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The Haunting of Long-Term Care, Part Four.

"It is Hide-and-Seek": Falling Back into the Status Quo and the Inauthentic

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Abstract

This paper is the fourth 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 fourth and final paper, the story descends without resolution. In the years since the pandemic, long-term care appears to have returned to the status quo, with few meaningful changes made to improve death and dying. I return to the structural integrity of the institution—the haunted house itself—and to how healthcare aides locate their experiences within enduring institutional failures that prevent quality care for dying residents. Remaining in the house, healthcare aides are understood as playing a game of hide-and-seek, where the structural problems laid bare during the pandemic have once again been hidden in dark corners. To explore this, I describe the ongoing limitations healthcare aides had "seen" during the pandemic, namely inadequate staffing and limited support. I then move to the "hide" section of the paper, which serves as the discussion, where I explore how these issues are being concealed again, the ghosts of the pandemic banished to the shadows, threatening to reappear. Finally, I offer a

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philosophical discussion of healthcare aides' positionality through Heidegger's understanding of the uncanny, particularly authentic versus inauthentic experience.

Keywords

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

> The summer had turned, the summer had gone; the autumn had dropped upon [the house] and had blown out half our lights. The place, with its gray sky and withered garlands, its bared spaces and scattered dead leaves, was like a theater after the performance – all strewn with crumpled playbills. (*The Turning of the Screw*, James, 1898/2021, p. 86)

Six months after my first interview, I found myself seated at another round table. This time, I am sitting at a small wooden table, tucked away in the corner of my favourite coffee shop, the late afternoon light fading in through the window beside me, and the stillness of dusk beginning to hug the building. Looking out, a cup of tea in my hand, I watch the people walking by. There seems to be a kind of relief in the air, the crisp and early evenings of spring given way to warm and late summer nights, the kind that make people linger in the streets a little longer.

"It's like a game of hide-and-seek?" My supervisor, Dr. Lorraine Venturato, also staring out the window, now puts down her coffee and pulls a pad of paper and pen from her bag.

"That's how one of the participants described it," I told her. "And it really does seem like that's what death and dying in long-term care is like. A never-ending game of hide-and-seek."

Having written down "hide-and-seek" in her notebook, she circles the words with her pen, nodding her head up and down, a dark ring entombing the letters.

"I agree. During the pandemic, it seemed like the healthcare aides you spoke with were playing seek, the reality of death and dying having come out of the shadows, showing itself to them. The lack of staff and limited support they experienced were in plain sight, too."

"And now death and dying is hiding again," I said. "Along with any responsibility of the institution to improve care or address healthcare aides' experiences." We both let the silence take us for a moment, our conversation from the last hour hanging heavy between us. Seated across from each other at a small table, a patchwork of notepads, scribbled drawings, and empty coffee mugs before us, I am reminded of the first interview I had with a healthcare aide. The table between us was much bigger, and free of the messy process of interpretations, only a small black audio-recorder placed on the table. Not knowing what the interviews would bring, I remember feeling eager, anxious even, my blank notebook ready to be written in. Now, poring over the data, Lorraine and I felt weary, the weight of healthcare aides' testimonies hard to shake, and the realization of the lessons not learned by the institution of long-term care an even heavier burden.

“Let me read it again,” Lorraine said, leaning forward. “What the healthcare aide said about caring for dying residents as being like a game of hide-and-seek.” I passed her the transcript:

> *Whenever something is going on with a palliative resident, we have to run and look for [the nurses], in order to tell them what is going on with a certain resident. It is hard when you don’t have enough equipment for good communication. You have to look for them. For example, the nurse is attending to other residents, they are not only focused on the palliative resident. This is a challenge in a way, that you have to look for your nurse in order to report what is going on. Especially when the resident is really struggling, or it is a code blue, anytime attention is needed immediately. It is a struggle that you have to shout in the hallway or, if you see anyone, it’s like a relay, “call the nurse, call the nurse, this is happening already with the resident!” We need them already with the resident and we need them ASAP! But because there is not much communication equipment it is a struggle.* ***It is hide-and-seek****. “Where is she, where is she, where is she.” Plus, if you are the only one there and you don’t see anybody, all you need to do is stay with that resident and comfort her. But if she is already grasping breath and already – you know she needed someone to be there during her dying time, in that moment. And there are times when it is already done when the nurse came, she is already gone. But what can we do, we don’t have enough, we don’t have enough resources for this kind of – In this pandemic time, we were not prepared for what was coming. We had no choice, but you do what you have to do while you are at work. If someone died in your hand, well, we have no choice but to just accept it. …There is nobody for you to help, and you are all by yourself there.*

She passes the transcript back to me, taking up her coffee again, a defeated look having returned to her face. “Nothing has changed, has it?” Looking down at the glaring data strewn between us, I know her question is more a statement we both know the answer to, the testimonies of healthcare aides having taken place almost four years after the start of the pandemic in Alberta.

“I guess healthcare aides are still playing hide-and-seek,” I respond after a long pause, and bury my face in my hands.

*

In the way that healthcare aides’ stories of death and dying in long-term care either pulled me back in time to the pandemic or brought me forward into their realities of working in the present, so did the game of hide-and-seek; my fond memories of playing the game as a child colliding with the dark truth it now revealed about healthcare aides’ experiences. As a familiar, and even comforting childhood game, I often played hide-and-seek with my brothers, myself wanting to be the one to “seek,” thinking there was no clever place they could hide that I could not find them, despite my exhaustive, and often unproductive, efforts. Now, the game felt unfamiliar, almost ominous, considering how it had been taken out of the context of childhood and used by the healthcare aide to make sense of residents dying in a state of panic in the long-term care home, or alone. In its familiarity, yet unfamiliarity, the game of hide-and-seek had an eerie uncanniness to it and seemed a fitting game to play in a suspicious kind of house, a haunted house.

Where part two of this serialization served to interpret the kind of isolation of death and dying healthcare aides would have seen in the haunted house, and part three the kind of fear experienced, this paper serves to bring these experiences back to the structural integrity of the institution, and as such, bring attention the never-ending game of hide-and-seek healthcare aides are forced to play. In keeping with this theme, I have separated this paper into two sections: seek and hide. In the first section of this paper, I begin by describing the structural and ongoing limitations that healthcare aides had "seen" during the pandemic, namely inadequate staffing and limited support. In the face of these two institutional shortcomings, I also explore how healthcare aides described themselves as being unable to do what they felt was right for dying residents, and how their experiences can be considered through the philosophical lens of *phronesis*. I then move onto the "hide" section of this paper, which serves as the discussion, where I explore how the structural issues found by healthcare aides are being hidden again, the ghosts of the pandemic now banished to the shadows, threatening to reappear at any moment. In this section, I also offer a philosophical discussion of healthcare aides' positionality in the haunted house through Heidegger's understanding of the uncanny, namely his consideration of authentic versus inauthentic experience.

