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Death, Dying, and Credibility in Long-Term Care: How Healthcare Aides Were the Voiceless Other During the COVID-19 Pandemic

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Abstract

Confronted by an unprecedented number of deaths in Long-Term Care (LTC) during the COVID-19 pandemic, society had no choice but to engage in a public discourse about the state of death and dying in LTC, and the staff who were caring for residents: healthcare aides. Despite being places where older adults die, death and dying has largely been hidden within LTC homes, serving to complicate and conceal healthcare aides' experiences at a time when LTC residents were visibly dying. Although being the subject of public discourse, healthcare aides remained voiceless during the pandemic, their experiences of caring for dying residents overlooked by the testimony of experts. Instead of healthcare aides being invited into a conversation to share their unique knowledge of death and dying in LTC, namely through that of touch and practical wisdom, they experienced a lack of epistemic credibility, having been served a testimonial injustice.

Keywords

healthcare aides, long-term care, death and dying, testimonial injustice, hermeneutic philosophy

For the first six months of the COVID-19 pandemic, the media was gripped by what was happening inside Long-Term Care (LTC) homes. A continuous news cycle reported climbing death tolls, family members standing outside of loved ones' windows, and military personnel deployed in their home country. Confronted by death and dying on an unprecedented scale,

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society had no choice but to engage in a public discourse about what was going on inside LTC homes, and the LTC staff who were caring for their residents. Similar to the way a child re-discovers a dollhouse long since outgrown and tucked away inside a closet, the roof was now being lifted off, the pieces pulled out, and those inside coming under close scrutiny in a shroud of controversy. The reclaiming of an old dollhouse with the potential for something new, yet familiar with childhood memories, is similar to that of *Aletheia*, the Greek philosophical understanding of "unconcealment, enlivening, and remembering" (Moules, 2015, p. 1). What was known by the public about the state of death and dying in LTC during COVID-19 came primarily from the testimony of experts, namely physicians, government officials, and those deemed credible in their opinion on the topic. This narrow selection regarding who was considered to have credibility to speak about LTC excluded the very people who could speak to something true of the experience of caring for residents at that time: healthcare aides.

Opposing *Aletheia* is *Lethe*, the river of forgetfulness and concealment that runs through the Greek underworld of Hades, its waters both foreboding and seducing for how we may either resist or welcome what can be hidden from us (Moules, 2002; Moules, 2015). Although the COVID-19 pandemic helped us rediscover LTC and consider long-standing quality of care issues, the absence of healthcare aides' voices from public discourse left us wading in *Lethe's* waters, having failed to uncover hidden truths about LTC that both complicated and concealed healthcare aides' experiences and testimony. The hidden truth is, that while there may be a common social knowledge that LTC is a place of death and dying, as was brought to light by the COVID-19 pandemic, this remains largely unspoken within LTC homes. Thus, to better understand healthcare aides' voicelessness during COVID-19 is to better understand death and dying in the LTC context, as healthcare aides' villainization in public discourse was directly related to the accelerated rates of death and dying in LTC homes. In this paper, I explore how the LTC context has shaped, concealed, and marginalized healthcare aides' experiences, and how LTC homes, being places of death and dying, also experience a kind of marginalization and voicelessness within society, making healthcare aides an invisible population in a largely invisible place.

Hans-Georg Gadamer (1960/2004) argued that if we are to understand the testimony of the other, we must maintain an openness and vulnerability about us, ready to put our pre-understandings at risk. Instead of openness and vulnerability in public discourse or from persons in authority, however, healthcare aides were the recipients of harmful misunderstandings, these misunderstandings or the willful refusal to grant them credibility having served to de-voice and marginalize them as less powerful others (Fricker, 2007). I make the claim that healthcare aides have been served what Miranda Fricker (2007) characterized as a testimonial injustice, having been wronged in their "*capacity as a knower*" of death and dying, their voices absent from public discourse and their experiences misunderstood, if understood in any way at all (p. 20, emphasis in original). Approaching this topic through the lens of testimonial injustice will allow me to better understand what it is about the LTC context that has fueled healthcare aides' experiences, and the unique kind of knowledge healthcare aides have that has granted them less epistemic credence as knowers of death and dying in LTC.

In the first section of this paper, I will explore the historical and social conditionedness of LTC as an institution, or its social epistemology (Goldman, 2020), turning to Gadamer's (1960/2004) concepts of history and tradition to shed light on the tension that exists between how society understands death and dying in LTC with how it is understood within the institution itself. In the second section of this paper, I will consider the ways healthcare aides have been granted less credence in their understanding of death and dying due to their knowing falling within the remit of a practical knowledge, or one of the senses, namely, touch, and in ways that are socially mediated by the LTC context. To make this connection, I turn to Richard Kearney's work on carnal hermeneutics and briefly Gadamer's concept of *phronesis*. Finally, I will bring this topic forward into the context of the COVID-19 pandemic, bringing attention to the ways in which healthcare aides were left out of the public discourse about COVID-19 in LTC, despite being the subject of much conversation and debate in the media.

