PANDEMIC DEATHS: MEDIA REPRESENTATIONS OF LONG-TERM CARE IN ONTARIO AS A SOCIOLOGICAL CASE STUDY

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Lay Abstract

The mass media influences our perceptions, especially of societal problems and potential solutions. Consistent with other periods of uncertainty, since the declaration of the COVID-19 pandemic, consumption of and reliance on news has increased among the public. Importantly, media messaging during a crisis often influences future public policy with the potential to further exacerbate the crisis. The death of nearly 4,000 long-term care facility patients in Ontario alone since March 2020, most of them older adults, has increased the salience of Long-Term Care in the news, but toward what end? In order to deconstruct media messages during this time of tremendous upheaval, this research asks: how are age(ing), care, and safety portrayed in newspaper coverage of LTC in Ontario during the first eight months of the COVID-19 pandemic? What are the consequences of these portrayals for an aging population whereby nearly all of us will either need assistance at some point in our lives, provide this assistance to others, or both?

Abstract

The mass media influences our worldviews and perceptions, especially of social problems and potential solutions. Importantly, media messages, especially when repeated over time and during a crisis (real or perceived), tend to influence future public policy. Consistent with other periods of crisis and uncertainty, the COVID-19 pandemicization has led to an increased consumption of and reliance on news for accurate information and guidance on what to do and how to act amidst changing public health regulations and social norms. While the aging demographic has made media headlines before the COVID-19 pandemic was declared, the death of nearly 4,000 long-term care facility patients in Ontario alone since March 2020, most of them older adults, has increased the salience of Long-Term Care in the news (television, radio, newspapers, and digital news platforms). In this regard, many claims have been made in the media regarding older adults and their care and safety. But how are the problems leading to mass deaths in LTCFs defined and subsequent solutions presented in the mass media? In order to answer this question, this research asks: how are aging, care, and safety constructed or portrayed in newspaper coverage of LTC in Ontario during the first eight months of the COVID-19 pandemicization? Moreover, what are the implications of these portrayals for an aging population whereby nearly all of us will either need assistance at some point in our lives, provide this assistance to others, or both? Newspaper articles in the National Post on the topic of LTC from March to November 2020 were reviewed using Critical Discourse Analysis. Findings indicate event bias in reporting, journalistic ignorance on the issues in LTC and for those confined therein, dehumanization of older adult subjects, and highly medicalized notions of care and safety.

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List of all Abbreviations and Symbols

LTC—Long-Term Care

LTCFs—Long-Term Care Facilities

CAF-Canadian Armed Forces

ADR—Adverse Drug Reaction

SDOH—Social Determinants of Health

AD-Alzheimer's Disease

CIHI-Canadian Institute for Health Information

Chapter 1: Introduction

Canada is performing poorly on the world stage with regard to older adults dying in long-term care facilities, herein referred to as LTCFs (Webster, 2021). In June 2020, the Canadian Institute for Health Information (CIHI) estimated that 80% of all COVID-19 deaths in Canada occurred in LTCFs. The mass deaths that have occurred across LTCFs are officially labelled as deaths due to COVID-19. However, public disclosures from family members who have loved ones in LTCFs alleging negligence and neglect (Common, 2020; Harris, 2020; Howlett, 2020; Paling, 2020; Roumeliotis & Mancini, 2020), class-action lawsuits from families of LTCF patients (Ontario Health Coalition, 2020b), and the release of the Canadian Armed Forces (CAF) report after being called into 5 Ontario LTCFs (Taylor, 2020) have challenged this narrative and illustrated the politics or value-laden process of naming cause of death. In part, these challenges have re-framed the problems leading to mass deaths across LTCFs as systemic neglect, systemic abuse, and the consequences of a free market or for-profit system for care provision rather than simply due to a novel virus.

Competing accounts as to the cause of death of LTCF patients, who so far, constitute a majority of officially-labelled COVID-19 deaths in Canada, raise questions about both the COVID-19 pandemic itself (including etiology, epidemiology, infectivity, virulence, and largely, how the pandemic is being named and framed) as well as the status and prospects for older adults in our aging society. While the latter is the main focus of this inquiry, the two are strongly related (the characterization of the COVID-19 pandemic and the status and prospects for older adults in our society) since cases of COVID-19 are being used as a rationale for the confinement of older adults (King & Gollom, 2021). For example, in the CIHI report on COVID-19 and LTC in Canada (2021), it was noted that "In all provinces where it could be measured, the total number of resident deaths from all causes was higher during the first wave lockdown than in the

same period in pre-pandemic years, even in parts of the country with fewer COVID-19 cases and/or outbreaks" (p. 4). This finding suggests the necessity of studying the social and iatrogenic[1] harm of current pandemic policies as potentially exacerbating existing public health concerns or crises.

In this regard, the pandemicization of society refers to both the COVID-19 virus and disease itself as well as the public response to the shifting and often conflicting expert pronouncements regarding the virus (Rimke, personal communication, 2020). Importantly, given the lack of consensus on the origins, cause, treatment, and prognosis of the COVID-19 virus, dominant knowledge claims and public health responses must be understood as both responding to and generating public health concerns whether factual, imagined, or exaggerated but nonetheless, real in their consequences (Merton, 1995; Perron and Rudge, 2015). For example, across Canada questions are being raised regarding the validity of PCR (Polymerase Chain Reaction) tests, what a positive "case" means or how the PCR tests are being or should be interpreted (Reuters, 2021; Justice Centre for Constitutional Freedoms, 2021). What is important here is the effect of medical diagnostic labelling (i.e. knowledge claims) on, in this case, older adults, especially when the knowledge claims are highly contested.

While the volume of knowledge claims in the mainstream media (particularly from politicians, policy-makers, medical practitioners, pharmaceutical representatives, and others positioned as "experts" in the news) regarding public health has been incredible since the

[1] Iatrogenesis refers to ill-health effects or outcomes stemming from medical intervention. Ivan Illich, who has done some of the most extensive theoretical work on iatrogenesis in contemporary society distinguishes between direct, indirect, and structural iatrogenesis. According to Illich, "Iatrogenesis can be direct, when pain, sickness, and death result from medical care; or it can be indirect, when health policies reinforce an industrial Organization which generates ill-health: it can be structural when medically sponsored behaviour and delusion restrict the vital autonomy of people by undermining their competence in growing up, caring, ageing; or when it nullifies the personal challenge arising from their pain, disability, and anguish" (1974, p. 921). Indeed, the extent to which mainstream medical practice is actually a threat to public health is best captured by the fact that direct iatrogenesis is the fifth leading cause of death in the world and within some countries, a leading cause of death (Peer & Shabir, 2018).

COVID-19 pandemic was declared, given the high deaths in LTCFs there has also been particular attention paid to the topic of older adults and their care and safety. Consistent with nearly all periods of significant uncertainty or crisis, consumption of and reliance on media for guidance on how to act has increased since the COVID-19 pandemic was declared (De Coninck, d'Haenens, & Matthijs, 2020). Furthermore, mainstream media coverage often influences future public policy, since it simultaneously defines problems, suggests possible solutions, and obscures or omits alternative definitions and solutions (Funk et al., 2020). In this regard, the news does not simply cover or report on issues and events but in part, produces them, particularly through the naming and framing of problems and their potential solutions (Allen & Ayalon, 2021; Fafard, 2008; Sparke & Anguelov, 2012).

Therefore, the purpose of this thesis was to deconstruct media reporting on LTC in Ontario during the COVID-19 pandemicization of society by asking: **how are age(ing), care, and safety constructed or portrayed in media coverage of LTC in Ontario during the first eight months of the COVID-19 pandemicization? Furthermore, what are the implications of these portrayals for an aging population whereby nearly all of us will either need assistance at some point in our lives, provide this assistance to others, or both?** This research is relevant because how age(ing), care, and safety are constructed in media reporting on LTC will significantly impact proposed solutions. Moreover, in-depth examination of media representations of LTC in Ontario since the declaration of the COVID-19 pandemic and situated within its social context is necessary for the public to better evaluate claims to health and security in old age.

Given the aging population in Canada, there is a potentially continued or increased demand for LTC whereby a significant amount of the population will be involved in the LTC

system as either a caregiver, care recipient, or both. While aging in place strategies are preferred by governments and the general public, the medicalization of dementia (or any dementia-like symptoms) means that institutionalization of older adults on the basis of incapacitation is likely to continue or increase, especially given the emergence of new screenings and diagnostic categories of dementia (i.e., broadening the scope of behaviours and physiological markings that can be classified as dementia or neuro-cognitive disease) (Bond, 1992; Bond, Corner, Lilly, & Ellwood, 2002). Indeed, a diagnosis of cognitive impairment often precipitates entry into a LTCF in Ontario. According to the Ontario Long-Term Care Association (OLTCA), 90% of LTC residents have "some form of cognitive impairment" (OLTCA, 2019). Therefore, despite long-standing documentation that institutionalization is harmful (Goffman, 1961; Ben-Moshe, 2013) and recent afore-mentioned allegations of systemic neglect within LTC, the existence of LTCFs are rationalized by politicians, policy-makers, LTC industry representatives, doctors, and sometimes, family members of patients as necessary due to an aging and ill population with nowhere else to go (Lavis & Hammill, 2016; Macleod, 2019). In this way, it is assumed that LTCFs are a type of safe haven for those who can no longer safely care for themselves or be safely cared for in the community even though the COVID-19 pandemicization has given much evidence to the contrary (El-Bialy et al, 2021).

Finally, while the number of LTCF patient deaths has been highest in Ontario and Quebec, systemic problems in LTC have become evident across the country. Therefore, while this research is focused on LTC in Ontario, much of the context and findings may be applicable across the country given the similar organization and provision of LTC across jurisdictions, including the same chain LTCF companies. For example, after what is popularly known as the 'first wave' of COVID-19 infections in Spring 2020, serious problems within LTCFs in Ontario

were essentially replicated in other parts of the country. For example, in Manitoba, two facilities, Maples Personal Care Home and Parkview Place, were in the news —both operated by chain company Revera (Crabb, 2020; McKendrick, 2020). Maples Care Home subsequently underwent an external review after paramedics were called to the facility on November 6, 2020 after eight people died in a 48-hour span. Between October 20, 2020 and January 12, 2021, 56 people died at the Maples facility (Government of Manitoba, 2021). Similarly, between September 15, 2020 and January 12, 2021, 29 patients died at Parkview Place (Coubrough & Levasseur, 2020). Outstanding issues remain at Parkview Place including an ongoing and persistent cockroach infestation (Coubrough & Levasseur, 2020). In fact, systemic problems in LTC across the country became so blatant that the federal government's 2020 Speech from the Throne promised "to set new national standards for long-term care" (Government of Canada, 2020b).

In the chapters that follow, I draw on the Sociology of Health and Illness in the literature review in order to contextualize the facts, forces, and relationships between society and individual health outcomes (i.e. the social determinants of health). Within the Sociology of Health and Illness I draw particularly on medical sociology which studies the role and effects of medicine as an institution, system, profession, and academic discipline (Bradby, 2009; Gabe & Monaghan, 2013). Medicine is also an industry whereby the upstream causes of human problems are obscured while the ill-health effects become both perpetuated and managed as significant sources of profit (Rimke, 2020).

I also reference relevant social gerontological work in the literature review given the focus on aging populations generally, and the institutionalization of older adults in particular. In doing so, I summarize a sociological approach to understanding aging as a social category and relationship and the current political economy of aging—particularly with regard to

medicalization. Additionally, I summarize the historical formation and political economy of LTCFs in Ontario and previous issues pertaining to care and safety within LTCFs in Ontario.

The methodology chapter (chapter 3) outlines my approach to the research, including the development of the research questions and assumptions regarding knowledge, the decision to use critical discourse analysis (CDA) as a research method, and the decision to use newspaper articles, specifically, articles in the National Post, as research data. While a full description of CDA will be presented in chapter 3, it is worth noting here that by definition, this research method does not seek to analyze discourse alone, but focusses on the function of discourse under study in a particular social context (i.e. time and place in history). For this reason, the literature review is largely dedicated to providing the context in which the news was produced. Chapter four presents the research findings (content of the newspaper articles reviewed). Chapter five presents an analysis of the data, with a particular emphasis on speakers and the naming and framing of problems and potential solutions as well as a discussion of how ageing, care, and safety are represented in the data, in what context, and to what effect, especially for an aging population.

Chapter 2: Literature Review

COVID-19 Pandemicization of Society and the Social Determinants of Health

Since the official declaration of the COVID-19 pandemic (March 12, 2020), public pandemic policies have and continue to rely on references to care and safety. Official authoritative claims by governments across Canada and the world emphasize: "stay home, save lives" (Government of Canada, 2020). Social interaction or contact then is suggested to contribute to not only ill-health, but death or worse yet, preventable death. Importantly, many of these claims have used older people and an aging population generally, as a moral imperative for the public to follow pandemic rules and regulations, including restrictions on movement, association, and consumption (see for example, protectourelders.ca). Politicians, public health experts, and policymakers alike have all argued or implied that age is an independent risk factor for illness and that older people are more susceptible to severe outcomes (including death) from COVID-19 (Reynolds, 2020). This discourse marks a new extreme in neoliberal conceptions of health whereby the individual is seen as the sole agent or point of control rather than social or structural factors that have long been known to contribute to (ill) health (broadly referred to as the social determinants of health).

The lack of attention to the social determinants of health (SDOH) from political leaders, policymakers, and public health experts is shocking given the significant body of theoretical and empirical work on this topic, including at the international level, such as the WHO International Commission on the Social Determinants of Health. Commissioned in 2005, this global initiative sought to outline causal models of disease distribution and investigate "entry points for interventions and policies" to improve population health and well-being (Solar & Irwin, 2010, p. 3). In short, SDOH refer to "non-medical factors that influence health outcomes" (Takian, Kiani,

and Khanjankjani, 2020, p. 521). While many SDOH have been listed over the years, the main pathways that result in differential exposure, vulnerability, and consequences to ill-health and disease are largely based on class. Class is directly related to living conditions such as housing, food (in)security, access to clean water, employment, level of environmental toxicity, and psychological or mental and emotional distress as a result of one's living conditions in a highly unequal society (Abrams and Szefler, 2020; Bambra, Riordan, Ford, and Matthews, 2020; Rollston and Galea, 2020; Solar & Irwin, 2010). According to Raphael, Curry-Stevens, and Bryant (2008), poverty, housing and food insecurity, and social exclusion "appear to be the primary antecedents of just about every affliction known to humankind" (p. 231). While biomedicine is often described in "life-saving" terms, historical epidemiological research has clearly illustrated that spending on social services is more central to improved health outcomes than spending in medical services (Rollston & Galea, 2020).

For example, the USA is the wealthiest country in the world, but also one of the most unequal in terms of income distribution. Out of all high-income countries, the USA spends the most on health care (i.e., medical services and interventions), yet has the worst health outcomes (Rollston and Galea, 2020). Similar trends have been noted in Canada with the ongoing neglect of SDOH despite ample documentation and evidence of its centrality and therefore, effectiveness, as an approach to health amelioration and disease prevention (Raphael, Curry-Stevens, and Bryant, 2008). From this perspective, if the SDOH are not met in any given environment, its inhabitants are not only more susceptible to ill health in general, but also more prone to serious outcomes from infectious disease outbreaks. This led former Director-General of the World Health Organization (WHO) Lee Jong-wook to remark: "interventions aimed at

reducing disease and saving lives succeed only when they take the social determinants of health adequately into account" (qtd in Solar & Irwin, 2010, p. 11).

A SDOH approach to understanding COVID-19 epidemiology has suggested that not only are the poor and working class more likely to become infected (through continuing to commute to low-wage jobs or to work and live in more crowded settings), but also poverty and pre-existing illness makes one more likely to become very sick, disabled, or die from COVID-19 (Bambra et al., 2020; Rollston & Galea, 2020). In this way, the COVID-19 pandemic has been described as a syndemic (Bambra et al., 2020). A syndemic occurs when risk-factors for illnesses overlap, interact, and/or accumulate, originally defined by Merrill Singer as "a set of closely intertwined and mutual enhancing health problems that significantly affect the overall health status of a population within the context of a perpetuating configuration of noxious social conditions" (*qtd in* Bambra et al., 2020, p. 965). To illustrate, the poor and working class have higher rates of almost all diseases that increase the severity and mortality of COVID-19 on account of their living and working conditions such as: hypertension, diabetes, asthma, COPD, heart disease, liver disease, renal disease, cancer, cardiovascular disease, and obesity (Bambra et al., 2020). Moreover, chronic stress resulting from poverty, racism, deprivation, and living in survival mode (especially over the long-term) is associated with immunosuppression (Bambra et al., 2020; Crear-Perry et al, 2020). To the point on racism and public health, racism not only leads to immunosuppression from chronic stress, but also material deprivation through racist policies and practices. For example, despite widespread public health messages on hand washing, hundreds of First Nations communities across Canada lack access to clean and safe drinking water (Palmater, 2019). This is not accidental or inevitable, but rather, the result of decades of willful inaction, neglect, denial, and corruption by federal and provincial authorities

(e.g. giving water treatment contracts to companies with shoddy records) while First Nations communities are victim-blamed in the mainstream media (Palmater, 2019; Russell, 2021).

