouth. Sometimes they put a butterfly for them, to administer the medication, right? But then, with the COVID, they only get their vitals checked. It's not like they get specific medication for COVID or pain, right?*

According to the healthcare aides I interviewed, they felt they were unable to conceal the physical symptoms of COVID-19, such as coughing or pain, and often described a kind of hopelessness for the resident, having felt there was nothing that could be done: "*COVID was like a hit on them. And there was nothing anyone could do."* However, healthcare aides did seem to conceal one significant symptom of death that they described dying residents as having: fear. Instead of cloaking residents' fear of death and dying in ways that would have brought them comfort or alleviated their suffering, healthcare aides described concealing their fear in ways that actually hid residents' experiences from the healthcare aides themselves, residents having been isolated in their rooms to face their ghosts in solitude:

> *And then it's not only pain, like they are in pain, but they are also in fear, like they need someone constantly there, right? Someone who is palliative, you can leave them. When they are in pain, you administer the pain medication, and they might sleep, right? So, their needs are different than someone who has COVID. When you have COVID, and the nurse is there, and they give you your regular medication, you are still in fear. Like you are anxious, like you are wanting something to be there. And you are coughing, and you are – it's not only pain but it is also fear. Fear of being left alone.*

It is well known that palliative care practices and approaches are inconsistent in long-term care, if not non-existent (Cable-Williams & Wilson, 2016; Hill et al., 2019). Often, residents are not declared palliative, even in their final moments of life (Cable-Williams & Wilson, 2016; Hill et al., 2019). Consequently, many residents living in Canadian long-term care facilities who do not

receive palliative care, despite benefiting from such care. For example, from 2021-2022, only 34% of residents identified as having less than six months to live received palliative care (CIHI, 2023). Therefore, I knew I wanted to ask healthcare aides about their experiences with death and dying, however chose not to use the word "palliative," as I thought healthcare aides may not understand their caring for dying residents through the lens of palliative care. However, in my wanting to know if the COVID-19 pandemic had changed the way healthcare aides cared for dying residents, I did ask if they considered residents dying from COVID-19 *to be* palliative. While I was not surprised to learn that residents dying from COVID-19 did not receive palliative care, I was surprised to learn that it was the resident's ability to verbalize their fear of death, pain, and neglect that made their dying different for healthcare aides, and why they had not been considered palliative:

> *It is different than you taking care of someone who has COVID, because that person verbalize their pain, they verbalize their fear, like they want to get out. They have been in one place for so long, they feel trapped. And isolated. They are not seeing many people like they used to before. So, it's totally different than you taking care of someone who is palliative.*

According to Gadamer (1960/2004), "language is the medium in which substantive understanding and agreement take place between two people" (p. 386). However, it seemed that for healthcare aides, it was residents' very use of language, having verbalized their fear and not wanting to die, that made their dying even more unknowable to healthcare aides, unintelligible, and in this unfamiliarity, it seemed residents were denied palliative care approaches that would have brought them any comfort.

> The force of illusion with which the gravely ill or the dying keep hold on their will to live speaks a language which cannot be misunderstood. We must ask ourselves what knowledge of death really means. For there is a deep connection between the knowledge of death, the knowledge of one's own finitude, that is, the certainty that one day one must die, and, on the other hand, the almost imperious demand of not wanting to know, of not wanting to possess this sort of certain knowledge. (Gadamer, 1993/1996, p. 64)

While it seemed that there was something unintelligible for healthcare aides about how residents had verbalized their fear of death and dying, the healthcare aides perhaps "not wanting to know," it was also clear healthcare aides considered palliative residents as accepting their deaths, evidenced by them having not verbalized their fears, and as such, their deaths were more understandable:

> *Interviewer: Maybe help me to make sure I am understanding. So, it sounds like even if a resident was very close to death, from COVID, it's not palliative care because of the fear?*
> *Healthcare Aide: The fear. The fear that they are voicing to you.*
> *Interviewer: The fear? That makes it not palliative?*
> *Healthcare Aide: Yeah. Because they are voicing it to you, right? So, someone who is palliative, they are not too verbal. They are not verbalizing. You see the fear like, you see the agony when you are turning them, but they are not verbal as much. …COVID is different than someone dying. When someone is in agony – because one thing I realized*