Testimonial Injustice, Prejudice, and Power

To understand testimonial injustice, we must first understand epistemic injustice as the "forms of unfair treatment that relate to issues of knowledge, understanding, and participation in communicative practices" (Kidd et al., 2017, p. 1). In all its various forms, epistemic injustice "wrongs a knower as a knower" (Pohlhaus, 2017, p. 14), in a way that is "harmful but also wrongful, whether because discriminatory or otherwise unfair" (Fricker, 2006, p. 97). Fricker (2007) argued there are two kinds of epistemic injustice: testimonial and hermeneutical, the distinction between the two hinging on whether language is shared or not. In the case of hermeneutical injustice, there is a "hermeneutical lacuna," where the absence of shared language places some people at a disadvantage when trying to make sense of their experiences with others (Fricker, 2006, p. 98). I argue healthcare aides in LTC already possess the language with which to understand their experiences with death and dying during the COVID-19 pandemic, and have instead experienced a kind of voicelessness, their testimony falling outside the realms of meaningful epistemic consideration both within and outside of LTC homes. Testimonial injustice, then, is a kind of epistemic discrimination, where those who experience a credibility deficit do so because of the prejudices others have toward their social identity, in ways that cannot be chalked up to innocent misunderstanding (Fricker, 2007).

In their use of the term prejudice, Fricker (2007) considered prejudice to be "ethical poison in the judgment of the hearer" (p. 22), which may resonate with many, as it so concisely conveys the negative meaning of the word. Fricker's use of prejudice to make sense of testimonial injustice is not to be confused with the way Gadamer used the term prejudice, however, as "simply that condition in which we at first experience something" (Risser, 1997, p. 68). This is not to say that Gadamer (1976/2008) implied we are not capable of holding ourselves accountable to our prejudices or exercising sensitivity, having argued, "we welcome just that guest who promises something new" (p. 9), but that we revitalize prejudice as having a positive value when we allow our prejudices to be changed through dialogue with the other (Nielsen & Utsler, 2023). The kind of prejudice about which Fricker is concerned, however, is one that is not open to dialogue, is rife with misunderstandings, and is closed off from what the other has to say (Nielsen & Utsler, 2023).

According to Caputo (2018), "Events do not take place in mid-air; they happen in institutional settings. There is almost nothing outside institutional contexts" (p. 220).What is of interest in this paper, then, is not how individual social agents may be considered perpetrators of epistemic injustice, more themselves “the vehicles of power,” but how the institution of LTC as a social system wields a kind of social power that is held above and over healthcare aides in ways that are deeply structural (Foucault, 1972/1977, as cited in Fricker, 2007, p. 11). Prejudices against healthcare aides’ social identity are not held by one particular agent, but instead are structural operations of power that “create or preserve a given social order” (Fricker, 2007, p. 13). We can think of registered nurses and licensed practical nurses (both will be referred to collectively as nurses from this point on), physicians, and healthcare aides as social agents, all operating in an epistemological social hierarchy of sorts that places healthcare aides at the bottom.

Fricker (2007) argued that the most harmful forms of testimonial injustice are those that stem from systemic social injustices, a person's identity prejudices having followed them throughout different social activities. Healthcare aides are a marginalized population both within LTC and broader society, often belonging to ethnic minorities, being predominantly female, and being the lowest paid healthcare workers in Alberta (DePasquale et al., 2016; Duan et al., 2020; Estabrooks et al., 2020; Lightman et al., 2021; Statistics Canada, 2021; Turcotte & Savage, 2020). Although healthcare aides experience an intersectionality of social inequalities, experiencing both marginalization and a lack of social support in the community and the LTC context, this paper will focus on how LTC institutions yield a kind of social power that disarms healthcare aides as credible knowers of death and dying, while acknowledging their testimonial injustice as traceable to systemic structural identity prejudices.

A Social Epistemology of Death and Dying in LTC

In order to better understand what was complex and concealed about healthcare aides’ experiences during the COVID-19 pandemic, and the ways they experienced a testimonial injustice, I must first explore how LTC as an institution has been concealed and marginalized within society, as well the hiddenness of death and dying within it, or its social epistemology. Broadly, social epistemology can be characterized as the ways in which knowledge, beliefs, and judgements are socially constructed and conditioned within communities (Fricker et al., 2020). At the 13th annual Canadian Hermeneutic Institute conference, Dr. David Vessey (personal communication, June 1, 2022) argued that social epistemology is the bridge by which we might connect Fricker’s (2007) work on testimonial injustice with that of Gadamer’s philosophical hermeneutics, namely history and tradition, and to whom I extend my deepest gratitude, as well to the other attendees of the conference for the meaningful conversations that took place there.