Therefore, apart from the moral and ethical imperative to address SDOH, failure to shape policies accordingly in any public health intervention is bound to be ineffective in actually reducing not only health disparity but also ill-health in general (Solar & Irwin, 2010). This can be currently observed in Ontario (and many other parts of the country and the world) whereby despite emergency lock-down measures for more than a year, daily case counts, hospitalizations, disability, and death due to COVID-19 virus and/or pandemic policies has not been and will not be ameliorated through current measures (largely targeting individual behaviours). Additionally, iatrogenic and social harm or 'side effects' (including death) of the public health measures taken so far are, by and large, not considered in most evaluations of the near universal pandemic policies we are living through.

For example, the possibility of or extent to which medical 'treatments' of COVID-19 are contributing to death rates in LTCFs and even in ICU's is generally not examined or considered, despite high death rates across LTCFs (CIHI, 2021) and ICUs in Ontario (Crawley, 2021) and other parts of Canada (Cole, 2021). Since COVID-19 is considered novel, its etiology, level of infectivity and virulence, the effectiveness of established and proposed treatments, co-morbidities, antibodies evidence, and prognostics are all highly contested both within and outside of medicine. Therefore, the possibility or extent to which biomedical uncertainty has made it easier to overlook the SDOH needs to be considered. As well, the possibility or extent to which current pandemic policies and medical interventions for COVID-19 are contributing to poor outcomes, including once hospitalized, also needs to be considered given that in Canada, more people die from direct iatrogenesis in the form of medical errors and adverse drug reactions

(ADR) than from COVID-19 (Rimke, 2020). Since the COVID-19 pandemic was declared in March 2020, 25,644 Canadians have reportedly died of the virus (as of June 5, 2021) (Government of Canada, 2021b). However, per year, an estimated 30,000-60,000 Canadians die of preventable medical error (Rimke, 2020) and another 22,000 Canadians die of adverse drug reactions (Adverse Drug Reaction Canada, 2021; Favaro, St, Phillip, & Ho, 2021).

These contradictions apparent between the long-standing knowledge of the SDOH (and associated differential exposure, vulnerability, and consequences to disease) and the near-universal pandemic policies relying largely on physical distancing and 'lock-down' measures raise a number of important concerns. First, older adults are positioned in public discourse as at higher risk of being hospitalized and/or dying from COVID-19 (Government of Canada, 2021). Age has been presented by mainstream medical experts, policymakers, and politicians as an independent factor that increases the likelihood of COVID-19 death or severe outcomes (i.e., requiring hospitalization) (Previtali, Allen, & Varlamova, 2020). Along these lines, older adults and an aging population generally have been used to stoke compliance for the public health measures being imposed. However, older adults have arguably been one of the most affected social groups by the pandemic *policies* (especially regarding isolation), implemented and enforced in the name of protection. Importantly, politicians, public health experts, and policymakers have all incorrectly used the term 'social distance', a sociological concept that refers to the "degree of intimacy and understanding" between individuals and social groups and dates back to at least the early 1900s (Wark & Galliher, 2007, p. 389). Ironically, the pandemicization of society (Rimke, personal communication, 2021) has led to greater social distance among certain groups, notably between young and old but also on racial terms (e.g., the rise in anti-Asian hate crimes).

In LTCFs (the focus of this study), older adults residing therein have died *en masse*. Since the declaration of a pandemic in March 2020, 3,757 LTCF patients have died in Ontario (as of May 1, 2021) (Government of Ontario, 2021). Given the few deaths that were investigated by provincial coroners, we will likely never know the extent to which LTCF patients, especially in Ontario, died as a result of COVID-19 infection, from institutional abuse and neglect, or a combination of the two. The cause of death of at least some of the thousands of LTCF patients in Ontario since the declaration of the COVID-19 pandemic are disputed and may have been, at least in part, the result of pre-existing health and safety issues in LTCFs and/or the effects of pandemic policies (Roumeliotis & Mancini, 2020). While LTCF patients were already confined and isolated by virtue of being institutionalized, pandemic policies which banned visitation and kept patients confined to their rooms have also contributed to death and disease (Diamantis, Vignier, & Gallien, 2020).

To illustrate, a National Academies of Sciences, Engineering, and Medicine (2020) report maintains that social isolation is associated with significantly higher risk of pre-mature death such that, "There is some evidence that the magnitude of the effect of social isolation on mortality risk may be comparable or greater than other well-established risk factors such as smoking, obesity, and physical inactivity" (p. 47). In addition to pre-mature death (mortality), social isolation and loneliness is linked to morbidity including cardiovascular disease and stroke as well as, significantly for older adults, dementia, cognitive decline, and depression and anxiety (National Academies of Sciences, Engineering, and Medicine, 2020). Applied to the ongoing COVID-19 pandemicization of society, research coming out of Europe where earlier and more far-reaching restrictive measures were in place suggests that patients in LTCFs died of hypovolemic shock due to their daily needs not being met (e.g. no assistance with movement,

toileting, and eating as well as lack of social interaction) (Diamantis, Vignier, & Gallien, 2020). Other research which studied the effects of confinement due to pandemic policies on older adults with a diagnosis of Alzheimer's Disease (AD) found a worsening of neuropsychiatric symptoms (Boutoleau-Bretonniere et al, 2020). Therefore, the question is not *if* pandemic policies contributed to ill-health and death, but rather, to what extent and furthermore, how is the public to distinguish between deaths due to the COVID-19 virus and deaths due to our response to said virus.

The emphasis that older adults especially must isolate (both in their homes out of fear directed toward their 'vulnerability' and in LTCFs) as a public health measure is both a product of and a contributor to systemic ageism. Ageism is a widespread problem among the general public as well as among health professionals (Reynolds, 2020). The COVID-19 pandemic, combined with pandemic responses, has both illustrated the deadly consequences of pervasive and systemic ageism as well as made it much worse through widespread claims by medical professionals and policymakers that age is a risk factor for severe outcomes from COVID-19 infection rather than pre-existing disease and social determinants of health (e.g., living conditions). This has led to age-based confinement policies that in effect, have contributed to the ongoing spread of COVID-19 as well as widespread neglect, ill-health, and death of older adults (Previtali, Allen, and Varlamova, 2020). In this way, age becomes a problem to be controlled for, rather than ageism and the social determinants of ill health. Willful ignorance surrounding the social determinants of ill-health with respect to infectious disease can be witnessed in the ongoing confinement of older adults - often against their will - while other obvious pathways for transmission and severe outcomes remain unaddressed. These include congregate settings such as LTCFs themselves, prisons, homeless shelters, blue-collar workplaces (such as meat

processing plants), and the ongoing denial of the necessities of life such as clean running water for large segments of the Canadian population. Therefore, societal neglect of entire populations has contributed greatly to the transmission of COVID-19 (Marrocco, Coke, & Kitts, 2020, 2021; Palmater, 2019), while Ontario Bill 218 gives legal protection to individuals, corporations and the crown from COVID-19-related lawsuits (Sweet & McGivney, 2020).

In these ways, the COVID-19 pandemic policies or pandemicization of society (Rimke, personal communication, 2021), has brought individualism (and inter-group conflict) to new extremes. Discourse surrounding the COVID-19 pandemic suggests that the ultimate act of care and safety for ourselves and each other (and presumably from ourselves and each other) is to isolate. Even before the COVID-19 pandemic was declared, dominant research on health and illness focused on individual-level behaviours as major risk factors such as smoking, obesity, and physical inactivity, suggesting that health is within the control of individuals (Raphael, Curry-Stevens, & Bryant, 2008). This leads to victim-blaming whereby those who experience ill-health are blamed for their presumed unhealthy choices and lifestyles and interventions are foreclosed to technical and reactive medical procedures whereby a patient is then returned to their same environment that likely caused ill-health in the first place (Raphael, Curry-Stevens, & Bryant, 2008). Given the high rates of illness and death within LTCFs in Ontario, detailed documentation and analysis of the living conditions in LTCF for patients both before and after the declaration of the COVID-19 pandemic is needed in order to give the social context in which the majority of COVID-19 deaths occurred.

What is Long-Term Care?

Generally speaking, long-term care (LTC) refers to a variety of health and other assistive services provided when we cannot perform activities of daily living without assistance. Activities

of daily living (ADL) generally refers to things like bathing, getting dressed, using the toilet, eating, and mobility. ADL are often contrasted with Instrumental Activities of Daily Living (IADL) which include: housekeeping, managing finances, taking medication, food preparation, shopping, and using the telephone or other communication device (National Institute on Aging, 2017). Based on these definitions, many of us will either provide LTC to a loved one, require LTC at some point in our lives, or both. Most long-term care is provided by unpaid family and friends in private dwellings (informal care) but LTC also includes formal programs such as day centres, homecare, and long-term care facilities (LTCFs) (National Institute on Aging, 2017).

While LTC can be provided and available for a number of health reasons including stroke, brain injury, or other disability, this research will focus on the formal provision of residential LTC in Ontario (herein referred to as long-term care facilities or LTCFs) for older adults. Consistent with trends across Canada (Doron, 2003), the proportion of the Ontario population over 75 years of age is projected to rise to almost 2.7 million people by 2046 and the population over the age of 90 is expected to triple in size, from 130,000 to 443,000 people (Ontario Ministry of Finance, 2020). At the same time, the prevalence of dementia (an umbrella term for numerous neuro-cognitive symptoms and diseases) is already reported to be high in Ontario and expected to increase in the years to come. In 2016, it was estimated that close to 228,000 Ontarians are reported to be living with dementia which is expected to rise to over 430,000 by 2038 (Ontario Ministry of Health and Long-Term Care, 2016, p. 7). Moreover, according to the Ontario Long-Term Care Association, an estimated 70% of people with dementia will eventually require or be moved into LTCFs (2019).

The rationale for the institutionalization of older adults is usually naturalized as inevitable given reported rates of dementia, however this labelling involves a significant exercise of power

by a number of actors while simultaneously obscuring or foreclosing alternative ways of understanding and caring with and for older adults. The extent to which dominant treatments contribute to ill-health and disability of institutionalized older adults also needs to be considered (Latimer, 2018). While it is generally agreed that assistance with daily living is required for an aging population, the form this assistance takes requires further documentation, analysis, and scrutiny so that the public may better evaluate claims to health and security in old age.

How Does the Long-Term Care System Operate in Ontario Today?

The LTC sector in Ontario today is a publicly-funded, privately delivered medicalized model of care provision. Regardless of ownership, the following accommodation monthly fees apply to clients of LTCFs (as of July 1, 2019): $1,891.31 for the basic option, $2,280.04 for semi-private room, $2,701.61 for private room (Government of Ontario, 2021). Note that the government can subsidize, based on need, only the $1,891.31 basic option for those who cannot afford the accommodation rates (meaning if you require financial assistance, you are only eligible for a shared room). Given the higher rates of COVID-19 transmission in shared rooms, those who are financially disadvantaged are at higher risk of ill-health and death from infectious disease than those who can afford to pay for private rooms.

In terms of admittance, the Ontario Long-Term Care Homes Act (2007) outlines the mandated procedures, eligibility criteria and admissions process. The Minister of Health and Long-Term Care designates one or more “persons, classes of persons, or entities as placement co-ordinators for long-term care homes” in the specified geographic areas (ibid, p. 25). People apply to a placement co-ordinator, who determines eligibility. The following are required to determine eligibility: first, an assessment of the applicant’s “physical and mental health, and the applicant’s requirements for medical treatment and health care” to be done by a physician or

registered nurse (ibid, p. 26). Second, an assessment of the applicant's "functional capacity, requirements for personal care, current behaviour, and behaviour during the year preceding the assessment" is to be completed by "an employee or agent of the placement co-ordinator who is also either a Registered Nurse, a Social Worker who is registered under the *Social Work and Social Service Act, 1998,* or any other person provided for in the regulations" (ibid, p. 26). The first and second assessments must be completed by separate individuals. The Admission of Residents Section of Ontario's Long-Term Care Act (2007) also has a clause titled, "Confinement to be considered" whereby, in addition to determining eligibility the placement co-ordinator has the authority and direction to:

> *consider whether the applicant may need to be confined in the home and shall make a recommendation to the licensee considering: whether there would be a significant risk that the applicant or anyone else would suffer serious bodily harm if the applicant were not confined; whether confining the applicant would be reasonable in light of the applicant's physical and mental condition and personal history; and whether a physician, registered nurse in the extended class or other person provided for in the regulations has recommended the confining.* (c. 2.1, s. 44)

In these ways, the placement co-ordinators, physicians, social workers, and all others professionals involved in the screening and admittance process exercise a significant amount of power over the life and liberty of all (potential) incoming LTCF patients through the naming and framing of behaviours as deviant, problematic, sick, or dangerous.

The idea that the current (medicalized and institutionalized) provision of LTC is part of the medical systems' continuum of care (Daly, 2015; Lavis and Hammill, 2016) and even a natural part of the life course (Gillese, 2019a; Ontario Long-Term Care Association, 2019) is

relatively recent. As a concept, LTC takes form via a government sector and industry 'providers.' LTC as a concept, sector, and industry each shape and mould the other such that industry changes can lead to a changed concept and practice of LTC and vice versa. Therefore, an examination and brief history of the LTC sector and industry illustrates how the concept and practice of LTC has evolved over time and will also serve to contextualize discourse on age(ing), care, and safety in LTC.

History and Political Economy of LTC Sector and Industry in Ontario. In Ontario, LTCFs were originally called "homes for the aged" and based on a charity model of custodial care for older adults living in poverty (Daly, 2015). These early institutions were largely run privately and operators were paid a per diem per resident from municipal governments to house those who required out-patient residential care (often after discharge from a hospital). Regulation of these institutions at this time is described as haphazard and leading to appalling conditions, particularly those that were run for-profit. It was not until 1966 that the Ontario provincial government passed *Ontario Nursing Homes Act* to legislate for-profit 'care providers.'

While legislation was enacted to respond to poor conditions in the institutions for the poor and aged, this legislation essentially consolidated a licensure and regulation system whereby custodial care was private and for-profit in delivery but publicly funded. Moving to a more medical model in 1972, the province of Ontario passed the *Extended Care Plan* which gave additional public funding (from the Ministry of Health) to institutions housing those deemed to have medical care needs. According to Daly (2015):

> *The for-profit industry grew quickly after the 1972 increase in provincial public funding. The sector changed from 'small single operator dwellings' of 20 beds that were owned primarily by women, to 'highly profitable, modern one-hundred to two-hundred bed*

> *facilities, owned by private corporate chains earning up to 15 percent rates of return for investors and dedicated to . . . make money for shareholders.'* (p. 42)

The reorganization of the Ministry of Health to the Ministry of Health and Long-Term Care is indicative that over time and through extensive lobbying by the private for-profit care providers, the provision of LTC became "cemented firmly in the medical care system" as opposed to a matter of social care and a responsibility of the Ministry of Community and Social Services (Daly, 2015, p. 47). Previous distinctions between custodial care and medical care and associated funding disparities were replaced by "a case mix formula for funding that rewarded the care of more medically complex individuals" (ibid, p. 47). The resulting more complex levels of classification and management favoured private, for-profit chain providers.

The new criteria and levels of classification increased reporting and data management requirements such that smaller non-profit providers have increasingly either closed altogether or, have had to contract out their management to for-profit providers. Resultantly, many LTC beds deemed to be in non-profit or municipal homes are actually run or managed by for-profit companies. Daly (2015) estimates that for-profit ownership or management of beds in Ontario has grown by over 80% between 1989 and 2013. This means that, 1) more older adults reside in institutions that are managed and operated based on a profit-logic than would be assumed by looking at facility ownership alone, and 2) management of LTCF's has become a new commercial area (Daly, 2015).

Broader economic arrangements (outside of Ontario and even outside of Canada) such as the General Agreement on Trade in Services (GATS) have significantly affected the organization and delivery of LTC. GATS is the first World Trade Organization (WTO) agreement that covers trade in services whereby, similar to trade in goods, the goal of the agreement is to "promote

progressive liberalization of trade in services over time, eliminating trade barriers to enable further participation in one another's markets" (Global Affairs Canada, 2013, para. 2). While the government of Canada offered that "health, public education, and social services and culture" are non-negotiable, many aspects of LTC, especially those which are contracted out, are not part of these protections (Global Affairs Canada, 2013, para.6).

Privatizing any aspect of LTC means that the publicly funded provision of care for older adults in our society essentially goes out to the lowest bidder on the 'open' market. Publicly funded social services are seen as lucrative by transnational companies because they are a guaranteed market. Resultantly, the LTC sector, especially in Ontario, consists of public-private partnerships (P3s) whereby ". . . governments and employers seek to cut costs and increase control by carving out significant aspects of public care to open it up for profit" (Armstrong and Armstrong, 2006, p. 184). Resultantly, privatization has occurred over time by an intentional blurring of the differences between public services and the private management and delivery of said services. While LTC can be characterized as having P3s from its inception in Ontario since public dollars were provided to private facilities on a per resident per diem basis, the signing of GATS along with other transnational agreements have consolidated a global commercial model of LTC, based on neoliberal policies and worldviews (Estes, Biggs, and Phillipson, 2003). Guaranteed public services implemented as part of the post-WWII Welfare State (Keynesianism) are seen as lucrative for transnational corporations and are being privatized over time. This regressive approach to economics and governance is known as **neoliberalism**.