> *with people who have COVID, like they are verbal until the point – like the resident who died, she was verbal until she couldn't speak…When her cough increased, when she got to the point of almost dying, the communication was slower, it wasn't as much as before. Whereas before she was constantly crying, like I can't stay, I need to go, I need to go. But then it became like, I need to go, I need to go, I can't – silence after that.*

Healthcare aides may experience palliative residents as not verbalizing their fears; however, they were still acknowledged as being fearful of dying by way of their facial expressions: "*You see the fear like, you see the agony when you are turning them."* According to Gadamer, it is not only through spoken language that we are able to understand or make sense of the other, but also through that which is not said, or silenced (Grondin, 1991/1994):

> Silent, wordless consent is often taken to be the highest and innermost type of understanding. Anyone who observes language carefully will immediately come across such phenomena as silent consent or guessing that something is the case without putting it into words. (Gadamer, 1970/2007, p. 92)

Where Gadamer may have been describing how something meaningful is always left unsaid in what has been said, it did not seem that healthcare aides interpreted palliative residents' silence as something left unsaid about their fear, and therefore meaningful, but more as their acceptance of death. As such, healthcare aides may miss opportunities to understand something important about palliative residents' experiences with death and dying, the familiarity of their deaths concealing something meaningful about their dying. Consequently, healthcare aides seemed unprepared to understand the unfamiliar ways in which residents died during the pandemic, while residents wanted care, support, and perhaps to participate in meaningful conversations about their fear, and in ways that would have demanded healthcare aides' presence as a willing interlocutor.

Healthcare aides seemed more comfortable with the kind of death and dying that took place in silence, and death is often described as a kind of silence, despite it often being used to evoke fear in the gothic genre: "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). Perhaps death requires the *right* kind of silence, being more akin to a kind of peace and contemplation. For example, healthcare aides seemed to described silence as not only being what confirmed a residents' dying time, but as accompanying a more natural, or better death, than the fear that had preceded it: "*I need to go, I need to go, I can't…silence after that."* However, it also seemed to be the suddenness of which silence fell about the room, how residents went from verbally expressing their fear of death and dying to their being silent, that made these deaths unnatural and unknowable to healthcare aides, and therefore traumatizing:

> *Interviewer: So maybe it sounds like it is the swiftness with which they died, that made them not palliative in your mind –*
> *Healthcare Aide: In my mind, yeah. Because they are verbal.*

> *Healthcare Aide: I have taken care of people who are palliative, and then sometimes it happens when you are not present. But with the COVID, it happens – I see it through the window. …But palliative, sometimes they pass away when you are not present. When you*

> *go back, you realize that person is gone and is no longer there. But [death from COVID] happened instantly, because I was present, and we just turn our backs for a moment. …When I went home, the next day I didn't come in. I called in sick, because I couldn't get up from bed. I was just numb.*
> *Interviewer: After the COVID patient died?*
> *Healthcare Aide: Yeah, I was just numb. It affected me different than someone dying natural, like taking care of palliative. And I was like, maybe because I didn't accept it? Or because it happened instantly, I'm still processing it, in the back of my mind. Because the whole time I was driving home, I was like, how? It was within five minutes. That's all I kept saying to myself.*

As a kind of governess in a house that had been subsumed under the haunting of a new and unfamiliar ghost, or a strange Other, healthcare aides were no longer able to protect the residents they had been entrusted with caring for, instead fearing them and their dead bodies. Even though residents may have been the ones (mostly) dying from the COVID-19 pandemic, it was clear that healthcare aides were the ones left to make sense of death and dying during that time, as the strange Other suddenly snatched life out of the house and disappeared into the silence.

> [the ghost] knew me as well as I knew him; and so, in the cold, faint twilight, with a glimmer in the high glass and another on the polish of the oak stair below, we faced each other in our common intensity. He was absolutely, on this occasion, a living detestable, dangerous presence. …It was the dead silence of our long gaze at such close quarters that gave the whole horror, huge as it was, its only note of the unnatural. …The moment was so prolonged that it would have taken but little more to make me doubt if even *I* were in life. I can't express what followed it save by saying that the silence itself . . . became the element into which I saw the figure disappear . . . straight down the staircase and into the darkness in which the next bed was lost. (*The Turning of the Screw*, James, 1898/2021, pp. 68-69)