“Over the hill to the poor-house I’m trudgin’ my weary way / I, a woman of seventy, and only a trifle gray” (Carelton, 1872, line 1). According to Gadamer, our very understanding of LTC is one in which history is operative, this understanding only made possible from within the tradition in which we already find ourselves (Gadamer, 1960/2004), tradition being “that which is handed over” to us (Vessey, 2022, p. 117). As the descendent of 19th and 20th century poor houses and almshouses (charitable institutions), LTC has a long history of filling a space in society that has not been well understood, its purpose handed over to us in ways that are socially reconstructed to fit the needs of society at the time (Estabrooks et al., 2020; Mah & Gallup, 2021). Historically in Canada, the eldest son in each family was expected to care for their parents as they grew older, and ensure appropriate and suitable living accommodations (Estabrooks et al., 2020; Mah & Gallup, 2021). If not afforded housing by family, older adults were subject to

Elizabethan Poor Law and sent to live their final years in poor houses, where it was understood they were no longer a person of value in society, being of lower class, and without means to pay for room and board were expected to work until they were too frail or until they died (Mah & Gallup, 2021). The movement of people into cities during 19th century industrialization resulted in increased numbers of older adults requiring shelter, and government began to problematize these older adults as “destitute, ill, and dependent,” ageing considered an issue of poverty (Montigny, 1997, p. 29). As a consequence, older adults were not only sent to live, and die, in poor houses, but insane asylums, and even prisons, as if growing old was a crime to be punished (Montigny, 1997). In late 19th century Ontario, for example, the rhetoric from institutional administrators, government, and the media at the time suggested institutionalized older adults were mere “decrepid [*sic*]” and “decaying” beings, destined to die in the streets if not for the institutions forced to take them in (Montigny, 1997, p. 29). In its origins, LTC is the latest manifestation of an answer to the ongoing question of the worth older adults have in society, and where people should go to die.

In the early 20th century, federal and provincial governments attempted to better support older persons to remain in the community with the introduction of pension payments, assuming that if people were financially prepared, they could avoid being institutionalized (Mah & Gallup, 2021). As such, ageing was becoming socially understood as an issue that should fall on the shoulders of the individual, and not society as a whole, effectively acquitting the federal government of having to claim responsibility for institutionalized older adults. For families who could afford it, the proliferation of private institutions in the early 20th century were seen as a preferable alternative to the public institutions that were poorly funded and poorly regulated by government (Emodi, 1977). LTC homes have since become increasingly privatized in Alberta, which is arguably constitutive of Canada's liberal welfare regime, and of the way market forces are encouraged to address social welfare issues (Béland et al., 2020).

Despite the advancements that would eventually be made for a universal publicly funded healthcare system in Canada, LTC remains outside the Canada Health Act (1985), and without regulation by federal government. LTC not falling under the Canada Health Act has been emblematic of the ways in which society has been conditioned to think of LTC as a place not demanding complex nursing skills, adequate resourcing, safe staffing levels, or the attention of research. Near the bottom in the hierarchy of healthcare, LTC is perceived as being a place of little technology, expertise, or curative medicine, stigmatized as simply custodial care for the old and dying. A lack of both federal government regulation and sense of public responsibility toward the care of institutionalized older adults has arguably meant limited funding and consistency of research across Canada (Canadian Healthcare Association, 2009). As “traditioned-beings who inherit various prejudices, customs, and practices” (Nielsen & Utsler, 2023, p. 64), it would seem that we have inherited a social collective knowledge that LTC is a place of little value, yet it continues to fill an essential need in society in the absence of community supports and government-supported home care options (Sinha et al., 2019).

While LTC is projected to become home for over 600,000 Canadians by the year 2031 (Deloitte, 2021), most older adults consider LTC a place to avoid at all costs, especially in the aftermath of the COVID-19 pandemic (Feil et al., 2021; Iciaszczyk et al., 2021), suggesting that many will not consider LTC to be home, even if they end up living and dying there. If residents do not consider LTC to be their home, does this mean they consider themselves only house guests? In this case, LTC homes, and subsequently healthcare aides, could be considered the hosts, as older adults who are required to move to LTC give up a sense of power and authority in exchange for hospitality. Of Dausner's (2018) account of conditional versus unconditional hospitality, Kearney and Fitzpatrick (2021) wrote, "many hosts never fully relinquish 'control' or 'power' over the situation—cautiously keeping guests at a distance, despite letting them into their house" (p. 5). We could, perhaps, think of LTC residents as the recipients of conditional hospitality, where residents are not guaranteed the right to stay, and behaviors considered "poor" would make them unworthy houseguests (Kearney & Fitzpatrick, 2021). Clearly, LTC being a place of exchange of goods and services is unlike the kind of virtuousness inherent in true hospitality, however, I argue this line of thinking brings attention to how residents may feel: like guests in a home they never wanted to stay at in the first place, in a place society, in general, wants to avoid.

While the marginalization of the older adult population in society has also contributed to a gap in our understanding of death and dying in LTC, Gadamer would argue that modern society has long been inclined to deal with "the very ungraspability of death" by systematically repressing it (Gadamer, 1993/1996, p. 63). Consequently, LTC as a place of death and dying becomes further marginalized in a society that is socially conditioned to repress death. About the increasing hiddenness of death in society, Gadamer (1993/1996) argued that "modern civilization eagerly and enthusiastically seeks to bring this tendency to repression which is rooted in life itself to institutional perfection and so to push the experience of death wholly onto the margins of public life" (p. 65). Namely, the ways in which society has been incapable of confronting death, it has become increasingly institutionalized, away from the domestic life of family, and in this institutionalization, becomes but a shadow we are left to wrestle with alone; "We portray death as the robber of life, a phantom cloaked in black that waits in darkness to descend upon its victim. We would like nothing better than to sweep the streets clean of all suggestions of our morality" (Smith, 2016, p. 113). No place is this sweeping of death from the streets more apparent than in the institution of LTC, where despite the expectedness of death, it is hidden away from the residents who are both living and dying, as well those who provide them with care.