Like Keynesianism, neoliberalism is both an economic theory, a set of policies and practices, and a culture. As an economic theory, it is associated with the Chicago School of Economics and assumes that government intervention and regulation of economic markets

causes undesirable distortions and that a privatized capitalist economy will automatically distribute income fairly based on supply and demand (Palley, 2005). However, the role of government intervention is poorly understood especially when it comes to preventing destructive competition. Destructive competition occurs when there are no regulations (i.e., a 'free market') which, given the profit incentive of capitalism, generates destruction and destitution. Examples of destructive competition include: "bribery, excessive advertising expenditures, tax competition between jurisdictions to attract business investment, and the global race to the bottom which has countries ratcheting down labour standards to attract business" (Palley, 2005, p. 28). For these reasons, it is argued that neoliberalism is based more on "ideological appeal" rather than "analytical rigour" (Clarke, 2005, p. 58) and that neoliberal models for economic growth lead to poor quality and outright unsafe products and services[2] (Ritzer, 2013). This level of irrationality exists due to prevailing myths in neoliberal ideology.

Neoliberal rhetoric and neoliberal policies often contradict such as the myth of government non-intervention or the concept of 'free markets.' In fact, as can be seen with the history of LTC in Ontario, governments simultaneously intervene in markets and fail to intervene in safety regulations in order to make the sector more desirable or hospitable to for-profit chain providers. For example, Ontario's Long-Term Care COVID-19 Commission's second letter of interim recommendations (December 4, 2020) noted that while all LTCFs are to be inspected each year, in 2019, only 27 of the provinces 626 homes were inspected. Additionally, after the COVID-19 pandemic was declared and outbreaks at LTCFs in Ontario began, from March 1 to October 15, 2020, only 11 LTCFs received a proactive inspection (ibid, p. 4). When facilities are inspected, fines and other penalties are "rarely applied", so that violations become

[2] For more detail on how neoliberalism leads to unsafe products in services in the context of LTCFs, see section on safety, pp. 29-34.

inconsequential from a business perspective (ibid, p. 5). Intervening in markets to make them more favourable to corporate providers with little to no regulation has the effect of reducing or eliminating competition, thereby greatly restricting the market and putting consumers and service recipients at great risk of harm and/or death. Therefore, neoliberal politics are often based on myths such that "the point for neoliberalism is not to make a model that is more adequate to the real world, but to make the real world more adequate to its model" (Clarke, 2005, p. 58).

The consolidation of LTC as a medical matter rather than a social one has arguably had significant impacts on the public's conception of what LTC is or ought to be, including mainstream notions of age(ing), care, and safety. First, aging has become wholly medicalized in that provisions of care are funded based on medical complexity rather than social need (Daly, 2015). There is no mechanism by which the per diem amounts awarded to LTCF's can be awarded to families or alternative care teams of the persons' choosing. Second and related to the first, care and assistance for older adults is almost solely framed in medical terms whereby LTC is now part of the Ministry of Health and constitutes one of the six sectors of the provincial health care system (Daly, 2015). In this regard, care consists of medical experts distinguishing between older adults who are deemed incapacitated, independent or somewhere in between (Ontario Long-Term Care Homes Act, 2007). Third, Daly (2015) outlined how the consolidation of the LTC government sector was publicly framed as responding to unsafe living conditions in many of the private facilities. However, the funding arrangements and governance of LTCFs in Ontario has resulted in a virtual monopoly of large for profit, chain providers owning, managing, and operating LTCFs which has placed profit above safety. Ontario's delivery and management of LTC is "perhaps the most commercialized area, with the possible exception of pharmaceutical marketing" relative to Canada's provincial health care systems (Daly, 2015, p. 52). This has

resulted in outright unsafe living conditions which contributed substantively to mass deaths in these facilities, especially during the (ongoing) COVID-19 pandemic (Taylor, 2020). This raises questions about many taken-for-granted concepts and assumptions surrounding LTC including age(ing), care, and safety. Therefore, each of these concepts and their associated discourse will be discussed in turn.

Age(ing)

As a social construct and "master status," age is a basis for social organization (Calasanti, 2003). Therefore, age is a *social category and relationship* as the concept of old age only has meaning in relation to other age categories such as young or middle-aged (Calasanti, 2003; Vincent, 2006). In this regard, old age is a "product of age relations" in a particular society, a status ascribed in relation to other age categories, and intersecting with other relations such as gender and race (Calasanti, 2003, p. 200). Old age is a political location in and of itself whereby "old age confers a loss of authority, status, and income; and old people are culturally devalued" (Calasanti, 2020, p. 4), but also one that is unique to other social categories in its fluidity—we are all aging (Calasanti, 2020; Hagestad and Uhlenberg, 2005). Therefore, it is necessary to study how a society constructs and acts around age, aging, and the aged and the consequences of these constructions including bodily or biological consequences (Baars, 1991). Today, medicalization is one of the defining features of aging.

Briefly, medicalization refers to the process by which everyday experiences and behaviours are re-cast as medical problems. While medicalization historically referred to the rise of scientific authority over particular behaviours that were previously depicted by religion as immoral, sinful, or uncivilized (Conrad, 2007; Rimke and Hunt, 2002), it has now encompassed life stages such as childhood and old age. According to Conrad (2007), the main aspect of

medicalization is definition: “That is, a problem is defined in medical terms, described using medical language, understood through the adoption of a medical framework, or ‘treated’ with a medical intervention” (p. 5). Brown (1995) refers to this process in his work “Naming and Framing: The Social Construction of Diagnosis and Illness”. Similar to Conrad, for Brown, the purpose of studying medical categories is to question the terms in which a condition or experience is defined without necessarily questioning the existence of the condition (e.g., an aged person in need of assistance with daily tasks may well exist, but we can still question how her needs are named and framed in medical terms). From the perspective of biomedicine, aging is framed as a medical problem that needs to be fought, treated, or otherwise managed (Estes & Binney, 1989). An aging population in a neoliberal society is constituted as a social problem, especially those who require more assistance with daily living (El-Bialy et al, 2021).

Since aging is defined (in the biomedical paradigm) as a type of cell degeneration, the biomedical definition of aging is itself inherently deficit-based. This perspective leads to the constitution of the aging population as inherently weak, dependent, and/or inferior. The construction of inferiority, weakness, and dependency based on natural or biological factors has a historical link with rationalizing oppression in that, “Perceiving individuals as members of a weak class validates the social practices that constrict their opportunities for connectedness” (Silvers, 1999, p. 204). Discourse on aging that centers on decline and deficits creates expectations that older adults will inevitably deteriorate. Therefore, deteriorated physical, mental, emotional, and social conditions and status of older adults becomes expected and even normalized by members of said society. Thus, framing certain social groups as weak, inferior, dependent, or burdensome is a common practice of domination—in this case, ageism (Calasanti, 2003; Fealy, McNamara, Treacy, and Lyons, 2011 Silvers, 1999;).

Indeed, it has long been acknowledged that social support and assistance with mobility (i.e., getting around) are the most frequent needs of older adults and of an aging society broadly (Chappell, 1994). However, the prominence of medical discourse regarding aging means that the public has largely bought into "the belief that the problems of aging are primarily biological and physiological, while ignoring the socially produced nature of many of these and other problems that occur in old age" (Estes & Binney, 1989, p. 594). Questions about resource distribution and government spending on expensive medical technologies while many older adults are isolated and need assistance with mobility are not generally asked. The biomedicalization of aging leads to costly technologies and medical interventions while at the same time, older adults are blamed for 'causing' high health care costs that more often than not, do not meet their needs (Calasanti, 2003; 2020). Older adults are often subject to extensive medical treatments which may be ineffective at best or harmful at worst. Armstrong, Choiniere, and Armstrong (2016) illustrate:

> When a frail elderly person walks into an emergency room with an impending heart attack, the system is instantly primed to spend tens of thousands of dollars for tests, surgery and a hospital stay. However, that is often the same person who languished at home, mildly depressed, isolated, physically inactive and malnourished—someone for whom the system refused to spend a few hundred dollars a month on home care to prevent the catastrophe that ended up in the emergency room and the operating room. (p. 4)

Extensive and reactive medical interventions have facilitated and fuelled the ageist notion that given the aging demographic, society will be unable to sustain current levels of support as the older generations are 'using up' health and pension reserves so that nothing will be left for younger cohorts when we age. This perspective has been labelled apocalyptic demography—a

set of exaggerated, misleading, and/or misinterpreted population statistics that have essentially become a form of fear mongering regarding an aging population (Wister, 2019). The implication is that the public should have lower expectations for guaranteed health and social services, something conveniently on par with neoliberalism (decreasing accessibility and quality of products and services). As an ideology, apocalyptic demography obscures the ill-effects of neoliberalism by scapegoating older people through ageist claims. Older people become grouped in and victim-blamed alongside other mythical groups based on classist, racist, and sexist stereotypes like 'Welfare Queens', 'Bums', and "Free Loaders' who are said to 'suck the system dry' by contributing nothing and taking all. Alongside the biomedicalization of aging, apocalyptic demography contributes to widespread conflict and ageism in the way we conceive of older adults and our own aging selves.

The biomedicalization of ageing also has the consequence of iatrogenic harm (Illich, 1974, 1975) and foreclosing other interpretations of age(ing) and age-related changes. Estes and Binney (1989) warned of the dangers of biomedicalization of aging contributing to both victim blaming for disease and/or disability as well as social control through medical management (drugs or institutionalization). As a result of the biomedicalization of aging, all issues, symptoms, questions, and so forth brought forward by older adults are likely to be either cast down as "just old age" or responded to with drugs (Calasanti, 2003; Waitzkin, Britt, and Williams, 1994). Moreover, nearly all actions of older adults are interpreted as possible signs of dementia (Bond, 1992; Parland, Kelly, & Innes, 2017). In this way, key determinants of health such as social connections/solidarity and nutrition (nutritional science) are neglected in the biomedical model (Estes, Biggs, and Phillipson, 2003; Rimke, 2020). Unsurprisingly, these are the leading health issues impacting older adults today, particularly in LTCFs.

In summary, the medicalization of aging implies medical dominance and is premised on the assumption that aging is a disease and the state of being aged a deficit. Consequently, individual and population aging is constructed as a crisis or looming crisis and used as a rationale for neoliberal policies (i.e. austerity measures). In a neoliberal society, when someone needs assistance outside of what their private resources can provide, they are deemed a social problem (El-Baily et al., 2021). Therefore, there are important relationships between the problematization of older adults (aged) and how care and safety in the context of long-term residential care are portrayed in the media.

Care

Care is first and foremost a relationship of survival since there is no such thing as a truly independent individual. From this perspective, care is most easily defined as a species activity of reproduction (Fisher and Tronto, 1990) and "the generative basis for social and biological life" (Seaman, Robbins, and Buch, 2019, p. 2). Care consists of the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something. Situated within a particular social context, care concerns the "roles and relationships between individuals and families, governments, community and market and how these components change over time" (Change-Ability, 2009, p. 4). In this way, how care is conceptualized and subsequently practiced depends on "who is drawn to care for whom and on the role institutions and national policies play in shaping those dynamics" (Buch, 2015, p. 279). Therefore, familial, medical, and corporate conceptions of care are likely to be at odds and care work or care provision has a particularly strong political economic component (Buch, 2015).

Efforts to recognize the labour value of care work have led to the quantification, bureaucratization, and fragmentation of care whether this care occurs at home or in a facility (Fisher and Tronto, 1990). Regarding quantification, while this is sometimes argued for in order

to ensure patients are receiving at least minimal levels of attention, this again has the effect of reducing patients to objects. For example, McGregor et al. (2005), in discussing the relationships between facility ownership, staffing ratios, and outcomes of care noted: ". . . it takes about 8 minutes to provide 1 episode of toileting assistance and protocols that increase residents' independence in morning activities of daily living take about 7 to 11 minutes. Group feeding assistance at a ratio of 1 RCA to 3 residents is estimated to take 18 minutes" (p. 648). Quantifying care in this way is alienating and dehumanizing to both the care worker, who is assumed to operate robotically, but most significantly, the patient who is denied authentic and dignified treatment as their everyday intimate activities of daily living are reduced to a checklist and a timetable.

Bureaucratic modes of caring are delivered by "large-scale hierarchical organizations" whose provisions of care are derived at a great social distance from those who ultimately receive care (Fisher and Tronto, 1990). Bureaucratic modes of caring prevent control by care receivers because they function via a detached division of labour performing standardized routines. Therefore, bureaucracy also fragments care as those providing care "on the frontlines" are performing standardized routines set by administrators and thus, "rarely have the power and resources to take responsibility for caring" (Fisher and Tronto, 1990, p. 52).

Consistent with neoliberal ideology, individualism and fantasies of independence are valued and sought after such that older adults are divided into categories of "older persons who do not require significant care from others and those who do" (Buch, 2015, p. 282) with the latter deemed as failures, burdensome, and even de-humanized (Calasanti, 2003, 2020). Those who are deemed dependent lose many of their fundamental human and citizenship rights. In this sense, care is a legal relationship epitomized in guardianship laws. Guardianship occurs when "one

specified individual with legal capacity (the guardian) is given legal authority to make decisions on behalf of another person (the ward of dependent adult)" (Landry, 1999, p. 70). While guardianship legislation can be used for anyone deemed incompetent or incapacitated (e.g., those who are labelled intellectually disabled), guardianship laws in Ontario are most often invoked in the case of institutionalized older adults deemed cognitively incompetent as verified by medical diagnostics (Doron, 2003)

In this sense, *care is a legal relationship* whereby one's assets (if applicable) are drained (for example, through LTCF daily or monthly fees) and one's autonomy violated. In this way, deeming someone in need of LTC is an exercise of power (Charpentier & Soulieres, 2013). In being coerced into certain 'care' arrangements, older adults lose control over almost every aspect of their selves (personhood) and their lives while at the same time, their institutionalization is framed as for their own safety and protection (including from themselves). As with all other total institutions (Goffman, 1961) such as group homes, orphanages, prisons, or psychiatric asylums, care is custody.

Safety

In order to understand safety in the context of LTC in Ontario, we need to connect predominant discourse around safety with empirical cases whereby safety is clearly violated. Issues pertaining to a lack of safety within LTC are problematic and often become confused given that LTC is meant to be a safe haven for vulnerable elders. Also, while the term safety has been chosen for analysis, the concepts of risk and security are highly related and at times synonymous with safety and will also be referenced accordingly.

Locking of doors, restricted exit and entry, and other forms of restraint are justified in LTCFs on account of safety and security. All LTCFs have "policies and mechanisms in place

that govern exiting, access, and security" (Tufford et al., 2018, p. 35). Labelling confinement an act of security immediately serves to depoliticize the confinement, making it seem natural or inevitable (Neocleous, 2000). To argue against locks, confinement, and restraint is then framed as arguing against safety and security.

For LTCF's, risk is defined in terms of legal culpability for the institution (Tufford et al., 2008). This has obvious effects on quality of life for the patients of these facilities. For example, patients are often placed in wheelchairs to prevent falls because falls are tracked and negatively impact the PR of the facility. Therefore, restraint in the form of psychotropic medications and/or wheelchairs with belts or tables so residents are strapped to the chairs, or reclining chairs so residents are prevented from standing up are widely practiced in LTCFs (Tufford et al., 2018). Additionally, the ability to go outdoors or access food and water is often extremely limited by controlling gatekeepers and/or lack of adequate staff on account of the safety of the resident (Tufford et al., 2018). In these ways, dominant practices of risk assessment and management "sacrifice long-term quality of life for short-term risk aversion" (Tufford et al., 2018, p. 45). The result is that older adults' control over aspects of their life as basic as mobility are taken from them so that if they were not truly incapacitated before admission then they may well be shortly thereafter.

In this way, risk assessment is value-laden in terms of how risks are "characterized, measured, and interpreted" (Renn, 2008, p. 52). For LTCFs, risks associated with institutionalization or custody are offloaded onto the patients; as the risk (e.g. legal liability for harm) decreases for the workers, facility administrators, and industry at large (e.g. through legislation such as Bill 218), risk of harm (lack of safety) increases for the patients. Using the example of restraints again, LTCFs will harm patients over time through excessive sedentariness,

polypharmacy, and by degrading their sense of self rather than *risk* numerous falls on their records. Therefore, particular types of risk-management are "prone to organizational failures and deficits that may increase the actual risk" (ibid, p. 52). For example, polypharmacy leading to iatrogenic harm is an example of a routine practice within LTCFs that increases the actual risk of harm for patients.