Seeking in the Haunted House: How Healthcare Aides Experienced Inadequate Staffing and Limited Support

It is well understood that the pandemic brought to light the structural inadequacies and limitations of long-term care as having been what prevented healthcare aides from providing quality care to living, and dying, residents. Many of the research articles I read in preparation for writing this paper began with an iteration of this statement, the authors acknowledging the ways long-term care was like a tinder box, ready to ignite, when the fire of COVID-19 blazed through its walls. It is well known that healthcare aides consider inadequate staffing and limited support as the determining factors in their ability to perform their work during both pandemic and non-pandemic times (Estabrooks et al., 2020; Graff-McRae, 2021; Lightman et al., 2021). The testimony of healthcare aides further along in this section may be expected, as they echo narratives already found in the literature. However, I argue it is important not only to further understand these institutional influences on healthcare aides' experiences within the context of death and dying during the COVID-19 pandemic, but to bring attention to the repetitiveness of such experiences and institutional failures as paving the way for the institution, and for healthcare aides, to return the status quo after the pandemic, or, a kind of hide-and-seek.

Searching for Staff

When I asked healthcare aides what their most significant challenge was in having to care for dying residents during the pandemic, they would often hang their heads with a kind of fatigue or tiredly throw their hands up in the air before they spoke about what seemed to be an obvious issue for them: a lack of staff:

> *Interviewer: What would you say made caring for dying residents the most challenging during the pandemic?*
> *Healthcare Aide: As I have said, no extra person. No staffing.*
> *Interviewer: Were there times that a resident who was dying did end up having to die alone because you didn't have the staff?*

> *Healthcare Aide: Yes. As I've said, we tried our best to be there for them while they are dying. But then, we have other people, too. Only three or four healthcare aides for thirty residents. Well, it depends too if you have a nurse. ...But the [registered nurse] has sixty residents. So, it happens.*

According to Wylie (2023), "Facilities not having enough staff was, by far, the most common issue identified" in continuing care homes (including long-term care) during the first two waves of the pandemic in Alberta, which "was a persistent, systemic weakness" (p. 29). While staffing issues may have been a point of crisis during the pandemic, healthcare aides are routinely expected to work below acceptable levels of staffing to meet resident care needs (Estabrooks et al., 2020; Graff-McRae, 2021; Lightman et al., 2021). Furthermore, when a healthcare aide is off sick, or the facility is unable to cover staff absences, healthcare aides are often expected to work short staffed (Graff-McRae, 2021). As such, while the happenings of the pandemic presented unfamiliar challenges, inadequate staffing in long-term care was also a familiar issue, though exacerbated, that had profound repercussions for resident quality of care:

> *They are telling us we are short of staff. Yes, we are short of staff, but they don't hire other people to cover who is off sick. They want us to cover, if not, we work short. When we are working short, we don't provide the good care enough to the residents, but it is also hurting us.*

Healthcare aides also spoke of how additional staff, casual workers, or healthcare aides from relief agencies were not brought in to help during the pandemic, but instead regular staff was expected to work overtime or take on additional shifts to compensate for the increased workload:

> *We were really, really exhausted. But instead of them getting casual workers maybe for relief, the regular workers were the ones working extra hours, double shifts.*
>
> *Some of us work like, six days straight. Sometimes without a break because of shortages of staff.*

Despite healthcare aides' frustrations, long-term care homes were severely restricted by government policy in their ability to cover staff shortages. Namely, in effort to limit the spread of the virus between sites during the pandemic, the province of Alberta had mandated that healthcare aides could not work in more than one facility, despite most healthcare aides relying on the income from employment in two or more facilities (Berta et al., 2013; Duan et al., 2020; Wylie, 2023):

> *We were not allowed to work in two places. So, we had to decide to work in one place or the other. ...I was so exhausted, I didn't know what to do. I was kind of confused working long hours, and seeing so many people passing away, and seeing family members crying all the time. I didn't know what to do. ...Then I say, okay I will just sign my resignation letter to this place.*
>
> *Interviewer: Did the 'one site' policy rules you spoke of, did that have any effect on you having to only work at one facility?*

> *Healthcare Aide: It did a lot. Because, from two paychecks to only one paycheck – and you have lots of bills and everything. The bills didn't change, they were still the same.*

Despite the challenges healthcare aides experienced in having to choose one long-term care home to work in, or their going from two or more paycheques to only one, the single-site order on facilities was considered a successful intervention for how it reduced the number of COVID-19 cases, and therefore deaths (Wylie, 2023). However, such measures also meant reducing the total pool of continuing care staff for long-term care homes by approximately one-third. This is because Alberta's continuing care sector is known to employ only 15% of its staff (including healthcare aides) on a regular full-time basis (Wylie, 2023). As such, the staffing challenges presented by the single-site order during the pandemic was arguably an anticipated outcome, for how long-term care homes already rely on a patchwork of part-time and casual workers, likely as way of reducing costs associated with full-time employees (Armstrong et al., 2023).

As was discovered in part three of this serialization, no changes to staffing are made to accommodate the caring of dying residents in long-term care, meaning healthcare aides had to go above and beyond to promote quality of care, or step into care roles they were unfamiliar or uncomfortable with. As the healthcare aide testimony at the beginning of this paper revealed, a resident dying from COVID-19 was an alarming situation for the healthcare aide, them having desperately searched for the nurse to be with the resident in their final moments of life: *"Where is she, where is she, where is she."* Unable to find the nurse, the healthcare aide had felt alone and unprepared to be the only person in the room with the resident at that time: "*there is nobody for you to help, and you are all by yourself there."* In interpreting this resident's death as occurring within a state of crisis, or searching for help to no avail, or as a failure of care ("*If someone died in your hand, well… we have no choice but to just accept it"*), the healthcare aide seemed to attribute quality of care issues to a lack of "*communication equipment"* or "*resources*," as opposed to explicitly naming a lack of staff. As such, I found myself wondering if this healthcare aide's routine exposure to inadequate staffing had somehow normalized their working situation, their wanting an additional phone for paging, for example, being a more realistic request than the additional nurse who would be able to answer the call. The normalization or internalizing of certain institutional-level failures is something I explore further in the discussion section of this paper.

As I have explored throughout the papers in this serialization, staffing issues during the pandemic not only had consequences for the quality of care dying residents received, but also impacted healthcare aides' physical well-being, as they were required to take on the additional workload:

> *I'm tired. Because, we don't have any extra person, and its long-term care, so its extra work, everything extra. Lots of things you need to do and things that need to be done. So, it is a lot of workload. No extra persons.*
>
> *It was a really challenging time for us. And then we are always short, too. Before, it was only four people for thirty residents. But we are always three, because we are always short. …Because the healthcare aides are getting sick. It's not just because of COVID, but because we are exhausted.*

The physical exhaustion healthcare aides experienced because of working short-staffed is perhaps not a surprising finding, it being well known their workload grew well beyond any reasonableness during the pandemic (Wylie, 2023). However, I still found myself surprised how my conversations of death and dying with healthcare aides always seem to pull to our discussing staffing issues. Where I had thought my interviews with healthcare aides would mostly centre around specific experiences of caring for dying residents during the pandemic, healthcare aides often steered the conversation back to a lack of staff or resources and single-site mandates, their experiences of caring for dying residents clearly occurring within the context of familiar and unfamiliar institutional failures. When healthcare aides spoke about staffing issues as being their primary barrier to providing quality care for dying residents, this often led healthcare aides to also reflect on the kind of support they received, or did not receive, in both pandemic and non-pandemic times, which I explore below.