Needing to overcome a long history of being a place where people went to die in deplorable conditions, LTC homes have been working to convince people that LTC is, in fact, a place older adults want to be. Names of LTC homes such as, Golden Years Long-Term Care (https://peoplecare.ca/long-term-care/golden-years/), and Better Living at Thompson House (https://mybetterliving.ca/long-term-care/), speak to a focus on quality of life, and very few LTC homes have any mention of palliative care services, or their philosophy towards death and dying. With the increasing privatization of LTC homes in Canada, it cannot be overlooked that homes are competing with each other for the business of older adults and their families, the perpetuated culture of quality of life over quality of dying therefore embedded within corporate interests and profit making. One administrator of a LTC facility told Cable-Williams and Wilson (2016) about their concern with presenting the reality of death and dying in marketing LTC to the public: "I can imagine that families wouldn't be too excited about that – oh yeah, we're taking Dad to die" (p. 7). In an attempt to be brought back from the margins of social life, it would seem LTC homes want to shake off the cloak of death, and with it, the epistemic privilege that should be granted to healthcare aides who are directly caring for those who are dying.

Cable-Williams and Wilson (2016) also attributed the hiddenness of death and dying in LTC, in part, to the culture within LTC homes, and the commonly held social belief among staff and administrators that LTC is not a place for dying but a place for living. This belief, they argued, manifests itself in practice, for the ways in which palliative care is not often considered until the final few days, or even hours before a resident's death. Palliative care practices are therefore more of a reaction to the unexpected inevitable than a guiding philosophy in LTC institutions. For example, the Director of Care for a LTC facility told Cable-Williams and Wilson (2016), "People don't understand long-term care - it's about care and living. It just happens that probably 95% of people do end up taking their last breath here" (p. 6). Eager to get away from the stigma of LTC being a place people go to die, healthcare aides may not associate their practice with death and dying or that of palliative care, even feeling it may be disrespectful, ageist, or neglectful to acknowledge the reality of death (Cable-Williams & Wilson, 2016). As a nurse, the culture of LTC being a place for the living and not for the dying is one that I have often experienced myself.

Walking into the room of a resident deemed palliative by the physician that morning, I could hear the Cheynes-Stokes breathing, the sound of rapid breaths between moments of silence. Upbeat music was drifting in from not far down the hall, the voice of the recreation therapist shouting, "Come on everybody, let's liven this place up!" Otherwise, her room was quiet. I pressed a damp cloth to her forehead while I checked her breathing. Wishing I could sit with her longer, I squeezed her hand before walking out of the room again, already behind on administering medications and completing paperwork. I walked past the dining hall, the music now louder, and took in the sight of the other residents. All seated in their wheelchairs, they were waving their arms in the air, shaping out the letters Y-M-C-A, unaware of the person taking their final breaths just down the hall. The healthcare aides were already busy, assisting more residents into the dining hall or helping others eat their supper, and I knew it would be hours before a healthcare aide would have time to provide care to our palliative resident. It was as if she no longer had a place, her dying an unexpected disruption to the routine of daily care, and beyond the limits of what healthcare aides could feasibly accomplish in an eight-hour shift.

What I have shown in this section, however briefly, are some of the ways in which history and tradition has socially shaped the institution of LTC in such a way that it holds a marginalized position within society, the reality of death and dying repressed within it. The barriers healthcare aides face when caring for those who are dying in LTC, such as unsafe staffing levels, heavy workloads, insufficient training and education, and inadequate resourcing (Cloutier et al., 2021; Giesbrecht et al., 2021; Hanson & Henderson, 2000; Knopp-Sihota et al., 2015; Mather & Bakas, 2002; Schell & Kayser-Jones, 2007; Song et al., 2020; Touhy et al., 2005; Unroe et al., 2015) are tethered to this origin story of LTC, these barriers like moveable beads on a thread that is being woven throughout history, giving us a way to look back to understand the present. To now support my claim that structural inequalities in LTC homes have led to healthcare aides experiencing a testimonial injustice, I inquire into *what* it is that healthcare aides understand about death and dying, *how* it is that they understand it, and *why* this kind of knowledge has been, and still is, perceived as less credible within institutions.