While the threshold number of prescriptions varies, polypharmacy refers to the use of multiple drugs by a single person for one or more health conditions and "whose toxic effects often go unreported to patients and the public at large" (Rimke, 2018). Polypharmacy has been identified as dangerous or potentially dangerous for older adults as seen in efforts to "deprescribe" (Farrell et al., 2019). Polypharmacy often leads to what are labelled adverse drug reactions (ADR) whereby a prescription drug is or becomes noxious (poisonous) to the body leading to reactions as mild as temporary rashes and as severe as memory loss and other symptoms of cognitive impairment, imbalance leading to falls, and/or death (Farrell et al., 2019; Wu, Bell, and Wodchis, 2012). Generally speaking, the more drugs and the more drug classes prescribed and taken, the higher the risk of ADR, especially among older adults (CIHI, 2018, p. 11). In addition to the medicalization of aging whereby older adults are the most drugged demographic in our society, physiological changes as we age such as decreased liver and renal functions leads to higher risk of ADR (Armstrong, Choiniere, and Armstrong, 2016). ADR Canada claims that ADR is the fourth leading cause of death in Canada and costs the health care system between $13.7 and $ 17.7 billion dollars annually (2021).

In the first population-based research to study ADR-related emergency department (ED) visits in Canada, Wu, Bell, and Wodchis (2012) used hospital data in Ontario from 2003-2007 to estimate the incidence and economic cost of ADR among those 65 years and older. They found

that in Ontario, ADR-related ED visits increased from 6040 in 2003 to 7222 in 2007 and on average, 78% were discharged, 21% were admitted (hospitalized) and .07% died. In terms of cost, the researchers estimate that at $333.00/ED visit and $7528.00/hospitalization, the total cost of ADR-related ED visits in Ontario in 2007 was $13.6 million. After ADRs listed as unspecified, ADRs leading to cognitive impairment were the most common including "mental disorders due to multiple psychoactive drugs, mental disorders due to opioids, and mental disorders due to sedatives or hypnotics" (Wu, Bell, and Wodchis, 2012, p. 773). Additionally, Wu, Bell, and Wodchis (2012) found that LTC residents are just over 2 times more likely to experience severe ADRs (resulting in hospitalization or death) than those living in the community.

Studies measuring the incidence and cost of ADR hospitalizations among those 65 and over have limitations that likely result in an underestimation of incidence such as misdiagnosis of ADR for a disease (e.g., dementia) as well as a lack of mandatory reporting of ADR (ADR Canada, 2021). The study by Wu, Bell, and Wodchis (2012), for example, depends on the diagnostic labelling of attending medical professionals at the hospitals. Ignorance surrounding ADR within medicine not only under-estimates the prevalence of ADR among the elderly, but also leads to further iatrogenesis in what the CIHI (2018) calls a "prescribing cascade" (p. 12). In these cases, ADRs are misinterpreted as symptoms of new diseases, especially dementia among older adults (recall that the most common ADR symptoms reported by Wu, Bell and Wodchis (2012) were mental disorders or cognitive impairments). Misinterpreted symptoms often lead to new diagnoses for which more inappropriate prescriptions are then provided. This not only fails to resolve the initial problem (ADR) but further compounds the problem by adding more prescriptions. This is supported by Wu, Bell, and Wodchis (2012) research findings whereby in

the 30 days preceding ED visits, patients had on average, between 1.7 and 2 prescriptions added to their drug therapy (p. 774).

Older adults living in LTCFs are, on average, prescribed more drugs and more drug classes than older adults living in the community (CIHI, 2018). In 2016, older adults living in LTCFs were prescribed, on average, 9.9 drug classes with 51% of male patients and 47.1% of female patients prescribed 10 or more drugs (CIHI, 2018, p. 36). Anti-depressants are currently the most commonly used drug-class among institutionalized older adults, prescribed 4 times as often as for those living in the community (CIHI, 2018). In recent years, drug classes targeted for reduction among institutionalized elderly due to negative health outcomes are benzodiazepines (tranquilizers), PPIs (proton-pump inhibitors generally used for acid reflux), and sulfonylureas (used to treat Type 2 Diabetes). Interestingly, while the use of benzodiazepines has reportedly decreased in LTCFs due to such efforts, the use of anti-depressants has increased. According to the CIHI (2016), "this may be due to trazodone [anti-depressant] increasingly being prescribed off-label as a sedative in place of prescribing benzodiazepines" (p. 40). This suggests that efforts to reduce particular drug classes are not making institutionalized elderly safer as other drugs are substituted until or unless they also become targets for intervention. Therefore, dangerous prescribing still occurs at alarming rates, especially for institutionalized older adults in LTCFs.

Regarding prescription drugs and ADR, it is important here to remember that apocalyptic demography and neoliberal rhetoric blame older adults for 'driving up' healthcare costs. However, research on ADR among older adults suggests that older adults are over-medicalized and subject to medical treatments which may not meet their needs but instead cause further harm, incapacitation, and even death (iatrogenesis), especially though the use of physical and chemical restraints (Frank, Hodgetts, & Puxty, 1996; Feng, et al, 2009). In short, this research suggests

that medicalization and dominant prescribing practices, rather than older adults, are contributing to high health-care costs. Therefore, polypharmacy as a dominant medical practice contributes to the insecurity of LTCF patients while also impacting public policies and healthcare spending.

Media Portrayals of LTC

Previous work examining media portrayals of LTCFs have shown the ways in which such facilities along with those who are confined therein are constructed as both a crisis and a tragedy (Funk et al., 2020; Latimer, 2018; Macleod, 2019). Using language associated with apocalyptic demography, aging and dementia are constructed as crises, generating public panic which is legitimized through the use of biomedical terms such as "epidemic" and "disease" (Funk et al., 2020; Macleod, 2019). What is framed as a public problem (the aging crisis) "problematizes individuals aging in public rather than acknowledge the insufficient public services for the aging population" (El-Bialy et al., 2021, p. 28). This raises important questions about public perception and provision of care for older adults and the implications on the safety and security of those institutionalized in LTCFs.

Crisis construction and fear mongering regarding aging, disability, care, and now too, COVID-19, have essentially rationalized the institutionalization and confinement of older adults and shaped their provision of care or lack thereof. For patients, their families, and the public at large, LTCFs are portrayed as naturalized spaces for an aging population with the emphasis that, despite all negative aspects, there is no alternative (Funk et al., 2020; Konietzny et al., 2018; Macleod, 2019). Systematic abuse is rationalized in LTCFs "particularly when older people are associated with care reduced, over and over again, to its economic cost" (Latimer, 2018, p. 842). This crisis construction obscures the widespread harm, including mass death, toward older adults in LTCFs. When harm is manifested in physical symptoms, these can be conveniently explained

away via the patient's age and medical or diagnostic label and presented as tragic (undesirable but inevitable). This is consistent with existing research on pandemics whereby mass human rights violations often occur as they are easily obscured in the confusion of an ongoing crisis. Indeed, the United Nations has confirmed that older adults are at a higher risk of human rights violations during COVID-19 outbreaks (Previtali, Allen, & Varlamova, 2020). Importantly, previous studies on the portrayal of residential LTC note that speakers or central actors are most often government officials and LTC industry representatives and less often patients and/or their families (Miller, Livingstone, & Ronneberg, 2017).

Research examining media representations of residential LTC in Canada in the context of the COVID-19 pandemicization of society is sparse, given the novelty of the situation. Preliminary media analyses of residential LTC in this context in the United States suggests an increase in media reporting on nursing homes, leading some researchers to be optimistic about longstanding issues in nursing homes gaining public saliency (Miller et al., 2021). However, the same authors also noted that tone of media coverage is also crucial. In this regard, other media analyses of residential LTC reporting found a negative framing of nursing homes as dangerous and disastrous (Allen & Ayalon, 2020). Importantly, the negative framing of residential LTC excludes and omits the voices, observations, and concerns of patients while at the same time, patients are negatively framed as helpless and their deaths as inevitable (Allen & Ayalon, 2020). Previous analyses of media reporting on residential LTC during times of crisis or disasters suggest that "the devaluation of residents is especially apparent during times of crisis" (Allen & Ayalon, 2020, p. 87).

In this regard, it is important is to deconstruct how age(ing), care, and safety, in relation to the COVID-19 pandemicization of society and long-standing safety issues within LTCFs are

portrayed. The COVID-19 pandemicization of society is an opportunity or case study to explore issues of age(ing), care, and safety in the mainstream media given the high number of deaths of LTCF patients attributed to COVID-19 and subsequent contestations over cause of death by LTCF patients, their families and advocates, and the report from the CAF in the Spring of 2020. Following Allen & Ayalon's (2020) exploratory research on this topic, attention to media reporting is crucial in determining agenda-setting and what will later become common parlance among government, industry, and the public at large. They note:

> "The depiction of residential care in newspapers is crucial to understanding how the cultural narrative surrounding older adults and residential care will change and subsequently impact the industry. Journalistic discourse during this time plays a particularly crucial role in future agenda-setting for policy and practice." (p. 87)

Specifically, my research gives attention to the articulation of problems and proposed solutions including and perhaps most importantly, what remains unsaid or unreported in regard to older adults' safety and security. This is important because how a problem is defined effects and potentially limits, what are imagined or proposed solutions. Contrary to the predominant view that public health policy is arrived at by systematically examining all evidence and acting based on the best available evidence toward a common problem, evidence and ideas do not speak for themselves. Rather, competing evidence is presented in a conflictual environment (organizations and lobby groups competing for resources). Moreover, politicians, advocates, lobbyists, and policy-makers are not outside of society, but implicated in ongoing social relations. Therefore, from a discursive perspective, research evidence is, at least in part, socially constructed (Fafard, 2008). This means that there are not only disagreements among proposed solutions based on available evidence, but also, on the definition of the problem at hand (Fafard,

2008). In short, the naming and framing of problems take on great significance as "prescriptive narratives" (Fafard, 2008, p. 16). According to Fafard (2008) in his consideration of various models of policy-formation, widespread deliberation and understanding of social problems is necessary for democracy. He notes: "What is possible and indeed essential is that policies be the product of democratic deliberation, facilitated by policy analysts as deliberative practitioners whose role is to develop a shared understanding of policy issues and policy problems" (p. 3). Fafard emphasizes, above all, dialogue among groups toward a shared understanding of policy problems.

There are relationships between media representations, public opinion, and policy-formation which in effect, prevent the democratic deliberation called for by Fafard (2008). In short, media representations influence public opinion which then effects the naming and framing of problems and proposed solutions. This becomes a cyclical or self-perpetuating process, ultimately limiting democratic engagement and enlightened thinking. Additionally, media representations, especially when repeated over time with little new information, risk compounding public health problems and consequences through psychological distress (Garfin, Silver, & Holman, 2020). For example, Garfin, Silver, & Holman (2020) note that following the Boston Marathon bombings, members of the public who reported the highest level of media exposure also reported higher stress levels than those who were actually present at the bombings. In this way, it is necessary to study media representations during times of crisis (in this case, the COVID-19 pandemicization of society) given the potential for media representations to exacerbate existing crises. Given some of the context of LTCFs outlined here, the purpose of my thesis is to ask: **How were age(ing), care, and safety talked about or constructed in print media reports on LTC in Ontario during the eight months following the declaration of the**

(ongoing) COVID-19 pandemic? In the broader demographic context of an aging society with projected increases in the number and proportion of older adults requiring or said to require LTC, the purpose of this research is to interrogate the ways we conceive of or think about what it means to grow old, to give and receive care, and to be safe.

Chapter 3: Methodology

Introduction

This research applied Fowler's (1991) critical discourse analysis to media (*National Post* newspaper articles) reporting on LTC in Ontario during the first eight months of the (ongoing) COVID-19 pandemic and pandemic responses (pandemicization of society). Specific attention was paid to the construction, portrayal, or constitution of *age(ing)*, *care*, and *safety* for older adults requiring or said to require LTC. Media archives collected were analyzed in the context of the COVID-19 pandemicization of society, the structural conditions (political economy) of LTCFs in Ontario, as well as previous social gerontological work and gray literature on LTC in Ontario as outlined in the literature review. A sociological approach was most suitable for this task given its inherent transdisciplinary nature and principles (Rimke, 2010). Sociological works examine the multi-faceted relations between individuals or personal experiences and the organization of the society in which they occur. This is epitomized in C. Wright Mills' (1967) concept of the Sociological Imagination whereby personal troubles are always also public issues and the result of broader social arrangements.

Importantly, CDA is used as a tool for deconstructing news as a social product. Fowler's (1991) work, *Language in the News: Discourse and Ideology in the Press* was relied on for methodological guidance in this research and is worth quoting at length:

> "News is not a natural phenomenon emerging straight from 'reality', but a *product.* It is produced by an industry, shaped by the bureaucratic and economic structure of that industry, by the relations between the media and other industries and, most importantly, by relations with government and with other political organizations. From a broader

> perspective, it reflects, and in return shapes, the prevailing values of a society in a particular historical context" (Fowler, 1991, p. 222).

Key Terms and Concepts

Theoretically, this research relied on post-structural theory in its consideration of aging subjects through the constitutive effects of power relations (Delanty & Strydom, 2003). Post-structural theory analyzes how knowledge claims, in part, construct what they purport only to name. Consequently, knowledge claims are "reality-creating forces" and cannot be separated from the context in which they emerged (Delanty & Strydom, 2003, p. 372). Thus, power is operationalized through techniques of claims-making and subsequent practices which become encouraged, normalized, or enforced. Resultantly, power is productive in the sense of forming norms of citizenship or personhood (Arribas-Ayllon, 2016). Rather than a linear cause and effect model for understanding power whereby knowledge is equated with power which one either possesses or fails to possess, knowledge contributes in various ways and contexts to the exercise of power (Adams & Sydie, 2001). For example, claims of ignorance or lack of knowledge are major exercises of power as a strategy to obscure facts, liability, and accountability (McGoey, 2012). Thus, power is exercised rather than possessed; productive rather than repressive; dispersed rather than centralized. Exercises of power through claims-making shapes identities, roles, activities, and relationships through **governmentality**:

> *Governmentality as a specific form of modern power is premised on knowledge as a regulatory mechanism, on the one hand, and the production of self-regulating subjects that draw on various forms of expertise, on the other. While the state remains a powerful player in the politics of regulation, governmentality is premised on the principle of 'governing at a distance' through intermediary agencies that, in turn, are also subject to*

> *various forms of surveillance. Thus, the web of governmentality is a lot wider than the power exercised by what we think of as 'the government'.* (McDonnell, Lohan, Hyde, & Porter, 2009, p. 97)

Therefore, this research was oriented to knowledge claims and the naming and framing of problems and potential solutions regarding older adults and LTC in Ontario in the context of COVID-19 and the *contingent* possibilities of age(ing), care, and safety which are produced.

Eventualization challenges social theories of inevitability and naturalism and instead highlights contingency—for every action that happened, other actions could have happened (Delanty & Strydom, 2003, Rimke & Brock, 2012). Eventualization is a central component of post-structuralism whereby the articulation of a problem (in this case, how a society deals with an aging population) is an event to be studied and deconstructed (Murphy, 2005). As such, the focus of analysis becomes how both a problem (requiring assistance with daily living) and its human subjects (older adults) are constructed through discourse.

Discourse refers to all elements (such as speech, text, and/or graphics) that contribute to or construct our understanding of any given phenomenon or concept. For example, the discourse on LTC can include commercials or promotional materials from LTCF companies, government public policies and documents, media representations of LTC, online blogs on the topic of LTC, as well as personal and interpersonal encounters with various dimensions and settings of LTC. All auditory and visual aspects of these documents and encounters, taken together, form a discourse on LTC. Thus, discourse is a system of representation whereby "a socially constructed model of the world is projected on to the objects of perception and cognition, so that essentially the things we see and think about are constructed according to a scheme of values, not entities directly perceived" (Fowler, 1991, p. 92). In this way, discourse is productive as it produces

certain conceptions of what LTC is or needs to be rather than describing something pre-existing, static, inevitable, or unchanging. Therefore, discourse is necessarily politically charged and strongly implicated in power relations and how such relationships are (re)produced or challenged over time (Fowler, 1991; van Dijk, 1985)

Discourse is not only about words and cognition but also actions. Therefore, CDA is about examining the relations between cognition and action (Qianbo, 2016). Discourse on aging is important because it affects how we perceive and subsequently act toward ourselves and each other as well as policies pertaining to an aging population. Thus, attention to discourse is important given that, "discourses, then, have material effects that 'specify what is morally, socially, and legally un/acceptable at any given moment in time'" (Macleod, 2019, p. 64). Therefore, the purpose of analyzing discourse within this project is to make clear the relationships between language, thought, and action regarding age(ing), care, and safety in LTC in Ontario.

Relating discourse to the Marxist concept of hegemony, Fairclough (2001) describes discourse as part of a "legitimizing common sense which sustains relations of domination" (p. 124). However, discourse is not static or unchanging but rather, contestable, especially with an awareness of its effects. Fairclough elaborates: ". . . hegemony will always be contested to a greater or lesser extent, in hegemonic struggle. An order of discourse is not a closed or rigid system, but rather an open system, which is put at risk by what happens in actual interactions." (Fairclough, 2001, p. 124). Deconstructing discourse is productive as it empowers us to understand how any given discourse became constituted and when necessary, develop alternative conceptualizations to re-imagine and transform our society (Keller, 2018), also known as counterhegemony (Rimke, 2017).