Seeking Support

Healthcare aides often described a lack of staff as the reason why they did not feel like they had enough support, seeing adequate staffing levels as an essential component of institutional support for them to care for dying residents. In addition to this, healthcare aides also described how they felt unsupported to tackle the changing policies and practices during the pandemic, feeling left out of the loop or in the dark, despite being the ones to carry out policy changes:

> *There were no supports at all. There were not supports at all. At my place of work there is still the same situation. Even though the COVID is still around, but it is not as bad as it was at the beginning, there is no support for healthcare aides. …They are not giving us support, but also, we don't have those kind of meetings where we need to know what is going on in the building or the changes coming.*

Healthcare aides are often left out of important conversations about resident care or changing policies, and even conversations about a dying resident that would directly influence practice (Bergqvist et al., 2023; Boerner et al., 2015; Cloutier et al., 2021; Hanson et al., 2002; Hanson & Henderson, 2000; Laher et al., 2022; Marcella & Kelley, 2015; Schell & Kayser-Jones, 2007; Titley et al., 2023; Touhy et al., 2005; van Riesenbeck et al., 2015). If healthcare aides were included in meetings or important conversations about changing policies during the pandemic, it seemed that, for many healthcare aides, such meetings were the extent of any formal support they received:

> *Healthcare Aide: Once in a while, there was a meeting, but it was just about policies or the state of COVID.*
> *Interviewer: So, you didn't have meetings where they checked in with you guys to see how you were doing or to see how people were doing?*
> *Healthcare Aide: No. Nothing. Nothing. Not in the place that I am working in right now.*

Healthcare aides also often spoke about getting sick themselves during the pandemic, and how they had not received enough support when they were sick with COVID-19, such as not receiving sick pay or having to prove being unwell to the facility:

> *In my case, I got twice positive during COVID. If I got sick, they still cannot believe. I would need a doctor's note to prove I was sick. …So that is not support. After we would be working sixteen hours, more than three times, every shift, how can they except us to be strong enough and like we can do this, that we can keep going to work. We are really exhausted, and we are sick, and I tested positive twice. …And I don't have support from nowhere. I have to call all the time, every single day. They knew I was sick, and they knew I was positive, and my family too. But they said no, you have to call every day or either bring a doctor's note to prove that you are positive. … It's like killing us. We need a job, yes. But that was like, that was too much for us. Working too hard and then they don't believe we are sick? So, I feel like, we didn't have enough support from management or from our supervisor [the nurse].*

Just as healthcare aides' experiences with staffing inadequacies could not be separated from their experiences with death and dying, this also seemed to be the case for when it came to support from management or persons in leadership positions. Where management and leadership had failed to support most of the healthcare aides I spoke with, healthcare aides described having to rely on each other for support instead. Although it is well known in the literature that healthcare aides had to rely on each other during the pandemic for support (Bergqvist et al., 2023; Blanco-Donoso et al., 2022; Cimarolli et al., 2022; Hung et al., 2022; Meershoek et al., 2022; Schulze et al., 2022; van Diepen et al., 2023), healthcare aides were also *unable* to support each other, as they were often physically separated from each other during their work day:

> *We couldn't even talk to each other about how we feel. Or how we are doing. Me, I was not eating. I bring lunch, but every time I remember, I can't eat. I just drink and drink. Most of the time it was coffee, or some kind of energy drink. Just to be able to stay up. And whenever I had time, I was laying down on the couch, far away from the work area. Because we used to have a lunch area, all together. But since we had COVID, no one can go together to the same room. Everyone has to separate. …My lunch break, I had to be alone. Completely separated from everyone. And everyone was doing the same thing.*

As a consequence of healthcare aides being unable to support each other, and being unable to debrief over break times, and management not stepping in to fill this gap, healthcare aides experienced a kind of isolation, themselves, in caring for dying residents, as was explored in part two of this serialization. Due to the lack of support healthcare aides received during the pandemic, both from each other and management or leadership, it seemed they were now left trying to make sense of death and dying at that time, and the mental and physical consequences of their traumatic experiences:[1]

> *The last person I saw passing away, she started one day vomiting too much, and then… the third day, she pass away. It was only three days. …COVID, it just took her away. And that*

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[1] I have chosen to include a longer portion of this healthcare aides' testimony below for the following reason: When read in its entirety, the healthcare aides' testimony reads like that of a gothic story, their experience frightening, uncanny, and even disturbing in how it portrays the institution as failing to support them. I argue a richer understanding can take place when their experiences with institutional support is understood through a kind of storytelling.

> *day, I went three days without sleeping. Three days, I'm telling you, I swear three days without sleeping. Every time I close my eyes, I see her face. Like, I went on break, and after my break I came into her room to check her oxygen. And I was going to check the oxygen, but instead of going to check the oxygen, I said, hey how are you doing, are you doing okay? But then she just grabbed my hand. She just grabbed my hand, and then, slowly, very slow, she closed her eyes, and stopped breathing. So, I couldn't go out, I couldn't go check the oxygen. I just grab my phone, and I call the nurse, and I say, this resident has passed away. And she says, "What!? When!? What time?! Oh my god I was just there!" I say I just came in to check the oxygen but before I check the oxygen I came and say hi to her, to see how she is doing, and how she is breathing. And she just grabbed my hand, and it was like she said, please stay with me, just to reduce the pain (crying). And then she stopped breathing. I'm telling you, in that moment, I was just – …Then I make everything, I remove everything, and the nurse has to call the family. And then we prepare the body – I left the place. When I get home, I take a shower and I tried to sleep. I close my eyes, and I see her again. It was three days I couldn't sleep. All the time I close my eyes, I see her, grabbing my hand. It was so – I had to get help, go see the doctor. He gave me a medication. He said I have a trauma. That I was traumatized from the death of that person. He said, I have to take that medication so I will sleep, otherwise I will faint. Then I was able to sleep. But I came to work, and I was not able – it was like I was there, but me was not there. Then they sent me home. Well, I told them, I think I can do it. But they said no, you need to go home and not come back until you recover. I said okay, but then they didn't pay me those days. You see, the support was not there. I was so in shock, and I still tried to come to work, but because I was not able to focus, they sent me home. But they saw after that death, after the last person I saw passing away – like I experienced so many people passing away or coming into the room and seeing people already dead, or knowing a person might not survive the night. But this person was different, because she was grabbing my hands. I think I have a panic, or a shock – I cannot explain. But at least they should give you two days to rest. Because I was not able to focus, but I still need to come to work. If I call in sick, they need a doctor note. If I am coming into work and I can't focus, I might make mistakes, so they sent me home. But then they didn't pay for the days I was away from work. So, then I say, this is incredible, they are killing us. There is no humanity there. Not at all, not being as a healthcare aide. It is not an easy job. It is really difficult, physically, mentally. …Also we have to listen to every single thing the nurse has to say, but when we inquire for some support we don't get it, we don't get support. I am still not recovering. I can still see so many things. I think maybe because of that, I have difficulty sleeping now. I'm not sleeping. …After the pandemic – every day working, working hard, trying to sleep, trying to eat properly, get up on time, do my activities – but it is not the same.*