Carnal Hermeneutics and *Phronesis*

Of the wisdom or tact we are granted through our senses, Kearney (2015a) wrote, “When we say that someone *sensible* is someone *sensitive:* they have ‘the touch,’. … by extension, they have the eye, the ear, the nose. They are attentive, tentative, in touch with things” (p. 16, emphasis in original). The practice of healthcare aides is one that is constitutive of the senses, namely touch; the holding of someone's hand, bathing or feeding them, requires a sensitivity or attentiveness to the body of the other, a kind of sensory know-how or understanding of themselves as embodied interpreters. For Kearney (2015a), sensation *is* interpretation, where one is “constantly *reading* flesh, *interpreting* senses, and *orienting* bodies,” or what he characterized as being the task of carnal hermeneutics (p. 17, emphasis in original). The majority of care that healthcare aides provide to dying residents is of the physical kind, even psychosocial care being largely expressed through physical touch (Estabrooks et al., 2015; McCleary et al., 2018; McClement et al., 2009; Thompson & McClement, 2019). For many older adults in LTC, the march of time has impaired their senses of hearing, sight, smell, and taste, as well they are often afflicted by the challenges associated with cognitive changes that have been found to be exacerbated by sensory impairment, such as dementia and Alzheimer’s disease that make engaging in spoken language more difficult (Banovic et al., 2018; Fischer et al., 2016). Touch remains a conduit for healthcare aides as a way of understanding something about residents that otherwise may have remained unintelligible, for “without the sensitivity of touch–bare-skinned and fragile–there would be no resourcefulness of tact” (Kearney, 2021, p. 43). Many times I have witnessed healthcare aides’ use of touch bringing forth emotion from dying residents that is telling of their well-being: a well-positioned hand on the shoulder of a resident who is dying alone bringing tears of being seen, or brushing a resident’s hair bringing a smile of gratitude. Of the kind of understanding that is granted only through touch, Kearney (2015a) argued that we mediate the otherness of who it is that we touch, “crossing back and forth between self and strangeness” (p. 20), a back and forth that connects us with the other and a shared sense of what it means to be human in a community with others.

Although I turn to some of the writing on carnal hermeneutics as a way to explore this kind of understanding I argue healthcare aides have about death and dying, I want to make clear that I am not entering into any kind of hermeneutic wager on the primacy of either sensation or language for epistemological understanding. While Kearney (2015b) wanted to rehabilitate carnal hermeneutics from what he argued was “an embrace of language at the expense of body” (p. 100), I avoid this debate, and instead seek what may help strengthen my claim that healthcare aides experience a credibility deficit.

The word tact is derived from the Latin word *tactus,* meaning “a touch, handling, sense of touch” (Online Etymology Dictionary, n.d.). While I focus on touch as being that of a tactile sense in order to draw attention to the differences in healthcare aides’ practices from that of nurses or physicians, Kearney (2021) argued that touch, “precisely as tact, it traverses all the senses” (touch, sight, smell, hearing, and taste) (p. 16). Having a sense of sensitivity and sensibility in practice involves a kind of synesthetic communion of all the senses through tact, or as having carnal wisdom (Kearney, 2021). For Gadamer (1960/2004), tact also involves a kind of distance, where in what is said tactfully, someone also leaves something unsaid, that if expressed, would be tactless. Touch also requires this kind of distance; to have a sense of tact, healthcare aides have to make judgments about when and how to use touch with their residents, a judgment that cannot be known ahead of time. In nursing practice, Moules (2022) argued that "Tact truly is an art of special and knowledgeable sensitivity and of being willing to recognize and receive difference, otherness, and sometimes even warnings" (p. 378). For the healthcare aide who practices with tact, they must act with attentiveness and sensitivity, which I argue is largely expressed through their use of touch.

Not all touch in healthcare aides' practice is tact, however. Kearney (2021) argued that tact is not synonymous with contact, but is instead having a way with others, putting ourselves at risk and in question in order to understand. In other words, "Being tactful here means being sensitive in our behavior with others, listening and responding to the other in a responsible way" (Kearney, 2021, p. 11). Faced with understaffing and highly routinized care, healthcare aides are systematically forced by the institution of LTC to forgo the kind of touch that would require tact and sensitivity, and instead are groomed to be the masters of technical skills that are simply the means to an end for dressing, feeding, and bathing residents. Tact takes time, and in the absence of time due to structural barriers, healthcare aides would be pressured by the institution to distance themselves from practicing with tact, instead having to become more mechanical in their delivery of resident care. In this environment, changing someone in bed or feeding someone in a busy dining hall can be reduced to a tactless use of touch that is not responsive to the needs of the other; "So there is touch and touch. And tact knows the difference" (Kearney, 2021, p. 11).

The kind of knowledge healthcare aides are granted through touch that is tactful is one that arises in the singularity of each case, requiring more of an "experiential *knowing-how*" than a "*knowing that*" of residents who are dying (Alloa, 2015, p. 200, emphasis in original). This experiential knowing-how is a practical knowledge, where judging the right thing to do cannot be known outside of what is concrete, requiring a sensitivity and flexibility toward a practice that is constantly being made anew (Moules et al., 2015). Practical knowledge is a kind of practical wisdom, or that of *phronesis* (Gadamer, 1960/2004), and when it comes to touch, a carnal wisdom of tactility (Kearney, 2021). In practical wisdom there is also self-understanding, a healthcare aide having to deliberate with themselves on what the right thing to do is in each concrete case, making each new event of understanding met by a changed self in its application (Gadamer, 2001). A practice of touch is inherently an ethical practice, Kearney (2021) having argued, "Tactile sensitivity involves moral sensibility–the combination of both implying tact" (p. 44). The healthcare aide who practices with tact, then, is one who knows such things as empathy, responsiveness, compassion, and trust through their use of touch, a practice I have witnessed often in LTC.

At the bedside of a resident who was recently deemed palliative, I stood across from the healthcare aide as I removed the oxygen from the resident as per the physician's orders. "She is not dying, not yet. Feel her feet," the healthcare aide said to me, lifting up the blanket so could I wrap my hands around the bottom of the resident's foot. "See, still warm," they said, then began to gently apply lotion to the resident's feet, massaging as they did so.