Discourse is also related to **ideology.** In short, ideology refers to value systems which are in part, encoded in language. Qianbo (2016) describes ideology as follows: ". . . language, as a social practice, helps humans make order of the world and society through naming, which at the same time classifies the world and even humans themselves into different categories. Gradually, these socially determined classifications become our taken-for-granted and fixed perceptions about the world, and that is called ideology" (p. 38). Discourse, hegemony, and ideology are all linked together in that ideology is encoded in discourse which can become hegemonic in that it serves the interests of persons or groups in positions of authority.

Critical Discourse Analysis of Media Representations

Fowler (1991) expresses these connections in the daily functioning of the news given the economy of time in producing daily news reports. In short, institutions, events, and people whom journalists monitor and solicit information from are usually in positions of authority and part of bureaucratic organizations including spokespersons with scheduled statements, and resources to pay for publicity and public relations (Fowler, 1991). Greer and McLaughlin (2017) summarize that journalists have "limited autonomy: in the final instance, they sit in a position of 'structured subordination' to the powerful sources upon whom they rely for newsworthy information" (p. 271). This is not because the press is necessarily conspiratorial, but rather because this is the automatic and daily operations of the media in a particular economic context (e.g., securing readership and therefore revenue through subscription and advertisement to daily news stories which attract readers via sensationalism). In this way, mainstream news media is essentially the naming and framing of problems and potential solutions by official sources which then become taken up by the public in various ways.

Importantly, the news media is considered by media scholars to be event-biased meaning that *events* are considered newsworthy (e.g., daily press conferences by governments with COVID-19 infection updates) while *issues* are rarely reported on (pre-existing issues within LTCFs and the social determinants of health). This has important consequences, as summarized by Nussbaum et al. (2000): "If the agenda being set by the mass media is inaccurate, such an agenda may serve to impede social progress and lead researchers and policy makers in the wrong direction" (p. 95). In this way, news that is event-biased can lead to widespread ignorance while appearing to cover leading issues.

While media reports have the potential to significantly shape worldviews given their immense platform (newspapers, television, cellphones, radios) and especially during times of crises (real or perceived) the influence of media on our conceptions does not mean there is a linear connection between media reporting and public or individual opinion as was once popularized with the 'hypodermic needle' or 'bullet theory' of media effects (Fowler, 1991; Nussbaum et al., 2000). Rather, for this research, media reports are understood as media productions whereby meaning is analyzed as the "interaction between the text and the social discourses it encounters at the moment of decoding" (Connell & Mills, 1985, p. 39). In this way, media reports are part of a constitutive, complex, and messy whole of ongoing social production rather than artefacts of a static, fixed, inevitable, or universal meaning. Importantly, following Fowler's (1991) work on discourse and ideology in the news, the media is understood to consist of ideas about the world rather than facts. In an industrial-capitalist society, "news is an industry with its own commercial self-interest" (Fowler, 1991, p. 2), however, this aspect is often neglected as media claims to represent contemporary social issues. Therefore, this research

deconstructed media discourse on LTC in Ontario *vis-à-vis* the social context in which it circulates.

While some have argued that print media is dying out given the prevalence of digital platforms for information sharing, other media scholars have argued to the contrary. Greer and McLaughlin (2017) maintain the digital transformation of the news market has actually increased corporate power to define the news across media forms. In a context of information overload, newspaper corporations "are reasserting their authority as powerful filters and legitimators, revalidating the distinction between 'information' and 'news' and imposing their own brand of interpretive order" (ibid, p. 265). Moreover, newspapers often have their print articles digitized on their online platforms, including the National Post, which was the newspaper reviewed and analyzed for this research using the principles of critical discourse analysis or CDA.

Ontological and Epistemological Assumptions

Post-structuralism can be understood as a theory or an intellectual movement (McDonnell, Lohan, Hyde, and Porter, 2009). A major component of post structural theory is recognizing that knowledge plays a constitutive role. By this is meant that rather than describing something pre-existing or claiming to represent reality in the form of a mirror image, knowledge is understood to play a role in constructing reality. Therefore, news does not reflect reality but rather, plays a role in producing what we regard as real. Resultantly, this research is **critical realist** because while it is acknowledged that a reality may exist independent of our knowledge of it, we have no way of stepping outside of this world to verify or determine whether something is 'really real' (Hammersley and Atkinson, 2007). Most of our knowledge of what is 'really real' is socially mediated. Therefore, when talking about social constructionism, it is necessary to distinguish a given phenomenon from how we conceive of it (Hacking, 1999). Rather than

'uncovering' underlying or pre-existing attitudes, motivations, beliefs, or practices, post structural theorists are focused on observing and recording the "dynamic ways in which people bring issues and problems to life by talking about them or acting around them" (Carter and Little, 2007, p. 1319).

Consequently, the epistemological framework for this research project is broadly that of constructivism. This means that the point is to deconstruct dominant discourse or repeated utterances to understand how our present reality is constituted. The theoretical tradition of discourse analysis includes a "commitment to exploring the ways that knowledges—the social construction of people, phenomenon, or problems—are linked to actions/practices" (Burr qtd in Gill, 2011, p. 3 of 21). As previously mentioned, discourse is not seen as revealing a reality behind the text but rather, at what the content, form, and context of the text produces. This represents a move from simplistic or linear accounts of representation (positivism) to more complex and nuanced theories of social production (Fowler, 1991).

However, when discussing social constructionism, it is necessary to clarify what, precisely is being constructed and in many cases, to delineate a phenomenon from how we conceive it (Hacking, 1999). To use age(ing) as an example, obviously, there are real biological and physiological consequences of aging (time passing) and social experiences such as medical interventions. Therefore, biology interacts with social constructions of what it means to grow old (including social status, roles, identity, and relationships) and vice versa. The point of social constructivism should be to examine these interactive effects in the lives of older adults rather than clinging to one or the other. Therefore, when I refer to the social construction of aging, I am not denying biological realities as to do so is harmful—for example, ignoring the documented

relationships between nutrition and cognitive impairment. Rather, I am seeking to link the real effects of how older adults are treated based on social constructions of aging, care, and safety.

Finally, a constructivist epistemology must acknowledge that the act of deconstruction also plays a role in the constitution of reality, particularly in the production of knowledge. In this way, I will be a co-creator of knowledge rather than representing something in an imagined pure form. The knowledge produced by this research will be a product of my specific interactions and relationships with the people and documents with whom I interact in a particular time and place.

Methods for Data Collection and Analysis

The ProQuest News & Newspapers database was used to obtain newspaper archives from the *National Post* from the start of the declaration of the global pandemic (March 12, 2020) to November 12, 2020 (the most recent media archival coverage that can be accessed in these archives is 3 months ago). Using search criteria of "Ontario AND "Long-Term Care" AND Safe* AND Care*" yielded 133 results. This search was conducted on January 30, 2021 and was saved to a ProQuest research portal. Criteria for exclusion included duplicates and articles where passing references to LTC were made only to case and death counts. While such references still constitute part of the media discourse on LTC during the pandemic, for the purposes of this research, I included any article with substantive information on LTC in Ontario (whereby LTC was the main topic of inquiry). For example, articles which focused on expected or anticipated dates for eased restrictions in Ontario often mentioned case and death numbers in LTCFs as part of the modelling forecasts but did not discuss LTC in any substantive way. Such articles were excluded as LTC was not the main topic of inquiry. Using this exclusion and inclusion criteria, a manual review of the 133 articles (reading through each article) deemed 38 to be relevant.

The *National Post* was chosen for two main reasons. The first is its authority and popularity. According to News Media Canada, Postmedia Network, the company which owns the National Post, has both a high number of editions in Canada (70) and Ontario (22) as well as some of the highest levels of circulation and distribution with over one million copies of Postmedia news circulating every day (Levson, 2020). While the *National Post* is only one product of Postmedia Network, the centralized corporate ownership of Postmedia network indicates that media content may be similar across various editions owned by the same company. For instance, Postmedia Network also owns the *Toronto Sun* and the *Ottawa Sun*. The second reason is more logistical. The *National Post* is the only Ontario-based newspaper which has up-to-date (delayed three months) digital media archives at McMaster University Library. Media archives collected were analyzed using Roger Fowler's Critical Discourse Analysis (CDA) as outlined in his work *Language in the News: Discourse and Ideology in the Press* (1991). CDA focuses on social issues and their representation and constitution (Fowler, 1991; Qianbo, 2016). In line with the previously outlined constructivist epistemology, discourse is not seen as revealing a reality behind the text but rather, at what the content and form of the text produces in a particular time and place (context), how the social context shapes the text, and how the text may influence the social context or conditions. Therefore, the analysis was multi-faceted, moving between what is written, by whom, in what context, and to what effect/function.

All selected articles were read several times. First, an article was read without taking any notes in order to achieve familiarity (Gill, 2000). During the second reading of the articles, attention in the form of systematic detailed notes for each article was directed toward: date (when was the article written in relation to other events?); authorship (who wrote the article?); style (what type of report?); speakers (who is speaking in the articles?); content (what is being

said about LTC including themes, main problems, and proposed solutions?); and function (how are age(ing), care, and safety constructed or constituted in media reporting on LTC in Ontario?) Given that news selection "immediately gives us a partial view of the world" (Fowler, 1991, p. 11). attention was also paid to what went unsaid or was absent from the articles reviewed (van Dijk, 1985). Findings for date, authorship, style, speakers, and content are presented in chapter 4. Chapter five presents an analysis of the data, with a particular emphasis on speakers and the naming and framing of problems and potential solutions as well as a discussion of how ageing, care, and safety are represented in the data, in what context, and to what effect, especially for an aging population. Important and long-standing social facts regarding age(ing), care, and safety in LTCF in Ontario which were omitted from the data reviewed are noted throughout the remaining chapters.

Finally, as mentioned in the discussion of epistemology reflexivity will be an important aspect of the data analysis given that researchers are also involved in producing discourse in particular contexts. In addition to the literature review and discourse analysis of newspaper text, this research involved keeping a journal to document my own involvement in the research (e.g. interaction, reactions, assumptions, emotions) and its effect on the research questions, assumptions, and outcomes and/or findings.

Chapter 4: Findings

Out of the thirty-eight retrieved articles, twenty-eight of the articles were news reports, three of the articles were full page news reports/feature stories, four were editorials by National Post columnists, and three were letters to the editor from members of the public. Authorship was largely varied (26 different authors in total) with only five authors writing more than one article on the topic of LTC in Ontario (Samuel Riches [2], Matt Gurney [2], Brian Platt [2], Randall Denley [2], Elizabeth Payne [3], and news reports from the Canadian Press [7]).

Newspaper articles on LTC in Ontario were most concentrated in the Spring (April and May) with fewer articles throughout the summer and into the fall. There were 14 articles in April, six articles in May, three articles in June, six articles in July, two in August, zero in September, four in October, and two in November. Two of the Letters to the Editor were published in July. Again, this reporting is consistent with events that occurred in the Spring including higher than forecasted deaths in LTCFs, the province's call for military support to care for older adults in institutions, and of course, the report released by the CAF (Taylor, 2020).

A number of patterns across all the articles over time were observed. These patterns can be summarized by the following themes: LTCFs as in a crisis from an out-of-control virus; LTCF patients as inherently sick and weak; and solutions to systemic problems framed as pragmatic reforms which would actually expand the LTC sector. Importantly, these themes connect to form a seemingly rational account of the mass deaths across LTCFs in Ontario and also align with the account presented by the Ontario Long-Term Care COVID-19 Commission Final Report (Marrocco, Coke, & Kitts, 2021). The connections between the themes in the newspaper articles reviewed and the Ontario LTC COVID-19 Commission Reporting will be further elaborated in the discussion.

LTCFs in Crisis from an Out-of-Control Virus

In the initial articles in the Spring of 2020 before the release of the CAF report, problems were most often framed as higher than expected death rates in LTCFs and the consequences on the general public (preventing eased pandemic restrictions). Toward this end, LTCFs were described in negative terms including "most vulnerable not protected" (Brean, March 31, 2020), "crisis" (Riches, April 11, 2020), as "driving death toll" (Thomson, April 14, 2020), workers as "scared and exhausted" (Humphreys, April 14, 2020), "carnage" (Gurney, April 15, 2020), and responsible for "breaking modelling forecast" (Platt, April 16, 2020). There was little focus on accountability as governments and LTCFs were depicted as genuinely or altruistically scrambling to get control of a mysterious or elusive virus. This was largely accomplished through personifying the virus. For example, the virus was described as "unexpected" and "catastrophic" (Riches, April 11, 2020), as "driving up fatality rates" (Platt, April 16, 2020), as "sneaky and deadly" (Gurney, April 15, 2020), as a "wildfire" (Platt, April 16, 2020), and as "sweeping" into LTCFs and having "severe impacts" (The Canadian Press, April 17, 2020). Subsequently, LTCFs are described as being "hit hard" (The Canadian Press, May 15, 2020) and "ravaged by the virus" (Platt, April 16, 2020). Importantly, even in the fall of 2020, the cause of death was still assumed to be the COVID-19 virus and the COVID-19 virus alone which was presented in elusive terms. For example, Kirkey's article (October 13, 2020) was titled, "COVID-19 seeps back into nursing homes".

LTCF Patients as Sick and Weak

Following discourse of crisis and an out-of-control virus akin to a natural disaster, age was tacitly presented as an independent risk factor for COVID-19 susceptibility and severe outcomes. In both of Denley's columns (April 24, 2020 and May 27, 2020) LTCF patients are

presented as inherently sick and near death. It is suggested that LTC be re-named "end-of-life care" (Denley, April 24, 2020). LTCFs are depicted as places where people die: "18,000 people a year die in LTC"; LTCFs house people who are in "dire straits" (Denley, April 24, 2020). Patients are described based on their ailments alone: "90% have cognitive impairment; two thirds have dementia; ¾ have heart or circulation diseases; and 61 percent take 10 or more medications and 21% have had a stroke" (Denley, April 24, 2020). The sector is described as housing the "oldest, sickest people, often in tight quarters"; "Yes, when a person enters long-term care he is only a year away from death, on average" (Denley, May 27, 2020). In these ways, Denley constructs older adults as medical cases who are destined to die. Similarly, in a July 4, 2020 article referencing the Royal Society of Canada COVID-19 Taskforce Report, the author (Lowrie) summarizes the report as characterizing LTCFs as "uniquely vulnerable to COVID-19, combining an already sick patient base with a novel disease to which nobody has immunity, the report says." This has the effect of naturalizing and de-politicizing high death rates in LTCFs. The positioning of LTCF patients as inherently sick led to calls to 'protect' (i.e., confine) the aged. While this aspect will be further elaborated in the next chapter, briefly, this was most explicit with Doug Ford's reference to an "iron ring" around LTCFs (Brean, March 31, 2020), but also Theresa Tam, Canada's Chief Medical Officer, was quoted as referring to deaths at LTCFs as "the chink in our armour", connoting military force and equipment (Platt, April 17, 2020).

Expansion of LTC Sector

Following the above depictions, problems and their proposed solutions in LTC in Ontario are framed as logistical, rational, or pragmatic in nature such as the need for more beds, the need to renovate existing facilities, the need to provide more public resources to the LTC industry (i.e.

more staff, better pay, and more infrastructure dollars), and after the release of the CAF report, the need to call an inquiry. Within this context, reporting on ongoing high infection and death rates in LTCFs during the Spring of 2020 were largely presented as a tragedy (sad but inevitable) and the result of the LTC sector as being over-regulated and unsupported over the years by multiple levels of government. For example, Donna Duncan, CEO of the Ontario Long-Term Care Association (OLTCA) was summarized by Riches (April 11, 2020) as follows: "Duncan says one of the many take-aways from this crisis is, despite best intentions, the legislation is so prescriptive that it creates barriers to how employees can respond to emergencies. Duncan describes it as a level of micromanagement that infantilizes the sector". Similarly, Denley in his column titled, "Long-term care crisis not due to 'greed'" (April 24, 2020) noted in the opening paragraph that the LTC sector "has been misunderstood and ignored for far too long". Blackwell's article on June 26, 2020 was titled, "How crowding killed hundreds" and also featured Donna Duncan as a speaker calling for more LTCFs and more LTC beds, ultimately positioning infrastructure to blame for mass deaths of LTCF patients. Finally, Wright's article (July 23, 2020) was titled, "Long-term care needs funds now: advocate" and positioned Jodi Hall (Chair of the OLTCA) as the advocate. Hall was quoted as calling for more federal dollars to construct more LTCFs and more LTC beds. Hall was quoted as externalizing the causes of mass deaths of LTCF patients and, given my interest in the naming and framing of problems and potential solutions, is worth quoting at length:

> "'Long-term care homes were uniquely vulnerable to COVID-19, combining an already sick patient base with a new coronavirus, to which nobody has immunity. Nursing homes in Canada are often older and feature shared bedrooms, bathrooms, and dining rooms,

which made containing COVID-19 a challenge in the early days of the pandemic when little was known of its ability to spread through asymptomatic people', Hall noted". Across these articles and succinctly summarized by Hall's quote, the news reporting had the effect of blaming the health status of LTCF patients, a presumably novel or mysterious virus, and old infrastructure for mass deaths of LTCF patients. This naming and framing of problems externalizes accountability for who can be held accountable for sick patients, a novel virus, and inherited infrastructure?