I have read the above testimony many times, often unsure where to even begin in my interpretation of it. Much of the healthcare aides' testimony belongs in other papers in this serialization, speaking about the hiddenness of death and dying and feeling powerless (part one), the isolation dying residents and healthcare aides experienced (part two), and the fear of death and dying that had haunted them (part three). However, any time I went to break up the length of the quote so I could include passages to support my interpretations in other papers, I always found myself putting it back together, the strength of its message feeling lost when not understood as part of the whole. The whole of this healthcare aide's story whispered something loudly to me about the lack of support they received, and about the ways in which their experiences were forced to disappear into the shadows. Although the above healthcare aide frequently described encountering death and dying in the house and even experiencing a traumatic kind of death during the pandemic, they also described having to hide their experiences away from those who could support them, such as management or the nurse. It seemed to me that the healthcare aide was welcome to work in a house of death and dying, but only so long as they suppressed or hid away any experiences with such ghosts that would threaten the efficiency or status quo of the institution.

According to Gadamer (1960/2004), "the movement of understanding is constantly from the whole to the part and back to the whole" (p. 291). When taken as a whole, or as a kind of story, Gadamer argued that our understanding of the topic is a movement between individual words, entire sentences, and even an entire literary work, allowing for a kind of circular motion of understanding that allows for a greater understanding that is always expanding. Therefore, understanding healthcare aides' experiences with death and dying through the papers in this serialization, all of which are reflected in the testimony above, is still to return to the whole of the institution, or, the haunted house. In other words, any understanding of death and dying must be understood within the context of institution-level issues that have shaped healthcare aides' experiences and testimony, most significantly, inadequate staffing and limited support. Much like healthcare aides' testimony revealed how their experiences with death and dying occurred within the context of staffing and support issues, so too must the parts of this story return to the whole of the metaphor guiding my interpretations: the haunted house. As a suspicious house full of both familiar and unfamiliar ghosts, the long-term care home not only served to shape healthcare aides' experiences and testimonies, but was an oppressive structure that also prevented them from being able to do what was right for residents, or themselves.

Understanding Healthcare Aides' Experiences Through the Lens of *Phronesis* or Practical Wisdom

As a kind of nursing practice, healthcare aides' practice is carried out in the flexible and responsive application of theoretical, or nursing knowledge, to the concrete situation, otherwise known as *phronesis*, or practical wisdom (Moules et al., 2015). Gadamer described *phronesis* as not only a practical knowledge, but an inherently moral one, where a healthcare aide would not only be tasked in each situation to carry out a particular action, but would also be called to make a decision that is for the greatest good of a long-term care resident (Moules et al., 2015). In his account of Aristotle, Gadamer would argue that *phronesis*, or moral knowledge, for the healthcare aide, is not objective knowledge, and therefore, *the right thing to do* arises from the concrete and the particular of the case, or the resident (Gadamer, 1960/2004). Namely, there would be no way to prepare for an event of understanding that would call on the healthcare aide to make a judgement about the right thing to do for a dying resident, nor could it be replicated or applied uniformly across cases (Moules et al., 2015). In other words, a knowledge of what is *good*, in an ontological sense, is of no help to the healthcare aide who is faced with a decision to make in the concrete, as *the good* is an answer to a question that arises only in the practical, requiring a kind of moral reasonableness, or *phronesis* (Gadamer, 1978/1986). However, this still begs the question: what is the *good* in the context of the choices a healthcare aide must make about a dying resident? For this, what Don Marshal, who co-translated *Truth and Method* into English, said in a Gadamer reading group, is helpful:

> When we are talking about choice, what is misleading about the word "choice," it seems to our minds as an individual autonomous activity. What Gadamer thinks, though, is that when we make an ethical choice, it is always in a social context, where we have been raised where these things are good, and those things are bad. (personal communication, October 17, 2021)

From this, we can understand that the *good* in the context of that to which healthcare aides' practice is oriented, is one that is conditioned within the nursing tradition as it pertains to the role of healthcare aides, or to their social context.

As I have argued throughout the papers in this serialization, healthcare aides' testimony was that of an institutionally mediated testimony, their experiences having been shaped by the culture, policies, and practices of the institution, and from a position of relatively little power. As a complex interplay of rules and norms that govern people within a physical space (Miller, 2019), institutions have their own kind of narrative, or way of storytelling, the people within the walls of an institution unknowing, yet participating, characters in an unfolding story about institutional culture:

> Aside from the formal and usually explicitly stated, or defined, tasks and rules, there is an important implicit and informal dimension of an institution roughly describable as institutional *culture*. This notion comprises the informal attitudes, values, norms, and the ethos or "spirit" which pervades an institution. (Miller, 2019, "Social Institutions: An Overview" section, para. 12, emphasis in original)

To understand healthcare aides' experiences through the lens of *phronesis*, or practical wisdom, is to acknowledge such experiences as occurring within a certain social context, such as the informal attitudes, values, and norms that may have prevented them from being able to do what they felt was for the good of the resident, or morally reasonable:

> *Interviewer: Looking back on it now, when families couldn't come, and residents maybe died alone in their rooms, or their last words were "help me," like you said. And family couldn't visit. Looking back on it now, how does it feel? What do you feel when you think of that time, when people were dying the way they were.*
> *Healthcare Aide: It was a helpless situation. It was a helpless situation for both we, and they, the victims. All the people involved. There was nothing anyone could do.*

As I have also explored in the earlier papers of this serialization so far, there have been many moments when healthcare aides were not able to do what was right or good for residents, where they described the times residents had died in isolation, without family, in fear, or even because of what some healthcare aides considered to be neglect.

> *When you think about it, it's hard. And sometimes the healthcare aides want to do more. You know, I've worked with some healthcare aides who have worked in facilities for like fifteen plus years, and they knew that resident. ...They had a personal relationship with that person. So, when the resident is dying, some of them cry, because they're attached to them, and they want to spend a little more time. They will go and talk to the person, but they can't spend too*

> *much time, because somebody will call, somebody needs to go to the bathroom, somebody needs to go to the dining room, the nurse is paging, you know?*

Instead of being able to sit with a dying resident and hold their hand, healthcare aides described being forced to forgo moments of human connection for task-based care instead, such as helping someone to the bathroom or the dining room. In contrast to *phronesis*, Gadamer uses the Greek word *techne*, which the Greeks considered to be technical skills, or learned skills for the purpose of practice (Gadamer, 1960/2004). For a healthcare aide, *techne* are the skills and competencies they possess that can be repeatable across situations (Moules et al., 2015). Healthcare aides are not only forced to prioritize *techne* over *phronesis* but are also constrained by a lack of staffing and support that would allow them to respond to the uniqueness of each resident and each event of understanding. Despite this, healthcare aides also described their practice as being a kind of moral obligation to the resident, or a kind of duty:

> *These people, they need our help. So, I was going to come in every day and help them. So, I guess it was a moral obligation inside of me that said I had to go help. But I never saw it as that way, though. I never sat down and said, "why am I doing this?" But I guess, yes. It was something inside me that says these people need help. I'm going to help them.*
>
> *We didn't want to run away from our duty, we just want to do our responsibility to the resident as a personal support worker.*
>
> *You can't leave the patients unattended or unchanged just because they are on isolation or because it's COVID. As a healthcare aide, you have some duties and you have to fulfill them, you know, morally, and that's your job. You have to take care of them, yeah. You just have to follow the precautions and all the procedures, but you still have to do your work.*

Although the healthcare aides above described their care as fulfilling a duty to the resident and a moral obligation, this also presented a tension point, in the way healthcare aides had also described leaving dying residents alone, unattended and even soiled, as was revealed in part two and part three of this serialization.