Having touched the resident to know something about circulation, it was clear this use of touch had warranted an act of reciprocity, the healthcare aide having the moral sensibility to provide the resident with comfort in that moment, their practice being that of tact. While one does not obviously see warmth in the way one feels it, I had been struck by the healthcare aide's likening of "seeing" to that of understanding, and what Kearney (2015a) wrote about Plato's consideration of sight as more noble a sense than that of touch: "of all the senses, sight was deemed the most theoretical in that it allowed for the most distance and detachment" (p. 24). The healthcare aide's use of the word "see" for having knowledge of something is fitting with Plato's articulation of sight as standing the closest to intellect of all the senses. Touch, on the other hand, Plato considered to be an unmediated sense, furthest from that of intellect, and "helpless before the flux of things," (Kearney, 2015b, p. 103). The perception of touch being that of a lowly sense still carries weight for the ways in which society perceives the testimony of healthcare aides who carry out their work largely through that of touching bodies.

In my experiences in LTC, physicians and nurses often only touch the bodies of residents in limited ways, most often done so as a way of informing theoretical or scientific understanding, diagnosing, predicting prognosis, or treating clinically. A nurse in LTC may place a hand on the forehead of a dying resident to sense temperature or provide comfort, or clean a pressure ulcer wound, but it is the healthcare aide who comes into contact with the bodily fluids and excrements of someone who is dying, experiencing the gritty realities of the bodily processes that take place during death. A nurse or physician in LTC must therefore rely on the healthcare aides for the kind of knowledge that comes only from touching and being exposed to the whole body. Although the surgeon may touch the whole body, their hands inside bodily cavities and in contact with bodily fluids, their touch would be different than that of the healthcare aides (G. McCaffrey, personal communication, June 23, 2022), often mediated by highly technical equipment, and for the purpose of treating and informing theoretical or scientific knowledge (L. Venturato, personal communication, June 29, 2022). Because the surgeon possesses the language of science and knowledge that comes from specialized and technical training, they are free from any negative stigma associated with their use of touch, esteemed in society as credible knowers of their patients and placed in positions of authority. As is the medical examiner, who, despite touching the bodies of dead people, something considered to be taboo in many cultures, is granted epistemic privilege due to their ability to explain bodily processes and causes of death scientifically. Conversely, healthcare aides' use of touch to know and understand LTC residents gives them a credibility deficit, and no position of authority, suggesting that it is not the touching of bodies that is stigmatized, but *how* bodies are being touched, *what* is being touched, and *who* is doing the touching.

Going back to the historical roots of nursing, touching the bodies of those who are sick and dying has long been problematic for women who were first looking for work outside of their father or husband's home. Where nursing was considered to be "impure" or "dirty" work, women were seen as having a kind of moral and physical contamination in their having to touch sickness, disease, poverty, and in the nineteenth century, largely that of men's bodies (Gordon & Nelson, 2006). To overcome this social stigma associated with touching strangers' bodies, and an overt sexualization that arguably still exists today, nurses sought the protection afforded by religion, and the ways in which nursing could be considered virtuous work, or a kind of calling laden with altruistic values (Gordon & Nelson, 2006). Perhaps responding to what the physician's practice was not, nursing practice was tightly interwoven with feminine ideals or expectations of caring, nurses serving to soften the hand of the physician, and to care for the patient as a whole in ways beyond medical diagnosis and treatment. Working under the physician who was considered to be the intellectual authority on all matters of the patient, nurses who wanted to avoid being a threat to the physician's knowledge domain had to stay in their own epistemic lane, surrendering any claim to being that of credible knowers of human anatomy or bodily processes (Gordon & Nelson, 2006). Instead, they had to claim their unique knowledge solely on the grounds of moral authority (Gordon & Nelson, 2006).

While touch has since been pulled from its relegation as the most inferior of the senses philosophically, notably beginning with Aristotle and his articulation of the primacy of touch for interpretation and a sense of wisdom, tact, and moral sensibility (Kearney, 2015a), touch is still perceived as a less credible way of knowing for nurses in medical institutions, and even more so for healthcare aides in LTC. Rather, theoretical knowledge, that which is distanced from practice, is often perceived to be at the top of an epistemological hierarchy of sorts in healthcare, denigrating practical ways of knowing deemed subjective to the bottom, especially that of touch (Risjord, 2006). In recent years, nurses have been fighting for the epistemic credence that comes from scientific nursing knowledge, the developments of evidence-based practice and high-level nursing theory being clear indicators of this pursuit (Risjord, 2006). Although these developments have been positive for the profession in many ways, nurses may end up relinquishing their claim to touch as being a unique kind of nursing knowledge, or as having a sense of tact, having to operate within institutions that favor quantifiable and performance-driven outcomes. Whereas nursing practice is becoming increasingly distanced from having to touch residents, healthcare aides' practice has been socially constructed within institutions as being only that of objective skills, or *techne*, reducing healthcare aides' knowledge to that which is learned, repeatable, and does not require moral knowledge (Gadamer, 1960/2004), or carnal wisdom (Kearney, 2021).