To summarize the first section of this paper, it seemed that healthcare aides had been subsumed into the haunting of long-term care, no longer able to offer residents any comfort as healthcare aides' fear intensified. Dying residents were also described as being afraid, and as such, were not considered as being palliative in their final moments of life. For healthcare aides, the experience of death from COVID-19 was identified as separate from, and different to, "normal death," both unexpected and strange. In the next section of this paper, I offer a philosophical discussion of healthcare aides' fear as being a kind of uncanny experience, and therefore a kind of anxiety. I then offer a second discussion, where I explore my suspicion of healthcare aides' understanding of fear and palliative care as being a kind of institutionally mediated testimony.

Making Sense of Fear and Anxiety as an Uncanny Experience: A Discussion

As the transcripts throughout this paper suggest, healthcare aides spoke to a sense of fear in the house, healthcare aides themselves having been afraid of the possibility of their own deaths while caring for residents infected with the COVID-19 virus or their dead bodies. *"There was such a huge fear when it started, like I felt it. Everywhere, you know?"* Healthcare aides also described residents as also being in fear, and in their ability to verbalize their fear, healthcare aides considered

their deaths to be unfamiliar, or unnatural, and as such, unlike the familiar kind of death experienced by a resident who is considered palliative. In my turning to the philosophical literature to better understand how healthcare aides' understanding of death and dying during the pandemic was shaped by fear, I realized this fear could perhaps be better understood as anxiety.

From a psychoanalytical perspective, Freud (1919/2003) suggested that moments of the uncanny speak to our inner fears, traumas, or experiences that have been repressed, and in moments of alienation from the familiar, that which was concealed shows itself to us. In other words, what scares us, like death, is hidden deep in our unconscious mind, beyond our awareness, and it is in moments of the uncanny that we are confronted by it. For the ways in which a fear of death and dying are part of our collective conscious and self-conscious, Gadamer (1993/1996) suggested we all grapple with "the very ungraspability of death" (p. 63), despite our cultural and societal tendency to systematically repress it:

> For every living person there is something incomprehensible in the fact that this human consciousness capable of anticipating the future will one day come to an end. Likewise, for those who witness it, this final coming to an end has something uncanny about it. (Gadamer, 1993/1996, p. 63)

Where Freud explored how the uncanny is what the inner-self represses, Heidegger (1927/1962) considered the uncanny as not necessarily a kind of fear, but instead a kind of existential anxiety that discloses to us the ways in which we find ourselves already being-in-the-world, or that which he called *Dasein:*

> Uncanniness is the basic kind of Being-in-the-world, even though in an everyday way it has been covered up. Out of the depths of this kind of Being, Dasein itself, as conscience, calls. The 'it calls me' ["es ruft mich"] is a distinctive kind of discourse for Dasein. The call whose mood has been attuned by anxiety is what makes it possible first and foremost for Dasein to project itself upon its ownmost *potentiality-for-Being*. The call of conscience, existentially understood, makes known for the first time what we have hitherto merely contended: that uncanniness pursues Dasein and is a threat to the lostness in which it has forgotten itself. (Heidegger, 1927/1962, p. 322, emphasis in original)

What I think Heidegger means by this, and with help from Withy (2021), is that anxiety, or what he calls *angst*, although typically hidden from us, is the "fundamental disposedness or fundamental mood" that makes us aware of our *potentiality-for-Being*, meaning, moments of anxiety are what allows us to become aware of our own finitude, or *being-towards-death*, and thus, our authentic-self (Withy, 2021, p. 37). It is in these moments of anxiety that one realizes we are burdened with the freedom to make choices, and in this awareness, we are no longer at home in the world, and experience the uncanny (Withy, 2021). For healthcare aides, this meant noticing the unfamiliar, death from COVID-19, within the familiarity of the long-term care home where death had been all along, although repressed, and as such, becoming burdened with the knowledge of their freedom to make choices, and realize their own authenticity.