As a practice discipline, healthcare aides must make sense of both learned technical skills and moral action within institutional settings with their own policies and agendas that influence the quality of care (Caputo, 2018). Although speaking about nurses, Caputo (2018) argued that the nurse may want to approach each patient as unique and to be responsive to the particulars of each case, however, they must also follow the policies or regulations set forth by the institution, even if it means doing an injustice to the patient. To ignore the policies or regulations of the institution, and instead do what would be for the good of the patient in a particular moment, would be at the risk of the nurse, such as possibly losing their job (Caputo, 2018). Not unlike that of nurses, healthcare aides must also balance the needs or well-being of their residents while toeing the line of institutional policies and regulations. However, unlike nurses who are likely in leadership positions in long-term care homes, healthcare aides have less autonomy and power to push back against the institution's demands:

> *To work in this field, people need to have a heart. Like compassion for the seniors. For me, it is not just a job. I really like to have compassion for that person. Because if that person is dying and she needs some water, I will go and give her water – even though I might get fired – and I'm not supposed to do that. That's one thing. You're not supposed to do that. Because if this person is on isolation, and I know I am not supposed to do what I need to do, what is right. As a healthcare aide, I cannot do what is right.*

In hermeneutics, a cultivation of self and reflection of practice is known as *Bildung* in the German, which Gadamer (1960/2004) described as "fulfilling one's profession wholly, in all its aspects" (p. 12). For Gadamer, this fulfilling of one's profession wholly is not simply to learn all that is necessary to become an expert, but to be changed by it, not only granting a universal sense about things, but changing how a person moves about in their practice (Gadamer, 1960/2004; Moules et al., 2015). As such, the healthcare aide who is open and ready for the situation ahead is one that is changed from the situations they have already encountered that demanded moral knowledge. From this ongoing cultivation of self, or *Bildung*, for Gadamer (1960/2004), Aristotle's claim of moral knowledge, or what is the right thing to do in a particular situation, is always contingent on human becoming. Meaning, the right thing to do at the right time is never the same, because in each new situation the person is never the same. If moral action is always made anew, and should therefore be in reach of the person engaging in the practice, therein lies the tension for healthcare aides caring for dying residents in the long-term care home during the pandemic: moral action was often not in reach:

> *And there was one time one of the resident's said, "I don't want you to do this" – there was something that was going on – "I want you to do what is right." And then I told him, "I can't do that, because I am following my management order and rules, if I don't do it, I won't have a job." And then he said, "but you always do what is right. Why don't you do what is right, right now? Instead of following orders?" And I feel so sad that I just walked away. I walked away and I went to the bathroom, and just started crying. Because honestly, I feel like the seniors' rights are being violated. And as the healthcare aide, we have no power to talk. We don't get any support if we want to say something that it might be a big problem, or I might get fired. And I don't want to get fired because I am the only one supporting my family.*

In consulting with the literature, two concepts that arose with powerful implications for the way healthcare aides had to prioritize *techne* over *phronesis* and were unable to do what was right for dying residents, were moral distress and moral injury. Well documented in the nursing literature, moral distress is what occurs when a nurse knows or recognizes something to be the right action (*phronesis*), but due to institutional constraints, is unable to act on their moral judgements (Lamiani et al., 2017; Lusignani et al., 2017), likely prioritizing *techne* instead. As was revealed by the healthcare aides' testimony above, the healthcare aide recognized the right thing to do for a resident, however still walked away from them, having to abide by what was called for by the social context of the institution, or by their fear of losing their job. Although moral injury is like moral distress in that it refers to committing or viewing acts that contradict one's ethical code, where it differs is in the feelings of betrayal that may be directed at persons in authority (Griffin et al., 2019). As I have explored so far in this paper, healthcare aides had to navigate a lack of staffing and support from persons in authority, all while fearing for their own safety, well-being, or missed pay due to sick leave.

Where healthcare aides often acted like ambassadors for the long-term care home, their testimony mediated by the institution in ways that served to hide the realities of death and dying during the pandemic (as discussed in part one of this serialization), this paper has revealed moments where this institutionally mediated testimony broke down. When healthcare aides' testimony revealed their experiencing of moral distress and moral injury, or described feelings akin to disappointment, frustration, and betrayal, they were no longer ambassadors for the facility but were instead healthcare aides who were unable to experience a cultivation of self in ways that come from fulfilling a persons' profession wholly. In his interpretation of nursing practice within institutions, Caputo (2018) said, "nurses don't get to leave the patients to their demons" (p. 223), as they are often the ones forced to make up for the limitations or inadequacies of the institutions to do what is right for the patient. This is perhaps untrue of healthcare aides' practice, however, them having left residents to their demons, letting them either die alone or in fear, and hidden in the shadows of the house. Left to make sense of their experiences as being a kind of moral distress or moral injury, and not being able to fulfill their profession wholly, healthcare aides are also haunted by demons, their lurking presence still whispering the painful memories of when they could not do what was for the good of a dying resident, and the times they had just closed the door and walked away.

Hiding in the Haunted House: Returning to the Status Quo and the Inauthentic: A Discussion

> 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. And they remind us that we have a choice: (a) to try to understand and accommodate our experience of strangeness, or (b) to repudiate it by projecting it exclusively onto outsiders. (Kearney, 2003, p. 4)

Many gothic novels about haunted houses echo the passage above, the telling of a ghost story often ending in either a reconciliation between the living and dead, or with the successful expelling of the ghosts that haunted the home. However, in some cases, the ghosts cannot be exorcized, and instead, are only banished to the shadows, slumbering, where they continue to linger and haunt. Not unlike a gothic story about a haunted house, the presence of ghosts, or a kind of strange Other, presented long-term care institutions and healthcare aides with a choice to make: a) better understand the strangeness of death and dying during the pandemic and accommodate it or b) cloak death and dying under the guise of ghosts that could be banished to the shadows, along with any responsibility of understanding their haunting. Through my conversations with healthcare aides, I had the sense that death and dying had not been better understood or accommodated, but had instead been banished back to the shadows, in that nothing had really seemed changed in long-term care in the years since the pandemic subsided. Furthermore, my working in long-term care as a registered nurse after the pandemic gave me first-hand experience of the ongoing inadequate staffing and limited support healthcare aides described, as well as the inconsistent and poor palliative care practices for residents. As such, the repeating of hidden institutional failures suggests that long-term care is a house that continues to be haunted, in its uncanniness, Freud (1919/2003) having argued that the uncanny is that which is repeated, or “something that has been repressed and now returns” (p. 147).