Following the release of the CAF report (May 14, 2020) other dimensions of LTC were framed including: the role of profit (Tumilty, May 29, 2020; Payne, June 6, 2020), LTCF accountability (Tumilty, May 29, 2020), whether to call a commission or an inquiry (Gurney, May 27, 2020), the potential for lawsuits (Berthiaume, June 8, 2020), reasons why deaths in LTCFs were so high (Blackwell, June 26, 2020; Lowrie, July 4, 2020; Lord, July 4, 2020; Cartan, July 4, 2020), and families' struggles to care for their loved ones inside LTCFs including lack of communication from facilities and overly-strict rules on visitations (Thompson, July 27, 2020). Importantly, these topics were anomalies in the 38 articles reviewed and despite mention of systemic problems like the profit incentive, the LTC industry was still presented as over-regulated, unsupported and underfunded with the main calls or solutions being: continued isolation of patients and staff, use of PPE, more staff, and more LTCFs and beds (i.e., expansion of LTC sector).

Speakers

Given the numerous stakeholders in LTC in Ontario, attention was given to speakers and the naming and framing of problems and potential solutions. A full list of all speakers from whom the newspaper authors elicited information and sometimes direct quotes is presented in

Appendix B. Speakers fell into one of the following categories according to the role in which they were speaking (these categories reflect the various groups or stakeholders in LTC in Ontario): Politicians and policymakers; LTC industry representatives; doctors; workers and their representatives; families of LTCF patients; LTCF patients; advocates for older adults; and members of the public. For each article reviewed, speakers were listed and then tallied. Therefore, if two different politicians were speakers in one story, it was counted as two. Overall, politicians and policymakers were included as speakers 33 times; LTC Industry Representatives 11 times; Doctors were also included as speakers 11 times; Workers or their representatives were speakers four times; Families of LTCF patients were speakers eight times; LTCF Patients four times; Advocates for older adults and institutionalized older adults nine times; and members of the public were speakers six times.

Speaker	**Frequency**
Politicians and Policymakers	33
LTC Industry Representatives	11
Doctors	11
Workers or their Representatives	4
Families of LTCF Patients	8
LTCF Patients	4
Advocates for older adults	9
Members of the Public	6

Figure 1: Speakers and Frequency

A reference list of all articles included in the final selection can be found in Appendix A.

Chapter 5: Analysis and Discussion

After all speakers were categorized and tallied, attention was then given to the content of what each speaker or group was presented by the author as expressing regarding problems and potential solutions regarding mass deaths in LTC in Ontario. In order to determine the relationships between speaker and content, the major themes, main problems, and proposed solutions, by each speaker in each article were systematically documented. From here, various patterns were noted in the naming and framing of problems in LTCFs in Ontario according to speaker. Finally, how the naming and framing of problems with or in LTC in Ontario constructed or constituted what they purported only to name (i.e. age(ing), care, and safety) will be discussed.

Analysis: Speakers and the Naming and Framing of Problems and Solutions

Politicians and Policymakers:

Politicians and policymakers were the most frequent speakers in the analyzed articles (33 times) and have legal responsibility to oversee LTCFs in Ontario, including those run as P3s (public-private partnerships). Political leaders and policymakers were positioned as suggesting that to reduce illness and death in LTCFs all Canadians need to submit to pandemic rules and regulations in order for older adults not to die in subsequent outbreaks. For instance, Federal Minister of Seniors Deb Schulte was quoted as warning the public: "'But it will take much more than these guidelines to keep our seniors and vulnerable Canadians safe . . . It would be impossible to keep them safe without individual Canadians practicing social distancing" (Thomson, April 14, 2020). In this way, governments were framed as putting the onus for reducing illness and death in LTCFs on individuals and insinuated that we are somehow all to blame or all to be held accountable for mass deaths in LTCFs. For example, in Platt's April 16,

2020 article one of the headings read: “Trudeau calls on Canadians to protect seniors” with Trudeau later being quoted in the article as saying “We all need to do better. We all need to take leadership for the seniors who’ve built this country.”

Other proposed solutions that were said to come from politicians and policymakers included: Restricting visitors to only those necessary for medical or compassionate care; screening all staff and visitors; sending home staff with symptoms to recover; training on infection control measures; routine cleaning of high-traffic areas; limiting employees to a single facility where possible; testing of all LTCF employees and patients; employees and residents physical distancing to greatest extent possible including at mealtimes; consistent LTC guidelines across the country; and eventually, pay increases and wage boosts for LTCF workers, especially PSWs. Following the release of the reports from the CAF who entered five LTCFs in Ontario, numerous MP’s were reported to have demanded that Ford call an inquiry rather than a commission since an inquiry involves a greater amount of independence from the LTC sector (Tumilty, May 29, 2020). Proposed solutions from politicians and policymakers to the problems outlined by the CAF were largely limited to staffing and pay increases (see, for example, McQuigge, August 7, 2020). Overall, even after the release of the CAF report, politicians and policymakers framed the problems in LTC as due to a virus with solutions being pragmatic such as more isolation, more staff, and better pay for frontline LTCF staff.

Subsequently, politicians and policymakers were generally positioned by authors as framing the LTCFs and the frontline staff as both victims and heroes of the COVID-19 pandemic. For example, in one article, Justin Trudeau is quoted as saying to LTCF workers: “we know conditions have gotten more difficult over the past weeks, and you need support right now”; “as we face an unprecedented threat to public health, you are our most important line of

defense. We will do whatever we can to help you do your job and support you through this time." (Platt, April 16, 2020). When LTCF patients are referenced by politicians, the emphasis is on protection (e.g., protecting the vulnerable) but it is clear that in the context of the COVID-19 pandemic, protection was synonymous with confinement or even explicitly with incarceration most clearly captured in Doug Ford's concept of an "iron ring" around LTCFs (Brean, March 31, 2020).

Industry:

Representatives from the LTC industry in Ontario were featured in the retrieved articles eleven times. Legally, LTC industry representatives are stakeholders for the industry itself and not for patients or staff. Donna Duncan, CEO of OLTCA was featured the most (4 times) while various administrators from specific LTCFs were featured six times and Jodi Hall, Chair of the OLTCA was featured once. While sometimes named as representing the industry, other times LTC industry representatives were actually introduced and presented as advocates for older adults ("Long-term care needs funds now: advocate"). Similar to politicians, the LTC industry was reported as framing mass deaths as tragic but nonetheless an act of an outside force (akin to a natural disaster), which experts are trying their best to control. Facilities are at the epicenter of the COVID-19 pandemic and in this way, facilities were framed as victims in duress: facilities as "stricken" and facility administrators and staff as "grappling" with an unprecedented situation (Duffy, April 14, 2020). LTCFs were depicted as overwhelmed by unexpected sickness and death from an unknown cause, etiology, and epidemiology and overwhelmed by a novel virus and emergency protocols.

External factors that industry representatives framed as attributing to the mass deaths in LTCFs included: a novel virus and therefore a lack of immunity; LTCFs as housing a sick and

frail patient-base(sickness is naturalized among patients); staffing shortages *as a result of* staff having to isolate; shared health care providers among patients and facilities; transfers from hospitals; building infrastructure (2, 3, and 4-bed rooms with shared bathroom); and government micromanagement of the LTC sector were all deployed repeatedly as reasons for continued confinement of LTCF patients as well as mass deaths across LTCFs in Ontario.

Donna Duncan (CEO of OLTCA) was reported to represent the LTC sector as "micromanaged" and "over-regulated" by the provincial government (Riches, April 11, 2020). She is reported to want less regulation of and more flexibility for LTCFs, particularly regarding staffing and scope of practice. Duncan and other industry representatives are positioned as arguing for more emergency measures such as "increased screening and isolation for staff and new residents"; "redeployment of health ministry inspectors to help with urgent care"; "removing the requirement to report certain complaints to the ministry, and allowing homes greater freedom to hire workers at their discretion under looser training requirements" (Riches, April 11, 2020)

While industry representatives were reported to attribute mass deaths as due to external factors such as old building infrastructure, they were also reported to rely on this aspect to acquire further public resources. For example, Duncan is reported to have said that converting 4-bed rooms to 2-bed rooms will take away 4,300 beds from the system, which already has a waitlist of 36,000. Duncan and others are quoted as suggesting the Province of Ontario consider converting unused buildings like hospitals, hotels, and arenas to build more LTCF beds (Blackwell, June 26, 2020). LTC industry representatives are also presented as arguing that the federal government should provide access to "existing federal infrastructure dollars" such as allowing LTCFs to access funds through the national housing strategy and for LTCFs to be

placed at the top of "shovel-ready" projects so that they will be more likely to get federal and provincial stimulus dollars to build new LTCFs and "modernize" existing ones (Wright, July 23, 2020).

Doctors:

The perspectives of doctors were elicited eleven times in the reviewed articles. Doctors have an authoritative position on matters regarding aging (biomedicalization of aging and LTCFs as part of the Health Care Sector) as well as mass deaths in LTCFs which are almost all attributed to the COVID-19 virus. Similar to political representatives and policymakers, doctors were presented as largely concerned with managing the population in the hopes of reducing hospital admissions from COVID-19 infection. While some concerns presented by doctors analyzed social structural issues or even errors in judgement on the part of political leaders and medical officers (e.g., the impossibility of physical distancing in LTCFs, homeless shelters, and prisons and the admission that hospitals were not the front-line of the pandemic), even here the conclusions generally came back to the technical management of individuals through hegemonic pandemic policies. For example, one doctor was quoted as saying: "'Our method of protecting ourselves and the public from being infected is social distancing', he said. 'And if you can't social distance . . . you're just inviting disaster to strike" (Warnica, April 25, 2020).

While assumed to be objective and value-neutral sources, doctors also depict patients in LTCF and also, recipients of home care, as overwhelming or having the potential to overwhelm the public healthcare system (Jeffords, October 2, 2020). This was most obvious in one feature (full page) article in the final authoritative quote from a doctor who framed LTCFs as potential sources of contagion: "There are people who go and work there [LTCFs]. And if we can't protect the health-care workers, then almost certainly we're not protecting the health-care workers

families and therefore we're not protecting the public that is in contact with the health-care worker and their families and therefore we're not going to be able to get a hold of whole problem." (Warnica, April 25, 2020). Solutions attributed to doctors largely included widespread "social" distancing among the entire population, reducing the number of patients/room in LTCFs, improving home care services and working conditions, restricting visitors to LTCFs, and the creation of field hospitals where infected patients can be treated.

Workers and their Representatives:

LTCF Workers and their representatives (in the form of union representation) were featured speakers only four times. Perspectives from LTCF workers such as PSWs (which are the highest proportion of staff across LTCFs), health-care aides, or nurses were minimal with only one worker interviewed who wanted to remain anonymous. All other speakers in this category were union representatives. Overall, workers and their representatives were presented as framing staffing shortages and low staff-to-patient-ratios as a problem pre-pandemic which was then exacerbated once infections started to rise among staff (Dawson, November 10, 2020). Structural issues pertaining to workforce such as staff having to work in multiple homes in order to make enough money were cited as common experiences among LTCF workers due to low pay and also inability to get full-time employment at any one facility (The Canadian Press, April 18, 2020).

LTCF workers and their representatives were presented as calling for "historic investments in human resources with more front-line staff, more full time employment, and increased universal wages, benefits, and pensions for all PSWs" (McQuigge, August 7, 2020). They also called for the Ontario government to reverse emergency COVID-19 policies such as

wage freezes and ability for government to deny or cancel vacation requests (McQuigge, August 7, 2020).

Families of LTCF Residents:

The perspectives of LTCF patients' families were included eight times and often positioned in opposition to LTCF owners, managers, and administrators (or the company as a whole). For example, in news stories focussing on COVID-19 outbreaks in LTCFs, questions from families often pertained to a lack of communication on what was going on inside the facility (e.g., phone calls not being answered or returned), exactly how many people were sick or infected, and the status of their loved one (Duffy, April 14, 2020). Families were presented as worried at the quality of care their loved one was or was not receiving, especially with visitations being banned given that family caregivers often do the work of the LTCFs: "I would help feed her. I would help her go to the toilet. I would help her get dressed if she needed to, or would put her to bed." (Thompson, July 27, 2020).

The other major complaint presented from families was the damage caused by prolonged isolation on their loved ones in LTCFs, that visiting restrictions were unsustainable, and that LTCFs were interpreting public health guidelines too narrowly which was said to have a deleterious impact on their loved ones' health (e.g., physically distanced visits while wearing masks was reported as confusing or distressing for both patient and family member). For example, families were presented as viewing the visiting restrictions at LTCFs as inappropriate which was most obvious in the following quotes: "I think that my father's visits with my mother are keeping her alive. Her seeing him is keeping her will to continue on"; "I am quite dismayed that interacting by just looking at one another through a window is not permissible when these people are so very, very isolated and really see no one but caregivers" (Payne, April 30, 2020).

And, “Her world is becoming smaller and smaller because for four months, she’s always in that home.” (Thompson, July 27, 2020).

Importantly, in news stories that involved complaints from families of LTCF residents, the main problems were explicitly toward the facility administrators or company and not toward any individual front-line worker. In multiple instances, quotes from families were included that explicitly praised LTCF workers for trying their best in very difficult circumstances. For instance, the daughter of a man who died during a LTCF COVID-19 outbreak was quoted as saying: “I cannot put any blame on the staff. I think they did all they could. I admire them for even keep coming in. It would be very scary. They have families of their own, Heaven forbid they infect them as well” (Humphreys, April 14, 2020)

Proposed solutions said to come from family members included higher pay and better working conditions for LTCF workers. In only one news story, a family member was quoted as calling for an end to for-profit care, noting that Sienna (where his family member is instituted) paid $15 million in dividends to shareholders during the first four months of the pandemic (Payne, June 6, 2020). This was the only instance in which the profit incentive was noted as a problem in LTC in the articles reviewed.

LTCF Residents:

In only one of the articles reviewed were LTCF patients’ perspectives elicited and four LTCF patients were quoted in one article (Casey, October 5, 2020). Older adults who have been placed in LTCFs are at the intersection of multiple entanglements such as family relations/arrangements; institutional workplace arrangements, training, policies, and procedures; medical categories and prescribed products; and broader political economic arrangements such as how LTCFs are funded, operated, and monitored. In the one news article whereby patients

were speakers, LTCF patients were framed as emphasizing the mental, emotional, or psychological effects from prolonged isolation which, they said, needed to be immediately addressed and prevented from happening again given the torment of a looming second wave of COVID-19 infections. Residents were quoted as feeling "lonely, depressed, muzzled, and trapped." Residents were reported as saying they were confined to their rooms for so long they did not know what day it was, if it was day or night, and felt utterly confused and disoriented. One resident was quoted as describing two medication mix ups due to staffing inconsistencies. Residents described the problems as stemming from a lack of activity and stimulation which, left residents eating "soggy meals alone in their rooms,", "dormant and sleeping all the time. . . watching endless television". In the single newspaper article that included the voices of LTCF patients, only one response on how to improve conditions in LTCF was included and that was that better treatment of staff will lead to better quality of care. Importantly, this story was titled, "Care-home residents tell of virus's impact" (Casey, October 5, 2020). This has the effect of reducing all harm experienced by LTCF patients as due to an external cause—a virus—and not to the actions of any individual people (e.g. setting and implementing pandemic policies).

The COVID-19 virus is explicitly framed as the problem in LTC in the Ontario Long-Term Care COVID-19 Commission mandate and final report which severely limits its scope. To illustrate, in the final report the mandate was presented as investigating "the cause of the spread of the virus in long-term care and how it affected residents, staff, volunteers, and family members" (p. 8). Again, this means that long-standing and systemic problems in LTC leading to mass deaths in LTCFs are rationalized as due to an infectious disease rather than the interaction effects of biology and social arrangements and living conditions.

Advocates for Older Adults:

Advocates for older adults were featured speakers in the newspaper articles on nine occasions. Advocates were often lawyers, executive officers at senior advocacy organizations, or in two cases, long time health care and social workers for older adults. Advocates were often positioned as responding to recent government announcements and interventions in LTCFs (usually analyzed as inadequate or even harmful) or in response to actions of LTCFs themselves. Where a news story covered issues of abuse or neglect of LTCF patients, advocates were reported to claim these problems have been documented and brought forward many times. For instance, Jane Meadus, a lawyer with the Advocacy Centre for the Elderly was quoted as saying in response to the CAF report "these are the kinds of complaints we hear all the time. . . on a daily basis"; "similar issues could be found in the governments own inspection reporting system" (Payne, May 27, 2020)

Advocates quoted within the articles framed the provincial system of inspection and enforcement as ineffective and staffing levels as inadequate so that care is dangerous. Some advocates, such as the Royal Society of Canada, commented that there are **"**Systemic and deeply institutionalized implicit attitudes about age and gender," within the LTC sector and LTCFs, however, this was not elaborated on (Lowrie, July 4, 2020). Advocates were also reported to claim that banning family visits had drastic impacts not only from less interaction and engagement but also because families routinely perform care that facilities fail to deliver (even though LTCFs are described as providing 24/7 care and patients are paying to be there on this basis) (Payne, May 27, 2020).