As a consequence of what I have discussed so far, healthcare aides, whose knowledge is largely constituted by that of institutionally mediated touch and practical knowing, are the ones left most significantly navigating the credibility deficit that has plagued nursing practice since its origins. As a nurse in LTC, I have experienced blatant instances of LTC being structured in ways that are epistemically unjust, and observed, as well participated in, practices and social norms that prevent healthcare aides from being given the epistemic credence in which to offer valuable knowledge about residents who are dying.

One such instance took place during the first care conference I attended in LTC, where my role as the registered nurse was to provide the care team and family members with an update on the status of a resident who was on the verge of death.

Having only met the resident that morning, I read aloud a summary of the resident's documented care. What I shared however, was not what the family, or what the other members of the care team, for that matter, really wanted to know. "Do you know how my father's spirits are in the morning before I arrive?" I did not know. "Do you know if the resident seemed more nauseated this morning than yesterday morning?" I did not know. "Do you know the time it takes for my dad to fall asleep each night after I leave to go home?" I did not know.

What the care team and the family wanted to know was only what the healthcare aides intimately knew, and what was not captured in the reports received by the nurses, or in scientific or medical knowledge. In a care conference that included a pharmacist, nutritionist, physician, rehabilitation therapist, social worker, and registered nurse, the only staff member who knew the resident better than all the rest had not been invited. The next time I crossed paths with the facility care manager I asked why healthcare aides were not invited to resident care conferences, to which I was told it was not feasible to spare a healthcare aide from the demands of the unit. It was clear that healthcare aides lacked epistemic entrée into the places where their knowledge was dismissed as being merely technical, and not possibly transferable from that of the bedside to that of a conference table.

Healthcare aides are experiencing a kind of epistemic exclusion (Hookway, 2010), being systematically overlooked by the institution, their practical knowledge and testimony of death and dying not credible enough to be formally recognized. What is of significant harm to healthcare aides is how this exclusion and lack of recognition may result in what Fricker (2006) considered to be the epistemic loss of intellectual character. Fricker (2006) argued that "intellectual virtue is not reducible to the value of those particular items of knowledge it might bring, but derives also from its place in the harmony of a person's intellectual character taken as a whole" (p. 105). Although Fricker was referring to the harms resulting from hermeneutical injustice, the concept still arguably applies in this context for that of testimonial injustice. The healthcare aide whose testimony is deemed less credible and is therefore excluded from participating in knowledge-making activities, such as care conferences or even education or training initiatives, is also harmed by their not being able to develop intellectual virtues, namely that of intellectual courage by way of epistemic confidence (Fricker, 2006). This means healthcare aides may begin to internalize their credibility deficit and not trust their knowledge, possibly resulting in a lack of courage to participate in conversations with residents and family members about death and dying, delegating these conversations to nurses instead.

Fricker's intellectual character could be considered akin to that of Gadamer's (1960/2004) *Bildung*, namely the cultivation of self in one's professional practice. In the same way a healthcare aide may suffer from a lack of epistemic confidence and intellectual courage, the healthcare aide who cannot fulfill their "profession wholly" is one who cannot be changed by their practice or granted a universal sense about death and dying (Gadamer, 1960/2004, p. 12). It is only through an ongoing cultivation of self that each situation demanding moral knowledge or *phronesis* is always made anew, the healthcare aide able to be changed by their practice, and their practice able to be changed (Gadamer, 1960/2004). For Gadamer (2001), *phronesis* "has the character of a conversation" (p. 79); while healthcare aides are not spared from having to make individual judgments about the right thing to do in their practice, they make these judgments within a social context that is mediated in dialogue with others (Gadamer, 1960/2004). Instead of healthcare aides being credited for their experiential know-how of death and dying, however, and the knowledge they have through touch, they are instead often excluded from conversations and dialogue with others. I argue this exclusion is a kind of testimonial injustice for healthcare aides, the resulting harm being that their intellectual character suffers, and they are denied a kind of self-understanding in their work that is harmful.

Testimonial Injustice and the COVID-19 Pandemic

Reflecting on the impacts the COVID-19 pandemic had on touch, Kearney (2021) wrote, “Touch is never so obvious as when confronted with its opposite—the untouchable. The imperative of social distancing, mandated by the coronavirus, made us acutely aware of how central touch is to our lives” (p. 133). At a time when the world stopped hugging, shaking hands, or kissing loved ones, healthcare aides in LTC went on touching, caring for LTC residents at a time when family could not physically be present. Healthcare aides became a kind of conduit for the touch of others, standing in for family members deemed “non-essential” during times of visitor restrictions and lockdowns, who had to trust that healthcare aides would have a sense of tact, or practical wisdom, in their absence. Certainly, while my own grandfather was living out his final months in LTC during the COVID-19 pandemic, my family had to place a considerable amount of trust in the healthcare aides, that their practice would be sensitive, sensible, and empathetic. While the pandemic may have brought to light the primacy of touch for LTC residents only through its absence, there was little public discourse surrounding how and what it was that healthcare aides knew of their dying residents through touch. Instead, healthcare aides were pulled into a kind of public court, society having perceived them to be accomplices to crimes committed by the faceless institution of LTC, and the last ones holding the smoking gun when people were dying in a place where, as argued throughout this paper, death had always been there.