The Returning of the Institution to the Status Quo

Revisiting how healthcare aides’ understanding and experiences of death and dying during the pandemic took place within long-term care homes, I once again return to what Caputo (2018) wrote about interpretation within institutions:

> Events do not take place in mid-air; they happen in institutional settings. …So, everything depends upon how institutions interpret themselves and how institutions themselves interpret. (p. 220)

While the pandemic may have been a shock to the system of long-term care, the chaos and disorganization of death and dying also allowed for a moment of possibility, where the institution could choose to position itself as open towards the future, and a better way of doing things, based on the lesson learned and issues identified during the crisis. As I sit here writing the last paper of this serialization, however, I fear long-term care homes have not learned the valuable lessons that were taught during the pandemic, healthcare aides’ testimonies revealing an ongoing state of inadequate staffing and support. Instead, the long-term care home has returned to the status quo.

In its etymological origin, the phrase *status quo* means “the state in which before, state of affairs previous” (Etymological dictionary, n.d.). Despite the breakdown of their institutionally mediated testimony at times, healthcare aides were often positioned as that of ambassadors for the institution, speaking and caring on behalf of an institution that seemed more concerned with corporate interests and profit making than quality of care (as discussed in part one of this serialization). Serving as a potent example of how the institution currently seems doomed to repeat the lessons not learned during the pandemic, one only has to look to the recent changes made to Alberta’s *Continuing Care Act* (Government of Alberta, 2022).

The *Continuing Care Act* (Government of Alberta, 2022) serves as the legal framework for Alberta’s continuing care sector, namely long-term care, supportive living, and publicly funded hospice settings. Under the legislation of the *Continuing Care Act*, the *Continuing Care Regulation* (Government of Alberta, 2024a) serves to operationalize the law set forth in the *Continuing Care Act* through practical applications. The *Continuing Care Health Service Standards* (Government of Alberta, 2024b) are the legislated requirements long-term care homes must meet as “operators pursuant to the *Continuing Care Regulation* under the *Continuing Care Act* (Government of Alberta, 2024b, p. 3). Service standards, include, but are not limited to, clinical, service, reporting, and licensing requirements. Effective April 1, 2024, the *Continuing Care Regulation* no longer includes language that identifies a minimum number of hours of nursing care that must be provided to residents (Government of Alberta, 2024a, s. 46). Simply put, long-term care residents are no longer protected by legislation under the *Continuing Care Act* (Government of Alberta, 2022) that would guarantee their right to a minimum amount of care. In response to this change, the president of United Nurses of Alberta (UNA), Heather Smith, stated with concern, “So we are taking the care out of continuing care” (UNA, 2024). Previously, the *Nursing Homes Operations Regulation*

(Government of Alberta, 1985) stipulated that each resident should receive a minimum of 1.9 hours of direct care each day by a care provider, offering at least some protection for residents (s. 14(5)). Furthermore, recent recommendations for long-term care have called for an increase to 4.5 direct care hours per day to provide quality care to long-term care residents (Government of Alberta, 2021). The changes made to *Continuing Care Act* (Government of Alberta, 2022) are a move in the opposite direction then, and will threaten to worsen the already inadequate staffing levels in long-term care homes, and consequently, healthcare aides' ability to care for dying residents.

When I first heard about the upcoming changes the Government of Alberta was planning for the continuing care sector, I had immediately researched anything I could find about what these changes would be. I was relieved to find an upcoming informational session online, provided by Alberta Health and the Ernst and Young Group (a consulting firm responsible for the recommended changes). My hopes were quickly crushed when the session began, however, as it became clear the moderators were uninterested answering difficult or challenging questions. Frantically typing in the "chatbox," I asked the moderators what had prompted these changes to direct care hours, or what this might mean for quality of care, especially for dying residents. Knowing there were concerned family members of residents in the audience as well, I was disappointed when my questions went unanswered, and that the moderators failed to address the subject that likely brought many participants to attend the session: a concern for quality of care.

While I do not want to digress into the political landscape of current staffing issues in Alberta long-term care facilities, what I do think this brief discussion brings to attention is how the lessons about inadequate staffing have not been learned. Consequently, it seems that long-term care homes do not interpret themselves in meaningful ways above their bottom lines – as Caputo suggested they should – that would better prepare them for pandemic-level events in the future. Addressing this point, Dr. Carole Estabrooks said: "If your workforce is strained to the limit, then you really shock it with a major event like a pandemic, it can't possibly respond in an elastic way" (Johnson, 2023, para.10). The current Alberta government has promised that recent changes to the continuing care sector will ultimately strengthen the system and improve the quality of care (Government of Alberta, 2023). However, the ominous removal of protective language in the *Continuing Care Regulation* (Government of Alberta, 2024a, s. 46) guaranteeing minimum nursing care hours as a legal right is concerning. Furthermore, the testimony of the healthcare aide below would suggest that long-term care homes are doomed to return to pre-pandemic approaches to staffing, even after experiencing significant staffing shortages during the pandemic:

> *Healthcare Aide: They also reduce our hours. ...So, what does that mean? ...There are so many mistakes. ...They reduced the time for part-timers.*
> *Interviewer: Why did they do that?*
> *Healthcare Aide: They say they are short on budget.*
> *Interviewer: They were short on the budget, so they reduced the hours during COVID?*
> *Healthcare Aide: Well, during COVID, no. But they did as soon as COVID started getting better.*

In addition to staffing issues, healthcare aides described how they experienced inadequate support to care for dying residents before, during, and after the pandemic; the testimonies of the healthcare aides I interviewed echoing what is well known in the literature (Bergqvist et al., 2023; Laher et al., 2022; Titley et al., 2023). However, it remains unclear if sweeping changes will be made to long-term care homes that would increase support for healthcare aides, and if any steps will be taken to improve palliative care. For example, the new *Continuing Care Regulation* (Government of Alberta, 2024a) and *Continuing Care Health Service Standards* (Government of Alberta, 2024b) do not indicate any concrete changes that would hold institutions to account. According to the *Continuing Care Health Service Standards* (Government of Alberta, 2024b), where an operator provides palliative care, they must "establish, implement and maintain documented policies and procedures identifying what specific Palliative Care and/or End-of-Life care it provides," as well document such practices accordingly and allow providers access to necessary information pertaining to the palliative resident (p. 15). However, long-term care homes are known to not adhere to these practices, as was made evident in the Canadian Armed Forces (2020) report that investigated working conditions during the pandemic and discussed in part three of this serialization. Furthermore, it is unclear what the standards of palliative care or end-of-life practices are to be for long-term care homes, the *Continuing Care Health Service Standards* simply stating that "where" a long-term care home provides palliative care, they must create and document policies and resident care (Government of Alberta, 2024b, p. 15).