Understanding healthcare aides experiences with death and dying during the pandemic as not being simply a kind of fear, but a kind of existential anxiety, allows for an important distinction for better

understanding their experiences as taking place within an institution, or a kind of haunted house. According to Freud, the distinction between fear and anxiety can be summarized as follows: "Apprehension (*Angst*) denotes a certain condition as of expectation of danger and preparation for it, even though it be an unknown one; fear (*Furcht*) requires a definite object of which one is afraid" (Freud, 1922/2009, p. 9). Where it may have seemed that healthcare aides were afraid of a "definite object," the COVID-19 virus, they also seemed to expect death, however unknown, the long-term care home already being a place of death and dying. Unlike Freud's anxiety, however, healthcare aides were unable to prepare for the kind of death brought by the COVID-19 pandemic, the institution of long-term care having failed to meaningfully establish a philosophy or culture of palliative care prior to the pandemic or even implement adequate end-of-life practices that would have comforted dying residents.

For Heidegger (1927/1962), the kind of existential anxiety healthcare aides' may have experienced would not be a fear of that which is in the world, or definite threat, but instead, an anxiety of nothingness: "it is already 'there', and yet nowhere; it is so close that it is oppressive and stifles one's breath, and yet it is nowhere" (p. 231). Healthcare aides often spoke of the insidiousness of the COVID-19 virus for the way it elicited fear, or perhaps more accurately, anxiety, as it was everywhere and nowhere, able to swiftly move from one resident to another, undetected: "…*you can find COVID everywhere. Where you walk, the hallway, the lifts, everywhere*…" In other words, anxiety is what discloses to us our authentic self as being-towards-death, as having "*the possibility of the impossibility of any existence at all*" (Heidegger, 1927/1962, p. 307, emphasis in original). Nothing is an "unactualized *something*" – death itself being a kind of nothingness (McCarthy, 2015, p. 124, emphasis in original):

> *Healthcare Aide: And death was nothing.*
> *Interviewer: Death was nothing?*
> *Healthcare Aide: Nothing. …Because it's so common. Of course, maybe because they're old. At that time. They're old, and at the facility, they're supposed to be there and enjoying their life. Giving them the best, making them live their life, making them happy. But COVID denied them.*

I have read the above transcript many times, and each time I am more convinced that what this healthcare aide was describing, the nothingness of death, is that of Heidegger's anxiety or angst: "In [Heidegger's] anxiety there is no object that I can run away from or, alternatively, run toward. There is nothing that one can immediately do about it. Yet it is there with me" (McCarthy, 2015, p. 125). In our confrontation with our own nothingness, or "that which is not yet and *might possibly be*," we ultimately face the question of our being-towards-death alone, as no one can face it for us (McCarthy, 2015, p. 124, emphasis in original). Although this healthcare aide was perhaps speaking about how powerful the COVID-19 virus had been at the height of the pandemic, as if it were nothing for the virus to inflict so much death, the ways in which they reflected on death as being nothing, and having no one able to protect the resident from that outcome, seemed to speak to that of an eerie and uncanny experience, having also acknowledged the reality of death and dying in the house: "*Of course, maybe because they're old. At that time. They're old, and at the facility…"* Consequently, the uncanniness of death and dying at that time meant healthcare aides were burdened with a sense of freedom to make choices about how they cared for dying residents, or a kind of existential anxiety, but lacked the *actual* freedom to make choices within institutional

spaces known to sweep death under the rug, of which I discuss further in the final paper of this serialization.

According to Freud (1919/2003), it is only after we are exposed to a sudden and surprising kind of fear, or fright, that we must return to think about such dangers in our dreams, the preparedness for our fears meaning to exist in a state of anxiety. In other words, for Freud, "the dream seems to be an attempt to prepare by means of anxiety for a danger which could not be prepared for at the time when it took place" (Svenaeus, 2000, p. 6). It seemed the healthcare aides I interviewed had to also return repeatedly to their initial frightening experiences, and therefore had to exist in a state of anxiety:

> *So, I went to this resident's room, and I started talking as usually I do. But no answer, no answer. So, when I opened the door and came in, she was just pale and not breathing. I couldn't do nothing. I just got like, I couldn't even move. I couldn't even talk. I was in shock. I had to stay there. I don't even remember how long. I couldn't move until my co-worker come, my partner. She said, are you doing okay, are you doing, okay? I don't even know how many times she talked to me. …Then I had to give the report to the nurse, and the nurse asked everything. So, I had to go over and over again with her. …I have to go all over it again. It was really difficult for me to say this again, again, again. And then I came home and I'm having nightmares because I'm dreaming about work. Where I have to explain, over and over again.*

Considering the ways in which the healthcare aide above was describing a kind of post-traumatic stress response, I would be remiss to not briefly situate anxiety from a biomedical perspective in this interpretation, only if to provide justification for my having focused on a philosophical perspective of the uncanny, and not a clinical understanding of anxiety.