Overall, problems articulated by advocates include: LTCF in Canada have allowed staff-to-patient ratios to drop and shift to unregulated workforce even while patients are living longer

with more complex conditions; unregulated workers receive the lowest wages in health-care sector; LTCF workers are given variable and minimal formal training in LTC provision, and rarely part of decision-making about care for residents; proportion of nurses in LTCFs have fallen; many residents lack access to comprehensive care like medical, social, and therapeutic; authorities have failed to listen to residents and their caregivers—both of whom are predominantly women; and finally, women are more likely to be LTCF patients' unpaid caregivers to fill gaps in the system.

Advocates were reported to propose the following solutions to problems in LTC in Ontario: national standards for staffing and training and make provincial funding contingent on meeting standards and training; systemic data collection on matters pertaining to resident quality of life, care standards, and worker satisfaction; have data analyzed by a third-party taking into account disparities based on race, ethnicity, gender, poverty, and other vulnerabilities; implement an effective inspection and oversight system; provinces to immediately implement appropriate pay and benefits including sick leave especially for direct-care aides and PSWs; ongoing training and mental health support for workers; and offering fulltime work rather than having staff work piecemeal at multiple facilities.

Members of the Public:

Members of the public were speakers in newspaper articles six times, three of which were letters to the editor and the remaining three were community members interviewed in Bobcaygeon, the small town in Ontario where the Pinecrest Nursing Home is located (where, as of August 29, 2020 29 out of 65 patients died—see Riches, August 29, 2020). The community in Bobcaygeon (home to Pinecrest LTCF) was reported to have fundraised to provide workers with gift cards for groceries and gas and to support mental wellness counselling for front-line workers

and local residents at Pinecrest (Riches, April 11, 2020). One community member was reported to be volunteering to deliver groceries to local seniors in community and community organizing to donate tablets to remaining residents at Pinecrest to video call with families (Riches, April 11, 2020). Residents of Bobcaygeon were reported to have fundraised to have music therapy at Pinecrest for staff and patients in order to help heal from stress and trauma (Riches, August 29, 2020).

In addition to the above articles, in the three letters to the editor, the writers made moral calls to take care of elderly people as we want to be cared for in old age. Also, two letters explicitly reframed the problems in LTC in Ontario as institutionalization itself: "congregation and regimentation does not enhance well-being at any age. Research shows that people's health tends to decrease after they enter a nursing home" (Lord, July 2, 2020); and "The institutional model itself is the problem regardless of room capacity, and no incremental improvements will cease the difficulties that institutions create in the field of care for others" (Cartan, July 2, 2020) Importantly, the letters to the editor are the only occasion in which institutionalization of older adults is questioned, rather than discussing ways to make it better. Exploitation of workers and caregivers are also mentioned as leading to substandard care in one of the letters to the editor (Lord, July 2, 2020). Solutions presented by members of the public in the letters to the editor include deinstitutionalization, creative living arrangements, more robust homecare to support aging-in-place, small and local LTCFs (not based on profit-model), and above all the principle that we care as we want to be cared for in old age.

Discussion

i. Speakers

Politicians and policymakers as well as doctors tended to be the main speakers in articles that spoke authoritatively about the virus and virus protocols, particularly case and death numbers and the repetition of infection control, "social" distancing, PPE, and testing. Articles discussing other aspects of LTC in Ontario such as concerns regarding prolonged isolation of LTCF patients, profit incentives, and how to heal from deadly outbreaks, tended to position families, industry representatives, members of the public, advocates, or workers and their representatives as speakers. Of note is that discussions of case and death numbers and universal precautions such as use of PPE, "social distancing", and isolation of LTCF residents largely put forward by politicians and policymakers were presented as unquestionable, self-evident, or objective. This was accomplished largely through repeated reference to these measures across articles and without any counter-speakers or counter-concerns. For example, articles which featured politicians, policymakers, and doctors as speakers rarely included other speakers which countered their naming and framing of problems in LTC (see for example Thomson, April 14, 2020; Platt, April 16, 2020; The Canadian Press, April 17, 2020; Platt, April 17, 2020; Kirkey, October 13, 2020; Banerjee, October 29, 2020; The Canadian Press, November 12, 2020). However, articles which featured concerns of family members regarding banning or limitation of visits and the effects on care provision (Payne, April 30, 2020; Thompson, July 27, 2020) or the management of LTCFs (Payne, June 6, 2020) were presented with more ambiguity through the inclusion of other stakeholders or aspects of LTC which were positioned as countering the concerns of families, especially LTC industry representatives and facility administrators. This has the effect of presenting the concerns of families and advocates as subjective and debatable

while the naming and framing of problems by politicians, policymakers, and doctors was presented as objective and unquestionable.

This is important because the provincial and federal governments in Canada are only assessing effectiveness of pandemic policies on the basis of ICU admissions and the concept of 'flattening the curve' (which essentially measures the number of infections and rate of hospitalization to make predictions about whether the medical system will have enough capacity in terms of ICU beds and medical supplies). This has led to an obsession with case and death numbers which, while seemingly objective, may in some cases be meaningless and obscure other very important indicators of public health (Justice Centre for Constitutional Freedoms, 2021). For example, some important factors pertaining to public health that were omitted from the data I reviewed include the social determinants of health (Raphael, Curry-Stevens, & Bryant,2008),previous cuts to health care funding including hospital beds (Ontario Health Coalition, 2019), and the relationships between isolation, morbidity and pre-mature death, especially among LTCF patients (Diamantis, Vignier, & Mallier, 2020; National Academies of Sciences, Engineering, and Medicine, 2020).

Similarly, because there were 26 different authors in total (out of 38 articles in total), coverage of LTCFs in Ontario during the COVID-19 pandemic was inconsistent with issues rarely being explored in-depth or followed up on. This also relates to style of report. For example, only three of the articles were full-page or feature stories whereby there is adequate space and opportunity to explore issues in LTC leading to mass deaths. Two of these stories were authored by the same person (Samuel Riches, April 11 and August 29, 2020) and included follow-up of one LTCF (Pinecrest Nursing Home) in a small town in Ontario (Bobcaygeon). However, the second article did not follow up on key issues highlighted in the first article, such

as whether the severe and dangerous staffing shortage had been resolved. Additionally, the three letters to the editor inevitably provided some consistency in that they were featured as public responses to previous news articles written on the topic of LTC in Ontario, but these were also rare and limited to a few short paragraphs. The inconsistency in reporting and the absence of follow up reports or feature stories exploring issues in LTC contributes to crisis construction as LTCFs tend to only be reported on when there is a major scandal (event-bias) (Nussbaum et al., 2000). Context for the scandals or follow-up on what is being done is not provided for readers, something that contributes to ignorance surrounding the daily operations and management of LTCFs and the implications for those confined therein. Even the release of the CAF report (Taylor, 2020) became an event to be reported on, rather than an opportunity to explore long-standing issues in LTC.

Regarding the various stakeholders in LTC (industry representatives, government, patients, patients' families, advocates, LTCF workers), what is significant is the exclusion of LTCF patients' voices themselves. Despite coverage often being about scandals in the institutions in which they live, patients were not included in the vast majority of news reports. This is consistent with the literature whereby a plethora of individuals and groups position themselves as speaking and acting on behalf of or in the best interest of older adults (the government, the LTC industry, physicians, social workers, workers, advocates, and even families) while older adults themselves are denied their fundamental human and citizenship rights (Charpentier & Soulieres2013; Doron, 2003; Allen & Ayalon, 2021; Macleod, 2019).

Importantly, with the exception of the two letters to the editor (Lord, July 4, 2020; Cartan, July 4, 2020), and one news article (Jeffords, October 2, 2020), all speaker groups, including LTCF patients, were presented as calling for more LTCF staff, better pay for frontline

staff such as PSWs, and more beds (less crowding). While advocates were presented as calling for more conditions of this expansion (e.g. more inspections, regulations, and evaluations), this essentially means an expansion of the LTC sector through more public dollars. This is the same process that Daly (2015) outlined in her examination of the historical development of LTC in Ontario whereby incredible safety violations were the impetus for reforming and reorganizing LTC. However, the reorganization of LTC in the name of patient safety actually resulted in the further consolidation of for-profit 'care'. Similarly today, the naming and framing of problems resulting in patient deaths impacts how the problem is treated. Rather than a failure of care on the part of the facilities, 'care' companies, and government health sector, large-scale deaths of LTCF patients is actually re-framed in order to secure more public resources and therefore expand the sector (arguably putting more people at-risk through institutionalization—rather than less). The discourse in the articles examined frames the LTC sector as unsupported and even, victimized by government regulations. From a broader perspective, this illustrates how organizations and industries reproduce themselves based on ability (financial and social capital) to lobby government and persuade the public for more public funds and less oversight rather than serve (in this case, care for) the public (Daly, 2015).

ii. How are age(ing), care, and safety constructed across media accounts of LTC in Ontario and what are the implications?

Age(ing)

Regarding the social construction of aging, ageism has clearly played a large role in the pandemicization of society. The high number of deaths among older adults, especially in LTCFs in Canada, has fuelled the idea that older adults are more susceptible to dying from COVID-19. That is, that they have both 'driven up' death rates in Canada as well as the idea that they need to

be confined for their own safety. When the nature of congregate and institutionalized settings for older adults is questioned, their existence is justified on the grounds that, similar to the measures taken for COVID-19, there is no alternative.

In the newspaper articles examined, older adults are represented as driving up case, infection, and fatality rates. Characterizing sickness among older adults generally (those 65 and older) as overwhelming the health care system is ageism by another name and aligns with apocalyptic demography—the idea that older adults are disproportionately driving up costs of public services (Calasanti, 2003, 2020; Wister, 2019). While older adults seem to be presented in a sympathetic light (e.g., as vulnerable), they are ultimately not represented at all except for the problems being caused by their existence (i.e., unable to control the virus or bring down case and fatality rates and hospitalizations). Also of significance is that the label of "vulnerable" for older adults is used, not to articulate their social location, but to reinforce the idea that older adults are inherently weak and in need of protection. This is most obvious where the framing of age is an independent variable for severe outcomes from COVID-19 infection—age alone is presented as a risk factor rather than the living conditions of older adults.

Significantly and with editorial support from Denley, older adults institutionalized in LTCFs are presented as inevitably sick. This has the effect of naturalizing or depoliticizing health ailments of older adults. Importantly, this leaves no room for the possibility of iatrogenesis such as ADR which, as discussed in the literature review, given the costs alone, warrants public attention, awareness, and scrutiny. Given the naturalized association of an aging population with high health care costs already predominant within public discourse, serious work directed toward the public (i.e. not other academics) needs to be done to clarify the associations or lack thereof between age(ing), medical services, and ill-health with an emphasis on the social

determinants of health and iatrogenesis. Public ignorance of the social determinants of health amidst widespread claims that older adults are a burden to the public health system and society at large aligns with not only apocalyptic demography but also eugenics discourse. This is dangerous as eugenics is not only about who can reproduce (sterilization), but also the idea that certain members of society are burdensome or degenerate and therefore, are undeserving of resources or the necessities of life (Ferrari, 2018).

The Eugenics movement gained prominence in the USA and Canada in the 1920's. Headed by leading medical and scientific 'experts' who were able to mobilize political support and resources, the systemic elimination of 'undesirable' groups (poor whites, racialized peoples, and those labelled 'disabled' or 'feebleminded') via medicine (sterilization) was actually framed as benevolently and progressively reducing social costs and became an institutionalized part of public health's mandate and legal purview (Ferrari, 2018; Martinez, 2019). Importantly, and similarly to the eugenics movement, the longer older adults are confined and labelled as weak, burdensome, or useless, the more likely that ideologies against their existence may take hold. In fact, this can already be observed in popular references of older adults as "bedblockers" (Latimer, 2018; El-Bialy et al, 2021) and in the context of COVID-19, the celebration of the "culling of elderly dependents" through popular hashtags such as "#BoomerRemover" (Previtali, Allen, & Varlamova, 2020, p. 508). Given the ill-health effects on particular social groups who have long been regarded as inferior, historically informed research examining eugenics discourse over time in regard to older adults is also needed in order to have an informed public response on the historical, economic, political, and social functions of public health campaigns and measures on society.

Care

Maintaining that age is a risk factor for severe outcomes including death as a result of COVID-19 infection leads to widespread acceptance of confining older adults most clearly manifested in Ford's concept of an "iron ring" around LTCFs. In this way, care is equated with confinement and to not confine older adults (in LTCF where older adults are already confined, this means confining patients to their rooms and banning visitations from loved ones) is thus a failure of care. Therefore, care is actually used as a rationale for essentially, neglecting older members of our society. Care was thus framed solely in medical terms which among older adults and the public at large has led to highly invasive treatments (medically-induced comas, sedatives, and ventilators) with poor outcomes and low survival rates. Families, advocates, and members of the public were quoted to have raised concern over other aspects of wellbeing such as love, inclusion, and social interaction, however these were not featured in the more authoritative news reports which cited seemingly objective facts and solutions such as case and death rates, social distancing, and isolation.

Across newspaper articles care was portrayed as following pandemic rules and orders even at extreme costs to LTCF patient well-being. Despite the inherent problems with LTC being made painfully clear via the CAF Report, treating care as a publicly and privately traded good/community was rarely named as problematic. At one point, Doug Ford was quoted as speaking to shareholders in LTCF chain companies and warning: "if you buy a stock, you have to do your due diligence to make sure the product is good." (Tumilty, May 29, 2020) This warning, combined with Ford's reported insistence that his government is going to fix a "broken system" at first seem that he is actually addressing the root of the problem. However, on closer reflection the system of for-profit care for arguably the most vulnerable members of our society

was reinforced by indicating that care and safety are achievable in a shareholder system so long as there are adequate regulations and standards.

The bureaucratic profit-based management of people's lives (older adults in LTCFs) is never flagged as problematic and the coercive nature of service providers simultaneously assessing competence and forcing treatment (as evidenced by the criteria for admission to LTCFs as well as guardianship cases from Ontario's Consent and Capacity Board) is naturalized as unproblematic or inevitable (Doron, 2003; Ontario Long-Term Care Homes Act, 2007). Even when widespread neglect and failures of care as documented by the CAF were reported, LTCFs were still characterized as acceptable on the grounds of an aging population and expected concomitant rise in dementia. At most, LTCFs and abuse of patients (in some cases leading to death) were presented as tragic (unfortunate but inevitable). Future research aimed at exploring and documenting the relationships between assessments of competence and treatments (care) among older adults will be useful to determine if and to what extent there are conflicts of interest between assessors of competence and service providers and the consequences for patients, including iatrogenic harm.

Safety

Safety was generally equated with predominant infection control measures such as physical distance (often incorrectly referred to by politicians and policy makers and public health experts as "social" distance). In one particular conflict reported on between Ottawa municipal LTCFs and residents' families, window visits were banned out of concern for physical distancing (it was not clarified whether this was for patients inside or families outside) and although described by families as "heartbreaking" for the Ottawa Director of LTC, this rule was carried out in the name of "prioritizing safety and health of residents and staff" (Payne, April 30, 2020).

Consistent with the literature on LTCFs and risk, quality of life of patients is sacrificed for short-term risk aversion for the facilities and the sector at large (Tufford et al, 2018). From the data reviewed, even once facilities were given the green light from provincial health authorities to allow visitation, families reportedly were still kept at a distance from their loved ones to the point where the patients may not have been able to recognize them or interact. Given that LTC operates as an industry, for purposes of public relations, facilities routinely compromised quality of life of patients (including the freedom to see and visit with loved ones) in order to declare or attempt to declare a COVID-free status or low case counts.

Connecting with discourse around aging, depicting institutionalized older adults as more vulnerable solely based on their age omits any discussion of whether pre-existing safety issues within LTCF contributed to high death rates. While having more than one person to a room was cited by LTC industry representatives as an infrastructural issue (with significant editorial support for this aspect), no mention was made of the ill-health effects of polypharmacy or the routine use of physical and chemical restraints (which can both compromise immune and other bodily systems from fully functioning).

In response to the litany of complaints and lawsuits alleging abuse and neglect leading to mass deaths in LTCFs, staffing has become framed as the main problem and safety was usually framed in terms of worker safety. Worker safety and protections are equated with patient safety, however, in at least some cases, worker safety cannot only lead to patients being unsafe, but also patients having no legal recourse for harm endured, given their daily dependency on their custodians. To illustrate, while numerous politicians were reported to have lobbied Ford to call an inquiry, The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (which was completed in July 2019, only one year ago), was never once

mentioned in the newspaper articles reviewed for this research over an eight month period. The purpose of this 2019 inquiry was to determine how a healthcare serial killer, Elizabeth Wettlaufer, killed at least eight people under her 'care' as registered nurse between 2007 and 2016 across a number of LTCFs in Ontario and went undetected until she voluntarily confessed in September 2016 (Gillese, 2019). In June 2017, Wettlaufer was convicted of eight counts of first-degree murder, four counts of attempted murder, and two counts of aggravated assault by intentionally overdosing her victims with insulin. The inquiry documents how all murders of Wettlaufer went undetected and uninvestigated as patient deaths were never deemed suspicious—they were regarded as old and frail.