Considering that a significant failing of long-term care homes during the pandemic was their ability to implement and maintain adequate palliative care practices, it would seem both a uniform approach and specific standards are needed. However, the limited direction provided by recent government policy for palliative care in Alberta long-term care homes, as well the recent decentralization and increased privatization of such facilities, suggests that uniformity and consistency are unlikely. Consequently, healthcare aides' experiences with death and dying are likely to be repeated, an uneasiness remaining about a house that has once again banished death to the shadows.

There have been many eye-opening reports of how long-term care failed to not only care for dying residents during the pandemic, but care for all residents. In response to these failings, reports written by experts in long-term care have called for increased staffing and better support for healthcare aides (Armstrong et al., 2023; Estabrooks et al., 2024; Estabrooks et al., 2020; Graff-McRae, 2021; Lightman et al., 2021; Wylie, 2023), and transparency of palliative care practices that remain largely unknown (Estabrooks et al., 2020). While these reports may have discovered different failures in long-term care, and in different Canadian provinces, what these reports all have in common, is how they have all been tucked away, like books shelved in an old library, gathering dust in the dark; what had been awakened during the pandemic was now slumbering, and what had seemed unfamiliar and strange about death and dying was now familiar in its being hidden again. In the returning of things to the status quo, or the hiding of institutional failures in an ongoing game of hide-and-seek, I suggest healthcare aides are still stuck inside an oppressive house that has shaped their experiences and mediated their testimonies, unable to escape "something that has been repressed and now returns," or that which is the uncanny (Freud, 1919/2003, p. 147).

Returning of Healthcare Aides to the Inauthentic

In part three of this serialization, I explored how healthcare aides experienced a kind of fear regarding the death and dying that had occurred in long-term care homes during the pandemic, and how this fear, when understood as anxiety, spoke to that of an uncanny experience. Healthcare aides had described their confrontation with the unfamiliar death brought by the COVID-19 virus, but within the familiarity of a house where death, although hidden, had been all along. Considering the way death was something familiar, then, like a ghost that had long haunted the halls of the long-term care home, but also unfamiliar, as it was a new kind of death during the COVID-19 pandemic, I argued healthcare aides' experiences were taking place inside a haunted house, or an "uncanny house" (Freud, 1919/2003, p. 148). That which can be described as the uncanny, or *das unheimlich,* is something that, while once familiar, like death and dying in long-term care, has become unfamiliar, strange, eerie, or "un-homely" in a particular context, like the COVID-19 pandemic (Freud, 1919/2003, p. 124). Therefore, an uncanny experience discloses something about what is homelike yet secret, or known yet repressed, and is frightening in the way what was once buried becomes resurrected, and is capable of haunting (Freud, 1919/2003; Svenaeus, 1999). For Heidegger, the uncanny is not just that of the frightening, but is an existential kind of anxiety, for how it discloses to us our Being-in-the world, and makes us aware of our *potentiality-for-Being* and finitude, and thus, our authentic-self (Withy, 2021). In this section, I explore Heidegger's understanding of existential anxiety as an awareness of the authentic-self versus the inauthentic-self, and how this understanding tells us something about healthcare aides' experiences with caring for residents during, and in the years since, the pandemic.

According to Heidegger (1927/1962), moments of existential anxiety are what allows a person to realize they are burdened with the freedom to make choices, or their own authenticity, and as such, find themselves pulled from inauthenticity, or their inauthentic selves. Regarding the difference between authenticity and inauthenticity, Heidegger suggested that both are fundamental aspects of our Being-in-the-world, or that which he called Dasein:

> Inauthenticity denotes Dasein's every day way of Being-in-the-world. It is characterized by Dasein's absorption in its daily dealings and involvement in the world and its unquestioned following of the public realm (the 'they'), and in this sense, it also signifies Dasein's lack of clear understanding of its own Being. Authenticity, on the other hand, refers to Dasein's understanding the truth about itself and acting upon it. Authentic Dasein knows that it is a 'thrown project towards death' – that it is finite and must define itself. (Rowan, 2016, p. 88)

For Heidegger (1927/1962), the inauthentic is therefore what happens when we find ourselves fallen into a kind of "everydayness" (p. 69). In other words, as Beings thrown into the world, we also find ourselves subsumed with everyday patterns and ways of doing things, or the status quo. Although considering someone as inauthentic may suggest something of the negative, in how the world "inauthentic" might be used in current-day language, Heidegger (1927/1962) considered inauthenticity to still be a necessary mode of Dasein:

> The inauthenticity of Dasein does not signify any 'less' Being or any 'lower' degree of Being. Rather it is the case that even in its fullest concretion Dasein can be characterized by inauthenticity – when busy, when excited, when interested, when ready for enjoyment. (p. 68)

Therefore, my use of the word “inauthentic” to describe something about healthcare aides’ experiences is not to suggest a sort of failing on the part of the healthcare aide to be authentic, but instead to bring to light the reality of inauthentic experience, and the unchanging nature of long-term care.

Returning to that of the uncanny, and a sense of our being at home, yet not at home, Heidegger (1927/1962) argued that it is our “fallenness” into life as it is, and our “absorption in Being-with-one-another” that we find ourselves in the familiarity of our being at home (p. 176). In the way we have “fallen into the *world*,” Heidegger (1927/1962) considered this fallenness to be our inauthenticity, and as such, “a definite existential characteristic of Dasein itself” (p. 176, emphasis in original). However, in moments of existential anxiety, or that which jolts us awake from the everydayness or status quo, we are burdened with the knowledge that we have the possibility to make choices. For healthcare aides, this meant coming face to face with moments of existential anxiety presented by death and dying during the pandemic, and as such, becoming burdened with the knowledge of their freedom to make choices, and realize their own authenticity. As discussed in part three of this serialization, healthcare aides were no longer at home in their anxiety, the unfamiliarity of death and dying during the pandemic having reminded them of their potentiality-for-Being, but within the familiarity of the long-term care home.

As the testimonies throughout the papers of this serialization suggest, healthcare aides reflected on their experiences during the pandemic with authenticity, having described that which brought them, or their residents, face to face with their own finitude, or moments of “being-towards-death” (Withy, 2021, p. 37). However, healthcare aides also described how they had felt stripped of their choices, and how they had been unable to care for dying residents with practical wisdom or *phronesis*. While healthcare aides may have become aware of a more authentic way of practicing, having witnessed many horrors during the pandemic, they also described a lack of freedom in their caring for dying residents, and as such, experienced a sense of moral distress and moral injury. Consequently, healthcare aides’ practice was often only that of *techne*, or technical skills. Although healthcare aides described their practice as consisting of mostly technical skills, such as changing soiled linens or reposition a dying resident, they also described deeply caring for residents and even loving them (as was discussed in part two of this serialization). This tension, between how healthcare aides were unable to properly care for dying residents, and the kind of care and love they described having for residents, clearly had an effect on healthcare aides’ experiences and well-being, of which can be further understood through that of Heidegger’s understanding of care.