Anxiety From a Scientific Perspective

In the clinical sense, the Cleveland Clinic (2024) characterizes anxiety disorders as "a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation" ("Anxiety Disorders" section, para. 1). If not a diagnosed disorder, symptoms of general anxiety include, but are not limited to, feelings of fear, dread, uneasiness, and irritability, uncontrollable or obsessive thoughts, and difficulty concentrating (Cleveland Clinic, 2024). According to the literature, healthcare aides, along with other healthcare workers in long-term care, experienced significant anxiety because of the COVID-19 pandemic (Hughes et al., 2023; Jones et al., 2022; Martín et al., 2021; Reinhardt et al., 2022). Considering clinical anxiety does not always exist within isolation, but may present alongside other mental health conditions (Koutsimani et al., 2019), it is important to note that healthcare aides or long-term care workers also experienced burnout, emotional distress or exhaustion, psychological distress, post-traumatic stress disorder, and depression (Blanco-Donoso et al., 2022; Brady et al., 2021; Cho et al., 2023; Ecker et al., 2021; Hoben et al., 2023; Huang et al., 2024; Hughes et al., 2023; Jones et al., 2022; Mangialavori et al., 2022; Martín et al., 2021; Richert & Zucchero, 2023; Snyder et al., 2021; Song et al., 2024; Titley et al., 2023).

Although it may be clear in the literature that healthcare aides experienced anxiety because of their working in long-term care during the pandemic, along with a myriad of other mental health afflictions, the healthcare aides I interviewed did not use the word "anxiety" or "anxious" when describing their own experiences, despite their experiences having clearly produced feelings of anxiety, or the uncanny. Instead, healthcare aides only used the words anxiety or anxiousness when talking from the perspective of the resident, and the kind of fear or anxiety they interpreted dying residents as having. For this reason, it seemed turning to the literature on clinical anxiety would only be to confirm an anticipated outcome of the COVID-19 pandemic, namely the increased prevalence of clinical anxiety or mental health conditions, and not to elucidate a new way of understanding healthcare aides' experiences as being uncanny within the context of the institution: "That is why understanding is not merely a reproductive but always a productive activity as well. …It is enough to say that we understand in a *different* way, *if we understand at all"* (Gadamer, 1960/2004, p. 296, emphasis in original).

A Suspicion of Healthcare Aides' Understanding of Fear and Palliative Care as a Kind of Institutionally Mediated Testimony: A Discussion

Listening to healthcare aides describe residents' fear of dying or the suddenness of their deaths as being why they were not considered palliative, even when healthcare aides knew or suspected a resident was actively dying, I found myself confronted with a sense of suspicion, and asking myself the following question: If residents dying from COVID-19 were not considered palliative on account of their verbalizing their fear of death and dying, did that mean healthcare aides considered palliative residents as not being afraid to die?

As discussed, healthcare aides seemed to interpret palliative care as being for people who were not in fear, but had accepted their deaths, and who primarily required physical tasks. While palliative care is certainly comprised of many physical tasks, such as repositioning and oral care, it is also an integrated and holistic approach that can begin at any stage of the illness trajectory, requiring tactful communication between the care provider and palliative person about their dying (Health Canada, 2018). However, healthcare aides seemed to consider the non-physical tasks of palliative care, such as talking to a resident about their fear of death and dying, as going above and beyond for residents during the pandemic, and remaining outside the reasonable limits of what they could accomplish during their shift:

> *Interviewer: Would you consider, then, you know holding someone's hand, sitting with them when they are fearful, as going above and beyond your job description?*
> *Healthcare Aide: It is. It is. Because when you are taking care of residents, and they ask you, please sit, or they said they are in fear, you can maybe give yourself three minutes to ask what are they fearing, or you can provide emotional support. Because the majority of the time, they need comfort. Like, holding someone's hand is like, providing support and comfort, right? But in the back of your mind, you know you have so many things to do, and this other resident is waiting for you, and you have staff waiting for you.*