While all the details of this particular healthcare serial killer cannot be detailed fully here (see Gillese, 2019, Vol II), the main issues pertaining to patient safety and security generally include: their near total-dependence on staff for their daily survival; staff are protected from liability for harm whether intentional or non-intentional due to worker protections and/or the higher legitimacy and credibility given to workers *vis a vis* residents and their families (especially when there is a cognitive impairment diagnosis); and that deaths in medical institutions are less likely to be investigated given the assumed ill-health of patients as well as unspoken allegiance and comradery among health care workers and coroners or attending physicians. While LTCF owners, shareholders, administrators, managers, and workers have recourse to legal protections from liability (although there is a hierarchy of protections), older adults who are institutionalized are not only often physically but also legally powerless to protect themselves from unwanted 'care', 'treatment', or in the case of Wettlaufer, aggravated assault and homicide. In this sense, in their very structure, LTCFs are unsafe as they are based on threats, restrictions, and violations of life and liberty (Doron, 2003; Laundry, 1999; Ontario

Long-Term Care Homes Act, 2007). Therefore, it is important to note that there is not a linear relationship between staffing and patient safety. While inadequate number and ratio of staff, minimum hours of care/LTCF patient, and differences across public and private facilities have been flagged as the main issues affecting quality of care in LTCFs, the power dynamics between staff and patients has not been addressed and is thus, obscured by calls for more staff and better staffing.

The extent to which previously documented problems pertaining to patient safety in LTCFs such as the 2019 Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System were omitted in news reports indicates willful ignorance. The Sociology of Ignorance should be drawn on in future research to analyze this phenomenon. As an important subset of the Sociology of Knowledge, an emphasis on ignorance highlights both intentional and unintentional ignorance, as well as the consequences for ignoring facts and evidence (McGoey, 2012). This highlights the politics of knowledge, and the ways in which ignorance can be used as a political tool or strategy, thereby obscuring facts, liability, accountability, or the alternative, perhaps more socially effective implementation of changes based on robust evidence and strong knowledge bases. Ignorance is not just "not knowing", but the willful choice to ignore available knowledge or the willful denial of knowledge. Therefore, future research ought to examine the social role of ignorance in the government, industry, media, and academic discourse on LTC in Ontario.

Despite the long-standing documented problems with institutionalization, it remains widely practiced and accepted as a response to an aging population, legitimated and authorized by medicine. Institutionalization is profitable and subsequent crimes against the elderly may best be investigated through Zemiology. While criminology often assumes crimes to be inter-

personal, Zemiology focuses attention on structures resulting in social harm (Hillyard & Tombs, 2017). Given the difficulty in pin-pointing exact perpetrators in crimes embedded in bureaucratic organizations and industries, Zemiology offers a promising approach. Importantly, an aging society has been capitalized on and exploited by, especially, transnational corporations, aided by government policies. Resultantly, older adults are reduced to cash cows without few if any, forms of redress. A Zemiological approach to understanding the social construction of aging and subsequent treatment of older adults in society may contribute to elder justice and intergenerational solidarity.

Finally, how care and safety are depicted in the context of the COVID-19 pandemicization of society is largely dependent on how the threat (in this case, the virus) is named and framed. While the virus was often personified and mystified in the data collected for this research, this was not systematically analyzed as part of the project. Future media analyses which deconstruct the naming and framing of the COVID-19 virus *vis-à-vis* medical and epidemiological research will be useful. Public perceptions of the causes of ill-health have long been impeded through advertisements based on health claims to sell products in general and the medical industry in particular. The mainstream media presents medical knowledge on COVID-19 as consensual, however, the extent to which COVID-19 is novel, its level of infectivity and virulence, the effectiveness of established and proposed treatments, the co-morbidities, antibodies evidence, and prognostics are all highly contested both within and outside of medicine. Future research is needed to determine the relationships between how the virus and pandemic is named and framed and how this shapes our public responses.

Chapter 6: Conclusion

My MA research was a critical discourse analysis of media representations of LTC in Ontario during a time of tremendous societal upheaval and change, perhaps not seen in Canada since World War II. Indeed, as with other crises or state of emergency (whether real or perceived), the characterization of the threat to the public (i.e. the naming and framing of problems and potential solutions) in the mass media has the potential to and often influences public perceptions and future policy directions. Given the large proportion of LTCF patients who have died since the declaration of the pandemic, attention to the discourse surrounding the crisis after its official pronouncement is of significance toward understanding what happened and to what effect, specifically, for older adults. My research was focused on LTC in Ontario as a topic or case study, to investigate how age(ing), care, and safety (central concepts in the discourse on the COVID-19 pandemic in Canada) have been constructed and the implications of these construction for an aging society, where nearly all of us will provide care to someone in old age, require this care ourselves, or both. Consistent with all CDA, my research also considered broader context including: the pandemicization of society (presence of virus/pandemic but also effects of pandemic policies); the social determinants of health, especially *vis-à-vis* pandemic policies, largely based on individual-level social control; the political economy and medicalization of ageing; previously documented issues within LTC in Ontario regarding patient care and safety; and finally, theoretical models of policy-formation with specific attention given to the role of mass media representations in shaping public health policy and campaigns.

While it is often remarked that COVID-19 has revealed or made undeniable the long-standing problems with LTC, I also explore in my research what the situation in LTC teaches us about the pandemicization of society or the naming and framing of threats to public health. These

considerations have been brought to the forefront, if only tacitly, in the tensions over cause of death in LTCF patients from families in Ontario and across the country and also academic work questioning the effects and intentions of the ongoing pandemic policies. In these regards, I drew heavily from the fields of social gerontology, sociology of health and illness, and medical sociology with particular emphasis on iatrogenic harm.

In short, the mass deaths across LTCFs in Ontario, along with similar patterns happening across Canada raise questions about two important phenomena in our society: The first is regarding the status and prospects of older adults in an aging society. Pandemic policies have largely not ceased and older adults continue to be confined, isolated, and in some cases neglected both inside of LTCFs, but also in the community. Second, questions regarding cause of death of patients in LTCFs also raise questions about the COVID-19 pandemic itself. This includes not only testament of harm endured by LTCF patients and witnessed from LTCF patient families, but also within medicine a lack of consensus on the etiology, epidemiology, infectivity, virulence, and largely, how the pandemic is being named and framed by government and mainstream media—hence my use of the concept pandemicization (Rimke, 2021). While this research explored the functions and implications of mass media discourse on LTC in Ontario during the (ongoing) COVID-19 pandemic, more detailed analysis of effect necessarily involves engaging directly with consumers of this particular news media (Nussbaum, 2000). As previously mentioned, consumers of news media are not passive sponges absorbing all aspects of media reporting but rather, interpret using various tools, experiences, and prior knowledge at our disposal (Gouldner, 1970). Additionally, since there are large media monopolies with a single company owning multiple media outlets and also buying and selling news from other media companies, one cannot say with precision who exactly is consuming any given media report,

under what conditions (time and place), and to what effect. Therefore, this research focussed on the text itself and its function in and interaction with a particular social context rather than commenting specifically on how any individual reader interprets or acts on media reports. Future research could focus on how media consumers interpret the texts analyzed in this research.

Additionally, numerous aspects of newsprint articles can be analyzed, many of which were beyond the scope of this study. For instance, data could have also been analyzed in relation to other articles and headlines on the same page. Scanning through the pages for relevant articles, I could not help but notice certain patterns (e.g. articles reminding the public of pandemic rules or thanking essential workers and thus framing what essential work is or is not), but I did not analyze these aspects systematically or in detail. Similarly, photos and images accompanying or on the same page as the articles under scrutiny were not analyzed here but could be included in more robust media analyses. Finally, future research could include searches across national newspapers (e.g. the Globe and Mail) to produce more generalizable results.

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Appendix A: National Post Newspaper Articles Reviewed

1. Brean, J. (2020, March 31). Most vulnerable are not protected. *National Post,* pp. A1, A16.
2. Cicero, E. (2020, April 4). Protecting the elderly. *National Post,* pp. A17.
3. Riches, S. (2020, April 11). A crisis crept up on Pinecrest. *National Post,* pp. A4
4. Thomson, S. (2020, April 14). Nursing Homes 'driving' death toll. *National Post,* pp, A1, A4.
5. Humphreys, A. (2020, April 14). 'I'm scared, it's exhausting.' *National Post,* pp. A1, A6.
6. Duffy, A. (2020, April 14). Death toll reaches 16 at 82-bed facility near Ottawa. *National Post,* pp. A6.
7. Gurney, M. (2020, April 15). Carnage in Care Homes Foreseeable. *National Post,* pp. A1, A8.
8. Platt, B. (2020. April 16). Care-home deaths break the modelling forecast. *National Post,* pp. A5.
9. The Canadian Press. (2020, April 17). COVID-19 impact on nursing homes 'more severe' than expected. *National Post,* pp. A6.
10. Platt, B. (2020, April 17). Elderly home-care patients also face huge COVID-19 risk. *National Post,* pp. A8.
11. The Canadian Press. (2020, April 18). COVID-19 claims life of personal support workers in Toronto. *National Post,* pp. A10.
12. The Canadian Press. (2020, April 24). Ontario Long-Term Care 'needs to be changed'. *National Post,* pp. A5.
13. Denley, R. (2020, April 24). Long-term care crisis not due to greed. *National Post,* pp. A5.
14. Warnica, R. (2020. April 25). The hidden pandemic: social distancing impractical in care homes, prisons, and shelters. *National Post,* pp. A4.
15. Payne, E. (2020, April 30). Ottawa bans window visits at nursing homes. *Financial Post,* pp. A1, A4.
16. The Canadian Press. (2020, May 15). Nursing home hit hard by COVID-19 says outbreak over. *National Post,* pp. A5.
17. The Canadian Press. (2020, May 22). Armed Forces seconded to care homes, 28 test positive for COVID-19. *National Post,* pp. A5.
18. Denley, R. (2020, May 27). Ford is left to answer for 'horrific' price. *National Post,* pp. A5.
19. Payne, E. (2020, May 27). Military report describes nursing home horrors. *National Post,* pp. A1, A5.
20. Gurney, M. (2020, May 27). Call an inquiry. Now. *National Post,* pp. A1, A6.
21. Tumilty, R. (2020, May 29). Homes will be held accountable, says Ford. *National Post,* pp. A7.

22. Payne, E. (2020, June 6). Long-term care corporation fires executive. *National Post,* pp. A12.
23. Berthiaume, L. (2020, June 8). Troops could be called to testify in lawsuits. *National Post,* pp. A4.
24. Blackwell, T. (2020, June 26). How crowding killed thousands. *National Post,* pp. A1, A6.
25. Lowrie, M. (2020, July 4). Canada's Long-Term Care System failed elderly, report finds. *National Post,* pp. A7.
26. Lord, J. (2020, July 4). Reform care for the elderly. *National Post,* pp. A17.
27. Cartan, D. (2020, July 4). Reform care for the elderly. *National Post,* pp. A17.
28. Wright, T. (2020, July 23). Long-term care needs funds now: advocate. *National Post,* pp. A7.
29. Thompson, N. (2020, July 27). Indoor visits at care homes stymied by strict rules. *National Post,* pp. A4.
30. The Canadian Press. (2020, July 30). Commission to look at COVID-19 effect on Long-Term Care. *National Post,* pp. A6.
31. McQuigge, M. (2020, August 7). Ford says PSWs are "grossly underpaid." *National Post,* pp. A7.
32. Riches, S. (2020, August 29). Bobcaygeon learning to heal through the power of music. *National Post,* pp. A3.
33. Jeffords, S. (2020, October 2). Ontario homecare providers push for expanded services to fight virus. *National Post,* pp. A8.
34. Casey, L. (2020, October 5). Care-home residents tell of virus's impact. *National Post,* pp. A3.
35. Kirkey, S. (2020, October 13). COVID-19 seeps back into nursing homes. *Financial Post,* pp. A1, A2.
36. Banerjee, S. (2020, October 29). Tam hoping to avoid another surge in long-term care deaths. *National Post,* pp. A7.
37. Dawson, T. (2020, November 10). Long-term care workers offered raises in March. *National Post,* pp. A6.
38. The Canadian Press. (2020, November 12). 29 dead in COVID-19 rest-home outbreak. *National Post,* pp. A7.

Appendix B: Speakers

(i) Politicians/ Political Representatives and Policymakers (33)

1. Prime Minister Justin Trudeau (4)
2. Theresa Tam (Canada's Chief Public Health Officer) (5)
3. Federal Seniors Minister Deb Schulte (2)
4. Federal Public Safety Minister Bill Blair
5. Ontario Premier Doug Ford (7)
6. Ontario Minister of Long-Term Carer Merilee Fullerton
7. Spokeswoman for Ontario Minister of Long-Term Care Gillian Sloggett
8. Ontario Health Minister Christine Elliott
9. Ontario Chief Medical Officer David Williams
10. Andrea Horwath (Ontario New Democrat Leader)
11. Haldimand-Norfolk Health Unit (Public health authority)
12. Ontario MPs (Judy Sgro, Gary Anandasangaree, Yvan Baker, Sonia Sidhu, and Jennifer O'Connell who each have one of the five facilities in their riding)
13. Jennifer O'Connell
14. Dean Lett (director of LTC for the city of Ottawa)
15. Counsillor Kathleen Seymour-Fagan (City of Kawartha Lakes Councillor) (2)
16. Lt. Stephany Laura (Military Spokeswoman)
17. Quebec Premier Francois Legault (2)

(ii) LTC Industry (11)

1. CEO of OLTCA Donna Duncan (4)
2. Chair of OLTCA Jodi Hall
3. LTCF Administrators/Managers (6)

-Dr. Mary Carr Administrator of Pinecrest (2)

- Lois Cormack (President of Sienna Senior Living)

- Howard Levitt (lawyer for All Seniors Care and Financial Post columnist)

-Sandy Lauder (Vice-President of Nutra 2000, management company for All Seniors Care

-Revera Public Statement

(iii) Doctors (11)

1. Dr. Jeremy Jones (Cardiologist at hospital near to Pinecrest Nursing Home) (2)

2. Dr. John Hirdes (University of Waterloo Professor, specializing in Geriatric health-care)
3. Dr. Andrew Morris (Professor of Medicine at University of Toronto)
4. Dr. Samir Sinha (Director of Geriatrics, Mount Sinai Hospital, Toronto) (2)
5. Dr. Naheed Dosani (Palliative care physician in Ontario who often works with homeless people)
6. Dr. Nathan Stall (Geriatriciain with Mount Sinai Health System and Toronto's University Health Network) (2)
7. Dr. Amit Ayra (Palliative care doctor and part of long-term rapid action response team)
8. Dr. Eileen de Villa (Toronto top doctor)

(iv) LTCF Patient (4)

1. Virginia Parraga (lives in LTCF in Toronto)
2. Barry Hickling (LTCF resident in Windsor for past ten years)
3. Carolyn Snow (lives in LTCF in Keswick, Ont.)
4. Sharon Cooke (President of Ontario Association of Residents' Councils and lives at LTCF in Newmarket, Ont.)

(v) Family Member of LTCF Resident (8)

1. Mena Stravato
2. Debra Cox
3. Rick Cox
4. Diana Pepin (mother lives at Peter D. Clark LTCF
5. Nancy Devonport (daughter of mother who is at Peter D. Clark LTCF)
6. Lorraine Thomas (87 year old husband lives at Peter Clark LTCF)
7. Anthony Manieri (sister lives in Sienna Woodbridge Vista Care Community)
8. Mary Oko (Mother is at LTCF);

(vi) Advocates for Older Adults (9)

1. Marissa Lennox (Chief Policy Officer at CARP)
2. Diana McNally (long time worker in Toronto homeless shelters)
3. Jane Meadus (Lawyer with the Advocacy Centre for the Elderly) (2)
4. Stephen Birman and Lucy Jackson (from Toronto law firm Thompson Rogers, leading lawsuit against Sienna)
5. Leighton McDonald (CEO Closing the Gap Healthcare)
6. Cathy Crowe (Nurse who has spent decades working with homeless people in Toronto)

7. Paul Champ (lawyer in Ottawa who sued federal government to have particularly vulnerable person released from prison)
8. Dr. Carole Estabrooks, Chair of Royal Society of Canada COVID-19 Taskforce report committee from University of Alberta

(vii) Member of the public (6)

1. Elizabeth Cicero (letter to the editor)
2. Aaron Shaw (local arborist and volunteer delivering groceries to elderly living in community)
3. John Lord (letter to the editor)
4. Douglas Cartan (letter to the editor)
5. Ann Adare (on board of BCRF)
6. Terry Stuart (Co-founder of Awesome Music Project)

(viii) LTCF Worker and Representatives (4)

1. LTCF worker who wanted to remain anonymous
2. Sharleen Stewart (SEIU Healthcare President)
3. Charlene Nero, (Director of Legal Department, Labourers International Union of North America, LIUNA, local 3000)
4. Candace Rennick (Secretary-Treasurer of CUPE Ontario and former PSW)