In his discussion of care and Dasein, Heidegger quoted the following ancient fable:

> Once when 'Care' was crossing a river, she saw some clay; she thought fully took up a piece and began to shape it. While she was meditating on what she had made, Jupiter came by. 'Care' asked him to give it spirit, and this he gladly granted. But when she wanted her name to be bestowed upon it, he forbade this, and demanded that it be given his name instead. While 'Care' and Jupiter were disputing, Earth arose and desired that her own name be conferred on the creature, since she had furnished it with part of her body. They asked Saturn to be their arbiter, and he made the following decision, which seemed a just one: 'Since you, Jupiter, have given its spirit, you shall receive that spirit at its death; and since

> you, Earth, have given its body, you shall receive its body. But since 'Care' first shaped this creature, she shall possess it as long as it lives. And because there is now a dispute among you as to its name, let it be called *'homo'*, for it is made out of *humus* (earth). (1927/1962, p. 242, emphasis in original)

What I think Heidegger wants us to understand from this fable, and with help from Scott (2014), is that the very nature of Being, or Dasein, is formed and shaped by that of 'Care,' and our understanding of the limited amount of time we have in life to be concerned with things in the world. Just as our spirit must one day return to Jupiter, and our body to the Earth, 'Care' is aware of our temporality, and as such, we have a sense of responsibility and urgency about that with which we concern ourselves. In other words, that which we care about is oriented towards the future in our potentiality-for-Being, and perhaps a better way of doing things or living with others in a finite amount of time. For healthcare aides, however, the kind of love they described having for residents (as discussed in part two of this serialization), comprises a practice that is at odds with an orientation towards the future. Consequently, healthcare aides are doomed to repeat old practices within institutions that have fallen back into a familiar way of doing things before the pandemic. To this point, healthcare aides often spoke about their experiences of caring for dying residents as being in a kind of tension with time, or temporality. Healthcare aides described residents who, because of their age, illness, or dying state, had limited time left to live, and described themselves as having limited time to properly care for them within institutional spaces.

According to Heidegger (1927/1962), our awareness of our Being-towards-death, or our temporality, is fundamental to what it is, or who it is, we care about: "*The primordial unity of the structure of care lies in temporality*" (p. 375, emphasis in original). Healthcare aides, however, found themselves influenced by the everydayness of institutional culture, and as such, felt themselves unable to disrupt the status quo from a position of relatively little power. Therefore, I argue, the institution not only shaped healthcare aides experiences with death and dying during the pandemic, but shaped their very nature of Being, through its ongoing influence on what healthcare aides are able to care about within a finite amount of time.

Although healthcare aides may want to care for dying residents with authenticity, their practice occurs within institutional spaces that limit their ability to care, or make choices, and consequently, shackles them to an inauthentic way of practicing. As many healthcare aides reflected in their interviews, and as was evident in the harrowing testimony shared by one healthcare aide earlier in this paper, healthcare aides had become aware of this shackling, and awake to the everydayness, or inauthenticity, of their practice. As such, healthcare aides had to exist in a state of anxiety or angst in their awareness of their being unable to care for residents:

> *I can still see so many things. I think maybe because of that, I have difficulty sleeping now. I'm not sleeping. ...After the pandemic – every day working, working hard, trying to sleep, trying to eat properly, get up on time, do my activities – but it is not the same.*

For the kind of anxiety or angst this healthcare aide seemed to be experiencing after the pandemic, Scott (2014) said: "*Angst* is something like a haunted spirit that seems to whisper, as though to itself, 'better take care … it's coming to pass … you come from nowhere … where are you headed … who are you?'" (p. 65, emphasis in original). These are the questions that some healthcare aides

I spoke with are perhaps still wrestling with in the years since the pandemic and likely wrestling with alone and without support. However, within the walls of the long-term care home, where healthcare aides remain still, the ghosts of death and dying that might have whispered such questions to healthcare aides are again being hidden in an ongoing game of hide-and-seek.

While the ghosts in the house have been concealed once again, healthcare aides are still positioned as ambassadors in the long-term care home, and their testimony institutionally mediated, in the way they have fallen back into inauthenticity, or the status quo, and only able to concern themselves with, or care about, the needs of the institution. Consequently, healthcare aides are unable to practice with authenticity, and in ways that limit their potentiality-for-Being. Instead, healthcare aides are haunted by their knowing that they *should* have the freedom to make choices about the care they deliver to residents, but, within the walls of a haunted house, cannot: "But since 'Care' first shaped this creature, she shall possess it as long as it lives" (Heidegger, 1927/1962, p. 242).

Closing Thoughts

In the first section of this paper, I have explored how healthcare aides' experiences with death and dying were influenced by the structural issues of the institution, namely inadequate staffing and limited support. In the way one healthcare aide had described searching for a nurse to care for a dying resident as being like a game of "*hide-and-seek*," I explored healthcare aides' experiences with death and dying using the metaphor of this childhood game. During the pandemic, healthcare aides described inadequate staffing and limited support like that of "seek," for how they had searched for additional staff or support, to no avail. Consequently, healthcare aides described how they had been unable to do what they felt was right for dying residents, and as such, seemed to experience moral distress and moral injury in their being unable to practice with practical wisdom, or *phronesis*.

In the second section of this paper, I explored how the returned hiddenness of the structural issues that healthcare aides had described was like that of "hide," the ghosts of death and dying having been cast back into the shadows. Considering how it seemed the institution had failed to make changes that would serve to improve the quality of care dying residents receive, and instead returned to the status quo, I argued the institution remains that of an uncanny house, where institutional-level failures are repressed, although recurring. I then explored how healthcare aides' experiences with the unfamiliarity of death and dying during the pandemic could be understood as a kind of existential anxiety, or authentic experience, as their anxiety disclosed something about their freedom to make choices, and their own finitude. However, healthcare aides also returned to a kind of status quo, having fallen back into a state of inauthenticity or everydayness in the years since the pandemic. As their institutionally mediated testimony revealed throughout the papers in this serialization, healthcare aides often concerned themselves with the needs of the institution, positioned as a kind of ambassador, instead of the needs of the dying resident. As such, healthcare aides seem doomed to repeat familiar practices, that at times are missing that of care, within institutional spaces that fail to understand not only healthcare aides' experiences, but to make meaningful changes that would improve the care dying residents receive.

In the years since the pandemic the curtains have been opened and the doors unlocked, and it seems the routine everydayness of what goes on in the house has drowned out that which would whisper to healthcare aides about their anxiety, or authenticity. In the familiarity of the long-term care home, or an unassuming, yet haunted house, healthcare aides find themselves falling back into the inauthentic, still playing a game of hide-and-seek among the slumbering ghosts of the house.

Note: The interpretations in this paper are contextualized to the Alberta long-term care context and the political and economic factors shaping the quality of death and dying care. While grounded in the Canadian and Alberta continuing care landscape, the experiences of healthcare aides described here are not unlike those of healthcare aides worldwide.

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