In addition to being unable to comfort dying residents or alleviate their fears of death and dying during the pandemic, healthcare aides are known to be unprepared or uncomfortable engaging in conversations about death and dying with residents even during non-pandemic times (Marcella &

Kelley, 2015; Schell & Kayser-Jones, 2007). For example, one healthcare aide I spoke with described how they had been uncomfortable caring for a resident who possessed the knowledge that they were soon going to die, and how they had wanted to communicate with the healthcare aide about their fear:

> *If they are told they are going to die, it should have been now, or it should have happened tomorrow. It took like, three weeks after. Because every time you come to take care of her, she is like, how soon am I going to die? I said, oh my god.*

Considering long-term care homes do not often consider palliative care as a philosophical approach to improving the quality of a residents' life and death (Cloutier et al., 2021), it is not surprising healthcare aides would consider verbalisation and a fear of death as being an "*unnatural*" kind of death. It seemed that a natural death, would be a silent kind of death, where the resident is likely bed-ridden and unable to communicate verbally, as might be expected when dying from old age, and often with cognitive impairment (Eisenmann et al., 2020). Considering 60% of residents living in Alberta long-term care homes have a diagnosis of cognitive impairment, such as dementia or Alzheimer's disease (Alberta Health, 2018), it is possible that healthcare aides may not consider these residents as even being aware of their dying, and therefore not fearful.

Healthcare aides' understanding of fear as impeding palliative care is not only telling of the quality of care dying residents in long-term care homes received during the pandemic, but also telling of how the institution of long-term care has failed to routinely implement a culture or philosophy of palliative care that would serve to familiarize healthcare aides with death and dying care for the older adult population. For the healthcare aides I interviewed, it seemed that a resident dying in fear demanded something from them, either comfort or conversation, whereas a resident who was interpreted as not dying in fear, on account of their silence or immobility, only required physical tasks. As such, I found myself suspicious of healthcare aides' testimony again, wondering if their understanding of fear and palliative care was a kind of institutionally mediated testimony, and therefore found myself asking another question: If long-term care is a place of death and dying, despite its hiddenness, as was explored in part one of this serialization, and more residents were dying in long-term care than ever before during the worst of the pandemic, how was it that palliative care was so infrequently implemented by the institution?

> *Interviewer: Did dying residents from COVID, anytime between then and now, did they ever become palliative when they were dying from COVID?*
> *Healthcare Aide: No.*
> *Interviewer: No. They never got…*
> *Healthcare Aide: Yeah. That's why I said it's different. When someone is dying naturally, they go through palliative, they go through the palliative stage, where you have to stop everything, nothing by mouth. You are just doing mouth care, and you are doing turning and you are preventing pressure sores. But, the resident from COVID, they were not laying there. You were not turning them, because they were capable of getting up, of standing up and voicing their pain and their fear to you.*

While the healthcare aide above is describing a resident with COVID as not receiving palliative care on account of their physicality or ability to verbalize their pain and fear of dying, many of the

healthcare aides I spoke with seemed to have a sense of which residents infected with COVID-19 were likely going to die, having described them, as was revealed in part two of this serialization, as being bed-ridden, too weak to eat or drink, as having trouble breathing, or as having been left alone in their rooms for unbearable lengths of time. Therefore, there seemed to be a tension between healthcare aides' testimony and the silent testimony of the institution – namely, between how healthcare aides understood residents as not receiving palliative care on account of their fear and the suddenness of their deaths, and how the institution was ultimately responsible for deeming residents as palliative or not and implementing or guiding palliative care practices.

According to a report by the Canadian Armed Forces (2020), the practices in five long-term care homes in Ontario during the first year of the pandemic were nothing short of horrific. Residents not only experienced inadequate palliative care but were often not offered palliative care at all. Examples of poor palliative care standards in long-term care homes included but were not limited to: residents not receiving appropriate or timely palliative care medications, sometimes due to staffing inadequacies, no proper mouth or eye care orders or even supplies, and palliative care orders not charted or completed (Canadian Armed Forces, 2020). Furthermore, the full report detailed appalling conditions in all five long-term care homes generally, even describing a resident who died due to a choking incident after being fed by staff while lying in the supine position (p. C-1/2), and other residents having been "observed crying for help with staff nor responding for (30 min to over 2 hours)" (p. B-1/3).