Where healthcare workers in hospitals were painted in the media as heroic and brave, LTC workers were often vilified, the easy scapegoats for long-standing institutional and structural inadequacies, their practice occurring against a backdrop of negative headlines, such as, “Canadian Military Details Horrific Conditions in Nursing Homes Battling Covid-19” (Forrest, 2020) and “Canada’s Nursing Homes Have Worst Record for COVID-19 Deaths Among Wealthy Nations” (Ireton, 2021). For example, White et al. (2021) found that LTC staff had felt their caring practices and hard work throughout the pandemic were not positively recognized in the same ways as that of hospital staff, and instead had to grapple with public blame and a lack of recognition. If Intensive Care Units and those who worked there were seen as being in the business of saving lives, then LTC was perceived by the public as the place that was taking lives. It was as if the world had fallen under the purple hue of an ultra-violet blacklight, every LTC facility aglow with the virus, and healthcare aides were the culpable vectors that would have to experience not only public scrutiny and emotional distress, but incur considerable financial loss as well. Healthcare aides are often employed at more than one LTC facility to make ends meet (Duan et al., 2020; Lightman et al., 2021), meaning, unpaid sick leave and single-site work policies implemented by the government to limit the spread of COVID-19 may have had significant financial consequences for healthcare aides (Lightman et al., 2019).

While healthcare aides would have undoubtedly experienced death and dying in LTC the most significantly, nurses experienced a credibility deficit and exclusion as well, the federal government having failed to instate a Chief Nursing Officer to speak for the largest healthcare workforce in Canada, for example. The pandemic made it clear that only physicians, government officials, and individuals deemed experts were considered credible in their knowledge and as having the authority with which to engage in a public discourse about what was happening in LTC. Where the epistemic authority of the physician or expert becomes problematic is when it goes unquestioned, garners blind obedience, or suppresses the testimony of others (Zagzebski, 2012). On the other hand, Gadamer (1993/1996) considered genuine authority to be that which recognizes its own limitations in the posing of questions, and the other as knowledgeable or true. Despite the majority of care continuing to be that of touch or practical knowledge during the pandemic, LTC homes, along with the government, seemed to value numbers over healthcare aides' stories or experiences with death and dying, the number of deaths, number of transmissions, and number of outbreaks speaking more loudly than the words of those in the thick of it.

Gadamer (1993/1996) argued that "authority is grounded in the superiority of that knowledge which has been accumulated and passed on by science as an institution" (pp. 121–122). As shown in this paper, the value and prestige assigned to theoretical and scientific knowledge in LTC has meant healthcare aides experience a testimonial injustice due to their practical ways of knowing being perceived as inferior, reduced to simply technical skills, or even stigmatized as women's work. I certainly do not mean to suggest that institutions should remedy this by denigrating theoretical or scientific knowledge, or the authority of the physician or expert in favor of practical knowledge. Instead, to quote Gadamer (1993/1996), we should "build a bridge over the existing divide between the theoretician who knows the general rule and the person involved in practice who wishes to deal with the unique situation" (p. 94). If we fail to pick up the bricks and build the bridge together over knowledge domains in social institutions, society will continue to suffer from an epistemic lacuna (Fricker, 2007), healthcare aides' knowledge and experiences of death and dying having been excluded from telling us something true.

Summary

Healthcare aides' testimony of death and dying has not been given epistemic credibility due to their knowledge being largely that of touch and practical wisdom, an injustice which has been socially mediated within the institution of LTC. Not only have healthcare aides been marginalized within the LTC setting, but LTC homes themselves have taken up a marginalized position within society, leading healthcare aides to experience a kind of double invisibility. In ways that have been historically and socially conditioned, the institution of LTC has largely repressed death and dying, with healthcare aides left to make sense of their experiences in institutions that do not support them to practice with a sense of tact and practical wisdom, and also exclude them from knowledge making activities and meaningful conversation. This tension within which healthcare aides are caught, their work being that of caring for those who are dying in a place where death is hidden, was exacerbated by the COVID-19 pandemic, and instead of healthcare aides being invited into a conversation to share their experiences and bring about new understanding, they remained voiceless.

Final Thoughts

"I Years had been from Home / And now before the Door / I dared not enter, lest a Face / I never saw before" (Dickinson, 1891, lines 1–4). Behind a row of view-obstructing oak trees on a quiet suburban street, a LTC facility stands hidden. No longer is a continuous flow of emergency medical services, stretchers, or white body bags moving in and out of its doors, the media are gone, as well. Instead, it is easy to imagine this place as having survived the COVID-19 pandemic unscathed, now hidden in a camouflage of ordinariness. When you look carefully, however, up close near the windows, you can sense the story inside still playing out, confronted not by what you see, but by what is hidden. The windows no longer serve their original purpose, to look in or out, but instead are covered with signs and symbols, a warning to some, a reality for others. Beyond its doors and windows healthcare aides still remain, the silent pillars of an institution that failed to understand the weight they carry—the kind of weight imposed by a weightless stranger, the kind of weight that cracks, splinters, and fractures the walls. Remnants from the last two years of pandemic are beginning to fade from collective memory, and so is any concern for the structural integrity of LTC, the cracks having been plastered over and the paint redone. But it is time we dare to enter, to open the doors, air out the rooms, and peer through the cracks.

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