Perhaps the most telling of poor palliative care practices in my research, one healthcare aide I spoke with described the long-term care home as making no changes to staffing levels to accommodate the care of a dying resident:

> *Interviewer: When you have palliative residents, does the staffing change at all? Like the staffing ratios, when you have a palliative resident do you get more time to be with them? Healthcare Aide: Normally, no. It is still the same staff on the floor.*

Consequently, healthcare aides must not only care for dying residents without any additional staffing, but while also routinely experiencing inadequate staffing that often prevents them from completing the required care for even non-palliative residents (Graff-McRae, 2021).

The report by the Canadian Armed Forces (2020) also detailed how long-term care staff had avoided post-mortem care, and how very few healthcare aides would assist with the care of deceased residents, and if able, would leave the military staff who had been deployed to the facility to do the care instead. Although healthcare aides may have been afraid of the bodies of residents who had died from COVID-19, seeing them as possibly still being infectious, healthcare aides are also known to feel unprepared and scared to do post-mortem care in non-pandemic times (Estabrooks et al., 2020; Schell & Kayser-Jones, 2007; Touhy et al., 2005). Furthermore, the long-term care context is likely the first place they find themselves confronted by death and dying, and often without having received adequate training, support, or guidance (Estabrooks et al., 2020; Schell & Kayser-Jones, 2007; Touhy et al., 2005):

> *In the long-term care, some staff, still to this day, are scared. Because of religious beliefs, like superstitious beliefs, when someone died, they are scared to touch it. They are scared*

> *that maybe they will come back to them when they are asleep and stuff. So, the majority of the staff in our work, they do not go inside the room when someone died. They will avoid that room. Even though we are taught to take care of someone who is palliative.*

As the decision to implement palliative care for a resident in long-term care rests not with the healthcare aide, but with the institution itself, I conclude this discussion by suggesting that healthcare aides' understanding of palliative care during the pandemic was a kind of institutionally mediated testimony that served to conceal a hidden truth in the house: While healthcare aides understood residents' fear of death and dying as being why they did not receive palliative care, residents were, in fact, fearful of death and dying, possibly on account of their being denied palliative care, and in ways that would have furthered their isolation and implicated the institution.

Concluding Thoughts

In this paper, I explored how healthcare aides had to make sense of death and dying as an unfamiliar ghost or strange Other, and the kind of fear that had settled throughout the house. In their confrontation with the suddenness of death brought by this stranger, healthcare aides were fearful about the possibility of their own death while caring for residents, as well the dead bodies of residents infected with the virus. Not unlike a governess entrusted to care for vulnerable children in an old house, the happenings of the haunting, or the COVID-19 pandemic, meant that healthcare aides, although entrusted to provide quality care, had avoided dying residents, on account of their fear or having been instructed by management to do so. Having left dying residents alone, healthcare aides described them as being afraid, anxious, and even neglected. I also explored in this paper how healthcare aides had considered residents dying from COVID-19 as not receiving palliative care because of their ability to verbalize their fear and anxiety of death and dying, and how residents' deaths had been unnatural and strange. I then offered a philosophical discussion of how healthcare aides fear of death and dying during the pandemic could perhaps be better understood as a kind of existential anxiety, or an uncanny experience, from a Freudian and Heideggerian perspective.

Coming face to face with the unfamiliar ghosts that had invaded the long-term care home, healthcare aides were burdened with a sense of freedom to make choices about the care dying residents received, having become aware of their own finitude in their anxiety, and thus their authentic-self. Although healthcare aides were burdened with a sense of freedom to make choices, they were also burdened with knowing they could not always choose the kind of care dying residents received within institutional spaces that do not prioritize palliative care. As such, I offered a second discussion where I returned to that of healthcare aides' institutionally mediated testimony as taking place within a haunted house that had shaped and molded their understanding of fear during the pandemic. Namely, I explored the tension between healthcare aides' testimony that residents dying from COVID-19 had not received palliative care on account of their fear, and the silent testimony of the institution, that was ultimately responsible for implementing palliative care practices that would have served to comfort residents' fear of death and dying. As I explore further in the next and final part of this serialization, healthcare aides were therefore unable to care for dying residents in the ways they wanted to, while also receiving very little support within institutions that were more concerned with banishing any trace of death and dying back into the shadows.

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